National Council for the Elderly

PROCEEDINGS OF SEMINAR

CO-ORDINATION OF SERVICES FOR THE ELDERLY AT THE LOCAL LEVEL

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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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FOREWORD

The National Council for the Elderly is an advisory body to the Minister for Health on all aspects of ageing and the welfare of the elderly. One part of its work is to advise on ways of ensuring better co-ordination between public bodies at national and local level in the provision of services for the elderly.

In 1992 the Council published *Co-ordinating Services for the Elderly at Local Level: Swimming Against the Tide,* an evaluation of two local area pilot projects on the co-ordination of services for the elderly. The findings of this evaluation report were outlined at a Seminar at the Carysfort Campus, University College Dublin on 12th November 1992, the proceedings of which are presented here.

On behalf of the Council I would like to express our thanks to the speakers for their thoughtful and informative contributions. I would also like to thank the Council's staff for compiling and editing these proceedings, in particular Ms Carol Waters for her meticulous work in transcribing recorded contributions.

Michael White,
Chairman.

WELCOME

Lady Valerie Goulding

As Chairman* of the National Council for the Elderly it is my great pleasure to welcome you to this Seminar on the *Co-ordination of Services for the Elderly at the Local Level.*

I know that the subject of co-ordination is not a very glamorous one. It is therefore most gratifying and encouraging that so many people from all parts of the country, as far away as Donegal and Kerry, have taken the trouble to come along.

Co-ordination of services for the elderly may be a diffícult issue but it is none the less of great importance, especially at times when resources are limited. Since 1985, when the Council's predecessor recommended the establishment of two pilot projects on the co-ordination of services for the elderly in its reports on *Housing* and *Institutional Care of the Elderly in Ireland,* progress has been made in developing structures to facilitate co-ordination in different parts of the country. Some of the recommendations of the chapter on co-ordination in *The Years Ahead* report are being implemented by some authorities. However, much remains to be done and it is our hope that this Seminar will provide further impetus to establishing an ethos of co-ordination in the country as a whole.

We are delighted that Mr. Kieran Hickey, Chief Executive Officer of the Eastern Health Board is able to be with us to chair the session this morning. A former member of the National Council and a member of the Working Party on Services for the Elderly which drafted *The Years Ahead* report, Mr. Hickey facilitated the establishment of the pilot project in Dun Laoghaire. We are most grateful for his commitment to the co-ordination of services for the elderly and for being with us here today.

Lady Valerie Goulding

•Lady Goulding is now the President of the National Council for the Elderly.

INTRODUCTION

Mr. Michael Coote

The Project Participants, Our Thanks

The evaluation report we are presenting and discussing today owes its existence to the dedication, tenacity, patience and "persistence-in-the-face-of-adversity" of over 100 people - the personnel who participated in the work of the project committees in Dun Laoghaire and Tipperary South Riding.

At the final stage of the pilot projects there were 89 participants involved in the two steering committees and six local committees which made up these projects. Of these, the voluntary sector accounted for 42 per cent, the health boards and local authorities a further 45 per cent

The personnel involved included a broad spectrum of health and social services professionals working at health board area or local level. Participants who invested much valuable time and energy in the projects included directors of community care, physicians, public health nurses, home help organisers, physiotherapists, occupational therapists, social workers, administrative officers and housing officials.

There were also many dedicated voluntary workers and representatives from general practice and the private nursing home sector involved.

The contribution of the project participants over a sustained period - four years in many cases, was very considerable. Moreover, it should be acknowledged that much of this contribution was in addition to the time and tasks of participants' ongoing professional work.

It should also be acknowledged, frankly, that these projects were set in train at a time of unprecedented cutbacks in public expenditure, when an embargo on the recruitment of staff at all levels was in force. In many instances services were being reduced.

This meant that the project participants were labouring under added pressures of work. They might well have thrown in the towel. But they did not. And for this we thank them.

Indeed such was the dedication of the many project participants in their spare time that many useful initiatives were set in motion. For example, three day centres were established under the auspices of the local committees and a number of housing associations were established.

The Purpose of the Seminar/Workshop

The learnings of the projects were explored both through the medium of an interim evaluation report and seminar in May 1989, and subsequently though a series of joint conferences involving all of the project participants.

Currently, the projects are completing their own reports which will deal with many specific issues to be taken up at area, regional and national level, and from which much more will be learned. It is hoped that these learnings will be given a thorough hearing at appropriate fora in the not too distant future.

The pilot projects were not National Council for the Elderly projects, though the Council commissioned the evaluation of them with their agreement. This was to determine what might be learned from the projects which would be of value in promoting co-ordination in the provision of services for the elderly in the country generally. The purpose of this Seminar is

therefore to focus on the analysis and conclusions of the independent evaluator's report and to discuss the issues raised in a wider context.

Those attending the Seminar at the invitation of the National Council for the Elderly have the privilege of "listening in" to the process and practice of co-ordination as experienced in Dun Laoghaire and Tipperary South Riding. They do so, not to go over these experiences in their concrete detail again, but to focus on the co-ordination issues of most importance for policy and practice and to stimulate discussion and thinking on this basis.

I think that it is fair to say that the subject of the report, and therefore of the Seminar, is not the individual successes or failures of the people who took part in the project - not at all. The subject, rather, is the successes or failures of the system of organisation under which the projects operated and the strengths or limitations of the philosophy which seems to underlie that system. As the report argues - the projects reveal the absence of an ethos of co-ordination at the highest level. This in turn hampers local co-ordination.

The Importance of Co-ordination

As I have already said, it is thanks to those who contributed so much to the pilot projects in Dun Laoghaire and Tipperary South Riding that it is possible to bring this issue into a wider arena here today.

The programme for the day and our efforts to involve as many people as possible from outside Dun Laoghaire and Tipperary South Riding in this Seminar are designed with this aim in mind: to highlight the issues of co-ordination in service provision for the elderly for a wider national audience.

Next year is the *European Year of Older People and Solidarity between Generations.* It provides an excellent opportunity to draw the attention of all sectors of society to the realities and challenges of an ageing society. I hope that during 1993 we will see particular efforts made to implement the recommendations of *The Years Ahead* report especially in relation to its chapter on co-ordination. *The Years Ahead* report made reference to the projects we are discussing today and looked forward to the publication of the evaluation of the projects. I earnestly hope that the valuable lessons of these projects can be translated, developed and implemented into a more concrete policy on co-ordination. It is not an easy subject either to grasp or to put into practice. But it is an essential aspect of policy development and we must therefore address it adequately.

PRESENTATION OF EVALUATION REPORT

Mr. Michael Browne

Introduction

This paper will present the main findings of the evaluation of the two pilot projects on the co-ordination of services for the elderly at local level. I will do this under four main headings.

First of all I will summarise the background, objectives and structures of the pilot projects. Secondly, the main outcomes of the projects will be outlined and discussed. Thirdly, the key factors arising out of the evaluation of the projects will be set out and, finally, the dimensions of service co-ordination and the related policy implications in respect of local co-ordination will be examined briefly.

Background, Objectives and Structures of the Pilot Projects

The pilot projects referred to were the first efforts in the Republic of Ireland at bringing together in a structured way different service-providing agencies - statutory and non-statutory, and in so doing they constituted a definite departure in the approach to service organisation at local level. They were located in the Dun Laoghaire Borough functional area and in the Tipperary South Riding County Council functional area. The projects were established jointly by the housing authorities and health authorities in the two project areas in the summer of 1987 - Dun Laoghaire Corporation and the Eastern Health Board in the case of the Dun Laoghaire Project and Tipperary South Riding County Council and the South Eastern Health Board in the case of the Tipperary Project.

The National Council for the Elderly drew up *terms of reference* for the pilot projects and acted as a catalyst in getting the projects established by the statutory bodies involved. The Council carried out an evaluation of the projects over the four-year period of their existence.

The objective of the pilot projects was the establishment of formal arrangements for the co-ordination of services for the elderly at local level. Local referred to local authority functional areas and health board community care areas which in many instances are co-terminous. The services for the elderly to be co-ordinated were those provided by the statutory bodies (local authority and health board) and those provided by the voluntary and private sectors.

Project Design

The design of the pilot projects provided for the establishment in each project area of:

(i) a project steering committee with a broad planning brief covering all aspects of services for the elderly in the catchment area,

(ii) district committees (referred to in the projects as local committees) for catchment areas of 15,000 - 20,000 population within the project area.

Composition of Committees

The composition of the steering committee provided for involvement of representatives of the range of agencies, disciplines and sectors involved in service provision for the elderly. This is illustrated in Figure 1 by the membership of Dun Laoghaire Project steering committee. Here

we have representatives of the housing and health authorities, representatives of the voluntary and private sectors and a consultant physician in geriatric medicine.

The composition of the local committees can be illustrated by reference to the core membership of the Tipperary South Riding Project local committee (See Figure 2). Here again there is health board representation, (public health nurses, community welfare officers), local authority representation and voluntary sector members. There are also general practitioners, gardai and family carers.

The project *terms of reference* set out a number of functions in respect of the project committees.

In the case of the project steering committees those were:

- the assessment of the housing, health and welfare needs of the elderly,
- the proposal of the programmes of action for parent bodies to implement,
- the identification of good practice elsewhere which could be emulated in the project area,
- the implementation of agreed joint programmes of action,
- the evaluation of programmes implemented,
- the establishment of and liaison with a number of local committees at district level with an action focus,
- the integration into the service delivery system of the private and voluntary sectors in the area.

Local Committees

The tasks assigned to the local committees were:

- improving co-ordination locally, (at district level)
- identifying local needs and resources,
- maintaining an up-to-date "at risk" register of elderly persons,
- evaluating the adequacy of existing service delivery mechanisms,
- advocacy on behalf of elderly clients,
- making recommendations to the steering committee on measures to improve services,
- offering consultation to local service providers.

The committee structure was put in place in the two project areas during 1987 and the projects operated to the end of 1991.

FIGURE 1

MEMBERSHIP STRUCTURE OF DUN LAOGHAIRE PROJECT STEERING COMMITTEE
1989 -1991

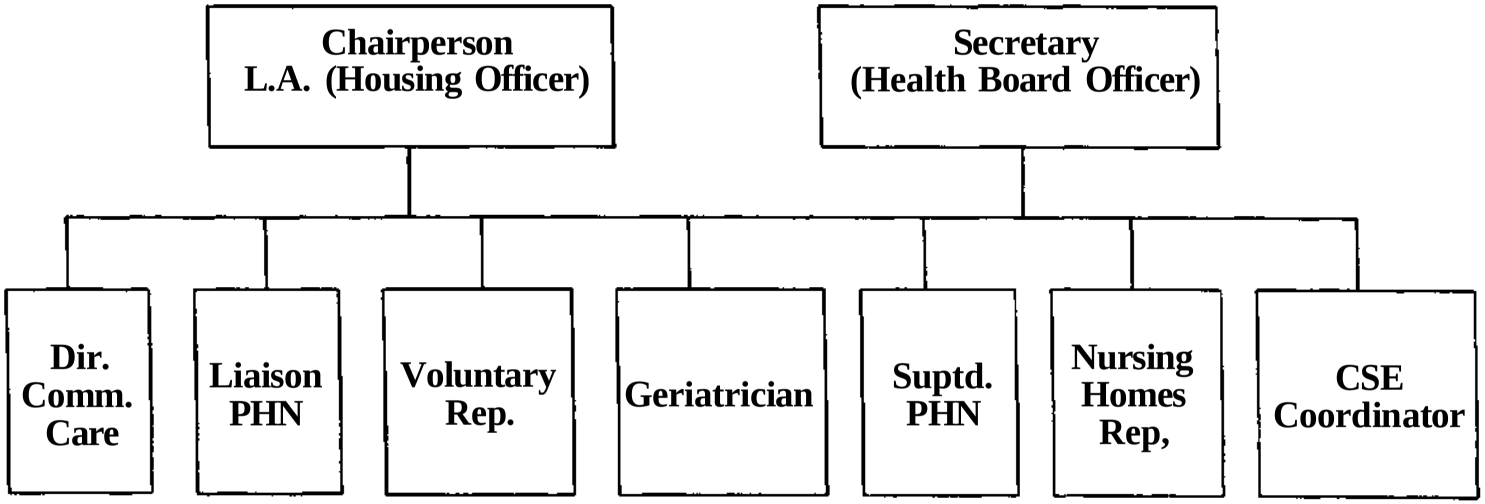
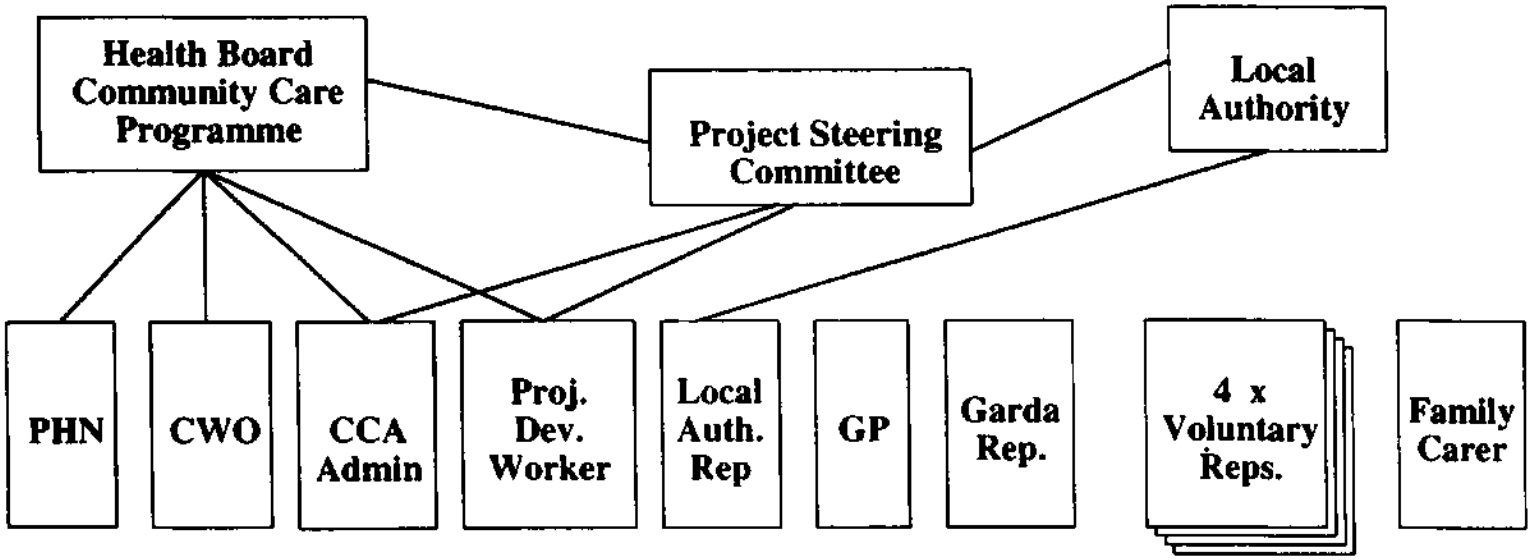


FIGURE 2

CORE STRUCTURE OF TIPPERARY SOUTH RIDING PROJECT
LOCAL COMMITTEE **1989 -1991**



Outcomes of Pilot Projects

I now want to consider the outcomes of the pilot projects and propose to do so under five main headings.

1. Implementation of project structures.

2. Implementation of project committee functions.

3. Difficulties encountered by projects.

4. Inadequacy of *terms of reference.*

5. Achievements of pilot projects.

Implementation of Project Structures

Despite a high level of commitment and strenuous efforts on the part of the personnel involved, both pilot projects experienced difficulty in implementing the project structures. The involvement of the voluntary sector, the general practitioner service and the private nursing home sector was less than satisfactory. The key difficulty in respect of the voluntary sector and the general practitioner service was one of representation. While individual voluntary sector personnel and some individual general practitioners made valuable contributions to the pilot projects, the systematic and representative involvement of these sectors was not achieved. Also, the private nursing home sector had only a limited involvement in the projects. Both projects also experienced difficulties in respect of health board involvement. While the community care programme was strongly represented in the structures of the two projects, the involvement of the hospital sector and the psychiatric services was somewhat peripheral.

Implementation of Project Committee Functions

The functions assigned to the project committees were elaborate and complex. In particular, the *planning* function assigned to the steering committees, based on a comprehensive and systematic assessment of need, proved beyond the skills and resources available to the projects. What happened in practice was a more *ad hoc* approach to issues as they arose and the identification of specific tasks that were achievable within the resource and personnel constraints which operated.

The type of co-ordination that occurred in the pilot project process was at the level of co-operation between personnel and agencies in respect of specific schemes as distinct from the more complex form of collaboration at the strategic level of policy-making, setting priorities and allocating resources, as envisaged in the *terms of reference.* Here it should be noted that co-operation is a necessary but not a sufficient condition for inter-agency co-ordination.

Difficulties Encountered by Projects

As might be expected in the case of pilot projects, for which no prior model existed, a number of difficulties were encountered in respect of their operation.

First, the initial establishment of the projects in both areas was problematic and the induction process for participants was not sufficiently systematic or extensive.

Secondly, full-time officers to work on the development of the projects were not deployed at the outset, a crucial time in the establishment and development of the projects.

Thirdly, the pilot project committee process was under strain for much of the time because the majority of participants were already highly pressurised in their existing work situations and

could not be released from any of their duties in order to carry out the work generated by the pilot project.

Fourthly, a goal-setting approach based on quantitative needs assessment, implied in the project *terms of reference* and initially emphasised by the project evaluation team, resulted in a high level of uncertainty, confusion and a certain sense of frustration and, indeed, some resentment, since such an approach was quite beyond the resources and skills available. This was particularly so in the case of the project local committees who were being asked initially to carry out a statistical and quantitative assessment of needs in their areas.

Fifthly, the projects were established and operated in a general climate of cutbacks and financial stringency which precluded the availability of any substantial additional funding.

Inadequacy of Project *Terms of Reference*

In retrospect it emerged that the project *terms of reference* were quite inadequate in terms of the complexity of establishing and developing innovative structures for local service co-ordination.

First, the *terms of reference* were elaborate and over ambitious in the context of the resources and skills available to the projects.

Secondly, the *terms of reference* underestimated the difficulties and complexity of the process of quantitative needs assessment. As stated earlier this was a task assigned to both steering and local committees.

Thirdly, while committee functions were set out in detail, project goals were not specified in the *terms of reference.* Rather it was implied that such goals would be set out by the project committees.

Fourthly, the *terms of reference* did not specify mechanisms for putting committee structures in place or advert to the need for a strong induction process.

Achievements of Pilot Projects

The pilot projects operated over a four-year period and strenuous efforts were made by project participants to work within and around the difficulties outlined earlier. The projects had a number of key achievements which were due in no small way to the high level of commitment on the part of project personnel. These can be summarised under four headings.

First, a number of gaps in service provision in both project areas were identified by the projects and proposals and recommendations on a number of issues were made to parent statutory and other relevant bodies.

Secondly, a number of new schemes were put in place in each project area as a result of initiatives taken by the pilot projects, for example:

- day care centres,
- sheltered housing projects,
- support systems for family carers,
- the establishment of an "elderly at risk" register.

These schemes required a level of collaboration and co-operation between agencies and sectors.

Thirdly, the pilot project process facilitated improved communication between personnel from the different agencies, sectors and programmes involved. Barriers were broken down through

the committee process and many participants had the opportunity to put faces on names for the first time.

There was also a related exchange of information, with different agency personnel having and creating opportunities to get to know more about the processes, plans and problems of other agencies. This was particularly pertinent in the case of voluntary sector participants who for the first time had access to detailed information on statutory policies, programmes and processes.

Open communication, regular exchange of information and mutual respect should be regarded as basic building blocks of a co-ordinated approach and in this sense the pilot projects made necessary and important beginnings.

Key Factors Arising out of the Evaluation of the Projects

There were a number of factors which affected the development and implementation of the pilot project structures and functions. Seven such factors were identified in the evaluation:

- underlying organisational arrangements,
- the role of a key development worker,
- the need for resources appropriate to the tasks assigned,
- the notion of agency interdependence,
- the need for joint planning mechanisms,
- inter-disciplinary working,
- the underlying policy on partnership,
- the absence of an ethos of co-ordination throughout the administrative system.

I want to say something about each of these in turn.

Organisational Arrangements

The evaluation of the pilot projects suggests that the development of a co-ordinated approach at local level requires the presence of certain organisational arrangements which facilitate inter-agency and inter-disciplinary working.

First, the pilot projects were an addition to the existing statutory administrative and budgetary frameworks and, consequently, remained outside the mainstream of service provision and planning in the two project areas. Potentially the projects could have had an advisory role to the parent statutory bodies on policies affecting the elderly. However, no formal mechanisms for consultation with the projects existed and in practice such consultation rarely occurred.

Secondly, as stated earlier, project personnel for the most part continued to carry their existing workloads and responsibilities. Their involvement in the pilot projects could almost be regarded as an appendage to their regular work, frequently having to be "squeezed in" during spare moments and at lunch times.

Thirdly, there was an absence of any framework at local level for integrating the various health board programmes and, consequently, a difficulty for the projects in involving the hospital sector and the psychiatric services at that level. It was also the case that structures at the district levels within community care areas, that is, at the levels at which the project local committees

operated, were not sufficiently developed or resourced in order to facilitate a co-ordinated approach at that level.

Fourthly, the relatively high number of health board community care personnel involved in the projects, particularly at steering committee level, tended to create some difficulties in respect of integrating in a co-ordinated approach individual representatives from other agencies and sectors.

Development Worker

Now to the role of a key development worker or animator.

The development of a co-ordinated approach involving a range of agencies and disciplines is a highly complex process which requires a strong developmental and animation input, particularly during the early stages of its evolution when there is inevitably a level of uncertainty and apprehension on the part of participants.

As stated already, neither project had a development worker in place during the early stages of their establishment and development. In retrospect, this was seen to have been a considerable shortcoming which affected the operation of the projects throughout.

Adequate Resources

A co-ordinated approach is, at least in the early and developmental stages, costly in organisational terms. It is not necessarily a cheaper option and cannot be regarded as a substitute for inadequate resources. The pilot projects were established in and operated during a climate of severe budgetary restraint when services were already very much under pressure.

The absence of additional resources for developing an innovative co-ordinated approach to service provision was exacerbated by:

(i) the lack of funds to deal with service gaps and needs identified,

(ii) the already over-heavy workload of many of the project participants.

Agency Interdependence

Existing policy and budgetary processes and the functional responsibilities of the statutory agencies involved tended to preclude the development of interdependence between agencies at local level and the pursuit of shared joint goals for service development. Issues tended to be addressed from the single-agency perspective in terms of existing legal and functional responsibilities and budget allocations. For example, the role of the local authorities was governed primarily by their existing functional responsibilities in respect of housing the elderly. It should be noted, however, that despite these functional barriers, some local authority personnel played key roles in the pilot projects.

Joint Planning

Arising out of the concept of agency interdependence is the notion of joint planning. There is a crucial distinction between joint planning and an exchange of views on separately prepared plans. There was little scope for joint planning in the pilot projects in that the projects did not have any formal involvement in the planning processes of the statutory agencies involved. While there was co-ordination between the housing and health authorities and the voluntary and statutory sectors in relation to specific schemes (e.g., day care centres, sheltered housing) this operated somewhat on an *ad hoc* basis, and outside the main planning and policy-making domains.

Inter-Disciplinary Working

As might be expected, collaboration and teamwork between professionals and disciplines presented some difficulties in the pilot projects. Separate education and training, and a tradition of independent working inevitably creates certain barriers:

- between professions,
- between professions and administrators,
- between professionals and volunteers.

There were some good examples of inter-disciplinary workings in the projects (e.g., collaboration in the design and preparation of a series of information leaflets for carers of elderly persons). However, a number of problematic areas were encountered:

- divulging confidential information about clients or agency plans to volunteers,
- administrators becoming involved in areas which were primarily the responsibility of trained health care professional personnel,
- local authority housing personnel becoming involved in what were primarily health matters.

Policy on Partnership

The concept of partnership requires the integration of the non-statutory sectors into the planning, policy-making and policy-implementation processes of the State. The non-statutory sector includes the voluntary sector, the private sector and independent professional groups (specifically the general practitioner service in this instance). At present we do not have a formally worked out policy on partnership in Ireland. As already stated, the involvement of the voluntary sector, the private nursing home sector and the general practitioner service in the pilot project process was far from satisfactory. Specifically, there was no mechanism at local community care area level to develop the voluntary sector which is frequently diverse and fragmented.

Ethos of Co-ordination

The pilot projects were operating in an administrative context where a co-ordinated approach was not the norm either at central government level, at regional level or at local level.

There was thus little scope for local co-ordination in the context of services for the elderly. The major thrust of policy and related budgetary allocations were already determined at central level.

Indeed, the question must be asked if service co-ordination for the elderly at local level is at all realistic in the context of the current administrative system.

Dimensions of Service Co-ordination

The experience of the pilot projects can be more adequately understood if placed in the overall context of service co-ordination which is a wide-ranging and complex field.

Here, we can point to a number of dimensions to this field at all levels of the administrative system. First, there is central government policy and practice on inter-agency co-ordination. This in turn is reflected in co-ordination at inter-departmental level; in regional co-ordination mechanisms and related local government structures and responsibilities.

Secondly, there is national policy and practice on partnership between the statutory and non-statutory sectors within an overall mixed economy of welfare provision.

Thirdly, there is the principle of inter-disciplinary teamwork which should govern all aspects of the caring system.

The pilot projects, in this overall context can be said to have been working in a substantial vacuum, operating as they were in only one segment of the co-ordination field.

Conclusion

To conclude, the experience of the pilot projects suggests that co-ordinated development at local level is a complex and challenging task which requires intervention at two levels:

(i) There is a need to develop an ethos of co-ordination and partnership throughout the whole of the Irish administrative system and to establish national, regional and local structures accordingly.

(ii) Effective co-ordination at local level, the current local authority and health board community care functional areas, requires:

- the allocation of resources commensurate with additional tasks assigned to develop any proposed co-ordination structures,
- the deployment of development workers/animators to promote co-operation and collaboration between agencies and between sectors,
- comprehensive induction and education programmes for key participants in co-ordination structures.

PRESENTATION OF COMMENTS AND RECOMMENDATIONS OF THE NATIONAL COUNCIL FOR THE ELDERLY ON CO-ORDINATION OF SERVICES FOR THE ELDERLY AT THE LOCAL LEVEL

Dr. Finbarr Corkery

Most people here I presume would be like myself in being very unfamiliar with research, its methodology, carrying it out and finally its presentation in report form. Through my involvement with the Council sub-committee on co-ordination, I have developed some insight into these processes and have learned from them, I hope.

In the first instance, I would like to comment on the skill, knowledge and the work required to produce a report like this. The value of the information gained seems great, and its importance to our developing services for the elderly fundamental. Yet the Council did note some problems, some significant difficulties.

The report is a research document and as such it has to be acceptable to serious workers in this field at a scientific level. Inevitably this means the presentation of detailed data and, as a result, the production of a lengthy document. For non-professionals in this field, it was felt that this could raise a barrier to the wide dispersal of the document, though it is a clearly written report, and free of jargon. However, with this potential difficulty in mind, the Council has also published a *Summary of the Evaluation Report,* including a *Summary of its Recommendations.* I emphasise that these documents go together.

The rationale for the views expressed is clearly laid out in the report. The recommendations inevitably have a degree of subjectivity, but they are based on data accurately gathered. They are therefore not just opinions; they are a genuine attempt to translate the data into practice.

To say that this is an era of change is undoubtedly a cliche' in the sense that it is a stereotyped and commonplace comment; it is also true. In our specific case, caring for the elderly, we know that fundamental changes have occurred. The numbers of the aged have increased, social changes tending to disrupt support groups have occurred and will continue to occur. Expectations are justifiably higher. I think a point which we tend to overlook is that there is a social consensus developing within the country, with regard to the nature of the services which we should provide for the elderly. It seems to me that this postulates a high standard of care and support for them, even if the question of funding may not be adequately addressed as yet. Acknowledging change, however, could be an unproductive exercise; it is our response to it that we should look to. In this context Michael Browne's sub-title *Swimming Against The Tide* may be a useful starting point. If the administrative structures in place are perceived as a tide flowing against necessary change, then it is hardly useful to keep on developing strategies for change. This is not to be interpreted as a negative attitude towards local or central administration, rather it poses the question, "where do we go from here?"

Dr. Moriarity, Chairman of the Culliton Task Force, speaking in a totally different context but making a point relevant to our discussion, said "Departmental boundaries have meant policies are inevitably developed or evolved in a blinkered or one-dimensional way." Similar attitudes arc suggested in the recommendation in *The Years Ahead* - A *Policy for the Elderly,* "we recommend that the Departments of Health, Environment and Social Welfare agree administrative arrangements to ensure co-ordination of policy towards the elderly at national level and the monitoring of progress towards the implementation of the recommendations of this report." With regard to the Departments mentioned, I would like again to quote from Dr. Mortality, this time with some modification: all policies have some impact on co-ordination; consequently they must overcome the narrow focus that departmental boundaries can cause

and work coherently to improve co-ordination. Attaining this co-ordination is a test for the civil service. Dr. Moriarity was speaking, in fact, about competitiveness, and I merely replace competitiveness with co-operation.

Co-ordination may be a test for the civil service, but how is it to be answered? I think this is where this report is invaluable. The fundamental precept is the promotion of an ethos of co-ordination at national level. This will mean attitudinal shifts and these are perhaps the most difficult of all to achieve.

It is undoubtedly the case that lack of resources is commented upon in the report, but I do not see it as a major pre-occupation of the report. In any event there will always be lack of resources, as expectations will tend to be ahead of them. We must develop the principles upon which resources should be allocated and use them to divide whatever resources are available. For example, the recommendation that the *terms of reference* for joint initiatives, should be worked out in concrete terms with specific objectives, tasks and methods of work does not appear very demanding of resources. Yet failure to do so seems to have been an important factor in the projects. Again participants at local level felt that the committee process envisaged in the pilot projects would be improved by an induction process for committee members, together with a provision for basic training in committee procedures.

This forms the basis for two of its recommendations.

(a) That the health boards and local authorities should arrange these induction and training programmes for all personnel becoming involved in co-ordination initiatives.

(b) That they should develop a comprehensive educational training programme in inter-agency co-operation and inter-disciplinary working.

Many members of these committees are totally new to this type of development. For some it will be a part of their everyday work; for others it may be the first time they have been involved.

The report says the experience of the pilot projects reflects the complexity of the co-ordination process and points to the major structural and institutional barriers which need to be overcome if effective service co-ordination at local level is to occur. The report lists the origins of these barriers and it suggests appropriate responses. Here again we must note the need for attidudinal change, change in work practice, change in existing administrative structures. Resource provision does not appear to be a great demand. However I do not want to suggest that it shies away from anything which could require allocation of resources. It recommends for instance, that there should be a method for providing joint financing for initiatives. It recommends, the deployment of a development worker on a full time basis by health boards and local authorities to facilitate collaborative arrangements and this obviously has resource implications. It says that personnel should be assigned to work with voluntary bodies providing services for the elderly and facilitate their more effective and more representative involvement in service planning and provision. We readily recognise the problem of resources. A group as widely representative as the Council could not do otherwise, as many members on it are actively involved in the practical work relating to services for the elderly. I have no doubt, however, that the Minister, to whom we are an advisory body, respects our views and will take such action as is open to him in the light of other commitments. It is worth pointing out, however, that failure to allocate even small additional resources in some situations can put substantial investment which is already in place at great risk.

As pointed out by Mr. Hickey, many positive features and developments are described, particularly the reservoir of goodwill amongst people, already very busy, who gave time to projects such as this. Good resulted from their efforts and if we fail to recognise this, we are failing to acknowledge their commitment.

We must remember furthermore that we speak about *pilot* projects. As such their purpose was to assess practicalities, to uncover problems and defects in their *terms of reference* and to note weaknesses; all with a view to learning. Thus all the findings add to our knowledge and are inevitably positive because of that.

The report shows that membership of the committees was less than satisfactory. The general hospital sector, the psychiatric services, voluntary sectors, GP services, private nursing homes and so on, were not adequately represented; neither were the family carers or indeed elderly people themselves particularly well represented. The Council recommends that these very significant deficiencies be addressed, and it would feel that failure to do so places co-ordination projects at a very severe disadvantage.

The notable successes achieved by both projects indicates what can be done in less than favourable circumstances. Never the less, when looking to co-ordination projects to efficiently provide integrated care, then I think it can be said that until all the elements are in place, none is satisfactorily in place.

Ireland, for many of its elderly people, is not a bad place to live in. Humane and sympathetic policies have been developed by government departments. As I have said earlier, there is a consensus in our society that the elderly deserve the best. This aim has been energetically pursued by various Ministers and by their Departments. All this indicates the existence of a fund of goodwill, politically, socially and administratively and the report confirms this. To me, however, it requires us to make a somewhat more radical and imaginative series of changes in our approaches. This will definitely call for courage and openness on the part of our policy-makers. From the Council's perspective it has sought to suggest changes compatible with or recommended by the Department of Health's policy as outlined in *The Years Ahead* report.

Generosity with resources is sincerely acknowledged. But developing a new paradigm of care based on innovative and imaginative co-operative projects would form the basis for a new and exciting era in our social development. Furthermore I am certain that we have the skills, the attitudes and imagination to undertake this. The report points the way, and the Council makes its recommendations, published in a short document, very accessible to anyone who is interested. Naturally, we hope they make their way into policy discussions, but perhaps more fervently we hope that policy-makers have the courage and enthusiasm to initiate steps along this new path, based, as the report would say, on an ethos of co-operation.

COMPLEX OF FRAGMENTS

Dr. Tom Harrington

Response to the Evaluation Report

I read with great interest the report, *Co-ordinating Services for the Elderly at Local Level: Swimming Against the Tide,* on the two experiments in co-ordinating services for the elderly at local level. Michael Browne's research represents a very welcome advance in putting a spotlight on a dark area of Irish public administration. I doubt if there is anything quite like it in this country, in its scope and in its thoroughness. The National Council for the Elderly are to be congratulated on taking the initiative for this research and in getting it published and publicised.

Fragmentation

Overall, the report is depressing in the degree that it illustrates how fragmented is our administrative system within the relatively narrow range of dealing with the problems of the elderly. But when one relates its findings to the whole range of government services, the myriad bits and pieces, disunities and disjunctions, the bewildering fragmentation of the whole when viewed from the bottom up, one cannot but wonder at the sheer number of difficulties facing any programme of co-ordinated action. Even in a relatively small country like Ireland the task of getting our fragmented systems to work in an orderly way, imbued with a common purpose, is a major problem. The pressing need is so to organise our administrative and institutional substructures as to achieve this sense of common purpose. This is a task that must be squarely faced for, as Dr Corkery has pointed out, there is a rising sense of dissatisfaction in the country about the way we govern ourselves.

But the basic administrative infrastructure needs a radical overhaul. We need, for a serious beginning, to ask ourselves probing, uncomfortable questions and to tease out the answers. Why does our overall performance in so many areas of government show us to be, in Professor Joe Lee's words, "perched, through our own efforts, at the wrong end of virtually every relevant league table"? (Lee 1985 p. 88) Why are our services so fragmented? The roots of that fragmentation are to be found in the nature of our State and the means we have adopted, since the time of Independence, in developing that State.

Economy and Efficiency

Seventy years ago, when we did get Independence, there was unanimity on the slogan, pursued by the Irish Government as a guiding light, the slogan of "economy and efficiency". The belief was that these twin aims would be achieved through centralising in central government as much of public operations as possible. The belief was that by so enlarging the *scale* of central government we would achieve both economy and efficiency. Indeed, there was plenty of inefficiency in the government services in those days and the pursuit of efficiency was well justified. But the problem was compounded by another factor, the new governors' extraordinary degree of distrust of their own people. This distrust became rigidified in the survival here - as, later, in other post-colonial countries - in the form of a "post-colonial society". It is not surprising that the British should show some distrust of the Irish; but it was highly surprising that our native rulers - politicians and officials, many of them from peripheral counties - should be even less trusting of their own kinsfolk in those counties and that they should build the new State on distrust, and with a growing disempowerment, of their own people. "Economy and efficiency" have had a long innings. Their results are plain for comparison.

Centralisation

The undisputed conventional wisdom was that the new State would achieve "economy and efficiency" through a very high degree of centralisation, now, it would seem, the most intense in Western Europe. In this way the "economies of scale" would be achieved. As this rested on a basic distrust of the people - the very antithesis of democracy which rests on its precise opposite - as many things as possible had to be regulated or constrained, with the result that there would be a minimum of spontaneous movement. Except to emigrate, a freedom accepted by about a net one-third of those born here in the past 70 years. The phrase "economies of scale" became a mantra in the mouths of Irish economists for continual collective chanting. Eastern mystics claim that this chanting leads to intense concentration, and concentration leads to new insights into reality. Something must have gone very wrong with the concentration of Irish economists, as measured by those international league tables, at the wrong end of so many of which we continually perch. To be fair, very considerable economies can be achieved in building bigger and better power stations, for instance, where a large amount of capital is needed: the more you put in, it would seem, the cheaper the unit of product becomes. The same applies to jumbo jets. But economy of scale seldom applies where little capital is required. Simply to agglomerate large numbers of people in large offices where little or no productive capital is required, leads to scale but seldom to economy. Too often it leads to confusion, fragmentation, poor communications, and low morale.

Devolution

A number of other countries have been facing into this question. How is it that, both at the point of service and even at the centre, so many of the public services are fragmented? Why is it so difficult to get cohesion in cognate services? And so on.

A study of this issue done in France some years ago as part of the planning process came to the conclusion that an inevitable result of centralisation, concentration at the centre, was fragmentation at the periphery. In addition there was the excessive growth of the population of Paris as compared with the other leading cities. It was decided to take active steps to change the way France was run. In consequence a programme of very substantial devolution to regional and local government systems was put in train over recent years (Ardagh 1990 pp. 249-79).

In Ireland we have not bothered to tackle such questions notwithstanding that the population of Dublin in relation to our total population is, relatively, about twice that of Paris to the total French population, and that we lack the local co-ordinating mechanisms that France had in the institution of prefects. Most European countries have either long enjoyed or recently implemented similar structural changes in the balance between central government and the various forms of local government, in altering the balance in favour of local democracy. So far as public services are concerned, the aim has been to improve local cohesion and public accountability. But we have kept ourselves almost totally untouched by such innovations and show every sign of not allowing ourselves to be touched by them in the future.

So far as the indicators go, Ireland seems to be the most centralised society in Western and Middle Europe (Barrington 1991 pp. 57, 59). A simple example is that we have fewer local authorities than any of these countries, even in countries very much smaller than Ireland. Luxembourg, with an area roughly equal to that of a typical Irish county, has a total of 126 local authorities as against Ireland's total of 112. Or, to make a more vivid comparison, 126 local authorities in a space just over half that of Kerry - with four in all! The usual defence for this is that we are a small, poor country and could not afford much in the way of local democracy.

Decision Centres

Switzerland is continuously the richest of the European countries in terms of GDP per head. Its area is about 60 per cent that of the Republic (OECD 1992 pp. 67, 24-25), yet contains over 3,600 local authorities (Barrington loc. cit p. 55) with wide powers of decision. Luxembourg, already cited, is the second richest of the 19 European countries of the OECD (loc. cit pp. 6-7, 24-25). It looks as if neither geographical smallness nor richness in local authorities is much of an impediment to economic success. What does look likely is that extensive and intensive local democracy, with the widespread decision centres it provides, is far form being an impediment to economic and other forms of growth. The comparative figures give some idea of the price Ireland pays in lacking those decision centres, those places where the disparate governmental threads can be woven together into (shall we say?) a seamless garment of devolved, efficient and economical government.

More Local Democracy

Over the recent decades a good deal has been done in European countries to revamp their democratic and governmental systems. In a number of countries such words as "decongestion" and "devolution" have become key expressions for significant changes. There have been two main reasons for this. One has been the vast increase in the scale and scope of modern government, leading to severe congestion at the top. The second has been the increasing consciousness that the people have resources of vitality and good sense that are neglected to the peril of democratic government. The problems with the Maastricht Treaty provide a vivid reminder of what happens in modern democracy when the people are treated as inanimate objects instead of active partners in government.

Big Government

A tell-tale index of democratic quality is the relative percentage of total public expenditure disbursed by local authorities. The norm for most European countries is 30 per cent to 40 per cent. In Ireland it is 10 per cent, and falling. In Denmark, the most decentralised of the unitary states, it is around 70 per cent. This is the result of a conscious decision by the Danes, implemented over the past two decades, to shift business from central government to local government, an overall system they have radically reformed, modernised and, above all, democratised (Mikkelsen 1992 p. 4).

The other factor that has been stimulating changes in governmental systems is the growth of what is called "Big Government". Government, as measured by what it spends and the numbers it employs, is now very big. In most European countries the ratio of the total public expenditure to GDP is in the percentage range from 40 per cent to 60 per cent (OECD loc. cit pp. 40-41). A consequence of such high ratios is the growth of bureaucracy. Ireland's ratios are not the biggest but are amongst the biggest. Unlike a number of the other sufferers from "Big Government", Ireland has made no real effort to address its consequences.

Growing Anarchy

The growth of government without a corresponding development of coherent, co-ordinated and democratised institutions leads to, both at the centre and at the periphery, intense fragmentation, compartmentalisation and bureaucracy, in effect to the growth of non-government or anarchy. What is really not to be forgotten about in *Swimming Against the Tide* is the extent of the *growing* anarchy at the grass roots and the problems in human terms posed by that anarchy. And this is but a glimpse of what is happening all over the country, made worse by, as Dr Corkery has pointed out, the competitiveness endemic between various public organisations.

I remember Garrett FitzGerald saying in public, shortly after he ceased to be Taoiseach, that the one most intractable issue he had come across in Government was the independence, the lack of co-operativeness, between government departments. If two departments wanted to engage in the same service or neither of them wanted it, then nothing would happen. Somehow, a way would be found to frustrate any action.

When I was a civil servant a thing that fascinated me was that instrument of co-ordination known as the inter-departmental committee. Attending a meeting was like playing a game of poker, somebody might win but it would be after a great deal of stonewalling by the others, whose task was to give little or nothing away. But the ideal solution was a verdict that "no effective action was possible", that is, non-decision.

Dynamics of **Decision**

This is the very antithesis of effective government. There is a famous French saying that "to govern is to choose", that is to say, to take decisions. Without decisions there is no government. Decisions release energy that can be harnessed to achieve progress. This is the big problem posed by congestion in government. The problem has two facets: decisions on major matters get brushed aside because everyone is too busy dealing with minor matters. The decisions on major matters could release substantial contributions of new energy; but decisions on minor matters release very much less energy. The potentialities of the system are not being efficiently tapped. What is needed is to clear the decks so that those who have big decisions to take will have time to think them through and that the less big decisions will be taken at lower levels of the hierarchy.

So, a big part of the success or failure of a polity rests on this matter of decision, the taking - and not the dodging - of the big decisions at the appropriate levels and the existence of sufficient decision centres for taking the less important decisions. Unless this kind of segregation of decision-making occurs we find that the smaller decisions, which so often present themselves as urgent, drive out the important. A number of reports of the National Economic and Social Council have deplored the lack of *strategic* thinking in this country on where the country is going, what are its long-term needs, how they can be tackled, and the quality of such decision-making as does go on (e.g. NESC report nos 83, 88, 89, 93).

Apart from the quality of decisions there is the problem of their *quantity.* So far as the governmental sector is concerned there is, by comparison with other democracies, an extraordinary dearth both of local decision centres and of problem seeking. Such decisions as may be taken locally are unnaturally "cabin'd, cribb'd, confin'd." It is as if the engine of the State were limited to firing on one cylinder. No wonder the overall performance is so relatively poor. We are one of the least economically successful of the countries of Western and Middle Europe. We have the second thinnest population; we have the second highest unemployment rate; our GDP per head is far below the average. Overall, our perch is one of the lowest (OECD loc. cit. pp. 24-25, 12-13). There are serious, unresolved problems in this country. Our governmental system does not work effectively; part of the reason is that it is held together with bits of string; another part is that it is not a coherent piece of machinery; a third part is that it is grotesquely top heavy. The result is that we are involved in drift rather than in purposive government. By their fruits shall they be known.

Energy Release

One feature that is relevant to the present discussion is that we have, by international comparisons, an extraordinarily low level of dispersed centres where effective decision-making can go on. It is impossible to run an effective society that is starved of facilities for taking decisions and for the release of the energy generated **by** decision-making throughout the society. Not only is this the failure to release energy but the failure also of the synergising process by which cognate activities are grouped together, rather than have

them pulling against one another, to the detriment of effective and economical performance. Where there is a scarcity of centres for decision and cohesion at the various levels of society the result is not government but drift

It has been realised in a number of European countries - but most strikingly in Denmark - that a major remedy for the ills of modern big government - is to decentralise to a revivified system of local government as much as possible of responsibility for decision-making and for achieving cohesion of services. That is, to get things done as near as possible to the people affected and to try to integrate services as closely together at the point of service. This provides a much more flexible system of government able to cope speedily with the changes that are occurring in society generally, and not least in this country.

Area and Function

Effective government requires a sophisticated balance between area and function, or, one might say, between place and people. We continually plump for function in this country rather than appropriate area, with the result that cognate services are delivered side by side by different bodies and in an unco-ordinated way. Even where we do have some sub-national systems - such as the health services - we tend, in unthinking capitulation to the economies of scale argument, to make their area of operation bigger and bigger with the net effect that there will be more fragmentation at the point of service. For the personal and caring services the rule should be not *scale* - but *scope,* not bigness - but cohesion, as indeed *The Years Ahead*report says (Ireland 1988 ch. 3).

Scope

We tend to treat symptoms rather than getting down to an understanding of the underlying disease. It is as if a parent, in the early stages of medicine, had three doctors to treat his/her child, one to deal with white spots in the mouth, a second to deal with pink spots on the face, and a third to cope with a high temperature. That is the way we tend to deal with many of our social ills, instead of getting down, as of course medicine did, to the hard graft of diagnosing the underlying disease and how to cope with it for the future. In the caring services the basic unit is a complex of individual, group and community. Such holism cuts across the divides of specialisation. *Swimming Against the Tide* makes clear that even within individual health boards there can be a lack of co-operation between the hospital and the psychiatric services and stresses strongly the overall need for co-ordination.

It is relevant to recall what happened recently in Neilstown, County Dublin, when a number of children began burning stolen motor cars. What was the remedy? There was no place for these kids to play, there was no proper policing of the area, widespread unemployment, disorientation, and much else that conflicted with the growth of a morally successful community. It was decided to set up an inter-departmental committee consisting of six or seven very senior civil servants from as many government departments. Since then the reports of car-burning in Neilstown seem to have stopped. Perhaps the committee succeeded in its political purpose of defusing the young people's incoherent protest at their neglect The moral is, I think, that it is not good enough simply to decant large numbers of deprived people into concrete deserts with admonitions to them to make as good a life there as one can. Something more fundamental needs to be done to underpin the growth of a genuine self-regarding community, to make good its social deficiencies, and to encourage a spirit of self respect

Another striking example was highlighted by the protests of two District Judges at the lack of places for seriously delinquent boys and girls. There was a considerable to-do about this, and eventually three government departments concerned, Justice, Health and Environment all publicly denied responsibility. There is a fourth, the Office of Public

Works, but it kept its head down. This kind of fragmentation, and denial, of responsibility is an open scandal.

Principles

There are in my view three main principles for effective action. They are specialisation, subsidiarity and cohesion. These will avoid the main ills of bureaucracy, namely, confusion, undue centralisation, and fragmentation.

Developing Democracy

One of the things now coming to be realised more widely is that our democracies have the need and the capability of being developed. As this happens our administrative system needs a matching degree of development. Developing democracy means that the people will have a greater say on what it is they want of society and what it is that they are at present getting. That is to say, that we have to bring about a more consensual society resting on institutions that have a lively sense of serving the people, respecting their opinions, evoking agreement for proposed activities, and ensuring that what is being done is in fact what the people want.

That is, I think, the road our democracies are likely to travel (e.g., Hesse and Sharpe in Hesse (ed) : pp. 603-621). The headline was set before World War II in Sweden and has spread widely in Europe since then (Mjoset, 1992). To a considerable extent Brussels has funnelled to us such expressions as "consensus", "subsidiarity", "consultation", "participation" and much else far removed from the old notions of class war, confrontation, winner takes all, and the rest of the battle signs. We have already domesticated some part of the new approach to governing, in the Programme for Economic and Social Progress, the Social Partners, and opportunities for consultation on past and future projects.

This new type of consultative democracy can apply at all levels of the polity, central government, regional government, county government and district government, in the workplace and the marketplace. This development of our democracy into a more articulate one opens the way for pressure coming over a wide area from the people themselves. We have learned from recent European history that people power can play a formidable part in shaping society. I think it will act as a strong force to end the fragmentation of so many of our public services. It may be that the tide has decisively turned.

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PRACTICAL WAYS OF PROMOTING AN ETHOS OF CO-ORDINATION FOR THE FUTURE

Mr. Donal O'Shea

Introduction

I wish to express my thanks to the Chairman, to the members and to the Secretary of the National Council for the Elderly for their kind invitation to me to address this very important Seminar regarding the co-ordinating of services for the elderly at local level.

I have read with great interest the report *Co-ordinating Services for the Elderly at Local Level: Swimming against the Tide* and can readily identify with some of the problems, the obstacles and the difficulties which those participating in the projects encountered as described in the report. Some of these problems arose from the structure of the projects themselves, others from either real or perceived obstacles within the structures of our systems. It is not my intention to comment in detail on the projects but, rather, to indicate how it may be possible, despite the obstacles and difficulties which exist, to create an environment which supports co-ordination where it matters, that is, at the point of delivery of the services.

Co-ordination

The desirability of co-ordination between the various agencies which deliver services for the elderly, whether these be statutory or voluntary, whether they be a local authority or a health board, is fully accepted where such co-ordination contributes positively to improving the quality, the effectiveness or the efficiency of service delivery. However, it must be stated that co-ordination is a means to an end, not an end in itself. The arrangements which we put in place to deal with areas which require inter-agency co-ordination or collaboration must be geared towards facilitating the delivery of services. There does not seem to be any point in having marvellous structures and systems of co-ordination and collaboration if they do not positively and practically help in the delivery of services to the patient or to the client. We should not set up structures and super-structures unless they are demonstrably needed, nor should we set up bureaucratic layers of committees unless they will clearly and practically facilitate service delivery. I am a great believer in the maxim "if it isn't broken don't fix it".

Before we deal with issues which may help co-ordination at local level, I would like to mention some of the strengths of the current system which it is too easy to overlook. We have in this country a single agency, the health board, which has statutory responsibility for the delivery of a wide range of health and social services including the acute hospitals, long-stay care, primary care, psychiatric services, services for the mentally handicapped, services for the physically handicapped, child services, services for the elderly, the full range of personal social services including social worker, public health nurse and home help services, for paramedical services, for support in both cash and kind to those with emergency needs, for some elements of housing, for health promotion, disease prevention and public hygiene. Such an agency is probably quite unique to the Irish situation and has few parallels internationally. I know that many countries look with envy at the possibilities which our system offers for the co-ordination of services at point of delivery and many countries put enormous efforts and resources into encouraging liaison between a myriad of separate agencies and separate services which we have virtually all under one roof. We have an enormous opportunity for maximising the advantage which this gives us and I would urge that we recognise its strengths rather than seek to dismantle it

While of course there is nothing which cannot be improved and very few things which cannot be substantially improved, never the less, I believe that, even within current structures, it is

possible to get a wide degree of co-operation and co-ordination between various agencies involved in the delivery of services for the elderly at local level, but, as it so wisely says in the report, it takes time, effort and some resources.

Meeting Needs in North Western Health Board Region

In this paper I will briefly outline some of the arrangements that have, over recent years, been put in place in my own board to meet the particular needs of the North West.

The North Western Health Board region is comprised of Counties Donegal, Leitrim and Sligo with an overall population of 208,000. The region has the highest dependency ratio of all eight health board areas at 76.9. The elderly constitute a significant population grouping with 30,318 (14.3 per cent) in the over 65 age bracket.

The region is 85 per cent rural which presents many challenges in the area of service provision and co-ordination. Significant social indicators are the facts that 46.2 per cent of the population has medical card eligibility (highest of eight health board regions) and there are over 53,000 direct social welfare recipients.

Objectives

The arrangements which we introduced in the region had the following stated objectives:-

(a) To ensure that resources for the care of the aged, both institutional and non-institutional, are allocated on an equitable basis by reference to designated catchment areas.

(b) That based on the principle of those most in need having first call on resources, access to these resources for the aged will be decided by reference to clear norms and standards and in accordance with revised admission and discharge policies.

(c) That the organisation and management of services for the elderly will be rationalised including the clarification of the role relationships of those who will operate admission, discharge and other procedures, so as to avoid waste and duplication.

These arrangements were an attempt to meet a number of complaints and criticisms which had emerged in relation to the procedures which had been in place in the past. It may be useful to outline what some of these complaints were and where they came from.

Reasons for Change

- Complaints from general practitioners that some of their colleagues had an "inside track" and easier access to beds than others; that because of inequality of allocation that access was easier in some districts than in others; that the then arrangements forced them to seek simultaneous admission for a patient to a district hospital, geriatric hospital and community nursing unit/welfare home; that admission to a general hospital consultant service was often sought unnecessarily because of the difficulty of access to the non-consultant resources.

- Complaints from consultants in general hospitals and in psychiatric hospitals that elderly patients were being inappropriately cared for within their services because of the difficulty of access to the non-consultant services.

- Complaints from within the non-consultant services for the aged that social cases were occupying nursing places, that short-stay nursing admissions became long-stay social cases, that places occupied by low dependency cases could not be released for urgent high dependency cases seeking admission.

- Complaints from community care staff that patients were being discharged without the community care staff being properly notified or getting a clear description of the medical, nursing, paramedical and social support which was needed.

- Complaints from the hospital staff that the community services as then delivered did not provide a suitable alternative which would facilitate the discharge of patients from the institutional services.

Among the arrangements put in place to meet the objectives referred to earlier was the division of the region into districts and the equitable assignment of beds to each district. District co-ordinators were assigned and an area co-ordinator for non-consultant services for the elderly was appointed with responsibility for County Donegal and Counties Sligo and Leitrim respectively.

District Co-ordinator

The district co-ordinators have responsibility for service management for a general population of 10,000-20,000.

A district co-ordinator for non-consultant in-patient and other services for the aged was appointed in respect of each of the 15 districts in the North Western Health Board region. County Donegal has 11 districts, Sligo two and Leitrim two. The district co-ordinator has responsibility for ensuring that all the general practitioners within district receive a fair "allocation" of beds, based on the principle that there will be equal access for those with equal need.

The general practitioner makes a referral for non-consultant in-patient services to his or her district co-ordinator. Transfers from other institutions including general hospitals are made through the patient's general practitioner, even where the patient moves directly from a general hospital to a district hospital or nursing home bed. A simple referral form exists to assist this process.

Where the referral indicates it, the district co-ordinator discusses with the general practitioner the best mix of services or package of care required or available, for example short-term or long-term in-patient services; domiciliary nursing with or without a home help; day hospital and domiciliary care, etc.

Where referrals are social rather than medical the district co-ordinator has responsibility for seeking the necessary social services.

The district co-ordinator has a comprehensive range of responsibilities including the management of the district hospital and day hospital or other residential unit, co-ordination with the local community services, co-ordination of assessments, the arrangement of packages of care including liaising with local voluntary organisations and private nursing homes, reviewing each referred case, and the management of contracts with local private nursing homes.

In establishing bed allocations for a particular district the availability of nursing home beds within that catchment is taken account of; the district co-ordinator liaises with the directors of the local nursing homes and where patients are placed there, has a responsibility to visit regularly. In practice, there is contact on a routine basis between the directors of the local nursing homes and the district co-ordinator in relation to the flow of patients between the different hospitals and residential centres. An example of this would be in South Donegal where the district co-ordinator and matron of Donegal District Hospital visit the private nursing home at Drumbeg House, Inver, about eight miles away on at least a weekly basis to ensure a high level of liaison and co-ordination in the services which are being provided in the catchment area.

Area Co-ordinator

The area co-ordinators have responsibility for service management for a population of over 100,000.

This includes management of all the residential services in the area, direct line management of the district co-ordinators and liaison at area level with the community care services. The area co-ordinators have a particularly strong liaison role in the matters of contact with voluntary organisation at area level, with transport services, with the housing authorities, with the transport fleet and in the matter of arrangements for alarms, alerts, etc.

The negotiation of contracts for the provision of residential services for the elderly with private nursing homes is a specific responsibility as is the overviewing of assessments and of service standards.

The area co-ordinators carry a particularly clear responsibility to integrate more fully the institutional based services with the community care services including domiciliary nursing, home help, meals, social services and contacts with the voluntary sector.

Importance of Community Care Services Management Structure

The introduction of the arrangements outlined above in respect of district and area co-ordination would not have been possible without, and were introduced against a background of, an established and clearly defined structure for the management of the community care services. This structure is based on a system which has a head or senior for each individual community care service who carries responsibility for all aspects of that service. This includes the management of budget and resources (pay and non-pay). Clear responsibility is assigned to each head of service for a fixed area of service and authority is given to explore and contract for various modes of delivery of the service, including arrangements with voluntary organisations. This ensures a stronger degree of co-ordination but also a good element of flexibility to take account of the practical realities on the ground.

Under this system the superintendent public health nurse, for example, has responsibility for all of the public health nurses in the community care area but also carries responsibility for the home help service. Part of the home help service is delivered through arrangements with local Care of the Aged committees who put the service in place in response to recommendations from the board's staff and are then funded by the board in respect of services provided.

This ensures a high level of co-ordination between established need at local level and the allocation of home help resources to meet this.

Specific Resources of Co-ordination

References are made in *Swimming Against the Tide* to the need for resources to ensure the co-ordination of services for the elderly particularly in the area of staffing. In the North Western Health Board region, examples of staff already in place who have specific co-ordinating functions with regard to services for the elderly are:

- The area co-ordinator - co-ordinating at sub regional level.
- The district co-ordinator - co-ordinating residential and non-residential services at local level.
- Community development staff - liaising and working directly and involved in the co-ordination of services with the voluntary agencies.

- Social workers for the elderly - allocated specific responsibility for liaising with the institutional and non-institutional services in the areas of assessment and follow-up services.

- Acute hospital social workers - direct liaison and co-ordinating responsibilities in the area of arrangements for discharge of patients.

- Acute hospital liaison nurses - liaising directly with community nursing services.

- Administrative staff with specific responsibilities in the area of supporting the work of voluntary organisations and liaising with them.

The Voluntary Sector - Care of the Aged Committees

There is an established ethos of co-operation between the North Western Health Board and the voluntary sector in all areas of the personal health and social services. The voluntary sector network in the region is particularly strong in the areas of the elderly, the handicapped and the mentally ill. There are close working relationships between board staff at all levels and the personnel of the voluntary agencies. In many instances, home help services are delivered by voluntary committees on the basis of a contract which they have with the board and in respect of which the board funds them. Partnership arrangements exist with Care of the Aged committees to provide a wide range of services including home help, meals-on-wheels, laundry and day centre services.

Several joint ventures have been undertaken in the area of providing day centres and these have been successfully provided in a number of locations where the voluntary committees have taken responsibility, with the board providing funding by way of loan repayments and assistance towards revenue costs. Currently, for example, three major day centre projects are underway in co-operation with Care of the Aged committees, each of which involves capital costs of approximately £100,000. Public health nurses and other locally based community care staff work in close liaison with the personnel of the Care of the Aged committees.

At administrative level, three staff officers in the region commit a large proportion of their time to working with voluntary organisations in relation to all aspects of joint service provision including planning new services and evaluating existing ones. The director of community care and community care administrators also take a leading role in terms of liaison with voluntary organisations. At this level also there are frequent interfaces between health board staff, the voluntary organisations and the local authority senior staff in terms of planning requirements and housing requirements for the elderly, etc.

Particularly strong liaison exists with County Care of the Aged committees who co-ordinate the work of local committees and act as advocates for the elderly at area level. Liaison and co-ordination with health board management is at a high level and generally with the programme managers, the heads of service and the area co-ordinators. Health board staff regularly attend meetings of County Care of the Aged committees on an invitation basis.

Housing Co-ordination

In the area of housing services particularly close liaison exists between health board staff and staff from the housing (local) authorities. Approximately 50 per cent of the environmental health officers employed by the board work full time, on an agency basis, for local authorities, mainly on housing matters. A large proportion of the time of the director of community care and medical officer of health is devoted to the work of the local authority mainly in relation to housing needs. Recommendations from the director of community care/medical officer of health are particularly influential in determining those who are awarded houses by the local authorities. Among the health board's professional staff, including public health nurses and social workers; and the voluntary organisations, there is a high level of awareness of the role of the environmental health officers and directors of community care in the matter of the local

authority housing allocation system. Because of this the director of community care is fully briefed on the housing needs of elderly persons in the different local areas.

The development by the local authorities of specific housing schemes for the elderly have provided opportunities for close working relationships between health board staff, those from the voluntary organisations and those from local authorities.

Health Board Co-operation with Local Authorities/Voluntary Organisations

There are very many recent examples in the North Western Health Board region where there has been three way co-operation between the local authorities, the voluntary organisations and the health board in providing housing for the elderly and associated day centre facilities. Co-ordination at a practical level has developed in terms of planning these schemes which have been put in place in all three counties in the region.

Health Board and Voluntary Organisation Co-operation

Close co-operation exists between the health board and the voluntary committees in the region in the operation of the Special Housing Aid for the Elderly Scheme. In 1992, for example, over £250,000 has been committed to repairing the homes of elderly persons in the region and in many instances clients are referred to the board by voluntary committees. The committees also assist with the assessment of need and in some cases with arrangements to have work undertaken. Examples of joint housing/day centre ventures between the health board and voluntary committees are projects at Ballymote, Co. Sligo; Creeslough, Co. Donegal; Glenties, Co. Donegal and Clonmany, Co. Donegal (with the Mental Health Association of Ireland).

Acute Hospital/Primary Care Co-ordination

Specific arrangements are in place and responsibility for co-ordination of certain services between the acute (general) hospitals and the primary care sector have been assigned to specific personnel e.g.,

- The area co-ordinator must ensure that procedures to co-ordinate non-acceptance or discharge of cases from in-patient services with the alternative community services are established and functioning.

- To discharge this and other responsibilities the area co-ordinator is authorised to bring appropriate staff from both the hospital care and community care programmes together to seek solutions to problems, assess the availability of resources to deal with demand and seek agreement to change existing arrangements in the light of changing circumstances.

- The matron of each unit acts as a district co-ordinator with a defined catchment area and has responsibility for, among other things, co-ordinating arrangements between the in-patient services and the community services to ensure there is in each individual case, the most effective and efficient provision of services.

- In each general hospital there are social workers employed with the direct responsibility for assessing home circumstances and support in the case of the discharge of elderly patients. Close co-ordination and liaison exists with the district co-ordinator.

- The district co-ordinator or unit manager works closely with the local public health nurse in relation to arrangements and support for elderly patients being discharged home from the acute services or the local unit for the elderly.

- In developing practice plans in the acute general hospitals in line with the revised common contract for consultants particular focus is being placed on the allocation of time, resources and priority to the specific needs of the elderly for cataract operation and joint replacements.

Links with General Practitioners

The general practitioners are fully involved in the referral of patients and clients for residential and community services. In the district and area co-ordinator structure the general practitioner deals with a single point of contact to refer a patient for health board services. They have a full and direct role in the assessment and review process and no longer have to "shop around" for residential care places.

The importance of the role of the general practitioner is reflected in a number of structures which have been put in place.

General Practitioner involvement in Local Hospitals and Units

Access by GPs to local hospitals has taken the form of formal GP Access Schemes which are in place at

- Sheil Hospital, Ballyshannon,
- District Hospital, Dungloe,
- District Hospital, Donegal Town,
- District Hospital, Lifford,
- District Hospital, Carndonagh.

Specific arrangements have also been made for the involvement of GPs in the provision of medical services to the following units:

- the Community Nursing Unit, Ramelton,
- the Community Nursing Unit, Falcarragh,
- the Community Nursing Unit, Buncrana,
- the Community Nursing Unit, Ballymote,
- St Joseph's Geriatric Hospital, Stranorlar,
- St Patrick's Hospital, Carrick-on-Shannon,
- St John's Geriatric Hospital, Sligo,
- the Rock Welfare Home, Ballyshannon,
- the Welfare Home, Manorhamilton,
- Our Lady's Hospital, Manorhamilton.

In terms of liaison and co-ordination there are established links between the GPs and:

(a) *The District Co-ordinator*

The GPs role in the local units facilitates contact and liaison; there is a direct role in assessment for services and review arrangements.

(b) *Community Care Services*

The public health nurse and other community care staff including social workers, community welfare officers, community psychiatric nurses, social workers and alcohol counsellors, etc., are based locally which in itself facilitates contacts and linkages with the general practitioner. In the case of the elderly the district co-ordinator can "open the gateway" to these services when a single referral is received from the GP. In several instances general practitioners now work from the same locations as these community services; this is a developing trend and a practical further example of service co-ordination in practice.

(c) *Health Board Management*

- Routine meetings between representatives of GPs and senior board management dealing with all aspects of general practice and all interfaces with the other health and social services.

- Meetings with all GPs on a district basis. The typical district has a population of 30 - 40,000 and approximately 20 GPs. Each district meeting is to be held twice each year and will involve all GPs and the local management of each of the other main health services.

- Easy and open access to management exists so that any GP can raise issues or problems directly.

Integration of Services

A good example of the co-ordination and integration of services at local level is the District Hospital at Dungloe, Co. Donegal which has been used as a resource base for integrated primary care services in the catchment area (pop. 15,000 approx.).

Services

- district hospital service with GP involvement
- day hospital for the elderly
- chronic sick care
- physiotherapy
- occupational therapy
- x-ray unit
- GPs based at hospital
- consultant out-patient clinics
  (surgery, medicine, obstetrics and gynaecology, psychiatry)
- public health medicine (area medical officer)
- public health nursing
- social worker
- environmental health officers
- community welfare officers
- community development worker
- community psychiatric - nursing, consultant and psychology back-up
- dentistry
- day centre for mentally handicapped
- hostel for mentally handicapped
- day centre for mentally ill
- supervised hostel for mentally ill (being commissioned)
- special housing (planned)

Conclusion

The arrangements which I have outlined in this paper are those which exist in the North Western Health Board and they have grown and evolved over the years in response to the actual problems which we have encountered on the ground in the North West. They were, by no means, the original solution to the problems and, certainly, are not the final shape of the arrangements. They have also had a long history.

For example, the devolution of budgetary responsibility and of services responsibility to the heads of the community care services took place over 10 years ago. While this helped enormously in the making of our services more sensitive at local level to community needs, it also gave rise to a need for co-ordination of the services. From this grew the concept of the sectorisation of our services and the introduction of the area and district co-ordinators which

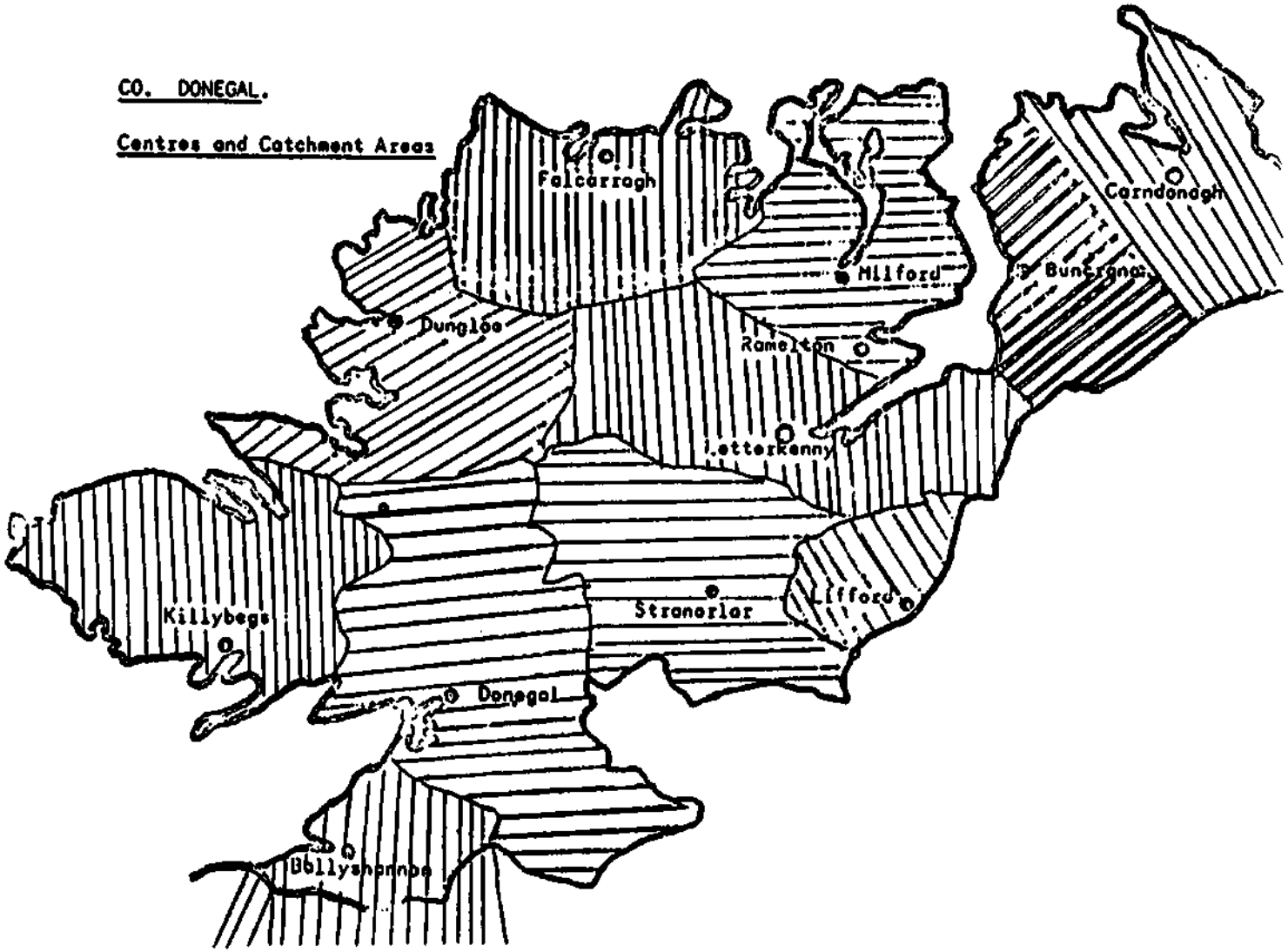
was put in place approximately six years ago. This gave rise to the need for new arrangements for linkages with the nursing home services, the community voluntary services and the transport and emergency services. During all this time our information systems were continually being asked to respond to new needs.

The arrangements continue to change and to grow, to adapt and to respond to changing needs and to perceived new needs. But what is more important is that there is an ethos for co-ordination and co-operation which enables the system to respond both to individual needs and to the collective needs of the elderly. When barriers to co-ordination exist or when they are perceived to exist, there is already a tradition and a linkage in place which enables those people who are committed to deliver a quality service to come together and change to meet the need.

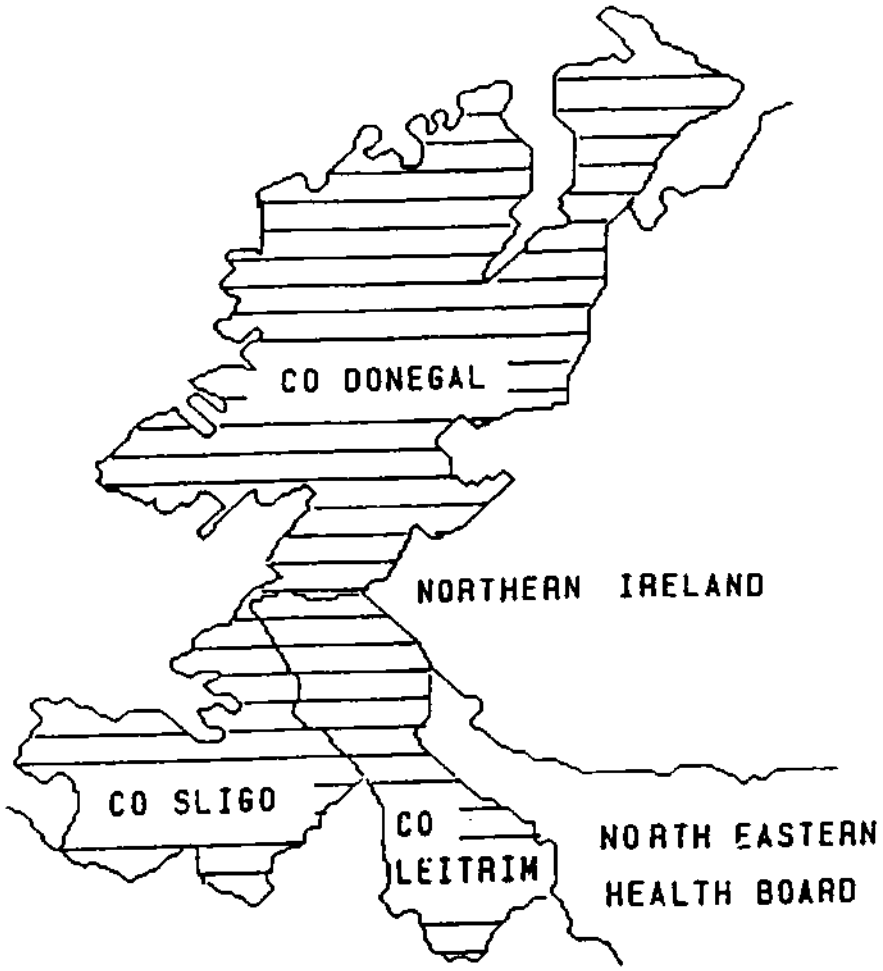
There is a total commitment from the top down to co-operate fully with all agencies involved in the care of the elderly. The board members themselves take pride in the degree to which the voluntary sector responds positively to its involvement in the shaping and delivery of the services. Senior managers and middle managers see it as part of their normal duty to ensure that co-ordination and collaboration between all agencies takes place. The appointment of the various co-ordinators and liaison persons act as the cement within the system to bind linkages together.

Our work is by no means complete. We have a lot to do. We want to further extend the role of the voluntary organisations in the befriending service. We are anxious to encourage developments among the Alzheimer Society and Multiple Sclerosis Society throughout our region. We need to develop further our assisted telephone and patient-alert systems to enable us to improve the security of elderly persons. We need to develop the services for those who are in need of "hands-on" care so that the needs can be met in a flexible manner covering a twelve hour day, seven day week. We need to develop further the services at our district and community units. We need to develop our ability to listen more to the elderly and to allow them to state their needs.

But I believe that we have in place structures which, without too much major modification, will enable us to carry on along that road.


CO. DONEGAL.
Centres and Catchment Areas
Falcarragh
Carndonagh
Milford
Buncrana
Dungloe
Ramelton
Letterkenny
Killybegs
Stranorlar
Lifford
Donegal
Ballyshannon

NORTH WESTERN HEALTH BOARD AREA



NORTH WESTERN HEALTH BOARD

AREA	**2,600 SQUARE MILES**
POPULATION	**213,000**
DISTANCE	**N-S 175 MILES**
URBAN/RURAL	**85% RURAL**

WORKSHOP REPORTS AND SUMMING UP

Dr. Michael Hyland

I am one of several Corkmen today at this meeting. I suspect the specific reason for being chosen was my speed of delivery, which is one of the main reasons you ask Cork people to sum up.

I will give you the headlines of the various discussions of the reports and the points made.

A. *Improving Representative Involvement of General Practitioners in the Co-ordination of Services for the Elderly at the Local Level*

- A key worker model at local level was necessary, but did not necessarily specify what group or profession that key worker would come from, this would depend on circumstances.

- The GPs felt that they would be represented at area level on policy issues but not below area level.

- They did not think that they would be represented on district teams which really focused on special target groups but would be available for discussions on a case level. So they stress that they see their involvement at the area level but not the sub area level.

B. *Developing the Voluntary Sector for Partnership in the Care of the Elderly*

- The necessary political commitment.

- The necessary funding, with written contracts for care which lasted for two to three years rather than one year. The involvement of key workers (a) for specific projects and (b) as development workers. That these would need a budget, would need a clear job description, would need accountability and access to networking services.

- That training should be available jointly for voluntary and statutory workers and that voluntary workers would be given an insight into the constraints of statutory personnel, and they felt that representation should be on the basis of service offered rather than individuals.

C. *Co-ordination between Housing and Health Authorities: Addressing Grey Areas in the Provision of Services for the Elderly*

- This group stressed the need for communication between housing, health and voluntary organisations. This is very good at an informal level but lacks formality. This lack of communication manifested itself particularly in three areas, first, the medical and welfare needs of sheltered housing residents, secondly, residents who have behavioural problems, and thirdly, the increasing needs of ex-psychiatric patients.

- They looked at planning and design of housing. The need to involve the users in this, both in the new housing and adaptation of existing housing.

- Finally, they stressed the need for more transfer of resources to the community.

D. *Improving Co-ordination between Acute Hospitals and Community Care Staff in the Interests of the Elderly Patient*

- The necessity of liaison and that it should be two way. It was felt that there was a big difference between the situation in urban areas and rural areas and there was greater ease of liaison at rural level.

- The need for social workers to work with the elderly in the community. That there was availability of social workers at hospital, not necessarily community level. The need at community level was stressed.

- It was felt that GPs should be seen as an integral part of the district team, in contra-distinction to the previous working group.

My second brief is really to look at our day as a whole.

Donal O'Shea who was the last speaker showed how things happened in one area of the country, an essentially rural area, how the structure was made up and how the people worked within it, which was in fact a most interesting exercise.

Going back to this morning we start with the report and something which in fact I think Dr. Barrington stressed, its originality; the fact that this so rarely happens in Ireland, and we are indebted to the National Council for the Elderly for instigating this report. It was an arduous task, but I think the task has been very well fulfilled. I was one of the group who was involved in its conception and I had great difficulties with it. My research is purely clinical research. I have no background in social research and had great difficulties in formulating this project.

Maybe the *terms of reference* were not exactly right but you had to start somewhere, these things have not been done before. There were four years of work ahead and I did not imagine it was going to last so long. What it produced was a mass of information involving at least 89 people, and Michael Browne, who after all had the key role in the whole study, synthesised and analysed these findings in a masterful fashion to produce a book which is succinct and which is a model of clarity. We owe an enormous amount to Michael for doing this, I do not think anybody else I know could have done it. He is a man with many attributes but I think what shines through this publication is his intellectual honesty.

He explained this morning the kind of problems that they had, particularly the way people felt that working on this committee was an appendage to their normal work. They all had lots of work to do. The *terms of reference* probably involved too many things, it certainly gave them a lot of responsibilities with no power and virtually no budget, the classic catch 22 situation, but that is not unusual in our health services and of course is not unusual in our local authority or government services.

Too often committees suggest co-ordination without appreciating the difficulties and Michael has opened a window here to show what the disturbing reality is on the ground and we do not often get this view. Instead of this rhetorical and aspirational language we see things as they really are, warts and all.

Finbarr Corkery felt there was a social consensus emerging about the needs for the elderly in that the people in general wish to fulfil these needs and that the elderly have a reasonably high profile in the political agenda, but of course profiles in political agendas are constantly changing and it is up to us to make sure that the elderly keep their place up there near the top, it is certainly important for we who are growing old to make sure they stay up near the top.

The situation of committees without power is an interesting one, and I suspect many of the frustrations that I and other people feel, is being put in situations where we are landed with responsibilities without the resources or the power to influence things. I think this is part of

all our lives and I think Dr. Barrington put this in context. So many people in this country are frustrated, so many people working with health boards and local authorities and government services are frustrated because of this centralisation of power.

Those who are down the line suffer great conflicts and I'm sure this is one of the reasons why we have a poor health status. We are constantly told we smoke too much, we drink too much, we eat too much fat, we have high cholesterol. I suspect with many of us it is because of how we work. Chief executive officers do not seem to get much in the way of coronary heart disease in my experience. Middle line managers seem to drop out like flies and I think many people down the line feel frustrated.

Increasingly, it is becoming evident that this situation of responsibility without the power is the real breeding ground of much of vascular disease that we see. Rather than changes in our lifestyle, maybe it's the structure of how we work and how we run our country, and I'm sure we would have a healthier country and we would all, hopefully, become like Dr. Barrington in later years, if we were able to come to terms with the structures in which we work and change them. *The Years Ahead* report stressed this co-ordination, that the key responsibility of the co-ordinator of services for the elderly who would be given the resources to manage, with the district teams and the district liaison nurse. In fact, in retrospect, having heard Dr. Barrington I think our district teams are rather large at 20-30,000. I think we should be thinking of much smaller entities for district teams.

One of my great bug bears is the co-ordinator of services for the elderly, because there is an essential epidemiological requirement here. One of the greatest difficulties for people who work with the elderly, who very often like myself become compartmentalised, we get totally overrun by our problems, the rising tide, swimming against the tide, that really typifies so many of our feelings, because we do not know the true extent of the problem with which we are dealing. We must know the epidemiology, we must know the demography, we must know the changes which are taking place, we must be able to project accurately what is happening next year, in five years and ten years time and we can, if we have trained people to do it. Co-ordinators must be trained to have this epidemiological role. They must explain exactly what our requirements are at each level. Alzheimer's Disease is not a great problem. Once you actually measure the number of people in any one area it is quite small. It is this feeling that the problems are overwhelming that leads to the defeatist attitude and the ostrich like attitude of so many people who work within the service. We need to know about our area. We need to know about our community and if we do not know the real demography of our elderly we cannot calculate their requirements and their needs and the skills that we will need and I think this is a first priority of the co-ordinator of services.

We must of course develop the ethos of co-ordination and I think this kind of meeting tends to foster this development. As the report states we need an openness and a new vision on the part of policy-makers, administrators, professionals and virtually everybody who works in the field. I think it has been a most enjoyable day and congratulations to those who organised it, and my sincere congratulations to my good friend Michael Browne who started it all.

NOTES ON CONTRIBUTORS

Dr. T. J. Barrington

Dr. T. J. Barrington is a former member of the Department of Local Government now the Department of the Environment. He has always been interested in sub-national systems and has written on Local Government systems. He is also the author of *The Irish Administrative System* and was Chairman of an expert committee on Local Government Reform.

Dr. Michael Browne

Dr. Michael Browne is the author of the Report. He is a former Research Officer with the National Council for the Elderly.

Mr. Michael Coote

Mr. Michael Coote is Chairman and founder member of the Alzheimer Society of Ireland. He is a member of the National Council for the Elderly since 1990.

Dr. Finbarr Corkery

Dr. Finbarr Corkery is a General Practitioner in Cork and member of the National Council for the Elderly. He was Acting Chairman of the Consultative Committee on Co-ordination.

Lady Valerie Goulding

Lady Valerie Goulding was appointed President of the National Council for the Elderly in 1993, having chaired it since 1990. She is founder of the Central Remedial Clinic.

Dr. Michael Hyland

Dr. Michael Hyland is a Consultant Physician in Geriatrics in Cork. He is a former member of the National Council for the Elderly. Dr. Hyland was a member of the Working Party on Services for the Elderly, which produced the report *The Years Ahead: A Policy for the Elderly.*

Mr. Dona! O'Shea

Mr. Donal O'Shea is Chief Executive Officer of the North Western and North Eastern Health Boards. He is Chairman of the General Medical Services Payments Board, Vice Chairman of the Mental Health Association of Ireland, a member of the Postgraduate Medical & Dental Board and former Chairman of the Health Education Bureau.

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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. *"Its Our Home": The Quality of Life in Private and Voluntary Nursing Homes in Ireland*, 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*, Second Edition 1992.
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 the 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(a) *Co-ordinating Services for the Elderly at the Local Level: Swimming Against the Tide, A Report on Two Pilot Projects*, September 1992.

23(b) *Co-ordinating Services for the Elderly at the Local Level: Swimming Against the Tide, Summary of an Evaluation Report on Two Pilot Projects*, September 1992.

24. *The Impact of Social and Economic Policies on Older People in Ireland*, January 1993.
25. *Voluntary-Statutory Partnership in Community Care of the Elderly*, January 1993.
26. *Measures to Promote Health and Autonomy for Older People:* A Position Paper, August 1993.
27. *Co-ordination of Services for the Elderly at the Local Level*, (Proceedings of Seminar, November 1992) September 1993.
28. *Voluntary-Statutory Partnership in Community Care of the Elderly*, (Proceedings of Seminar, February 1993) September 1993.
29. *Dementia Services Information and Development*, (Proceedings of Seminar, June 1993) September 1993.
30. *Bearing Fruit*, A Manual for Primary Schools, September 1993.
31. *In Due Season*, A Manual for Post Primary Schools, September 1993.

National Council for the Elderly Fact Sheets

Fact Sheet 1	Caring for the Elderly at Home
Fact Sheet 2	Carers You Matter Too!
Fact Sheet 3	Ageing in Ireland: Some Basic Facts
Fact Sheet 4	Voluntary Sector Services in the Community