Report No 17/2003

northern area health board
bord sláinte an limistéir thuaidh

REVIEW OF SERVICES FOR OLDER PERSONS

June 2003

1. INTRODUCTION

1.1 BACKGROUND

The demographic profile of the population in our Board's area is changing with increasing numbers of people living into old age. Whilst most people will have an active and healthy old age, there are a sizeable minority of old persons who are likely to require support and care, as they grow older. Research indicates that many older persons are in need of some care and some in need of significant levels of care up to and including residential care.
It is important that ageing is not perceived as an illness and that the vast majority of older persons live healthy and fulfilled lives independent of the health services, with assistance from Family, friends and neighbours. Their experiences, values and knowledge should be recognised and incorporated into all services planned for and with older persons in mind.

Current service provision is underpinned by the findings, recommendations and policies established by the reports: -

- *The Years Ahead* - 1988
- *Shaping a Healthier Future* – Department of Health (1994)
- *10 Year Action Plan For Services For Older Persons* – Eastern Health Board (1989)
- *Quality and Fairness; health system for you – Health Strategy* - Department of Health (2001)
- Report of the Working Group on the Short and Medium Term Service Needs of Older Persons and Young Chronic Disabled (Collaborative Working Group Report) - NAHB 2001
- *The Psychiatric Services – Planning For the Future* (1984)
- *Acute Hospital Bed Capacity - A National Review (2002)*

From the late sixties there has been a marked increase in the level of affluence in the country as a whole. This however, has been accompanied by significant social change such as the decline in the pattern of extended families and the decrease in the incidence of volunteerism and relative carers. The increasing general demand for services associated with demographic and societal changes reflected in the aging population and increased demand and expectations for long stay care and other residential, day and community supports has led to a move away from volunteer/relative carer provision of service to health service provision.

In the years following the publication of *Planning for the Future* the inappropriate placement of geriatric patients and patients with dementia, in psychiatric hospitals in our Board's area has

discontinued. One of the recommendations of that report was *that a comprehensive integrated geriatric service was required to cater forthe needs of the elderly, including older people who have developed psychiatric disorders or dementia with behavioural or psychological problems for the first time over the age of 65 years.*

1.2 DEMOGRAPHICS

The demographic profile of the population of he Northern Area Health Board indicates an ageing population which, when matched with significant areas of social deprivation, demonstrates the need for increased and enhanced services across the continuum of care.

The 1996 census of population indicatedthat there were 43,616 people aged 65 and over in the Northern Area Health Board area - 9.58% of the population. - of these 16,700 were aged 75. (2002 census figures will not be available until end of July 2003)

- Estimated increase in over 65years population by 2011 is 40%.
- Estimated increase in over 75years population by 2011 is 8%.

These projected increases in the number of elderly population, in the main is due to the number of people living longer and the predicted increase in the general populatin for 2002. It is significant that of the twenty-five RAPID Areas nationally, six are located in our Board's region. The North Inner city (east), North Inner city (west), Darndale/Belcamp, Ballymun, Blanchardstown and Finglas.

1.3 COMMUNITY SERVICES INFRASTRUCTURE

The *10 year Action Plan* and the *Collaborative Working Group Report* identified that older persons wished to continue living and/or be cared for at home and current information indicates that the majority of older persons continue to reside at home with the support of friends, family, neighbours, the voluntary sector and community service, where required.

These reports also indicated that there were significant service gaps across the continuum of care and that there was a particular need to increase services in areas such as public health nursing, professionals allied to medicine, low support day care and other community supports.

There was also a clear indication that our Board needed to develop services seven days a week and to explore high support services, as epitomised by the Home First Project, and the supply of client centred care packages. Other areas highlighted for development included the supply of respite services in the home setting.

The information with regard to the demographic profile of the numbers of elderly persons living in our Board's area is currently the 1996 census figures. This information is contained in appendix 1. We await the 2002 census figures, which are reported to be available later in 2003.

2. STRATEGIC DIRECTION

As with all other care groups the launch of the new Health Strategy- *Quality and Fairness - A Health System for you* -in November 2001, was of major significance to the development of services for older persons. It is our Board's policy to continue to develop our services to reflect the ethos and principals underpinning the Strategy in 2003 and the years ahead

The widening of Medical Card eligibility in July 2001, further improved by the Strategy, will make a profound positive contribution to the health issues affecting older persons, as will the planned changes in Primary Care, which will bring care closer to home and streamline the multiplicity of supports older persons can require. The Strategy plans the recruitment of a multi disciplinary range of staff to support the development of primary care services of particular relevance to older persons, including domiciliary care, day and respite services.

The new Health Strategy set out the following actions for older persons.

- A co-ordinated action plan to meet the needs of aging and older people will be developed by the Department of Health and Children in conjunction with the Department of the Environment and Local Government; Social, Community and Family Affairs; and Public Enterprise. (Action point 26)
- Availability of information on entitlements including use of information technology will be improved. (Action point 44)
- Appropriate care in the most appropriate setting. (Action Point 53)
- Community groups will be funded to facilitate volunteers in providing support services such as shopping, visiting and transport for older persons.(Action point 54)
- The organisation and management of services will be enhanced to the greatest benefit of the patients. (Action point 84)
- Health boards will continue to take the lead role in implementing the Health Promotion Strategy for Older People, Adding years to life and life to years(1998).
- An action plan for dementia, based on the recommendations of the National Council for Ageing and Older People, will be implemented.

In addition, the following specifics are planned within the Strategy on a national basis and are applicable to the Northern Area Health Board on the basis of the percentage of the population aged 65 years and over in the area.

- Putting in place programmes to support informal caregivers through the development of networks, provision of basic training and greater availability of shorterm respite care.
- Putting in place programmes to foster voluntarism and community responsiveness to local needs.

- Extension of the remit of the social services inspectorate to include residential care for older people - and development of national standards for such care.
- Examination of the concept of the introduction of a home subvention scheme.

In terms of immediate service enhancement, the Strategy indicates the need to put in place on a national basis the following actions, which also apply to our Board on a pro rata basis:

- *7,000 additional day centre places.*
- *Increased funding for aids and appliances in people's homes.*
- *1,370 additional assessment and rehabilitation beds.*
- *Appointment of additional geriatricians to aid planned development of acute geriatric medical services.*
- *600 additional day places covering specialist areas such as falls, osteoporosis treatment, fracture prevention, Parkinson's disease, stroke prevention, heart failure and continence promotion clinics.*
- *800 extended care/community nursing unit places per annum over the next seven years, including provision for persons with dementia.*
- *Improved staffing in extended care units.*

The role of Health Promotion with regard to the elderly is significant, in that it is acknowledged that the primary cause of premature morbidity is linked to an unhealthy lifestyle. The role of Health Promotion is to develop programmes in the community setting, to enable the older person to acquire the information and skills that will help them to make good decisions in relation to their health and well being. The National Cancer Strategy 1996 and the Cardiovascular Strategy 1999 identifies that the groups of persons 65years (particularly men), that the main cause of death is due to cardiovascular disease.

3. PRINCIPLES OF SERVICE DELIVERY

3.1 OUR BOARD'S MISSION FOR OLDER PERSONS

Our Board's Service for Older Persons promotes the enhancement of the health and social status of older persons in our Board's area. Our Board's goal is to provide appropriate care in an appropriate setting with timely and adequate access to a full range of services, while working in partnership with Voluntary providers, Statutory Agencies and Service Users, to provide and develop effective and sustainable services to meet the developing needs, to allow older persons remain in their homes for as long as is practical with dignity, independence and a good quality of life. The transfer of an older person from his/her home to inpatient care should only be considered when the older person has been medically assessed as in need of such care and when all other care options to support and facilitate the older person to continue living at home have been exhausted.

3.2 STRATEGIC FOCUS

Our Board works in partnership with the voluntary providers, statutory agencies and service users, so as to provide and develop effective and sustainable services.

The following principles underpin our Board's approach to service delivery:

- To maintain older persons in dignity and independence at home in accordance with their wishes as expressed in various studies.
- To restore to independence at home those older persons who become ill or dependent.
- To encourage and support the care of older persons in their own community by family, neighbours, and voluntary bodies in every way possible.
- To promote healthy ageing with the assistance of voluntarybodies involved with older persons.
- To ensure that the Health and social gain needs of the population are met while ensuring that the customer and patients are provided with a seamless service achieved through co-ordination of resources and structures.
- The provision of equitable access to services for older persons.
- The continuous assessment and evaluation of service delivery.

3.3 STRATEGIC CHALLENGES

The services for older persons in 2003 will require the Board to deliver services in a proactive creative way as requirements for care will outstretch available resources. This is compounded by the projected increase in the number of elderly population, due to the number of people living longer and the predicted increase in the general population. Flexibility will be applied, in order that packages of care can be provided to those most in need.

4. FUTURE OPERATING ENVIRONMENT

The main features of the operating environment to be taken into account for the future development of services for the elderly includes the following: -

- Significant population growth and particularly rapid growth of the elderly in the population as a whole.
- Service adjustments through out the Health Services.
- The current downturn in economic growth with resulting income levels
- Continuing social change with the ongoing change from traditional values.
- Predictable areas of high deprivation.
- Multiplicity of needs of those presenting for and requiring services.
- A desirable increase in advocacy exerting pressure for improved quality and range of service.
- Decrease in the incidence of volunteerism and relative carers.
- Improved interest by and rapport of the elderly population with the service leading to their accessing services as a right.
- The widening of the Medical Card eligibility to include all those over 70.
- Ongoing pressure for accountability and value for money.
- Difficulties in attracting and retaining staff.

5. CORE SERVICE PROVISION

Services for older persons incorporate:-

- Community Day Hospital, inpatient and assessment services.
- A wide range of community based services (which includes General Practitioners and their support services)
- Services provided by the voluntary sector
- Residential services, convalescent, respite and extended care
- Contractual arrangements with the private sector (nursing home), respite, convalescent extended care and subvented accommodation.

As recommended in the *10 Year Action Plan* our Board recognises and is committed to the concept of providing client centred care packages for older persons in our area. A care group structure has focused individual disciplines to the delivery of services towards an integrated model. Central to this is the role of the General Practitioners and heads of disciplines in the community who work closely with the Manager of Services for Older Persons, the Consultant Physician in Medicine for the Elderly, and the Consultant Psychiatrist in the Psychiatry of Old Age, and the management of acute hospitals, to provide the most appropriate care in the most appropriate setting for older persons.

5.1 COMMUNITY SERVICES

5.1.1 General Practitioners Services

There are one hundred and eighty six General Practitioners, a significant number of most of whom have the support of Practice Nurses and other staff providing a range of medical services in the community. General Practitioners are key players in the provision of front line services for older people. It should also be emphasised that the General Practitioner together with the Public Health Nurse act as gatekeepers to the service and tend to be the first professionals who review older persons when ill and their decisions are vital in deciding on the 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 GP takes 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.

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 approximately 142 Public Health Nurses and 100 Registered General Nurses in the three Community Care Areas with each area managed by a Director of

Public Health Nurse. The average time spent by a PHN on care of the sick and dependant at home comprises approximately 44% of the average working day (Burke 1986), whilst the commitment of the RGN is almost full time. A significant commitment of the Community Psychiatric Nurse's time would also be allocated to elderly services in supporting those with an overriding psychiatric condition. Notwithstanding the increasing number of patients requiring nursing care, the complexity of the care required has also increased. It is the responsibility of each PHN to prioritise her work by assessing the needs of patients in her care. Professionals allied to medicine, psychology, social work, occupational therapy, physiotherapy, speech and language therapy, provide services to older persons as appropriate and are deployed in the community and residential services.

5.1.2 Primary Care Partnership

From the earlier days of our Board existence, there has been ongoing consultation with the General Practitioners with a view to their amalgamation into partnerships. These partnerships play an important role in the further development of services for the elderly.

5.1.3 Vaccine Campaign

Our Board built on the influenza vaccine campaign, which was undertaken in 2001 in 2002 and continued to work closely with key stakeholders with regard to uptake rates of influenza and pneumoccal vaccine:

- GP's with respect to older persons and carers
- Private Nursing Homes
- Hospitals/Homes for Older Persons
- Acute Hospital (Older Persons)
- Psychiatric Hospitals
- Services for persons with special needs/disability and their carers
- Frontline staff dealing with above services

There were 50,850 influenza and 7,568 pnuemoccal vaccines issued to General Practitioners in the Northern Area Health Board. This represents a very high *uptake relative* to the population 65+ in our Boards area.

5.1.4 Day Hospital

Day hospitals for the elderly are established at St Mary's Hospital, James Connolly Memorial Hospital, Beaumont Hospital and The Mater Hospitals. These day hospitals cater for all elderly clients referred by their General Practitioners or by Consultants within the hospitals. The day hospital service provides functional and medical/multidisciplinary assessment and a full range of health care interventions, which assist elderly persons to continue to live at home.

5.1.5 Community Ward Teams

Community Ward Teams were established in each Community Care Area to provide outreach care services for older people in their own homes. At present our Board has three Community Ward Teams in each Community Care Areas. The service facilitates the earlier discharge of patients from acute hospital service and obviates the need for referral of patients by general practitioners to acute general hospitals in certain circumstances. These services include Rehabilitation, Extended Care and Intermittent/Short Term Care. The multi- disciplinary team consists of:

- Team Leader / Senior Public Health Nurse
- Registered General Nurses
- Physiotherapist
- Occupational Therapist
- Home Care Attendants

Currently, all Teams are experiencing some staffing shortfalls; priority staff is seconded from the broader staff complement within the Areas.

5.1.6 Day Centres

Our Board funds a number of day centres, which provide a range of social and other services for the elderly.
Day care services in Community Areas are provided at three levels:

- Nursing/medical orientated services such as those at Lusk Community Unit/ St Clares, SeanChara, St Monica's and Cuan Ros.
- Community based day services such as those located at St. Gabriel's Nursing Home, Skerries Day Care Centre, at Lourdes Day Care Centre, Santa Maria Cabra West, West Finglas Day Care Centre, Clareville Court Day Care Centre.
- Board provided support funding to a number of voluntary organisations, who provided a more social oriented day services supplied from numerous parish halls and centres.

5.1.7 Home Help

The objective of this service is to enable elderly and incapacitated persons to be maintained at home for the longest possible time. This service is provided by Voluntary Community based Organisations in partnership with our Board. The support may include domestic support and/or personal care provision.

5.1.8 Meals On Wheels

Meals on Wheels services are managed by voluntary organisations that are grant aided by our Board. Meals are also prepared for Meals on Wheels by service from our Board's

hospitals and homes catering departments. This valuable and worthwhile servicenables older persons to avail of a well-balanced nutritious diet in their own home

5.1.9 Mobile Day Hospital

The mobile day hospital brings the benefits of a day hospital to the elderly in areas distant from a general hospital and is staffed by a multidisciplinary team. The mobile day hospital visits centres in Swords and Balbriggan and liases closely with the local GP's and Public Health Nurses. This service allows for an intensive medical assessment to be carried out on dder persons without recourse to in-patient admission. The service visits Balbriggan and Swords on a weekly basis.

5.1.10 Adaptation Of Housing

Eastern Community Works Ltd. carries out adaptation to houses of older persons living alone with funding provided by the Department of the Environment and Local Government. This service provides minor home improvements and essential repairs to the residence of older person who own their own homes. The service is provided through the local authority and is funded by our Board. The service may include minor repairs to gutters, roofing and plumbing in some cases the installation of central heating systems. Persons are assessed to ensure that the service is provided to those most in need and contributes to the overall strategic objective of enabling older persons to remain at home in comfort for as long as possible.

5.1.11Community Developments Including Voluntary Housing

Considerable progress is being made in discussions with the local authorities and voluntary housing associations. These discussions are centring around proposals for innovative sheltered housing developments which will bridge the gap between conventional/sheltered housing units and residential care. The residents of these facilities will require significant input from health professionals; this is somewhat similar to services provided to older persons in conventional housing. Senior management from our Board and Fingal County Council are involved in ongoing discussions from a planning perspective. Discussions on the needs for the elderly population sheltered housing, site for day centres and community units for the elderly are an integral part of the overall agenda.

5.1.12 Carers Support

The majority of care of older people, in the home setting is provided by voluntary carers, either relatives, friends or neighbours. A number of voluntary agencies support carers for older persons in our Boards area. The groups work in close liaison with our Board staff and are in many cases partfunded by our Board. Their involvement assists our Board in the planning and delivery of services for older people in a manner, which is oriented towards an increased quality of life for the older person.

5.1.13 Care Packages

These home based care packages are provided to older persons whose care needs have increased to such an extent that the general community services available are no longer adequate to allow that person remain at home and where long stay residential care is being considered. It is a person centred service that identifies and responds to individual needs. This service allows older persons to be discharged from the acute hospitals and in some instances avoided the need for older persons to access acute hospital care.

Community Services Activity

Service	Community Services Activity Report	2002 Totals
Meals on Wheels:	No. of meals	301,168
Eastern Community Works	No of applicants approved	115
Home Help Service	No. of hours	389,674
District Care Unit	No. of referrals	492
Home Care	No. of Packages approved	* 84
Respite Care	No of Clients	*372
Home First Project (CCA8)	No. of Clients	* 40
Day Care Centres	No. of Persons attending No. of attendances	3,128 36,362
Day Centres	No. of Persons attending No. of attendances	1,371 190,290

* New Services for 2002

5.2 SPECIALIST GERIATRIC SERVICES

The development of specialist Geriatric Departments in general hospitals has been one of the most significant advances in the care of older persons in recent decades.

Departments of Medicine for the Elderly are located at the three acute hospitals in our Board's area. There are five Consultant Physicians in Medicine for the Elderly who hold joint appointments with our Board and the various voluntary hospitals.

The service is provided by a Consultant led multidisciplinary team who has access to the full range of diagnostic facilities in the acute hospital. Access to this service is by way of GP referral. These units ensure the prompt and appropriate admission of older persons to hospital, and their appropriate planned discharge or placement in the appropriate setting to meet their ongoing needs.

5.3 PSYCHIATRY OF OLD AGE

Dedicated Psychiatry of Old Age services are located at James Connolly Memorial Hospital/Eccles Street and St Ita's Hospital/Beaumont Hospital. A full range of community and hospital facilities are available including assessment and outreach service to older persons in our Boards area. Psychiatry of Old Age is responsible for those older persons who have developed functional psychiatric disorders such as depressions or dementia with behavioural or psychological problems for the first time over the age of 65 years. The ethos of this service is to provide prompt assessment together with active treatment in the person's home as far as practicable, thereby causing the minimal disruption to their life. The service is supported by day hospital at James Connolly Memorial Hospital and Eccles Street, has access to assessment beds (6) at St. Vincent's Hospital Fairview and a unit for disturbed elderly at James Connolly Memorial Hospital (40 beds) There are acute assessment beds and high support long stay beds located at St. Ita's Hospital.

This service is being enhanced by developing close working relationships, between the Consultant Psychiatrists, Consultant Psychiatrist in the Psychiatry of Old Age and Consultant Physicians in Medicine for the Elderly in the area. This will be enabled by the implementation of an agreed action plan, which will put older persons at the centre of the care package and ensure that the older person is cared for in the facility most suitable to his/her care needs.

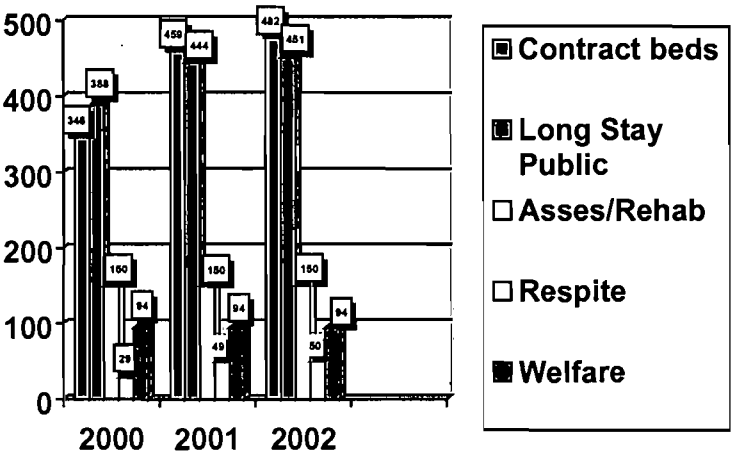
5.4 ADULT MENTAL HEALTH SERVICES

Older persons who have had a mental illness for some time (prior to reaching the age of 65) continue to be seen within the generic adult mental health service. These older persons - *graduates* - who have a mental illness also require services which provide for their needs in a way which takes account of the particular life stage they have reached. Some of their needs may be more physical than mental as the person gets older and when residential care is required this is provided mainly in nursing homes and our Board's elderly units. A small number of patients, because of their psychiatric needs, are accommodated in our Board's psychiatric hospitals. There are approximately 111 elderly beds in St. Ita's which are being re-engineered at present to accommodate the psychiatry of old age and extended care for the elderly generally in North Dublin. There are also approximately 27 beds for older persons in St. Vincent's Hospital, Fairview as well as 30 beds at St Elizabeth's Court, North Circular Road.

5.5 NON-ACUTE RESIDENTIAL SERVICES

Our Board provides a broad menu of residential care services as a step-down from acute care and as a step-up/support to the community services. The detailed graph outlines the number and range of beds available in 2000,2001 and 2002. This analysis illustrates growth since 2000 and reflects our ability to maintain and increase capacity by 22% for a wide range of services for older people, in addition increasing supports to allow older people remain living at home.

Figures show a 39% increase in contract beds between 2000 and 2002, a 16% increase in Long Stay public beds and a 72% increase in respite beds. The total number of beds available at the end of 2002 increased from 1,007 to 1,227.



5.5.1 Welfare Homes

Welfare homes provide care for older persons who are of low to medium dependency and who do not require a high level of nursing/medical care. Welfare homes are located in Ashgrove, Navan Road and Clarehaven, St. Canice's Road while welfare beds are also located at St. Mary's Hospital, Phoenix Park.

5.5.2 Respite Care/Convalescence

Respite care is a valued service, which allows carers take a planned break in the knowledge that their relatives are receiving quality care on a short-term basis. These services are available in all community units while respite care is also available in St. Monica's Home, St. Clare's Home, Lusk Community Unit, St. Mary's Hospital, Phoenix Park and James Connolly Memorial Hospital.

5.5.3 Extended Care/Residential Hospital/Homes/Community Units

The residential/extended care services are provided at St. Mary's Hospital, Phoenix Park, St. Monica's Home, Belvedere Place, Claremont residential services, James Connolly Memorial Hospital, Cuan Ros, Navan Road and Lusk Community Unit.
These services provide residential accommodation and care for older people with varying dependencies. Currently these services operate as a resource for the older people within the three community service areas within our Board's geographical area. Our Board acknowledges that there is considerable demand in the eastern region for non-acute beds and this in turn means that older person remains inappropriately in an acute bed in the acute hospitals in our Board' area.

5.5.4 Contract Beds

These are fully funded beds in private/voluntary-registered homes and are located in a wide range of facilities in our Board and outside the Board's area. These beds are utilised in providing extended care and respite care to older persons.

5.5.5 Nursing Home Subventions

The nursing home subvention is available to assist families financially, to avail of a nursing home placement for their older relative who has been medically assessed as requiring varying levels of inpatient care. This assistance is afforded to persons who meet the financial requirements laid down in the Nursing Homes (Subvention) Regulations 1993.

5.5.6 Assessment and Rehabilitation Services

All of our Board's Day and In-patient services provide functional and medical assessment of clients, which is undertaken by the multidisciplinary team and in partnership with the Acute Hospitals and the client's General Practitioner. Rehabilitation is an active process by which those people who are disabled by injury or disease achieve full recovery or realise their optimal physical, mental and social potential and are integrated into their most appropriate environment. Rehabilitation can take place in a variety of settings such as hospital, day hospital and within their clients own home.

Range of Non-Acute Residential Service

** 10 beds relate to Psychiatry of Old Age.*

	Assess/Rehab	Respite/Intermittent Care	Welfare	Extended Care Beds
AREA 6				
Mater	20	-	-	-
JCM	54	2	-	60
St. Mary's	52	12	16	207
Ashgrove	-	-	39	-
Cuan Ros	-	10	-	35
AREA 7				
Clarehaven	-	-	39	-
St. Clare's	-	2	-	61
Sean Chara	-	10	-	40*
Clontarf Orthopaedic Hosp.	-	2	-	-
St. Monicas Home	-	2	-	43
AREA 8				
Beaumont Hospital	24	-	-	-
St. Gabriel's	-	1	-	-
Lusk Community Unit	-	9	-	*36
Baldoyle				
Contract Beds	-	-	-	490
Subventions Granted	-	-	-	178
Enhanced Subventions	-	-	-	323
TOTALS	**150**	**50**	**94**	**1473**
1767				

5.5.7 INSPECTORATE OF NURSING HOMES

Under the Registration of Nursing Homes our Board is required to register nursing homes. Our Board is in the process of developing a more enhanced function of the inspectorate services, as indicated in various reports, to include other professional inputs such as Environmental Health, Fire Safety, Health and Safety, Pharmacy, Infection Control, this will be linked to and given priority by our Board's Corporate Governance Department.

6. SERVICE DEVELOPMENTS 2002

The following outlines the priority developments achieved during 2002 in meeting our Board's objectives:

6.1.1 NURSING HOMES

During 2002 additional Private NursingHome places were sourced to allow patients in the acute hospitals who had completed the acute phase of care transfer to more appropriate levels of care. These beds were taken out in September 2002 as part of the 2002 Winter Initiative (Winter Vomiting Bug) and allocated to Beaumont Hospital.

10 Beds

Additional beds were sourced and allocated as part of the 2002 Winter Initiative (Additional Beds) and allocated to the Mater Hospital in September 2002.

10 Beds

6.1.2 NURSING HOME SUBVENTIONS

The base rate for a total of 545 individuals in receipt of Nursing Home Subvention was increased by 14.3% from 1/4/02.

6.1.3 COMMUNITY UNITS

Lusk Community Unit, which has 50 residential short and long stay places, continued to extend services in 2002. The Unit which will address the identified need for a range of residential places for older persons in North county Dublin, will develop respite, convalescent and long stay services for patients including residents who suffer from dementia. The associated day centre will came on stream in 2002 with an additional 10 places. Difficulties experienced in the recruitment of nursing staff in Lusk Community Unit only permitted the opening of 39 beds in Lusk by the end of 2002.

In 2002 the residential and day care services at Claremont Community Unit (St.Clare's, Sean Chara, & Clarehaven) were reconfigured into a unified administrative and clinical structure providing the necessary planning and management for the further development of the services.

6.1.4 PSYCHIATRY OF OLD AGE

A new Psychiatry of Old Age service located at St. Ita's Hospital / Beaumont Hospital to service the needs of Community Services Area 8 came on stream in 2002. Acute assessment beds and high support long stay beds are located at St. Ita's Hospital. Acute assessment beds are planned for Beaumont Hospital, as a replace for those in St Itas. A Day Hospital consisting of a multidisciplinary

service with the following additional staff members, Consultant, Registrar, ACNO, Social Worker and Secretary, was in place by December 2002.

6.1.5 HOME FIRST

The Home First model pilot in 2002 between Beaumont and Community Care Area 8, has led to flexible and responsive interventions, assessments, care plans and care organisation, which has enabled older people to continue living at home. The advances made by assistive technology will support the independence of the vulnerable older person at home. This technology was installed unobtrusively in the homes of the Home First clients in 2002 in community care area 8 and is currently being monitored.
This is a significant development, which will become an integral part of the development of care management for older person. The Home First philosophy is: a) Person centred, b) Seamless and integrated partnerships between primary care, acute hospital and community based specialist services and c) needs led.
Preliminary planning to expand the 'Home First' project's in community care area 8 and to roll out in community care area 6 and 7 and James Connolly Memoal Hospital and the Mater Hospital commenced

6.1.6 CARE PACKAGES

An evaluation of this service took place in 2002 with positive results. It is noticeable that there is a constant through put in this service reflected by the dependency levels of the recipients. Response from carers and community staff indicate that these clients could not have remained at home without this service.

6.1.7 PRIMARY CARE PARTNERSHIP

The Primary Care Partnerships have had a specific focus on the elderly. This has led t the appointment of two nurses and a social worker to work as a link between the GPs, community services and the geriatric services in the Mater Hospital early in 2002, in the provision of a seamless service to be regarded as extending the day hospital tothe community.

6.1.8 COMMUNITY SUPPORT SERVICES

- **Day Services**

The number of day care centre attendances increased to 42,120 in 2002 due to the following;
The provision of expanding the five-day service in St. Gabriel's Nursing Home, Lusk Community Unit Day Care Centre opened in 2002, St. Monica's Day Centre became fully operational in 2002. Additional day services were provided at An Siol Macro, West Finglas, Sybill Hill, The Brendan Behan Service Ballybough and East Wall. The opening of the Granby Row, Day Centre for persons with Alzheimer's disease was finalised in late 2002 and will become fully operational in early 2003.

Enhanced transport was put in place for Clareville Court Day Centre catering for 25 persons this will further develop the scope of the day centre.

Funding for the development of day care services in Community Services Area 8 was allocated in 2002; there were 163 people on waiting lists for day care in December 2002. Baldoyle Day Care service was allocated funding in 2002 and it is planned to commence the service in 2003.
An Occupational Therapy service commenced in Skerries Day Care Centre in September 2002.

- **Meals On Wheels**

To enhance the good safety, quality and standard of Meals on Wheels.taff involved in the preparation of meal onwheels in Community Services, were trained in Food Safety and Food Hygiene in 2002. Premises and equipment were upgraded in areas as appropriate, to comply with environmental health standards. A new initiative with a private supplier to provide outreach meals on wheels service commenced and was piloted in Community Care Area 6 in 2002.

- **Home Help/ Home Care Packages and Progress in Quality / Standards**

A total of 16,510 people were assisted in 2002 through the home help service. An additional 84 people were assisted through the development of customised care packages were also funded. In 2002 protocols were developed for referral and assessment to the home help service and introduced in community care area 6. A training course to meet identified needs of the home help worker took place over the year.

The improved rates of pay to Home Helps assisted in attracting recruitment for this service and also the enhancement of the services to facilitate personal care in addition to the customised home help package.

- **Northside Counselling Service**

The Ageing with Confidence project to assist older persons to stay healthy (physically, emotionally and mentally) through peer support was expanded during 2002 and 4 groups were facilitated. Facilitators led these groups from the Northside Counselling Service.

- **Social Work Service for Older Persons**

A social work team leader and social worker were recruited in 2002 in Community Care Area 6.

- **Multi Disciplinary Teams**

Preliminary work commenced with regard to Multidisciplinary Team working in primary care in the health centre in community care area 6 in 2002, to provide a more responsive and integrated service to older persons in the community. This initiative will involve an Occupational Therapist and Physiotherapist, who would normally work from the

community care area headquarters, would now be based in the local health centres with the existing nursing, social work and community welfare staff to facilitate local discussion and a team response to service needs in the local community. The Board's foreign recruitment drive, early in 2002, helped us attract these professionals in late 2002 and in early 2003.

6.1.9 COLLABORATION WITH ACUTE GENERAL HOSPITALS

Following the adoption of the Working Group Report in 2001and inline with the National Health Strategy action point 26, an integrated approach to meeting the needs of ageing and older people, our Board and the management teams of the Acute Hospitals meet on a monthly basis to proactively review common issues and concerns regarding care for older persons.

6.1.10 HOUSING INITIATIVE

Sheltered Housing based on a care model concept is being developed, which will provide residential accommodation as an alternative to extended care, progressed in 2002 in partnership with FOLD Housing Association/Northern Area Health Board/Fingal County Council with regard to sites at Hartstown and St Clares. These discussions also took place with RESPOND Housing Association/Northern Area Health Board/Dublin City Council with regard to sites at Merchants Gate, East Wall and Hyde Park, Drumcondra. Planning and the design brief are at an advanced stage and it is expected an initial work programme will be agreed mid 2003.

6.1.11 PUBLIC PRIVATE PARTNERSHIP

Our Board welcomes the announcement by the Minister for Health & Children on the 29th July 2002 regarding his plans to pilot a Public Private Partnership initiative in the Health Sector. Three Community Nursing Units for older persons are proposed totalling 150 extra beds for our Board's area.

7. SERVICE DEVELOPMENTS 2003

7.1.1 St Mary's Hospital

The operational budget for St Mary's Hospital in 2003 is€ 17.657m. The projected cost of providing services in St Mary's Hospital is at least€2.7m more than we had available in 2002. Investment in St Mary's is priority for our Board and is why resources are redirected. The valuable service provided in St Mary's Hospital meets the care needs of high dependency clients.

7.1.2 Rapid Access Clinic

This new service commenced in March 2003, the requirements are equipment, a part-time secretary and a part-time Staff Nurse from existing resources. This service will provide acute assessment for the older person who would normally attend Accident and Emergency. This service is currently receiving clients from the Acute Hospitals and proposes to open to General Practitioners.

7.1.3 Dementia Care Unit

This unit will be renovated to improve the Health and Safety of clients with Dementia by providing a safe and secure environment. The proposalis to develop a garden and shelter through "Mountjoy Prisoner Project" this will involve no cost to our Board.

7.2 REVIEW OF 2002 SERVICE DEVELOPMENTS

The following developments were ring-fenced as priority for roll out in 2003 with 2002 funding.

7.2.1 Research Unit *(St Mary's)*

Accidents particularly falls are the greatest cause of debility and death in the older person.
In late 2002 St Mary's under took to research this lifestyle risk and make recommendation in relation to their findings. This research will continue in 2003.

7.2.2 Stroke Unit *(St Mary's)*

The development and equipping of the Strokeunit at St Mary's will progress during the year. The cost of refurbishment and equipment is€200,000. The cost of the staffing will be €100,000. The Commissioning of the unit will be subject to our Board's capacity to fill the necessary posts within approved compliment.

7.2.3 Psychiatry of Old Age

A joint Psychiatry of Old Age/Beaumont Day Hospital has been negotiated within community care area 8. A temporary facility within the vicinity of Beaumont Hospital has been identified. It is likely this development will be deferred until the later half of the year depending on staff ceiling levels.

7.2.4 Home First

Discussions around the Home First project's expansion in Community Care Area 8 and roll out to community care area 6 and 7 and James Connolly Memorial Hospital and the Mater Hospital commenced in 2002. It is hoped to provide the service to older persons throughout our Board in 2003. A significant development, which should become an integral part of the development of care management for older person. The Home First philosophy is: a) Person centred, b) Seamless and integrated partnerships between primary care, acute hospital and community based specialist services and c) needs led. This development will be subject to our Board's capacity to fill the necessary posts within approved compliment.

7.2.5 Improved Bed Management System and Bed Configuration

Our Board has developed a policy for the equitable and transparent division of the long stay impatient bed resource. Through a common hospital/community waiting list equity is ensured through the implementation of an automatic bed management system, the bed-stock will be visible and activity can be recorded. The bed management system was developed by our Board and ICT Eastern Health Shared Services and with the assistance of the IT departments in Beaumont and the Mater Hospitals. This system will allow better and more cost effective management of this valuable bed resource by dividing the bed stock equitably, which in turn will achieve maximum usage of contract beds and maximise efficiency. As planned, the bed management system went live on May 1st 2003, in which the integrity of the system is being audited by an independent auditor from Trinity College, Dublin who will ensure that protocols are in place and reviews are facilitated.

8. SIGNIFICANT CHALLENGES

8.1 SIGNIFICANT CHALLENGES

The services for older persons in 2003 will require our Board to deliver services in a proactive innovative way in the delivery of services as requirements for care will outstretch available resources and employment ceiling. This is compounded by the projected increase in the number of elderly population, the number of people living longer, and the predicted increase in the general population. In addition the demand created by the cohort of over 70's elderly who avail of the non-means tested medical card has increased demand in all areas health and social gain. Flexibility will be applied, in order that packages of care can be provided to those most in need. Our Board and our partners in the service provision will manage within our Board's operational budget and employment ceiling. Therefore this will be a year of consolidation for our Board with the adjustment of services in order to meet our financial obligations. Service adjustments set out hereunder.

Direct expenditure on Services for Older Persons in 2002 amounted to €60.655m; the operational budget in 2003 is €60.225 representing a decrease of .7 of 1%. This does not take into account inflationary pay and non-pay costs pressures.

The principal cost pressures within this care group in 2003 are :

- Cost pressures associated with contracted beds in private nursing homes including

  - 35 beds approved by ERHA 2002 **€1.391m additional in 2003.** Funding unallocated to date.
  - Impact of 2002 annual price increase related to bed stock of private nursing homes **€1.1m**
  - Contract bed resource prioritised and redirected to St Mary's to off set 50 bed closures at St Mary's - **€500,000 in 2003**

- Cost impacts of the increasing dependency levels of clients within our directly provided residential facilities in particular St Mary's Hospital and the 4 Community Nursing Units – Based on 2002 expenditure levels St Mary's alone has additional unfunded capacity equating to 70-80 beds or approximately **€3.0m** (see also contract beds above) in 2003 with an estimated minimum **€500,000** arising in respect of the combined Community Nursing Units.

- Overtime (primarily nursing) and agency costs within the service associated primarily with vacancy levels, running at approximately €200,000 per month (excluding medical overtime)-equivalent of approximately 45 staff WTE's per month **€2.4m per annum**

- Cost impacts associated with the failure to fund the impact on Elderly Services generally of the granting of automatic medical card eligibility to over 70's for example increased costs related to:

  - Adult Optical Scheme – see Primary Care
  - Medical and Surgical Appliances Scheme – See Primary Care
  - Chiropody Scheme - **minimum €250,000 unfunded 2003**

- Minor capital costs associated with backlog priority maintenance and re-equipping in service – **minimum €450,000 required in 2003.**

- Costs associated with increased demand for home support / home care packages

M Windle
Chief Executive **23rd June, 2003.**