10 YEAR ACTION PLAN FOR Services FOR Older Persons 1999 - 2008

“Working for the community, in partnership with the community”
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A multi-disciplinary/cross programme working group was formed in August 1997 to prepare this present report.

The working group met on 13 occasions and consulted widely with care providers, carers and voluntary organisations. The working group, held a one day workshop to which 55 voluntary organisations were invited and gave their views on services for older people and discussed how we as a Board might develop services into the next millennium.

In addition separate meetings were held with representatives from the General Practice Unit at Dr Steevens’ Hospital and with representatives from the Irish Private Nursing Homes Association. The Working Group also received submissions from many professional groups.

The working group also met with representatives of each of the local authorities in our Boards area with a view to developing partnerships for the development of services for older people in a seamless fashion particularly in the area of sheltered housing.

The membership of the Working Group was:

Mr Edward Matthews, Eastern Health Board Co-ordinator of Services for the Elderly (who acted as Chairperson)

Mr Adrian Charles, Senior Administrative Office.

Dr Morgan Crowe, Consultant Physician in Medicine for the Elderly.

Mr David Dunne, Director of Mental Handicap Services.

Ms. Deirdre Earle, Senior Community Physiotherapist.

Mr J. Fallon, Director of Services, Daughters of Charity Services.

Mr Martin Farrell, Chief Nursing Officer.

Dr Catherine Hayes, Specialist in Public Health Medicine.

Ms Mary O’Connell, Researcher.

Ms Ena O’Mahoney, Director of Nursing, Cherry Orchard Hospital.

Ms Sheila O’Malley, Superintendent Public Health Nurse.

Dr Margo Wrigley, Consultant Psychiatrist in the Psychiatry of Old Age.

The committee was assisted in its work by Ms Lorraine Ashe and Ms. Michelle Forde who provided secretarial support and who together with Ms Valerie Kavanagh collated the report and to whom the Working Group are greatly indebted for their efforts.
The Terms of Reference for the Group were:

- To carry out detailed assessment of the requirements for services for older people over the next 10 years.

- To carry out a detailed needs assessment with regard to community services for older people e.g. community ward teams, public health nurse services, home help service, community and residential services for the elderly mentally infirm and the need for secondary rehabilitation services.

- To examine the care requirements for the increasing number of older persons with mental handicap in our Board's area.

- To prepare a 10 year plan based on the needs assessment for the development of services both community and residential based for older persons for the next 10 years 1999 - 2008.

In considering the future requirements of services for older people the group will work closely with the many voluntary organisations involved with care of older people and with the local authorities, having particular regard to a closer integration of the day services provided by our Board with the sheltered housing complexes provided by the local authorities.
Policy Objectives

The Eastern Health Board’s objectives for the provision of services for the elderly are as outlined in its policy document “Services for the Elderly - adopted in 1989”. These stated policies are reaffirmed in the Health Strategy “Shaping a Healthier Future” and are:

- to maintain older people in dignity and independence at home in accordance with the wishes of older people as expressed in many research studies
- to restore to independence at home those older people who become ill or dependent
- to encourage and support the care of older people in their own community by family, neighbours and voluntary bodies in every possible way
- to provide high quality hospital or residential care for older people when they can no longer be maintained in dignity and independence at home
- to co-ordinate the existing services into a cohesive support package unrestricted by programme or service agency boundaries with the sole objective of providing the best and most comprehensive range of care for older people which is client centred and focused.

1.1 Ten Year Action Plan

It will be essential over the 10 years of the plan to prioritise certain areas which must be addressed:

- Promotion of healthy ageing with the assistance of the National Council for Aged and Older People, Age & Opportunity and other voluntary bodies involved with older people.
- The development of care groups for older people and the encouragement and development of a positive consumer attitude by older people and a corresponding response from care providers.
- The practical involvement of older people and their carers and advocates in the planning and developing of services.
- Strengthening the role of the general practitioner, the public health nurse, para-medical staff, the home help and the other primary care professionals in supporting older people and their carers who live at home. The target will be to ensure that not less than 90 per cent of those over 75 years of age continue to live at home.
- Further evaluation and redefining of the Community Ward Team concept, to provide enhanced services e.g. 24 hour respite care in the home, twilight/night care and more intensive convalescent/step down care.
- Further development of Departments of Psychiatry of Old Age so that a service is available to every Community Care Area and to meet the expanding service needs of an increasing aged population.
- Further development of Departments of Medicine for the Elderly to meet the expanding service needs of an increasing elderly population.
- The development of dedicated services to deal with problems relating to:
  (i) Older People with Mental Handicap
  (ii) Services for Older Psychiatric Patients residing in Psychiatric Hospitals/Hostels.
- Provision of additional places for convalescent care for older people who do not need acute medical care.
- Provision of adequate secondary rehabilitation on acute hospital campuses where possible.
- Ensuring that adequate funding is available to meet in full the requirements of the Health (Nursing Homes) Act 1990.
- Provision of a number of small scale nursing units (i.e. 50 bed units) in the community to replace unsuitable accommodation and to meet the needs of the expanding population of older people. These units will provide a range of services, i.e., respite/intermittent care, convalescent/ rehabilitation, long stay and day care.

1.2 Monitoring and Evaluation of Ten Year Action Plan

Shaping a Healthier Future - A strategy for effective healthcare in the 1990’s set as one of its main targets the challenge of measuring the quality of services by constantly monitoring and evaluating quality through various means including clinical audit, and customer surveys and by monitoring the service outcomes to ensure that they are as effective and efficient as possible.

While acknowledging that the Irish Health Services including those specifically provided for older people were of a high standard and were managed by committed caring staff, Shaping A Healthier Future did state that “Many of the services are not sufficiently focused towards specific goals or targets and it is therefore difficult to assess their effectiveness. The information which would support this focusing is frequently unavailable if available under utilised.” The Health Strategy places an explicit onus on health providers to monitor, evaluate and re-orientate if necessary, services for older people to ensure that the optimum service is provided to those who might require it.

The Working Group is satisfied that the original Four Year Action Plan and the follow-on 10 Year Action Plan are both compiled in the spirit of the Health Strategy. Both reports quantify care needs across a wide range of services, community and in-patient based, set clear objectives and set out measured and phased costings.

The Working Group is also conscious that evaluation and measuring quality has become more important in recent years. This has been evidenced in the service plans prepared by our Board in 1997 and 1998 which set specific evaluation targets for selected services.

The Working Group is conscious that examination of outcomes, evaluation of services, and the setting of targets applies in equal measure to every chapter in this report. Therefore it is recommended that all new service developments for older people should be pre-evaluated if possible, and if not, should be evaluated as soon as possible after they have been put in place. Key to this work will be the Department of Public Health Medicine whose expertise will be invaluable in assisting service providers.

Equally the Working Group consider that agreed indicator mechanisms or measurement tools should be selected whereby existing services, i.e., Community Ward Teams, Community Units for Older Persons, Respite Services etc. should be examined and decisions reached as to whether they are operating efficiently or whether they should be re-defined.

The Working Group consider this work is vital if scarce resources are to be utilised and allocated to best effect.
Existing Services

Health services for older people are provided under the auspices of the Programme for Acute Hospital Services and the Elderly which deals primarily with the in-patient element of Medicine for the Elderly. The day to day provision of services for older people in the community and those older people in need of psychiatric care is organised from within the individual Programmes respectively.

The Programme Manager for Acute Hospital Services and the Elderly has overall responsibility for promoting and ensuring the development and implementation of policies and services for older people across the various programmes and also ensuring that a range of services are put in place that are customer friendly, easy to access and appropriate to the care needs of older people.

In this task the Programme Manager for Acute Hospital Services and the Elderly is assisted by a full time Director of Services for Older People with Board wide responsibility, who works closely with nominated representatives from each of the programmes to ensure that the development of services for older people is planned in a considered and cohesive fashion.

In addition to this post there are ten Co-ordinators of Services for Older Persons, located in our Boards Community Care Areas whose function is to ensure that a cohesive and seamless service is provided for older people at area and cross area level.

Within our Board area there is a range of services for older people which are provided by our Board and by voluntary groups on behalf of our Board. These services include:

- General Practitioner Services
- Community Ward Teams
- Public Health Nursing Service
- Home Help Services
- Care Assistant Services
- Community Paramedical Services
- Dental/Aural/Ophthalmic Services
- Meals on Wheels
- Assessment, Supply/Fitting Medical Appliances
- Home Improvement Scheme
- Day Centre/Clubs
- Support for Carers (Voluntary and via Public Health Nurse Scheme)
- Rehabilitation/Stroke Day Service.
- General Hospital Services
- Acute Departments of Medicine for Older People
- Day Hospital for Older People
- Day Care Units for Older People
- Respite/Intermittent Care
- Secondary Rehabilitation Care
- Welfare Accommodation
- Convalescent Care (Voluntary/Health Boards)
- Palliative Care
- Long Stay Care
- Mobile Day Hospital
- Subvention towards Private Nursing Homes
- Continence Advisory Service
- Nutritional Advisory Service
- Acute Psychiatric Services
- Departments of Psychiatry of Old Age
- Day Hospitals for Psychiatry of Old Age
- Community Psychiatric Services of Old Age

It can be seen there are a large number and type of services provided directly and indirectly by our Board for older people which help to emphasise the need for co-ordination and cooperation between the various health providers to meet the diverse care needs of older people.
Demographic Information

The following table illustrates the trends in the population in our Boards area for people aged 65+, 75+ and 85+ in the last four available censuses.

### TABLE 1

Eastern Health Board, County/County Borough level of population for persons aged 65 plus 1981 - 1996

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<tr>
<td>Over 65</td>
<td>101,570</td>
<td>108,315</td>
<td>6.64%</td>
<td>117,443</td>
<td>7.19%</td>
<td>125,271</td>
<td>6.67%</td>
</tr>
<tr>
<td>Over 75</td>
<td>36,133</td>
<td>41,073</td>
<td>13.67%</td>
<td>46,452</td>
<td>13.11%</td>
<td>50,363</td>
<td>8.42%</td>
</tr>
<tr>
<td>Over 85</td>
<td>6,060</td>
<td>7,226</td>
<td>19.24%</td>
<td>8,965</td>
<td>24.07%</td>
<td>10,558</td>
<td>17.72%</td>
</tr>
<tr>
<td>E. H. B Population (All Age Groups)</td>
<td>1,194,735</td>
<td>1,232,238</td>
<td>3.14%</td>
<td>1,245,225</td>
<td>1.05%</td>
<td>1,293,964</td>
<td>3.91%</td>
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The figure of 125,271 is consistent with the projections of population growth as outlined in the National Council on Ageing and Older People report entitled “Health and Social Care Implications of Population Ageing in Ireland 1991 - 2011” which anticipated that 9.8% of our population would be aged 65+ in 1996 (see Table 2).

### TABLE 2

Projected Eastern Health Board, County/County Borough level of population for persons aged 65 years and over 1991-2011 (figures in parentheses are % of total area population)

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<tr>
<td>Eastern Health Board</td>
<td>117,446 (12.8)</td>
<td>126,162 (9.8)</td>
<td>137,063 (10.3)</td>
<td>153,327 (11.2)</td>
<td>176,034 (12.5)</td>
</tr>
<tr>
<td>Dublin Borough</td>
<td>61,335 (12.8)</td>
<td>63,329 (13.4)</td>
<td>65,027 (14.1)</td>
<td>66,870 (14.8)</td>
<td>68,022 (15.5)</td>
</tr>
<tr>
<td>Dun Laoghaire</td>
<td>19,889 (10.7)</td>
<td>21,866 (11.1)</td>
<td>24,187 (11.6)</td>
<td>27,610 (12.6)</td>
<td>31,584 (13.8)</td>
</tr>
<tr>
<td>Dublin County</td>
<td>17,516 (4.8)</td>
<td>20,972 (5.4)</td>
<td>26,021 (6.2)</td>
<td>33,761 (7.6)</td>
<td>45,467 (9.6)</td>
</tr>
<tr>
<td>Kildare</td>
<td>8,887 (7.2)</td>
<td>9,459 (7.2)</td>
<td>10,252 (7.3)</td>
<td>11,951 (8.1)</td>
<td>15,261 (9.8)</td>
</tr>
<tr>
<td>Wicklow</td>
<td>9,816 (10.1)</td>
<td>10,536 (10.4)</td>
<td>11,576 (11.0)</td>
<td>13,135 (12.1)</td>
<td>15,700 (13.9)</td>
</tr>
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</table>
The accuracy of the 1996 figures as projected by the National Council on Ageing and Older People when compared to the actual 1996 census figures lead us to believe that the Council's projections up and until the year 2011 are themselves as accurate as is possible at this time. On examination of the various figures in the census projections for 2001 and 2006, it is therefore reasonable to estimate that the population aged 65 and over by the year 2008 will have reached approximately 165,000, an increase of 40,000 or 23%.

It should be noted that population ageing is reflected not only in the growth of the population aged 65 and over but also secondary ageing, that is the growth of the numbers of elderly (those aged 80 and over). The most dramatic change in the elderly population in the period to 2008 will be an estimated increase of almost 50% in those aged 80 and over as per projections by the National Council on Ageing and Older People. This sizeable increase in the population aged 65 and over leaves our Board with a clear impetus to provide a measured response to the community and inpatient needs of older people over the next 10 years.
5.2 Executive Summary of Recommendations: 1999 - 2008

The following is a summary of the Working Groups recommendations taking on board the projection that our Board's elderly population will expand rapidly between now and the year 2008. This will be particularly relevant for those people aged 75 and over and 85 years and over where the increase will be even more substantial.

5.2.1 Health Promotion (para 7.5.10)
The employment of:
1 Senior Health Promotion Officer
3 Health Promotion Officers
1 Researcher

Revenue Cost £136,800 (full year)

5.2.2 Service Providers and Customers (para 8.9)
The creation of 3 liaison officers with responsibility to network with various voluntary organisations

Revenue Cost £75,000 (full year)

5.2.3 Services in the Community - Nursing Service (para 9.3)
The creation of 29.5 WTE Public Health Nurse posts and 23 Senior Public Health Nurse posts

Revenue Cost £1.230m (full year)

5.2.4 Services in the Community - Home Help Service (para 9.4)
Phasing out of arrangement with Community Welfare Services

Revenue Cost £150,000 (full year)

Increase in hourly rate paid to Home Helps over 2 year period to £4.50 per hour

Revenue Cost £3.00m (full year)

Increased finance required to meet additional demand for Home Help Service

Revenue Cost £5.00m (over 10 years of plan)

5.2.5 Services in the Community - Meals on Wheels (para 9.5)
The provision of additional meals and the cost of increasing grant aid per meal over a five year period

Revenue Cost £1.34m (full year)

Upgrade and develop local based Meals on Wheels centres

Capital Cost £750,000 (once off)

5.2.6 Services in the Community - Occupational Therapy Service (para 9.6)
The provision of 20 WTE posts of Occupational Therapists

Revenue Cost £400,000 (full year)

5.2.7 Services in the Community - Physiotherapy Services (para 9.7)

The creation of an additional 25 WTE posts of Physiotherapist

Revenue Cost £494,000 (full year)

5.2.8 Services in the Community - Continenence Advice (para 9.13)
The creation of 2 additional WTE posts of Continenence Advisor

Revenue Cost £57,500 (full year)

5.2.9 Services in the Community - Nutritional Services (para 9.14.2)
The creation of 2 additional WTE posts of Nutritionist

Revenue Cost £42,000 (full year)

5.2.10 Services in the Community - Social Work Service (para 9.15.4)
The piloting of a social work service by providing 2 WTE posts of Social Worker

Revenue Cost £44,000 (full year)

Following evaluation of this project and subject to a satisfactory outcome the following staff levels will be required.
3 Head Social Workers
8 Senior Social Workers
6 Social Workers

Revenue Cost £470,000 (full year)

5.2.11 Services in the Community - Speech and Language Services (para 9.16.6)
The creation of 12 WTE posts of Speech and Language Therapists

Revenue Cost £248,000 (full year)

5.2.12 Services in the Community - At Risk Register (para 9.18)
The development of computerised ‘At Risk’ register

Equipment Cost £50,000 (once-off)

5.2.13 Carer Support (para 10.3.2)
The creation of carer support groups in South Dublin, East Wicklow/West Wicklow

Total Revenue Cost £160,000

5.2.14 Community Ward Teams and Associated Care Services (para 11.5.4/11.5.7)
The provision of 150 WTE staff (PHNs, RGNs, Paramedic, Home Care Attendants and Support Staff)

Revenue Cost £2.24m (full year)

The creation of 2 posts of Area
Co-ordinator of Services for the Elderly
Revenue Cost £70,000 (full year)

5.2.15 In-Patient Hospital and Residential Services-
Department of Medicine for the
Elderly(14.2.3)
The creation of 3 acute hospital based Liaison Sisters posts
Revenue Cost £66,000 (full year)

5.2.16 In-Patient Hospital and Residential Services-
Department of Medicine for the
Elderly (14.2.5)
The creation of an additional 11 posts of
Consultant Physician in Medicine for the Elderly
Revenue Cost £1.177m (full year)

5.2.17 In-Patient Hospital and Residential Services - Acute
Assessment/ Rehabilitation
(para 14.2.5)
The provision of an additional
190 acute assessment beds
Capital Cost £7.60m (once off) (est)
Equipment Cost £1.52m (once off) (est)
Revenue Cost £8.30m (full year) (est)

5.2.18 In-Patient Hospital and Residential Services - Secondary Rehabilitation
(para 14.4.3)
The provision of an additional 311 secondary rehabilitation places in the Board’s area during the lifetime of the Action Plan
Capital Cost £12.45m (once off) (est)
Equipment Cost £2.50m (once off) (est)
Revenue Cost £12.50m (full year) (est)

5.2.19 In-Patient Hospital and Residential Services - Welfare Homes(para 14.7.3)
The provision of 4 additional posts of staff nurse and 10 posts of care attendants at St. Broc’s, Clarehaven, The Orchard and Ashgrove Welfare Homes
Revenue Costs £210,000
Upgrading of Supervisors and Assistant Supervisors posts at the four Welfare Homes
Revenue Costs £ 60,000
Adaptation to St. Broc’s, The Orchard, Clarehaven and Ashgrove Welfare Homes
Capital Cost £180,000 (once off) (est)
Equipment Cost £ 50,000 (once off) (est)

5.2.20 Community Units for Older People
(para 15.7)
The construction of 29 Community Units including Day Units throughout our Board’s area
Capital Cost £52.00m
Equipment Cost £11.20m (once off)
Revenue Cost £63.20m (full year)

5.2.21 Mental Disorders in Older People
(para 16.4.3)
1999 Enhancement of Current Services
The creation of 11 additional WTE staff posts for the existing Departments of Psychiatry of Old Age, i.e Community Nurses x 6, Registrar x 1, Psychologist x 1.5, Occupational Therapist x 1, Social Worker x 1, Secretary x .05
Revenue Cost £237,000
Provision of an additional 6 acute psychiatric and 8 additional long stay beds for severely disturbed patients
Revenue Cost £463,000
Extension of Day Hospital/Therapeutic Centre at James Connolly Memorial Hospital
Capital Cost £25,000 (once-off)

1999 - 2001
Provision of 4 acute beds located at the various acute general hospitals or elsewhere as appropriate
Capital Equipment Revenue
£1.760m £352,000 £2.102m
Creation of Day Hospitals/Base x 5 at the appropriate acute general hospitals
Capital Equipment Revenue
£230,000 £50,000 £405,000
Provision of 6 contract beds manageable Alzheimer’s patients
Capital Equipment Revenue
£3.00m £560,000 £1.60m
Years 4 - 10 of Action Plan
It is projected that the population aged 65 and over will increase to 165,000 by the year 2008 the following resources will be required to meet the service demands as per the accepted norms in the “Years Ahead” Report.

Staffing No. Revenue Cost
Consultant Posts 7 £749,000
Community
Staff Nurses 10 £188,000
Paramedical Staff 21 £528,000
N.C.H.D.’s 7 £172,000
Clerical 7 £ 93,000

Total Revenue £1,728,000
Provision of 160 Additional Acute beds and 200 long stay/respite beds for severely disturbed patients with dementia i.e EMI Units in modules of 20 beds each
Capital Equipment Revenue
£14.40m (est) £2.88m (est) £11.745m (est)

Dementia in the Community (Appendix A)
Provision of 1.5 Staff WTE (PHN, Registrar)  

Memory Clinic (Appendix B)
Provision of 1.5 Staff WTE  
(Registrar, Psychologist)  

Renovation of area in an appropriate hospital.  
The creation of 5.5 WTE Posts i.e 2 Research Registrars,  
2 Research Nurses  
1 Clerical Staff,  
5 Clinical Psychologist  

Presenile Dementia (Appendix C)
Provision of 1 Staff WTE  
(CPN, Registrar)  

5.2.22 Older People with a Mental Handicap (para 18.8)
The following capital/equipment, revenue resources are required during the lifetime of the Action Plan to anticipate the care needs of the mentally handicapped who will grow older and more frail.

1999

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<th></th>
<th>Capital Estimated</th>
<th>Revenue Estimated</th>
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<tbody>
<tr>
<td>3 x 5 bedded Specialist Units - Profound and Multiple Handicaps</td>
<td>0.900m</td>
<td>0.900m</td>
</tr>
<tr>
<td>1 x 6 bedded Specialist Unit - Challenging Behaviour</td>
<td>0.300m</td>
<td>0.300m</td>
</tr>
<tr>
<td>30 residential beds in 5 Unit Complex (6 beds per unit)</td>
<td>1.800m</td>
<td>1.100m</td>
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2000

<table>
<thead>
<tr>
<th></th>
<th>Capital Estimated</th>
<th>Revenue Estimated</th>
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<tr>
<td>3 x 5 bedded Specialist Units - Profound and Multiple Handicaps</td>
<td>0.900m</td>
<td>0.900m</td>
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<tr>
<td>1 x 6 bedded Specialist Unit - Challenging Behaviour</td>
<td>0.300m</td>
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30 residential beds in 5 unit complex (6 beds per unit)  

2001 - 2008 Inclusive

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<thead>
<tr>
<th></th>
<th>Capital</th>
<th>Revenue</th>
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<tr>
<td>8 x 30 residential beds in 5 unit Complex (6 beds per unit)</td>
<td>14.40m</td>
<td>8.80m</td>
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5.2.23 Replacement of Old/Unsuitable Buildings - Providing Care for Older People (para 19)
Bru Chaomhín, Cork Street (para 19.3.1)
The Development of 4 x 50 bed Community Units and the medium/long term phasing out of Bru Chaomhín

Capital Costs £8.00m (once off)

St Brigids Home, Crooksling, (para 19.3.2)
The Development of 3 x 50 bed Community Units and the medium/long term phasing out of St. Brigid’s Home

Capital Costs £6.00m (once off)

St Mary’s Hospital, Phoenix Park (para 19.3.3)
The Development of 4 x 50 bed Community Units and the medium/long term phasing out of approximately 200 long stay beds on the St. Mary’s campus

Capital Cost £8.00m (once off)

Comment:
(i) It should be noted that all costs outlined above are calculated at 1/1/98 prices
(ii) Recommendations which do not have a cost implication are included in the summary at the end of each chapter
(iii) The Working Group note that at present there is considerable difficulty being experienced in recruiting many grades of staff particularly paramedical and nursing grades. This Action Plan recommends a significant increase in the number of various grades of staff over its lifetime. This should be noted by the relevant education/training authorities to ensure that there is an adequate supply of staff in the various specialities to meet the inevitable demand.
5.3 10 Year Action Plan

COST SUMMARY AND PROPOSED PHASING 1999 - 2003 PARA 5.2.1 - 5.2.14

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### 10 Year Action Plan

#### COST SUMMARY AND PROPOSED PHASING 1999 - 2003 PARA 5.2.15 - 5.2.22

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*Includes for Equipping
## 10 Year Action Plan

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# 10 Year Action Plan

## COST SUMMARY AND PROPOSED PHASING 1999 - 2003 PARA 5.2.15 - 5.2.22

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*Includes for Equipping

Revenue costs each year includes roll on costs from previous years and are calculated at 1/1/98 prices.

Capital and Equipment costs are also calculated at 1/1/98 prices.
# 10 Year Action Plan

## TOTALS OF COST SUMMARY EACH YEAR 1999-2008

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- Revenue costs each year includes roll-on costs from previous years and are calculated at 1/1/98 prices
- Capital and Equipment costs are also calculated at 1/1/98 prices
6.1 The Years Ahead - A Policy for the Elderly which was published in 1988 was the first major publication which dealt exclusively with the development of services for older people. This chapter deals with aspects of the review in so far as they apply in the Eastern Health Board area.

6.2 The report which emphasised that services should be comprehensive, equitable, accessible, co-ordinated, planned and cost effective made more than 120 main recommendations on services for older people, in their own homes, in the community and in hospitals and residential homes and laid the foundation for the health strategy document 'Shaping a Healthier Future' published in 1994.

6.3 The Review of The Implementation of The Recommendations of The Years Ahead Report which was published in late 1997 by the National Council on Ageing and Elderly People stated that The Years Ahead was no longer an adequate blueprint for the development of services for older people. The Review made the point that much had changed since 1988 recommended "That a strategy for the development of health and social care services for elderly people be developed under the guidance of the Department of Health. This strategy would contain an explicit statement of the principles that should underline the delivery of services to older people, incorporating the values of equity, quality of service and accountability expressed by Shaping a Healthier Future and the guiding values of The Years Ahead report".

6.4 While awaiting the preparation of this strategy it is worth recording that the Working Group would like to emphasise the importance and relevance of the "Years Ahead Report" as a major force for change in its time in the development of services for older people. The Years Ahead was the catalyst for many welcome changes since the year 1988 to date which most certainly would not have occurred without its publication and influence.

6.5 The Working Group also note that:
- The Years Ahead was written before the major shift towards involving the consumer and carer in their own care as espoused in Shaping a Healthier Future.
- It predated the publication of the Health (Nursing Homes) Act 1990.
- The Years Ahead came into being at a time of major financial cutbacks in the Health Sector which were sustained for the following years. The fact that so many developments have occurred is quiet remarkable in this context.
- The Years Ahead was a framework document and was written in a national context. The fact that different Health Boards and indeed areas within Health Boards took different approaches to its implementation was no surprise. Even within our Boards area the different social, economic and demographic balance in the older population would preclude an exact replication of some service provisions - flexibility is required.
- Again the Working Group notes that as the Review is written in the national context that the global criticisms in respect of certain issues do not always apply to our Board and do not reflect how our services have evolved since 1988.

6.6 The Working Group with some justification feel that the following achievements highlight the progress we have made since 1988 while also agreeing that we still have major steps to take in the coming years.
- Appointment of ten Medical Co-ordinators of Services for the Elderly and a board wide Co-ordinator of Services for the Elderly
- The comprehensive development of a network of Departments of Medicine for the Elderly including Day Hospitals
- The development of two further Departments of Psychiatry of Old Age
- The provision of a large number of additional respite/intermittent, convalescent/rehabilitation, longstay and day care places - over 1,000 places
- The commencement of the programme for the development of a number of Community Units for older people including day units
- The speedy development of a Community Ward Team network throughout our Board
- The development of carer’s associations
- The development of a customer friendly ethos as evidenced by the creation of a Customer Services Department and more recently a department dealing with appeals and complaints. This department will also be developing customer fora to encourage feedback
- The creation of Departments of Nutrition and Continence Advice within our Board
- The creation of the Department of Public Health Medicine with an emphasis on Health Promotion
- The development of a partnership with our voluntary colleagues as evidenced by services developed at Peamount Hospital, Leopardstown Park Hospital, Caritas Convalescent Centre, St Monica’s Home and St Vincent’s Hospital, Fairview among others.

6.7 The review itself comments at length on the recommendations contained in The Years Ahead and places great emphasis on the need to introduce a legislative framework to govern the provision of essential services for older people. The review recommends that consideration be given to identifying core services which should be supplied as a right and which are fundamental to the maintenance of quality of life at a reasonable level for older people. While the Working Group has no fundamental difficulty with these recommendations they also feel that the new strategy for older people is required should be developed under the guidance of the Department of Health and will have to address this issue as central to its strategy.
6.8 In conclusion the review of the Years Ahead report highlighted services which they felt deserved attention.
- Home Help service.
- Respite service at home and in residential homes.
- Sheltered housing.
- Day care centres with accompanying transport service.
- Paramedical services at home and in the community.
- Social work services for older people.
- Services for older people with mental disorders.
- Community hospital service.

All these services have been specifically addressed within various chapters in this report and recommendations made in the context of a phased 10 Year Action Plan.
7.1 Introduction

Health promotion for older people starts with health promotion for those in younger age groups. Of particular relevance is health promotion in middle age, for example in the workplace and in community settings. Pre-retirement planning and courses should include information and skills development for the maintenance of good health status well into old age. Lifestyle issues relating to physical, mental and emotional well-being should be addressed.

The Workplace Programme of the Irish Heart Foundation will be developed within our region with the imminent joint appointment of a Health Promotion Officer on a three year contract. The workplace programme aims to reduce the risk of cardiovascular and other chronic diseases, and addresses issues such as smoking, nutrition, physical activity and stress management. The extent to which health issues are covered in existing pre-retirement courses and the feasibility of incorporating a pre-retirement component into the Irish Heart Foundation Programme will be explored.

While many health promotion programmes focus on the lifestyle and responses of the individual, family or community, the environment in which people live their lives has a major impact on health status and quality of life.

The physical environment is important, including housing, transport, clean air and access to sunlight, as well as freedom from threats of robbery, violence or other abuse. Access to an adequate income is fundamental to the maintenance of health. Social interaction and involvement of older people in their neighbourhoods and in voluntary groups can add to the quality of life for older people, as well as making an important contribution to the community. Support for carers, who may themselves be old, can also improve the environment in which older dependent people live.

7.1.1 Health promotion for older people can involve action in a number of arenas, including:
- advocacy for the development of public policies which support the health of older people
- work with statutory and voluntary agencies, community groups, families and individuals to improve the physical and social environment in which older people live
- work with statutory and voluntary agencies, community groups, families and individuals to provide the information and skills necessary to maintain health in older people
- reorientation of health services and training of personnel to increase the extent to which resources are expended on promotion of health and prevention of disease in older people.

7.2 National Policy

A national health promotion strategy for older people will be published in April 1998, developed by the National Council on Ageing and Older People. The strategy will review the current health status of older people in Ireland, identify models of good practice, set goals and targets, and make recommendations to attain the goals and to achieve health and social gain. The diseases, lifestyle factors, aspects of the physical and social environment, and settings for health promotion which are addressed are listed in Table 1.

The Working Group has been guided by the forthcoming national strategy document in the development of this plan for health promotion. There will be consultation to develop our Board's strategy for health promotion for older people in response to the national strategy and to gain commitment from personnel at all levels for the implementation of the policy.

7.3 General Strategy

Through activities with statutory and voluntary agencies, our Board supports and will continue to advocate for the development of public policies and environments which promote the health of older people. This will be done through the active involvement of Board personnel on intersectoral committees, for example, in the Community Ward. Teams, with Dublin Healthy Cities etc., and through financial and other supports for a range of voluntary agencies.

7.3.1 The main thrust of our Board's health promotion plan for older people will be on:
- the dissemination of information
- education for the development of attitudes, knowledge and skills towards health promoting behaviour in older people and their carers
- the incorporation of health promotion within all health services for older people, with staff training to improve effectiveness

Attitudes to ageing and to the old are important for health promotion in older people. This includes the attitudes of younger people, those of older people and those of health professionals. In all of the arenas of action for health promotion our Board will encourage positive attitudes towards ageing and towards older people. In this regard our Board will continue to work closely with Age & Opportunity to promote the ethos of positive ageing in older people.

7.4 Personnel

A health promotion function is being developed within our Board. In order to ensure that health promotion for older people receives sufficient attention, while being
7.5 Plans for Health Promotion

7.5.1 Cardiovascular Disease

The goal is to reduce morbidity and mortality from cardiovascular disease in older people. The target, similar to the national target, is to reduce the death rate from ischaemic heart disease and stroke in people aged 65 to 74 by at least 15% by the year 2005. With falling mortality rates from coronary heart disease in younger age groups and increased life expectancy at age 65, it is likely that larger proportions of the surviving population will have chronic disease of the cardiovascular system. Primary prevention remains important in older people, for example, the promotion of non-smoking, physical activity and healthy eating. In addition, secondary and tertiary prevention assume increasing importance in older age groups i.e. to reduce risk of a further event in those who have evidence of disease and to support rehabilitation and improve the quality of life in those with established disease. Indeed, older people, because of their intrinsically higher risk of cardiovascular disease, may enjoy greater benefits from prevention programmes than younger adults.

Our Board plans to work with the Irish Heart Foundation and the GP Unit to develop guidelines and support implementation of best practice to reduce risk of cardiovascular disease. Special attention will be paid within that initiative to appropriate practice for risk reduction in older people. Attention will also be paid to the process of care in those with chronic disease and to methods of improving compliance in taking medications as prescribed. Lessons from improved care in cardiovascular disease could then be applied to other chronic conditions.

7.5.2 Accidents

The goal is to reduce the number of accidents and associated mortality and morbidity among older people. The targets are:

(a) to reduce the death rate from all accidents and their adverse effects in people aged 65 and over by at least 17% per cent compared to the baseline year 1995;

(b) to reduce hospital admissions due to falls in people aged 65 and over by at least 17% per cent by the year 2005 compared to the baseline year 1993.

Strategies for multisectoral collaboration to reduce accidents are contained in the national document on accidental injury in Ireland as well as in the national health promotion strategy for older people.

Our Board has been involved in a home accident prevention project for older people. The Dundrum/Ballinteer Community Accident Prevention Initiative is a pilot project aimed at the whole population under the auspices of the Dublin Healthy Cities Project. The lessons from these projects will be incorporated into an overall plan to reduce accidents in older people in our region.

7.5.3 Mental Health

The goals are to reduce the prevalence and severity of mental illness in older people and to raise awareness of mental health issues. Old age presents challenges to the maintenance of mental health, for example, coping with retirement, the onset of physical illness, illness in a spouse, and bereavement due to deaths of family members and friends. Health promotion initiatives which promote physical health and environments which support physical and social well-being are also likely
to support mental health.

Specific initiatives to promote mental health will include:
- Pre-retirement preparation for the challenges associated with later life (see ‘Introduction’ above)
- Implementation of a health education programme designed to increase self-esteem and develop skills to improve personal relationships and to cope with stressful situations (see under ‘community initiatives’ below)
- Improved information and training for health professionals and carers on the early detection of depression and anxiety

7.5.4 Smoking
The goals are to reduce the prevalence of smoking in older people and to reduce the number of people entering the older age group with smoking-related diseases.
The target is to reduce the prevalence of smoking in people aged 55 and over by at least 16 per cent to no more than 20 per cent by the year 2005 (from a baseline of 24 per cent in 1993/94).
The Smoking Tobacco Action Group at national level and the Cardiovascular Risk Action Group in our Board plan to train general practitioners and other health professionals to increase their effectiveness to reduce smoking among clients through ‘brief intervention’. The Health Promotion Officers for Older People will encourage health professionals to pay special attention to supporting older people to stop smoking.

7.5.5 Nutrition and Diet
The goal is to ensure that older people have an affordable diet which provides adequate nutrition and which optimises their health status.
Our Board employs two Nutrition Advisors for the Elderly and a number of initiatives have been undertaken to improve the nutritional status of older people. The Senior Nutrition Advisor is Chairperson of the multidisciplinary group which has been developing a national food and nutrition policy for older people, which is now being done under the auspices of the newly established Food Safety Authority of Ireland.
When the national policy is published, our Board will plan and implement a strategy to improve the nutritional status of older people.

7.5.6 Physical Activity
The goal is to promote physically active lifestyles among older people.
Through its involvement with Dublin Healthy Cities our Board has been promoting activity among older people, through PROAction and the annual Senior Games Festival. In addition, Dublin Healthy Cities and Fingal County Council launched the Swords Active Living Project. Special efforts will be made to involve older people in that as well as in the ten Million Mile Walk, also co-ordinated by Dublin Healthy Cities.

7.5.7 Housing and the Environment
Issues relating to Housing are addressed in the chapters ‘Partnership with Local Authorities’. Through the Environment initiative under the Dublin Healthy Cities umbrella, our Board will support the provision of a health promoting environment for older people.

7.5.8 Community Initiatives
Results will be available in mid 1998 on two community-based health promotion initiatives for older people in Ireland. The ‘Lifewise Programme’ provides education for small groups on physical activity, relaxation and on health topics relevant to the group. The Cork Social and Health Education Project has developed ‘Health, Wellbeing and Empowerment for Older People’. In addition, ‘Senior Health Mentoring’ has been developed by Ageing Well in the U.K.
These programmes will be examined and, if found suitable, will be implemented on a phased basis in our Board by the proposed Health Promotion Officers for Older People.

7.5.9 Information
The Women’s Health Initiative and the overall health promotion programme of our Board are considering how best to meet the information needs of clients.
Information is provided through the Customer Services Unit in Dr. Steevens’ Hospital, as well as through health centres, general practitioners’ surgeries and hospitals. In addition, libraries and Citizen’s Information Centres are sources of information on a range of topics, including health.
A special project will be undertaken to assess the information needs of older consumers in the health services and to plan how these needs can best be met.

7.5.10 Summary of Chapter Recommendations:
The employment of 1 Senior Health Promotion Officer for Older People
Annual Revenue Cost £30,400
The employment of 3 Health Promotion Officers for Older People
Annual Revenue Cost £84,000
The employment of 1 Researcher
Annual Revenue Cost £22,400
It is clear from references to consumerism in “Shaping a Healthier Future” that the entire area of the involvement and encouragement of older people in decision making in so far as is practical, concerning their own care and welfare is of paramount importance.

It is essential in this era of consumerism that our Board should play a lead role in developing customer friendly services which are clear and unambiguous and meet the needs and wishes of older people.

8.1 It is vital that older people should play a role in initiating and developing services in
- a hospital/home setting by being empowered to advise and assist in improving the ambience and service provided from an older persons perception
- in the community setting by influencing the way services are delivered and the service gaps that are obvious to them
- and in general terms in influencing and articulating their views on the service needs for older persons in partnership with service providers who themselves have a valuable knowledge of services and service delivery.

8.2 The following are examples of what we have achieved to date in the area of consumerism and empowerment which will help focus us as service providers for the future
- A Complaints/Appeals procedure with a dedicated Appeals Officer separate from the service areas involved has been put in place by our Board.

In addition to this dedicated Appeals Officer, complaints officers and complaints committees as outlined in the “A Charter of Rights for Hospital Patients” are in situ in all our hospital/homes for older people.

- A workshop/study day involving representatives of the voluntary groups in our Boards area took place as part of the preparatory work in this report. The feedback and discussions were extremely valuable in assisting the Working Group in its deliberations. To facilitate the workshop which was held on 9th December 1997 a pre workshop questionnaire was issued to 55 voluntary organisations involved with older people, to allow the organisations to be divided into compatible sub groups in readiness for the workshop. The workshop itself was facilitated by an independent assessor and the various groups were chaired by various members of the 10 Year Action Plan Working Group. The deliberations and points raised on the day were informative and illuminating and the members of the working group present felt it gave them a clearer perspective of the carers viewpoint while the voluntary organisations expressed a view that the workshop was unique and should be built on. A summary of the workshop procedures is attached in Appendix 1.

8.3 Our Board has entered into partnership with Age & Opportunity to co-promote a positive attitude to ageing among older people and care providers. To assist in this work our Board has seconded an officer for an initial period of six months to work closely on a number of projects involving older people in our Boards area. Principle among this work is
- The organisation of a two day conference in the Grand Hotel Malahide on 13/14 November, 1997 on the theme “Older People as Consumers - A Challenge for the Health Services”.
- The piloting of leadership skills training among older people in Day Centres/Clubs in 1998
- The organisation and launch of a National Award Scheme for the Elderly in 1998.

8.4 Our Board decided as a matter of policy to introduce information handbooks in all our hospitals or residential homes for older people in 1997.

- The purpose of these books is to provide clear, unambiguous information on the services and facilities available to older persons in hospitals and homes. A key element of the handbook is the encouragement of suggestions, a procedure for complaints and a questionnaire to elicit the older persons views on services he/she is receiving.

It is proposed to ask the Department of Public Health Medicine to evaluate the use of the patient handbook in one particular hospital/home and use the resultant evaluation to improve on their content in other areas.

8.5 A pilot patient advocacy programme is currently been initiated in St. Mary’s Hospital, Phoenix Park in co-operation with Age Action Ireland.

The methodology utilised is to provide professional training for voluntary workers who in turn will act as advocates for older patients who cannot speak for themselves or have no carer who can act as an advocate for them.

The feedback from advocates will be used to improve the quality of the service for older people in the particular hospital/home.

8.6 In recognition that service provision should be of an excellent standard and oriented towards the older persons needs, our Boards policy of providing outreach community ward teams and developing a number of community based units for older people which provide a wide spectrum of services is a conscious effort to bring the service to the consumer and to ensure that care packages are accessible geographically.

8.7 It is vital that older people receive quality care that does not vary according to the area they live in and avoids the transfer of older people to hospital and homes far removed from where they lived and grew-up. In this regard it is recommended that the views of the customers using these services should be sought by means of satisfaction surveys and the findings acted upon.

- Our Board’s Customer Service Department plays a vital role in providing information to the public, including older people, on the services available and how they should access these. The extension of this service to other major population areas of our Board will be a logical step in the policy of providing clear and succinct information to older persons.

- Our Board recently undertook an evaluation of discharges from the Acute General Hospitals and the various services
they accessed principally the Community Ward Teams. The principle method of evaluating satisfaction with the Community Ward Teams was by way of interview and questionnaire involving the older persons themselves. This proved both practical and helpful and was a valuable tool in helping our Board estimate the value of the Community Ward Teams.

- Our Board is also preparing a comprehensive guide to Services for Older Persons in co-operation with our Customer Services Department. This guide will to give crystal clear information on the complete range of health services for older persons, how they can be accessed and the key people to be contacted in the event of difficulties arising.

8.8 While it can be seen from the foregoing that our Board is engaged in many worthwhile initiatives which take on board the views of older people there is also a clear recognition that much has yet to be done in this area.

It is recommended that key to the development of a customer service provider working relationship is the acknowledgement that

- customers aspirations should not be unrealistic
- and that service providers take an enlightened view and do not take up a traditional entrenched position

8.9 Summary of Chapter Recommendations:

- The drafting of a Charter of Rights for Older People in a hospital or residential home setting and in a community care setting
- The extension of the pilot advocacy project to other hospitals and residential homes for older people.
- The setting up of patient/carer - service provider fora in all our hospitals and residential homes to take on board the views of the patients and carers.
- The introduction of questionnaire type mechanisms similar to these in place in hospitals/homes for older people into the community. This could be organised on a random selection basis via the Public Health Service on a yearly basis and the results evaluated and acted upon on in each Community Care Area and across the Health Board in an effort to improve service provision.
- The extension of the pilot which has allowed an officer of our Board to be seconded to Age & Opportunity as a liaison officer to network on a range of consumer/older persons problems. It is also recommended that there should be a further two full time posts linked to other key voluntary organisations on an agreed basis, i.e a total of three posts.

Revenue Cost £75,000 p.a.

- It is recommended that a mechanism be put into place where regular contact should be made with any service provider of services for older persons and with key organisations acting as advocates for older persons. This should be organised at Community Care Area level/or Board level as appropriate.

- This could be done either by means of:
  (i) an annual work study day.
  (ii) seeking older people’s views by questionnaires.
  (iii) face to face meetings or a combination of all three.
9.1. Policy

The principles underpinning the provision of services to older people are the provision of support and strengthening of primary health services to allow older people remain in their homes for as long as is practical with dignity, independence and a good quality of life. This is the objective and goal of all the community services.

The transfer of an older person from their home to inpatient care must only be considered when the older person has been medically assessed as in need of that level of care and when all other care options to support the older person at home have been exhausted.

9.2 General Practitioner Services

General Practitioners are key players in the provision of front line services for older people. It should also be emphasised that General Practitioners together with the public health nurses act as gatekeepers to the service and tend to be the first professionals who review older people when ill and their decisions are vital in deciding on which care path an older person is placed on and what services should be accessed.

Both the “Years Ahead” and the “Health Strategy” advocate that the G.P. take a holistic approach to the care of patients - including older persons - taking full account of the psychological, social and environmental factors which influence the patient’s health status.

One of the main initiatives undertaken by our Board in recent years has been the setting up of the General Practice Unit. The main purpose of the Unit is to develop general practice and to forge links between hospitals and general practice services, while identifying and remediying deficiencies that prevent General Practitioners from providing an adequate level of care for older persons at primary level.

To this end the General Practice Unit has and continues to make arrangements with practices to provide additional services, where this can be done more cost effectively.

General Practitioners in our Board’s area are actively participating in service initiatives for older people, mainly those provided by the Community Ward Teams, which operate in each Community Care Area. The Community Ward Team’s provide a community based outreach rehabilitation service for older people which enables them to be maintained in their own home with appropriate multidisciplinary support thereby maximising their rehabilitation potential and avoiding the need, in many instances, for admission to an acute hospital setting.

The Community Ward Team’s also enable the earlier discharge of older people from the acute hospitals into a step down community based service. The General Practitioner’s role is vital in this area as he/she retains clinical responsibility for his/her patients (see separate chapter on Community Ward Teams).

In preparation of this report members of the Working Group held a meeting with representatives of the General Practice Unit at Dr. Steevens. The following issues were raised which are commented elsewhere in this report as appropriate:

- The urgent need for additional respite and convalescent care both at in-patient and in the home setting.
- The need for improved level of supports for carers i.e. twilight, night sitting, overnight care etc.
- That sheltered housing and housing for older persons should be life long housing.
- In considering initiatives in the area of Health Promotion for older persons that liaison should take place between Health Promotion officers and General Practitioners to ensure that a positive health promotion ethos reaches older persons in their homes. Areas that would be highlighted include: vision, hearing, falls, incontinence, nutrition etc.
- Improvements in the Home Help Service are necessary
- There should be strong links between service providers and voluntary organisation operating on behalf of older persons.
- Greater efforts should be made to make information on services for older people available both to General Practitioners and the public at large.
- A nominated person in each Community Care Area i.e. Co-ordinator of Services for the Elderly should be identified as a key person General Practitioners can liaise with re accessibility to service for older persons on a rapid response basis.
- Where possible the development of Departments of Medicine for the Elderly and Psychiatry of Old Age should be planned in a co-ordinated fashion on General Hospital campus’s.
- The concept of General Practitioner’s accessing a small number of beds in selected hospitals/homes for older persons for non acute admissions should be revisited, perhaps in a rural setting.
- Links between General Practitioners and Public Health Nurses should be strengthened and reinforced.

9.3 Nursing Services

As stated in “The Years Ahead” - A Policy for the Elderly “a comprehensive nursing service is as vital to caring for older people at home as a good medical service”.

Our Board employs up to a total of 460 Public Health Nurses in the ten Community Care Areas with each area managed by a Superintendent Public Health Nurse. This service is of vital importance and is highly valued and acknowledged by older patients and their carers alike.


9.3.1 The objective of community services for older people were identified in The Years Ahead and are endorsed by Public Health Nursing A Review July 1997
- to maintain older people in dignity and independence in their own home
- to restore those older people who become ill or dependant to independence at home
- to encourage and support family, neighbours and voluntary bodies in every way possible.
Meals on Wheels

There are about 140 voluntary organisations involved in delivering meals to elderly people in our Board’s area. During 1997, 1.2 million meals were delivered by these organisations. Our Board acknowledges the tremendous work of the organisations in providing this valuable and worthwhile service to older people enabling them to live in dignity in their own homes for as long as possible.

In general, meals are provided by the voluntary organisations who usually prepare the meals themselves, in a variety of premises, purpose-built kitchens, shared kitchens in community centres, in limited circumstances they may buy the meals from factory canteens or restaurants. Approximately, one-third of the meals are provided directly from our Board’s hospital kitchens to the voluntary organisations for delivery.

During the past year, nutritional seminars were held in most Community Care Areas for the organisers and members of the Meals on Wheels voluntary organisations. These seminars were arranged by the Nutritional Advisor for the Elderly and the Co-ordinators for the Elderly in each area. The seminars were also available as an opportunity to consult with the Meals on Wheels organisers as to the priorities for developing the service.

The presentations at each seminar focused on the following:

a) Nutritional needs of older people including special diets
b) Food Safety and Food Hygiene
c) Health gain for older people from Meals on Wheels

The response to these seminars was extremely positive. The voluntary organisations welcomed the opportunity to meet with our Board’s staff and found the presentations useful and relevant to their work. There were requests for further seminars covering topics such as:

1. Health and Safety
2. Fire Safety
3. Management / Administration

Many issues were raised by the participants and areas of concern identified:

a) The participants at the seminars valued their work in providing meals to older people at home. They particularly valued the social aspect of their work and considered that their contact with older people through delivering meals was a vital component in the daily lives of many of the older people.

b) They also value their links with Public Health Nurses and with nursing staff in hospitals in relation to the assessment of older people in general in relation to their need for a meals service. Many of the organisations would welcome a greater involvement with the Public Health Nurse, particularly in relation to ongoing review with regard to each individual need overall.

c) There were concerns about the standard of some of the premises from which the service is provided.

d) There were also concerns that a major investment in kitchen equipment (especially refrigeration equipment) will be required to provide meals at the high standard expected by modern society and anticipated under pending EU Regulations.

e) Many of the organisations expressed a preference for the divided container to deliver the meals because of it’s higher quality, more attractive presentation of the meal and greater safety in handling.

f) Some organisations were concerned about insurance and public liability for their volunteers while carrying out their work.

g) Recruitment of volunteers was also a major issue. Most of the volunteers are more than 60 years old and it is not uncommon to have a volunteer in their mid-seventies delivering meals to much younger clients. Availability of drivers to deliver the meals. This is more of a problem than finding volunteers to prepare or cook meals.

h) Some organisations proposed that more formal contracts with the Eastern Health Board and more accountability for their activities would improve their relationship with the EHB, whilst other organisations considered there is already too much paperwork.

i) All of the organisations considered that the current subsidy of 65p per meal is insufficient. However, some organisations considered that grants to upgrade equipment would have a higher priority.

j) Some of the organisations complained that when they received intervention beef, the cuts were too large to work with, i.e. to store in their fridges, to defrost or to cook the meat.

It can be seen that the Nutritional Seminars have provided very useful feedback from the Meals on Wheels organisations showing their main concerns. Our Board is addressing these concerns. However, where cost implications are involved they are addressed hereunder in the context of this Action Plan.

9.5.1 Recommendations:

- A Review Group should be set up within the next year to examine the needs of older people in our Board’s area for Meals on Wheels and to determine how best to meet those needs. The Review Group should determine what actual investment is required to provide this service to comply with current and anticipated legislation. It is felt that, a minimum capital investment of £750,000 will be needed to upgrade and develop locally based meals on wheels centres.

- The subsidy for the meals should be increased to 75p per meal from 1/1/99 (cost: £90,000 for 1999) and then by incremental increases annually to reach £1 per meal by the year 2003 (cost for years 2000 to 2003 - £500,000). A further £750,000 will be required for the remaining five years to cover increased numbers and increases in the subsidy.

Total Revenue Cost: £1.34m

- Our Board should develop service agreements with the Meals on Wheels organisations following the review process.
- Our Board should continue to provide seminars and in-service training for Meals on Wheels volunteers on an ongoing basis.

9.6 Occupational Therapy Service

The main contribution of Occupational Therapy to the care of older people is to advise on adapting their homes to cope with increasing disability which in turn will allow them to remain at home with a greater sense of safety and security. The role of the Occupational Therapist is crucial as part of the planned discharge of an older person from an acute hospital setting to their home.

Our Board is experiencing a continuous growth in demand for occupational therapy services particularly for older people.

The policy and emphasis on provision of care in the community, the speedier discharge from acute hospitals following completion of the acute phase of treatment and...
the advent of Community Ward Teams are among the reasons for additional referrals.
The development of the Community Ward Team concept has seen the creation of 12 WTE Occupational Therapist posts in our Board’s area who are mainly dedicated to the service supplied by the Ward Teams.
This number of Occupational Therapists in no way meets the service need to older people under the Ward Teams. In this regard the report Occupational Therapy Community Care - A Healthier Future July 1996 recommended a ratio of 1 Occupational Therapist to 20,000 of the general population.
As 66% of an Occupational Therapists time is estimated to be taken up with services for older people, and taking into account the multiple medical problems which older people suffer from the Working Group would recommend that 16 additional WTE posts of Occupational Therapists should be employed over the life time of the Action Plan to meet the dedicated needs of the increased population of older people in the community and 4 additional posts to meet the need in our established hospitals/homes for older people.
The Working Group would recommend that an integrated client centred service could be provided to these clients through intervention of a co-ordinated Occupational Therapy Service in conjunction with the public health nurse, physiotherapist and general practitioner at local level. The need for such local health centre based services was indicated in recent reviews of Occupational Therapy.
With future resources the priority areas for development within the Occupational Therapy Service include the following:

9.6.1 Housing Alterations and Adaptations
To facilitate older people to remain at home with greater independence and a sense of safety and security to cope with increasing disability.

9.6.2 Hospital Discharges
To provide a seamless service to older people, Community Occupational Therapists need to be involved in discharge planning near the time of a client’s admission to the acute hospital.

9.6.3 Lifting/Handling
In recent years Health and Safety concerns have placed greater emphasis on lifting and handling for families, carers and staff. This is a growing area of demand for Occupational Therapy intervention both in terms of training and also in the assessment, and provision of appropriate appliances.

9.6.4 Day Activity Centres
The O.T has a role both in relation to individual self care programmes within the Day Centre and also group activities e.g. reality orientation programmes, reminiscence groups and group exercise programmes.

9.6.5 Community Units
These existing and proposed units provide among other services a stepdown facility from hospital where slow stream rehabilitation can take place. It is important that an Occupational Therapist be part of the multidisciplinary team in order to promote effective long term discharge from hospital and to enable clients to reach their maximum level of independence.

Provision has been made for a .5 WTE Occupational Therapist in each of the proposed Community Units for the Elderly.

Total Revenue Cost £400,000 phased in over the of the 10 Year Action Plan.

9.7 Physiotherapy Services

9.7.1 Physiotherapy is a health care profession which primarily adopts a physical approach aimed at the prevention treatment and alleviation of a wide range of disorders. Physiotherapists examine, assess and plan treatment programmes, monitor and evaluate patient responses and counsel and advise patients and carers.

Community and hospital based physiotherapists must have an in-depth knowledge and understanding of the social, environmental, and economic factors which may influence a patient’s management in order to provide appropriate intervention.

The literature clearly indicates that the physiotherapy has obvious benefit to older persons who require support in the community. “The Years Ahead” states that domiciliary physiotherapy has a number of advantages, as it:
- Assists in the preservation of mobility and independence of older persons
- Facilitates earlier discharge from hospital
- Prevents acute hospital admission
- Decreases the need for long term care
- Provides training and instruction in the handling of individual patients resulting in increased safety for carers.

Physiotherapy can also prove of benefit to patients in longstay hospitals/homes in enhancing their mobility and quality of life.

It has also been highlighted in the literature that community based physiotherapy services promotes a clearer understanding of the benefits, and limitations of physiotherapy intervention and allows families to participate fully in the management of the clients problems (MacMillan).

Furthermore Needs and Pryor have indicated that a substantial reduction in hospital stay was experienced by patients who suffered fracture of proximal femur and were rehabilitated at home. The author went on to report that these patients recovered pre-injury independence sooner than similar patients managed conventionally.

9.7.2 Current Community Physiotherapy Services for Older People
Community Physiotherapy services for older people can be considered under two main headings:
1. Clinical
2. Health Promotion

Clinical
This category can be sub-divided into the following:
(a) Community Ward
Intensive multi-disciplinary rehabilitation. At present there are 8 WTE Physiotherapists employed by the Community Care Programme for the Community Ward Teams. This valuable service has a very defined function for a specific number of older people.
(b) Rehabilitation
For patients requiring intensive physiotherapy input in
the treatment of a specific problem e.g. post fracture, post stroke, incontinence.

(c) Frail Elderly
Non-specific mobility problems/balance problems/history of falls etc.

(d) Dependent Elderly
Clients requiring manual handling assessments, adaptive devices, education, training and support for their carers. Increasing numbers of these clients in the community also has major implications for the manual handling training needs of health board staff.

Apart from the Community Ward there has been no specific allocation of staffing for these clinical services. There is a need for an expanded Community Physiotherapy Service which is responsive, easily accessed, and rapidly mobilised. This could be achieved through the establishment of health centre based services which would also facilitate improved liaison with general practitioners and local staff. The need for this type was highlighted in a recent review Physiotherapy Services (Moving Community Physiotherapy Towards the twenty-first Century, January 1997).

However it is also well documented that there is a need to improve liaison with other service providers. The development of a physiotherapy liaison/discharge post (.5 WTE) in each of the major hospitals would further improve the delivery of a seamless, client focused physiotherapy service to older patients in the community.

Health Promotion
The role of the Community Physiotherapist in health promotion needs to be acknowledged particularly in the following areas:

(a) Fitness for Older People
(b) Accident prevention - particularly with regard to balance, mobility and footwear. There is a need for a screening process where there are identified elderly at risk e.g. welfare homes, day centres.

(c) Promotion of Continence
(d) General Education on specific relevant topics
(e) Carer Support/Education
(f) Manual Handling Training

There is currently no staffing allocation to fulfil any of these functions.

9.7.3 Additional Posts

- There is no management structure within the Eastern Health Board Community Physiotherapy Services. It is felt that there is a need for an appropriate management structure to co-ordinate all community physiotherapy services within a designated area i.e. community care area.
- Community Ward posts and additional posts for older people should be senior specialist grade to allow expertise in this area to be developed.
- Community Units for Older People. There are a spectrum of services provided by these units including day care, respite/intermittent, convalescent, and long stay care. Some of the clients therefore may require domiciliary assessment, or equipment that is beyond the remit of the unit based physiotherapist to provide, or assess as being appropriate in the domiciliary setting. It is suggested that it might be appropriate to forge links with these posts and those in the community setting.

Physiotherapy personnel employed in these units are currently working in isolation and it may make the posts more attractive in terms of career development to be part of a larger professional group.

9.7.4 Developments

In regard to community based services, no formula exists from which manpower needs and priorities can be realistically estimated. Indeed the great majority of research tends to be descriptive rather than analytical, thus limiting its value in terms of service planning. Hence, the literature contains very little guidance as to how to best plan for and quantify future service are at present significantly under resourced.

Workload measurement is difficult due to variations in contact time, percentage of time spent in non patient related activity, the number of treatments required to obtain a reasonable outcome and the casemix. Therefore manpower requirements in the first instance should be based on perceived need and should take account of direct patient contact time, administration, staff development and management functions.

It is estimated that up to 80% of Physiotherapists workload in the community would be directly related to older people it would therefore be recommended that 25 additional posts for older people (various grades) be provided for at community care level, to include three posts to forge links with the acute general hospitals and five posts in our established hospitals/homes for older people on a phased basis. It is felt that these 25 posts are not an excessive demand bearing in mind the service demands to be phased in over the lifetime of the 10 Year Action Plan.

Revenue Costs - £494,000

9.8 Chiropody Services

A service for medical card holders aged 65 years and over is provided by up to 50 private chiropodists. Three visits per annum is provided by our Board in such cases.

The availability of a chiropody service to older people is vital in retaining mobility in old age and is paramount in maintaining and improving the quality of life of older people with the obvious social gains. The increase in demand for this service will be met via the private chiropodists for older persons with a medical card.

9.9 Dental Services

With the introduction of the Dental Treatment Services Scheme in November 1994 our Board formed a panel of private dental practitioners who now hold contracts under this scheme.

Older People who are medical card holders who require emergency treatment may now attend the dentist of their choice from this panel if they so request.

Initially priority for routine treatment and/or full dentures is being given to eligible persons aged 65 and over. Persons requiring full dentures are, in the main, referred to our Board's clinics for treatment.

9.10 Ophthalmic/Aural Services

Failing eye sight is a major factor in educating the quality of life and increasing the disability of older people.
The acute hospital service is available to address curative problems. Many older people can achieve a significant social/health gain by way of sight testing and use of spectacles.

There are 150 opticians including some Ophthalmologists contracted with our Board for the provision of optical services including sight testing (free).

A deterioration in the ability of older people to hear can be a major handicap in their day to day lives.

Treatable or curable hearing loss is usually first diagnosed by the General Practitioner who will refer the individual to an Ear Nose and Throat specialist for diagnosis and treatment.

Those who require fitting of a hearing aid to improve their hearing and consequently their quality of life are referred to the National Rehabilitation Board who carry out the work on behalf of our Board.

9.11 Day Centres/Clubs

The main objectives of Day Centres/Clubs as reiterated in “The Years Ahead” - A Policy for the Elderly are:
- To provide a service such as a midday meal, a bath and a variety of other social services
- To promote social contact among older people and prevent loneliness
- To relieve caring relatives, particularly those who have to go to work, of the responsibility of caring for older people during the day
- To provide social stimulation in a safe environment for older people

In our Board’s area Day Centres/Clubs are mainly managed by voluntary/parish based organisations. In total there are up to 180 voluntary organisations who provide a wide range of services such as day centres, clubs, visits, transport services for older people. These are grant aided by our Board in accordance with the level of service provided.

There are up to 156 Day Centres/Clubs. Consideration should be given to structured/planned development of Day Centres/Clubs for older persons in our Boards area in partnership with our voluntary service colleagues to meet the needs that will present with the increase in the population of older people.

9.12 Home Improvement Scheme for Older People

Our Board operates a Home Improvement Scheme for older people with funds made available by the Department of Environment and Local Government for the provision for Special Housing Aid for Older People. This scheme is operated by a subsidiary company of our Board, Eastern Community Works Ltd.

Works are carried through a combination of the FAS Community Youth Training Programme (CYTP), outside contractors and direct labour. At present there are 5 CYTP teams operating with a average of 10 trainees in each team.

The full cost of trainees’ wages in met by FAS from whom a substantial portion (75%) of the cost of foreman’s wages are also recoupable. The cost of materials for the works is met out of our Board’s allocation from the Department of the Environment and Local Government.

Persons who wish to avail of the scheme may be referred through the local Community Care office where application forms are available.

In 1997 necessary repairs were carried to the homes of over 300 older people.

9.13 Continence Advice

The Continence Promotion Unit under the direction of a clinical specialist is based at Dr. Steevens’ Hospital. The main functions of the Unit are to foster a greater awareness of the condition of continence among staff and patients at in-patient and community level to organise a treatment programs that with maximum social gain and quality of life for the patients. Additionally the service highlights the need to increase the dignity of older persons and to minimise the embarrassment often associated with this condition.

The main practical areas which are addressed are:
- The education of staff at community and hospital level
- The correct assessment of patients
- Ongoing monitoring of patients
- The implementation of an improve patient care plan
- Cost effective use of incontinence wear.

The Continence Promotion Unit has started to put in place a process for ensuring that relevant data is available regarding the needs and provision of the service in community care. This is particularly important in view of the increase in the older population and the over 75 age group up to the year 2008. The incidence of incontinence increases with age.

Assessment for continence is critical to ensure that the older person receives a service that meets their needs. To ensure appropriate assessment and rehabilitation, services are in place in the community setting (Community Ward Teams in particular) and hospital (assessment unit, stroke, respite, day care, long term care). The education of the professionals and the general public will continue to be essential so that incontinence is understood and can be effectively managed. To meet the anticipated needs for this older population into the next millennium it is recommended that 2 additional continence advisors be employed to augment the current continence advice service.

Revenue Cost £57,500 phased in over lifetime of 10 Year Action Plan

9.14 Nutritional Services

9.14.1 The Nutritional Advisory Service for the Elderly in the Eastern Health Board is unique.

It’s focus to date is on secondary care for older people in both an inpatient and community care setting. There has also been a Health Promotion/Primary Care focus in the service which is being developed.

The service will over the coming years expand to cover the following areas of care:

Nutrition Health Promotion for the Older Person

This would involve local media information, involvement in local projects with the elderly based on the “settings” approach to Health Promotion.

Settings appropriate for health older people would include:
- Work place: pre-retirement courses
- Retirement Groups
- Voluntary Organisations e.g. Age & Opportunity

Primary and Secondary Health Care

This would involve liaison with General Practitioners, Community Ward Teams and informal carers of older people. Focus on this group would ensure that older
people in the community with a poor nutritional status would be seen early, preventing or reducing hospital admissions.

This service should also be a link with Acute Hospital Sector ensuring continuity of care for older people on artificial feeding regimes. Again this would reduce the need for hospital admissions for a review of the feeding regime.

Work in long-stay hospitals and homes for older people in both the areas of Medicine for the Elderly and Psychiatry of Old Age will continue to engage a large part of the workload of this service. This will give support to staff caring for older people and provide a service for respite patients, allowing follow-up domiciliary visits. It would also ensure (as would all services in every setting) that clients/patients on artificial feeds or Supervisor feeds have access to an Eastern Health Board Dietician. At present company dieticians have direct patient access.

Tertiary Referral Centres (Acute Hospital Care)

A dedicated dietetic service for older patients in the Acute Hospital setting is essential. This would enable nutritional screening and acute input in this setting - research shows that there is increased incidence of malnutrition developing in older patients in the acute hospital setting (Kings Fund 1992).

Quaternary - Palliative Care

Many older people require nourishing and appetising meals at this stage of an illness. Advise for formal and informal carers is essential to provide every possible comfort for these patients.

Mental Handicap

Dietetic Service for older patients in this area of care is essential whether in a long stay or community setting. There are numerous nutrient drug interactions in this group of clients resulting in deficiencies which can mask other conditions. Difficulties with feeding these patients is common place.

9.14.2 Clinical Inputs of a Nutritional Advisory Service for Older People

- Undernutrition: results in prolonged hospital stay, poor wound healing increase susceptibility to acute and chronic illness.
- Over nutrition: results in poor mobility, respiratory and cardiac problems and can contribute to poor control of chronic diseases.
- Diabetes Mellitus: can result in lethargy and urinary tract infections if not kept under control, could also result in falls.
- Micronutrient Deficiency: frequently occurs in older people - especially vitamin D and Folate.
- Artificial Nutritional Support: requires monitoring to ensure patients are not under or overfed and are using the appropriate nutritional feed.
- Continence: the promotion of continence and prevention of constipation has major benefits to the patient and reduces costs to the Health Board of laxatives etc.
- Poor Swallowing: if undiagnosed can result in chest infections requiring antibiotic therapy, aspiration can also cause death. Prevention of aspiration via thickened fluids and modified foods is extremely beneficial.

It recommend that 2 additional Nutritionists be employed during the life time of the Action Plan and that the management structure of the Department of Dietetic be redefined in the light of this.

Revenue Cost £42,000 phased in over 10 years

9.15 Social Work Service

9.15.1 Currently community Social Workers are employed in all the major public hospitals in the Eastern Health Board area. Within this setting some staff work as part of multi-disciplinary Medicine for the Elderly teams and Psychiatry of Old Age services while other work attached to other specialties where the needs of the older patients are dominating their caseloads.

In the community setting social workers in some areas of the country have a small number of older clients however, statutory obligations in relation to child care have resulted in this service being virtually abandoned in most parts of the country as is the case in the Eastern Health Board area. Social Workers are also employed in local authorities usually in Housing Department where again older people make up a significant part of their caseload, and social workers are involved in some Social Services Councils throughout the country, their main roles being the co-ordination and development of voluntary services to older people.

More recently the Eastern Health Board has employed 3 part-time social workers in the new community units for older people in addition to the 2 existing WTE posts based in St. Mary's Hospital, Phoenix Park, while an additional post is being provided at Cherry Orchard Hospital.

9.15.2 Many of the services currently available, and those recommended by various reports, are largely social services rather than health services rather than health services and as such it would seem reasonable that they be planned, managed and developed by social care professionals in consultation with health colleagues. The reverse would also hold that health services are best planned, managed and developed by health professionals in consultation with social care professionals. All services have many dimensions and can only benefit from a broader planning base. The following is a short list of the main dimensions of social work with older people:

- Assessment of social situation - understanding the complexity of same, the interaction of physical, psychological, emotional and social factors.
- Looking at coping ability of client and carers.
- Liaison with multi-disciplinary teams in drawing up care plans for future management
- Linking with other agencies statutory and voluntary e.g. housing departments and charities etc. in organising support services for clients
- Psycho-social support and counselling - work with individual clients to assist health adjustment to loss, lack of independence and long-term care issues.
- Family work - giving families and opportunity to explore patterns of past relationships and their influence on the present.
- Service to carers - counselling and support to carers individually and in groups

While it is accepted that social work with older people and their carers will continue to be vital in all hospital settings, much of the work initiated cannot be continued due to the lack of a community based service it is therefore
imperative that such a service be developed to continue this work and to provide a service for the healthy older population.

In this regard it is important to note the following comments in two important reviews by independent bodies which argued for an increase in social work services:

“A further gap in the care of older people identified in the review is the lack of a community social work services ... there appears to be an attitudinal issue among managers whereby the full potential of a social work service for older people is not recognised. This must be countered and, as in most other European countries, social workers must be involved in the key areas of the care of older people such as needs assessment, case management, resolution of family conflict and advocacy.”


An increase in service provision by social workers is one of the most effective ways in which community care could be strengthened. They could help families in a number of ways such as providing information or currently given by GPs and hospital services liaison between patient, carer and professionals. This would involve (i) planning long-term care regime in partnership with carer and professional (ii) assessment of the patient and the social supports (iii) assessment of the carer and their needs. This present study would indicate targeting is often poor.”

“Care Provision and Cost Measurement Dependent Older people at Home and in Geriatric Homes”


9.15.3 To recognise the need for a comprehensive community based Social Work Service it is worthwhile highlighting the shortfalls in the community service.

- Older people must be sick before they can access a social work service (i.e. be eligible for referral to and treatment in hospital) or be a tenant of a limited number of local authorities who employ social workers.

- Older people not in the above categories who are experiencing problems such as stress, marital problems, problems with family relationships, bereavement, loneliness, social isolation and poverty are bereft of a social work service which could provide counselling and crisis intervention work to enhance social functioning, coping mechanisms and general quality of life.

Following discharge from hospital services such as the coordination of social care services and counselling are discontinued.

- Currently there is no social work service in the community to support carers and help prevent carer stress through support and counselling and mobilisation of resources such as respite care, sitting services and carer support groups.

There is a growing climate of awareness of potential elder abuse and exploitation. Again a community based social work service to assess, support and work towards the protection of older people is not available. Much work needs to be done to develop a comprehensive response to the problem of potential elder abuse/neglect.

- The lack of community based social work service may mean that older people are going to explore a range of services and care options to meet individual need.

- There is also a need for social workers to work in partnership with the voluntary sector in highlighting and responding to the needs and rights of older people and working against negative stereotyping of ageing in our society.

The development of a community based social work service with older people and their carers would facilitate older people remaining in their homes with dignity, independence, social interaction and an improved quality of life. The provision of a community based social work service would provide for areas of social need such as:

- Social isolation (eccentric elderly)
- Alcohol and drug misuse
- Accommodation needs
- Abuse/neglect/exploitation
- Familial disharmony
- Support for carers
- Bereavement and loss

9.15.4 In order to provide a community based service in conjunction with current social care provision the Working Group recommends that a pilot project be initiated early in the lifetime of the Action Plan with the employment of 2 social workers. One to be located on the northside of the city and one on the southside of the city in selected Community Care Areas.

Revenue Costs: £44,000

These new postholders will during the pilot, form an integral part of the Community Care Area structure and have clear and agreed responsibilities within the area. They will deal solely with issues relating to older people and complement the role of the public health nurse who to date has carried out much of this work.

It is recommended that these social workers will forge close links with colleagues and other professionals in the acute hospitals and community units for older persons. A key role of the Social Worker involved in the pilot will be the arranging of suitable placement of older persons in appropriate care settings in order to ensure effective and smooth transfer of patients between hospitals, residential settings and home.

As the concept of a community based social work service is a new one it is strongly recommended that the pilot project be thoroughly evaluated to ascertain its effectiveness in addressing patient/carer needs. Only after this should consideration be given to expanding this service.

It is recommended that subject to the findings of the above evaluation that consideration be given to the employment of an additional 17 WTE staff of various grades (i.e. Head, Senior, Basic Social Worker) to meet service needs over the duration of the plan. It should be noted that while this element of the service is costed both here and in the executive summary it is contingent on a positive evaluation of the pilot project.

Revenue Costings:

- 3 Head Social Workers £97,000
- 8 Senior Social Workers £241,000
- 6 Social Workers £132,000
9.16 Speech and Language Therapy Services

9.16.1 Introduction
Speech and Language Therapists work with this client group who could present with swallowing disorders/communication disorders. Their difficulties might result from cerebrovascular accident, head injury, tumour, degenerative disorders and dementia. The Speech and Language Therapist as part of a multidisciplinary team would assess the clients communication skills/swallow function. The Therapist would then make a diagnosis and plan future management. Management would include direct intervention/group work/education of carer/liaison with other members of the team.

9.16.2 Clients Residing at Home
There is no service available to older people in most Community Care Areas, at present. If a client is taken into a Community Ward Team, some limited therapy is offered in four of the ten Community Care Areas. There is no service available in the remaining six Community Care Areas. Clients discharged from hospital are not receiving the follow-up care they require in the community. Most of these clients are unable to continue to attend for therapy as out-patients in hospitals, due to mobility difficulties/geographical

9.16.3 Long Stay Units/Community Units
At present there are more than ten Long Stay Units and Community Units for older people administered by the Eastern Health Board. Apart from a very limited service in Rathdrum Hospital, there is no service to these units. Once clients are discharged from a hospital to a long stay unit, therapy comes to an end. Therefore the clients full recovery potential is not realised. Many of them suffer from Dysphasia (swallowing difficulties), which if not managed correctly by a trained Speech and Language Therapist, could lead to aspiration pneumonia and other problems.

9.16.4 Day Care Centres
Many older people from the community attend local Day Care Centres for a period of time during the week. It would be extremely beneficial to these clients to have a Therapist providing sessions in these centres. As well as being more cost effective, it would allow for group therapy which is an appropriate treatment strategy for this client group. At present Speech and Language Therapy is not provided to Eastern Health Board Day Centres. These could also provide an appropriate location for the establishment of Stroke Clubs.

9.16.5 Shortfalls

- No service available to older people in six Community Care Areas and only an extremely limited service in the remaining four.
- Our of more than ten long stay facilities, a limited service is only available in one.(Rathdrum)
- No service to Day Care Centres
- Lack of Community based Speech and Language Therapists trained in the management of Dysphasia (swallowing disorders).
- Extremely limited service available to this client group on a private basis. Therefore, if the Eastern Health Board does not provide a service, clients have no other way to access therapy.

9.16.6 Increase in the Older Population
Over the next ten years it is expected that the number of older people in the Eastern Health Board region will increase by 35,000 (from approx. 130,000 at present to approx. 165,000 in 2008). In order to cater for the future needs of this client group, the following is recommended in terms of Speech and Language Therapy Provision.

(a) Community Clients (based on recommendations for staffing needs, Frenchay (HSTMS Data)

- For clients following CVA
  3.5 Therapists for 160,000 population
- For clients suffering progressive illness
  1.2 Therapists for 160,000 population
- Communication problems following head injury
  0.8 Therapists for 160,000 population
- Communication problems of unknown/uncertain diagnosis (general deteriorations and ageing process)
  1.7 Therapists for 160,000 population

It is recommended that 7 Speech and Language Therapist posts be created to cater for the needs of older people in the community during the period 1999 to 2008.

Revenue Cost (estimated) £145,000.

(b) Long Stay Units/Community Units
In order to provide adequate Speech and Language Therapy Services to the current Long Stay Units the recommended requirement would be for 5 Speech and Language Therapists. It is noted that the proposed Community Units have a provision for Speech Therapy included in their staff WTE.

Revenue Cost (estimated) £103,000

9.16.7 Benefits to the Older Population
If appropriate intervention were available in terms of staff/equipment, the well being of these clients would be greatly enhanced in terms of:

Communication
Inability to communicate effectively is extremely frustrating/upsetting for clients who may also have lost their mobility. This leads to further isolation from those around them. Being able to communicate effectively would allow the client to take an active part in decision making/family conversations/group interaction.

Nutrition
Clients with swallowing difficulties should have their nutritional needs met in the most pleasant manner possible. The Speech and Language Therapist, following assessment of the client, would make recommendations re the consistency/amount and appropriate presentation of food. The simple activity of being able to partake in meals in the company of others helps the clients integrate with the group.
c) Medically

If the client’s swallowing difficulties were managed appropriately, medical complications such as repeated chest infections/pneumonia etc., would be avoided, as would repeated hospital admissions.

9.17 Vulnerable/Eccentric Elderly

The report Survey of Eccentric Vulnerable Adults Living in the Greater Dublin Area 1997 highlighted the problem relating to a group of people numbering 233 who led a reclusive life and did not partake in any way in the outside world and did not wish to access health or social services. The report made the point that 30% of the figure of 233 were people aged under 65 and that the majority of problems were directly associated with personal hygiene, suspicious, secrecy, hoarding and living conditions i.e. non health related conditions. While over 35% of those surveyed had with a history of alcohol abuse or psychiatric illness.

The Working Group endorses the recommendations outlined in this report and particularly feel that the recommendations made elsewhere in the chapter relating to Social Work Service and the provision of an At Risk Register will greatly improve the management and support of these vulnerable and recluse older people.

The following recommendations from the report were considered the more important and will be pursued immediately:
- In each community care area individuals meeting the criteria used in this study should be included in the “at risk” register.
- The use of family, friends, neighbours and local service providers (such as shopkeepers) can provide a valuable informal, non intrusive monitoring system and such a network should be encouraged.
- The case conference model at area level and involving all the relevant agencies, is the most effective way to identify the appropriate method of intervention.
- Early intervention has been shown to be more successful. Case conferences should be held when individuals at risk have been identified rather than waiting until a crisis situation arises.
- A key worker should be identified at the case conference. This should be the person most likely to be acceptable to the client and thus the most likely to achieve a successful outcome to an intervention.
- Within the home help services additional training, resources and support should be made available for those willing to provide personal services in what can be very difficult circumstances.

To facilitate local administration, the Director of Community Care and management team in each area will sub-divide the clients in their area amongst the sectors/districts with each sector/district taking on responsibility for the clients in the district; the numbers involved are generally in single digits.

This local knowledge will facilitate the identification of a key worker and support plan for each individual. This process will involve both the Community Services and Health Promotion, Mental Health, Addiction and Social Development and Acute Hospitals and Services for the Elderly Programmes working very closely together and involving agencies locally, police, church and voluntary groups etc.

It is accepted that respite care may be necessary from time to time and will be provided by Health Promotion, Mental Health, Addiction and Social Development Programme and Acute Hospitals and Services for the Elderly Programme.

The Director of Community Care will also involve the local Housing Welfare Officers on the district committees and meetings will be arranged involving Senior Management of our Board and the Local Authorities and in particular Senior Management from Dublin Corporation.

This networking together with the actual involvement of a community based social work services and the activation of an “At Risk” register would help:
- Develop a profile of reclusive people
- Identify reasons for service refusal
- Identify methods for successful interactions
- Help develop a positive service response for the group of people

It is felt that the proposal at para 8.15.4 which refers to the need for a community social work service will be key to the management of persons identified as vulnerable/eccentric elderly.

9.18 At Risk Register

The report Services for the Elderly - A Policy Document stated as one of it’s objectives the setting up of an “at risk” register for those people aged 65 and over deemed to be at risk.

In the intervening years various efforts have been made to set up community area based registers but without complete success.

What is currently in place is that each Community Care Area maintains a register of all older people aged 65 and over in their areas and each Public Health Nurse service takes special note of all older people who they consider to be vulnerable or in need of special monitoring.

The Working Group feel that the concept of a register for vulnerable or at risk older people is necessary and is worth pursuing.

In this regard, it is recommended that a small working group with representation from the service areas and our Board’s Information Technology Department examine this issue with a view to setting up a registrar as early as possible.

In deciding on such a register the Working Group recommend that it be simple to use and implement. The Group also recommended that all professionals in the Community Care multi-disciplinary teams should feed information into the “register” in order to built up an information base on an older person until a threshold is reached indicating the older person is “at risk”.

A sum of £50,000 should be set aside to commence the introduction of the computerised at risk register.

9.19 Abuse of Older People

The entire area of the potential abuse of older people whether physical, mental, financial or neglect is one which the Working Group feels should be addressed.

The Group is aware that work has commenced on benchmarking the various types of potential elder abuse and also how to readily identify them. The group is also aware that the National Council on Ageing and Older People has commissioned a report on the topic of elder abuse.
It is recommended that on publication of this report that an expert group be set up by our Board including appropriate professions with a view to preparing draft guidelines for staff to assist them in identifying potential elder abuse in the residential and home setting and most importantly to set down protocols which staff must follow in such cases. While primarily abuse may occur in the home setting the Working Group is conscious that it may also occur in a hospital or residential home setting or first come to the attention of professionals in such a setting. Any guidelines developed should cover home and residential setting.

### 9.20 Summary of Chapter Recommendations:

<table>
<thead>
<tr>
<th>Paragraph</th>
<th>Recommendation</th>
<th>Revenue Cost</th>
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<tbody>
<tr>
<td>9.3</td>
<td>The creation of 29.5 WTE Public Health Nurse posts and 23 WTE Senior Public Health Nurse posts.</td>
<td>£1.230m</td>
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<td>9.4</td>
<td>Phasing out of arrangement with Community Welfare Service</td>
<td>£150,000</td>
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<td></td>
<td>Increase in hourly rate paid to Home Helps over 2 year period</td>
<td>£3.00m (full year)</td>
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<td></td>
<td>Increased finance required to meet additional demand for Home Help Service</td>
<td>£5.00m (over 10 years of plan)</td>
</tr>
<tr>
<td>9.5</td>
<td>The provision of additional meals and the cost of increasing the grant aid per meal over a full year period</td>
<td>£1.34m (full year)</td>
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<td></td>
<td>Upgrade and develop local meals on wheels centres</td>
<td>£750,000 (once off)</td>
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<tr>
<td>9.6</td>
<td>The provision of 20 WTE posts of Occupational Therapy</td>
<td>£400,000 (full year)</td>
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<td>9.7</td>
<td>Creation of 25 WTE posts of Physiotherapists</td>
<td>£494,000</td>
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<tr>
<td>9.13</td>
<td>The creation of 2 additional posts of Continence Advisor.</td>
<td>£57,500 (full year)</td>
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<td>9.14.2</td>
<td>Provision of 2 additional posts of Nutritionists</td>
<td>£42,000 (full year)</td>
</tr>
<tr>
<td>9.15.4</td>
<td>The piloting of a Social Work services by providing 2 WTE posts of Social Worker</td>
<td>£44,000 (full year)</td>
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<td></td>
<td>Provision of 3 Head Social Workers, 8 Senior Social Workers, 6 Social Workers</td>
<td>£470,000 (full year)</td>
</tr>
<tr>
<td>9.16.6</td>
<td>(a) The creation of 7 posts of Speech and Language Therapists</td>
<td>£145,000 (full year)</td>
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<tr>
<td></td>
<td>(b) Creation of 5 posts of Speech and Language Therapists</td>
<td>£103,000 (full year)</td>
</tr>
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<td>9.17</td>
<td>Creation of a group to co-ordinate the management of vulnerable/eccentric elderly cases.</td>
<td>N/A</td>
</tr>
<tr>
<td>9.18</td>
<td>Creation of an 'At Risk' register for vulnerable/at risk older people</td>
<td>£50,000 (once-off)</td>
</tr>
<tr>
<td>9.19</td>
<td>An expert group be established to identify/ set up protocols and draft guidelines to help identify potential elderly abuse in residential and home settings.</td>
<td>N/A</td>
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Carer Support

10.1. It is accepted and acknowledged that the majority of care of older people in the home setting is provided by voluntary carers either relatives, friends or neighbours. It is recognised that this support is essential in ensuring that the health and social care of older people are maintained and enhanced and ensuring that older people can remain in his/her home for as long as possible.

10.2 As a Group we were conscious that it is important to illicit the views of organisations involved with supporting carers in their own homes and the following organisations associated with carers together were invited to attend a workshop to discuss issues pertaining to the support of carers of older people:
- The Alzheimer's Society of Ireland
- The Carers Association
- Curam Carers
- Fingal Carers
- The Irish Wheelchair Association
- Crosscare
- National Multiple Sclerosis Care Centre
- The Parkinson's Association
- Voluntary Stroke Scheme
- Soroptoists International

The involvement of these and other voluntary groups can only assist and help our Board in this planning and delivery of services for older people in a manner which is oriented towards an increased quality of life for the older people.

10.3 Support Groups

10.3.1 In 1994 our Board helped establish support groups for carers at Baggot Street Community Hospital and Clontiffe College (Crosscare Support Group). The support group involves approximately twenty-five carers taking part in an induction course consisting of a series of talks, meetings and group sessions. The course is of six months duration during which time the full range of problems and possible areas of concern for carers are discussed by various professionals and voluntary organisations. Following the induction course each group is encouraged to continue to meet, to share their experiences, problems and positive news in a spirit of self help and self reliance.

10.3.2 The Working Group acknowledges that there is a need to improve and augment the carers support groups currently in place. While the Crosscare Support Group has expanded and draws participants from all of North Dublin, the support group at Baggot Street is not as broad based and covers a smaller geographical area.

In recognition that voluntary carers play a major role often at great personal, financial and emotional cost to themselves, the Working Group would recommend as priority that a support group which would complement work in place in Baggot Street be set up in South Dublin. It would be envisaged that this support group would be managed by a voluntary organisation and utilise Health Board facilities - perhaps the community units at Dalkey, South Circular Road and Baggot Street Hospital - to hold their seminars, meetings and lectures. It is estimated that the annual cost of such a service would be approximately £80,000.

Similarly the Working Group recommends that a smaller care support group be set up in each of East Wicklow and Kildare/West Wicklow at a cost of £80,000 in total, similarly to that proposed for South Dublin.

The Working Group also recommends that we build on the good work drawn from recent meetings with the care support organisations and the feedback from the recent workshop held with the Voluntary Organisations. These care groups could be met on an annual basis by a small team from our Board to discuss issues pertaining to the care of older people and in an effort to find common ground and to co-ordinate the planning of services. This could be organised at Community Care level or Board wide level as appropriate.

10.3.3 It should also be noted that while the support groups offer front line help to older people and carers they cannot sustain effort done without the support of our Boards services i.e.
- General Practitioner Services
- Public Health Nurse visits
- Paramedical Services
- Care Assistants
- Home Helps
- Community Ward Teams
- Day Clubs/Centres
- Day Care Units (hospital/home based)
- Convalescent Care
- Respite/Intermittent Care
- Meals on Wheels

10.3.4 Our Board has already acknowledged that there is an urgent need to continue to develop day care, convalescent and respite care services to assist carers, not only to meet current needs but also the needs of an increasing aged population.

Our Boards policy of building small scale community units strategically located throughout our Boards area and which contain a wide spectrum of services for older people is recognition that our Board intends to provide appropriate services to meet the urgent needs of older people who wish to remain in their own homes.

10.3.5 Recommendations:

10.3.2 Creation of support group in South Dublin.  
Revenue Costs £80,000

10.3.2 Creation of small care support group in East Wicklow and Kildare/West Wicklow  
Revenue Cost £80,000

10.3.2 Carer support groups be met and liaised with on an annual basis either at Community Care Area or Board level as appropriate annually  
N/A
Community Ward Team

In response to "The Years Ahead...a policy document for the elderly", the Eastern Health Board established District Care Units later known as Community Ward Teams (CWT) in each of the Community Care Areas (with 2 being set up in Community Care Areas 1, 2, 6 and 7) in late 1990. Thus fourteen units were established in total and in latter years they have been increased to 25 teams in total. The objective of the CWT was primarily to facilitate earlier discharge from the acute hospitals. The aim of the CWT was to maximise the rehabilitation potential of patients admitted by providing multidisciplinary intervention in the domiciliary setting for a maximum 12 week period.

The multidisciplinary team consisted of
- Team Leader (Senior/ Public Health Nurse) – 1 W.T.E.
- Registered General Nurses – 3 W.T.E.
- Physiotherapist – 0.5 W.T.E.
- Occupational Therapist – 0.5 W.T.E.
- Home Care Attendants – 3 W.T.E.

It was intended that each team would serve a catchment area of 25,000 population. The General Practitioner retained clinical responsibility for the patient in the CWT. The Co-ordinator of Services for the Elderly played a crucial role in the establishment and on-going development of the CWT.

Management of Community Ward Teams:
In general, the Community Ward Team is managed centrally at area level in relation to rehabilitation services. Decisions regarding admissions and care plans are made at weekly multidisciplinary team meetings. Management of resources for short-term and extended care varies between areas but tends to be delivered at local health centre level with registered general nurses and home care attendants working under the supervision of public health nurses. As the service expands to meet increasing need, the challenge will be to develop the appropriate structures to manage these resources effectively and efficiently and to ensure that this service is fully integrated with the wider range of services provided for older people in hospital and in the community. Alternative approaches to local service management should be explored.

11.1 Historical Perspective

11.1.1 Referral Procedure
All CWT patients initially required a referral by a Consultant Geriatrician before being assessed. This assessment generally occurred after the patient was discharged from hospital. A standard referral form was used.

11.1.2 Admission Criteria
The criteria for admission to the unit were:
- The patient had rehabilitation potential
- The patient required the input of at least 2 members of the multidisciplinary team
- The patient was sixty-five years of age or older.

If a patient, following the multidisciplinary assessment, was not suitable for admission to the CWT, s/he would be supported by relevant community care personnel as appropriate.

The members of the team, following assessment, drew up an individual care plan identifying treatment goals for each patient. An admission meeting/case conference was held and relevant personnel were invited to attend i.e. all members of the team, the patient’s Public Health Nurse (P.H.N.), the Home Help Organiser, and the patient’s General Practitioner (G.P.). Close communication was maintained with each patient’s G.P. throughout their admission to the CWT.

Weekly meetings were held at which team members discussed each patient in relation to the original treatment/management goals ensuring continual re-evaluation of his/her progress.

11.1.3 Discharge Procedure
Discharge from the CWT occurred when:
- The objectives of the admission had been achieved.
- The patient had maximised his/her rehabilitation potential whether the original objectives had been achieved or not.
- The patient requested discharge.
- The patient was admitted to an acute hospital or other facility.

The patient’s G.P. and P.H.N. were notified when the patient was discharged from the unit.

11.2 Development of Community Ward Teams

11.2.1 Referral Policy
When the CWT was operational for approximately 1 year, it became apparent that the original policy of referral was limiting the scope and potential of the CWT. It was recognised that certain patients in the community would also benefit from intensive co-ordinated multidisciplinary input. It was also recognised that such intervention could prevent admission of those patients to acute hospital, or long term care. It addition hospital consultants other than Geriatricians requested that they would be facilitated with referral of suitable patient’s to the CWT.

In order to accommodate these new demands a protocol was developed allowing referrals to be accepted from all hospital consultants (step down referrals), and General Practitioners (step up referrals).

11.2.2 Changes in Admission Criteria
The admission criteria also developed to include patients who although having no actual rehabilitation potential, did have significant difficulties associated with their maintenance in the community. The CWT teams’
multidisciplinary expertise has been invaluable in resolving complex patient management problems and planning issues.

Some Community Ward Teams have because of local circumstances have had to adapt different care programmes. Factors influencing this include:
- Access to rehabilitation beds and other rehabilitation facilities.
- The level of dependency of the population served.
- The extent of family and community supports available.

11.3 Resources assigned to the CWT have been utilised in the following ways:

11.3.1 Short Term Care

Patients may need increased support from the team e.g. during an acute illness, following bereavement or to provide respite to carers.

11.3.2 Extended Care

Additional nursing supports e.g. from a Registered General Nurse (R.G.N.), or HCA may be required on a longer-term basis in order to allow a patient to remain in his/her own home. As highlighted above this may include patients who have been discharged from the CWT. This level of input may extend from one weekly visits assisting with personal care to more intensive daily care, and twilight nursing services as needs dictate. These patients may also require physiotherapy and or occupational therapy services as appropriate.

11.3.3 Day Centre Support

In some Areas the CWT has linked with the local day centre with a sharing or augmenting of staff. This has enabled these centres to cater for more heavily dependent patients, thus facilitating ongoing care in the community and providing additional support and respite to carers.

11.3.4 Carer Support

Apart from personal contact within the home, personnel from Community Ward Teams have organised locally-based training programmes for carers in some areas. These programmes have addressed issues such as lifting and handling, nutrition, safety awareness, stress management, common medical conditions in the elderly and entitlements to the various health and social services. This programme also provides a useful forum for carers to share experiences and avail of peer support.

11.4 Literature Review

Has provision of the CWT resulted in health gain and improved quality of life for the elderly? The concept of the CWT has evolved since its initial conception, and many different models now operate in different Community Care Areas. It is hence very difficult to evaluate the CWT comprehensively in terms of effectiveness.

Johnson et al did a follow up of patients over 65 years of age discharged into various models of care from acute hospitals within our Board’s region, to compare service inputs in different models of care, and to determine patient and carer satisfaction with health care services following discharge (19).

In the study a total of 130 patients were followed up over a 4 month period 15 of whom were referred to the CWT. Although the numbers in this study relating to the CWT were small the following points were felt to be relevant.

- There was a high degree of satisfaction on the part of the patient and carer with the community support services (including the CWT) following discharge from hospital.
- Support provided by the public health nursing service and voluntary organisations (i.e. home-help and meals on wheels) was generally found to be in place within 24 hours of discharge from hospital. Physiotherapy and occupational therapy staff from the CWT tended to first visit the patient at home a number of days following discharge.
- Limitations in mobility were the most frequently mentioned problems in the immediate post discharge period.
- The referral rate to the CWT from the acute hospitals in the region was low, suggesting that the true potential of the service in encouraging earlier discharges may not be fully utilised. Routine access to the more traditional support services (e.g. convalescence), difficulties in rapidly accessing the CWT, complexity in the criteria for acceptance, and unfamiliarity with the role of the CWT may all contribute to this finding.

A further evaluation of the CWT was carried out in Community Care Area 7(15). The findings of the study provide valuable indicators as to how the operation of the CWT might be reshaped. Community Care Area 7 has the highest proportion of older people in the Eastern Health Board (13.3%) and 2 Community Ward Teams have operated there since their inception.

The aim of the evaluation was to assess the effectiveness of the service in terms of patient outcome, including satisfaction. The methods used were a retrospective analysis of referrals over 3 years as well as a prospective study of patients admitted for care. Patients, carers and doctors using the service were surveyed to ascertain their views and knowledge of the service. Criteria for admission were that the patient would benefit from multidisciplinary rehabilitation at home, and would be capable of living in the community with normal community supports after a defined period - between 6 and 12 weeks.

- 621 patients were referred in the 3 year period.
- More than four fifths of referrals (83%) came from acute hospitals.
- 368 patients (59.2%) were accepted for care.
- Patients referred from consultant physicians for older people or GPs were more likely to be accepted for care than those referred from general physicians or surgeons. Patients were more likely to be accepted if they were postoperative general surgery (85% accepted), had a history of stroke (75% accepted), had problems with mobility (62% accepted) and orthopaedic surgery (70% accepted).
- Those least likely to be accepted were patients with dementia and miscellaneous problems (50% accepted).
- The principal objective for almost 50% of the patients was to improve mobility.
- For 33% of patients the main objective was to
Partnership with Voluntary Organisations

12.1 It is widely recognised that the care of older people is in many cases a tripartite arrangement involving families, voluntary organisations and Health Boards.

Voluntary organisations in many cases provide types of care which are diverse and innovative and which were often more readily accepted by the older person.

Examples of voluntary boards/organisations are:
- Voluntary/Charitable/Religious Homes
- Voluntary Day Centres
- Clubs/Day Centres organised by volunteers on a parish basis
- Meals on Wheels Organisations
- Voluntary Transport
- National Council on Ageing and Older People
- Alzheimer’s Society
- St. Vincent de Paul
- Victim Support
- Age Action Ireland
- Friends of the Elderly
- ALONE
- Simon Community
- Salvation Army
- Age & Opportunity among others

12.2 There is clear recognition that voluntary organisations play a key role in providing a core community social/health service to older people on behalf of and in partnership with our Board.

A good example of this was the workshop held on 9th December 1997 (already referred to in Chapter 8) at which 23 voluntary organisations attended and at which a very broad discussion took place on a wide range of service issues for older people.

It was evident that much could be learnt by both the voluntary and health board representatives from each others experiences and it was clearly evident that the voluntary organisations regarded the workshop concept as a mechanism for involvement in putting their views forward in a constructive manner.

It is incumbent on our Board to enter into ongoing discussions with voluntary organisations in each of our Boards Community Care Areas to ensure that the services are planned and implemented in a co-ordinated fashion, and are complimentary to the services provided by the statutory sector.

To this end it is vital that where voluntary organisations are grant aided by our Board that transparent mechanisms are put in place to ensure that the monies expended are accounted for and utilised in an agreed fashion, and that two to three service plans agreed by both parties are put in place and monitored throughout the year.

Equally it is important that we as a Board are seen to support the voluntary organisations in each Community Care Area in their vital community work. Key to the support is accessibility to the public health nurses service, Day Units, Respite/Intermittent Care and Community Ward Teams. The General Managers and/or The Co-ordinators of Services for Older People are seen as the key persons in liaising with voluntary organisations (many of which are locally based) in the Community Care Areas.

12.3 It is recommended that voluntary organisations should be involved and consulted with in the planning of the total care package for older people in each Community Care Area. Their expertise and local knowledge need to be tapped into and will result in a more complete and even spread of services for older people.

12.4 This consultative process should take place at Community Care level (as many voluntary organisations are locally based) and could be done on an annual basis by a combination of methods i.e.

(a) written submissions
(b) individual meetings
(c) annual study day/work shops

While option (a) is practical, it is recommended that option (c) be pursued at once as it would elicit a more open and comprehensive response and be seen as a more democratic method of consultation. It is felt that the communication pathway will help forge closer, more personal links between those working in the statutory and voluntary agencies.

The area General Managers and/or Co-ordinators of Services for Older People are seen as the key persons in initiating these workshops in liaison with other key care personnel.

These workshops do not negate the need for communication with the major voluntary organisations regarding policy issues pertaining to older people - as occurred in the preparation of this report - which will be organised at Board wide level.

12.5 Summary of Chapter

Recom mendations:

12.3 The establishment of a consultative process with Voluntary Organisations in planning the total care package for older people at Community Care Area and/or Board level as appropriate.
13.1 It is recognised that much work is required to improve liaison particularly between our Board and the local authorities in our area i.e. Dublin Corporation, Fingal County Council, Dun Laoghaire-Rathdown County Council, South Dublin County Council, Kildare County Council and Wicklow County Council.

13.2 In this regard “The Years Ahead” outlined the concept of an “Area Care Team” mechanism which might improve liaison between our Board and other organisations. This multidisciplinary team comprised of care workers in the hospital/community setting and also included a general practitioner, a representative of a voluntary organisation and a local authority housing officer. It is worth noting that the remit for the team as set out in Services for the Elderly - A Policy Document, Eastern Health Board 1989 was as follows:

- to develop and implement appropriate preventive, health education and health promotion programmes for older people in their area.
- to ensure that the needs of older people are identified and that a register of older people at risk is established and maintained
- to plan for and ensure the provision of a comprehensive range of services and supports for older people in a community setting including services provided from an institutional base.
- to identify the various housing needs of older people and ensure that these needs are met
- to ensure that the provision of all services is co-ordinated, as between the various services and service providers, both statutory and voluntary
- to ensure that appropriate advice and support is made available to carers of older people
- to monitor the on-going provision of services.

While initially these groups met on a quarterly or bi-annually in each Community Care Area, in latter years they have fallen into abeyance, except in the case of one or two Community Care Areas.

While the general feeling was that these groups were somewhat cumbersome and unwieldy they did fulfill a need in allowing the various groups concerned with the health and welfare issues of older people to meet.

The Working Group recommends that the operation of the Area Care Team in each Community Care Area be re-examined, deficiencies highlighted and that a new replacement structure be put in place if necessary to reflect alignments between the Health Boards and the Local Authorities.

13.3 Notwithstanding the above our Board has in recent times increased our working contacts with the local authorities through areas such as:

- Reach Out/Good Neighbour Campaign.
- Dublin Healthy City Project.
- The development of enhanced community services for older people at Clareville Sheltered Housing Complex.
- University of the 3rd Age Project - Finglas.
- The preparation of a report on Eccentric/Reclusive Adults.

13.4 In another area an Eastern Health Board group has met with officers of Dublin Corporation to assist them in the preparation of the new Dublin City Development Plan and also met with Dun Laoghaire-Rathdown County Council to assist in the preparation of their Draft Development Plan.

13.5 In addition the Working Group for the preparation of the 10 Year Action Plan took the opportunity to meet with a nominated representative from each of the local authorities to discuss common issues relating to services for older people and how they might impact on all our organisations.

The meetings were most useful and centred on:

- Our Board’s policy of maintaining older people in their home environment for as long as possible with appropriate community support and the obvious impact this will have on the community/social services.
- The demographic information to hand and the predications available on trends for our Board’s older population with a consequent need for an increase in housing, including sheltered housing.
- With regard to sheltered housing, the recognition that care must be taken to develop such facilities in secure areas with the support of a warden.
- The need for further liaison between our organisations with the aim of co-ordinating the development of our services, particularly the Community Units for Older People, and proposed developments of sheltered housing wherever possible.
- The concept that in developing sheltered housing that common rooms might be designed to incorporate facilities that could be used by the Health Boards to provide in community services, to develop day services for isolated people and to perhaps involve some local residents from outside the individual complexes.
- The concept of lifetime adaptable housing for older people.

13.6 To further develop the above initiatives our Board has discussed the setting up of a small working group to meet with officers of Dublin Corporation on an ongoing basis to co-ordinate the planning of services for older people and it would be recommended that similar arrangements be put in place with the remaining local authorities as a matter of urgency.

13.7 Summary of Chapter Recommendations:

13.2 Re-examination of the role of the Area Care Teams to reflect alignments between the Health Boards and Local Authorities.

13.6 Liaison between our Board and Local Authorities to co-ordinate the planning of services for older people.
In-Patient Hospital and Residential Services

14.1 Policy

In conjunction with this policy and in line with the Health Strategy - "Shaping a Healthier Future" it is also our Board’s policy to provide appropriate levels of hospital and residential care for older people when they can no longer be maintained in dignity and independence at home.

Key to this policy is that older people should be medically assessed as appropriate in the relevant Department of Medicine for the Elderly in order that a co-ordinated individual care plan is put in place for them.

14.1.1 The following service areas are critical in ensuring that the treatment or care for older people is provided in the most appropriate care setting:
- Acute assessment/rehabilitation (Departments of Medicine for the Elderly)
- Secondary Rehabilitation
- Respite/Intermittent Care
- Convalescent Care
- Day Hospitals
- Day Care Units
- Mobile Day Hospital Service
- Long-Stay Residential Care
- Subventions in Private Nursing Homes

14.1.2 Services for older people are provided in our Board’s hospitals and homes as follows:
- James Connolly Memorial Hospital
- St. Columcille’s Hospital
- Naas General Hospital
- St. Mary’s Hospital
- Clonskeagh Hospital
- St. Brigid’s Home
- Bru Chaoimhin
- St. Clare’s Home
- St. Vincent’s Hospital, Athy
- Baltinglass District Hospital
- St. Colman’s Hospital, Rathdrum
- Wicklow District Hospital
- Baggot Street Community Hospital
- Cherry Orchard Hospital
- Cuan Ros, Navan Road
- Sir Patrick Duns Hospital
- Community Unit, South Circular Road
- St. Broc’s, Clonskeagh
- Clarehaven Finglas
- Ashgrove House
- The Orchard, Bray
- The Drogheda Memorial Hospital
- St. James’s Hospital
- Beaumont Hospital
- Mater Hospital
- Meath Hospital
- St. Vincent’s Hospital
- Royal Hospital, Donnybrook
- Leopardstown Park Hospital
- Simpsons Hospital, Dundrum, Dublin 14
- Caritas, Mount Merrion
- Peamount Hospital
- St. Monica’s Home
- Voluntary, charitable and religious homes
- Private Nursing Homes

14.1.3 Our Board’s hospitals and homes also provide the following range of services for older people:
- Nutritional Advice
- Physiotherapy
- Occupational Therapy
- Social Work Service
- Chiropody
- Diversional Therapy
- Reminiscence Therapy
- Meals on Wheels

14.2 Department of Medicine for the Elderly - Acute Assessment/Rehabilitation

14.2.1 "The Years Ahead" - a Policy for the Elderly was instrumental in highlighting the need for Departments of Medicine for the Elderly in all of the acute general hospitals in our Board’s area. It stated that "the development of specialist Geriatric Departments in general hospitals had been one of the most significant advances in the care of older people in recent decades."

Latterly the Health Strategy - "Shaping a Healthier Future", reiterated this concept and recommended that the number of specialist Departments of Medicine of Old Age be increased until either every general hospital has such a Department or ready access to one.

14.2.2 The policy of providing Departments of Medicine for the Elderly on the campus of each of the General Hospitals will be completed in the Dublin area with the advent of a Department of Medicine for the Elderly at St. Michael’s Hospital, Dun Laoghaire. To this end the management of St. Michael’s are currently in discussion with the Department of Health with a view to agreeing the timescale for this development as soon as possible.

The Departments are under the control of a Consultant Physician in Medicine for the Elderly who have available the full range of diagnostic facilities in the acute hospital. A multi-disciplinary team approach is taken which decides on the appropriate level of care needed for a particular patient. Whilst traditionally access to these units has been by way of GP referral, increasingly the facility is being
used for patients, admitted through Accident & Emergency. To ensure the most appropriate use of the unit and its proper development in the interests of older patients, it is imperative that all the acute assessment, rehabilitation beds and other resources remain under the control of the Consultant Physician in Geriatric Medicine.

These units ensure the prompt and appropriate admission of older people to hospital. On admission the patient receives full medical assessment, treatment, nursing care and rehabilitation if required. In addition a follow-up care plan is devised to facilitate the patients early return to the community where-ever possible with appropriate support services. The role of the Liaison Public Health Nurse in this process is crucial in forging strong links between the acute hospital and the community nursing services, thus ensuring the appropriate and planned discharge of patients. Key to the early and appropriate discharge of older people is the implementation of a planned discharge policy by each acute hospital in liaison with Department of Medicine for the Elderly. This discharge plan must commence as early as possible following admission and involve professionals, patients and carers.

14.2.3 Hospital/Community Liaison

Hospital/community liaison is an essential element of discharge planning. It also offers opportunities for strengthening links between hospital and community personnel. The recent appointment of full-time Hospital Liaison Sisters in some of the large acute general hospitals (who work closely with Community Liaison Public Health Nurses in organising appropriate care plans prior to the patient’s discharge) has improved the standard of communication between hospital and community personnel. It is recommended that this initiative be extended to all acute general hospitals where appropriate.

Revenue Cost in respect of Acute hospitals directly managed by our Board.

3 Liaison Sisters posts Revenue Cost £66,000

14.2.4 Acute Assessment/Rehabilitation Units - Departments of Medicine for the Elderly are located at:
- James Connolly Memorial Hospital
- St. Columcille’s Hospital
- Naas General Hospital
- Mater Hospital
- Beaumont Hospital
- St. Vincent’s Hospital, Elm Park
- St. James’s Hospital
- Meath Hospital

While Assessment/Rehabilitation units are located at:
- St. Mary’s Hospital
- St. Vincent’s Hospital, Athy
- St. Colman’s Hospital, Rathdrum
- Wicklow District Hospital
- Baltinglass District Hospital

14.2.5 It is our Board’s policy to support the expansion of these Departments to meet the increased need of older people as indicated by the most recent census of population.

To this end application has been made to the Department of Health for financial clearance for three additional posts of Consultant Physician in Medicine for the Elderly i.e.

- One post shared Eastern Health Board, Mater Hospital, Beaumont Hospital
- One post shared St James’s Hospital, Eastern Health Board
- One post shared Manch Group of Hospitals, Eastern Health Board

In addition to the demographic trends, the increased workload on Geriatricians, resulting from responsibility for patient care on multiple sites outside the general hospitals in the South East Dublin/East Wicklow area and on call commitments to the General Hospitals, suggests the urgent need for an extra post in this area.

It is estimated that a further additional seven posts of Consultant Physician in Medicine for the Elderly will be required over the lifetime of the 10 Year Action Plan at a revenue cost of £1.177m approximately.

In addition, it is estimated that an additional 190 acute assessment beds will be required not only to meet the service demands brought about by the projected increase in the elderly population but to meet the current shortfall in line with the bed norms in “The Years Ahead”. These beds were possible should be located on the appropriate campus of the acute general hospitals.

The approximate costs of this would be:

<table>
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<th>Capital</th>
<th>Equipment</th>
<th>Revenue</th>
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</thead>
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<td>£7.60m est</td>
<td>£1.52m est</td>
<td>£8.30m est</td>
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14.3 Day Hospital

14.3.1 “The Years Ahead” - A policy for the Elderly recommended that every hospital with a specialist geriatric department should provide a day hospital service to facilitate diagnosis, treatment and rehabilitation of older patients.

14.3.2 The Day Hospital Service is a vital element of the service for older people. The objective of the day hospital is to provide all services available within the relevant hospital on a day basis, thereby making it possible to carry out a full medical assessment of an older person while obviating the need for admission to the acute facility. Efficient transport taking into consideration the special needs of older physically and mentally disabled persons is an essential part of such a service.

Patients attending have access to the full range of hospital services under the medical direction of a Consultant Physician in Geriatric Medicine.

14.3.3 Day Hospitals are located at:
- James Connolly Memorial Hospital
- St. Columcille’s Hospital
- St. Mary’s Hospital
- St. James’s Hospital
- Beaumont Hospital
- Mater Hospital
- Royal Hospital, Donnybrook
- Naas General Hospital
- St. Vincent’s Hospital, Elm Park

14.3.4 It is important that the cycle of providing Day Hospitals in each of the acute hospital in our Board’s area be completed as soon as possible.

To this end it is recommended that
14.4 Secondary Rehabilitation

14.4.1 Secondary or slow stream rehabilitation is usually for older patients who have completed the acute phase of their treatment, but require further intense rehabilitation over a planned period.

This intensive secondary rehabilitation programme is put in place for the patients by a multi-disciplinary team and is critical in allowing the patient attain the highest possible health gain so that he/she can return to their home in the community.

Secondary/rehabilitation facilities are available in our Board’s directly managed hospitals/homes at:
- St. Mary’s Hospital, Phoenix Park
- James Connolly Memorial Hospital
- St. Vincent’s Hospital, Athy
- St. Colman’s Hospital, Rathdrum
- District Hospital, Baltinglass
- Wicklow District Hospital

and also at:
- St. James’s Hospital
- Royal Hospital, Donnybrook

14.4.2 An additional 311 secondary rehabilitation beds will be required in the next ten years to meet the service needs for the projected increase in the older population and to meet existing shortfalls. These beds should where possible be located on the campus of an acute general hospital. The cost of this development is as follows:

<table>
<thead>
<tr>
<th>Capital</th>
<th>Equipment</th>
<th>Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>£12.45m est</td>
<td>£2.50m est</td>
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14.5 Respite/Intermittent Care

14.5.1 The benefit of the respite/intermittent care facility was emphasised in “The Years Ahead” - A Policy for the Elderly as “playing a vital role in supporting relatives caring for dependent older people at home by providing respite care while the family is on holiday, crisis admissions due to a health, illness or other event in the family and the regular (intermittent) admission of a dependent relative for a short period of time to a bed which is retained for this purpose.”

This service is of immense social gain to both relatives and patients alike and has enabled patients remain in their own home for longer that would otherwise have been possible.

14.5.2 Respite/intermittent care facilities are available in our Board’s directly managed hospitals/homes at:
- James Connolly Memorial Hospital
- St. Mary’s Hospital
- Clonskeagh Hospital
- St. Brigid’s Home
- St. Clare’s Home
- Bru Chaoimhin
- St. Colman’s, Rathdrum
- Wicklow District Hospital
- St. Vincent’s Hospital, Athy
- Baltinglass District Hospital
- Baggot Street Community Hospital
- Cuan Ros, Navan Road
- Sir Patrick Duns Hospital
- Community Unit, South Circular Road

and also at:
- St. James’s Hospital
- Royal Hospital, Donnybrook
- Leopardstown Park Hospital

Private nursing home places are also contracted for respite care where necessary.

14.5.3 All or our Board’s hospitals/homes have a flexible approach to the use of respite care places, and every effort is made to facilitate respite/intermittent admissions. Our Board is fully committed to extending this service which is vital in the support of carers in their effort to maintain their elderly dependent relatives in the home environment for as long as possible. This commitment has been evidenced in the development of the Community Units for Older People and this service will be further increased as the programme for the development of future such units gathers pace.

14.6 Day Care Units

14.6.1 Day Care Units provide a service similar to that provided in a day hospital setting. While the Consultant Geriatrician is not usually in attendance he/she is readily available to the Day Care Unit and a close liaison is maintained between the unit and the appropriate acute facility. Day Care Units make a vital contribution in the care of older people and provide a full range of medical, nursing, paramedical and social services on a day basis. These services lessen the need for admission to in-patient care and also provide a valuable support for carers.

14.6.2 Day Care Units are based in the following hospitals/homes:
- St. Colman’s’ Hospital
- Wicklow District Hospital
- St. Clare’s Home
- St. Vincent’s Hospital, Athy
- Baltinglass District Hospital
- Baggot Street Community Hospital
- Cuan Ros, Navan Road
- Sir Patrick Duns’ Hospital
- Community Unit, South Circular Road
- St. Brigid’s Home

and also at:
- Leopardstown Park Hospital
- St. Joseph’s Crinken
Our Board is committed to extending the number of Day Care places as part of the development of Community Units for Older People including Day Units throughout our Board's area. These units will also cater for manageable dementia patients.

14.7 Welfare Homes

14.7.1 Introduction:

A Health Board review group is currently examining the role of the welfare homes in our Board's area in the context of how best the homes can be utilised to respond to the need of older persons in the late 1990's in light of the development of services following the recommendations of the working report "The Years Ahead". It is expected that the group will publish its report in the near future.

For the purpose of the review the following welfare homes were commented on:

Clarehaven Welfare Home
Ashgrove Welfare Home
St Broc’s Welfare Home
The Orchard

The facility at the Drogheda Memorial Hospital was not included in the final deliberations as its staffing levels are far in excess of the normal staff in a typical welfare home and is not strictly classed as a welfare home.

For the purpose of this report the Clevis Welfare home which is directly managed by Leopardstown Park Hospital has also not been included. However the Clevis will be commented on in the report of the Welfare Home Group and any staff implications/adaptation necessary will be considered by Leopardstown Park Hospital Board and dealt with in consultation with our Board.

On examining the above four welfare homes it is clear that each had evolved separately to reflect the areas in which they are located and their relationship with the appropriate Departments of Medicine for the Elderly.

14.7.2 Admission Policy

The criteria for admissions to St Broc’s had remained as originally laid down, i.e. patients should be independent and ambulant. Patients who admitted under the criteria were subsequently transferred to other facilities for older people if they subsequently became medically dependant. This placed an increased burden on the general Geriatric services and resulted in vacancies in the homes due to adherence to the original strict admissions criteria.

However in the case of Clarehaven, Ashgrove and The Orchard welfare homes there has been a loosening of the admission criteria with ambulant patients and low medical dependency patients being admitted. In addition patients in these homes have remained there as their medical dependency level increases and only transferred elsewhere as a last resort. The low staffing levels in these homes has placed an added burden on staff which needs to be addressed as soon as possible.

While the review group examining the welfare homes is due to report shortly and will elaborate on the above issues, the Working Group preparing the 10 Year Action Plan feel it is timely to place the matters being considered by the review group on the agenda.

14.7.3 The Working Group Recommend that:

- admission to the four welfare homes be broadened to effectively cater for welfare and low dependency patients.
- patients should remain in the welfare homes until they can no longer be managed there, i.e. when they have moved beyond medium medical dependency level as is developing in Clarehaven, Ashgrove and The Orchard welfare homes.
- the Supervisor in each home be retitled as Home Manager and be of Ward Sister level.
- the two existing Assistant Supervisors in each home be increased to three and be of staff nurse level and rotate over the Day and Night to give 24 hour nursing cover due to the need to dispense medication and to reflect to dependency level of the patients.
- two additional Care Attendants be employed in St Broc’s to bring it up to the current base level applying in the other homes.
- two additional Care Attendants be employed immediately in each home which will allow for additional cover relative to the medical dependency of the patient.
- each Home be adapted and upgraded by supplying additional day space, dirty utility, assisted bathroom/shower.

<table>
<thead>
<tr>
<th>Capital Cost</th>
<th>Equipment Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>£180,000</td>
<td>£50,000</td>
</tr>
</tbody>
</table>
- each home’s bed complement be increased by two by converting the rooms currently being used as staff sleeping accommodation.
- the Care Attendants be immediately included in the cycle of training involving care attendants working in the Community Ward Teams.

It is felt that these main recommendations which will be elaborated on in the report to be issued by the Welfare Home review group will enable the homes to function on a more effective footing to the benefit of the patients.

14.8 Long-Stay Care

14.8.1 In keeping with our Board’s policy a vital aspect of our efforts to effectively cope with an ageing population is that we develop a range of community support services.

It is equally important that our Board ensures that quality facilities are available for those older patients who can no longer be maintained at home and who have been medically assessed as in need of long-term care.

14.8.2 Long-stay care facilities are provided in a variety of settings:
- Hospital Board Geriatric Hospitals/Homes
- Community Units
- James Connolly Memorial Hospital
- St. James's Hospital
- Royal Hospital, Donnybrook
- Leopardstown Park Hospital
- Peamount Hospital
- St. Monica’s Home
- Voluntary, Charitable and Religious Homes
- Private Nursing Homes
14.8.3 Longstay places becoming vacant in our Board's directly managed hospitals and residential homes are accessed directly via Departments of Medicine for the Elderly, Psychiatry of Old Age who will then make the necessary arrangements for transfer of the patient in accordance with particular medical priority needs of patients at that time.

Access to the long-stay facility at St. James's Hospital is organised via the Departments of Medicine for the Elderly at St. James's and Meath Hospitals.

Similarly, places in the Royal Hospital, Donnybrook are accessed by application directly to the Medical Officer while those at Leopardstown Park Hospital are accessed via the Departments of Medicine for the Elderly at St. James's Hospital, the Meath Hospital, St. Vincent's Hospital and St. Columcille's Hospital.

14.8.4 Since 1995 an increased number of long stay places have been provided by our board. However, it is obvious that additional extended nursing care beds will be required if future long term care needs for our older population are to be met. This fact is further confirmed by examining the number of discharges from our hospitals/homes for older persons in 1992 and 1997. Despite the increase in beds available, the fact that individuals are living longer, entering longstay care at a later age there is however no significant increase in bed turnover. The Eastern Health Board is committed to providing these additional facilities predominantly through its own geriatric hospitals, homes and community units.

14.8.5 In examining the various bed norms for long-stay care the working group was conscious that the bed norms as outlined in “The Years Ahead” were not completely compatible with today's needs.

However, in the absence of relevant modern day norms the group felt that a figure of 50 beds per 1,000 population of older people would adequately cover the care needs for the older people in the areas of respite/intermittent care, convalescent, welfare and long-stay care including manageable dementia patients.

These beds needs are outlined and quantified in the chapter on Community Units.

14.8.6 The Working Group would recognise that it is important to maintain the highest standards and facilities for older patients in all our longstay hospitals/homes. It is recommended that consideration should be given to the phased introduction of quality initiatives into our hospitals/homes which will evaluate the services being provided and make recommendations as to improvements.

It is recommended that consideration should also be given to the establishment of an expert multidisciplinary group to assist in the drawing up of guidelines not only for nursing care but also for medical care, secondary rehabilitation care and paramedical led care with a view to autonomy, promoting continence, improved nutrition, optimising drug use, preventing pressure sores, and minimising falls and accidents. Any guidelines drawn up should be taken on board by any review undertaken in respect of Private Nursing Homes and applied as appropriate.

14.8.7 Summary of Chapter Recommendations:

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Capital</th>
<th>Equipment</th>
<th>Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.2.3 Creation of 3 Hospital Liaison Sister posts</td>
<td>—</td>
<td>—</td>
<td>£66,000</td>
</tr>
<tr>
<td>14.2.5 Additional 11 posts of Consultant Physician in Medicine for the Elderly</td>
<td>—</td>
<td>—</td>
<td>£1.177m</td>
</tr>
<tr>
<td>14.2.5 Provision of additional 190 Acute Assessment Beds</td>
<td>£7.60m(est)</td>
<td>£1.52m(est)</td>
<td>£8.30m(est)</td>
</tr>
<tr>
<td>14.3.4 Extension of Day Hospital Service at Beaumont</td>
<td>Funding to be provided by Beaumont Hospital</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>14.3.4 Creation of Day Hospital Service at St. Michael's Hospital</td>
<td>Funding to be provided by St. Michael's Hospital</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>14.3.4 Provision of an additional 112 day hospital places in our Board's Area</td>
<td>N/A</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>14.4.3 Provision of an additional 311 Secondary Rehabilitation Beds</td>
<td>£12.45m(est)</td>
<td>£2.50m(est)</td>
<td>£12.50m(est)</td>
</tr>
<tr>
<td>14.7.3 Admission to the four Welfare Homes be broadened to effectively cater for welfare and low dependency patients</td>
<td>N/A</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Patients should remain in the welfare homes until they can no longer be managed there</td>
<td>N/A</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Upgrade Supervisor posts to Ward Sister Level</td>
<td>—</td>
<td>—</td>
<td>£19,000</td>
</tr>
</tbody>
</table>
### 14.8.7 Summary of Chapter Recommendations continued

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Capital</th>
<th>Equipment</th>
<th>Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upgrade Asst. Supervisor to Staff Nurse Level and increase by 4 WTE</td>
<td>---</td>
<td>---</td>
<td>£126,000</td>
</tr>
<tr>
<td>Employment of 2 Additional Care Attendants in St. Broc's</td>
<td>---</td>
<td>---</td>
<td>£25,000</td>
</tr>
<tr>
<td>The provision of an additional 2 Care Attendants in each Welfare Home</td>
<td>---</td>
<td>---</td>
<td>£100,000</td>
</tr>
<tr>
<td>Upgrading of Welfare Homes (x 4)</td>
<td>£180,000</td>
<td>£50,000</td>
<td>---</td>
</tr>
<tr>
<td>Increase bed complement in each Welfare Home (x 2)</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inclusion of Care Attendants in cycle of training involving Care Attendants</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Introduction of quality initiatives in our hospitals/homes to evaluate the</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Introduction of guidelines for nursing, medical and paramedical care to</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>maximise the quality of care in our hospitals/home</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Community Units for Older People

15.1 The development of the Community Units concept as outlined in the 1995–1998 Action Plan has proved of immense benefit in the provision of a spectrum of services for older people either as short stay patients i.e. day care, respite/intermittent, convalescent/rehabilitation care or as long stay patients. They have also played a key role in providing a full range of services for the elderly mentally infirm who can be managed in the community units. The provision of Community Units has resulted in a responsive humane service and has allowed older people to remain in their own homes for as long as possible. The Working Group would re-emphasise that our Board should maintain the momentum of constructing quality public facilities for older people such as the Community Units during the lifetime of the Action Plan.

15.2 The Community Units fill some but not necessarily all of the non acute in-patient needs of older people. Other strategies such as the use of private nursing homes in appropriate cases have also been adopted. However, there is an urgency to continue the development of the strategically located Community Units proposed by our Board not only to provide additional facilities for the care of older people as close as possible to their own home environment but also to commence the replacement of out-dated and unsuitable buildings currently being used for the provision of long-stay care (see Chapter 19 Replacement of Old/Unsuitable Buildings). The Working Group, are also of the opinion that as these Units will cater for older persons with dementia who tend to wander, that care should be taken in their design to ensure that such patients can be managed in tandem with other patients in the Unit.

15.3 It is the opinion of the Working Group, on examination of known norms and having taken into account the development of convalescent and respite care services, that a rate of 50 beds per 1,000 of the older population who have no aggressive/disturbed tendencies. The Working Group did note that the figure of 50 beds per 1,000 older people was based as far as possible on the norms that have been in place for many years and identified in the Years Ahead Report. The Group felt that these norms should be reassessed by an expert group to ascertain if they are relevant to today's service requirements.

15.4 However the group in deciding on norms of 50 beds also studied a paper "Nursing Homes in 10 Nations: A Comparison Between Countries and Settings (Age & Ageing 1997 Vol. 3 No 13). This paper examined the number of people aged 65 and over living at home and in institutions in 10 countries (see Table 1 below).

The information provided shows a variation from a low of 4% in Italy to a high of 15% in Denmark of people aged 65 and over who are occupying long stay care places. In countries which are closest in type to Ireland i.e. the United Kingdom and France 7% and 6% of older people are occupying longstay care beds respectively. On this basis and bearing in mind both the development of the Community Ward Teams and the spectrum of services available in the Community Units the Working Group are of the opinion that a norm of 5% or 50 beds per 1,000 older people is not excessive.

15.5 In order to plan for necessary inpatient service for older people into the new millennium it is necessary to examine the population for our Board’s older people aged 65 and over which will have reached approximately 165,000 by the year 2008, a net increase of 33,877 over the estimated 1998 population.

Again if one utilises the bed norm as outlined above, this would indicate that an additional bed requirement of 1,700 will be required to meet the projected care demands. To this figure must be added 150 places for older people in appropriately occupying further hospital beds at the present time.

TABLE 1
Percentage of People ≥ 65 Years Living at Home and in Institutions
(prevalence date; difference years in the early 1990’s)

<table>
<thead>
<tr>
<th>Country</th>
<th>USA</th>
<th>Japan</th>
<th>Iceland</th>
<th>Sweden</th>
<th>Denmark</th>
<th>Netherlands</th>
<th>UK</th>
<th>France</th>
<th>Italy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Own Home: independently or with informal and/or formal care (including domestic help and home nursing)</td>
<td>–</td>
<td>94.0</td>
<td>87.0</td>
<td>94.0</td>
<td>85.0</td>
<td>90.0</td>
<td>93.0</td>
<td>94.0</td>
<td>96.0</td>
</tr>
<tr>
<td>Residential homes, homes for the aged, old people’s homes (low level of care)</td>
<td>1.5</td>
<td>0.5</td>
<td>5.0</td>
<td>3.0</td>
<td>10.5</td>
<td>6.5</td>
<td>3.5</td>
<td>4.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Nursing Homes (high levels of care)</td>
<td>5.0</td>
<td>1.5</td>
<td>8.0</td>
<td>2.0</td>
<td>4.0</td>
<td>2.5</td>
<td>2.0</td>
<td>–</td>
<td>&lt;2.0</td>
</tr>
<tr>
<td>Hospitals (intensive medical care)</td>
<td>–</td>
<td>4.0</td>
<td>–</td>
<td>&lt;1.0</td>
<td>&lt;2.0</td>
<td>&lt;1.0</td>
<td>1.5</td>
<td>–</td>
<td>1.0</td>
</tr>
</tbody>
</table>
While it is reasonable to assume that some of this demand will be met from within the private nursing home area it is also reasonable to assume that the majority of places, perhaps 1,450 will have to be met from within the public sector.

This will result in a requirement for approximately 29 x 50 bed community units to be build over the lifetime of this report. 11 of these units would be located at sites already identified in previous reports i.e.

- St. Clare's (capital monies from sale of lands at St. Clare's, Construction completed April 1998)
- Dalkey (capital monies from sale of lands at St. Clare’s)
- Raheny
- Lusk
- Beaumont
- Fairview
- Maynooth
- St. Clare’s (2nd Unit)
- St. Brendan’s
- St. Loman’s
- Leopardstown Park Hospital

(funding to be arranged by Leopardstown Park)

15.6 Again, considering the projected increase in population in Kildare and Wicklow between 1999 and 2008, it is recommended that two community units be strategically located in County Kildare in mid-Kildare and near to Naas and in County Wicklow at Bray and at South Wicklow i.e. four in total with the remaining 14 units to be located in the greater Dublin/Dun Laoghaire area. Suggested sites could include Portrane, Ashbourne, Ballymun, Balbriggan/ Naul, Tallaght, Walkinstown, Meath Hospital site, Terenure, Ballyboden, Dundrum, Stepaside, Booterstown, Ballinteer/Monkstown and Shankill among others.

15.7 The total cost of developing 29 Community Units at 1997 prices phased over the lifetime of the 10 Year Action Plan is as follows:

<table>
<thead>
<tr>
<th>Component</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital</td>
<td>£52.00m approx</td>
</tr>
<tr>
<td>Equipment Costs</td>
<td>£11.20m approx</td>
</tr>
</tbody>
</table>

15.8 The group recommends that the development of community units should compliment the existing acute assessment and rehabilitation services for older people on the general hospital campus and other sites. Accordingly it is important that the relevant Consultant Physician in Geriatric Medicine and/or Consultant in the Psychiatry of Old Age, have appropriate involvement to ensure optimal co-ordination of services between the general hospital and the community units. This would also include providing specialist medical advice to the staff of the community unit and participating in monitoring agreed policies of the community unit in relation to admission and discharge of patients and standards.

It is obvious that an agreement will have to be reached into with the Department of Health to fund the development of Community Units on a phased basis as outlined above as soon as possible.

15.9 Summary of Recommendations:

15.7 Development of 29 Community Units

<table>
<thead>
<tr>
<th>Component</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital</td>
<td>£52.00m approx</td>
</tr>
<tr>
<td>Equipment Costs</td>
<td>£11.20m approx</td>
</tr>
<tr>
<td>Revenue</td>
<td>£30.00m approx</td>
</tr>
<tr>
<td>Staff WTE</td>
<td>1,169 approx</td>
</tr>
</tbody>
</table>

15.8 The Group recommends that the development of Community Units should compliment the existing acute assessment and rehabilitation services for older people on the various general hospital campus and other sites.
Functional mental illnesses in old age cause considerable distress to people and also to their relatives and sometimes neighbours if behaviour is disturbed. It is, therefore, extremely important to recognise and treat these conditions. An important aspect of this is an awareness that these conditions respond just as well to treatment as do similar conditions in younger people and, indeed, there is evidence that depression, for instance, responds better to treatment when it occurs de novo in older people than in younger people.

All of these factors cause difficulties with managing functional illnesses in old age.

In addition there is a reluctance among older patients to present themselves for treatment because of a sense of shame or because of the illness itself, i.e. schizophrenia.

As with dementia, a comprehensive range of services within and without the psychiatric service are required to meet the needs of this group of people.

16.3.2 Primary Care Services

Most cases of depression are assessed and treated at primary care level by general practitioners. There is an increasing awareness amongst general practitioners of the prevalence of depression, particularly amongst older people, and they are now well able to recognise it and the advent of newer non-toxic, well tolerated anti-depressant drugs has helped them in treating this condition very successfully.

16.3.3 Secondary Care Services - Old Age Psychiatry

However, a substantial number of cases of depression in old age may present atypically or may be of such severity that psychiatric intervention is required. This is ideally provided by specialist Psychiatry of Old Age services which have a particular expertise in recognising and treating depression in older people and which are community oriented, providing domiciliary psychiatric assessment and treatment in so far as this is possible.

It is essential that our Board develops Psychiatry of Old Age Services comparable to its Medicine for the Elderly Services. At the time of writing five and a half of the ten Community Care Areas have Psychiatry of Old Age Services. However in the most recently set up service in South East Dublin there are no acute psychiatric beds designated under the Mental Treatment Act available so it is not as yet providing a comprehensive service to its catchment area.

The range of services available within Psychiatry of Old Age are based on having a multidisciplinary consultant led team which provides domiciliary psychiatric assessment and a comprehensive community psychiatric nurse follow up service.

The facilities required include:
- a day hospital for each catchment area.
- acute treatment beds designated under the Mental Treatment Act.
- access to the Community Unit network for the less difficult patients.
- a small number of long-stay psychiatric beds for people with intractable functional mental illness particularly difficult to manage e.g. some cases of schizophrenia or rapidly recurrent and relapsing affective disorders.

16.4 Psychiatry of Old Age

16.4.1 Overview

The Psychiatry of Old Age is a recognised psychiatric specialty which is concerned with mental disorders arising anew in people over the age of 65 years. Broadly it deals with two groups of people:
- Dementia sufferers with behavioural or psychological problems for which psychiatric intervention is required.
- Older people developing functional psychiatric disorders for the first time over the age of 65 years.

16.4.2 Current Situation

To analyse the Psychiatry of Old Age in our Board, it is perhaps best to examine it in the context of the various Departments of Psychiatry of Old Age, bearing in mind our Board's policy to expand the Departments of Psychiatry of Old Age until each area has access to such a service.

Our Board over recent years has in conjunction with other agencies developed three departments of Psychiatry of Old Age in our Boards area, one in Dublin North which caters for community care areas 6 and 7 one in Dublin South West which caters for community care area 3 and part of 4 and latterly a department in Dublin South East which caters for community care areas 1 and 2. The facilities available to these services are detailed in the appendices.

Our Boards overall strategic policy is to promote the concept of joint departments of psychiatry of old age in (i) North Dublin/County (ii) Dublin South East/East Wicklow and (iii) Dublin South West, Kildare and West Wicklow with links being forged by individual Department of Psychiatry of Old Age with the appropriate Acute General Hospitals in their area. It is envisaged that there will be close working relations between the various teams within each joint Department of Psychiatry of Old Age to maximise the service to the older patients.
16.4.3 Summary of Chapter Recommendations:
It is recommended that the priority service requirements for the lifetime 187 of the Action Plan are as follows:

16.4.4 Enhancement of Current Services
The following service needs are required to augment the existing structures as soon as possible.

North Dublin
4.0 WTE staff for Day hospital/Community Service
Cost - £84,000 revenue(estimated)

Extension of Day Hospital, Therapeutic Centre JCMH to provide OT/group room with assessment facilities
Cost - £25,000 capital (estimated) once-off

South-East Dublin:
3 WTE staff for Day hospital/Community Service
Cost - £66,000 revenue (estimated)

6 Acute Psychiatric beds to be contracted from St John of Gods
Cost - £263,000 revenue (estimated)

South-West Dublin:
Provision of 8 additional long stay beds for severely disturbed patients with dementia at St Patrick’s hospital
Cost - £200,000 revenue (estimated)

4 WTE staff for Day hospital/Community Service
Cost - £87,000 revenue (estimated)

16.4.5 1999 - 1st Year of Action Plan
Priority 1: Appointment of a Psychiatry of Old Age Team located at Tallaght hospital to include a day hospital and base to cover a catchment area of Community Care area 5 and part of 4.

Service Requirement
4 Acute Beds (additional)

Capital £160,000(est)
Equipment £32,000(est)
Revenue(full year) £175,000(est)

Day Hospital/Base
Capital £454,000(est)
Equipment £110,000(est)
Revenue(full year) £395,000(est)*

Longstay/Respite beds will be provided in a unit in Cherry Orchard or in a Unit in St Lomans for severely disturbed patients with dementia and at the Community Unit on the South Circular Road for manageable dementia patients.

*Post of Consultant Psychiatry of Old Age and Post of Registrar already provided for.

Priority 2: Appointment of a Psychiatry of Old Age Team at Beaumont hospital including acute beds and day hospital to cover a catchment area of Community Care area 8 and part of 7.

Service Requirement
10 Acute Beds

Capital £400,000(est)
Equipment £380,000(est)
Revenue(full year) £438,000(est)

Day Hospital/Base
Capital £455,000(est)
Equipment £110,000(est)
Revenue(full year) £527,000(est)*

Longstay/Respite beds will be provided at Reillys Hill/St Ita’s for severely disturbed patients with dementia and at the proposed Community Units for manageable dementia patients.

16.4.6 Year 2000 - 2nd Year of Action Plan
Priority 3: Appointment of a Psychiatry of Old Age Team at St Vincents hospital including a day hospital and acute beds to cover a catchment area of Community Care area 10 and part of Community Care area 1.

Service Requirement
20 Acute Beds (to be shared with existing team)

Capital £800,000(est)
Equipment £160,000(est)
Revenue(full year) £876,000(est)

Day Hospital/Base (to be shared with existing team)
Capital £540,000(est)
Equipment £125,000(est)
Revenue(full year) £527,000(est)

6 Beds Bloomfield Hospital for manageable Alzheimers/dementia patients.
Longstay/Respite beds will be provided at Tivoli Road/Clonskeagh for severely disturbed patients with dementia and at the Community Units at Sir Patrick Duns and Dalkey and other community units as they come on stream for manageable dementia patients.

Priority 4: Appointment of a Psychiatry of Old Age Team at Naas hospital including a day hospital and acute beds to cover a catchment area of Community Care area 9 and redistributed portion of Community Care area 5.

Service Requirement

6 Acute beds to be provided at Naas hospital from within the current acute unit.

Capital

Equipment

Revenue(full year) £96,000(est)

Longstay/Respite beds for severely disturbed patients with dementia will be located in the Community Unit at Maynooth and in Peamount, Baltinglass and St Vincent's. Athy hospitals for manageable dementia patients.

Priority 5: Appointment of a Psychiatry of Old Age Team at James Connolly Memorial hospital including acute beds and day hospital with subsequent redistribution of the catchment areas for the service in North Dublin/County.

Service Requirement

10 Acute beds at JCM Hospital

Capital £400,000(est)

Capital £1.20m(est)

Equipment £240,000(est)

Revenue(full year) £700,000(est)

Longstay/Respite beds for manageable dementia patients will be available in the Community Units for the elderly being developed in North Dublin City and County.

Priority 6: Department of Psychiatry of Old Age to be located at St Columcilles Hospital including acute beds and a day hospital. This department will allow for the redistribution of the catchment area covering community care areas 1, 2 and 10 among the three teams.

Service Requirement

4 additional acute beds (contracted from St John of Gods)

Capital

Equipment

Revenue(full year) £175,000(est)

Day Hospital/Base

Capital £455,000(est)

Equipment £320,000(est)

Revenue £900,000(est)

Longstay/Respite beds will be provided at Newcastle Hospital for severely disturbed patients with dementia and the Community Units in the area for manageable dementia patients.

It should be noted that each Department of Psychiatry of Old Age listed in Priority 1 - 6 will be led by a Consultant Psychiatrist of Old Age and a multidisciplinary team of 14 WTE each.

16.4.8 Service Needs Year 4 - 10 of Action Plan:

As it is projected that the population aged 65 and over will increase to 165,000 by the year 2008 the following staff and facilities will be required to meet the service demands as per the accepted norms agreed in the "Years Ahead" Report.
<table>
<thead>
<tr>
<th>Staffing</th>
<th>No.</th>
<th>Revenue Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant Posts</td>
<td>7</td>
<td>£749,000</td>
</tr>
<tr>
<td>Community Staff Nurses</td>
<td>10</td>
<td>£186,000</td>
</tr>
<tr>
<td>Paramedical Staff</td>
<td>21</td>
<td>£528,000</td>
</tr>
<tr>
<td>N.C.H.D.'s</td>
<td>7</td>
<td>£172,000</td>
</tr>
<tr>
<td>Clerical</td>
<td>7</td>
<td>£93,000</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td></td>
<td><strong>£1,728,000</strong></td>
</tr>
</tbody>
</table>

160 Additional Acute beds to be provided in modules of 20 beds each

<table>
<thead>
<tr>
<th>Capital</th>
<th>£6.40m(est)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equipment</td>
<td>£1.28m(est)</td>
</tr>
<tr>
<td>Revenue</td>
<td>£7.00m(est)</td>
</tr>
</tbody>
</table>

An additional 200 long stay/respite beds for severely disturbed patients with dementia will be required.

<table>
<thead>
<tr>
<th>Capital</th>
<th>£8.00m(est)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equipment</td>
<td>£1.60m(est)</td>
</tr>
<tr>
<td>Revenue</td>
<td>£4.745m(est)</td>
</tr>
</tbody>
</table>

An additional 150 Day hospital places are required and will be provided by maximising the use of the 9 Day hospitals already existing or prioritised in this chapter.
Appendix A: Dementia in the Community

North Dublin Old Age Psychiatry and Medicine for the Elderly Services, Area 6 Community Care Services.

People with dementia and their families require a seamless service which offers:
- Early assessment and diagnosis
- Practical and emotional support to include:
  - Assistance with self care and home supports such as meals on wheels
  - Day and respite care
- Management of medical illnesses
- Management of behavioural and psychiatric problems
- Residential care.

This necessitates a range of services which are well co-ordinated and flexible enough to meet the changing need of sufferers and carers.

In practice, it is difficult to provide, this flexible, seamless service for a number of reasons. These include there being several service providers at primary and secondary level and also a significant deficit of provision at primary care level; particularly day care, respite care, public health nurses with dedicated time for dementia sufferers and local residential care.

This pilot project will be a joint initiative involving all three main service providers and will concentrate on building up primary care provision in the Cabra area. The area consists of 7 designated electoral districts with a total population of 3,287 people over the age of 65 years.

All dementia sufferers in the community will have a key worker (PHN with dedicated time for people with dementia) who will follow up patients and liaise with families to ensure patients can access the services they require.

The PHN will also liaise with General Practitioners and other PHNs to ensure people suspected of having dementia will be referred to the medical personnel involved in the study for definitive diagnosis at an early stage.

Patients will be followed up over two years by the PHN during which time information will be collected on the utilisation of services. Using this information, it will be possible to determine:

(i) if the key worker system is effective in ensuring continuity of care
(ii) the total service requirements for dementia sufferers in the designated area and also, by extrapolation, throughout the EHB's area.

Facilities
- access to two respite beds which will be managed by the designated PHN
- access to day places
- enhanced access to home support such as home care attendants
- access to long stay care (assessment of need for placement will be made in the usual way).

Recommendations:
The creation of 1.5 WTE Posts, i.e PHN, Medical/Psychiatric Registrar

Revenue Cost £38,000
Appendix B: Memory Clinic

North Dublin Psychiatry of Old Age and Medicine for the Elderly Services

Memory clinics provide multi-disciplinary assessment of people with possible dementia with a view to making as accurate a diagnosis as possible and advising on further interventions in the broadest possible sense.

Early diagnosis enables:

(i) Legal and financial arrangements to be made whilst the person is still mentally competent.

(ii) Advice to be given regarding treatment which may delay the progression of the condition. For instance, Alzheimer's disease may benefit from vitamin E and, in women, possibly hormone replacement therapy.

(iii) Specific treatment with a view to reversing the process - even if only in a limited fashion. One drug has recently been licensed for this purpose and a number of other such drugs will become available in the next year or two.

It is proposed to set up a memory clinic in North Dublin using existing facilities at either the Mater Hospital or James Connolly Memorial Hospital. This will be an outpatient clinic which will actively encourage early referral by General Practitioners for patients suspected of suffering from dementia. The assessment will include mental status evaluation, physical evaluation, investigations (including neuroradiological if indicated) and psychological assessment.

A follow up clinic will provide monitoring e.g. of any medication prescribed together with education for family members.

- Consultant supervision by the appropriate Consultant Physician in General Medicine and Consultant Psychiatrist of Old Age.

The clinic will be evaluated after one year of operation to assess whether it is meeting the needs of the catchment area and whether it should be extended to other areas.

Recommendation:

The creation of 1.5 WTE, i.e Psychiatric/ Medical Registrar, Psychologist

Revenue Cost £44,000

Following the above evaluation process it is recommended that consideration be given to the creation of an Institute for Research on Ageing to be located on a North Dublin hospital site, to mirror the Mercer’s Institute for Research on Ageing at St. James’s Hospital. This proposed Institute would incorporate the Memory Clinic and its aims would be to provide information, education and training for statutory, voluntary and private service providers and to maintain a database on services and on dementia-related research. The Institute which would be jointly managed by the Departments of Medicine for the Elderly and Psychiatry of Old Age in the North City/County would forge strong links with similar centres at home and abroad.

The principal objective of the Institute would be to promote and carry out research into diseases associated with ageing and to explore ways of improving the quality of life of older people particularly those in the early stages of dementia.

The revenue/capital costs for this extended service are included here under and are conditional on the satisfactory evaluation of the Memory Clinic pilot.

Recommendations:

Renovation of area on an appropriate hospital site

Capital Cost £50,000 (once off)

The creation of 5.5 WTE Posts

i.e. 2 Research Registrars, 2 Research Nurses, 1 Clerical Staff, 0.5 Clinical Psychologist

Revenue Cost £122,000
Appendix C: Presenile Dementia Service

St James Hospital Old Age Psychiatry Services

A recent survey of people with presenile/early onset dementia in the catchment area of this service (Community Care Area 3 and part of 4) identified 12 people with presenile dementia. Extrapolation from these figures suggest that there are approximately 100 such people within the Eastern Health Board area.

This pilot project recommends that as an initial step a presenile/early onset dementia service be developed within the Old Age Psychiatry Service in St James’s Hospital for its catchment area with input from a community psychiatric nurse and part-time medical registrar. The service should include both diagnostic and management aspects. These should be integrated as an isolated diagnostic service is of limited benefit in the absence of follow up services. Diagnostic facilities should include psychiatric and neurological evaluation and also access to neuropsychological assessments where necessary. Ongoing management facilities should include community supports, dedicated CPN time, day hospital provision, access to respite and long-term facilities together with the dedicated involvement of a consultant in Old Age Psychiatry with an additional part-time registrar. Ongoing evaluation and monitoring of the service would be carried out before a decision on whether to expand the service is made. It should be noted that this expansion would only occur in other Departments of Old Psychiatrist by prior agreement and consultation and would necessitate the required staff and resources to be put in place at the appropriate time.

Recommendations:
The creation of 1 WTE staff, i.e CPN, Psychiatric Registrar. Revenue Costs £23,000

Summary of Recommendations Appendix A,B,C:
The creation of 1.5 WTE Posts, i.e PHN, Medical/Psychiatric Registrar
Revenue Cost £38,000
The creation of 1.5 WTE, i.e Psychiatric Registrar, Medical Registrar, Psychologist
Revenue Cost £44,000
Renovation of area on an appropriate hospital site
Capital Cost £50,000 (once off)
The creation of 5.5 WTE Posts i.e 2 Research/Registrars, 2 Research Nurses 1 Clerical, .5 Clinical Psychologist
Revenue Cost £122,000
The creation of 1 WTE staff, i.e CPN, Psychiatric Registrar.
Revenue Costs £23,000
17.1 This chapter refers to people who have developed functional mental illnesses below the age of 65 and now have grown old in the psychiatric services. This is an extremely common problem and is related to the recurrent nature of many psychiatric illnesses such as depression, mania and schizophrenia. It is also in part related to the practice of continuous hospitalisation that was offered to many people in the asylum system. Another aspect to this is that in past years the psychiatric services were based on admission rather than community based treatment and many elderly patients with psychiatric illnesses have become accustomed to the practice of being admitted when they were ill rather than being managed at home or in a day hospital setting so this group of patients are particularly heavy users of acute inpatient psychiatric beds.

17.2 There are two aspects to this problem which need to be considered.

(i) Those older people within the General Psychiatry Services who are still living at home.
(ii) Those who are long term residents in psychiatric hospitals/hostels. Quite a substantial number of the latter in North Dublin have been resettled from St. Brendan’s Hospital following the closure of the Lower House.

The needs for these two groups of patients will now be considered separately.

17.3 Community Dwelling Older Patients with Chronic Psychiatric Problems

These patients are the responsibility of the General Psychiatry Services and, therefore, need access to outpatient clinics and CPN follow up. For this particular group of patients, psychiatric day centres are important especially for those who suffer from chronic schizophrenia and the day centre attendance should ideally be arranged on a five day a week basis. Medical problems will be dealt with by the person’s GP so it is important that close links are maintained between the psychiatric services and general practitioners. Likewise, this group of patients also require and currently have access to Medicine for Elderly Services. There is also a substantial requirement for long-stay care for these people. While some may be suitable for nursing home care, others will require such care in a psychiatric setting because of the nature of their behaviour. They should, therefore, have access to the hostel programmes within the general psychiatric services and also to more infirmary type psychiatric care if they suffer from a combination of physical dependence and significant mental health problems.

17.4 Patients Growing Old in Psychiatric Hospitals/Hostels

A substantial number of patients with chronic mental health problems currently housed in psychiatric hostels in the Eastern Health Board area are now growing old. In many instances, the hostels are unsuitable for older people because they have two and three storeys and also because they do not provide the degree of care required by people who are physically frail as well as mentally unwell. There is a clear need for purpose built accommodation for people who have mental health problems but whose increasing medical dependency make it impractical for them to be managed in psychiatric hospitals/hostels. For many such people transfer to nursing homes is not a good option because their behaviour would distress other residents in nursing homes and it requires psychiatric skills to manage it. This makes the case for infirmary type accommodation within the psychiatric service. It should be based on single storey buildings staffed by psychiatric nurses and care attendants thereby meeting both behaviour and physical needs.

Like other older people, those with chronic functional mental illness may also develop dementia. There is, therefore, a dilemma as to how this group of people might be dealt with. The same principle should apply as for the general population. Some may be dealt in a nursing home setting but where there are severe behavioural problems related to the dementia or behaviour problems related to the original chronic functional mental illness, it would be more appropriate for care to be within the psychiatric service. Again, infirmary style accommodation would be appropriate and could be the same accommodation as is provided for those without dementia who are physically frail and mentally ill. However, such units should also have a safe area to allow those who develop a proclivity for wandering to be cared for adequately.

17.5 Study

17.5.1 In order to assess the needs of those over 65 years and also the 55-64 year age group who will come within the 10 year time frame of this action plan, a study of these two age groups currently availing of residential and out-patient general psychiatry services in the Eastern Health Board’s 10 psychiatric areas was carried out. The psychiatric residential settings are of two types:

- hostels
- long-stay units

The latter are capable of managing those with severe mental illnesses associated with marked physical frailty. The number occupying acute psychiatric beds for longer than six months was also ascertained to obtain an estimate of the immediate unmet residential requirement of both age groups.

17.5.2 Results

Information was received from all ten psychiatric areas with a total catchment area population of 1,295,939 of whom 9.66% or 125,271 are age 65 years or over (“96 census figure”). (See Table 1) St. Brendan’s Hospital also provided this information but it is shown separately since its patients originate city-wide.

Of these areas, Kildare has no psychiatric hostels or long-stay wards and St. Brendan’s in its process of decanting and closure has very limited access to long-stay psychiatric wards on the campus. Area 6 has an exceptionally large hostel population reflecting the previous practice of moving patients in St. Brendan’s to the hostels on the North Circular Road. There is also a particularly large long-stay population in St. Ita’s, reference to which is made later.
Older People with a Mental Handicap

18.1 Advances in modern medicine have improved the quality of life for people with a mental handicap. This has resulted in a substantial increase in their life expectancy and as a result elderly people now constitute a growing proportion of the overall population of people with a mental handicap. While the general needs of this group of people mirror those of other older people in the community their higher level of dependency necessitates the provision of special services to meet their additional needs.

18.2 This report defines older as being aged 65 or over. In order to carry out a detailed assessment of the requirements for older persons with a mental handicap over the next ten years it is necessary to quantify the current numbers aged 65 and over and also those aged 45 and over. In dealing with persons with a mental handicap it is important to establish what constitutes being elderly. The Report of the Review Group on Mental Handicap Services Needs and Abilities which was published in 1990 recommended that people with a mental handicap over forty years of age should have a multidisciplinary assessment because of the increased likelihood of certain diseases. For example, the known association between Down’s Syndrome and Alzheimer’s Disease has been the focus of much recent research. Needs and Abilities recommended that older people with a mental handicap should have access to appropriate comprehensive services for older people. The Report also pointed out that there was some evidence to show that people with a mental handicap may become dependent or require more specialised care at an earlier age than those in the general population. If this is the case there is an urgent need to further examine and determine the age at which persons with a mental handicap will require specialist services for older people.

18.3 As outlined in Table 2 attached there are 1,637 persons with a mental handicap aged 45 and over in the Eastern Health Board area. Of this total there are 1,118 age 45 and over with moderate, severe and profound handicap of which a total of 357 have a need for a more intensive level of in-patient service in the medium term (see Table 1).

<table>
<thead>
<tr>
<th>Age</th>
<th>In Residential Care</th>
<th>Living at Home</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 45 - 54</td>
<td>159</td>
<td>41</td>
<td>200</td>
</tr>
<tr>
<td>Age 55 - 64</td>
<td>85</td>
<td>7</td>
<td>92</td>
</tr>
<tr>
<td>Age 65+</td>
<td>61</td>
<td>4</td>
<td>65</td>
</tr>
<tr>
<td>Totals</td>
<td>305</td>
<td>52</td>
<td>357</td>
</tr>
</tbody>
</table>

The above data has been extracted from the Database of the Eastern Health Board.

For the purpose of this Report details of the numbers, degree of handicap and secondary disabilities for three age categories of persons with a mental handicap currently in residential care with a future need for enhanced care and those living at home with a future residential requirement are as set out in Tables 3 & 4.

18.4 It should also be noted that there are presently 778 people aged 45 and over who are deemed to be in an appropriate residential care setting but in some cases, persons from this group will transfer over time to vacancies in the proposed new units for older mentally handicapped.

18.5 The attached Table 3 indicates that many existing placements are deemed inappropriate and do not meet the many specialised needs of this group. Service-providers with large numbers of older persons have been addressing these issues and have identified staffing and accommodation needs for this group. The need to develop specialised care services for the frail older people and a palliative care service for the dying are priority requirements. Those aged over 65 in residential care who are not in immediate need of these specialised services also need support to maintain their dignity and independence.

Elements such as environment, clothing and dress, leisure, friends, attitudes and values of staff are significant in promoting a quality life for the elderly. The vast majority of those listed in Table 3 are living with their families in the community. In receipt of day services from the Eastern Health Board or voluntary agencies. Many in this category are being cared for by elderly parents. Where possible, these people should utilise the services available generally to older people at Community Care level in their locality, especially the social and recreational services.

18.6 In order to ensure that older people with a mental handicap receive specialist services appropriate to their needs it will be necessary for the mental handicap agencies to develop appropriate services. Some agencies have already commenced work in this area and are developing expertise in palliative care and geriatrics. It is advisable that nursing staff specialising in these fields should have a background in dealing with mental handicap. Arising from this there is a need for a recognised and accredited course in the care of older persons with a mental handicap. It will also be necessary to provide specialist clinicians to deliver services for the ageing population with a mental handicap.

18.7 Implications for Services for Older People with a Mental Handicap

18.7.1 Based on the future requirements of those 305 persons over 45 years age currently in residential care and the future needs outlined in respect of the 52 persons currently residing at home the pattern of future service requirements is as follows:

<table>
<thead>
<tr>
<th>Places</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 Day Residential Care</td>
<td>306</td>
</tr>
<tr>
<td>5 Day Residential Care</td>
<td>3</td>
</tr>
<tr>
<td>Specialist Placements - Profound or Multiple Handicaps</td>
<td>35</td>
</tr>
<tr>
<td>Specialist Placements - Challenging Behaviour</td>
<td>12</td>
</tr>
<tr>
<td>Nursing Home</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>357</td>
</tr>
</tbody>
</table>
On the basis that 305 persons would transfer from mainstream mental handicap this will free up significant resources for the generic mental handicap services. This would enable many of those on the priority waiting list for residential care to avail of placements vacated by those transferring to specialist services for the older mentally handicapped.

18.8 Summary of Chapter Recommendations
The requirements of these clients will be spread over a 10 year period. Given factors such as life expectancy and early age at which some persons with a mental handicap will require these services it is advisable to plan as follows:

<table>
<thead>
<tr>
<th>Year 1999</th>
<th>Capital Estimated</th>
<th>Revenue Estimated</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 x 5 bedded Specialist Units - Profound and Multiple Handicaps</td>
<td>0.900m</td>
<td>0.900m</td>
</tr>
<tr>
<td>1 x 6 bedded Specialist Unit - Challenging Behaviour</td>
<td>0.300m</td>
<td>0.300m</td>
</tr>
<tr>
<td>30 residential beds in 5 Unit Complex (6 beds per unit)</td>
<td>1.800m</td>
<td>1.100m</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2000</th>
<th>Capital</th>
<th>Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 x 5 bedded Specialist Units - Profound and Multiple Handicaps</td>
<td>0.900m</td>
<td>0.900m</td>
</tr>
<tr>
<td>1 x 6 bedded Specialist Unit - Challenging Behaviour</td>
<td>0.300m</td>
<td>0.300m</td>
</tr>
<tr>
<td>30 residential beds in 5 unit complex (6 beds per unit)</td>
<td>1.800m</td>
<td>1.100m</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Years 2001 - 2008 Inclusive</th>
<th>Capital</th>
<th>Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 x 30 residential beds in 5 unit Complex (6 beds per unit)</td>
<td>14.40m</td>
<td>8.80m</td>
</tr>
</tbody>
</table>

The Working Group also makes the following recommendations in respect of persons with a Mental handicap:
- The development of appropriate residential facilities for older people.
- The development of specialist care units for the frail older people and the terminally ill.
- The provision of appropriate home support for older people living in the community as part of the general mental health support/ service.
- The education and training of medical and nursing staff within the mental handicap services to meet the specialist needs of its older population.
- The development of a recognised and accredited course in the care of older persons with a mental handicap.
- The development of age and disability-appropriate day services for older people as part of the development of the general mental handicap service.
- The development of an awareness programme for General Hospitals, Psychiatric Hospitals and Nursing Homes who are likely to deal with older persons with a mental handicap.

### TABLE 2

Intellectual Disability Database, EHB 1997,
Age, Gender and Degree of Intellectual Disability

<table>
<thead>
<tr>
<th>Age</th>
<th>Not Verified</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Profound</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>45-54</td>
<td>14</td>
<td>16</td>
<td>109</td>
<td>122</td>
<td>162</td>
<td>233</td>
</tr>
<tr>
<td>55-64</td>
<td>11</td>
<td>14</td>
<td>54</td>
<td>81</td>
<td>89</td>
<td>159</td>
</tr>
<tr>
<td>65+</td>
<td>4</td>
<td>7</td>
<td>25</td>
<td>42</td>
<td>14</td>
<td>79</td>
</tr>
<tr>
<td>66</td>
<td>66</td>
<td>453</td>
<td>756</td>
<td>287</td>
<td>75</td>
<td>1637</td>
</tr>
</tbody>
</table>
### TABLE 3

**List of Individuals in residential care with a future residential requirement within the next 5 years**

<table>
<thead>
<tr>
<th>Age</th>
<th>Number</th>
<th><strong>Current Service</strong></th>
<th><strong>Future Service Requirement</strong></th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>45-54</td>
<td>4</td>
<td>5 day community group home - goes home for hols</td>
<td>7 day x 52 week community group home</td>
<td>4</td>
</tr>
<tr>
<td>45-54</td>
<td>3</td>
<td>7 day village type/residential centre - goes home for hols</td>
<td>7 day x 52 week village type/res. centre</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>7 day x 52 week community group home</td>
<td>Other Intensive Placement with Special Requirements due to profound or multiple handicap</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>7 day x 52 week village type/res. centre - goes home for hols</td>
<td>7 day x 52 week village type/res. centre</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>5 day village type/res. centre - goes home for hols</td>
<td>7 day x 52 week village type/res. centre</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>34</td>
<td>7 day village/res. centre - goes home for hols</td>
<td>7 day x 52 week village type/res. centre</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>54</td>
<td>7 day x 52 week village type/res. centre</td>
<td>7 day comm. group home - home for hols</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>7 day x 52 week comm. group home</td>
<td>37</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>7 day village type/res. centre-home for hols</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nursing Home</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Intensive placement due to challenging behaviour</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Intensive placement due to profound or multiple handicap Crisis &amp; Relief Centre</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Nursing Home</td>
<td>Intensive Placement due to profound or multiple handicap</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>57</td>
<td>Psychiatric Hospital</td>
<td>7 day comm. group home-home for hols</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>7 day x 52 week comm. group home</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>7 day village type/res. centre-home for hols</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>7 day x 52 week village type res. centre</td>
<td>36</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Intensive placement due to challenging behaviour</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Intensive placement due to profound multiple h’cap</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>
### TABLE 3.1
List of Individuals in residential care with a future residential requirement within the next 5 years

<table>
<thead>
<tr>
<th>Age</th>
<th>Number</th>
<th>Current Service</th>
<th>Future Service Requirement</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>55-64</td>
<td>1</td>
<td>5 day community group home - goes home for hols</td>
<td>7 day community group home - home for hols</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>7 day x 52 week community group home</td>
<td>same</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>5 day village type/res. centre - home for hols</td>
<td>Intensive place due to profound/multiple disability</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>18</td>
<td>7 day village type/res. centre - home for hols</td>
<td>Intensive place due to profound/multiple disability</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>7 day x 52 week village type/res. centre</td>
<td>Intensive place due to challenging behaviour</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>50</td>
<td>Psychiatric Hospital</td>
<td>7 day x 52 week community group home</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Other</td>
<td>7 day x 52 week village type/res. centre</td>
<td>25</td>
</tr>
<tr>
<td>65-69</td>
<td>1</td>
<td>7 day x 52 week village type/res. centre</td>
<td>7 day x 52 week village type/res. centre</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>7 day x 52 week community group home</td>
<td>Intensive place due to profound/multiple disability</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>33</td>
<td>Psychiatric Hospital</td>
<td>7 day x 52 week village type/res. centre</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Intensive place due to challenging behaviour</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other</td>
<td>7 day x 2 week community group home</td>
<td>2</td>
</tr>
</tbody>
</table>

### TABLE 3.2
List of Individuals with a future residential requirement currently living at home

<table>
<thead>
<tr>
<th>Age</th>
<th>Number</th>
<th>Current Service</th>
<th>Future Service Requirement</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>70-74</td>
<td>1</td>
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<td>Intensive place due to profound/multiple disability</td>
<td>1</td>
</tr>
<tr>
<td></td>
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<tr>
<td></td>
<td>1</td>
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<td>Intensive place due to challenging behaviour</td>
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<td></td>
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<td></td>
<td></td>
<td>Intensive place due to profound/multiple handicap</td>
<td>1</td>
<td></td>
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<td>80-84</td>
<td>1</td>
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<td>Intensive place due to profound/multiple disabilities</td>
<td>1</td>
</tr>
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<td></td>
<td>1</td>
<td>7 day x 52 week village type/res. centre</td>
<td>Intensive place due to profound/multiple disabilities</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Psychiatric Hospital</td>
<td>Intensive place due to profound/multiple disabilities</td>
<td>1</td>
</tr>
<tr>
<td>85+</td>
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<td>Intensive place due to profound/multiple handicap</td>
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<tr>
<td>Age</td>
<td>Number</td>
<td>Current Service</td>
<td>Future Service Requirement</td>
<td>Number</td>
</tr>
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<tr>
<td>45-54</td>
<td>8</td>
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<td>7 day x 52 week village type/res centre</td>
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</tr>
<tr>
<td>5</td>
<td>5</td>
<td>At home with sibling</td>
<td>7 day x 52 week community group home</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>7 day village type/res. centre - home for hols</td>
<td>1</td>
</tr>
<tr>
<td>6</td>
<td>6</td>
<td>At home with relative</td>
<td>7 day community group home - home for hols</td>
<td>4</td>
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<td></td>
<td></td>
<td></td>
<td>7 day village type/res. centre - home for hols</td>
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<tr>
<td>1</td>
<td>1</td>
<td>Living Independently</td>
<td>7 day x 52 week community group home</td>
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</tr>
<tr>
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<td>1</td>
<td>Living semi-independently</td>
<td>7 day x 52 week community group home</td>
<td>1</td>
</tr>
<tr>
<td>55-64</td>
<td>4</td>
<td>At home with sibling</td>
<td>7 day x 52 week community group home</td>
<td>2</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>7 day x 52 week village type/res centre</td>
<td>2</td>
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<tr>
<td>2</td>
<td>2</td>
<td>At home with relative</td>
<td>7 day x 52 week community group home</td>
<td>1</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>7 day community group home - home for hols</td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>Living semi-independently</td>
<td>7 day x 52 week community group home</td>
<td>1</td>
</tr>
<tr>
<td>65-69</td>
<td>2</td>
<td>At home with sibling</td>
<td>7 day x 52 week community group home</td>
<td>2</td>
</tr>
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<td></td>
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<td></td>
<td>7 day x 52 week village type/res. centre</td>
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<td>7 day x 52 week community group home</td>
<td>1</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>7 day village type/res. centre - home for hols</td>
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</table>
Replacement of Old/Unsuitable Buildings

19.1 Our Board is conscious of the need to provide a range of quality services for older people as is evidenced by the proposal to provide a number of Community Units for Older People and also by the replacement of outdated and unsuitable accommodation which is proving increasingly difficult and expensive to maintain at a level that meets modern day quality standards.

19.2 This was reiterated in our Board’s response to the Programme for Government 1993 - 1997 in its comment “To commence the replacement of out-dated and unsuitable buildings currently being used for the provision of long stay care” and was reiterated in the report adopted by our Board “Review of Services for the Elderly and Four Year Action Plan 1995-1998”, which recommended the provision of a range of quality services both community and hospital/home based for older people who had been medically assessed as in need of appropriate levels of care.

It is now perhaps timely to revisit a proposal for the replacing of some of the old and unsuitable facilities in our Board’s area in the context of a phased medium to long term strategic action plan. Such a plan would have the direct effect of providing a vastly improved quality of service for elderly people in community units strategically located throughout our Board which is in line with the policy outlined in the Health Strategy “Shaping a Healthier Future”.

The Working Group are conscious that there is an excellent medical/nursing care regime in place in all our residential homes/hospitals for older people and would reiterate that this proposal is primarily made in the interest of providing quality facilities for older people.

19.3 Following careful consideration it would be proposed that a ten year timeframe for the replacement of outdated facilities be adopted as follows:

19.3.1 Bru Chaoimhin, Cork Street - built in 1807 as the “Recovery and Fever Hospital - 183 bed facility.
Proposal
The medium/long-term plan is to phase out Bru Chaoimhin and based on the available demographic information to develop four 50 bed Community Units in the following areas.
- Churchtown
- Rathfarnham
- Rathmines/Terenure
- South Inner City (Retained portion of Bru Chaoimhin site)

19.3.2 St. Brigid’s Home, Crooksling - built originally to treat tuberculosis is located on the Blessington Road in an isolated position, removed from the local community - 150 bed facility.
Proposal
The medium/long-term plan would involve the construction of three 50 bed community units for older people on a phased basis and the subsequent closure of St. Brigid’s Home.

Based on the demographic information available the proposed units might best be located at:
- Tallaght/ Walkinstown
- Drimmagh/Crumlin
- Templeogue

19.3.3 St. Mary’s Hospital, Phoenix Park - built in 1769 as the Royal Hibernian Military School and located in the Chapelizod end of the Phoenix Park.
Proposal
The medium/long-term plan is to phase out the use of St. Mary’s hospital and replace it with four community units. The demographic information available would suggest that the following sites would be suitable for this phased development.
- Phibsboro/East Cabra
- Finglas East/West
- Palmerstown
- Manor Street/Stoneybutter area

It is recommended that the Young Chronic Disabled Unit and the Day Hospital and Secondary Rehabilitation Service and a 50 bed long stay/respite rehabilitation unit be retained on the campus on a reduced site.

The Group was also conscious that any decision to replace St. Mary’s Hospital in the medium to long term with a number of small scale community units should not result in a reduction of the excellent medical/nursing service which is currently provided at St. Mary’s

19.3.4 The phasing out of old and outdated facilities such as Bru Chaoimhin, St. Mary’s and St. Brigid’s and the putting in place of 11 Community Units for older people strategically located in our Board’s area will require substantial capital funding of approximately £22m at current day prices. There may also be an element of revenue/equipment costs involved in the project at the appropriate time.

19.3.5 As previously stated it is proposed that modern day facilities be phased in over a 10 year period commencing at the earliest possible date (i.e. 1999) with careful consideration given to the managed parallel phasing out of the existing old facilities.

This would entail a commitment by our Board and from the Department of Health for capital funding in the order of £2.2m approximately for each year of the plan.

19.3.6 Summary of Chapter Recommendations
It is recommended that discussions be entered into with the Department of Health seeking approval to the phased implementation of the above plan which will allow our Board replace it’s unsuitable hospitals/homes for older people as follows:

19.3.1 Bru Chaoimhin, Cork Street
19.3.2 St Brigids Home, Crooksling.
The Development of 3 x 50 bed Community Units and the medium/long term phasing out of St. Brigid’s Home
Capital Costs £6.00m (once off)

19.3.3 St Mary’s Hospital, Phoenix Park
The Development of 4 x 50 bed Community Units and the medium/long term phasing out of approximately 200 long stay beds on the St. Mary’s campus
Capital Cost £8.00m (once off)
Total Capital Cost £22.0m

The Development of 4 x 50 bed Community Units and the medium/long term phasing out of Bru Chaoimh
Capital Costs £8.00m (once off)
**Private Care in Nursing Homes**

20.1 “The Years Ahead” clearly recognised the role which private nursing homes play in caring for older people and the right of older people to avail of a private nursing home care as a matter of choice.

21.2 The Health (Nursing Home) Act 1990 was implemented on 1st September 1993 and included:

- The registration of private nursing homes.
- The payment of subventions related to the patients dependency level, in respect of older persons in need of that level of care and in need of financial assistance towards the costs.

20.3 Registration

Under the new Act nursing homes with more than two dependant persons are required to register with the Health Board and such registrations are granted in accordance with the Nursing Homes (Care and Welfare) Regulations 1993.

20.4 Subvention

Any person can avail of the services of a private nursing home. However under the Health (Nursing Home) Act 1990, subvention can only be paid to those persons who have been medically assessed as in need of nursing home care and who are unable to pay any or part of the cost of such care. The amount of subvention paid is determined by reference to the dependency level of the patient and their individual financial means.

There are three dependency levels, each attracting a maximum weekly rate of subvention as follows:

<table>
<thead>
<tr>
<th>Level of Dependency</th>
<th>Maximum Subvention</th>
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</thead>
<tbody>
<tr>
<td>Medium</td>
<td>£70</td>
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<tr>
<td>High</td>
<td>£95</td>
</tr>
<tr>
<td>Maximum</td>
<td>£120</td>
</tr>
</tbody>
</table>

20.5 Review

In 1994 the Department of Health established a group to review the operation of the Health (Nursing Homes) Act 1990. The group comprised of members of the Department of Health and the Health Boards. The result of the review was the publication of the Nursing Homes (Subvention) (Amendment) Regulations 1996 which had two main provisions:

- That the Subvention Regulations be amended to increase the allowances listed in the Third Schedule to the Nursing Homes (Subvention) Regulations, 1993 and in particular, that personal allowances be increased, with the intention of easing the burden on adult children who have been assessed as being in a position to contribute towards a parent’s nursing home fees.

To allow Health Boards to pay more than the maximum rates of subvention in certain cases. This particular change also enables health boards to deal with those cases where the maximum amount of subvention assistance and the applicant’s means will still not sufficiently meet the nursing home fees.

20.6 The Working Group in examining the role of private nursing homes and voluntary nursing homes (the latter mainly run by religious orders) in the cycle of care for older people acknowledges that their contribution is a substantial one very much in partnership with the role of the statutory services provided by our Board and the voluntary hospitals/homes.

20.7 The Working Group considers that while it is our Board’s policy to continue to build quality public in-patient facilities for older people, private nursing homes have a partnership role to play in this care model which will undoubtedly expand as future market forces allow. This may be accelerated as a result of the tax incentives for the construction or adaptation of private nursing homes announced in the 1998 Finance Bill.

20.8 The Working Group acknowledges that there has been significant improvement in the level of care provided in private nursing homes since 1993. This has been achieved by the introduction of a uniform system of regulations which includes regular inspection of nursing homes by our Boards staff to ensure that the highest standards are maintained.

20.9 With the expanding role of the private sector in extended nursing care the Working Group are of the opinion that it is essential that the highest standards continue to be maintained for those frail and vulnerable people in this care setting.

In the ongoing inspection of private nursing homes – which is undertaken by officers of our Board - particular care should be taken to ensure that the medical input is adequate in order to avoid unnecessary readmission to the acute hospital setting and that the requisite paramedical services are made available as appropriate.

20.10 The Working Group also acknowledges that the monies to fund the subvention scheme has also increased significantly from £4.7m in 1993 to £12.752m at the present day. The increased finance has allowed the average subvention paid per person rise to £92 per week which in turn has allowed additional older people enter into and remain in private nursing home care.

20.11 The Working Group also met with representatives of Private Nursing Homes in our Boards area and while they agreed that considerable progress had been made they also said that they felt that there were still shortcomings in the system i.e.:

- There had been no increase in the core rates of subvention since 1993.
- Considerable cost increases had occurred since 1993 particularly in regard to staff.
- The base rates of subvention did not allow older people on the basic rate old age pension to access private nursing home care without significant financial help from family members.
- There still was not a real choice between public and private nursing home care.

20.12 While acknowledging the viewpoint as expressed above the Working Group are conscious that there are finite monies available to resource public and private care for
older people in our Boards area. In this regard close liaison is maintained with the Department of Health to ensure that adequate funding is made available were possible to fund the requirements of the Nursing Home Act.

20.13 It is also worth noting that the number of new subventions continue to rise to meet the increase in our Boards population.

<table>
<thead>
<tr>
<th></th>
<th>1995</th>
<th>1998</th>
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<tr>
<td>Number of registered nursing homes</td>
<td>117</td>
<td>124</td>
</tr>
<tr>
<td>Number of registered nursing home places</td>
<td>3987</td>
<td>4496</td>
</tr>
<tr>
<td>Number of persons in receipt of subvention</td>
<td>2307</td>
<td>2586</td>
</tr>
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</table>

The uptake of subventions will continue to be monitored to ensure that the maximum benefit is applied to the maximum number of people in our Boards area.

20.14 The Working Group in conclusion acknowledge the role of Private Nursing Homes and the fact that they will undoubtedly expand in partnership alongside the statutory services. However the Working Group are equally concerned that our Boards programme for the development of services as outlined in the report should continue to provide a range of services not usually associated with Private Nursing Home care, i.e. respite/intermittent care, convalescent/ rehabilitation care, day care, day hospital care etc. as well as longstay care, for the most heavily medically dependant of our Boards older population.
Appendix I – Workshop

1.0. SECTION ONE - BACKGROUND

In August 1997 the Eastern Health Board conscious of the need to further review the services for older people set up a multidisciplinary group to prepare a 10 Year Action Plan 1999-2008.

The Terms of Reference for the Group were:
- To carry out a detailed assessment of the requirements for services for older people over the next 10 years.
- To carry out a detailed needs assessment with regard to community services for older people e.g. community ward teams, public health nurse services, home help service, community and residential services for older mentally infirm and in particular the need for secondary rehabilitation services.
- To examine the care requirements for the increasing number of older people with mental handicap in our Board’s area.
- To prepare a 10 year plan based on the needs assessment for the development of services both community and residential based for older persons for the next 10 years 1999-2008.

In considering the future requirements of services for older people the group will work closely with the many voluntary organisations involved with care of older people and with the local authorities, having particular regard to a closer integration of the day services provided by our Board with the sheltered housing complexes provided by the local authorities.

1.1 Consultation Process

This advisory group has engaged in a range of consultation processes with local authorities and voluntary organisations involved in work with older people. These have included meetings, seminars and a questionnaire for voluntary organisations, the seminar on which this report is based was part of this process.

1.2 Consultation Seminar - December 1997

In addition to the questionnaire mentioned above it was decided that it was important to give voluntary organisations an opportunity to further input in to the 10 year plan in a more discursive and interactive way. A seminar was proposed for December 1997 and an independent facilitator was contracted to assist in planning this and facilitating the process on the day.

1.3 Purpose of the Seminar

- To facilitate the input of voluntary organisations into the proposed 10 year plan
- To identify the propriety needs of the different organisations and their clients constituents
- To engage voluntary organisations and Health Board representatives in a discussion of these needs
- To identify how further consultation processes might develop between voluntary organisations and the Board

1.4 Format of the Seminar

To ensure maximum participation a predominantly workshop approach was adopted, four theme groups were identified and each group was allocated a facilitator and note taker. Guidelines were developed by the overall facilitator for the workshops and these were provided to the workshop facilitators.

1.5 Outline of the Day

The seminar had five main sections:
- Short inputs by Mr. Eddie Matthews and Dr. Catherine Hayes
- Workshops
- Feedback from workshops
- Open forum discussion on needs/issues identified
- Buzz groups and brief discussion on future consultations, brief reflection on the day

1.6 Who Attended?

57 organisations were invited, 22 organisations were represented on the day with 28 people attending. The workshop facilitators and note takers were Eastern Health Board personnel. See list of organisations invited, list of participants and list of workshop personnel at the conclusion of the report

2.0 SECTION TWO - REPORT ON THE SEMINAR

2.1 Inputs

At the planning phase it was decided to keep inputs short to allow maximum time for workshops, therefore both Mr. Eddie Matthews and Dr. Catherine Hayes gave very brief inputs.

The following summarises this:

2.1.1 Input - Mr. Eddie Matthews

Mr. Matthews' input focused on outlining the background to the seminar and the proposed 10 year plan, the terms of reference of the working group, the list of areas which the group will address, the policy objectives which inform the current Four Year Action Plan 1995-1998.

These are:
- To maintain older people in dignity and independence at home in accordance with the wishes of older people as expressed in many research studies
- To restore to independence at home those older people who become ill or dependant
- To encourage and support the care of older people in their own community by family, neighbours and voluntary bodies in every way possible
- To provide high quality hospital or residential care for older people when they can no longer be maintained in dignity and independence at home
- To co-ordinate the existing services into a cohesive support unrestricted by programme or service agency boundaries with the sole objective of providing the best and most comprehensive range of care for older people

He also highlighted the current Board boundaries and its target population, staff and budget. This was followed by
an outline of the proposed changes in the structure of the Eastern Health Board, which will become the Eastern Regional Health Authority with three area councils namely, Northern Area Health Council, South Western Health Council and South Eastern Health Council.

Finally he outlined specific points of progress in relation to the Four Year Action Plan, in particular, the provision of Community Units for Older People and the development of Community Ward Teams. 25 of the latter have already been established and it is proposed to increase these to 30 in 1998. With regard to the Community Units, 3 are in place with a further 8 named locations indicated in the short-term. The total number is still under review.

This input was followed by a brief session allowing for clarifications. Two main points were raised;

- The kind of services provided in the Community Units: Mr. Matthews explained, giving the example of Cuan Ros on the Navan Road, that the services included long stay and day care, respite/intermittent care, convalescent/rehabilitation care. The Unit also caters for dementia/alzheimer patients.
- Recruitment of nursing staff to work with older people: Mr. Matthews pointed out that there is a small group working on these issues.

2.1.2 **Input - Dr. Catherine Hayes**

Dr. Hayes gave a brief summary of the responses contained in the postal questionnaires referred to earlier. The questionnaire contained three questions;

- **Q1** What are the needs of the clients served by the voluntary organisations?
- **Q2** What service needs are currently met by your organisation?
- **Q3** What needs are not currently being met by your organisation?

Please prioritise these.

55 organisations were surveyed, 23 responded.

**Current Needs**

In the analysis of the questionnaires, the following were the main areas of need identified, these combined responses to Q1 and Q2

- Information
- Lobbying
- Support
- Networking
- Policy influence
- Outreach
- Research

With regard to information the main areas identified were entitlements, FLAC, advocacy, education and training

Support referred to clients and carers

Within policy influence, aspects highlighted were policy development, policy in relation to specific services housing, counselling, social activities etc.

**Future Needs (Q3)**

**Influence Policy/Development**

Income equality, transport (access), services (access), security, support for isolated older people

**Home based services**

Out of hours, respite, home care/nursing assistants, specialist units (nursing/disease specific), financial (carers)

**Care workers**

Volunteers, formal liaison (voluntary–statutory) recognition/awareness, training, transport

**Community based services**

Paramedical, social work, psychologists, counselling, chiropodists

**Care Options**

Respite, rehabilitation, care-post hospital discharge, community units

**Other Needs**

Information on entitlements, awareness on drug costs, cardiac ambulance, case based needs assessment, house adaptations, security, expansion in personnel and facilities

**Questions and Responses Arising from Dr. Hayes Input**

**Means Testing**

This was not specifically mentioned in the responses but income equality was highlighted as an issue

**Forms**

Difficulties regarding non standardisation of forms from one health board to another was raised.

2.2 **Workshops**

Four theme groups had been identified from the list of participating organisations.

These were:

- Carers
- Positive Ageing
- Housing
- Specific Illness

Representative were allocated to the groups based on their interests/area of involvement, in some cases categorisation was not straightforward as some organisations did not fit neatly in into any group. Therefore on the day, participants were given the opportunity to pick a different group if they wished.

**The objectives of the workshops were:**

- To facilitate focused discussion regarding priority needs
- To ensure maximum participation by those attending the seminar
- To identify and agree as a group; 2 short term priorities, 2 medium term priorities and 2 long term priorities.
- To articulate why these priorities
- To write these on flipchart paper and a group member to feed this back to large group.

**Main Points Raised in Workshops**

These are based on the notes recorded by the notetakers and have subsequently been organised under headings where possible. Whilst the following issues were raised their inclusion does not necessarily indicate consensus.

2.2.1 **Carers Group**

(a) Carers

- Need for tax concessions
- Funding issues
- Disbarred from part-time work, can lose allowance
- Health needs for carers e.g. stress, free medical check-ups
- Can be disbarred from homehelp scheme if carer available
- Support needs of carers
(b) Homehelp
- Difficulties in getting homehelp
- Need to advertise as an attractive job with adequate levels of pay
- Training required e.g. lifting patients, first aid
- Need to be paid, drop off in volunteer
- Job description should be provided

(c) Accident and Emergency Departments in Hospitals
- Reduce the amount of time older people have to wait through prioritising, fast tracking
- Make more comfortable while waiting
- Volunteers to visit older people whilst waiting
- Provision of specific A&E Departments for older people
- Improved quality standards/customer services in A&E Departments

(d) Other Issues
- Improve communications between hospitals and community following discharge of older people
- More access and flexibility re respite care
- More physiotherapists in the community
- Use 10 Year Plan to lobby for extra money and resources
- Provision of alarm systems
- Provision of incontinence wear to medical card holders in private nursing homes.

2.2.2 Positive Ageing Group

(a) Active Retirement
- Preparation and planning for retirement
- Health and social involvement promotion
- Recognise difference needs of women and men e.g. women’s economic dependency
- Recognition of older people’s contribution of Irish society
- Acknowledge wide age range within older people i.e. 65 to 90+
- Avoid treating older people as dependants/helpless

(b) Financial Issues
- Medical cards for all over 65
- Review adequacy of state pensions/social welfare payments
- Review nursing home subventions, remove maximum of £120pw
- Remove assessment of family income for purpose of nursing home subvention

(c) Services
- Health; free medical check-up once a year, promotion of preventative medicine
- Public transport; in rural areas, and in general, needs to be available, accessible and affordable
- Paramedical services, i.e. physiotherapists, chiropodists, more needed in the community

(d) Lobbying
- All older people should organise under one “banner”
- Advocacy a priority

(e) Voluntary /Statutory Relations
- Need to formalise relations between voluntary service providers and health board service providers
- Health Boards should adequately support voluntary organisations

(f) Other Issues
- General needs assessment for all other people and their carers
- Need for recognition of the contribution of carers
- Concern at the number of Community Units, displacing private section provision

2.2.3 Housing Groups

(a) Housing
- Adapt homes to suit individual needs
- Involved local groups in schemes concerning home improvements
- Sheltered housing must be secure
- Community Units are the preferred option as follow on to sheltered housing if necessary
- Retain people in their local area is preferred, private sector need to be aware of this
- Nursing care in the home should be more widely available in all areas
- Ideal scenario purpose built units in a village environment with support facilities where older people can avail of medical services, on a short term or long term basis

(b) Mental Handicap and Older People
- Information and support needed for older parents caring for persons with mental handicap
- Need to be aware of the complexity of the relationship between parents and child with mental handicap as they both grow older e.g. become dependent on each other, need for adaptations to home

(c) Other Issues
- Provide more one stop shops for information on entitlements
- Proactive approach to make people aware of their entitlements
- Compile a data base indicating the level of care by each individual

2.2.4 Specific Illnesses Group

(a) Strokes
- Need for special units on the lines of Baggot Street
- Need for training for those caring for stroke victims

(b) Alzheimer’s
- More information to sufferers and families on the disease
- Further development of a day care centres - cost effective way of alleviating the situation
- Increased use of FAS schemes to provide personnel for home support

(c) Parkinson’s
- Lack of facilities for sufferers
2.3 Priorities as Indicated by Workshop Groups

Each group were asked to identify 2 short term, 2 medium term and 2 long term priorities, the following outlines these priorities.

2.3.1 Carers Group

Short Term
(a) Carers allowance - level of payment and eligibility
(b) Home Help - recruitment, level of payment (lack of uniformity here), training, job description
(c) Respite care

Medium Term
(a) Improved communication between hospitals and community
(b) Information/awareness strategy - for older people re their entitlements, for service providers re older people and their carers and counselling for older people and carers

Long Term
(a) General awareness regarding older people - anti-ageist education e.g. intergenerational initiative with schools

2.3.2 Positive Ageing Group

This group did not designate objective as short, medium or long term. This group expressed some concern about the consultation process on the grounds of adequacy of time. They also felt that it could have been helpful to allow for comments on the Board’s thinking to date.

(a) Need to clarify and debate what is meant by domiciliary/community care, look at the reality versus the theory
(b) Review need for means test for medical card
(c) Review adequacy of income issues i.e. levels of state pensions etc.
(d) Provision of affordable, accessible public transport
(e) Provision of quality of life services e.g. physiotherapists, chiropodists etc.
(f) Creative use of new technologies e.g. for monitoring, security

2.3.3 Housing Group

Short Term
(a) Provision of physical supports in the home e.g. hoists, grab rails etc.
(b) Survey of needs of older people at local level

Medium Term
(a) Develop greater links between statutory and local authorities in relation to housing
(b) Sheltered Housing in local areas
(c) More economic use of assets and income of older people in the provision of housing

Long Term
(a) Develop a continuum of services i.e. locally based housing with support and ancillary services i.e. nursing, paramedical
(b) Consultation regarding design of homes
(c) Provision of services to address the needs of older people in their own home reducing the need for access to long term care for as long as feasible

2.3.4 Specific Illness Group

Short Term
(a) Review of financial support for older people in private nursing homes
(b) Development of day care provision

Medium Term
(a) Designated beds in community units for people with specific illnesses e.g. stroke
(b) Development of transport services
(c) Development of social work service for those living in isolation
(d) Support and information of people with specific illnesses, development and support for support groups

Long Term
(a) Training for nurses and other care workers
(b) Development of Health Promotion and preventative medicine/approaches

2.4 Open Forum

The feedback from the workshops was followed by an open forum discussion, the following highlights the main points realised by participants and responses from Eastern Health Board Personnel.

2.4.1 Medical Cards
- The need for means testing was questioned and the cost effectiveness of this procedure
- If means testing is required for different services, individual older people should only have to go through the process once
- The difficulty of application forms needs to be addressed
2.5.2 How

2.5.3 What Format?

2.5.4 Brief Reflection on the Seminar by Participants

Some Comments

Other Suggestions

2.6 Conclusion

Overall the seminar was a useful exercise, participants were fully engaged and responded positively to the opportunity offered. Based on their feedback the initiative was appreciated and valuable input was received both from participants and Eastern Health Board personnel. Many felt that this was the start of a process and hoped that it would be further developed. It is important that a relationship based on trust continues to be developed between the Board and the voluntary organisations. It would be useful to consider developing a consultation strategy. This could be done by a working group which would include representatives from voluntary sector.

It would be also useful to circulate this report to the relevant voluntary organisations, as suggested by seminar participants. Also, if the time still allowed, to contact those organisations who did not respond to the questionnaires and encourage them to do so.

Maureen Bassett, Facilitator
<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
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<tbody>
<tr>
<td>Mr. Eddie Matthews</td>
<td>Co-ordinator of Services for the Elderly</td>
</tr>
<tr>
<td>Dr. Catherine Hayes</td>
<td>Specialist in Public Health Medicine</td>
</tr>
<tr>
<td>Mr. Adrian Charles</td>
<td>Senior Administrative Officer</td>
</tr>
<tr>
<td>Mr. David Dunne</td>
<td>Director of Mental Handicap Services</td>
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<tr>
<td>Ms. Deirdre Earle</td>
<td>Senior Community Physiotherapist</td>
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<tr>
<td>Ms. Lorraine Ashe</td>
<td>Clerical Officer</td>
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<tr>
<td>Ms. Valerie Kavanagh</td>
<td>Clerical Officer</td>
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<tr>
<td>Ms. Anita Behan</td>
<td>Clerical Officer</td>
</tr>
<tr>
<td>Ms. Patrice Purcell</td>
<td>Clerical Officer</td>
</tr>
<tr>
<td>Ms. Louise D'arcy</td>
<td>Clerical Officer</td>
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</table>
Voluntary Organisations Invited

Action for Mobility
Age & Opportunity*
Alzheimer Society of Ireland*
Arthritis Foundation of Ireland
Barbara Bailey, Sheltered Housing*
Care for Dublin’s Old Folks Living Alone
Combat Poverty Agency
Down’s Syndrome Association
Dublin Health Cities Project
Federation of Active Retirement Assoc.*
Friends of the Elderly*
Home Help Council*
Huntington’s Disease Association
Irish Cancer Society
Irish Deaf Society
Irish Heart Foundation*
Irish Registered Nursing Homes Assoc.*
Irish Senior Citizens National Assoc.*
Little Sisters of the Assumption*
M.S. Ireland
National Association for the Mentally of Ireland
National Council on Ageing and Older People*
Parkinson’s Association of Ireland*
Retirement Planning Council
Simon Community
South Inner City Community*
The Irish Hospice Foundation
Volunteer Stroke Scheme
St. Michael’s House

* Attendees

Age Action Ireland Ltd.*
ALONE
AOSTA
AWARE
Brabazon Trust
Carers Association
Crosscare*
Dublin Council for the Aged
Energy Action Ireland
Focus Ireland
Helpful Hands
Health & Safety Authority
Irish Association of Older People*
Irish Council for Social Housing
Irish Diabetic Association
Irish Motor Neuron Disease Association
Irish Traveller Movement
Killbarrack Home Carer’s Association*
Mental Health Association of Ireland
National Association for the Deaf
National Association of Home Care Organisers*
National Federation of Pensioners’ Association
Polio Fellowship of Ireland*
Retired Workers Committee
Soroptimist International*
Sue Ryder Foundation
Victim Support*
Daughters of Charity*
## Appendix II

### Overall Summary of Existing Services in the Board’s Area

#### EASTERN HEALTH BOARD

1. **Population (1996 Census)**
   - Total Population: 1,295,939
   - Over 85 years: 10,558
   - 75 - 84 years: 39,805
   - 65 - 74 years: 74,908
   - Total Population over 65 years: 125,271
   - % of Total EHB Population over 65 years: 9.66%

2. **Day Centres/Clubs and Other Services Grant Aided by Board**
   - Day Centres: 65
   - Clubs and Other Services: 101

3. **Home Help Services**
   - No. of Organisations: 37
   - Older people in Receipt of Services: 4,446

4. **Meals Services**
   - No. of Organisations Providing Meals: 138
   - No. of Meals Provided Per Annum: 934,239

---

#### EASTERN HEALTH BOARD

**BED/PLACES COMPLEMENT BY COMMUNITY CARE AREA**

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<th>Welfare Beds</th>
<th>Convales.</th>
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COMMUNITY CARE AREAS

1 - Dun Laoghaire
2 - Dublin South East
3 - Dublin South Central
4 - Dublin South West
5 - Dublin West
6 - Dublin North West
7 - Dublin North Central
8 - Dublin North
9 - Co. Kildare
10 - Co. Wicklow
## Appendix III
Details of Services by Community Care Area

### DUN LAOGHAIRE & PARTS OF SOUTH COUNTY DUBLIN - Community Care Area 1

![Map of Dun Laoghaire and parts of South County Dublin]

### EASTERN HEALTH BOARD COMMUNITY CARE AREA 1

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<td>% of Total EHB Population over 65 years</td>
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#### 2. Day Centres/Clubs and Other Services Grant Aided by Board

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#### 3. Home Help Services

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#### 4. Meals Services

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### COMMUNITY CARE AREA 1

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* Psychiatry of Old Age/Includes Respite Care Facility
**COMMUNITY CARE AREA 2**

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* Psychiatry of Old Age/Includes Respite Care Facility
**DUBLIN SOUTH CENTRAL - Community Care Area 3**

**EASTERN HEALTH BOARD COMMUNITY CARE AREA 3**

1. Population (1996 Census)
   - Total Population: 92,900
   - Over 85 years: 8,541
   - 75 - 84 years: 3,547
   - 65 - 74 years: 6,188
   - Total Population over 65 years: 10,589
   - % of Area Population over 65 years: 11.40%
   - Area % of Total EHB Elderly Population: 8.45%

2. Day Centres/Clubs and Other Services Grant Aided by Board
   - Day Centres: 7
   - Clubs and Other Services: 4

3. Home Help Services
   - No. of Organisations: 2
   - Older people in Receipt of Services: 366

4. Meals Services
   - No. of Organisations Providing Meals: 10
   - No. of Meals Provided Per Annum: 103,454

### COMMUNITY CARE AREA 3

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* Psychiatry of Old Age/Includes Respite Care Facility
1. Population (1996 Census)

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<th>75 - 84 years</th>
<th>65 - 74 years</th>
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<td>% of Area Population over 65 years</td>
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2. Day Centres/Club and Other Services Grant Aided by Board

<table>
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<tr>
<th>Services Type</th>
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<td>Day Centres</td>
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<tr>
<td>Clubs and Other Services</td>
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</tbody>
</table>

3. Home Help Services

- No. of Organisations: 2
- Older people in Receipt of Services: 327

4. Meals Services

- No. of Organisations Providing Meals: 7
- No. of Meals Provided Per Annum: 74,621

---

**COMMUNITY CARE AREA 4**

<table>
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<th>Assess/ Rehab</th>
<th>Respite/ Intermittent</th>
<th>Welfare</th>
<th>Convales.</th>
<th>Extended Care Beds</th>
<th>Day Hosp.</th>
<th>Day Care</th>
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**EHB hospital/homes outside Community Care Area 4 but also serve this Area 4:**

- St. Brigid's Home, Crooksling - Refer to Community Care Area 5 for beds/places
- Bru Chaoimhín - Refer to Community Care Area 3 for beds/places
- Cherry Orchard
- Beechhaven
- St. Joseph's

**Non EHB hospitals/homes outside Community Care Area 4 but also serve this Area 4:**

- St. James' Hospital - Refer to Community Care Area 3 for beds/places
1. Population (1996 Census)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Total Population</th>
<th>Over 65 years</th>
<th>% of Area Population over 65 years</th>
<th>Area % of Total EHB Elderly Population</th>
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</thead>
<tbody>
<tr>
<td>0-85 years</td>
<td>715</td>
<td>8.815</td>
<td>7.82%</td>
<td>7.04%</td>
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<tr>
<td>75-84 years</td>
<td>2,682</td>
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<td>65-74 years</td>
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<td>7.82%</td>
<td>7.04%</td>
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</table>

2. Day Centres/Club and Other Services Grant Aided by Board

- Day Centres: 6
- Clubs and Other Services: 3

3. Home Help Services

- No. of Organisations: 3
- Older people in Receipt of Services: 373

4. Meals Services

- No. of Organisations Providing Meals: 14
- No. of Meals Provided Per Annum: 50,628

### COMMUNITY CARE AREA 5

<table>
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<th>Assess/Rehab</th>
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<th>Welfare</th>
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<th>Extended Care Beds</th>
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Voluntary/Charitable & Religious Homes:

|                  | -            | -                    | -       | -         | 51                | -         | -       |

Private Nursing Homes:

|                  | -            | -                    | -       | -         | 308               | -         | -       |

* Psychiatry of Old Age/Includes Respite Care Facility
## Commnunity Care Area 6

### 1. Population (1996 Census)

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<td>Over 85 years</td>
<td>1,003</td>
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<tr>
<td>75 - 84 years</td>
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<td>65 - 74 years</td>
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<td>Total Population over 65 years</td>
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<td>% of Area Population over 65 years</td>
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<td>Area % of Total EHB Elderly Population</td>
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### 2. Day Centres/Club and Other Services

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<th>Services</th>
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<td>Clubs and Other Services</td>
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### 3. Home Help Services

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<th>No. of Organisations</th>
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### 4. Meals Services

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<th>No. of Meals Provided Per Annum</th>
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<tr>
<td>No. of Organisations</td>
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### COMMUNITY CARE AREA 6

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<th>Extended Care Beds</th>
<th>Day Hosp.</th>
<th>Day Care</th>
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<td>96</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

* Psychiatry of Old Age/Includes Respite Care Facility
1. Population (1996 Census)
   - Total Population: 118,550
   - Over 85 years: 1,298
   - 75 - 84 years: 5,208
   - 65 - 74 years: 9,171
   - Total Population over 65 years: 15,677
   - % of Area EHB Population over 65 years: 13.22%
   - Area % of Total EHB Elderly Population: 12.51%

2. Day Centres/Club and Other Services Grant Aided by Board
   - Day Centres: 4
   - Clubs and Other Services: 9

3. Home Help Services
   - No. of Organisations: 8
   - Older people in Receipt of Services: 821

4. Meals Services
   - No. of Organisations Providing Meals: 22
   - No. of Meals Provided Per Annum: 211,107

---

**COMMUNITY CARE AREA 7**

<table>
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<th>Assess/ Rehab</th>
<th>Respite/ Intermittent</th>
<th>Welfare</th>
<th>Convales.</th>
<th>Extended Care Beds</th>
<th>Day Hosp.</th>
<th>Day Care</th>
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</table>

* Psychiatry of Old Age/Includes Respite Care Facility
**EASTERN HEALTH BOARD**  
**COMMUNITY CARE AREA 8**

1. **Population (1996 Census)**
   - Total Population: 193,476
   - Over 85 years: 971
   - 75 - 84 years: 3,995
   - 65 - 74 years: 9,139
   - Total Population over 65 years: 14,105
   - % of Area Population over 65 years: 7.30%
   - Area % of Total EHB Elderly Population: 11.26

2. **Day Centres/Club and Other Services**
   - **Grant Aided by Board**
     - Day Centres: 13
     - Clubs and Other Services: 5

3. **Home Help Services**
   - No. of Organisations: 8
   - Older people in Receipt of Services: 531

4. **Meals Services**
   - No. of Organisations Providing Meals: 19
   - No. of Meals Provided Per Annum: 99,386

---

### COMMUNITY CARE AREA 8

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<th>Extended Care Beds</th>
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<td>81</td>
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</table>

Voluntary/Charitable & Religious Homes

Private Nursing Homes

* Psychiatry of Old Age/Includes Respite Care Facility
EASTERN HEALTH BOARD
COMMUNITY CARE AREA 9

1. Population (1996 Census)
   Total Population 134,992
   Over 85 years 763
   75 - 84 years 3,125
   65 - 74 years 5,725
   Total Population over 65 years 9,663
   % of Area Population over 65 years 7.16%
   Area % of Total EHB Elderly Population 7.72%

2. Day Centres/Club and Other Services Grant Aided by Board
   Day Centres 5
   Clubs and Other Services 22

3. Home Help Services
   No. of Organisations 0
   Older people in Receipt of Services 450

4. Meals Services
   No. of Organisations Providing Meals 9
   No. of Meals Provided Per Annum 40,165

COMMUNITY CARE AREA 9

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* Psychiatry of Old Age/Includes Respite Care Facility
# Eastern Health Board Community Care Area 10

## 1. Population (1996 Census)

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<thead>
<tr>
<th>Category</th>
<th>Count</th>
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<td>962</td>
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<tr>
<td>75 - 84 years</td>
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<td>65 - 74 years</td>
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<tr>
<td>Total Population over 65 years</td>
<td>10,420</td>
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<tr>
<td>% of Area Population over 65</td>
<td>10.15%</td>
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<tr>
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<td>8.32%</td>
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## 2. Day Centres/Club and Other Services

Grants Aided by Board:
- Day Centres: 2
- Clubs and Other Services: 19

## 3. Home Help Services

- No. of Organisations: 4
- Older people in receipt of Services: 427

## 4. Meals Services

- No. of Organisations Providing Meals: 8
- No. of Meals Provided Per Annum: 13,759

## Community Care Area 10

<table>
<thead>
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<th>Service Type</th>
<th>Assess/ Rehab</th>
<th>Respite/ Intermittent</th>
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</tr>
<tr>
<td><strong>Non E.H.B. Hospitals/Homes:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>34</td>
<td>14</td>
<td>109</td>
<td></td>
<td>174</td>
<td></td>
<td>90</td>
</tr>
<tr>
<td><strong>Voluntary/Charitable &amp; Religious Homes</strong></td>
<td></td>
<td></td>
<td></td>
<td>21</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Private Nursing Homes</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>655</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Psychiatry of Old Age/Includes Respite Care Facility
Appendix IV
Demographic Information:
Number of Persons Aged 65 and Over per Community Care Area and Five Year Age Group

EASTERN HEALTH BOARD
ANALYSIS OF 1996 SMALL AREA POPULATION STATISTICS
NUMBER OF PERSONS AGED 65 AND OVER PER COMMUNITY CARE AREA,
BY 5 YEAR AGE GROUPS

<table>
<thead>
<tr>
<th>Community Care Area</th>
<th>65 - 69</th>
<th>70 - 74</th>
<th>75 - 79</th>
<th>80 - 84</th>
<th>85 +</th>
<th>All 65 +</th>
</tr>
</thead>
<tbody>
<tr>
<td>Area 1</td>
<td>4,991</td>
<td>4,016</td>
<td>2,982</td>
<td>2,021</td>
<td>1,536</td>
<td>15,546</td>
</tr>
<tr>
<td>Area 2</td>
<td>4,227</td>
<td>3,813</td>
<td>2,909</td>
<td>2,177</td>
<td>1,629</td>
<td>14,755</td>
</tr>
<tr>
<td>Area 3</td>
<td>3,344</td>
<td>2,844</td>
<td>2,117</td>
<td>1,430</td>
<td>8,541</td>
<td>10,589</td>
</tr>
<tr>
<td>Area 4</td>
<td>4,336</td>
<td>3,311</td>
<td>2,112</td>
<td>1,387</td>
<td>8,271</td>
<td>11,973</td>
</tr>
<tr>
<td>Area 5</td>
<td>2,895</td>
<td>2,523</td>
<td>1,641</td>
<td>1,041</td>
<td>715</td>
<td>8,815</td>
</tr>
<tr>
<td>Area 6</td>
<td>4,709</td>
<td>3,832</td>
<td>2,591</td>
<td>1,593</td>
<td>1,003</td>
<td>13,728</td>
</tr>
<tr>
<td>Area 7</td>
<td>4,961</td>
<td>4,210</td>
<td>3,178</td>
<td>2,030</td>
<td>1,298</td>
<td>15,677</td>
</tr>
<tr>
<td>Area 8</td>
<td>5,228</td>
<td>3,911</td>
<td>2,486</td>
<td>1,509</td>
<td>971</td>
<td>14,105</td>
</tr>
<tr>
<td>Area 9</td>
<td>2,995</td>
<td>2,730</td>
<td>2,009</td>
<td>1,116</td>
<td>763</td>
<td>9,663</td>
</tr>
<tr>
<td>Area 10</td>
<td>3,199</td>
<td>2,833</td>
<td>2,111</td>
<td>1,315</td>
<td>962</td>
<td>10,420</td>
</tr>
<tr>
<td>TOTAL</td>
<td>40,885</td>
<td>34,023</td>
<td>24,136</td>
<td>15,669</td>
<td>10,558</td>
<td>125,271</td>
</tr>
</tbody>
</table>
Appendix V – Demographic Information: Number of Persons Aged 65 and Over per Eastern Regional Health Authority and Council Area

DISTRICTS
- SOUTH CITY
- SOUTH DUBLIN COUNTY
- KILDARE WEST WICKLOW
- D/L RATHDOWN PEMBROKE
- EAST WICKLOW
- NORTH EAST CITY
- NORTH CITY
- FINGAL

Proposed District Boundaries

Scale 1:267480
EASTERN REGIONAL HEALTH AUTHORITY

Proposed District Boundaries

AREAS
SOUTH EASTERN
SOUTH WESTERN
NORTHERN

Scale 1:550570

0 10 20 30 km
**ANALYSIS OF 1996 SMALL AREA POPULATION STATISTICS**

**NUMBER OF PERSONS AGED 65 AND OVER PER EASTERN REGIONAL HEALTH AUTHORITY AND AREA COUNCILS BY 5 YEAR AGE GROUPINGS**

<table>
<thead>
<tr>
<th></th>
<th>65 - 69</th>
<th>70 - 74</th>
<th>75 - 79</th>
<th>80 - 84</th>
<th>85+</th>
<th>All 65+</th>
<th>% Total Area Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern Council Area</td>
<td>14,942</td>
<td>12,014</td>
<td>8,329</td>
<td>5,247</td>
<td>3,400</td>
<td>43,932</td>
<td>9.66</td>
</tr>
<tr>
<td>Fingal</td>
<td>3,141</td>
<td>2,443</td>
<td>1,822</td>
<td>1,188</td>
<td>745</td>
<td>9,339</td>
<td>21.26*</td>
</tr>
<tr>
<td>North City</td>
<td>7,075</td>
<td>6,005</td>
<td>4,110</td>
<td>2,633</td>
<td>1,617</td>
<td>21,440</td>
<td>48.80*</td>
</tr>
<tr>
<td>North East City</td>
<td>4,726</td>
<td>3,556</td>
<td>2,397</td>
<td>1,436</td>
<td>1,038</td>
<td>13,153</td>
<td>29.94*</td>
</tr>
<tr>
<td>South Western Council Area</td>
<td>14,459</td>
<td>12,233</td>
<td>8,543</td>
<td>5,396</td>
<td>3,413</td>
<td>44,044</td>
<td>8.53</td>
</tr>
<tr>
<td>Kildare/West Wicklow</td>
<td>3,409</td>
<td>3,103</td>
<td>2,310</td>
<td>1,326</td>
<td>864</td>
<td>11,012</td>
<td>25.00*</td>
</tr>
<tr>
<td>South Dublin County</td>
<td>4,424</td>
<td>3,067</td>
<td>1,989</td>
<td>1,190</td>
<td>759</td>
<td>11,429</td>
<td>26.00*</td>
</tr>
<tr>
<td>South City</td>
<td>6,626</td>
<td>6,063</td>
<td>4,244</td>
<td>2,880</td>
<td>1,790</td>
<td>21,603</td>
<td>49.00*</td>
</tr>
<tr>
<td>South Eastern Council Area</td>
<td>11,484</td>
<td>9,776</td>
<td>7,264</td>
<td>5,026</td>
<td>3,745</td>
<td>37,295</td>
<td>11.49</td>
</tr>
<tr>
<td>East Wicklow</td>
<td>2,785</td>
<td>2,460</td>
<td>1,810</td>
<td>1,155</td>
<td>861</td>
<td>9,071</td>
<td>24.30*</td>
</tr>
<tr>
<td>Pembroke</td>
<td>8,699</td>
<td>7,316</td>
<td>5,454</td>
<td>3,871</td>
<td>2,884</td>
<td>28,224</td>
<td>75.70</td>
</tr>
<tr>
<td><strong>Total Eastern Regional Health Authority</strong></td>
<td><strong>40,885</strong></td>
<td><strong>34,023</strong></td>
<td><strong>24,136</strong></td>
<td><strong>15,669</strong></td>
<td><strong>10,558</strong></td>
<td><strong>125,271</strong></td>
<td></td>
</tr>
</tbody>
</table>

* % of Respective Area Council Population aged over 65
# References


3. Care of Elderly People with Mental Illness - Specialist Services in Medical Training. A joint report by the Royal College of Physicians and the Royal College of Psychiatry - 9th February 1989.


10. Accidental Injury in Ireland - Priorities for Prevention - Drs Laffoy M, Igoe D & O’Herlihy B.


