MIDLAND HEALTH BOARD

Results of Consultation in the Midland Health Board with:

- Statutory/Voluntary Agencies,
- Special Interest Groups and
- Users of Service

- Midland Health Board – Board Members
- Midland Health Board – Corporate Team

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INTRODUCTION

The development of the new Health strategy which will provide for improved health status and the development, reform and modernisation of the health and personal social services over the next 5 to 7 years is intended to be a highly participative process as reflected in the statement by The Minister for Health and Children, Micheál Martin TD,

> 'I am anxious that the development of this new Strategy should incorporate an open and highly participative consultative process'.

The Midland Health Board within the time available endeavoured to undertake such a consultative process.

Planning of the Consultation Process

The planning of the consultation process with statutory/voluntary agencies, special interest groups, and service users involved a number of meetings with key stakeholders (General Managers, Directors of Care Groups, Projects Specialist, Communications Officer, Health Promotion Personnel, Partnership Facilitator) to provide:

- an overview of the consultation process
- scope of consultation process
- identification of resources required which included secretarial provision and the expertise of a research officer
- identification of facilitator within each care group,
- identification of key agencies to be consulted with,
- identification of key reports
- time frames,
- promoting awareness of and involvement in the process

The nomination of a Facilitator(s) from within each of the care groups to consult with statutory/voluntary agencies, special interest groups, and service users was considered to hold the following benefits. This person would have:

- specialist knowledge of the particular care group area,
- they would be aware of key agencies/committees, hard to reach groups within their care group
- they would be aware of and in a position to, address specific issues that may require particular attention.
- the feedback would benefit the particular care group, and
- well managed consultation could strengthen links with agencies.

The second key meeting was convened with the nominated facilitators per care group/specialism. The purpose of this meeting was to;

- brief facilitators on the process,
- determine the methodology to be employed and introduce standardisation where appropriate and relevant in the consultation process, allowing for the specific needs of individual groups
- advise on key issues in the process of consultation,
- provide each facilitator with 'pack' containing relevant information materials,
- advise on report format and timeframes.

Where key personnel were unable to attend, individual meeting have been convened/arranged by the liaison person with them. In all approximately 6/7 meeting of this nature have been held.

Awareness of and Participation in the Process

In increasing awareness of and participation in the process and to offer maximum opportunities to the public, statutory/voluntary agencies, special interest groups, and service users to have their views heard about the future shape of health services and the health system a range of awareness mechanisms of the development of a new health strategy were organised locally.
These included:

- Press release in local papers serving as reminder of consultation process for new health strategy and encouraging on behalf of the Midland Health Board, members of public, voluntary/community groups/agencies, users to make submissions.

- Radio advert placed with midland radio stations over two day period reminding of consultation process for new health strategy and encouraging on behalf of the Midland Health Board, members of public, voluntary/community groups/agencies, users to make submissions.

- Information on Board's website, providing information on new national health strategy and encouraging staff to avail of consultation opportunities available.

- Notices throughout the Board of proposed consultation with staff.

- Information on new health strategy and consultation process provided in the Midland Health Board News, April 2001 edition.

- Information packs located in various centres throughout the Board.

General Methodological Framework

The general methodological framework adopted for consultations with statutory/voluntary agencies, special interest groups, and service users is as follows.

- Presentation on key aspects of 'Shaping a Healthier Future'.

- Presentation on new Health Strategy - principles, themes, key questions, issues for consideration.

- Identification/affirmation of key questions.

- Small group discussion and feedback on each question.

- Reconvening of larger group and examination of response in context of consensus/conflict.
- Consideration of response in regard to omission/general discussion on issues raised.

It was recognised that this framework might need to be amended where there were considerations of group size, specific needs of individual groups, access issues to particular groups in light of time frame.

Key Questions Identified for Use

- What is it that people think would be a preferred health service?
- What are the strengths of the existing system?
- What requires fixing?
- What are the barriers which need to be addressed in the 'fixing'?
- How do we overcome these barriers?
- What are the key changes that needs to happen to improve the health of people living in poverty or experiencing social exclusion?

The Consultation Process

The Consultation Process was influenced by the short time frame available in which to carry out the consultations. Within that time frame there were the additional factors of Easter holidays and the constraints pertaining to Foot and Mouth Disease.

The Consultation process with statutory/voluntary agencies, special interest groups, and service users, took place between 6th April and was targeted for completion by April 25th. The final consultation took place on 10th May'01. The consultation process with statutory/voluntary agencies, special interest groups, and service users, was facilitated by both Health Board staff, and key staff in the voluntary sector who had specialist knowledge of the particular area.

Consultation with the Midland Health Board Members was undertaken on 17th April. The Consultation with the Midland health Board Corporate Team took place on 26th March '01. The issues arising and proposals for change are contained within the body of the report, with the full report contained in the Appendices.

The Consultation with staff was undertaken by the Midland Health Board Partnership Committee through a series of 19 workshops, attended by 600 staff, held in eight locations throughout the Board. This report has been forwarded through the Partnership Committee directly to the Department of Health and Children. For the purpose of completion, the full report on staff consultation is nonetheless contained in the Appendices of this report.

Report Structure

The Report is structured into two sections. Section A, (Pages 8-77) contains the Particular Groups of Older Persons, Persons with a Disability, Children & Families, Women's Health, Carers,

Special Interest groups which include; Refugee/Asylum Seekers, Travellers and Homelessness. The final group is Acute Care which include Hospice Services.

Section B, (Pages 79-84) reports on the findings of the Consultation Process undertaken with the Board Members of the Midland Health Board and the Corporate Team of the Midland Health Board.

In structuring the report, the format outlined by the Dept. of Health & Children is broadly adopted. The report provides as an initial step, a generic feedback of the different consultations carried out with statutory/voluntary agencies, special interest groups, and service users, in relation to some of the key strengths of the health/healthcare service of the Midland Health Board area. In regard to the ***Issues arising and Proposals for Change*** feedback from the different consultations carried out with Voluntary agencies/Committees/ Service Users/ Hard to Reach Groups is merged under the Particular Groups of Older Persons, Persons with a Disability, Children & Families, Women's Health, Carers, Marginalised Groups which include; Refugee/Asylum Seekers, Travellers and Homelessness. The final group is Acute Care which include Hospice Services.

The full report of each of the consultations undertaken is contained in the appendices

Consultations Undertaken

The Consultations undertaken with voluntary agencies, hard to reach groups, users are as follows:

Older Persons

Mr. Barry O'Sullivan consulted with the Regional Consultative Forum for Older People.

Ms. Geri Quinn and Ms. Eimear Mc Carthy consulted with 22 women service users in the older persons' age group in one location.

Mr. Paddy Lowbridge consulted with Tullamore Active Retirement Association

Persons with Disabilities – Intellectual/Physical & Sensory

Mr. Moss Mc Cormack and Mr. Thomas Reilly consulted with the Regional Co-Ordinating Committee for Physical and Sensory Disability, the Mental Handicap Services Consultative Committee and the Mental Handicap Services Development Committee on 24th April.

Mental Health

Ms. Moira Tysell and Ms Geri Quinn consulted with key voluntary organisations in mental health area. These included GROW, AWARE, Schizophrenia Ireland, Mental Health Association of Ireland and the Boards Health Promotion Service along with Mental Health Service Workers.

Ms. Finola Colgan consulted with Midland Alliance for Mental Health, which comprises GROW, AWARE, Bodywhys, Samaritans, Alzheimer Society Ireland, Schizophrenia Ireland/Phrenz.

Ms. Moira Tysell consulted with 10 Mental Health Service Users.

Mr. Bill Ebbitt consulted with Longford and Athlone Drug Awareness Groups (9 people).

Children & Families

Ms. Anne Mc Guinness and Ms. Imelda Donohoe from the Granard Action Project which caters primarily for disadvantaged families consulted with 1 users of their services, and 4 Mothers from the Mother and Toddlers Group.

Mr. Joe Whelan and Ms. Fiona Murphy consulted with the Midlands Schools Health Project Steering Group (11 in attendance)

Ms. Fiona Lane, Regional Co-ordinator with Barnardos arranged for Ms. Clare Dean, Ms. Roisin Daly, Ms. Veronica Burke and Ms. Breeden Doolan to undertake consultation with their staff in Athlone Children & Family Centre, Edenderry and Tullamore Family Support Centre. Consultation was undertaken with 2 individual service users.

Ms. Catherine Samuels as Chairperson consulted with the Child Care Advisory Committee (9 Members present)

Mr. Bill Ebbitt consulted with Youth Service Providers which included representatives from Tullamore Youth Initiative, Midland Regional Youth Service, Foroige and Longford Youth Service (4 in attendance)

Ms. Joan Mc Loughlin, Midlands Foster Care representative consulted with 5 delegates from each of the Midland region branches.

Womens Health

Ms. Mary Hegarty consulted with the Women's Health Advisory Committee of the Midland Health Board (7 in attendance)

Ms. Mary Hegarty consulted with a group of 22 women who have/are experiencing disadvantage.

Ms. Mary Hegarty further made available a report, which had been derived from a consultation with women carried out in the Midland Health Board area as part of her thesis for MA in Health Promotion. It involved consultation in the form of five focus groups carried out with 23 female participants from lower socio-economic groups in June 2000 in relation to lay perspectives on health.

Carers

Ms. Marian Delaney Hynes, Ms. Paula Brophy and Ms. Finola Colgan consulted with 135 carers in Mullingar, Athlone and Longford areas between February and April 2001.

Asylum Seekers/Refugees

Mr. Eamon Rogers consulted with 6 Asylum Seekers families.

Mr. Eamon Rogers consulted with Athlone Asylum Seekers Support Group, Community Welfare Officers and shared experiences and dialogue with professional and colleagues from other Health Boards/Authorities.

Travellers

Ms. Geri Quinn and Ms. Joan Tierney consulted with staff and 25 Traveller Women at the Senior Training Centre, Mullingar.

Traveller Women currently undertaking training as primary health care workers consulted with 20 Travelling Families. This was organised by Ms. Deirdre Kavanagh.

Homeless Persons

Mr. Eamonn Rogers consulted with 5 occupants of St. Joseph's Hostel, Longford which caters for persons who are homeless.

Mr. Eamonn Rogers consulted with Streetwise, Athlone Community Information Centre, Management and Staff of St. Martha's Hostel, Community Welfare Officers and the Disabled Federation of Ireland.

Westmeath Homeless Forum made available through their chairperson Mr. George Lambden, relevant areas of their Draft Action Plan 2001-2003

Acute/Episodic Care

Mr. Moss Mc Cormack consulted with Friends of the Hospital from the region.

The key findings of the National Patient Perception of the Quality of Healthcare Survey, 2000 were drawn upon in the report.

The top five complaint categories identified for the period 1/1/99 to present day pertaining to acute/episodic care were drawn upon in the report.

The view of one service user who had intensive contact with the three acute hospitals was obtained.

Ms. Eleanor Dowling consulted with the Hospice Movements of Laois / Offaly / Longford / Westmeath in the region.

Ms. Eleanor Dowling extracted the key findings of the Report of the Working Party Group on Hospice Service(1997).

Other Consultations

Ms. Sharon Foley consulted with representatives from the four County Development Boards in the Boards area.

Ms. Sharon Foley consulted with Offaly Community Forum.

Mr. Bill Ebbitt consulted with ADM Companies and LEADER (ADM Companies which include Athlone Community Task Force, Tullamore Wider Options, Portlaoise Community Action Project, Offaly leader 11 Co., OAK Partnership Edenderry, Longford Community Resources Ltd., and Laois Leader Rural Development County.

Mr. Bill Ebbitt consulted with FAS, NTDI (National Training and Development Institute), OffalyVEC (Vocational Educational Committees)

Mr. Bill Ebbitt consulted with Longford Health Services Action Committee

Mr. Bill Ebbitt consulted with Justice Partners – Senior probation and Welfare Officer Midland Region, Garda Member Laois/Offaly division and Sergeant Longford/Westmeath division.

Consultation with Board Members and Corporate Team of Midland Health Board

Both of these consultations were facilitated by Director of Public Health and Planning, Dr. Pat Doorley and Project Specialist Children & Families, Ms. Eileen O'Neill.

Secretarial support to the process was provided by Ms. Mary Coughlan, Ms. Breda Dowling and Ms. Paulette Fitzpatrick.

Ms. Ashling Duggan-Jackson acted as research specialist to the process.

The Consultation process was co-ordinated by Ms. Eileen O'Neill.

STRENGTHS

Throughout the consultation process, many positives were identified in relation to health and healthcare in the Midland Health Board area.
A compendium of these strengths is outlined below:

- Resources.

- Funding - Financial support has improved, although there is still a huge funding deficit for healthcare in Ireland.

- Structures in place - awareness of the need to implement new management structures that respond to changing demands.

- Staff in the health services are perceived as being well trained, highly skilled, have a positive ethos, with a high level of commitment – particularly those working in frontline services within the system. Staff seek the best for their users. The fact of many staff living locally was perceived as a positive. Local personnel provide a good response, have an understanding of issues, there is good co-operation. There is a reserve of experience within system. There is also a perception of Health Board staff working alongside community, with a breaking down of barriers. Very caring professionals overall.

- Openness to define health in its widest sense. Focus is growing on lifestyle and its impact on public health from an early age. Emphasis on prevention has grown strongly over last number of years. Supportive role of Health Promotion.

- Open to consultation – willing to collaborate. Willingness to engage with community sector and local development groups to plan delivery of public health and promotion of healthy lifestyles. Increased level of partnership and joint approaches. Networking between health boards and local authorities.

- The fact that we have a system of healthcare was identified as being positive, as was the fact that there are now moves to consult on the development of a new Health Strategy. It was hoped that the process of consultation would be continued in the future.

- Awareness of issues (somewhat especially non-traditional). The healthcare system has become increasingly responsive and innovative. Moves and changes when necessary.

- Overall good service e.g. infant mortality.

- The involvement of the community and voluntary sector was seen as pivotal to the delivery of quality healthcare support in a client-centred manner. The fact that many groups now have service contracts was seen as positive. Developing partnership.

- Increased co-ordination in the last number of years.

- Education/ Life long learning. Knowledge base and willingness to share. Availability of expertise in terms of training (support).

- The MHB seeks to develop specialisation.

- There is recognition of the special skills of the Voluntary Sector.
- There is commitment to partnership approach.
- There is a proactive approach to recruiting.
- There is a commitment to training.
- Flexibility of Service.
- Diversity of services, which are now being provided. Meeting needs from differing perspectives.
- New regional specialisation.
- The multi-disciplinary nature of the service is a strength.
- Outreaching of services.
- Access to services.
- Community based services. Community Supports.
- Quality of local services which exists.
- Level of care received is good.
- Primary medical care is good. – Public Health Nurses, community mental health etc.
- G.P. service is very good and very accessible.
- Good networking. Contact established at local level between the agencies.
- First class service.
- Receptive at certain levels (mainly staff on the ground).
- The size and geography of the Board is a strength in promoting networking.
- New technology.
- Overall environment is healthy.

OLDER PERSONS

ISSUES RAISED

(1) USERS/VOLUNTARY GROUP

(Tullamore Active Retirement Association)

- Not knowing their entitlements.
- Suffering long delays in Casualty Wards.
- Being placed at the bottom of a waiting list when needing attention.
- Being discharged from hospital too soon.
- Having nobody to take care of them when they go home.
- Doctors seldom available at weekends.
- Some medication not available to Medical Card Holders.

(2) USERS/VOLUNTARY GROUP

(Portlaoise Women's Group; 22 older persons)

- Casualty services very slow with long waiting times and after a long wait, clients may then have to be taken to another hospital for the treatment they require.
- Not enough beds in the Midland Health Board Service to meet the growing population's need.
- Local Health Service not responding or developed to meet the local community's health needs.
- Staff shortages/overworked and tired staff.
- All staff should be well paid to ensure adequate staffing levels.
- Local/Regional health services slow – long waiting times for treatment and referral – it is quicker to be referred to Dublin Hospitals.
- Screening Services – people need more information on the Screening Services available – and follow-up information.
- The 'two-tier' health service, there is a big difference in the two services specifically waiting times, for treatment and referrals and in out-patient clinic systems.
- Paying for screening services is a barrier for many people.
- Poor quality of care and service in public health care.
- Lack of accountability within service.
- State of health service poor – the hospital in Portlaoise is dirty, unhygienic – leads to cross-infection.
- The lack of customer care – service is not person/people friendly, not a pleasant experience having to use the current service.
- Public transport service is very poorly developed in Midlands – difficult to access local health services; it is easier in a lot of instances to go to Dublin for health services.

- Out-patient clinic appointment system - everyone asked to attend at the same time, this leads to long waiting times within areas that have poor support services i.e. no crèche services.

- Lack of good information on Health issues and the Health services.
- Security in hospitals – staff and patients are very vulnerable.

SERVICE PROVIDERS/VOLUNTARY AGENCIES MIDLAND REGIONAL CONSULTATIVE FORUM – (Older People)

In attendance representation from Edgeworthstown Nursing Home, Offaly County Council, Retired Nurses Association, I.Y.O.P. Committee, T.A.R.A., Heart Support Group, Community Alert, I.C.A., Mountmellick Active Retirement Group, Longford Community Resources, N.C.B.I., Westmeath V.E.C., Community Alert (Regional), Mountmellick Development Association, Westmeath County Development Board.

- Inequity of service -Public V's Private.
- Poor accessibility to information and communications.
- 9 – 5 system, no cover out of "hours".
- Isolation – poor communications, information and networking.
- Poor attitude of junior Doctors when dealing with older people.

PROPOSALS FOR CHANGE

(1) USERS/VOLUNTARY GROUP

(Tullamore Active Retirement Association)

- Have social workers to visit elderly people living alone and to explain to them what are their entitlements.
- Carers are most essential and, even if the carer is a relative he/she should receive financial assistance and be given respite occasionally.
- Home help should also be provided where necessary.
- Funding should be made available for the provision of such facilities to meet and socialise such as community halls.

(2) USERS/VOLUNTARY GROUP

(Portlaoise Women's Group; 22 older persons)

- Health promotion should start in school – (nutrition, anti-smoking and drugs education and advice, mental health promotion).
- Build new hospitals and renovate the old run-down buildings – need more money invested in maintaining the buildings.

- The health service should be developed and funded to meet the local community's needs.
- Public Health Service should be developed and properly funded to provide an excellent standard of care and service comparable to the private health service.
- Customer-care training and awareness for health service staff.

- Staff should be better paid to retain staff and to ensure staff feel valued in their work.
- The medical card should be available to a wider range of people with the income bands increased to reflect inflation. The medical card should be available to all families and to people over a certain age. Ideally the 'Medical Card' should be available to all.
- Public transport service should be developed in Midlands to access health services and all relevant services.
- Screening services should be free to the public as those outside the GMS and with big families cannot afford to pay for screening.
- Local health service should meet the needs of the local community.
- More health information for people on low incomes on healthy living and smoking.
- More community development and investment. There are no facilities for local community groups to meet and provide support for each other.

(3) SERVICE PROVIDERS/VOLUNTARY AGENCIES

MIDLAND REGIONAL CONSULTATIVE FORUM – (Older People)

- More support financial and other for voluntary organisations.
- Life-span developmental approach to universal access.
- Need for more emphasis on preventing secondary illnesses.
- People need to be aware that they have a right to a quality service.
- Carers – more training, support and co-ordination.
- Improved discharge procedures – simple and proper instructions/care plan.
- Access to services needs to be improved (Inequity VHI etc).
- Improved contact with health board officials – continuity not phone calls.
- Rapid response to emergency situations.
- Improved service standards.
- Community support via partnership and collaboration - need for active development.
- Access on basis of need.
- Community based supports and services (including voluntary organisations) work for older people and should be supported, expanded and developed. Older people are entitled to quality services and supports on a par with other care groups and these services should be available on a twenty four-hour basis.

PERSONS WITH DISABILITIES – INTELLECTUAL/ PHYSICAL/SENSORY

ISSUES RAISED

(1) USERS – VOLUNTARY/COMMUNITY GROUPS/SERVICE PROVIDERS

(Mental Handicap Consultative & Development Committees and Regional Co-ordinating Committee – Physical / Sensory Disability).

In attendance Westmeath VEC, St.Christopher's Services, Longford, Midlands Branch – Irish Society for Autism, St. Cronin's Association Ltd., FAS, Midlands, APT (Aontacht Phobail Teoranta), IWA (Irish Wheelchair Association), NCBI (National Council for the Blind of Ireland), National Association for Deaf People, National Training and Development Institute, Midlands Region, People with Disabilities of Ireland, St. Hilda's Service, Athlone, Multiple Sclerosis Society, Midlands, Westmeath Centre for Independent Living, Laois Centre for Independent Living, Laois Centre for Independent Living, Midland Health Board Personnel – Area Medical Officer, Occupational Therapy, Speech & Language Therapy, Physiotherapy, Community Physiotherapy.

- Little consultation/participation occurred with the voluntary organisations in developing the care group approach and now negotiation of budgets for voluntary organisations involves two MHB functions rather than the previous one.

(2) COMMUNITY VOLUNTARY GROUPS

OFFALY COMMUNITY FORUM

In attendance representatives from Barnardos, IWA, Tullamore Youth Initiative, Harbour Centre (for the out of home), GROW, Bracknagh Women's Group, Tullamore Travellers Movement, Friends of Ofalia House).

- The housing needs of people with a disability is not being appropriately addressed. The present system is cumbersome and time consuming.

PROPOSALS FOR CHANGE

(1) USERS – VOLUNTARY/COMMUNITY GROUPS/SERVICE PROVIDERS

(Mental Handicap Consultative & Development Committees and Regional Co-ordinating Committee – Physical / Sensory Disability).

In attendance Westmeath VEC, St.Christopher's Services, Longford, Midlands Branch – Irish Society for Autism, St. Cronin's Association Ltd., Fas, Midlands, APT (Aontacht Phobail Teoranta), IWA (Irish Wheelchair Association), NCBI (National Council for the Blind of Ireland), National Association for Deaf People, National Training and Development Institute, Midlands Region, People with Disabilities of Ireland, St. Hilda's Service, Athlone, Multiple Sclerosis Society, Midlands, Westmeath Centre for Independent Living, Laois Centre for Independent Living, Laois Centre for Independent Living, Midland Health Board Personnel – Area Medical Officer, Occupational Therapy, Speech & Language Therapy, Physiotherapy, Community Physiotherapy.

Legislative Framework

- The right to a range of disability services must be enshrined in legislation.
- The status of the disabled needs to be increased in the eyes of the population and the increased status should be more visible in policies, legislation, strategies and plans.
- Enforcing the existing legislation on employment and opportunity.
- Applying conditionally to government and lotto allocations to sports, the arts etc to ensure the needs of those with disability are met in regard to access to social opportunities.
- The Minister and Health Board CEO needs to display commitment to the disabled by seeking where possible to have disabled persons attached to their teams –*'even as a form of tokenism at the outset'.*

Funding - Accessibility

- Health services must be free to all disabled persons.
- Health services should be free to all persons 0-18 years of age.
- Extension of the refundable schemes to include refund of GP fees for all disabled people if medical card not provided to all.
- More money should be allocated to disability services.
- The output from the disability database should be used for planning and to set budgets.
- Medical card is made available to all persons on the basis of need and not on income. Removal of the review of medical card eligibility and the review of domicilary allowance.

Package of Interventions

- Defining the package of promotive, preventive, diagnostic, treatment, rehabilitative and care interventions that all are available to disabled persons in the home, in the community, in hospital and in residential care.
- Requesting the Department of Health & Children to produce realistic costs for the range of appropriate interventions and services that should be available to those with disability.
- Ensuring that all children and adults including the disabled have access to 30 minutes of exercise each day as a health promotion initiative.

Needs Assessment

- Formal structures to support needs assessment, planning and evaluation are needed.
- Standards for service delivery should be set and published.
- Performance indicators for measuring progress towards achieving the standards should exist. The performance indicators should be used for monitoring and evaluation of services and their delivery.
- Developing evidence based protocols for delivering interventions and auditing to ensure compliance with good practice.
- Instituting periodic needs assessment and database update and validation.

Facilities

- Reinforcement of the policy on physical access to all buildings and auditing for compliance.
- New facilities and improvement/upgrading of existing facilities for residential and respite care of the disabled are required.
- Transport systems in general and in particular for the disabled should be improved and existing and future transport systems should be better co-ordinated.

Staffing

- Additional skilled-staff are required in the disability area – not enough exist currently.
- Defining staff to workload ratios for the package of interventions and ensuring the necessary numbers and skills-mix is available and funded.
- Strategies and incentives for retaining skilled and competent staff are needed.
- Ensuring that GPs are part of the multidisciplinary team providing services to disabled persons.
- GPs should have stronger links with disability services.

Structures

- Management structures in the MHB must facilitate voluntary providers in carrying out their role through streamlining the budgetary, monitoring and evaluation processes.
- MHB management structures need to be client focused.
- Representing the interests of persons with a disability on all consultative committees, which should review all legislation, policy and plans for disability sensitivity.
- Instituting network meetings that are attended by policymakers and users of services to deal with the gap in knowledge that currently exists between policymakers and users.
- Establishing other structures that ensure stakeholder representation in all planning and evaluation exercises and projects for services for persons with disabilities.
- Appropriate structures should be in place to reflect the multisectoral approach required for delivering services to disabled persons.
- Devolving budgets and the authority to make decisions to line management.
- Assigning a key-worker to persons with a disability including those with a mild disability.
- Local (Sectoral) Health and Education Committee need to exist to deal with disability issues including: appropriate equipment and technology to assist the disabled in learning and living.

Cost of Care

- The full economic cost of the care put into caring for the disabled by family members should be computed to highlight the value of such care to the state.
- Publication of the extent to which disability represents a cost on society.
- Carers allowance to families with disabled persons who carry the burden often at a hardship to themselves.
- Choices for the disabled: respite and carer relief with home assistance service.

Information / Communication / Awareness

- Better and more accessible information is required on: need; service available; interventions; standards and performance in terms of outputs and outcomes.
- There should be one point of contact for all services.
- Ensuring that services are user friendly with:
    - ease of access
    - simple information
    - simple language
    - simple forms
- Communication should be improved between deliverers and the public and between deliverers themselves and the complaints system should be used as a monitoring tool and as a learning tool for quality improvement.
- Instituting campaigns that enhance awareness in the community of the contribution that can be made to society by persons with a disability.
- Appointing facilitators to assist persons with disabilities in gaining access to services, making choices and using services.

(2) COMMUNITY VOLUNTARY GROUP

OFFALY COMMUNITY FORUM

(In attendance representatives from Barnardos, IWA, Tullamore Youth Initiative, Harbour Centre (for the out of home), GROW, Bracknagh Women's Group, Tullamore Travellers Movement, Friends of Ofalia House).

- Systems to deal with the housing needs of people with disabilities must be streamlined in order to ensure a speedy, efficient and effective response. The current piloting of one-stop shops under the REACH initiative is seen as pivotal in relation to this difficulty.
- As has been mentioned, transport is a vital requirement, particularly for certain client groups, which includes people with disabilities. Accessible transport is necessary in order to enable people with disabilities to participate fully in society.

MENTAL HEALTH

ISSUES RAISED

(1) USERS

(10 users of Mental Health Services)

Respect

- Doctors need to treat people with respect.

Service Provision

- Administrative errors e.g. forgetting to label bloods should not happen, losing test results should not happen.
- Diagnosis over the phone is not acceptable.

Home Visits

- Locums or covering doctors should not be miles away and should be responsive and willing to visit.

(2) VOLUNTARY AGENCIES

(Midland Alliance for Mental Health. Representatives from: GROW, Schizophrenia Ireland/Phrenz, Alzheimer Society Ireland, Samaritans, Bodywhys, AWARE).

Services

- Inadequate counselling/psychotherapy services.
- Alternative therapies not readily available.
- Rotation of NCHD – unsatisfactory for professional patient relationship.
- Lack of choice.
    - Community Mental Health Service and/or Psychiatrist – Sectorisation of service has limited choice for service user.

Service hours not flexible.

- 9-5 not adequate and lack of availability of a community based service during weekend hours.
- Non availability of a 24-hour mental health crisis support service.
- Lack of recognition of out-of-hours input of volunteers.

Stigma

- Stigma – mental health service –"poor relation".
- Stigma and discrimination attached to mental illness.
- Mental illness often viewed as a life long illness unlike some physical illnesses.

Consultation

- Lack of consultations
  - between service user and professional
  - professional and carer
  - voluntary organisations and local
- Lack of commitment to advocacy for the service user or carer

Funding

- Funding not adequate.

Training

- Voluntary organisations not sufficiently involved in staff training programmes for health professionals.
- There are no training/ information strategies for carers around the nature of mental illness, signs and symptoms and or how to look after their own mental health.

Structures

- Inadequate appropriate accommodation for service users being discharged into the community.
- Waiting areas often too busy or inappropriately located as part of another service.

Needs Assessment/Planning

- Service user not involved in the planning, implementation and or evaluation of projects.
- Service users not involved in identifying their needs and individual coping strategies that could lead to a need led programme for personal development and over coming the stigma attached to mental illness.
- Limited consultation with voluntary organisation in similar processes.
- Research of mental illness largely funded by multi- national pharmaceutical companies. This is not desirable and should be challenged.
- Gateway drugs too accessible

Carers

- Insufficient support for the carer.
- Caring for someone with a mental illness is very stressful.
- The carer needs of a family member with mental illness can vary.
- Substantially than with someone with a learning disability. This can stem largely form the fact that the focus is on the mental illness rather than the carer's own needs.
- Carers find it difficult to access information about the nature.
- Prognosis and treatment of the mental illness.
- It was viewed that Care Plans are beneficial but the carer(s) is often not involved in this process.
- Carer in mental health services largely having to cope with the stigma
- Of the mental illness and often do not see any end to the situation. They have to deal on their own with the vulnerability of the persons in terms of social integration and employment opportunities.

Young People and Mental Health

- Existing Mental Health Services not attractive or appropriate for the young person or their families.
- Underage drinking not sufficiently tackled.

Voluntary Organisations

- Limited vision of the role of the potential of voluntary organisation.
- Difficult to recruit volunteers.
- Consideration be given to allocating tax credits to volunteers to coincide with the fact that tax credit is given to organisations who donate money to voluntary organisations.

Consultation Process

- The consultation process for the "Health Strategy" is more geared towards a statutory lead response.

NAPS - National Anti Poverty Strategy.

- The groups that we viewed as most vulnerable and who may feel uncomfortable about accessing mental health services are:
  - -Travellers
  - -Lone Parents
  - Long term unemployed
  - Refugee/Asylum Seekers
- Consideration to bringing the service to them and meet their needs.
- Keep the mental illness jargon to a minimum.
- Make allowances for lack of literacy skills.
- Be sensitive to their perception of mental illness.

(3) VOLUNTARY AGENCIES

(Health Service Providers GROW, AWARE, Mental health Association Irl., Health Promotion, Mental Health Service Workers, Hospice Services)

Legislation

- Existing legislation is out-dated:- low priority in developing new legislation.
- No national policy directing Mental Health Service planning and development.
- Poor understanding of concept of 'Mental Health/Illness' within the Department of Health and the Health Boards.

Resources

- Lack of resources – both human and other.

Infrastructure

- The settings within the Mental Health Services are not always appropriate/suitable for delivering the ideal service.

Service

- People at 'high risk of mental illness' are now given due priority/recognition.

Mental health Promotion

- There is a huge opportunity for mental health promotion.

Choice

- There is a very limited choice for patients on the Consultant who treats them.

Psychology Service-Schools

- The school's psychology service is a separate service at present and is therefore a stigmatising experience for the children who use the service.

(4) VOLUNTARY AGENCIES

(Longford Drugs Awareness Group, Athlone Drugs Awareness Group).

Planning

- Healthcare long-term planning shambles and totally dependent on funding

Health Board Size

- Is the M.H.B. too big for everyone to get a voice?

Waiting Lists

- Waiting lists

Needs vs Funding

- Local communities can identify needs yet funding not available

Communication within the Board

- Integration within the M.H.B. section doesn't communicated with each other

Border Areas of Health Boards

- Insecurity of being located between two Health Boards (Athlone/Longford = WHB & MHB).

Service Agreements

- Openness in terms of service agreements and what people can expect.

Regional disparity

- Perceived disparity in provision of services in region e.g. A&E, 24 hour casualty, off peak hospital service.
- Longford poor relation in Midland Health Board – loosing out to regional approach small therefore don't have off peak hospital service.

(5) STATUTORY SERVICES

(Gardai, Probation & Welfare Service Views of 2 Chief Superintendents and one Senior Probation & Welfare Officer).

- Getting GPs on board in terms of the methadone service – waiting list is unacceptable.

PROPOSALS FOR CHANGE

(1) USERS

(10 users of mental health services)

Respect/Dignity of patient

- The system needs to change i.e. there should be more doctors who would then have the time to treat people properly.
- Doctors need training in how they treat people.
- People being able to comment on services, anonymously.

User Friendly Forms

- Forms need to be user friendly and catering to all groups, e.g. Literacy issues

Communication

- Better communication.

Flexibility of service

- The service should be more flexible in terms of house and home visits.

(2) VOLUNTARY AGENCIES

(Midland Alliance for Mental Health.Representatives from: GROW, Schizophrenia Ireland/Phrenz, Alzheimer Society Ireland, Samaritans, Bodywhys, AWARE).

Health Service

- That the health services be fair, appropriate and accessible irrespective of income.

Mental Health Services should provide:

- Choice
- Empowerment to service users and their carers.
- Information on entitlements and supports.
- Appropriate - meets the specific needs of individual mental health service users and their carers.
- Planned and delivered through regular consultations.

- Partnerships be developed on a firm footing.

Funding/Resources

- Health service should be well funded and staffed to incorporate different service user needs.
- Improve resources of the voluntary sector to encourage them to lead and initiate change.

Standards

- That standards of good practice and quality be established and monitored.

Legislation

- New Mental Treatment Act should be enacted – there appears to be a lack of commitment to it. It has low priority and has not been afforded high priority or commitment to its implementation.
- That consideration be given to attaching statutory powers to the Inspector of Mental Health Services to ensure his recommendations are implemented.

Equality/Discrimination

- Need to review equal opportunities and mental illness in relation to
- recent Equality Legalisation so that the service user does not experience discrimination because of a mental illness experience.
- P.U.M. forms are readily used for convenience, this remains a lasting
- record attached to the service users personal records.

Dignity

- Service providers to be aware of the dignity of the service user.
- A Health Service gives guarantee of confidentiality.

Care Plans

- Establish *care plans* for all service users and their carers that are practical and manageable.
- Identify training needs of service users and carers to be better advocates.

Counselling Services

- Develop and improve counselling services.

Communication

- More communication and consultation between the different partnerships.
- Provide more training to key communicators re roles and supports available through the voluntary sector.

Partnerships

- There is a need to ‘partnership’ on a better platform/forum so that when voluntary organisations are at the “table” with the statutory structure there is equality with a genuine commitment to consultation and working in partnerships.

Voluntary organisations

- Funding be guaranteed so that voluntary organisations are not struggling or "limping" along to achieve their aims and objectives.
- That the input of the voluntary organisation into service delivery be recognised and clearly established.
- GPs need to be more informed of the role and likely benefits/supports that voluntary organisations can provide.
- Voluntary organisations need higher profiles through out education systems –from primary to third level.
- Need to look at best practices and be able to adapt them and to share experiences.
- Voluntary sector can be a good voice for the service user.

Access

- Service need to be more user friendly and flexible.
- Accessibility – physical access to the service, some CMHC services not wheelchair friendly and or suitable for use by persons with other forms of disability.
- Accessibility of information – service users their carers be more informed of the role and functions of Community Mental Health Service, the range of professionals that work there.
- Accessibility is affected by the stigma that can be associated with Mental Health Services/Mental Illness.
- Mental Health Service be a central point of contact for local voluntary organisations and other voluntary groups.
- Develop Community Mental Health Centres or Drop-in Centres so that someone with a mental health problem can walk in without the requirement of a referral letter.

Flexible Service

Provide alternative service outside of 9-5.

Research

- Expand and carry out research into alternative therapies.

Consultation Process

- Better equity in consultation process, not the professional v the service user.

(3) VOLUNTARY AGENCIES
Health Service Providers GROW, AWARE, Mental health Association Irl., Health Promotion, Mental Health Service Workers, Hospice Services)

Legislative Framework/National Policy

- Update existing legislation.
- Develop a Mental Health Promotion Policy at national level.
- Joint service planning between the government departments (Dept. of Health, Dept. of Social, Community and Family Affairs) and interagency, (NAPS, Housing, Education) around health but especially mental health.

- Need a dedicated national focus on counselling services. "Peer support" counselling an option to complement professional counselling service.
- Equal status Act 2000 must be incorporated and awareness/knowledge of this increased.

Funding

- Ring fencing of funding to give autonomy and importance to Mental Health Services.
  - More funding:
  - Capital Funding
  - Mental Health Promotion
  - Mental Health Service in general.

Staffing

- Need to increase the number of consultant psychiatrists and psychologists:
  - Permanent contracts:- Reduce staff turnover.
  - Improved expertise base.
  - Improved patient choice.
  - Improved patient care.
- Needs for specialist workers or generic workers with specialist interests/skills.
- Support for Parents with children who have mental health difficulties.

Infrastructure

- Buildings and infrastructure of Mental Health Service in need of capital investment and planning. Old buildings are 'terrifying' and add to the negative stigma.

Carers

- Carer's 'Means Test' should be abolished immediately in recognition of their contribution to the health services and the community.
- Carers' mental health needs to be recognised.

Mental Health/Health Promotion

- All planning processes should address the 'Health Question'.
- Mental Health should be incorporated with Occupational/workplace Health and Safety programmes and risk assessment. Positive mental health should be promoted and addressed at all levels within all workplaces, addressing bullying, working conditions etc.
- Greater focus on preventing mental illness and recognising people who are at a high risk of mental distress.
- Stronger emphasis on Mental Health (Positive Mental Health, Mental Health Promotion).
- Mental Health should be prioritised and 'lobbied' at local, regional and national levels through community development action and community groups.
- Mental Health and Mental Health Promotion should be incorporated within the Education system as part of the 'Health Promoting School' project.

Literature

- Literature should be available to all and in many formats and languages.

Voluntary organisations

Voluntary organisations should have a voice and a platform.

Psychology Service - Schools

- All schools should have an accessible and equitable psychology service. It should also be incorporated into the normal development screening service provided within the schools.

Transport

- Public transport service should be developed and planned around the health service provision, especially in rural areas.

Attitudinal

- Reduction of 'Stigma' associated with Mental Illness.
- Need a change of thinking or 'mindset'.
- Need to breakdown stereotypes and culture of 'elitism' within the services.

Client Centred

- The Mental Health Service should be client centred incorporating empowerment and consultation within the service planning process. The prime users of the service must have a voice.

Access

- The Mental Health Service provision and delivery should be locally based and accessible to the local community.

Training

- Increased Mental Health training/education for all health professional especially GP's.

VOLUNTARY AGENCIES

(Longford Drugs Awareness Group, Athlone Drugs Awareness Group)

Ambulance Service

- Development of Ambulance Service throughout the Region.

Access

- Community Health Service – brings service to people or provide transport.

CHILDREN & FAMILIES

ISSUES RAISED

(1) USERS/VOLUNTARY ORGANISATIONS

(Barnardos staff in Athlone Children & Family Centre, Edenderry Family Centre and Tullamore Family Support Centre along with consultation with two individual service users).

Quality

- Two-tiered system where level of income and/or access to private health insurance has a direct correlation to quality of service (if any) received.
- Poor communication between sectors with resulting negative impact on quality of service to users.
- Absence of clear national standards of good practice re service provision against which performance can be measured.
- Lack of information available to the public.

Services

- Lack of early assessment, intervention, respite care.
- Scarcity of specialists services.
- Lack of female G.P.'s.
- Lack of services for children with psychiatric problems. "Child Guidance – restrictive referral process i.e., through G.P. service only, long waiting lists.
- Psychological Referrals – long waiting lists/ crisis intervention.
- Children in mainstream education with special needs have difficulty assessing services i.e. Speech Therapy and Physiotherapy.
- There is no accident and emergency unit in Athlone.

Lack of access

- Long waiting lists for medical card holders
- Lack of choice
- Transport difficulties (in particular for children, families and the elderly in Rural areas or sprawling urban areas)
- Individuals or families who are marginalised experience particular difficulties in accessing information/services and exercising their rights.
- Costs of children's health care make many parents have to consider if they can afford to bring their child to the doctor." - Exasperated where has special medical needs.
- Difficulties in accessing what information is available due to literacy difficulties or special needs

Poverty

- Cost is often a prohibitive factor
- Family Commitments/Context e.g.
- Carer of relative
- Child Care Commitments
- Multi-problem family

- Inappropriate/insensitive treatment by health service staff. – the attitude of some health care staff has been experienced by families as superior and unsupportive.
- Prejudice – lack of respect for cultural background of service user.
- Non User-friendly environment for children and young people.

(2) COMMUNITY VOLUNTARY GROUPS

OFFALY COMMUNITY FORUM
(Children, Childcare and Family Supports)

(In attendance representatives from Barnardos, IWA, Tullamore Youth Initiative, Harbour Centre (for the out of home), GROW, Bracknagh Women's Group, Tullamore Travellers Movement, Friends of Ofalia House).

- Services for children who are in care and deemed to be at risk are considered to be grossly inadequate and in need of attention. Other preventative services at community level are considered to be inadequate. It was felt strongly that the current system is very reactive and needs to change to being highly proactive. Intervention is seen as much more desirable than crisis.
- Childcare is essential, both for parents and their children. The County Childcare Strategy Committees need to become more effective at local level in addressing this problem. Childcare in Ireland requires systematic investment, expansion and development.

(3) VOLUNTARY AGENCIES

(Youth Service Providers - In attendance representation from Tullamore Youth Initiative, Midland Regional Youth Service, Laois Youth Service, Foroige, Longford Youth Service).

- Lack of staffing (too much of a Fire Brigade response)
- Territorial issues
- Local personalities in Health Board affect responses
- Passing the buck (you cannot depend on all people)
- Understanding of Partnership at various levels within the system
- How consultation takes place with young people in terms of their needs, checks and balances
- Receptiveness, Openness and Transparency
- Listening acknowledging creative ideas

(4) COMMUNITY VOLUNTARY GROUPS

OFFALY COMMUNITY FORUM (Young People)

(In attendance representatives from Barnardos, IWA, Tullamore Youth Initiative, Harbour Centre (for the out of home), GROW, Bracknagh Women's Group, Tullamore Travellers Movement, Friends of Ofalia House).

- Parents are in need of support, particularly young parents. There is, however, a lack support services for parents and their children within the state.
- Youth information on healthcare is lacking and needs to be revamped and re-targeted urgently.
- There are few facilities, projects and information sources for young people.

(5) USERS/STATUTORY SERVICES

(Granard Action Project, Views of Women from the area and Mother & Toddler Group)

- People are not aware of where local facilities are and what is available to them.
- Not enough information or advertisements of services available especially when you have a baby.
- Quality of treatment received in hospitals.
- Waiting lists for health services.
- Young people are not made aware enough about teenage pregnancies.
- Women feel ashamed or embarrassed to get smear tests etc.
- Inadequate transport to facilitates.
- People living in cramped conditions.

(6) STATUTORY SERVICES

(Gardai, Probation & Welfare Service Views of 2 Chief Superintendents and one Senior Probation & Welfare Officer).

- Time frame of young people being seen by service providers.
- Falling through the school system – affects on health.
- Some staff inexperienced in terms of difficult children (residential services).
- 24 hour service re: Child Protection.

(7) SERVICE PROVIDERS

(FOSTER CARERS - Views of delegates of 5 branches of Irish Foster Care Association in M.H.B.)

- Lack of awareness by hospital staff of a list of authorised people who are mandated to sign medical consent forms on behalf of the Health Board in respect of medical treatment from foster child.
- Short notice that is sometimes given to have school medical consent forms signed.
- Change in schools (sometimes as a result of a breakdown in a placement) – sometimes results in child in foster care missing out on school medical services.
- Pre-placement Medical does not always happen before children are placed in care and very often where it does the medical is not as thorough as it should be.
- Lack of Family Room in Health Centres for Access Visit, with appropriate facilities and materials.
- Waiting lists for child guidance, speech therapy, child psychology too long.
- Lack of out-of-hours Social Work Service.
- Lack of a standardised system of investigating allegations of Abuse against Foster Carers.
- Shortage of Social Workers and Caseload size too large.

(8) STATUTORY SERVICES

(CHILD CARE ADVISORY COMMITTEE)

In attendance were Chairperson, Senior Clinical Psychologist, General Manager, Community Care Services – Laois/Offaly, Director of Public Health Nursing, Director of Child Care Service, Garda Inspector from Laois/Offaly Division, Secondary School Teacher, Psychiatric Nurse and Secretary to the Committee.

- Child Protection Services are normally delivered by staff from the middle income group to children and families in the lower socio-economic group.
- Services for children are delivered by public service and voluntary organisations. Within the Health Board structure these services are fragmented into various care groups. The question was raised as to whether there was merit in adopting a similar structure to Northern Ireland services where all services are within one management structure.

- Access to various services by GP referral. All children are not medical card holders, thus maybe denied treatment if parents cannot meet costs of GP visits.
- Sometimes there is a lack of sufficient time and resources to deal with the affects of new legislation.
- Accountability and transparency.
- Accommodation for services needs to be improved.
- Lack of reward/recognition for positive behaviour by staff.

It has been well documented that poverty has a significant impact on the health and well being of people.

PROPOSALS FOR CHANGE

(1) USERS/VOLUNTARY ORGANISATIONS

(Barnardos staff in Athlone Children & Family Centre, Edenderry Family Centre and Tullamore Family Support Centre along with consultation with two individual service users).

- Needs to be clearer information for the public on what health services are available and also how to access services
- Need for development of strategies to meet needs of adolescents, in particular personal health and well being

Needs/Assessment/Planning

- An assessment of local needs which are then matched with appropriate services.
- Real consultation with staff and service users within a realistic time scale before introducing new policies or practices.
- Adequate availability of all essential services.

Structures

- Hospitals should be upgraded and patient care improved.
- Upgrading of services for the elderly including residential care.
- Introduction of "well woman" and "well man" clinics.
- Childcare services need to be reasonable and responsive to the needs of parents when trying to get them to access services e.g. drop in childcare facilities – health centres – hospitals.
- Proper health records for a child's first sixteen years as in the UK.
- Health service departments working together.

Access

- Services which are accessible i.e. available and affordable/ free.
- Free medical care for all children (0-18 years).

- Development of measures to ensure people on a low income are able to access services especially primary preventative care.

Staff

- An environment of respect for patients needs and rights needs to be developed amongst all Health Care services through staff training, staff supervision etc.

Information

- A heart and lung unit for cystic fibrosis children.

(2) COMMUNITY VOLUNTARY GROUPS

OFFALY COMMUNITY FORUM (Children, Childcare and Family Supports)

(In attendance representatives from Barnardos, IWA, Tullamore Youth Initiative, Harbour Centre (for the out of home), GROW, Bracknagh Women's Group, Tullamore Travellers Movement, Friends of Ofalia House).

- More co-ordination and planning of the County Childcare Committee process is necessary if the childcare difficulties currently evident nation-wide are to be rectified.
- A drop-in childcare service should be examined for members of the public who have short-term emergency day-care needs. The childcare needs of health service employees must also be addressed as part of a quality healthcare service. Family support services should be one of the underpinning principles of the new healthcare system.
- Responsibility for family support currently rests with a number of departments. It is recommended that one department assume overall responsibility for the co-ordination of family services and the delivery of financial support in order to attain quality delivery of such services.
- The availability of nutritious meals within schools should be investigated in order to promote diet and lifestyle change in young people. Such a service need not be free, but should be affordable for all.

(3) VOLUNTARY AGENCIES

(Youth Service Providers- In attendance representation from Tullamore Youth Initiative, Midland Regional Youth Service, Laois Youth Service, Foroige, Longford Youth Service).

Information

- Provision of information - not only within health service buildings.
- Awareness of Information (Types of services available, Resources available).
- More accessible service (Access to information, Young people – freely available).

Perception of Board

- Change the perception of how the Health Board works.

- Health Board should challenge misinformation about its services and promote existing and new developments.

Prevention

- Emphasis on prevention – rather than corrective actions. Pro-active approach.

Partnership

- Developing a concept of Partnership throughout the organisation through: training, promotion of concept, open to change.

(4) COMMUNITY VOLUNTARY GROUPS

OFFALY COMMUNITY FORUM (Young People)

(In attendance representatives from Barnardos, IWA, Tullamore Youth Initiative, Harbour Centre (for the out of home), GROW, Bracknagh Women's Group, Tullamore Travellers Movement, Friends of Ofalia House).

- Specific childcare supports should be made available to young parents who wish to access training and employment and hence improve their quality of life. Interdepartmental co-operation should be employed in delivering such services, which could be located in local health centres.
- Youth counselling and information strategies should be developed in co-operation with groups active in youth work/issues.
- Preventative education is important and should be delivered in an integrated manner, with a particular emphasis on education in schools to ensure healthy practices among young people which will last for life.
- Community Care budgets should reflect the need to develop youth services in the community, particularly the development and sustainability of Neighbourhood Youth Projects and the establishment of Drop-in and Information Centres for youth. These centres should integrate local agencies in the provision of a one-stop-shop service for young people which is holistic and responsive.

(5) USERS/STATUTORY SERVICES

(Granard Action Project and Women from the area and Mother & Toddler Group)

Information

A booklet given to each mother/parent after having a child to know where locally services are for them and when and where they need to have check ups for their child and themselves.

Services

- More contraception information is needed on health issues such as smear tests and breast examination.
- Free consultation for U16.

Staff

- More home visits need to be made from specialist services
- People in ambulance need to be trained as paramedics for the scene of an accident.

Linkage/Continuity of Care

- Better liaison with Department of Social Welfare & Health Services
- Transport needs to be made available to Health Services

Care/Services in the Community

- Housing transfers should be facilitated by the County Council where it is clear that families needs are not being met.

(6) STATUTORY SERVICES

(Gardai, Probation & Welfare Service Views of 2 Chief Superintendents and one Senior Probation & Welfare Officer).

- More accessible service with earlier interventions
- 24-hour service
- More focus towards pro-active preventative work
- Infrastructure developed for co-ordinated responses – appointment of key personnel within each organisation
- Clear time frame of activities/responsibilities
- Development of trust & understanding in terms of roles and responsibilities
- Sharing of information/feedback within appropriate settings
- Joint training
- Holistic approach

(7) SERVICE PROVIDERS

(FOSTER CARERS - Views of delegates of 5 branches of Irish Foster Care Association in M.H.B.)

No proposals made

(8) STATUTORY SERVICES

(CHILD CARE ADVISORY COMMITTEE)

In attendance were Chairperson, Senior Clinical Psychologist, General Manager, Community Care Services – Laois/Offaly, Director of Public Health Nursing, Director of Child Care Service, Garda Inspector from Laois/Offaly Division, Secondary School Teacher, Psychiatric Nurse and Secretary to the Committee.

- Increased consultation and participation by service users necessary.
- Provide medical cards to all children up to the age of 18 years.
- Self-referral to service may also be appropriate.

- Develop further the current consultation processes with the service users and their carers.
- Improve planning to ensure appropriate “lead in time” for all new legislation.
- Continue to improve systems to increase current levels of accountability and transparency.
- Match appropriate capital costs to each new head of staff. Provide capital programme to ensure customer friendly appropriate premises for all services.
- Provide focussed programmes appropriate to client needs e.g. budgeting programmes, nutrition programmes, and health programme for various marginalised groups.
- Encourage positive behaviour of staff through recognition e.g. development of specialised senior posts.

WOMEN'S HEALTH

ISSUES RAISED

(1) USERS

(23 female participants from lower socio-economic group in Boards area and group of disadvantaged women [22]).

- Nowhere to go except to GP who is often 'too busy'.
- Limited access to Female GP for particular "female problems".
- Lack of knowledge regarding health issues, services and entitlements.
- Lack of local services.
- Lack of Drop-in/Resource Centre
- Lack of transport.
- Lack of availability of services outside hours.
- Lack of information – lack of information people can understand.
- Difficulties with relationship with professionals sometimes due to lack of confidence on part of patient, often due to not being treated with respect and dignity.
- No counselling services – no service for when things go wrong if the problem is not medical.
- Schools service inadequate – e.g. dental, aural, sight.
- No free medication for long term illnesses (asthma etc).
- Communication is generally weak.
- Students – no automatic entitlement to medical cards.
- Waiting lists.
- Inadequate services re drugs/alcohol – rehabilitation not widely available and not locally available – Not targeting young people enough – national schools.
- Government – getting priorities right.
- Don't ensure that services are equally available to all.

(2) VOLUNTARY/STATUTORY SERVICES

(Women's Health Advisory Committee. In attendance 6 Health Board Staff and National Women's Council representative).

- Consultant control of services.
- Glaring lack of women in decision making process – why are ministers appointees to health boards not representative of women.
- Gender composition – health boards – management teams – steering group of strategy.
- Structure of Boards – political arena – politically driven services.
- Access – women have different access needs – childcare, respite, transport, time, money.
- Transport – no co-ordination – linked to availability of out of hours service.
- Attitudinal access – inflexible, rigid, bureaucratic service shaped to suit provider.
- Need more focus on supporting parents – also high-risk groups.
- Need more provision of health protective elements and counselling.
- Lack of quality mental health service and promotion.
- Contract of GP with Health Boards

- Lack of legislative principles for GPs.
- Persistence of medical model.
- Newness of strategic thinking.
- Lack of leadership from DOH e.g. women's health.
- Lack of balanced media – need to disseminate lessons learned and the positive side.
- Resources.
- Actual lack of beds.
- Private/public mix.
- Complexity of service – makes integrated service difficult although the various specialisms are necessary (lack of understanding of this is linked to media point above).
- Understanding of health not equal to understanding health services.
- Need systematic resourced consultation – where consultation is ineffective it is worse than nothing.
- Equity issues with E systems – test assumption that all population groups have access.
- Literacy problems.
- Waiting lists.
- No integrated system.

(3) COMMUNITY VOLUNTARY GROUPS

OFFALY COMMUNITY FORUM

(In attendance representatives from Barnardos, IWA, Tullamore Youth Initiative, Harbour Centre (for the out of home), GROW, Bracknagh Women's Group, Tullamore Travellers Movement, Friends of Ofalia House).

- Women's health is at risk due to the cost of assessing screening systems and a dearth of information on the importance of being aware of the risks, causes, symptoms and effects of cancers and infections.

Men

- There is no men's health strategy, a glaring omission in the current climate.

(4) STATUTORY SERVICES

(Gardai, Probation & Welfare Service Views of 2 Chief Superintendents and one Senior Probation & Welfare Officer).

Lack of Refuge Centre (Domestic violence etc.) (women and children) Offaly.

PROPOSALS FOR CHANGE

(1) USERS

(23 female participants from lower socio-economic group in Boards area and group of disadvantaged women [22]).

- Provide information and resources around health issue to facilitate people having more control over their health.
- Provide comprehensive, user-friendly information services.
- Establish clinics or centres with the range of required services, and to have these adequately staffed.
- Counselling services should be available. It is important that people would be able to self-refer.
- Provide childcare to help people on social welfare return to education or to take up employment.
- Delivery of all services should take account of the dignity of the person and be based on respect for the individual client at all times.
- Support groups and centres should be established, with the government providing the necessary resources.
- Provide services on a local basis, including
  - Casualty
  - GP on call – 24 hour
  - Social Welfare
  - Guards
  - Social worker – early response to call necessary from these
  - Family support/counselling
  - Midwife – to check people locally rather than travel to hospital unnecessarily
  - Drugs/Alcohol service
  - Well Woman Centre

- Ensuring private sector does not take away from public sector care.
- More respite care.
- Adequate support to facilitate independence of the elderly.
- Adequate services and supports for carers.
- Treatments like dialysis, chemotherapy more locally available – where this is not possible, the effect of distance on the patient should be addressed, and on their family.
- Hospital appointments quicker.
- Services for men.

(2) VOLUNTARY/STATUTORY SERVICES

(Women's Health Advisory Committee. In attendance 6 Health Board staff and Women's Council representative).

- Revise consultant contract.
- Look at skills mix necessary to support consultants. Is separate team necessary for each consultant?
- Separate private/public. 1st loyalty should be to public patient.
- Develop quality mental health service with stronger focus on promotion and prevention.

- Consumer focus must be developed.
- Well woman centres in every town.
- Stronger structures for women's health, with identified leadership role for Dept. of Health & Children, Women's Health Council.
- Establish HEBE (Health Boards Executive Agency) to enhance joint healthboard work.
- Need integrated patient information system – smart swipe cards – mapping of medical history.
- Incorporate all of the WH issues in the national strategy.
- Integrate primary and acute services – dedicated understandable pathways.
- Women's health needs to be integrated into all service lines of DOH.
- National carers strategy with funding from Dept. of Finance.
- Dedicated funding for regional parenting support programme.
- Implement Best health for Children & Families.
- Develop protocols on violence against women.
- Parents of rehab drug users – support for.
- Develop minimum standards of FP with free access to and choice of provider.
- FP clinics in every health Board region.
- Provision of teenage clinics tailored to requirements of the age group.
- Provision of a comprehensive screening clinic for STIs in every region.
- The inclusion of Health on National anti poverty strategy Agenda.
- Legitimacy for health promotion in all areas of health service, built into service provision, and built into structures at all levels.
- Liaison person to deal with cultural ethnic difficulties – Interpretative services.

(3) COMMUNITY VOLUNTARY GROUP

OFFALY COMMUNITY FORUM

(In attendance representatives from Barnardos, IWA, Tullamore Youth Initiative, Harbour Centre (for the out of home), GROW, Bracknagh Women's Group, Tullamore Travellers Movement, Friends of Ofalia House).

- The Women's Health Strategy should be implemented in full and free access to cervical smear and breast check services should be made available to all women.
- Women need greater access to information on women's health, particularly in relation to the prevention of illnesses in later life, reproductive health and the importance of a healthy diet and nutrition in their lives.
- Women living in poverty and experiencing social exclusion need to be particularly targeted, and innovative ways of so doing should be explored with relevant non-Governmental organisations at national and local level.

Men

- There is a need to develop a Men's Health Strategy in co-operation with agencies particularly concerned with men's issues. Men are less likely to engage with health systems, but have high incidences of chronic illness which could have been minimised with early diagnosis.

(4) STATUTORY SERVICES

(Gardai, Probation & Welfare Service Views of 2 Chief Superintendents and one Senior Probation & Welfare Officer).

- Please refer to full consultation document with Garda, Probation & Welfare Service.

CARERS

ISSUES RAISED

USERS

(61 "Carers in the Home" in Laois/Offaly and 74 "Carers in the Home" in Longford/Westmeath).

- Carers often require specialist services which they may not even know exist, let alone know how to access.
- Lack of seamless service.
- No specialist services exist for young Carers.
- Practitioners are not adequately trained to work with young Carers.
- Health Care professionals do not currently have any measures in place to adopt principles of involving and encouraging Carers.
- There is currently no training strategy for Carers.
- Communication is extremely poor between members of the multidisciplinary team.

PROPOSALS FOR CHANGE

USERS

(61 "Carers in the Home" in Laois/Offaly and 74 "Carers in the Home" in Longford/Westmeath).

Strategic

- A National Strategy specific to Carers.
- The service for carers should be rapid, responsive and accessible.

Day Care Service

- Day Care Services need to open earlier and close later.
- Day Care Services need to provide adequate activities and stimulation for the people who attend in order to encourage them to continue attending.
- Rehab services should be an integral part of all day care services.

Respite services

- Need to be sensitive to the role and needs of the Carer.
- When appropriate, should provide respite care within the Carer's Home.
- Should cover reasonably long periods of time to allow for carer to go on holiday, i.e. two weeks.

- Cater for shorter periods, i.e. week-end or long respite at week-ends.
- Should allow the Carer the opportunity to work some hours or avail of a training programme.
- Needs to be more flexible – some services are rigid, pre-determined and 'take it or leave it' is the attitude.

- Provide emergency respite in the event of a crisis in the home.

Home Helps

- Should be adequately trained and competent to carry out their duties.
- The service needs to span over 24 hours.
- The Home Help job description requires re-definition.
- Should provide an emergency response service, specifically for Carers.

Customer Care

- Service Providers and Professionals need welcoming and encouraging in attitude.
- Customer Care training required.
- PHN services need to incorporate a Carer Care Plan.
- Carers working in Partnership with service providers.

Information Services

- Help Line for Carers
- To hand information for Carers should include:
  - respite care
  - social services
  - PHN service
  - Financial benefits and entitlements
  - Carers rights
  - Crisis support
  - Day care services
  - Carer support groups
  - Stress management programmes

ASYLUM SEEKERS / REFUGEES

ISSUES RAISED

(1) USERS

(6 Asylum Seeker Families)

The government enforced barrier on employment was by far the largest issues affecting their lives, health and well being.

- That their accommodation or any of the options of hotels, hostels, apartments and mobile homes are only suitable in the short-term.
- That it is unreasonable and inequitable to keep people and families in these conditions for any extended period.
- That the impacts of this policy are:
  - contributing to social exclusion of asylum-seekers.
  - having negative impact on their physical and mental health.
  - creating tension and confrontation between families and ethnic groups.
- Dietary requirement, choice and control over food, nutrition is severely restricted and unacceptable and undignified.
- That the government-set targets in processing time for applications for refugee status are not been met, with subsequent stress/uncertainty and curtailment to participation and integration in the economy and society.
- That the group expressed satisfaction with and appreciation of the educational facilities made available to their children. They were also appreciative of the language classes given to adults.

(2) VOLUNTARY

(Asylum Seeker Support Group)

- That government policies and responses are inequitable and induce or exacerbate social exclusion.
- That work permits should be granted to asylum-seekers after 6 months in Ireland.
- That government "disposes" of its obligations to integrate asylum seekers and refugees by dispensing inadequate and inequitable grants to voluntary groups, who are then left with this responsibility.

(3) SERVICE PROVIDERS

(Community Welfare Officers/ Professionals/Colleagues Other Boards)

- There is a lack of clear rules and regulations from a national perspective, and a consequent variation in responses and outcomes of service delivery to asylum seekers.

(4) COMMUNITY VOLUNTARY GROUPS

OFFALY COMMUNITY FORUM

In attendance representatives from Barnardos, IWA, Tullamore Youth Initiative, Harbour Centre (for the out of home), GROW, Bracknagh Women's Group, Tullamore Travellers Movement, Friends of Ofalia House).

- Translation services are inadequate to effectively service the medical and health support needs of people whose first language is not English. This service exists in large urban centres, but is not available in rural communities.

PROPOSALS FOR CHANGE

(1) USERS

(6 Asylum Seeker Families)

- That government reverse its ploy of not allowing Asylum Seekers to work.
- An inventory of the skills, qualifications and work experience of Asylum Seekers to be completed and this inventory to be examined against current labour shortages.
- ***"that government agree and implement a time-limit for keeping people and families in Direct Provision"***
- ***"that subject to where personal cooking facilities exist on Direct Provision sites, asylum seekers be allowed the choice of eating in the canteens or being provided with or allowed to obtain the raw ingredients to do their cooking in privacy"***
- ***"government clarify its policy regarding asylum seekers who are parents of Irish-born children, their right to leave Direct Provision and the timeframe within which they can exercise that right"***
- ***"that more training and educational opportunities for adult asylum seekers be provided"***

(2) VOLUNTARY

(Asylum Seeker Support Group)

- That there should be more recreational facilities, particularly for children, at Direct Provision sites.
- Statutory bodies should apply a minimum of bureaucracy in allowing these recreational facilities to be developed, thus **promoting exercise and good health practices for children.**
- The voluntary group would welcome **active participation** and support from Irish citizens in integrating asylum seekers and consider that political and statutory leadership has a significant role to play in getting this message across.
- That there should be more responsible and accurate media reporting.

(3) SERVICE PROVIDERS

(Community Welfare Officers/ Professionals/ Colleagues Other Boards)

- There is a need for development of training programmes for staff who deal with asylum seekers, particularly in areas that would enhance awareness of cultural differences and how to deal with those differences.
- The Health Services should also be supportive of General Practitioners, who are coping with the considerable challenge in the delivery of quality healthcare to asylum seekers and their families.
- The General Practitioners would welcome the development of strategies and programmes that:
  - Maximise asylum seeker's awareness, appreciation and expectations of the workings of the Irish Health Services.
  - Facilitate asylum seekers to disclose full information of their medical histories that will assist appropriate treatment.
  - Address language barriers so as to optimise diagnosis and treatment and maintain the ethos of the informed consent of the patients.
- Health Boards and Health authorities need to engage in service provision and advocacy with other involved and empowered organisations to optimise the likelihood that asylum seekers will receive the same positive outcomes that are envisaged for everyone in the new Health Strategy.

(4) COMMUNITY VOLUNTARY GROUPS

OFFALY COMMUNITY FORUM

(In attendance representatives from Barnardos, IWA, Tullamore Youth Initiative, Harbour Centre (for the out of home), GROW, Bracknagh Women's Group, Tullamore Travellers Movement, Friends of Ofalia House).

- Translation services must be provided in each Health Board area. Interdepartmental co-operation on the language training needs of people whose first language is not English is necessary.

TRAVELLERS

ISSUES RAISED

(1) USERS / SERVICE PROVIDERS

[(A) 25 Traveller Women attending Training Centre, Mullingar and 2 staff at Centre (B) 9 Traveller Women who are receiving training in Health Care provision consulted 20 Traveller families and (C) Consultation with Tullamore Travellers Movement].

- Lack of information and support service while waiting to be referred or treated.
- Long waiting times from referral to consultant.
- Clinic appointment system need to be addressed – appointment times, facilities, contact with Travellers to remind them of appointments.
- Language difficulties –foreign staff and the medical words used by staff.
- Lack of information available and poor advertising of the health services for Traveller men.
- Child care facilities in out-patients clinics.
- Service not friendly.
- Culture awareness.
- Poor awareness of literacy problems with Traveller Community.
- Better accommodation.
- Poor halting sites, with no hygiene / sanitation facilities or general public service e.g. public telephones.

(2) COMMUNITY VOLUNTARY GROUPS

OFFALY COMMUNITY FORUM

(In attendance representatives from Barnardos, IWA, Tullamore Youth Initiative, Harbour Centre (for the out of home), GROW, Bracknagh Women's Group, Tullamore Travellers Movement, Friends of Ofalia House).

- Traveller Health Services do not have enough priority nationally, with GP discrimination and a lack of intercultural awareness by Healthcare staff.
- The Traveller's Health Strategy has still not been published, a cause for concern in terms of public perception and policy.

PROPOSALS FOR CHANGE

(1) USERS / SERVICE PROVIDERS

[(A) 25 Traveller Women attending Training Centre, Mullingar and 2 staff at Centre

(B) 9 Traveller Women who are receiving training in Health Care provision consulted 20 Traveller families and

(C) Consultation with Tullamore Travellers Movement].

- More health information.
- Health promotion that is easily understood.
- Health promotion for Traveller men.
- Advertise Health Services for men.
- Individual clinic appointments and reduced waiting times – a "friendly" quick, open health service.
- Language used needs to be "user friendly".
- Support and information for people waiting for treatment.
- Follow up telephone calls to remind traveller of outpatient appointments.
- Screening services – more information on service available and information on the reasons for screening. If service for women then female doctor should be available.
- Mobile clinics for Travellers to go out to communities and accommodation sites (Halting).
- Staff Training on travelling culture.
- Crèche facilities for children while using the health services.
- Accommodation appropriate for Travellers needs.
- Consultation with Travellers on their needs.

(2) COMMUNITY VOLUNTARY GROUP

OFFALY COMMUNITY FORUM

(In attendance representatives from Barnardos, IWA, Tullamore Youth Initiative, Harbour Centre (for the out of home), GROW, Bracknagh Women's Group, Tullamore Travellers Movement, Friends of Ofalia House).

- The Traveller's Health Strategy should be published and implemented as a priority.
- Interagency co-operation in the delivery of services to members of the travelling community is vital in the context of a holistic resolution to the issues of Traveller health. In particular, the accommodation needs of the Travelling Community need to be health-proofed.

HOMELESSNESS

ISSUES RAISED

(1) USERS

(5 men who are homeless)

"Our strongest view is that there is a prevalent belief in society that homelessness is a self-inflicted condition. This misguided belief needs to be challenged". Homelessness is quite often an outcome or consequence of mental illness, addiction(s), social disadvantage and/or psychological disorders.

- Procedures should be put in place to ensure that homeless people are guaranteed a percentage share of local authority dwellings, as is the case with other disadvantaged groups.
- Homeless people rarely get a mention where anti-discrimination measures are being promoted, unlike other minority ethnic groups.
- The mortality rate for homeless people, which is reputedly the highest of all, gets no media coverage.
- Only the voluntary bodies have a real interest in their welfare.
- There is a lack of interest and co-operation between statutory bodies in addressing homelessness.
- More money was being spent on administration and "jobs" than services for the **target group**.
- Many local authority units throughout the country lie idle, while they remain homeless.
- An absence of rehabilitation and re-integration programmes to support the resettlement of persons who are homeless, coupled with lack of acceptance by the host community, impedes the successful resettlement of homeless persons.

(2) VOLUNTARY AND COMMUNITY BODIES

("Streetwise", Athlone Community Information Centre Management and Staff of St. Martha's Hostel, Longford, Disability Federation of Ireland).

- There appears to be a reluctance by statutory bodies to make full use of their powers and available responses in addressing genuine homelessness.
- Outcomes that suggest **a difference between schemes described and services delivered.**
- Inappropriate use of regulations and red-tape.
- Lack of information.
- Adversarial approaches to homeless people by statutory bodies.
- Continued lack of appropriate responses for under 18's.
- The "*foisting*" of responsibility by statutory bodies of complex cases and emergencies onto voluntary bodies.
- Avoidable evictions (e.g. earlier contact with M.A.B.S., An Post Easipay, partnership approaches where social problems are evident).
- The Disability Federation of Ireland has demonstrated that there is a considerable link between mental illness and homelessness.

(3) SERVICE PROVIDERS

(Community Welfare Officer)

- Transient nature of homeless person barrier to taking up additional service.
- The implementation of Homelessness – An integrated Strategy 2000 is crucial. Resources must be provided to statutory bodies to enable them deliver on the envisaged desired outcomes where resources provided, monitoring mechanisms and performance management system need to be put in place to demonstrate the value of programmes, responses and outcomes.

(4) STATUTORY PROVIDERS / VOLUNTARY GROUP

Westmeath Homeless Forum

Membership Westmeath County Council, Midland Health Board, T.E.A.M., St. Vincent de Paul, Athlone Streetwise Association, St. Mary's Youth Ministry, Athlone Urban District Council, Probation & Welfare Service, The Samaritans, Esker House Women's Refuge)

- The existing response is agency based rather than client focused. Each agency has defined its role and its level of responsibility. However the sum of all roles and responsibilities does not necessarily constitute a comprehensive service for the client.
- In the existing response is an over reliance on private rented accommodation and Bed & Breakfast Accommodation to resolve homelessness. It is now extremely difficult to source sufficient private rented accommodation for the homeless.
- The 'first phase' or emergency facilities are not sufficiently available in County Westmeath.
- Where the only accommodation which can be accessed in Bed & Breakfast Accommodation there are severe difficulties being experienced by the Homeless who find themselves out in the street from early morning until late in the evening.
- No strategy in place to accommodate those homeless who have serious addiction problems and who are sleeping rough.
- No co-ordinated strategy to assist those who are vulnerable.
- A gap exists in supporting vulnerable people in the private rented sector. This is caused by placing individuals and families incapable of full independent living into this type of accommodation.
- Another consequence of the lack of private rented accommodation is the 'clogging up' of available hostel space.
- The existing response is agency focused, there is no present strategy to trace individuals and families and ensure that necessary supports are made available.
- Some individuals have become homeless in Westmeath on being released from prison.

PROPOSAL FOR CHANGE

(1) USERS

(5 men who are homeless)

- Access to day centres or suitable daytime activities should be made available.
- The arrangement of emergency medical cards to facilitate needed treatment.
- ***The need to address the lack of "no fixed address", the need to address the receipt or transfer of social assistance payments*** *and* ***training, education and employment opportunities from persons with no fixed address.***

(2) VOLUNTARY & COMMUNITY BODIES

("Streetwise", Athlone Community Information Centre Management and Staff of St. Martha's Hostel, Longford, Disability Federation of Ireland).

- Statutory bodies need to make full use of their powers and available responses in addressing genuine homelessness

(3) SERVICE PROVIDERS

(Community Welfare Officer)

- That other disciplines of the service, as resources permit, should positively embrace the concept of rehabilitation and re-integration of homeless people into the community.
- The Health Service should re-evaluate its perspective of its role and responsibility towards homeless people.
- Prioritise the evident disabilities and disadvantages of homeless people such as mental illness, addictions, social disadvantaged and/or psychological disorders, as the dominant factor that contributed to homelessness occurring.

(4) STATUTORY PROVIDERS / VOLUNTARY GROUP

Westmeath Homeless Forum

(Membership Westmeath County Council, Midland Health Board, T.E.A.M., St. Vincent de Paul, Athlone Streetwise Association, St. Mary's Youth Ministry, Athlone Urban District Council, Probation & Welfare Service, The Samaritans, Esker House Women's Refuge)

- To develop a seamless service.
- Existing practices be formalised
  - Referral procedures and assessments
  - Strategies for financial support
  - Strategies for outreach support, medical assistance, and post-institutional care.
  - Strategies and training for re-integration and independent living.

  - The Document of Understanding betweenWestmeath County Council and The Midland Health Board.

- The employment by Westmeath County Council of a social worker to liase with the Midland Health Board and Homeless persons in the provision of aftercare services.
- That assistance be channelled into the voluntary sector.
- That sheltered accommodation with activity rooms and playrooms are provided as part of any accommodation that is to be funded.
- The development of a 'seamless service' between Westmeath County Council and the Midland Health Board.
- Bed & Breakfast accommodation to remain as the first emergency.
- The formulation of a strategy for dealing with the needs of those people arriving into the country from abroad.
- The provision of hot meals and general welfare needs at any facility which is provided as a result of the recommendations of the Homeless Forum.

ACUTE SERVICES

ISSUES RAISED

(1) USERS

(National Patient Perception of the Quality of Healthcare Survey 2000 undertaken in several Group One and Group Two hospitals nation-wide)

- The rating by respondent of their satisfaction with several aspects of their care accordingly to whether they were very satisfied, satisfied, dissatisfied and very dissatisfied are extremely positive with satisfaction ratings varying from 88.9% to 95.7%.
- Many of the problems found in this survey relate either directly or indirectly to communication.
  - On arrival, patients often receive no printed information about the hospital.
  - When admitted to the hospital they may be told little about their daily routine, that being the meal times, visiting hours and time of ward rounds.
  - During their stay they are often not informed about their condition or treatment in a way they understand, and at times are given little opportunity to discuss these matters with staff.
  - In the cases where patients are informed, they often feel their family members were not.
  - Furthermore, many patients reported low awareness with regards to medication administered to them and tests.
  - At discharge, patients are rarely given information about how they should continue with their lives when they reach home.

(2) USERS

(Top Five Complaint Categories identified from period 1/1/1999 to present day pertaining to acute/episodic care – out of total of 177 complaints.

(1)	**TREATMENT** – concerning treatment by staff of patients	(47)
(2)	**MEDICAL ISSUES** – concerning medical treatment received	(20)
(3)	**OTHER** – miscellaneous	(14)
(4)	**DELAYS** – inclusive of waiting lists and waiting times	(12)
(5)	**DOCTORS** – concerning attitudinal issues	(10)

(3) USERS

View of one Service User who had contact with 3 acute hospitals on an intensive basis

Standards

- Issue of variation in standards across 3 hospital sites.

Partnership

- Continued persistence of medical model rather than partnership with patient.

Communication

- Poor English on part of some foreign doctors.
- Lack of communication skills with particular reference to foreign doctors in Accident & Emergency

Facilities

- Lack of "bell" facility to call nurse at bedside.

(4) VOLUNTARY AGENCIES

Friends of the Hospital, Tullamore and Portlaoise – 11 persons.

- Lack of sufficient staff and beds. There is however acceptance that there will continue to be a shift towards day casework and that the use made of beds will change. Medical beds it is felt will need to be increased.
- Political interference with waiting lists and access to services is seen as a barrier and against the principle of equal access and treatment for equal need. Service provision based on formal needs assessment alone is seen as the appropriate approach.
- The unwillingness of many professionals and others to change what they do and how they do it.
- The poor communication and listening skills of professionals.
- The lack of home care, after care, step down facilities for individuals discharged, often with too much haste, from acute hospitals.
- Public to private inequality in access to the package of services and treatment.
- Lack of information about entitlements and services available.
- Lack of definition of a specified package of services available for given conditions. This makes it difficult for people to be aware of what to expect from health and social services.
- The less than desirable portfolio/package of services.
- Lack of information on: need; services available; interventions; standards and performance in terms of outputs and outcomes.
- Lack of involvement in choices about treatment and about service provision.
- Inefficient use of resources.
- The numbers of managers and administrators relative to service providers. The health services are seen as top heavy.

(5) Statutory Service

Eleven Members of the Midland Schools Health Project Steering Group

consisting of University Lecturer, 3 Primary School Principals, 2 Primary Teachers, 1Teacher, Second Level), Education Centre Director, 2 SPHE Support Service) and Inspector DES

Hospitals

- Queues
- Poor organisation e.g. bulk appointment
- Shortages of beds
- Ward closures
- Lack of privacy

- Critical and non critical treated together
- The awe, fear and vulnerability experienced by patients
- Overworked staff e.g. Junior Doctors hours
- Drugs are too easily dispense
- Fear about possible drug side effects
- The lack of skilled personnel in the hospital services
- The Lay-Medical divide – regard for the person

Accountability

- Lack of accountability e.g. medical error

Equity

- Lack of equality between private and public
- Unequal access to consultations

PROPOSALS FOR CHANGE

(1) USERS

National Patient Perception of the Quality of Healthcare Survey 2000

undertaken in several Group One and Group Two hospitals nation-wide

- This survey has identified specific care processes that could be improved upon, in particular, communication about discharge planning, treatment and hospital routines.

(2) USERS

Top Five Complaint Categories identified from period 1/1/1999 to present day pertaining to acute/episodic care – out of total of 177 complaints.

- No proposals for change

(3) USERS

View of one Service User who had contact with 3 acute hospitals on an intensive basis

Quality

- Need for customer care training in admissions for all staff.
- Different professional / therapies meeting patient on ward should introduce themselves.
- Treatment of the patient needs to include their "total well being".
- Need to develop relationship between hospital staff and patient/carer.
- The dignity and privacy of the patient needs to be preserved by all staff in all regards, from admission through to discharge.

Patient Care

- Need for continuity of care for all patients but particularly elderly patient.
- Floating member of nursing staff needs to be on duty during reporting and rotating of staff to ensure continuity of patient care
- Nursing support staff required to address the basic, ordinary care needs of patient that sometimes go unmet – e.g. washing.
- Issue of systematic review of patient on ward should be replaced by priority of patient care needs.

(4) VOLUNTARY AGENCIES

Friends of the Hospital, Tullamore and Portlaoise – 11 persons.

Quality Needs Assessment and Service Planning:

- Assessing population need on a periodic basis
- Establishing structures that ensure stakeholder representation in all planning and evaluation exercises. For acute hospital services it is suggested that Hospital Boards with representation from staff, public representatives and voluntary groups would ensure better consumer orientation of planning and evaluation.

- Developing information technology and assessment instruments to support needs assessment and publishing needs to increase public awareness.

Quality Services and Service Delivery

- Defining the package of promotive, preventive, diagnostic, treatment, rehabilitative and care interventions that are available in the home, in the community, in hospital and in residential care.
- Publishing the packages of services that will be available/contracted for given conditions so that people will know what they can expect.
- Implementing Health Promotion Strategies
- Ensuring that services are user friendly with:
    - ease of access
    - simple information
    - simple language
    - simple forms

- Defining staff to workload ratios for the package of interventions and ensuring the necessary numbers and skills-mix is available and funded.
- Providing more medical beds.
- Shifting towards more day case work for surgery etc.
- Increasing the specialist services with more self sufficiency at health board level. Ophthalmology, Dermatology etc.
- Adopting the principle of timeliness – where need will be responded to at the appropriate time and not when it is too late.
- Extending the working day for appropriate parts of the services and professionals so that the package of services is actually available to meet needs.
- Providing support to Nursing Homes to ensure patients/clients have the necessary package of services including activation etc.

- Guaranteeing appropriate 24 hour GP access.

(5) Statutory Service

Eleven Members of the Midland Schools Health Project Steering Group

consisting of University Lecturer, 3 Primary School Principals, 2 Primary Teachers, 1Teacher, Second Level), Education Centre Director, 2 SPHE Support Service) and Inspector DES).

Hospitals

- Consult all stakeholders including patients
- Increase the attractiveness of the medical profession
- Improve the ratio of staff to patients

HOSPICE SERVICE

ISSUES RAISED

(1) VOLUNTARY AGENCY

(Laois, Offaly, Longford, Westmeath Hospice Foundations)

- Bureaucracy and red tape appear to delay and hinder improvements in the Health Services at a time when money appears to be available for same.
- The time span taken in implementing decisions takes far too long – hence the public suffer as a result.
- Primary Care: This service is stretched to the limit. It is disjointed. The pressures are increasing. There is no strategy; GPs are working in one building, PHNs in another, there is no plan. The Primary Care scene is growing daily with an emphasis on keeping people in the community etc. but there is no support, thought or finance being invested in this field.
- Hospital Care: Patients can not get appointments to be seen. They have to go on long waiting lists for procedures. Access to simple procedures like x-rays, O.T., physio. Is getting slower to everybody's annoyance.
- Very poor communication/trust between administrators and medical personnel.

(2) VOLUNTARY / STATUTORY PROVIDERS

(Working Party [1997] on review of hospice services in the region

comprising representatives from each of the Hospice Groups in the region, along with Health Board Personnel)

- All groups (Laois, Offaly, Longford, Westmeath Hospice Foundation) were critical of the inaction of the Health Board in relation to the Working Party Report, 1997 on review of Hospice services.

PROPOSALS FOR CHANGE

(1) VOLUNTARY AGENCY

(Committee of Laois Hospice Foundation)

- A Palliative Care Unit 4/6 beds incorporated into the General Hospital, Portlaoise together with adequate staffing.
- The current services for Hospice patients to be maintained in Mountmellick and Abbeyleix.
- Central Government and the Health Board to take over the funding of Hospice Services – where appropriate this could be aided by funds raised by Laois Hospice Foundation.

(2) VOLUNTARY AGENCY

(Laois, Offaly, Longford, Westmeath Hospice Foundations)

- The siting of a unit needs urgent attention.
- Groups with special needs such as the handicapped, the elderly, the young the terminally ill etc. should have access to structural programmes tailored to their appropriate needs at a local level if possible.
- That a proper programme in all areas of preventative medicine be put in place.
- Develop a sensible strategy, which involves all the interested parties – administrators, primary care team, secondary care team and public health section, so that all are working to a practical, sensible goal.
- Inject more money into the Health Services.
- Development of a more open, frank and equal co-operation between administrator and medical personnel.
- Medical manpower needs must be addressed.
- Suitable and adequate facilities must be put in place.
- Central Government and the Health Board to take over the funding of Hospice Services.
- That groups with special needs such as the handicapped, the elderly, the young, the terminally ill etc. should have access to structural programmes tailored to their appropriate needs at a local level if possible.
- That a proper programme in all areas of preventative medicine be put in place.
- More open, trusting, frank and equal co-operation between administrator and medical personnel.

(2) VOLUNTARY / STATUTORY PROVIDERS

(Working Party [1997] on review of hospice services in the region

comprising representatives from each of the Hospice Groups in the region, along with Health Board Personnel)

- The Working Party holds the strong view that a more co-ordinated approach to the delivery of the service be forged and that the service would benefit from a more consolidated financial arrangement and a sound structure, which would facilitate a smooth operational network.
- That a Consultant in Palliative Care be appointed. The Consultant would head up the recommended structure, with the emphasis on localised care, if not in the patients home, then in the most appropriate facility as close to the patients home as possible.
- That a regional 6-bed purpose built hospice care unit is provided at a General Hospital to serve the Midland Health Board area.
- The availability of existing hospice beds should be maintained in the interests of localised care, These beds should be available to terminally ill patients in the same flexible way as heretofore.
- That the structure referred to under co-ordinate and partnership sections be set in place.
- The Working Party underlines the need for a 24 hour palliative care service. It recommends that 2 specialists care nurses are available to the home care service in each county within the region. These nurses should be appointed on a permanent capacity to the Board's staff.

- The specialist Palliative Care Team led by a Consultant in Palliative Care and a Regional Nursing co-ordinator be set up. The team will be based in the purpose-built unit already recommended.
  - Medical support should be available to the teams from medical personnel with training and experience in the area.
  - A Nurse Manager with recognised qualifications in palliative care should be appointed to each hospice unit.
  - Nurses appointed to the service should have a skill mix and experience to meet the needs of the service. The number required to staff units on a 24-hour day basis is shown under staff requirement section.
  - That the need for ongoing education of General Practitioners in updating their skills in Palliative care provided for.
  - That a sub-committee on education be set up within the recommended structure on a regional basis.
  - That a partnership approach for hospice care within the recommended structure can address the ad-hoc nature of funding arrangements, more resources put in place in a partnership approach for palliative care users.
  - This process should address existing service needs with the acceptance of a proportionate 65:35 percentage funding from Health Board and Voluntary Sector.

HEALTH/HEALTH SERVICE – OTHER AGENCIES

ISSUES RAISED

(1) VOLUNTARY AGENCIES

Representation from: Oak Partnership, Laois Leader Rural Development County, Longford Community Resources Ltd., Offaly Leader II Co., Portlaoise Community Action Project, Tullamore Wider Options, Athlone Community Taskforce

Co-ordination

- Lack of co-ordination

Awareness/Information

- Lack of awareness within system of own Health Board personnel
- Awareness within Health Board and the public
- Lack of public awareness of all Health Services
- Need to counter public disillusionment in certain sections of community (Awareness)
- Public perception around Mental Health Services

Waiting lists

- Waiting lists

Access

- Accessibility to services in rural areas.

Equity

- Equity of service is challenged via ability to pay.

Funding & management of funding

- Funding and management of existing funds

Change

- Resistance to change

Vested interests

- Vested interests – political and medical

Strategy

- Strategy itself may become out-of-date through lack of review and assessment

Recruitment

- Recruitment difficulties

Societal Changes

- Volunteerism in decline

- Society becoming more fragmented (increased vulnerability for some sectors of society)

(2) STATUTORY SERVICES

Gardai, Probation & Welfare Service Views of 2 Chief Superintendents and one Senior Probation & Welfare Officer

Resources

- Conflict between Garda and Health Board (Hospital) due to lack of resources

Personalities

- Territorial issues
- Services should not depend on individuals
- Personalities versus Service Provision

Communication

- Structure of communication between the agencies
- Lack of feedback

Staffing

- Continuity of service re: retention of staff
- Lack of provision of training for staff working together

Proactive/Prevention

- Involved in times of crisis – need to be involved in terms of proactive/prevention etc (Inter-agency issues not just Health Board)

Data Protection Act

- Restricting agencies sharing information
- Widening of scope
- What can be discussed within a specific context

(3) VOLUNTARY

(Longford Health Services Action Committee)

- Accessibility (26 mile away from hospital, A&E lack of full time service, Doctor on call (full time?)
    - A range of issues were identified pertaining to Longford which included:
    - The upgrading of Longford Westmeath General Hospital
    - To have a Trauma Clinic in Longford
    - To obtain transport for Longford patients requiring orthopaedic treatment
    - To seek an improved ambulance service for Longford
    - To have a qualified midwife available for ambulance duty as and when required
    - To obtain a twenty bed step down facility for Longford
    - To improve the services for the elderly by way of additional beds and a dedicated Alzheimer's Unit in St. Joseph's Hospital.

(4) STATUTORY SERVICES

(Offaly VEC, NTDI, FAS)

- Services are driven by funding rather than needs

Flexibility

- Lack of flexibility

Co-ordination

- Lack of co-ordination of services for patients.
- Need for para-medical services at local level.

Equity

- Two tier system / public versus private

Criteria

- Lack of criteria – user-friendly service

Information

- Lack of quality criteria for monitoring services.
- Lack of information lead to inaccessible services for people on the ground only the informed can access the service.

Transport

- Transport (Rural)

(5) Local Development/Local Government & Social Partners/State Agencies

Members of the County Development Boards of Laois, Offaly, Longford, Westmeath

Services in General

- Disability services/Mental Health Act not being tackled
- Not Enough Youth information and services
- Absence of support for carers
- Not enough forward planning for nursing and capital resources - No unit within health to deal with trends in environment (treatment and preventative) and the dynamics of a changing environment, e.g. staff shortages could have been foreseen.
- Staff (nurse) shortages
- There is a query as to whether there is always best use of resources
- Outpatient services and multiple booking – why?
- Minimum service levels not decided versus regionalisation of specialist services – the group acknowledged that some services needed to be specialised but these should be an easily accessible, locally based set of minimum emergency and non-specialist services
- Not enough services for older persons

- Not enough resources overall e.g. NDP funding was inadequate
- Respite Services
- Counselling back up
- Long waiting lists
- Children should be a priority for waiting lists – otherwise delayed developmental

Lack of Partnership and Co-ordination

- Very many government departments dealing with aspects of health e.g. medical card, psychological services – not enough collaboration e.g. minimum wage not examined for effect on medical card eligibility
- Communication skills of senior consultants can be poor

More Flexibility about services

- GP service at weekend, late at night, home visits are inadequate – co-operatives need to be developed
- Transport – need for integrated solution
- Social work service – biggest demand is at weekend/nights – 9 to 5 not adequate
- Homelessness – no services in Midlands – no one taking responsibility
- Shelter services for women – only one centre in Midland/services are inadequate

Midland Health Board Specific Issues

- There is a query as to whether there is always best use of resources in rationalisation e.g. broken bones must go to Tullamore where they could be dealt with locally.
- Longford – absence of adequate local services, reflected in every consultation. Not having an equitable service - Issue for peripheral counties
- HB are not selling rationale for regionalisation and services offered

Equity and Transparency

- Is it fair? Waiting lists, disparity between rich and poor e.g. VHI
- Transparency about decisions – needs to be equitable and fair
- Public reps on HB (public representation is a strength) – Decisions should be for the good of the people, Parochialism can be difficult to ensure that decisions are 'people centred'
- How are decisions made?

Not Enough Focus on Prevention / Health Promotion

- Need for more emphasis on prevention and reaching out to communities/education
- Need to involve other agencies – sharing responsibility for health
- Education/life-skills in school e.g. cooking skills
- Supports around drug misuse – not enough health supports for all areas

(6) COMMUNITY/VOLUNTARY GROUPS

Offaly Community Forum

Representatives from Barnardos, The Irish Wheelchair Association, Tullamore, Tullamore Youth Initiative, Harbour (Centre for the out of home), Bracknagh Women's Group, GROW Travellers Movement, Friends of Ofalia House).

Legislation

- There are problems with some of the legislation underpinning the delivery of health services. Examples quoted include the Mental Health Act and various Children's Acts. It was felt that proposed amendments to these Acts should be implemented as a matter of priority in order to ensure that services for at-risk groups are as transparent as possible.

Accessible Information

- Easy access to information is vital to the development of positive health attitudes within the community. At present information is available but not accessible, a major weakness within the system.
- There are poor levels of information and awareness among the public in relation to the services offered by the Health Boards.
- Healthcare staff have a tendency to use jargon, which alienates clients and leads to confusion in understanding their condition and its treatment.
- Literacy has been identified as a major problem for up to 25% of the Irish population, many of whom have a functional literacy level which would not allow for them to read the instructions on a medicine bottle properly. This needs to be addressed in the provision of information within the community, particularly disadvantaged communities.

Schools Health Education

- Health education delivered within the school system is no longer seen as being effective.

Medical Card scheme

- The existing Medical Card scheme is inadequate and does not reflect the hardship that healthcare can inflict on people with low incomes. The need to address income limits has been exacerbated since the implementation of the National Minimum Wage.

Counselling and Listening services

There is no provision at present for community counselling and listening services at health board level. Voluntary provision can no longer cope with the demands being placed on it as stress levels increase among the population.

Community Healthcare

- The existing Public Health Nurse service is grossly inadequate but has the potential to be a highly innovative part of our community healthcare system.

Marginalised Groups

- Public attitudes to marginal groups, such as travellers, people with disabilities, people with mental health difficulties, refugees and asylum seekers need to be addressed in order to bring equality to the system.

Statutory and Voluntary sectors

- Statutory and voluntary sectors need to develop mutual respect and trust in respect of the delivery of services.

Hospital waiting lists

- Hospital waiting lists are a public shame. As long as preferential treatment is given to people who can afford to pay for fast-tracking, inequalities will exist within our system. This is not desirable.

Application forms

- Application forms for Health Board grants and assistance are unwieldy and full of jargon, leaving people confused and reluctant to apply for funds.

Transport

- Transport is a major issue in accessing healthcare services, particularly in rural and isolated areas. Currently, bus services are provided by private contractors in order for people to attend appointments. Additionally, existing roads infrastructure is in a dire state and seriously curtails the response times of the emergency services. Roads also claim the lives of hundreds of people annually.

Hospital beds

- There are not enough hospital beds, a situation which demands immediate attention.

Centralisation

- Current policy is to centralise services. This is seen as a regressive step, which further alienates people from their health service.

Choice of provider

- There is no choice of provider at present, which also alienates clients.

Consultation

- Consultation should be sustained and meaningful rather than rushed.

(7) Statutory Service

Eleven Members of the Midland Schools Health Project Steering Group

consisting of University Lecturer, 3 Primary School Principals, 2 Primary Teachers, 1Teacher, Second Level), Education Centre Director, 2 SPHE Support Service) and Inspector DES

Inter-developmental Approach

- Lack of inter-development approaches to ‘fix’ things

Procedures – drug abuse

- Procedures to deal with drug abuse

Equity

- Dispense with private and public differences
- Excludes certain social groups

Promotion/Prevention

- Look at prevention before illness through Health Promotion
- Provide health promotion in the community e.g. smoking cessation, substance misuse
- Use health messages in the media e.g. encourage soaps to have responsible attitude to portrayal of alcohol on T.V. programmes for example
- Provide more screening and health checks
- Provide more medical care for primary and secondary level students
- Improve youth services and child guidance in schools

Attitudinal

- Attitudes

Equity

- The exclusion of certain social groups
- The medical card limits

Financial Support

- Lack of financial help for severely handicapped

Older Persons

- Older people live longer but with an unimproved quality of life

Carers

- Service needs of parents at home and carers

PROPOSALS FOR CHANGE

(1) VOLUNTARY AGENCIES

(Representation from: Oak Partnership, Laois Leader Rural Development County, Longford Community Resources Ltd., Offaly Leader II Co., Portlaoise Community Action Project, Tullamore Wider Options, Athlone Community Taskforce).

Broad Health Definition

- Top management support for broad health definition

Equity

- Elimination of 2-tier system
- Database of low-income families
- Multi Agency targeting of vulnerable low income families (taking into account FOI)

Information

- Improve clarity of information on range of services provided
- Directory of services (user friendly)

Facilities

- Enhance facilities – both active and community based

Customer focus

- Stronger customer focus orientation

Co-ordination within Health Services

- Need for co-ordination of Health Board with other agencies e.g. SLD, Schools, Community Childcare and Social Workers

Partnership

- Maintain Partnership for to discuss and review health policy
- Pro-active support of volunteers at local level e.g. training network

Transport

- Willingness to experiment with new transport and service ideas

Investment in people and infrastructure

- Focussed investment in people and infrastructure

Community Facilities

- Use of community facilities

(2) STATUTORY SERVICES

Gardai, Probation & Welfare Service Views of 2 Chief Superintendents and one Senior Probation & Welfare Officer

- More accessible service with earlier interventions
- 24 hour service
- More focused towards Proactive/Preventive work.
- Infrastructure Developed for co-ordinated responses
- Clear timeframe of activities
- Who is to do it?
- How is it to be done?
- Holistic approach – no one service with all the answers
- Appointment of key personnel within each organisation who have are responsible for feeding back within a time frame.
- Early identification within family system. " Holistic approach".
- Joint training for Health Board Staff (working with other agencies).
- Development of trust and understanding in terms of roles and responsibilities.
- Bring the services into communities i.e. Barnardos Athlone (Proactive)
- Quality of service through the system.
- Sharing of information/feedback within appropriate settings
- Review of - How services are provided

- Blocks
- Alternatives
- Accessing information/help

(3) VOLUNTARY

(Longford Health Services Action Committee)

Health Board meetings

- Structure for reporting back from Health Board meetings

Needs

- Identify real needs. Response to it ….
- Budget for local structure

Proactive

- Proactive rather than reactive

Transparency

- Transparency

Co-ordination

- Co-ordination

Communication/Information

- Communication – Accountability re: plans
- Information about services provided

Training

- Training/empowering (staff and local communities)/education

Transport

- Transport for patients to different specialist unit as required

(4) STATUTORY SERVICES

(Offaly VEC, NTDI, FAS)

Health Promotion

- Increased Health Promotion initiatives – proactive/prevention focused - Provision of sporting facilities in towns

People centred approach

- People centre approach

Needs

- Needs driven

Flexible

- Flexibility

Information

- More information to allow for informed choice

Training

- Training for Health Board staff in terms of public relations

(5) LOCAL DEVELOPMENT/LOCAL GOVERNMENT/SOCIAL PARTNERS/STATE AGENCIES

Members of the County Development Boards of Laois, Offaly, Longford, Westmeath

General Services and Midland Specific Services

KEY RECOMMENDATION

REGIONAL SERVICES : Open decisions
: People Centred
: Marketed/Communicated to public on rationale

LOCAL SERVICES: Minimum level of services for life threatening/emergency services.

Establish a minimum service level - (Longford) – need to decide MSL for emergency and non specialist services (e.g. removal of casts)

- More Resources Overall for health – increase % of GDP spent of health
- Appoint a Health Ombudsman to monitor strategy
- Innovation needs to be developed and rewarded to meet varying demands and achieve minimum level of service. Mainstream innovative projects such as, PHC models of care e.g. lay health workers
- Health Board should locate services to achieve minimum response rate e.g. Longford needs locally based emergency services or innovative solutions to meet emergency needs adequately (e.g. defibrillators with GPs)
- Forward planning for staff and capital resources and demographic changes (e.g. increase in older persons)– need for a stronger planning unit at national and regional level
- Establish a minimum service level for all regions especially remote counties
- Increase respite services and build supports for carers

- Improve childcare provision (e.g. crèche)
    - Childcare committees
    - Structures should be formalised and standards set
    - Interdepartmental communication/joint working
    - Decide where the buck stops for childcare

Health Promotion Services

- Resource and develop positive health promotion – built into education system, more focus on physical activity, alcohol, drug abuse
- Education for parenting
- Need to move from 'fire brigade' approach to preventative in generic services e.g. parenting in antenatal/innovative approaches e.g. extension of PHC initiative to communities
- Develop programmes to reduce the stigma around mental health
- Involve other sectors in the development of partnership approaches to tackling determinants of health
- Ensure that all areas of the health service take a role in health promotion
- Build on current good work e.g. partnership for youth health, substance misuse work.

Solutions for Other Sectors

- State of road infrastructure and emergency services need more focus on intermediate needs
- Transport, especially in rural area such as the Midlands, needs to be addressed by all agencies – there is a need for a lead agency (Local Authority) to take charge of this and work proactively.
- Developing civil society – role of CDB in building communities, so that there are more social supports

Communications and Consultation

- HBs/DOHC should demonstrate proactive communication and dialogue
- Build on consultative forum for older people
- Have a consultative forum for community
- Health Community Strategy needed
    - Information to Public
    - Communications training for staff
    - Intercultural awareness training
    - Proactive 'engagement' with ethnic groups
    - Transparency about decisions
    - Marketing of Health Services

- Develop stronger 'Forward' planning units at national and regional levels – build into consumer feedback
- Communication training should be built into the undergraduate training of health care staff.

Partnership

- Develop systems to measure and reward inter agency/dept co-operation and collaboration

- Introduce health impact assessment for all sectors and ensure they must work together to develop seamless services – partnerships for health at national and regional level (could try different approaches).
- Utilise Opportunities for Health Boards to work with other agencies through CDB
- New innovative systems can be developed with people not just for people – joint working/participation/consultation
- Partnership for youth health in the MHB – build and develop this model

Governance

- Separate 'political' gains from 'people centred' approaches by re-examining how best health Boards should be governed.
- Develop stronger 'Forward' planning units at national and regional levels – build into consumer feedback
- Each Health Board needs to be able to identify emerging critical areas – if in existence already, is this process working and how is it measured and evaluated – structures to measure performance of planning.
- Feedback mechanisms should be developed to allow feedback to the public and contribute to transparency in Health Board decisions.

Increase Flexibility of Services

- Social work services need to be developed with flexible access at weekend/evening.
- Supports for children at risk/ongoing supports – how can services be preventative/easily accessed/early school learning/co-ordination between agencies/more resources
- Extended provision of services
    - Counselling for sub-misuse
    - Homelessness/support services
    - Domestic violence
- Develop GP co-operatives to extend services (24/7)
- Develop Good family support services for older persons, disability etc (to replace traditional family supports/to recognise diminishing family supports)
- Allow for increased PHN visits as these are highly regarded/useful given less contact between people

Equality of outcome – focusing on Social Exclusion and Poverty

- 2 Tier System – look at ways to eliminate this, should be equal waiting times for public and private
- GMS eligibility – higher threshold, more flexibility
- Integrating minority groups
    - Need to be treated equally, opportunity to address problems, specific integrated programmes
    - Looking for equality of outcome, so will need more targeted approaches
    - Develop Mental Health Supports – need to develop support/supervision systems for those in the community e.g. to prevent crime, continue medication – peer support and links
    - Social exclusion and poverty are key issues for health services
    - Need to identify key areas for action (social exclusion zones?) and put systems in place
    - Need to keep sight of poverty issues

(6) COMMUNITY VOLUNTARY GROUPS

Offaly Community Forum,

Representatives from Barnardos, The Irish Wheelchair Association, Tullamore, Tullamore Youth Initiative, Harbour (Centre for the out of home), Bracknagh Women's Group, GROW Travellers Movement, Friends of Ofalia House

Funding

- The Department of Health and Children and the Department of Finance need to come to an agreement on the delivery of proper and adequate funding for the delivery of a quality healthcare system.

User Friendly

- Services need to be promoted in a user-friendly manner and literacy proofed.

Prevention

- Preventative education is important and should be delivered in an integrated manner, with a particular emphasis on education in schools to ensure healthy practices among young people which will last for life. The co-operation of the Department of Education and Science is pivotal in the delivery of quality information to young and disadvantaged people

Information

- Information should be more accessible and should be user-friendly, high quality, accurate and durable

Communication

- Healthcare needs to be appropriately communicated to the general public, with an emphasis on lower socio-economic groupings, which are particularly susceptible to the effects of poverty on health. A communications strategy must be put in place at every level of the healthcare system. Communications modules should be an integral part of the training of future healthcare staff.

Literacy

- Literacy is a huge problem for almost one quarter of our population, many of them living in poverty and isolation and therefore at risk. Information should be literacy proofed with the help of the National Adult Literacy Agency, who can advise on the use of alternatives to written media in the development of information and resources. Healthcare providers should undergo literacy awareness training and the Department of Health and Children should explore the possibilities for co-operation in relation to the National Adult Literacy Service.

GP Surgeries

- Practice nurses should be funded in all GP surgeries. This would lead to a more efficient service within general practices and a greater ability to service general information needs.

GMS Scheme

- The GMS Scheme should be realistically extended to take account of the needs of low income households and students.

Counselling

- Counselling and listening services should be widely available.

Transport

- Transport services must be provided in order to make the healthcare system accessible

Legislation

- Legislation needs to be enacted, repealed or amended as appropriate. This task is of the utmost urgency, particularly in relation to people with mental health difficulties and children at risk. Constitutional amendments to ensure the rights of the child can be incorporated into legislation are an integral part of this process.

Strategic Management Initiative

- The Strategic Management Initiative should be applied at every level within the civil service in order to improve co-ordination of services. An emphasis must be placed on proper co-ordination of services across government departments (Education, Public Enterprise, Justice Equality and Law Reform, Heritage, Gaeltacht and the Islands, Agriculture, Social Community and Family Affairs, Health and Children). Furthermore, inter-sectional communication within departments must be improved. Thought should be given to utilising further consultative committees to develop future policy and programmes.

Service Agreements

- Service agreements are a useful tool and assist in the delivery of responsive services at community level and should continue to be used.

Consultation

- Consultation must be the cornerstone of the development, implementation and delivery of the new Health Strategy. Evaluation should be an ongoing process and involve the clients of the service at every level.

Proofing

- Proofing mechanisms must be applied universally for optimal effect. These should include poverty proofing, gender proofing, equality proofing, disability proofing and environmental impact assessments. Client groups can assist in proofing programmes and policies.

Long Term Planning

- In order to make effective change, the Department of Health and Children should look at international models of best practice for the long term, rather than focussing on short-term emergency measures as a solution to problems

Transparency

- Evaluation of services should be independent and transparent.

DSCFA White Paper

- The Department of Health and Children should be aware of the provisions of the DSCFA White Paper, Supporting Voluntary Activity, and implement its recommendations as appropriate in its relationship with voluntary bodies within the healthcare system. The current use of the Community Fora at county level is to be commended.

Accountability

- Health Boards need to become more accountable to the public, who should have a sense of ownership over their local health services. This can only serve to strengthen relationships between service users and providers in the long-term.

Strategy Implementation

An Ombudsman should be appointed to ensure that the strategy is being implemented, is on target and is reflecting the issues raised in the consultation process. Implementation targets should be set in co-operation with the Ombudsman and reviewed at 6 monthly intervals.

(7) Statutory Service

Eleven Members of the Midland Schools Health Project Steering Group

consisting of University Lecturer, 3 Primary School Principals, 2 Primary Teachers, 1Teacher, Second Level), Education Centre Director, 2 SPHE Support Service) and Inspector DES

Planning

- Improve the quality of planning

Partnership

- Better partnership, interdepartmental level and community

Need

- Put structures in place to address real needs
- Fund and resource the preferred future
- Identify common good

Poverty or experiencing social exclusion?

- Provide an outreach service e.g. mobile unit going to marginalised areas
- Bring the services to the people
- Train key staff in health promotion e.g. Community Welfare Officers as a way of reaching the marginalised

- Provide Health Promotion in the Community
- Provide mobile crèches

SECTION B

- **Midland Health Board Members**
- **Midland Health Board Corporate Team**

BOARD MEMBERS CONSULTATION

ISSUES

Funding
- Funding below with European Average

Information Deficit
- Information System deficit

Equity
- Equity

Budgetary Planning
- Poor Budgetary Planning (2/3/5 year planning)

Physical Infrastructure
- Physical Infrastructure
    - Financial Input inadequate
    - Deficit in infrastructures
    - Existing projects impeded by red tape

Staff
- Recruitment shortages
- Changing roles and expectations of staff requires a supportive work environment. Issues of stress and bullying identified.

Waiting Lists
- Hospital Waiting Lists – problematic. Examples given were in the area of orthodontics and elective surgery. Also identified was accessing specialist opinion and treatment.

A&E
- A & E
    - Delay
    - Quality of service
    - Lack of information – patient and relatives
    - Communication difficulties
    - Overcrowding.

Community Services

- Lack of emphasis on Community Services

Out of Hours

- Community - Out-of-hours service to incorporate services by
  - GPs
  - Nurses
  - Social Workers
  - Community Welfare Officers
  - Home Help

Respite Care

- Structured Respite Care

Gaps in Service

- Gaps in Services leading to inappropriate use of other services
  e.g. (services to those with alcohol problems, clogging up Casualty).

PROPOSALS FOR CHANGE

Funding

- Increase G.D.P. percentage on Health

Social Responsibilities

- Promote Social Responsibilities

Health Promotion

- Health Promotion needs to be more focused (people taking more responsibility) and further developed in the following areas of:
- Lifestyle
- Alcohol
- Drugs
- Obesity
- Smoking
- Road safety

Communication

- Improve communications with consumers of service

Infrastructure

- Further develop the infrastructure to accommodate ongoing need

Increase Beds

- Increased beds – acute + step down

Information

- Develop a proper information system

CORPORATE TEAM

ISSUES

Strategic Focus

- Lack of strategic focus and farsightedness as evidenced in insufficient long term planning. Lack of clarity of roles with respect to government and local health agencies.

Systems Approach Deficit

- Lack of a systems approach particularly in relation to risk management and quality generally

Managerial Accountability- Clinical Authority

- Deficit in authority of management viz a viz their accountability. Consultants and GPs contracts are significant factors here
- Lack of involvement of Clinicians (i.e. all professionals) in management
- The perception that clinical authority is synonymous with lack of managerial accountability

Equity

- Lack of equity especially concerning access to services, as between private and public hospital patients.

Capacity

- Lack of capacity which constrains health sector from benefiting from potential increased funding. Funding low by comparison to other developed health services. Infrastructural deficiencies such as skill shortages, shortage of acute hospital beds and in some areas long-term beds for older people. Deficiencies in health centres and other local facilities and insufficient accommodation for staff. Other Infrastructural deficiency is the area of I.T.

Waiting Lists

- Waiting lists unacceptably long

Multi-annual budgeting

- Lack of multi-annual budgeting

Population health

- Over pre-occupation with services particularly hospital services at expense of population health focus

Information deficit

- Lack of health status, health services information constraining needs assessment evaluation and audit

Public Involvement

- Lack of opportunities for public involvement in planning and evaluation

Fragmented services

- Some services fragmented e.g. as between hospitals, GPs and other community care services

Politics

- Inappropriate politicisation of some issues resulting in decisions which are not in keeping with best practice

Blame Culture

- A blame culture, which at times inappropriately targets health sector – can demoralise staff

User friendly

- System not sufficiently user friendly

Professional-Consumer Models

- Dominance of "professional" viz a viz consumer models

Planning

- Under-developed planning function

Public relations

- Relatively poor public relations

Voluntary Sector

- In some parts of the voluntary sector the piecemeal funding from various sources is a barrier to achieving a quality service and evaluation

New Health Strategy

- Level of cynicism in relation to 'new health strategy'.

Public Attitudes

- Unenlightened public attitudes towards local services for vulnerable groups –
  Children, mentally ill, intellectually disabled.

PROPOSALS FOR CHANGE

Manpower Plan

- Develop a comprehensive manpower plan for all disciplines in the health services for five years and beyond so that health services can avail of improved funding and opportunities

Equity

- Address the area of equity through:
  - Further limiting private practice in hospital medicine
  - Creating general eligibility for medical card
  - Further development of Health Promotion interventions for low income people and other vulnerable groups
  - Health proofing of all government policies and all major projects – A structure to be established and chaired by the Minister for Health
  - Further promotion of a Partnership approach to health

Consultants and GPs contracts

- Change Consultants and GPs contracts so that management has the full authority to deliver e.g. on waiting lists

Clinical authority - Management accountability

- Clarification of clinical authority viz a viz management accountability
- Clinical governance structure to be put in place.

Primary Care Services

- General Practice and other primary care services need to be enhanced so that GPs can treat a lot of patients who currently go to hospital. This will require supports such as nutrition, therapies, psychology etc.

Community services

- Community services need to be developed so that some people opting for institutional care could have more confidence in community services. This development will required enhanced multidisciplinary services.

Public input

- Structure and fora to be established for public input.

Multi-annual budgeting/Resource requirements - strategy

- Provide for multi-annual budgeting. Strategy to identify resource requirements for strategy life-time. Representative group at national level to monitor its implementation.

Evidence Based

- An explicit commitment to evidence based guidelines, protocols and needs assessment and the establishment of a national technology assessment structure

Funding Alternatives

- Explore alternative systems of funding e.g. insurance based.

NDP Shortfall

- Explore public, private partnership as a solution to NDP shortfalls.
- To create an onus on private health insurers

Private health insurers

(a) to share data with public sector to facilitate needs assessment
(b) to develop protocols for quality and to conduct audit.

Information Strategy

- The development and funding of a comprehensive information strategy for the health services to include a major upgrading of current I.T. system.

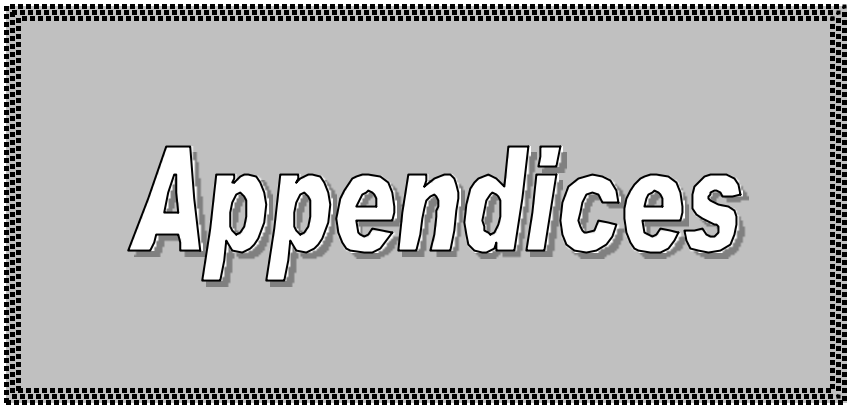
Health technology assessment

- The undertaking of a health technology assessment

New health strategy

- The development of new health strategy to provide: rationale for strategy, evidence of success from Shaping a Healthier Future. It should create ownership of new strategy, be explicit, have strong ministerial

Appendices



REGIONAL CONSULTATIVE FORUM FOR OLDER PEOPLE

- **Consultation with:**
  - Regional Consultative Forum for Older People

- **Facilitator:**
  - Mr. Barry O' Sullivan

- **Date:**
  - 10th May 2001

Regional Consultative Forum - Older People

Health Strategy Consultation

A meeting of the regional consultative forum for older people in the Midlands took place in Tullamore on 10 May. The principle item on the agenda was to conduct a consultation of the new Health Strategy 2001 – 2008. The following is the feedback from this consultation.

Methodology

Initially a presentation was conducted outlining the background in the context of the vision and the principles guiding the formulation of the new strategy. Then a work shop style approach was adopted and two questions were put to the groups in order to elicit their views and opinions. The questions which were posed were:-

- What works and what are the strengths of the existing system.
- What requires fixing and what are the barriers, which need to be addressed in this 'fixing'?

The meeting was divided into three groups and a summary of the feedback from each group is outlined below. The responses were extensive and the points listed were the key or salient points as identified by each group. The order in which they are listed is important as they were selected and prioritised by the each group in this order.

Question 1:- What works and what are the strengths of the existing systems.

Group 1

- Personal responsibility for health.
- Community based services.
- Role of the religious community in healthcare – caring ethos and legacy.
- Primary medical care is good. – PHNs, community mental health etc.
- Level of care received is good.

Group 2

- GP service is satisfactory
- Education
- Community based services.
- Networking between health boards and local authorities.

Group 3

- Skilled professional expertise.
- Community supports.
- Good networking.
- Access to services.
- Life long learning.
- Health promotion.
- New technology.
- New regional specialisation.

Question 2:- What requires fixing and what are the barriers, which need to be addressed in this 'fixing'?

Group 1

- More support financial and other for voluntary organisations.
- Life-span developmental approach to universal access.
- Inequity of service -Public v's Private.
- Poor accessibility to information and communications.
- 9 – 5 system, no cover out of "hours".
- Need for more emphasis on preventing secondary illnesses.
- People need to be aware that they have a right to a quality service.

Group 2

- Carers – more training, support and coordination.
- Improved discharge procedures – simple and proper instructions/care plan.
- Isolation – poor communications, information and networking.
- Poor attitude of junior Doctors when dealing with older people.
- Access to services needs to be improved (Inequity VHI etc).
- Improved contact with health board officials – continuity not phone calls.

Group 3

- Rapid response to emergency situations.
- Improved service standards
- Community support via partnership and collaboration - need for active development.
- Access on basis of need.

Conclusion

The results of the consultation process with the Older Peoples Forum in the Midland region will no doubt be reflected through out the country. Healthcare is such a vast area, which is personal and subjective, that makes it is impossible to condense or summarise findings to everybody's satisfaction. However in order to develop a significant theme or viewpoint that came forth from the consultation process I would say that (in my opinion) a principle issue that is contained in the responses of all groups to each question was -

Community based supports and services (including voluntary organisations) work for older people and should be supported, expanded and developed. Older people are entitled to quality services and supports on a par with other care groups and these services should be available on a twenty four-hour basis.

Barry O'Sullivan

Meeting Co-ordinator

Attached please find the attendance list for this meeting.

Midland Regional Consultative Forum/Older People.

Date : 10 May 2001
Venue : Tullamore Court Hotel
Time : 10 a.m. - 1 p.m.

Attendance:

Sr. Ursula Butler, Edgeworthstown Nursing Home
Ms Molly Buckley, Offaly County Council
Mr. Tom Colgan, Retired Nurses Association
Mr. Patsy Campion, Community Care, Laois/M.H.B.
Ms. Margaret Feeney, M.H.B./Mullingar I.Y.O.P. Committee
Mr. Joe Doheny, T.A.R.A.
Ms Anna De Suin, Researcher M.H.B.
Mr. Fionn Gallagher, Mullingar I.Y.O.P. Committee
Ms. Catherine Leavy, Community Care/Longford Westmeath/M.H.B.
Ms. Anne Matthews, Heart Support Group, Community Alert
Ms. Kathleen Maxwell, I.C.A.
Ms. Emer McCarthy, Health Promotion/M.H.B.
Ms Ann McNamara, Mountmellick Active Retirement Group
Ms. Monica O'Malley, Longford Community Resources
Mr. Moss McCormack, M.H.B.
Ms. Barbara Murphy N.C.B.I. Cloghan House, Tullamore
Mr. Jim Dwyer (for Orlaith O'Brien), St. Vincent's Hospital, Athlone
Mr. Douglas O'Connor, Westmeath V.E.C.
Ms. Cathy O'Grady, Intellectual Disability Services.
Mr. Barry O'Sullivan, Older People/M.H.B.
Ms. Mary Quinlan, Community Alert (Regional)
Ms. Rosemary Richardson, Mountmellick Development Association
Mr. Maurice Stenson, Westmeath County Development Board

Apologies:

Sr. Maeve Brady, Dolmen Failte Club
Mr. Louis Brennan, Laois County Council
Ms. Kate Brickley, Health Promoting Hospitals/M.H.B.
Ms. Paula Brophy, Carers Co-ordinator
Ms. Finola Colgan, Mental Health Association
Ms. Mary Culliton, Dir of Corporate Fitness/M.H.B.
Ms. Kay Delamere, Edenderry Forum/Social Services
Dr. Patrick Doorley, Dept. of Public Health/M.H.B.
Mr. John Kincaid, Community Care/Laois Offaly M.H.B.
Mr. Donie Murtagh, Community Care/Longford
Ms. Rosie Horan, Social Services/Offaly
Mr. Matt Lennon, Gardai
Ms. Anne Marie Maher, Laois Sports & Recreation Officer
Mr. Tony Mahon, Laois Education Centre
Mr. Tadhg O'Brien, OAK Partnership
Ms. Susan Temple, Community Care/M.H.B.

OLDER PERSONS GROUP - WOMEN

- **Consultation with:**
  Portlaoise Women's Group - Older Persons (22)

- **Facilitator(s):**
  - Ms. Geri Quinn
  - Ms. Emer McCarthy

- **Date:**
  - Late April

Health Strategy Consultation – Report

Older Persons Group- Women

Group Consulted:	Portlaoise Women's Group- Older Persons
Members present:	22 women, Secretary; Maureen Hickey.
Methodology:	Group Discussion and flip chart
Facilitator:	Geri Quinn, Emer Mc Carthy, Health Promotion Department
Report	
Vision- Principles:	• **Quality;-** The public health service should be of an excellent standard and be comparable to the private service not acceptable to have different standards of care and service within the 'two tiers' of the current service. • **Accessible;-** The local/ regional health services should de developed to meet the needs of the local communities it serves. • **Equitable;-** The health services available in all areas of the health board should be the same (at present some areas of the board have more/ better services than Portlaoise). • **People- Centred;-**The service should be friendly and welcome the public/ community when using the services • **Accountable;-** All people, but especially the sick, should be treated with respect, dignity and have some privacy when using the health service • All hospitals and health service buildings should be well-maintained, clean. The old unhygienic buildings should be demolished or renovated
Strengths	• Nursing staff are doing a good job despite being overworked • GP service accessible • In some areas of the board there is an accessible equitable health service – not in Portlaoise • Maternity Service is good but very busy and appears to be under-staffed
What needs to be fixed;- Areas for Development- Weakness	• The Buildings- Portlaoise Hospital is " dirty, unhygenic"- the tiolets are in a terrible condition. • Casualty Services very slow with long waiting times- and after a long wait, clients may then have to be taken to another hospital for the treatment they require(ENT Services no service in Portlaoise Hospital) • The disrespectful undignified service that ill- people have to endure whilst waiting for beds in casualty- not acceptable for ill-people to left in corridors for long periods • Not enough beds in the Midland Health Board Service to meet the growing population's need. • Local Health Service not responding or developed to meet the local community's health needs • Overworked and tired staff-

	• Staff shortages- all staff should be well- paid to ensure adequate staffing levels. • Service not friendly or welcoming- People feel bad having to use casualty. • Local/ Regional health services slow- long waiting times for treatment and referral- it is quicker to be referred to Dublin Hospitals. • Screening Services- people need more information on the Screening Services available- and follow-up information • Poor Public Transport service to access health services within the Midland Health Board
Barriers within the Health Service and to General Health	• The 'two-tier' health service, there is a big difference in the two services-specifically waiting times, for treatment and referrals and in out-patient clinic systems. • Long waiting times for referrals to local/ regional health services- local GPs in Portlaoise often refer patients to Dublin as it is quicker. • Paying for screening services is a barrier for many people – especially families who are not on the GMS and with only one income, screening service not an accessible or equitable service for them • Poor quality of care and service in public health care • Lack of accountability within service • State of the Buildings- The hospital in Portlaoise is dirty, unhygienic- leads to cross-infection • The lack of customer care – service is not person/people – friendly, not a pleasant experience having to use the current service • Public transport service is very poorly developed in Midlands- difficult to access local health services, it is easier in a lot of instances to go to Dublin for health services. • Casualty services- current service is not;- (a) people –friendly, (b) accessible to local people. • The health services in portlaoise are not equitable when compared to other areas. • Out-patient clinic appointment system;- everyone asked to attend at the same time, this leads to long waiting times within ares that have poor support services i.e. no creche services • Lack of good information on;- Health issues and the Health services • Security in hospitals- staff and patients are very vulnerable
Building Bridges around the barriers	• Health Promotion should start in school-(nutrition, anti-smoking and drugs education & advice, mental health promotion) • Build new hospitals and renovate the old run-down buildings- need more money invested in maintaining the buildings • The health service should be developed and funded to meet the local community's needs. • Matrons should be 'brought back'- to ensure all hospital

	services are well run and of a good standard. • The medical card should be available to all families and to people over a certain age. Ideally the 'Medical Card should be available to all. • Public Health Service should be developed and properly funded to provide an excellent standard of care and service comparable to the private health service. • Customer- care training and awareness for health service staff • Staff should be better paid to retain staff and to ensure staff feel valued in their work.
The 'Key Changes' that need to happen within Health Service to address poverty and social exclusion.	• The medical card should be available to a wider range of people with the income bands increased to reflect inflation. • Public Transport Service should be developed in Midlands to access health services and all relevant services. • Screening services should be free to the public as those outside the GMS and with big families cannot afford to pay for screening. • Local health service should meet the needs of the local community • More health information for people on low incomes on healthy living and smoking. • More community development and investment. There is no facilities for local community groups to meet and provide support for each other-

The group, whilst happy to participate in the consultation expressed some scepticism regarding the value of the public consultation process and it's value and influence on the development of the health strategy. The group has requested a copy of their consultation report and have also requested a copy of the report that will be sent from the Midland Health Board to the Department of Health.

ACTIVE RETIREMENT ASSOCIATION

- **Consultation with:**
  - Tullamore Active Retirement Association

- **Facilitator:**
  - Mr. Paddy Lowbridge

- **Date:**
  - Late April

SUBMISSION FROM TULLAMORE ACTIVE RETIREMENT ASSOCIATION

There is a feeling among elderly people that they are being sidelined by the State.

They live on very meagre incomes and, therefore, are no longer in a position to purchase cars, houses etc. so are no longer considered "economic units".

These are people who have reared families who are the present tax payers.

THEIR FEARS:

- Being attacked in their homes or being mugged in the street
- Loneliness: Loneliness: Loneliness
- Not knowing their entitlements
- Being ill and maybe alone
- Suffering long delays in Casualty Wards
- Being placed at the bottom of a waiting list when needing attention
- Being discharged from hospital too soon and
- Having nobody to take care of them when they go home
- Doctors seldom available at weekends
- Some medication not available to Medical Card Holders

REMEDIES

- Have Social Workers to visit elderly people living alone and to explain to them what are their entitlements.
- Explain what is a people-centred Health System
- What advantage is it to the elderly?

- Carers are most essential and, even if the carer is a relative he/she should receive financial assistance and be given respite occasionally.
- Home help should also be provided where necessary.

OF COURSE PREVENTION IS BETTER THAN CURE

Active Retirement Associations can help here in keeping elderly people mentally and physically active. Social Service Councils also provide wonderful assistance in this regard.
Unfortunately there are very few community halls available where elderly people can meet regularly and socialise comfortably with friends and neighbours.

Funding should be made available for the provision of such facilities.

Money provided for such amenities would be far better spent than the millions of punts that will be spent on the "Bertie Bowl" and on the "Spike" in O'Connell Street, Dublin.

Chairman: Paddy Lowbridge. Secretary: Mary Hennessy

DISABILITIES - INTELLECTUAL / PHYSICAL/SENSORY

- **Consultation with:**
  - Regional co-ordinating Committee Physical/Sensory Disability
  - Mental Handicap Services Consultative Committee
  - Mental Handicap Services Development Committee (in total 27)
- **Facilitator(s):**
  - Mr. Moss McCormack
  - Mr. Thomas Reilly
- **Date:**
  - 24th April 2001

Submission from stakeholders in the field of Disability to the MHB in respect of the New Health Strategy.

The Vision of the Future:

The group involved in the exercise challenge government with a vision of the future that sees:

- Individuals as having well-being and quality of life in the first instance albeit with some of them carrying a disability and society at large focused on improvement in quality of life for all including those with disabilities.
- The vision sees a society where a major effort is being made in promoting health and preventing disease with the objective of maintaining as many people as possible with quality of life.
- The vision sees statutory and voluntary providers with clear roles and responsibilities and appropriate resources, operating in an environment of close partnership with clients and their families to deliver client-friendly services.
- Where when there is need, the individual needs of the disabled and their carers are assessed, with the appropriate assessment being facilitated by a structure such as a "facilitator" who will ensure the assessment is comprehensive, appointments are made and adhered to, and generally guide the client and family through the process. Information on need will be published in order to increase awareness within society.
- Once assessment has been carried out the vision sees a world where access to appropriate services is based on need, and not on, ability to pay or geographical location. There will also be widespread access to information concerning services through a variety of communications including and no physical barriers to access.
- Planning for delivering services to meet need will be more bottom-up to ensure it meets with the principle of consumer oriented services and delivery processes. Disabled people must be involved in policy development and in the development of strategies and action plans as well as in service evaluation.
- In our visionary world, services for people with disability and supports and respite for carers will be free of charge or cost limited. They will be available for access as required and not confined to any 40 hour working week.
- In our vision, service standards will ensure equality issues are to the forefront and that interventions to population ratios and facilities to population ratios are transparent and published.
- Interventions, including: health promotion; disease prevention; diagnosis and treatment and rehabilitation and care interventions will be provided by an appropriate number of qualified professionals who will work to evidence based good practice protocols. Services will be provided in the home, in the community, in hospitals and in residential institutions as appropriate. Clients will be informed about alternative options for interventions available and will be engaged and assisted in making the necessary choices.

- In our vision, service delivery will be monitored and controlled against pre-defined good practice standards of delivery and changes made as appropriate.
- Finally, services will be evaluated for improvements in health status and quality of life. Mechanisms or instruments will exist that show that people/clients get a benefit from each contact with services. Members of the public as well as statutory and voluntary providers will be involved in the evaluation process and the results will be published to increase public awareness of service quality.

What Needs Fixing:

While many strengths exist within services in the MHB area, and are highlighted in appendix 2 this presentation focuses on things that need to be fixed in the hope of achieving the vision outlined.

1 The status of the disabled needs to be increased in the eyes of the population and the increased status should be more visible in policies, legislation, strategies and plans.
2 The right to a range of disability services must be enshrined in legislation.
3 Health services must be free to all disabled persons.
4 Health services should be free to all persons 0-18 years of age.
5 Better, and more accessible information is required on: need; services available; interventions; standards and performance in terms of outputs and outcomes.
6 Formal structures to support needs assessment, planning and evaluation are needed.
7 The full economic cost of the care put into caring for the disabled by family members should be computed to highlight the value of such care to the state.
8 More money should be allocated to disability services.
9 The output from the disability database should be used for planning and to set budgets.
10 New facilities and improvement/upgrading of existing facilities for residential and respite care of the disabled are required.
11 There should be one point of contact for all services.
12 Transport systems in general and in particular for the disabled should be improved and existing and future transport systems should be better co-ordinated.
13 Additional skilled-staff are required in the disability area – not enough exist currently
14 Strategies and incentives for retaining skilled and competent staff are needed
15 GPs should have stronger links with disability services.
16 Health workers, teachers and other students should be educated in disability issues and should be trained in dealing with the disabled.
17 Appropriate structures should be in place to reflect the multisectoral approach required for delivering services to disabled persons.
18 Management structures in the MHB must facilitate voluntary providers in carrying out their role through streamlining the budgetary, monitoring and evaluation processes.

19 Communication should be improved between deliverers and the public and between deliverers themselves and the complaints system should be used as a monitoring tool and as a learning tool for quality improvement
20 Budgets and the authority to make decisions should be devolved to line managers and they must then accept accountability.
21 Sufficient staff must exist and they must actually have the time to deliver the appropriate interventions in accordance with good practice protocols.
22 Standards for service delivery should be set and published.
23 Performance indicators for measuring progress towards achieving the standards should exist.
24 The performance indicators should be used for monitoring and evaluation of services and their delivery.

What needs to be done to remove barriers to progress (Strategies)

The following strategies are proposed by the group for removing the barriers to progress in improving health status and quality of life:

Health status and quality of life can be improved by:

Policy and Consumer Oriented

1 Enshrining in legislation, the rights of persons with disabilities to an appropriate range of services.
2 Instituting campaigns that enhance awareness in the community of the contribution that can be made to society by persons with a disability who have the right to all opportunities to allow them to achieve the best they can be. The campaigns will also highlight the needs of those with a disability and promote patient-centred approaches to service planning and delivery and will put emphasis on health promotion and disability prevention.
3 Representing the interests of persons with a disability on all consultative committees which should review all legislation, policy and plans for disability sensitivity.
4 Instituting network meetings that are attended by policymakers and users of services to deal with the gap in knowledge that currently exists between policymakers and users.
5 Establishing other structures that ensure stakeholder representation in all planning and evaluation exercises and projects for services for persons with disabilities.

Need

6 Instituting periodic needs assessment and database update and validation.
7 Adopting the principle of timeliness – where need will be responded to at the appropriate time and not when it is too late. The database to be used to guide service provision.

Access/ Equity

8 Establishing mechanisms for ensuring services are free to all persons with disabilities. Options to include access to medical card, state-funded health insurance, extension of refund schemes etc.

9 Establishing one point of contact for all services for persons with disabilities. Such centres should have all information on services available and should employ a range of communication technology suitable for persons with disabilities – deaf, blind etc.

10 Appointing facilitators to assist persons with disabilities in gaining access to services, making choices and using services. The facilitators can guide individuals and families through the process of accessing health, education, social welfare and other services.

11 Assigning a key-worker to persons with a disability including those with a mild disability

12 Establishing a network of transport services throughout the midlands for persons with disabilities, based on options that can include: refund of taxi fares; money allocations instead of free passes. Ensuring that the transport initiatives being undertaken by Community Development Boards are sensitive to the needs of persons with a disability.

13 Reinforcing the policy on physical access to all buildings and auditing for compliance.

Quality Services

14 Computing the cost of the extent to which disability represents a cost on society especially the contribution made by family members in care provision and accordingly providing carers allowance to families with disabled persons

15 Requesting the DoHC to produce realistic costs for the range of appropriate interventions and services that should be available to those with disability. National cost bands can be developed for needs of different level and type.

16 Defining the package of promotive, preventive, diagnostic, treatment, rehabilitative and care interventions that are available to disabled persons in the home, in the community, in hospital and in residential care.

17 Ensuring that services are user friendly with:

- ease of access
- simple information
- simple language
- simple forms

18 Defining staff to workload ratios for the package of interventions and ensuring the necessary numbers and skills-mix is available and funded.

19 Ensuring that all children and adults including the disabled have access to 30 minutes of exercise each day as a health promotion initiative.

Quality Service Delivery

20 Developing evidence based protocols for delivering interventions and auditing to ensure compliance with good practice

21 Devolving budgets and the authority to make decisions to line management.

22 Providing additional funding under the NDP to provide additional residential and respite places for persons with disabilities.
23 Defining service standards with appropriate resourcing and monitoring delivery against the standards.
24 Enforcing the existing legislation on employment and opportunity.
25 Applying conditionality to government and lotto allocations to sports, the arts etc to ensure the needs of those with disability are met in regard to access to social opportunities.
26 Training to sensitise all health professionals and teachers to the needs of persons with a disability.
27 Ensuring that GPs are part of the multidisciplinary team providing services to disabled persons.

Evaluation

28 Ensuring evaluation teams are set up and key stakeholders are represented on all evaluation teams for services for disabled persons.
29 Ensuring appropriate performance indicators are developed for measuring performance against standards and project targets.

Feedback from the Workshop:

The following details the issues raised by stakeholders in attendance at the workshop in the Shamrock Lodge Hotel. The contents were agreed with the facilitator before the session finished as a true reflection of the views of the group.

Vision:

A world/community where:

1 Medical card is made available to all disabled on the basis of need and not on income. Removal of the review of medical card eligibility and the review of domiciliary allowance?
2 More GP practices exist, which will deliver improved access, reduce waiting times, increase competition and maybe reduce fees.
3 Adequate numbers of therapies and other essential cadres for disability services exist based on a series of Workforce Planning Studies.
4 Hospital and community staff are skilled in communication with physical and sensory disabled.
5 Health insurance systems cover the cost of services if medical card is not automatically available to the disabled.
6 Technological and other innovation enhances communicative links in the community for the disabled such as the deaf, blind, etc.
7 While current structures for planning are good, a more bottom up approach is pursued with greater input from users of services.
8 Facilitated identification of needs and gaps in services promotes a more seamless and co-ordinated service delivery.
9 Health promotion strategies exist which promote greater access for the disabled to sports and other quality of life improvement activities.
10 Access to necessary services and activities are extended to evenings and week-end.
11 Personal assistants are available to disabled persons as required.

12 Disability is made an issue in all areas of economic and social life: work, entertainment arts and sports etc with some element of state funding being made conditional on implementation of the full integration of disabled.
13 Health promotion is perceived as "healthy life as part of the community".
14 The concept of the disabled "never being asked what they want, but told what they are getting" is reversed, as a challenge to health professionals in particular.
15 There is an appropriate Casualty Unit in Athlone.
16 Care partnerships exists between client and deliverer so that services are tailored to individual need.
17 Services are more client friendly and structures exist to support this, such as:
- care pathways for all
- key worker approach
- facilitation in moving along the continuum of services
- improved linkages between hospitals and community that give real credence to the desire for living within the community.

18 The roles and responsibilities of the statutory and voluntary sectors are clear and resources and delivery of service issues have been clarified.
19 Equity exists within disability services and where:
- Access to information is timely
- Access to services takes account of:
  - Geographical issues
  - Standards for services – staff to population ratios etc
  - The need for replacing the current "crisis response approach" by statutory services by a more "ongoing maintenance therapy" approach.
  - The need for disability proofing of all services through training by introducing modules in disability.

Q2/3 Strengths and Weaknesses ("What needs Fixing")

Strengths:

1 Human Resource:
- Human resource personnel within the region have a positive ethos
- Staff are highly skilled
- All staff step out of their brief displaying much commitment beyond their contracts
- Staff seek the best for their users.

2 The size and geography of the Board is a strength in promoting networking.
3 The Board is one of the first in the country to develop and use the database and much of the subsequent targeted development has been due to the database. Also funding for aides and appliances is high due to the database.
4 The MHB seeks to develop specialisation
- There is recognition of the special skills of the Voluntary Sector
- There is commitment to partnership approach
- There is a proactive approach to recruiting

- There is a commitment to training

What Needs Fixing:

1 Additional skilled-staff are required in the disability area – not enough exist currently.
2 New facilities and improvement/upgrading of existing facilities need to be targeted by the NDP.
3 More money needs to be allocated to disability services in the NDP.
4 GPs need to have stronger links with disability services – GPs should be part of the multidisciplinary teams.
5 Communication between deliverers and consumers needs to be improved and the complaints system needs to be used as a monitoring tool and as a learning tool for quality improvement.
6 Access to information needs to be improved.
7 Transport systems in general and in particular for the disabled need to be improved and existing and future transport systems need to be better co-ordinated.
8 Increase numbers of key staff : therapies, social work etc need to be trained and recruited.
9 The status of the disabled needs to be increased in the eyes of the population by assigning more carer and home help supports etc.
10 The full economic cost of the care put in to caring for the disabled by family members needs to be computed and highlighted in order to substantiate the call for more supports to the disabled.
11 Improve communication is needed between the various staff groups – "listen, hear, then understand and take action".
12 Standards for appropriate caseload for the many cadres involved in care of the disabled are needed.
13 *Performance Indicators* are needed for a variety of areas such as the time lapse between the identification of need and the delivery of services. Continuous improvement needs to be based on such indicators.
14 Output from the disability databases needs to be used for budget determination.
15 Budgets and the authority to make decisions needs to be devolved, line managers need to be held accountable thereafter.
16 Disabled needs to be given a higher (more visible) profile and the disabled need to be heard.
17 The Minister and Health Board CEO needs to display commitment to the disabled by seeking where possible to have disabled persons attached to their teams – *even as a form of tokenism at the outset.*
18 MHB management structures need to be client focused. MHB management structures are academic and not client focused – little consultation/participation occurred with the voluntary organisations in developing the care group approach and now negotiation of budgets for voluntary organisations involves two MHB functions rather than the previous one.
19 Incentives need to be targeted at retaining key staff, such as creche facilities to attract staff back to work.
20 More residential and respite places need to be provided.

21 One point of contact needs to exist for all services through appointing facilitators that can assist clients and family and guide them through the processes involved in accessing services..
22 Planning processes and tools, standards and guidelines need to be evaluated for their usefulness in reflecting the user perspective on services and their access to same.
23 Staff need to actually have the necessary time to implement the protocols for delivering the various interventions this is not always the case currently.
24 The right to a range of disability services needs to be enshrined in legislation.
25 Health services need to be free to all aged between 0 and 18 years.
26 Teachers and other students need to be educated in disability issues and need to be trained in dealing with the disabilled.
27 Local (Sectoral) Health and Education Committee need to exist to deal with disability issues including: appropriate equipment and technology to assist the disabled in learning and living.

Q4/5 What needs to be done to remove barriers?

1 Structures that ensure consultation and feedback leading to proper evaluation of services, projects etc.
2 Network meetings that are attended by policy-makers as there currently appears to be a gap in knowledge between policymakers and users.
3 Campaigns to enhance awareness of needs and to promote patient-centred approach.
4 Adequate representation of the disabled interests on all consultative committees.
5 Services that are user friendly:
- simple information
- simple language
- simple forms
- access

This is mandatory in the US, why not here?
6 Reinforcement of the policy on physical access to all buildings
7 Publication of the extent to which disability represents a cost on society
8 Carers allowance to families with disabled persons who carry the burden often at a hardship to themselves
9 Realistic costs produced by DoHC for the range of appropriate interventions and services available to the disabled.
10 Statement required that need will be responded to at the appropriate time not when too late. The Database to be used to guide service provision.
11 National cost-bands for needs of different levels and type.
12 Removal of bureaucratic barriers with autonomy and authority to decide vested in line managers
13 Facilitator to guide families through the Health and Education systems for a disabled child. The facilitator must be assigned only a manageable caseload.
14 Those with mild disability to have a keyworker.
15 Extension of the refundable schemes to include refund of GP fees for all disabled people if medical card not provided to all.

16 Appropriate skills-mix to be promoted as a philosophy and an approach to meeting need.

17 Choices for the disabled: respite and carer relief with home assistance service.

18 Service standards with appropriate resourcing.

19 Enforcement of current legislation on employment and opportunity etc.

20 Sport allocations from government and lotto etc to be conditional on disability need being met.

21 Transport for all including the disabled especially those in need in rural areas. Options to include:

- Refund of taxi fares
- Money instead of free bus passes

It is recognised that Community Development Boards are developing transport policies. There is a need to ensure that such policies are sensitive to the needs of the disabled.

22 Improved planning to ensure that the appropriate needs of the disabled are taken into account in the Capital Development Plans for residential services, day care and health centres.

23 All children and adults including the disabled with access to 30 minutes exercise each day as a health promotion initiative.

MENTAL HEALTH VOLUNTARY/STATUTORY ORGANISATIONS

MENTAL HEALTH VOLUNTARY/STATUTORY ORGANISATIONS

- **Consultation with:**
  - The Mental Health Promotion Project Team
  - Health Promotion
  - Mental Health Association of Ireland
  - Hospice Services
  - Mental Health Service Workers
  - GROW
  - AWARE
- **Facilitator:**
  - Ms. Moira Tysell
  - Ms. Geri Quinn
- **Date:**
  - Late April

NATIONAL HEALTH STRATEGY

Report of consultation with Voluntary Organisations, Mental Health Services.

Groups consulted:	GROW AWARE HEALTH PROMOTION MENTAL HEALTH ASSOCIATION IRELAND HOSPICE SERVICES MENTAL HEALTH SERVICE WORKERS
Methodology:	GROUP DISCUSSION INDIVIDUAL INTERVIEWING USING SET QUESTIONS AS DETAILED BELOW

Questions asked:

1. What is it that people think would be a preferred health service?
2. What are the strengths of the existing service?
3. What requires fixing?
4. What are the "barriers" which need to be addressed in the "fixing"?
5. How do we overcome these barriers?
6. What is the impact of poverty?

Response from Voluntary Services

1. Vision – Principles?

" ***The Health Strategy should have a holistic view of 'Health', incorporating the mind and the body and this should be reflected in the service development".***

The Health Service, (Mental Health Service) should be:

- ***Person centred***, placing the user at the centre
- ***Continuous***;- medical staff contracts not conducive to continuity in patient/client care as most contracts are only for six months. This has a detrimental effect on the clients progress (slows down relationship building and trust).
- ***Equitable;-*** Equitable standard of service available to all. The private mental health service is not well developed in the Midlands, therefore the public service is the main service provider. The Public service requires greater funding and commitment
- ***Quality driven service at every level*** of service: Standards of care and service should incorporate all the hallmarks of quality.
- ***Professional***;- at every level of its service delivery
- ***Mental Health Promotion*** should be incorporated into main mental health service /care- all professionals practising mental health promotion. Mental Health Promotion should be adequately funded and given due commitment.
- ***All health Professionals to have a good understanding of mental health and its role within the Health Service.*** GP's should be more informed and aware of the comprehensive mental health services available and then refer appropriately,(Counselling, Bereavement,)
- ***The Voluntary Organisations*** should be recognised and valued by the health service for their contribution and support input.
- ***Accessible through appropriate information provision*** (Staff and public)
- ***Accessible*** to all in the community.
- ***Available*** to all. Not based on the money an individual has.
- ***User Friendly*** literature and promotion should meet the needs of all, irrespective of ability to read, first language etc.

2. Strengths

- There is a statutory system in place
- The service is available
- The service is multi-disciplinary
- There is a "culture of change" – legislation is changing slowly but there is a willingness to change
- There is a good network of Community Mental Health Centres throughout the Midlands, providing an accessible service to the local communities.
- There is a "great Voluntary Sector network" and linkages within the Midlands
- The Staff
- Good liaison and bridges between hospital services and community services.
- Alternative service available for new clients
- Support Groups for clients and their families.

3. Areas for Development – "fixing" weaknesses?

- Legislation needs to change
- Ring fencing of funding to give antonomy and importance to Mental Health Services
- Need for specialist workers or generic workers with specialist interests/skills
- Stronger emphasis on Mental Health (Positive Mental Health, Mental Health Promotion).
- Reduction of 'Stigma' associated with Mental Illness
- Buildings and infrastructure of Mental Health Service in need of capital investment and planning. Old buildings are 'terrifying' and add to the negative stigma
- Poor understanding of the concept of 'Mental Health/ Illness' within the Department of Health and the Health Boards
- Existing legislation is out-dated:- low priority in developing new legislation
- People at 'high risk of mental illness' are not given due priority/ recognition. There is a huge opportunity for mental health promotion
- User/ Client empowerment within Health Service (Mental Health Service).
- Carers mental health needs to recognised
- Public transport service should be developed and planned around the health service provision, especially in rural areas.
- No permanent contracts for Irish Drs. Current medical contracts need to be changed as at present the short contracts are a contributing factor on 'inconsistent patient care' and service which at present is not a 'needs-led' service
- Lack of choice for patients within Mental Health Service; - Mental Health does not appear to be an attractive career option for Irish doctors. There is very limited choice for patients on the consultant who treats them

4. Barriers?

- Need a change of thinking or "mindset" and the way things are done
- Need to breakdown stereotypes and culture of "elitism" within services
- Lack of funds
- Lack of resources – both human and other
- No national policy directing mental health service planning and development.
- More Funding-
  - Capital funding
  - Mental Health Promotion
  - Mental Health Service in general
- Counselling Services. There is a general lack of clarity on this service at present; need a dedicated national focus on counselling services. "Peer support" counselling an option to complement professional counselling service.
- Update existing legislation.
- The Department of Health's capacity and commitment on mental health should be addressed and action-planned.
- All schools should have an accessible and equitable psychology service

- Joint service planning between the government departments (Dept. of Health, Dept of Social Community and Family Affairs) and interagency, (NAPS, Housing, Education) around health but especially mental health.
- All planning processes should address the 'Health Question'.
- Mental Health should be incorporated within Occupational/workplace Health and safety programmes and risk assessment. Positive mental health should be promoted and addressed at all levels within all workplaces, addressing bullying, working conditions etc.
- The Settings within the Mental Health services are not always appropriate / suitable for delivering the ideal service.

5. Overcoming barriers/building bridges around barriers

- Begin to overcome through commitment
- Promote cohesive new service
- Expect to change "little by little"
- Literature should be available to all and in many formats and languages
- Equal status Act 2000 must be incorporated and awareness/knowledge of this increased
- Voluntary organisations should have a voice and a platform, and should be taken seriously
- Develop a Mental Health Promotion Policy at national level.
- Legislation should be updated.
- Adequate funding allocation to develop existing services.
- Stronger focus and emphasis on Mental Health and Mental Health Promotion within the service planning of the Department of Health.
- Mental Health should be prioritised and 'lobbied' at local, regional and national levels through community development action and community groups.
- Mental Health and Mental Health Promotion should be incorporated within the Education system as part of the ' Health Promoting School' project.
- The school's psychology service is a separate service at present and is therefore a stigmatising experience for the children who use the service. It should be incorporated into the normal development screening service provided within the schools.
- Support for Parents with children who have mental health difficulties.
- Greater focus on preventing mental illness and recognising people who are at a high risk of mental distress.
- Need to increase the number of consultant psychiatrists and psychologists;
- Permanent contracts;- Reduce staff turnover
- Improved expertise base
- Improved patient choice
- Improved patient care
- The Mental Health Service should be client centred incorporating empowerment and consultation within the service planning process.
- The Mental Health Service provision and delivery should be locally based and accessible to the local community.
- Public transport services should be planned around the health service delivery points.

- Carers' 'Means Test' should be abolished immediately in recognition of their contribution to the health services and the community.
- Increased Mental Health training/education for all health professional especially GPs-

6. Poverty – The Impact?

- Poverty or isolation should be viewed not just in monetary terms but also in terms of relationships/supports etc. Health and social gain should be addressed.
- Access to the health service should not be based on the individuals ability to pay
- The Health Service should be person centred and respectful of the social determinants of health.
- Health professionals need to be aware of their own lack of knowledge on these issues- specific training programmes need to be developed within the health service sector.
- Poverty causes ill health especially mental ill health, there is a need for joint service planning to address poverty issues that affect health (housing, income, welfare)
- Marginalised groups such as Travellers are not treated professionally within Health service. Mental ill health a real issue for these excluded groups.
- Personal development / capacity building programmes should be developed and available to marginalised groups to empower and enable them to access the Health service.
- Staff attitudes /prejudices should be addressed and appropriate training programmes developed and delivered at every level of the Health service and other statutory departments and organisations

MIDLAND ALLIANCE FOR MENTAL HEALTH

- **Consultation with:**
  - GROW
  - Schizophrenia Ireland/Phrenz
  - Alzheimer Society Ireland
  - Samaritans
  - Bodywhys
  - Aware

- **Facilitator:**
  - Ms. Finola Colgan

- **Date:**
  - May 2001

SECTION B

- **Midland Health Board Members**
- **Midland Health Board Corporate Team**

Midland Alliance for Mental Health

Health Strategy 2001
Consultation

Submission to
Eileen O'Neill
Planning & Commissioning

Facilitator: Finola Colgan Development Officer MHAI
May 2001

CONTENTS

Midland ALLIANCE for MENTAL HEALTH
Consultation re Health Strategy 2001

1.1 Introduction

This consultation was developed around group discussion with members of the Midland Alliance for Mental Health following from which an initial report was compiled. This was followed by a review of the report, which now form the substance of our submission as an Alliance for Mental Health.

This consultation comprised of representation from

- GROW, Mary Greene and Harriet Horan
- Schizophrenia Ireland/Phrenz, Mary Kennedy
- Mary Barden Alzheimer Society Ireland
- Deirdre Collins – Samaritans
- Jennifer Kelly – Bodywhys
- Aware- Mary Mooney

Facilitator: Finola Colgan Development Officer Mental Health Association of Ireland

1.2 Background:

The following report represents the outcome of two meetings with the above groups. While we may appear to be critical of existing systems, we also appreciate the support that is given to voluntary organisations in the Midland Health Board.

The Midland Alliance for Mental Health was established in March 2001. We convened in April to put forward our views on the Health Strategy 2001 and welcomed the opportunity to do so.

The following submission reflects how voluntary organisations and their members view themselves in terms of health service delivery, particularly in relation to Community Mental Health services. This report follows the suggested format issued by the Department of Health & Children.

1.3.Methodology:

We held two meetings; the first meeting included a short presentation on the background, aims and objectives and consultation process of the Health Strategy 2001. An initial draft report was collated and discussed at our second meeting from which this Report has been finalised.

Our key focus based on the guidelines was mainly on

- *our view of the Mental Health Service, - particularly community based rather than hospital*
- its relationship with voluntary organisations
- how we would like to see the Mental Health services benefit the service user and their carers

We agreed to use the notion of service user through out this report to reflect all clients/patients availing of Mental Health Services. We deliberately did not address specific mental health issues such as suicide, depression, schizophrenia etc in order to keep a general focus within our consultation process.

2.0: VISION OF OUR IDEAL HEALTH SERVICE

2.1.*General*:

- That the health services be fair, appropriate and accessible irrespective of income
- That the input of the voluntary organisation into service delivery be recognised and clearly established
- Funding be guaranteed so that voluntary organisations are not struggling or "limping" along to achieve their aims and objectives
- Health service should be well funded and staffed to incorporate different service user needs
- Better equity in consultation process, not the professional v the service user
- Voluntary sector can be a good voice for the service user

2.2.Partnerships

We accept that partnerships are being successfully established. However there is a need to place them on a better platform/forum so that when voluntary organisations are at the "table" with the statutory structure there is equality with a genuine commitment to consultation and working in partnerships. It also seemed to us that the consultation process for the "Health Strategy" is more geared towards a statutory lead response

2.3. Mental Treatment Act

Proposed new Mental Treatment Act should be enacted – there appears to be a lack of commitment to it. It has low priority and has not been afforded high priority or commitment to its implementation

2.4 Access

- Service need to be more user friendly and flexible
- Accessibility – physical access to the service, some CMHC services not wheelchair friendly and or suitable for use by persons with other forms of disability
- Accessibility of information – service users their carers be more informed of the role and functions of Community Mental Health Service, the range of professionals that work there
- Accessibility is affected by the a stigma that can be associated with Mental Health Services/Mental Illness
- Mental Health Service be a central point of contact for local voluntary organisations and other voluntary groups
- Develop Community mental Health centres or drop in centres so that someone with a mental health problem can walk in without the requirement of a referral letter

2.5.GPS –

- need to be more informed of the role and likely benefits/supports that voluntary organisations can provide

2.6.A Preferred Health Service

- gives guarantee of confidentiality
- standards of good practice and quality be established and monitored
- consideration be given to attaching statutory powers to the Inspector of mental health Services to ensure his recommendations are implemented

2.7 Equality/Discrimination

- Need to review equal opportunities and mental illness in relation to recent Equality Legalisation so that the service user does not experience discrimination because of a mental illness experience.
- P.U.M. forms are readily used for convenience, this remains a lasting record attached to the service users personal records**.**

3.0 STRENGTHS– of existing services

- Community based
- Multi disclipinary
- Committed staff
- Recognition of the need to put in place Care Plans
- Partnership role of voluntary organisations in
    - profiling local services
    - addressing stigma
    - encouraging and supporting social integration of service user

4.0 Weakness of existing services:

- 9-5 not adequate and lack of availability of a community based service during week end hours
- Non- availability of a 24-hour mental health crisis support service
- Stigma – mental health service –"poor relation"
- Lack of choice
    - Community Mental Health Service and or Psychiatrist -Sectorisation of service has limited choice for service user
- Insufficient consultation with service user and or carer
- Alternative therapies not readily available
- Lack of commitment to advocacy for the service user or carer
- Rotation of NCHD – unsatisfactory for professional patient relationship
- Funding not adequate
- Inadequate counselling/psychotherapy services
- Voluntary organisations not sufficiently involved in staff training programmes for health professionals
- Inadequate appropriate accommodation for service users being discharged into the community
- Mental illness often viewed as a life long illness unlike some physical illnesses
- Insufficient support for the carer
- Lack of consultations
    - between service user and professional
    - professional and carer
    - voluntary organisations and local services
    - Lack of recognition of out of hours input of volunteers

5.0 BARRIERS:

- Stigma and discrimination attached to mental illness
- Service user not involved in the planning, implementation and or evaluation of projects
- Service users not involved in identifying their needs and individual coping strategies that could lead to a need led programme for personal development and over coming the stigma attached to mental illness.
- Limited consultation with voluntary organisation in similar processes
- Research of mental illness largely funded by multi- national pharmaceutical companies. This is not desirable and should be challenged
- Gateway drugs too accessible
- Underage drinking not sufficiently tackled
- Limited vision of the role of the potential of voluntary organisation
- Service hours not flexible –
- Waiting areas often too busy or inappropriately located as part of another service
- There are no training/ information strategies for carers around the nature of mental illness, signs and symptoms and or how to look after their own mental health

Predisposing cause of mental illness in young people

6.0 SPECIFIC SERVICES

6.1 Carers and Mental Health –

- the carer needs of a family member with mental illness can vary
- substantially than with someone with a learning disability. This can stem largely form the fact that the focus is on the mental illness rather than the carer's own needs.
- it was viewed that Care Plans are beneficial but the carer(s) is often
- not involved in this process.
- Carers find it difficult to access information about the nature, prognosis and treatment of the mental illness
- Carer in mental health services largely having to cope with the stigma
- of the mental illness and often do not see any end to the situation. They have to deal on their own with the vulnerability of the persons in terms of social integration and employment opportunities.
- Caring for someone with a mental illness is very stressful

6.2 Young People and Mental Health

Existing Mental Health Services not attractive or appropriate for the young person or their families.

6.3 Other Comments re Voluntary Organisations

- Difficult to recruit volunteers
- Consideration be given to allocating tax credits to volunteers to co-incide with the fact that tax credit is given to organisations who donate money to voluntary organisations
- Voluntary organisations need higher profiles through out education systems – from primary to third level
- Need to look at best practices and be able to adapt them and to share experiences

7.0 SOLUTIONS:

- More communication and consultation between the different partnerships
- Improve resources of the voluntary sector to encourage them to lead and initiate change
- Provide alternative service outside of 9-5
- Identify training needs of service users and carers to be better advocates
- Expand and carry out research into alternative therapies
- Provide more training to key communicators re roles and supports available through the voluntary sector
- Develop and improve counselling services
- Establish *care plans* for all service user and their carers that are practical and manageable
- Service providers to be aware of the dignity of the service user

8.0 NAPS - National Anti Poverty Strategy:

The groups that we viewed as most vulnerable and who may feel uncomfortable about accessing mental health services are

- Travellers
- Lone Parents
- Long term unemployed
- Refugee/Asylum Seekers

- Consideration to bringing the service to them and meet their needs
- Keep the mental illness jargon to a minimum
- Make allowances for lack of literacy skills
- Be sensitive to their perception of mental illness

9.0 CONCLUSION:

Overall as a group we believed that the Mental Health Services should provide

- Choice
- Empowerment to service users and their carers
- Information on entitlements and supports
- Appropriate - meets the specific needs of individual mental health service users and their carers
- planned and delivered through regular consultations
- partnerships be developed on a firm footing

Alliance for Mental Health
May 2001

MENTAL HEALTH SERVICE USERS

- **Consultation with:**
  - Users of Mental Health Services (10)

- **Facilitator:**
  - Ms. Moira Tysell

- **Date:**
  - Late April

NATIONAL HEALTH STRATEGY

Report of consultation with Mental Health Service Users.

Methodology: GROUP DISCUSSION
INDIVIDUAL INTERVIEWS
USING SET QUESTIONS AS DETAILED BELOW.

Questions asked:

1. What is it that you think would be an ideal health service?
2. What are the strengths, or what is good, about the service as it is?
3. What needs “fixing” to make it better?
4. What might stop us “fixing” it?
5. How can we become able to “fix” it?
6. How might being poor affect things?

1. **The Vision – The ideal Health Service?**

- People should be kept informed all the way along the line.
- Doctors should not act "superior" or "snotty".
- Waiting times, for appointments and when being seen, should be reduced.
- People should be told if a referral to a specialist has been received.
- Doctors should take a patients view point seriously.
- Services should be local, both for the person and the family visiting.
- Transport should be more flexible and people should be collected at their own door.
- People from the country, being seen in Dublin, should be seen first, so that they can go home and not spend all day. Some people have children to think of.
- Family visits should be supported/made provision for.

2. Strengths

- You can switch doctors.
- Transport is available, but could be better.

3. "Fixing"?

- When changing doctors you ned to give a reason on the form – this should be made anonymous in some way.
- The forms are difficult especially if you can't read or have sight problems – this should be addressed.
- Services should operate longer hours.
- Locums or covering doctors should not be miles away and should be responsive and willing to visit.
- Diagnosis over the phone is not acceptable.
- Home visits should be more available, not just the person going in to the doctor.
- Administrative errors e.g. forgetting to label bloods should not happen. Losing test results should not happen.
- Night time is difficult – the service should be more flexible.

4. **Barriers?**

- Doctors, and their attitudes, vary.
- Doctors need to treat people with respect and should be trained to do this.
- There should be no verbal abuse (e.g. “snottiness”) from doctors
- Doctors should not be dismissive.
- The system needs to change i.e. there should be more doctors who would then have the time to treat people properly.
- Doctors need training in how they treat people.

5. Solutions – being able to “fix” it?

- Training for doctors to make the treat people with respect.
- More money for more doctors to do the job properly.
- More money for other things – like flexible transport, to make getting to a doctor or treatment easier.
- Better communication, so that people know what is happening.
- People being able to comment on services, anonymously.

6. Poverty – the impact?

- People with money are able to get treatment quicker.
- People with money are treated differently – with respect.
- People with money don’t have to use transport, for example, that is inflexible.
- People with money get a service that suits them, not one that they have to fit into.

DRUGS AWARENESS GROUPS

- **Consultation with:**
  - Longford Drugs Awareness Group (7)
  - Athlone Drugs Awareness Group (2)

- **Facilitator:**
  - Mr. Bill Ebbitt

- **Date:**
  - 25th April 2001

National Health Strategy

Consultation Process – Health Board Level

Invited:
Longford Drugs Awareness Group (7 members present)
Athlone Drugs Awareness Group (2 members present)

Terri McGority	LCRL
Eddie Ward	Co. Longford Youth Service
Nicola Cummins	Health Promotion Service
Alan Mitchell	Local Councillor/Solicitor
Frank Gearty	Longford Neighbourhood Watch
Patsy Kenny	Community Games
Clodagh O'Reilly Morgan	MHB
Joan McLoughlin	Parents of Primary School Children
James Henson	Athlone Drugs Awareness Group
Frankie Keena	Athlone Drugs Awareness Group

Q: What is it that people think would be a preferred health service?

- Smaller caseloads more proactive and preventive work (Community Care)
- Equality between counties/needs basis
- Equality between departments in Health Board
- Focus on real local needs
- Departmental partnership (Government)
- Widen view of "health" away from illness. Development of Health Promotion -preventative and education initiatives
- Identify <u>local</u> needs in any strategic plan
- Quick and easy access/transparent criteria for access and no waiting lists
- Accurate information made available rather than seeing as "problems" look for solutions.

Q. ***What are the strengths of the existing system?***

- Addiction Counselling Service in Longford/Athlone
- Support for local Drugs Awareness Group
- Training available from Health Promotion Service – Locally based Health Education Officers – Substance Misuse
- Openness in term of resources available
- Service provision in Casualty Unit in Longford
- Personnel live in locality/community health board

St. Jospeh's Hospital → Geriatric Service Model
→ Community Health in Granard, B.M

Small County – quality compact service but how to get out into community.

- Community Care MHB & Longford Community Resources Ltd., - partnership – adventurous/pushing boundaries.
- PHN's – co-operative, creative (Longford)
- Holistic approach to health (Longford)
- CWO's (Longford) – Services provided in main area solid/good committed services.
- Flexibility of Service
- Outreaching of services
- Moves and changes when necessary
- Social Work Team: delicate nature – exceptional service (Longford)

Q. ***What requires fixing?***

- Stigma of St. Loman's (Mental Health)
- Development of Ambulance Service throughout the Region
- Resources allocated by population.
- Planning of service/facilities allocation
- Healthcare long-term planning shambles and totally dependent on funding
- Lack of confidence in questioning i.e. People feel fob off.
  (Role of Politicians and how they feedback at local level)
  Is the MHB too big for everyone to get a voice?
- Waiting Lists
- Longford looses out to regional approach
- Local communities can identify needs yet funding not available
- Integration within the MHB sections doesn't communicate with each other. Should know what each other do.
- Gross under expenditure in psychological service. Psychological services up to 18.
- **Mental Health** – More funding for these services due to waiting lists. (Drug treatment services)
- Insecurity of being located between two Health Boards (Athlone/Longford = WHB & MHB) Openness in terms of service agreements and what people can expect.
- Transport (small county – more elderly) – if service are to centralise in Longford.
- Community Health Service – bring service to people or provide transport.
- Longford poor relation in Midland Health Board – small therefore don't have <u>off peak hospital</u> service.
- Provision of emergency care.
- <u>Mullingar Hospital</u> is loosing therefore Longford too. Compared to Tullamore and Portlaoise.
- Monitoring of service – regional monitoring
- Absence of industry in Longford could have to do with lack of health service <u>– off peak.</u>
- Regional view versus community health.
- Longford in service plan very few times.

- Density of population in Athlone. 24 hour casualty/A&E
- Substance Misuse – Heroine – Methadone service in Athlone – waiting list – addiction counsellors/service needs to be fulltime.

Q. ***What are the barriers which need to be addressed in the "fixing"?***

- Motivation level of staff due to existing structures
- Funding
- Lack of staff at ground level & decision making at local level
- Communities de-motivated run up against "funding" wall.
- Lack of communication between departments within Health Board.
- Bureaucratic model. - Public perception of bureaucracy.
- % of budget going on administration/chiefs.
- Territorial issues of departments within Health Board.
- OK to work with individual yet cross departments is difficult.
- Partnership <u>within</u> Health Board a difficulty.

Q. How do we overcome these barriers?

- Monitoring group independent of Health Board
- County Health Committees? Addressing county needs rather than regional Health Board monitored by local outside agency. i.e. County Development Boards.
- Funding
- Resources: Staff
- Develop a vision/plan/target problems
- Evaluation of administration/budgeting of existing expenditure.
- Preventative/educational approach versus fire engine approach.

GRANARD ACTION PROJECT

- **Consultation with:**
  Mother &Toddler Group (4)
  Individuals (1)

- **Facilitator(s):**
  - Ms. Imelda Donohoe
  - Ms. Ann Mc Guinness

- **Date(s)**
  - 10th & 24th April 2001

Report for National Health Strategy 2001 – 2008

From: Granard Action project

Methodology Adopted:

We interviewed some women from the area individually. We received very good feedback from this as we would explain in detail to them what the report is about. We explained to the different individuals the purpose of putting together this report and what would be required on the report. We then put a series of questions to them (as recommended in information pack). We also asked them if they had any further suggested changes. We informed them that while they feel that these changes would be beneficial, they will not necessarily happen, but that their opinion will be taken into account. We also gained information in a group format from the Mother & Toddlers Group.

Facilitators:
Imelda Donohoe, Child Care Worker, Granard Action Project

Anne McGuinness, Child Care Worker, Granard Action Project

Date of Consultation & Location:
Individual consultations occurred on 19th April 2001 at Resource Centre, Granard.
11th April 2001 at women's own homes.
Group consultation occurred on 24th April 2001 at Resource Centre, Granard

Barriers: - How to overcome them:

- More homes visits need to be made to houses from specialist services such as speech therapy
- Transport needs to be made available to Health Services for those who do not have private transport as weather conditions can often determine whether a person goes to a needed service
- Department of Social Welfare & Health Services need to be connected so when a person is in hospital their spouse can get money
- Housing transfers should be facilitated by the County Council where it is clear that families needs are not being met. Are there not enough council houses? Are council houses not being properly maintained, so that families can live healthily?
- People in ambulance need to be trained as paramedics for the scene of an accident
- A doctor needs to be on call for weekend and evenings for emergencies.
- More contraception information is needed and health issues such as smear tests and breast examinations.

Vision of Health /Health Services:

- That doctors treat people with medical cards the same as those who pay – it was felt by one woman that "the doctor has great smiles for a person who pay up but is not so friendly with those who have medical cards and don't want to see you as often".
- That you know where to go to and who to contact when you have a health problem and be able to get there.
- That those who need special facilities for their illness do not have to wait for it long, one lady had a mother in law who had diabetes and had to wait to get a chair made for her.
- When you are feeling down that you have someone to talk to, you could talk to your neighbours or friends but might not be able to trust them.
- Be able to trust your doctor, incident with one woman where she felt the doctor gave wrong medicine to her child.
- That there be transport made available to those in isolated areas such as Ganard, to get tot all of the Midland Health Board hospitals for appointments especially for those who have no other means of transport.
- Free consultation for U16 years.
- A booklet given to each mother/ parent after having a child to know where locally services are for them and when and where they need to have check ups for their child and themselves.

Strengths:

- Speech and language therapy for children – one woman said that it is a great service for my child because when I grew up if I couldn't speak properly I would be left alone and would have to live wit hit.
- Media is a good source of learning to deal with health problems and finding out about health issues.
- Montessori, playschool, Mother & Toddlers Group

Weaknesses:

- Inadequate transport to facilities for those who do not own private transport
- Housecalls are needed from speech therapy facilities as one lady feels her child is being stigmatised when her son is being seen in the play school.
- People are not aware of where local facilities are and what is available to them
- Waiting lists for health services
- People feel stigmatised when services such as speech therapy come to them in public places such as play school.
- People living in cramped conditions one lady lives in a one bedroom flat for her husband, herself and her four year old child who still sleeps in a cot – 2 people brought up similar issues
- When a person who signs on to social welfare is in hospital and cannot sign on their wife/partner are left without any money, one woman told her story that she was not allowed sign on for her husband and had no money for two weeks.
- Quality of treatment received in hospitals. One woman broke her arm on 21st May 2000, her arm still has not been set even though she attended Tullamore

hospital directly after it occurred – she has a plaster on it for 8 weeks, but she didn't have an operation to set it.

- Doctor not available all the time
- On the scene of an accident there needs to be more paramedics in ambulances.
- Young people are not made aware enough about teenage pregnancies.
- Women feel ashamed or embarrassed to get smear tests etc.
- Not enough information or advertisements of services available especially when you have a baby.

MIDLAND SCHOOLS HEALTH PROJECT

- **Consultation with:**
  - Midland Schools Health Project Steering Group (11)

- **Facilitator(s):**
  - Mr. Joe Whelan
  - Ms. Fiona Murphy

- **Date:**
  - 25th April 2001

Report

The group consulted were members of the Midland Schools Health Project Steering Group.

Eleven members attended:
Ms. Fidelma Healy-Eames, University Lecturer, Anne Buggie, Christine Connolly, Katherine White, (Primary School Principals), Evelyn O'Callaghan, Teresa Sullivan, (Primary Teachers), Marion Drennan, (Teacher, Second Level), Padraig Griffin, Education Centre Director, John Lahiffe, Kevin O'Hagan, (SPHE Support Service), Eddie Bracken, Inspector DES.

Methodology adopted
The group was divided into two, discussed questions and provided feedback using overhead transparencies.

Facilitators
Joe Whelan, Senior Health Promotion Officer, Fiona Murphy, Health Promotion Officer.

Date of consultation and location
April 25, 2001 at The Bridge House Hotel, Tullamore. (4.30 – 6.30 p.m.)

Report

- **Vision of health/health service**

✓ It is easily accessible to all
✓ It is an equitable system
✓ It is a meaningful channel to voice choices/complaints
✓ It is a service that values our children
✓ There are not privatised health services
✓ It is needs based
✓ It is managed
✓ There are no huge waiting lists
✓ Consultants get a realistic pay
✓ Services are provided as close as possible to the patient
✓ The same quality of care/accessibility to care is provided at a greater distance
✓ It prevents illness through health promotion
✓ It is better planned
✓ There is better partnership
✓ It is able to deal with patients who need to go abroad for medical help
✓ People do not have to go abroad because equipment is standardised
✓ It provides screening and health checks every year

- **Strengths**

✓ It is comparatively cheap
✓ The quality of the caring profession
✓ The quality of skills
✓ Special needs people – rights and entitlements of all are catered for
✓ It is people friendly because the infrastructure has improved

- ✓ The development of Health Promotion
- ✓ It is more accessible to people e.g. very old, very poor
- ✓ It is very proactive/preventive medicine, e.g., vaccines, screening, etc.
- ✓ The links with other agencies, voluntary groups and greater emphasis on partnership
- ✓ Communication has improved.
- ✓ The links with DES and DoH&C e.g., SPHE service
- ✓ The promotion of SPHE is innovative, creative
- ✓ The care of terminally ill patients – free drugs, community care, the PHN, the hospice nurse
- ✓ Publications – effective, useful
- ✓ The free drugs scheme
- ✓ Innoculations for school-going children
- ✓ Free health service for the needy

- **Weaknesses**

- ✓ Queues
- ✓ Shortages of beds
- ✓ Ward closures
- ✓ Lack of privacy
- ✓ Critical and non critical treated together
- ✓ Drugs are too easily dispensed
- ✓ Excludes certain social groups
- ✓ Older people live longer but with an unimproved quality of life

- **Barriers**

- ✓ Attitudes
- ✓ Procedures to deal with drug abuse
- ✓ Lack of inter-development approaches to 'fix' things
- ✓ Lack of equality between private and public
- ✓ Unequal access to consultations
- ✓ Lack of financial help for severely handicapped – service needs of parents at home and carers
- ✓ The medical card limits
- ✓ The exclusion of certain social groups
- ✓ The lack of skilled personnel in the hospital services
- ✓ Poor organisation e.g. bulk appointments
- ✓ The Lay-Medical divide – regard for the person
- ✓ The awe, fear and vulnerability experienced by patients
- ✓ Overworked staff e.g. Junior Doctors hours
- ✓ Lack of accountability e.g. medical error
- ✓ Fear about possible drug side effects

- **Solutions (What are the strategic changes/actions/developments that should happen to promote best health and well being).**

- ✓ Consult all stakeholders including patients
- ✓ Identify common good
- ✓ Put structures in place to address real needs

- ✓ Fund and resource the preferred future
- ✓ Use health messages in the media e.g. encourage soaps to have responsible attitude to portrayal of alcohol on T.V. programmes for example
- ✓ Provide more medical care for primary and secondary level students
- ✓ Dispense with private and public differences
- ✓ Look at prevention before illness through Health Promotion
- ✓ Improve the quality of planning
- ✓ Better partnership, interdepartmental level and community
- ✓ Increase the attractiveness of the medical profession
- ✓ Improve the ratio of staff to patients
- ✓ Provide more screening and health checks
- ✓ Provide health promotion in the community e.g. smoking cessation, substance misuse
- ✓ Improve youth services and child guidance in schools

- **What are the key changes that needs to happen to improve the health of people living in poverty or experiencing social exclusion?**

- ✓ Provide an outreach service e.g. mobile unit going to marginalised areas
- ✓ Bring the services to the people
- ✓ Train key staff in health promotion e.g. Community Welfare Officers as a way of reaching the marginalised
- ✓ Provide Health Promotion in the Community
- ✓ Provide mobile creches

BARNARDOS

- **Consultation with:**
  - Staff teams of
    - Athlone Children & Family Centre
    - Edenderry Family Centre
    - Tullamore Family Support Centre
  - Individual service users (2)

- **Facilitator(s):**
  - Ms. Clare Deane
  - Ms. Roisin Daly
  - Ms. V.Burke
  - Ms. Breeden Doolan

- **Date(s)**
  - 23rd &24th April 2001

Health Strategy 2001

Submission to
Midland Health Board

by

Barnardos
National Voluntary Child Care Organisation
Midlands & West Region

For attention of	:	Ms Eileen O'Neill Midland Health Board
Date	:	25 April 2001
From	**:**	**Fiona Lane** Regional Manager Barnardos Midlands & West Region 6 St Brendan's Road Woodquay Galway

Introduction

This is a composite report of five consultation exercises undertaken by Barnardos, Midland & West Region as a part of a national consultation process to guide the development of the new National Health Strategy 2001 – 2007.

If follows an invitation by the Midland Health Board on 6-4-01 to prepare a report based on needs and issues identified by Barnardos staff and service users in the Midlands – for incorporation into the Midland Health Board's overall submission to the Department of Health & Children on the Health Strategy.

Key Theme

Within the Midlands region the core focus of Barnardos' work is to provide a range of family support services to children and families who are experiencing varying levels of need. Many of these families experience marginalisation within their own communities and society at large.

The general health and well-being of these families is a critical issue and one which impacts significantly on the overall quality of life of children and their parents and ability of individual family members to reach their potential.

Consultation Details

A) **Barnardos Staff**: Three separate consultation exercise were undertaken with Barnardos staff in the Midlands Region as follows:

	Location	Date	Facilitated by
(i)	Athlone Children & Family Centre Leader)	23-4-01	Clare Deane (Project
(ii)	Edenderry Family Centre	24-4-01	Roisin Daly (Co-ordinator)
(iii)	Tullamore Family Support Centre (See list of participants Appendix 1)	24/4/01	V Burke (Co-ordinator)

B) **Service Users**: Consultations were also undertaken with two individual service users who attend the Athlone Children & Family Centre as follows:

	Location	Date	Facilitator	Participant
(iv)	Athlone Project	23-4-01	Breegen Doolan	Parent
(v)	Athlone Project	23-4-01	Breegen Doolan	Parent

Ability to consult with a wider representative group of service users, including children, although desirable, was not possible due to the limited timeframe allowed. (Additionally, many services and programmes do not take place during the Easter holiday period thus limiting access for consultation purposes.)

This was a cause of some disappointment to Barnardos staff who would have welcomed the opportunity to facilitate service users in a comprehensive and meaningful fashion in discussing their experiences of the Health services and ideas re the possible development of same to meet their needs.

Consultation Outcomes

Feedback collated under standardized headings as follows:

VISION OF HEALTH/HEALTH SERVICES

- Holistic approach to health and well-being.
  - That the design and delivery of Health Services recognises the fundamentally inter-related nature of an individual's physical, emotional, psychological and social needs and that these are considered in the context of their family and environment.

- Access to quality health care as a basic human right.
  - That the health services should be underpinned by a policy framework which ensures equality of access regardless of

    (i) Socio-economic status
    (ii) Cultural background
    (iii) Geographical location
    (iv) Intellectual or physical capacity
    (v) Age

- Adherence to responsibilities in relation to the U.N. Convention on the rights of the child (0-18 years) as ratified by Ireland in 1992, in particular:
  - Article 12*: **The child's opinion**. The child has the right to express an opinion, and to have the opinion taken into account, in any matter of procedure affecting the child, in accordance with his or her age and maturity.*

- Article 23*: **Children with disability**. Upholds the rights of the child with physical or mental disability to effective access to care and education in order that the child will achieve the fullest possible social integration and individual development.*

- Article 24*: **Health and Health Services**. The child has the right to the enjoyment of the highest attainable standard of health possible and to have access to health and medical services. In its provision of health services, the State shall place special emphasis on primary and preventative health care, public health education and the diminution of infant mortality. The state has on obligation to work towards the abolition of harmful practices prejudicial to the health of children. States which ratify the Convention have an obligation to promote international co-operation to advance the realisation of the child's right to health especially in developing countries.*

- And responsibilities under the Child Care Strategy 2000.

- Meaningfully people-focused and user friendly (i.e. respectful of needs and rights of all service users including children, teenagers and adults).
  - Partnership approach to Health Care
- Balanced investment in primary preventative health care
  - Proactive approaches to promoting good health and quality of live for everyone.
- Needs-led provision
  - Based on local and regional needs assessment, which are subject to ongoing review and evaluation.
- Efficient, effective, accountable
  - In particular to services users
- Proactive responses to barriers which prevent most vulnerable groups in society accessing services.
- Accessible service provision e.g. Available, affordable.

STRENGTHS

- Positive investment in family support services at Community level in recent years.
- Increase in proactive health promotion strategies
- Greater evidence of collaboration/partnership by health board's with voluntary and community sectors.
- All frontline staff who are committed, responsive to needs and respectful of service users and fellow professionals.
- "*I had a baby on January 25th, ante-natal visits very god, good professional, helpful service and advice. Also whilst in hospital maternity care was excellent – good maternity service*" (Barnardos staff member)

WEAKNESSES

- The Health Service does not adequately recognise the special support needs of children and families who are marginalised or experiencing difficulties in family life, to overcome the many barriers they face in accessing health care services. (An overview of these barriers are documented in the next section). Individuals or families who are marginalised experience particular difficulties in accessing information/services and exercising their rights.
- Two-tiered system where level of income and/or access to private health insurance has a direct correlation to quality of service (if any) received.
- Absence of clear national standards of good practice re service provision against which performance can be measured. Perceived lack of accountability by service providers.
- Fragmented nature of health services. Poor communication between sectors with resulting negative impact on quality of service to users.
- General lack of information available to the public re particular health services and health sector in general: -

  "*Needs to be clearer information for the public on what health services are available and also how to access services. People do not know what service are available, who to contact, Etc.*"
  (Tullamore Project Staff Member)

  "*In order for services to be accountable people need to know who runs and manages the different services at a local level. There is a lack of awareness and frustration in the community about how to access services. It would be beneficial if the public knew who runs the different services at a local level and what service are provided by the health board*"
  (Tullamore Project Staff member)

  - "*Costs of children's health care make many parents have to consider if they can afford to bring their child to the doctor."*
  - "*There is a lack of female G.P.'s"*
  - "*The attitude of some health care staff ahs been experienced by families as superior and unsupportive."*
  - "*There is a scarcity of specialists services such as Speech and Language therapists and child guidance clinics"*

- "*There is no accident and emergency unit in Athlone, the nearest one being 15 miles away which is unacceptable in a town with approximately 30,000 population.*"

(Athlone Project Team)

- Views of Parents

Parent One
"*Childbirth terrible, incompetence of medical staff caused ill health*"
"*Aftercare good but experienced as intrusive*"

Parent Two
"*My son has Cystic fibrosis, his needs are I.V. treatment, and I have no medical support. He needs 24-hour attention and I get no relief from this. Extra foods cost £30-£40 a week extra for which I receive on extra financial support*"

- Psychological Services
"*Psychological Referrals – long waiting lists*"
"*Can respond only in crisis intervention as opposed to preventative intervention.*"
"*Child Guidance – restrictive referral process i.e., through G.P. service only, long waiting lists*".
(Edenderry Project)

- Mental Handicap Services
"*Lack of early assessment and intervention*"
"*Lack of respite care*"
"*Children in mainstream education with special needs have difficulty assessing services i.e. Speech Therapy and Physiotherapy*"
(Edenderry Project)

- Psychiatric Services
"*Lack of services for children with psychiatric problems. Poor support services for the family*"
"*Lack of sheltered accommodation and employment facilities*"
"*Need for advocate for children with psychiatric problems*"
(Edenderry Project)

- Teenagers
Health Service provision to teenagers is wholly insufficient. Need for development of strategies to meet needs of this group, in particular
  - Drugs/alcohol awareness
  - Sexuality and relationships
  - Family planning
  - Personal health and well-being

Innovative ways of accessing marginalised youth critical.
(Edenderry Project)

BARRIERS
Children and families who are marginalised and/or experiencing difficulties in family life experience a number of barriers in relation to accessing health services: including

- Lack of information re services available

- Difficulties in accessing what information is available due to literacy difficulties or special needs

- Lack of access

    - Long waiting lists for medical card holders
    - Lack of choice
    - Transport difficulties (in particular for children, families and the elderly in Rural areas or sprawling urban areas)

- Scarcity of Specialist services at community levels e.g. Speech and Language Therapy, Counselling/Therapeutic Services

- Poverty

    - Cost is often a prohibitive factor
    - Family Commitments/Context e.g.
        - Carer of relative
        - Child Care Commitments
        - Multi-problem family

- Gender imbalance
  E.g. Lack of sufficient numbers of female G.P.'s

- Restricted referral protocols to some services

- Fear

- Poor previous experiences e.g. Inappropriate/insensitive treatment by health service staff.

- Prejudice – lack of respect for cultural background of service user.

- Non User-friendly environment for children and young people

SOLUTIONS
- Please also refer to previous section on Vision of Health/Health Services

    - An assessment of local needs which are then matched with appropriate services

- Services which are accessible i.e. available and affordable/ free
- Hospitals should be upgraded and patient care improved
- Introduction of "well woman" and "well man" clinics
- Free medical care for all children (0-18 years)
- Adequate availability of all essential services
- Upgrading of services for the elderly including residential care
- An environment of respect for patients needs and rights needs to be developed amongst all Health Care services through staff training, staff supervision etc.

(Athlone Project Team)

-
  - Childcare services need to be reasonable and responsive to the needs of parents when trying to get them to access services/drop in childcare facilities – health centres – hospitals.
  - Working together between health service departments especially in relation to children aged 0-18 at local and national level
  - Improved communication between health services and community at a local level about what services are available, where and how to access them.
  - Development of measures to ensure people on a low income are able to access services especially primary preventative care.
  - Real consultation with staff and service users within a realistic time scale before introducing new policies or practices

    (Tullamore Project Team)

- Key Areas
  - Low income marginalised families with children/preventative family support, childcare services, and health education.
  - Young parents and parents under stress. Encouraging them to engage with support service at local level.
  - Preventative services: Children at risk of abuse and neglect.

- Parents Views

Priorities

Parent One

- The elderly
- Children, vaccinations, maternity cover etc
- Proper health records for a child's first sixteen years as in the UK

<u>Parent two</u>

- A heart and lung unit for cystic fibrosis children
- Homes for the elderly
- Home care for the elderly
- More Pre-schools for children
- Support groups for people with medical needs

- An Accident an Emergency unit in Athlone.
- More family support services
- Free medical care for all children
- More friendly staff in the heath care services who are sensitive to individuals needs.

- Proposals/Solutions

Parent one

- More play facilities for children and play groups/ parent and toddler groups.

Parent two

- Staff need to be friendlier towards you
- People should be able to have their views heard on decisions about their health and their lives.

Details of Consultations involving Barnardos Staff

1. Athlone Children &Family Centre

7 Ashdale Estate
Athlone
Co Westmeath

Project Leader:	Clare Deane

Staff Team

Project Worker	Breege Doherty
Project Worker	Jo Moore
Child Care Worker	Miriam Kelly
Day Care Worker	Breegen Doolan
Admin/Info Worker	Tina Finneran
Date of Consultation:	24-4-01

2. Edenderry Family Centre

Edenderry Business Park
St Mary's Road
Edenderry
Co Offaly

Project Co-ordinator	Roisin Daly

Staff Team

Child Care Worker	Margaret O'Connell
Child Care Worker	Deirdre Kelly
Child Care Dev. Wkr	Emma Berney
Admin/Info Worker	Aileen Fanning
Date of Consultation	24-4-01

3. Tullamore Family Support Project

Patrick Street
Tullamore
Co Offaly

Project Co-ordinator	Veronica Burke

Staff Team

Project Worker	Margaret Hand
Admin/Info Worker	Lois Doyle
Date of Consultation	24-4-01

Note: In addition, Bernadette Foy (Child Care Worker) completed a standard consultation form, which was forwarded directly to the Department of Health & Children.

CHILDCARE ADVISORY COMMITTEE

- **Consultation with:**
  - Child Care Advisory Committee
- **Facilitator:**
  - Ms. K.Samuels (Chairperson)
- **Date:**
  - 20th April 2001

The Child Care Advisory Committee met on Friday, 20th April to engage in consultation regarding the New Health Strategy in the Boardroom, Central Office, Arden Road, Tullamore. The following members were present:-

- Ms. K. Samuels, Chairperson.
- Mr. E. McMonagle, Vice-Chairperson.
- Mr. Alex Carroll.
- Mr. Liam O'Callaghan.
- Mr. Tom Mooney
- Mr. Donough O'Brien.
- Ms. Eleanor Dowling.
- Mr. Aidan Waterstone.

- Also present: Ms. Susan Temple.

The Chairperson briefed the meeting regarding the background to the New Health Strategy and then made a formal presentation in this regard (copies of overheads enclosed). Group discussion was facilitated by the chairperson and the Vice-Chairperson. The following key issues were addressed:-

- Vision of health/health service.
- Strengths of the current service.
- Weaknesses of the current service.
- Barriers.
- Solutions – what are the strategic changes/actions/developments that should happen to promote best health and well being.
- What are the key changes that need to happen to the health of people living in poverty or experiencing social exclusion?

It was agreed at the outset that discussions would focus on the childcare services rather than on broader health services.

The advances and improvements made under "Shaping a Healthier Future" were acknowledged. Discussion took place on all issues and the following represents the views of the group on the key issues:-

1. <u>Vision of health/health service</u>:-

Everybody should have access to an equitable quality health service. Access should be based on need. Services should be locally based and integrated. A Team approach should be adopted at all levels. Links between hospital and community services and within community services should be further developed and strengthened to support this team approach. Services should be user friendly (including physical environment).

Great emphasis should be placed on preventative programmes and appropriate outreach services should be provided on a needs basis. Eliminating poverty should be a priority.

Services to be appropriately staffed and resourced.

The following points were also noted:-

- Child protection services are normally delivered by staff from the middle income group to children and families in the lower socio-economic group.
- Services for children are delivered by public service and voluntary organisations. Within the health board structure these services are fragmented into the various care groups. The question was raised as to whether there was merit in adopting a similar structure to Northern Ireland services where all services are within one management structure.

2. <u>Strengths of the Current Service</u>.

- Geographic distribution of services.
- Quality, commitment and flexibility of staff.
- Voluntary Sector.
- Partnership approach vis a vis community groups, consumer groups, trade unions etc.
- Accountability and transparency
- Caring society in general
- Ethos of the services.
- Expertise – well educated staff.
- Good range of services.
- Freedom of Information Act
- Ombudsman Office
- Finance now available to develop services
- Linkages with various statutory and non-statutory organisations
- Good record keeping.

3. & 4. <u>Weaknesses/barriers of the current service</u>:-

(a) Access to various services by G.P. referral. All children are not medical card holders, thus maybe denied treatment if parents cannot meet costs of G.P. visits.
(b) Increased consultation and participation by service users necessary.
(c) Sometimes lack of sufficient time resources to deal with the affects of new legislation.
(d) Accountability and transparency.
(e) Accommodation for services needs to be improved.
(f) It has been well documented that poverty has a significant impact on the health and well being of people.
(g) Lack of reward/recognition for positive behaviour by staff.

5. **Solutions:-**

(a) Provide medical cards to all children up to the age of 18 years. Self referral to service may also be appropriate.

(b) Develop further the current consultation processes with the service users and their carers.

(c) Improved planning ensure appropriate 'lead in time' for all new legislation.

(d) Continue to improve systems to increase current levels of accountability and transparency.

(e) Match appropriate capital costs to each new head of staff. Provide capital programme to ensure customer friendly appropriate premises for all services.

(f) Provide focused programmes appropriate to client needs e.g.:-

Budgeting programmes.
Nutrition programmes.
Health programme for various marginalised groups

(g) Encourage positive behaviour of staff through recognition e.g. development of specialised senior posts.

Youth Service Providers

YOUTH SERVICE PROVIDERS

- **Consultation with:**
  - Tullamore Youth Initiative
  - Midland regional Youth Service
  - Foroige
  - Longford Youth Service

- **Facilitator:**
  - Mr. Bill Ebbitt

- **Date:**
  - 20th April 2001

National Health Strategy

Consultation Process – Health Board Level

Youth Service Providers

Invited:

Anne Starling, Chairperson, Tullamore Youth Initiative.
Seamus Boland, Regional Director, Midland Regional Youth Service
Elizabeth Quinn, Chairperson, Laois Youth Service
Mary McDermot, Regional Manager, Foroige
Eddie Ward, Project Worker, Longford Youth Service

Present:

Anne Starling, Chairperson, Tullamore Youth Initiative.
Eddie Ward, Project Worker, Longford Youth Service.
Gerry Prior, Regional Youth Worker, Foroige
Charlie Kellagher, Board Member, Midland Regional Youth Service

Q. What is it that people think would be a preferred health service?

- Diverse Service
  - Diverse Programmes
  - Locally based projects. Reaching out.
  - Creative projects dealing with health
  - Listening to rural projects
- Flexibility
- Training/up-skilling of health board staff (Tutorial Training)
- Enabling/empowering service
- Quality service
- Service which asks for support and advice for other agencies
- Forum (Local Forum to move new strategy forward)
  - Where & How
  - Follow through
  - Feedback
- Funding appropriate to new Strategy

Q. What are the strengths of the existing system?

- Local personnel good response, understanding of issues, good co-operation.
- Perception of Health Board – staff working along side community breaking down of barriers
- Availability of expertise in terms of training (support)
- Receptive at certain levels (mainly staff on the ground)
- Supportive (Health Promotion)
- Knowledge base and willingness to share
- Diversity of services, which are now being provided. Meeting needs from differing perspectives.
- Developing partnership.

Q. What requires fixing?

- More accessible service - Access to Information
  - Young People - freely available
- Awareness of Information - types of services available
  - Resources available
- Prevention – Rather than corrective actions. Proactive
- Local personalities in Health Board affect responses.
- Lack of staffing (to much of a fire brigade response)

Q. What are the barriers which need to be address in the 'fixing'?

- Personalities
- Passing the buck (You cannot depend on all people)
- Understanding of partnership at various levels within the system
- Territorial Issues
- Openness & Transparency
- Receptive listening
- Acknowledging creative ideas
- How consultation takes young people in terms of their needs, checks and balances.

Q. How do we overcome these barriers

- Developing a concept of partnership throughout the organisation through
  - Training
  - Promotion of concept
  - Open to change

- Health Board should challenge misinformation about its services and promote existing and new developments
- Change the perception of how the Health Board works.
- Promotion of services. Changing Profile
- Challenge to groups to work together
- Provision of information not only within health service buildings

Foster Carers

FOSTER CARERS

⇨ Consultation with:

Delegates of 5 Branches of Irish Foster Care Associations in the Midland Health Board

⇨ Facilitator:

- ➙ Ms. Joan Mc Loughlin

⇨ Date:

- ➙ Late April

HEALTH STRATEGY 2001

CONSULTATION REPORT

FOSTER CARERS

Medical consent and signing for same

This causes many problems for foster carers and foster children alike. The fact that foster carers are not authorised to sign medical forms is not always understood by hospital staff or medical teams visiting schools. I had a foster child who felt embarrassed because the signature of his social worker was questioned in front of his classmates. Luckily his teacher was aware of the situation and took care of the problem quietly.

I have had telephone calls from foster carers who had to attend the following hospitals with foster children – Mullingar General, Athlone, Tullamore and Portlaoise. In each of these hospitals, staff were unaware of a list of authorised people who are mandated to sign consent forms on behalf of the Health Board. These incidences have caused much delay to carers and unneccary suffering to the children.

School Visiting Team (Medical)

1. Foster carers have a problem with the short notice that is sometimes given to have consent forms signed, sometimes as little as twenty four hours.
2. Sometimes children are missed out on these services should they happen to change schools for any reason (sometimes as a result of a breakdown in a placement)

Pre-Placement Medical

This does not always happen before children are placed in care and very often where it does the medical is not as thorough as it should be.

Family Room in Health Centres for Access Visits

We feel that these rooms should be big enough and colourful with lots of appropriate activities to keep children occupied. An adjacent toilet or one off the Family Room would help. Facility to make a “cuppa” would be a plus.

Waiting Lists

Waiting time to see some professionals such s Child Guidance, Speech Therapy, Child Psychologist are far too long.

Out-of-hours Service

We know it is a nation-wide problem but the fact that we have no social worker on duty from 5.30 p.m. until 9.30 a.m. and none over the weekend leaves foster carers very isolated when an emergency arises.

Allegations of Abuse against Foster Carers

There has been a marked increase in the number of allegations made against foster carers in recent times. It is a major concern to us that the M.H.B. does not seem to have a standardised system of investigating these allegations. It has proved impossible to obtain verification of the allegation in writing. Very often the substance of the allegation tends to change as time progresses. Further more the length of time it takes to process an allegation is unacceptable, consequently foster carers have to wait and worry. Unfortunately as a result we have lost some excellent foster carers.

Social Workers

Social Workers are a joy to work with, but we haven't got enough of them. They each seem to have too many cases in hand.

One Positive

A note in Athlone Clinic acknowledging that foster carers are not authorised to sign for dental treatment.

WOMEN'S HEALTH

⇨ Consultation with:

Female participants from lower socio-economic group (23)
Disadvantaged women (22)
Health Board Staff (6)
National Women's Council (1)

⇨ Facilitator:

- Ms. Mary Hegarty

⇨ Date:

- 4th April 2001

MHB Consultation re Health Strategy 2001
Women's Health

This consultation comprised seven focus groups of women (N=52) aged app. 20 – 65. In the MHB Region.

1. The women's Health advisory group of the Midland Health Board (Report 1)
2. Women from lower socio-economic groups (Report 2)
   a) A group of women in the MHB who would be regarded as of lower socio-economic status (Appendix 1)
   b) 5 groups of women across the four counties of the MHB who were asked about their perspectives on women's health and inequalities in women's health in June of 2000 as part of wider research on inequalities in health. (Appendix 2)

Facilitator: Mary Hegarty

Overall Observations

The discussion of the public private mix highlighted a difference in perspective between the WHAC consultation and that with the lower socio-economic groups. While both felt that the mixed system contributed to inequalities, the disadvantaged women felt that to separate the services would drain the best talent and resources from the public system. Consequently, their solution is to ensure that the private system does not take away from services in the public system rather than separation of the two.

There was an emphasis on *understanding* that has not been highlighted in the literature to date, and this was common to all groups. Services, information, supports, health issues all need to be understood - knowing they are there is not enough. Understanding and empathy are also required on the part of those who deliver services.

Communication has emerged as a major issue on all fronts for the health system, client to provider, provider to provider, and provider to wider system.

The WHAC consultation report (Report 1) is included on page 2, and this is followed by Report 2, (page 7) a combined report from the consultations with women from lower socio-economic groups, actual reports are included in appendices (pages 11 & 14).

Report 1. Consultation with Women's Health Advisory Committee re Health Strategy 2001
Bloomfield Hotel, Mullingar, April 4th, 2001

The Group:

This group was comprised of seven female members of the Women's Health Advisory Committee of the MHB. Six of these were Health Board Staff, the other member representing the National Women's Council.

Facilitator: Mary Hegarty, Health Promotion Officer, Women's Health, MHB

Methodology: A focus group was held opening with a brief presentation of the background, aims, objectives and modus operandi of the Health Strategy 2001. The facilitator then recorded participants views on a flipchart under the five headings reported below.

1. Vision of our ideal health system
General

- Nation-wide universal quality healthcare
- Focus on 'health' rather than only on health service
- Multisectoral responsibility for health
- Women's health issues integrated into main stream services
- Consumer focus a priority – consider life issues – dependent children, elderly relatives
- No Public/Private Mix – separated and full public service
- Better 'health protective' integrated services
- Consumer driven and monitored
- Support for parents and those at high risk
- Link people service to service, and services to client
- Include specific focus on women's health

Access

- User friendly
- Easily accessible
- Locally based as far as possible
- Equal for all women regardless of finance, social or geographic barriers
- 24 hour accessibility
- Telephone access

Principles

- Appropriate – needs based
- Quality – match international excellence standard
- Accountable
- Equitable
- Appropriate
- Cost effective
- Timely
- Evidence based
- Well resourced
- Responsive
- Rapid response

Specific Services

- Well woman centres in every town
- Counselling freely available to all for sexual abuse, domestic violence, disability etc.
- Understanding and support for carers - respite, equipment, transport, childcare
- Multiple approaches to information supported by trained staff
- Monitoring of front line service

Staff Training

- Training of staff to highest standards, including ongoing training and development
- Customer service training – sensitivity

2. Strengths of existing service

- Emergency services – critical care are highly effective
- Highly trained staff
- Becoming more open to criticism
- Needs based analysis
- Quality acute maternity services
- Free antenatal
- Legislation protection – maternity
- Recognised focus - Dedicated women's health officers
- Incoming flexibility of working hours

3. Weaknesses of existing services

- Lack of structured ongoing professional development
- Consultant control of services – e.g. 60 miles to get plaster off
- Glaring lack of women in decision making process – why are ministers appointees to health boards not representative of women
- Gender composition – health boards – management teams – steering group of strategy
- Staff 80% female
- Political governance too localised - people not informed about the wider picture
- Structure of Boards – political arena – politically driven services
- Need national centres of excellence
- Access – women have different access needs – childcare, respite, transport, time, money
- Drive to centralisation raises issues of access
- Transport – no co-ordination - Linked to availability of out of hours service
- Attitudinal access - inflexible, rigid, bureaucratic service shaped to suit provider
- Need more focus on supporting parents – also high risk groups
- Need more provision of health protective elements and counselling
- Lack of quality mental health service and promotion

4. Barriers to better system

- Power hierarchies – GPS, consultants
- contract of GP with Health Boards
- Lack of legislative principles for GPs
- Persistence of medical model
- Newness of strategic thinking
- Lack of leadership from DOH e.g. women's health
- Lack of balanced media – need to disseminate lessons learned and the positive side
- Resources
- Actual lack of beds
- Private / public mix
- Complexity of service – makes integrated service difficult although the various specialisms are necessary (lack of understanding of this is linked to media point above)
- Understanding of health not equal to understanding health services
- Need broader balance in distribution of resources
- Need systematic resourced consultation - Where consultation is ineffective it is worse than nothing
- Equity issues with E systems – test assumption that all population groups have access
- Literacy problems
- Waiting lists
- No integrated system

5. Solutions

Consultants

- Revise consultant contract
- Look at skills mix necessary to support consultants
- is separate team necessary for each consultant?
- Separate private / public
  - 1st loyalty should be to public patient

- develop quality mental health service with stronger focus on promotion and prevention

Customer care training

Consumer focus must be developed

- use media to develop this properly
- planned media use rather than ad-hoc

Planning

- Have solutions tied to service plan
- Well woman centres in every town
- Stronger structures for women's health, with identified leadership role for Dept. of Health and Children, Women's Health Council.
- Structure to find balance between identified need and standards of excellence
- Efficiency and effectiveness of service delivered and means of delivery
- Establish HEBE (Health Boards Executive Agency) to enhance joint health board work
- Need integrated patient information system – smart swipe cards – mapping of medical history
- Incorporate all of the WH issues in the national strategy
- Integrate primary and acute services – dedicated understandable pathways
- Women's health needs to be integrated into all service lines of DOH

Specific Topic Issues

- National carers strategy with funding from Dept of Finance
- Dedicated funding for regional parenting support programme
- Implement best health for children
- Develop protocols on violence against women
- Parents of rehab drug users – support for

Communications

- Positive media campaign to communicate health services (link to local politics point)
- Need to raise profile of services locally

Women and primary care

- Develop group practices
- Develop minimum standards of FP with free access to and choice of provider
- Free cervical smears
- Free access to FP clinics
- Develop counselling services

Sexual Health/Family Planning

- Formal arrangements for inter-colleague referral for family planning services
- FP clinics in every health Board region
- Access of young people to the services
- Provision of teenage clinics tailored to requirements of the age group
- Provision of a comprehensive screening clinic for STIs in every region
- Family planning – need to adopt Gillick principles
- Minimum standards of FP and STI clinics

6. Perspectives on Inequalities

- The inclusion of Health on National anti poverty strategy Agenda
- Legitimacy for health promotion in all areas of health service, built into service provision, and built into structures at all levels.

Communication

- Embrace diversity in consumer and staff
- Identify oral communication needs of consumers
- Liaison person to deal with cultural ethnic difficulties - Interpretative services

Report 2 Consultation re Health Strategy 2001

Combined report from women in lower socio-economic groups

(see Appendix 1&2 for details of the individual groups)

1. Vision of an Ideal Health System

- Equal Treatment for all
- Based on need, not on strings/money
- Comprehensive services – including OT, Physio at all health service outlets – not just at hospitals
- More co-operation between health boards
- Co-ordinate services so one visit covers all necessary tests etc.
- Minimised waiting lists
- Doctors – Ensure accountability
    - More support for patients from doctors and nurses
    - Where doctors haven't time, more prominent role for nurses especially in General practice
    - Availability on weekends and out of hours
    - Doctors fees would be controlled and regulated
- Cervical and breast cancer screening services available to all women
- Well woman centres in every town

2. Weakness of Services

- ***No one to listen*** - need understanding doctor or professional to ***Listen***
- Communication is generally weak – also problems with foreign staff
- Waiting lists – difference in way public / private patients are treated
- Rushed through services with no time to talk
- Need for dignity and respect for all service users – essential for building of trust
- Lack of provision of peer support on a structured basis
- Lack of Drop in Centre/resource Centre

- Lack of Information provided by ‘someone’ who had the time – someone to explain things
- Lack of information regarding entitlements
- Lack of information people can understand
- Lack of training in parenting skills
- Limited access to female practitioners for particular ‘female’ problems
- No counselling services – no service for when things go wrong if the problem is not medical
- Schools service inadequate – e.g. dental, aural, sight
- Inadequate services re drugs/alcohol – rehabilitation not widely available and not locally available - Not targeting young people enough – national schools Lack of clinics
- Students – no automatic entitlement to medical cards
- No free medication for long term illnesses (asthma etc)

3. Strengths of Existing Services

- Staff generally nice, competent
- Some very good quality services
- Some services were very efficient
- Some GPs provided excellent services
- Subvention for nursing homes

4. Barriers to better system

- Money – budget
- Government – getting the priorities right
- Don’t ensure that services are equally available to all
- Discrimination
- No help for unemployed trying to get back to work – esp. childcare
- No one to listen
- Nowhere to go except to GP who is often ‘too busy’
- Little awareness of services outside of GP

- When you don’t understand, there is no one to ask
- Lack of knowledge regarding health issues, services and entitlements
- Lack of confidence to seek out information
- Lack of education
- Lack of local services
- Lack of transport
- Lack of availability of services outside hours
- Difficulties with relationship with professionals sometimes due to lack of confidence on part of patient, often due to not being treated with respect and dignity
- Not being taken seriously

5. Solutions

Information

- Provide information and resources around health issues to facilitate people having more control over their own health
- Provide comprehensive, user-friendly information services.
- Methods of information giving should allow for contact with necessary personnel and services and provide for follow-up where required.

Services Generally

- Services should be open to all with no stigma no matter who they are or what their background.
- Waiting lists

  Ensuring private sector does not take away from public sector care. **(There was a lot of discussion around this, as to what would be the best solution. Separating public and private was dismissed as an option, participants fearing that it would lead to the best doctors and services working only in the private sector).**
- Responsibility at the first point of contact in terms of ensuring that women are provided with the appropriate assistance or service.
- Establish clinics or centres with the range of required services, and to have these adequately staffed.
- Counselling services should be available, one should know where to go, and a service should be available within a short period of time. It was important that people would be able to self-refer.
- Delivery of all services should take account of the dignity of the person and be based on respect for the individual client at all times.
- Provide appropriate education and training.
- Support groups and centres should be established, with the government providing the necessary resources.

Services - Specific

Provide services on a local basis, including

- Casualty
- GP on call – 24 hour
- Social welfare - early response to call necessary from these.
- Guards
- Social worker –
- Family support /counselling
- Midwife – to check people locally rather than travel to hospital unnecessarily
- Drugs/alcohol service

- Provide well woman centres
- Screening
- Counselling
- Drop in facility
- Information – entitlements
- Provide specific services for men
- Encourage regular check ups for everyone
- Free condoms, information and access re family planning, sexual health, Sexually transmitted infections
- Free nicotine patches
- Hospital appointments quicker especially in respect of major illness even if chronic
- Elderly
  - More respite care
  - Adequate support to facilitate independence of the elderly
  - Adequate services and supports for carers
- Treatments like dialysis, chemotherapy more locally available - Where this is not possible, the effect of distance on the patient should be addressed, and on their family.
- Provide childcare to help people on social welfare return to education or take up employment.

6. Perspectives on Inequalities in Health

- The participants thought that the less well off were no more susceptible to getting ill than the more affluent. However, the resources of the to deal with this would be superior.
- The more affluent would have
  - More information
  - More education
  - Would be more aware of their rights and entitlements
  - They wouldn't have to deal with waiting lists
- Public patients could meet a different doctor on every visit (particularly at antenatal) – this experience was often experienced as degrading.
- Communication was perceived as poor, participants felt this would be better if they were treated the same as private patients.

Appendix 1

Report 2a. Consultation with Five Women's Groups (MHB)
June 2000

This report has been derived from a consultation with women carried out in the Midland Health Board and presented as thesis for MA in Health Promotion, N.U.I. Galway, in September 2000.

Aims of the Research: Current evidence indicates that health inequality is probably the biggest issue for public health and health promotion nationally and internationally. The aims were to produce new insights through qualitative consultation with women, while examining the usefulness of this approach.

Researcher: Mary Hegarty

The groups: Lay perspectives on health were explored in five focus groups carried out with 23 female participants from lower socio-economic groups in the four counties of the Midland Health Board Region. The study aimed to develop understanding of how these participants experienced the health services in their own context.

Methodology: A vignette methodology (below) with a series of focus group questions was used to encourage participation and discussion; a quantitative questionnaire obtained

data on demographics, socio-economic status and health status. Data was transcribed verbatim and thematic analysis was systematically carried out.

The Vignette

> Let me tell you about Catherine. She is in her early forties and lives on a large housing estate. Catherine generally finds life a struggle. She has experienced depression on and off over the last number of years. She has been feeling particularly unwell over the last few months, experiencing tiredness, loss of energy, headaches.
>
> More recently, she has had fairly severe pain and tightness in the chest on a few occasions. Catherine went to her doctor, who told her that she was suffering from angina. The doctor explained that while the pain can be relieved by drugs, it is a sign of heart disease, and a warning that heart attack could occur

The information regarding inequalities was generated by asking participants if the situation would be the same if *Catherine* was better off.

The following information was provided by the participants – These groups were not asked for their vision of an ideal service.

2. Strengths of existing services

- Some services were very efficient
- Some GPs provided excellent services

3. Weaknesses of existing services

- Need for dignity and respect for all service users – essential for building of trust
  Understanding doctor or professional to ***Listen***
- Peer support on a structured basis
- Drop in Centre/resource Centre
- Someone to explain things
- Information provided by 'someone' who had the time
- Information regarding entitlements

- Information people can understand
- Training in parenting skills
- Access to female practitioners for particular ‘female’ problems

4. Barriers to better health services

- No one to listen
- Nowhere to go except to GP who is often ‘too busy’
- Little awareness of services outside of GP
- When you don’t understand, there is no one to ask
- Lack of knowledge regarding health issues, services and entitlements
- Lack of confidence to seek out information
- Lack of education
- Lack of local services
- Lack of transport
- Lack of availability of services outside hours
- Difficulties with relationship with professionals sometimes due to lack of confidence on part of patient, often due to not being treated with respect and dignity
- Not being taken seriously

5. Solutions

- Provide information and resources around health issues to facilitate people having more control over their own health
- Provide comprehensive, user-friendly information services.
- Methods of information giving should allow for contact with necessary personnel and services and provide for follow-up where required.
- Responsibility at the first point of contact in terms of ensuring that women are provided with the appropriate assistance or service.
- Establish clinics or centres with the range of required services, and to have these adequately staffed.

- Counselling services should be available, one should know where to go, and a service should be available within a short period of time. It was important that people would be able to self-refer.
- Services should be open to all with no stigma no matter who they are or what their background.
- Provide childcare to help people on social welfare return to education or take up employment.
- Delivery of all services should take account of the dignity of the person and be based on respect for the individual client at all times.
- Provide appropriate education and training.
- Support groups and centres should be established, with the government providing the necessary resources.

6. Perspectives on Inequalities in Health

- These participants thought that the less well off were no more susceptible to getting ill than the more affluent. However, the resources of the to deal with this would be superior.
- The more affluent would have
  - More information
  - More education
  - Would be more aware of their rights and entitlements
  - They wouldn't have to deal with waiting lists
- Public patients could meet a different doctor on every visit (particularly at antenatal) – this experience was often experienced as degrading.
- Communication was perceived as poor, participants felt this would be better if they were treated the same as private patients.

Appendix 2

Report 2b. Consultation with Women re Health Strategy 2001

Westmeath April 11th, 2001

Group Profile

This was a group of disadvantaged women on a pre-employment course in a town in Westmeath. There were twenty two members, and the age range was app. 23 –50. The majority were married, and the group included some lone parents.

Methodology:

The facilitator presented the background to the health strategy, using a copy of the 1004 strategy to illustrate points. A focus group was held with the facilitator recording participants contributions on a flipchart under the headings given below. Respondent validation was used consistently throughout, particularly at the end of each section, and again at the end of the focus group.

Facilitator: Mary Hegarty, Health Promotion Officer, Women's Health, MHB.

1. Vision of an Ideal Health System

- Equal Treatment
- Based on need, not on strings/money
- Comprehensive services – including OP, Physio at all health service outlets – not just at hospitals
- More co-operation between health boards
- Co-ordinate services so one visit covers all necessary tests etc.
- Minimised waiting lists
- Doctors – ensure accountability
- More support for patients from doctors and nurses
- Where doctors haven't time, more prominent role for nurses especially in General practice
- Availability on weekends and out of hours

- Doctors fees would be controlled and regulated
- Cervical and breast cancer screening services available to all women
- Well woman centres in every town

2. Weakness of Services

- No counselling services – no service for when things go wrong if the problem is not medical
- Schools service inadequate – e.g. dental, aural, sight
- No free medication for long term illnesses (asthma etc)
- No one to listen
- Communication is generally weak – also problems with foreign staff
- Students – no automatic entitlement to medical cards
- Waiting lists
- Inadequate services re drugs/alcohol – rehabilitation not widely available and not locally available - Not targeting young people enough – national schools
- Lack of clinics
- Rushed through with no time to talk

3. Strengths of services

- Staff generally nice, competent
- Subvention for nursing homes
- Some very good quality services

4. Barriers to better services

- Money – budget
- Government – getting the priorities right
- Don't ensure that services are equally available to all
- Discrimination
- No help for unemployed trying to get back to work – esp. childcare

5. Solutions

Provide services on a local basis, including

- Casualty
- GP on call – 24 hour
- Social welfare
- Guards
- Social worker – early response to call necessary from these.
- Family support /counselling
- Midwife – to check people locally rather than travel to hospital unnecessarily
- Drugs/alcohol service
- Provide well woman centres
- Screening
- Counselling
- Drop in facility
- Information – entitlements
- Provide specific services for men
- Encourage regular check ups for everyone
- Free condoms, information and access re family planning, sexual health, Sexually transmitted infections
- Free nicotine patches
- Hospital appointments quicker especially in respect of major illness even if chronic

Waiting lists

Ensuring private sector does not take away from public sector care. **(There was a lot of discussion around this, as to what would be the best solution. Separating public and private was dismissed as an option, participants fearing that it would lead to the best doctors and services working only in the private sector).**

Elderly

- More respite care
- Adequate support to facilitate independence of the elderly
- Adequate services and supports for carers

- Treatments like dialysis, chemotherapy more locally available - Where this is not possible, the effect of distance on the patient should be addressed, and on their family.

CARERS

⇨ Consultation with:

Laois/Offaly Carers Association (61)
Longford/Westmeath Carers Association (74)

⇨ Facilitator(s):

- ➙ Ms. Finola Colgan
- ➙ Ms. Paula Brophy
- ➙ Ms. Marian Delaney-Hynes

⇨ Date(s):

- ➙ 15th February - 19th April

NATIONAL HEALTH STRATEGY 2001

CONSULTATION WITH CARERS

INTRODUCTION

Family members and others have been looking after and caring for dependants throughout history. However, the term "Carer" is still relatively unknown in Ireland, the first dictionary entry was as late as 1984.

In 1998 a co-ordinator of services for Carers was appointed to Laois/Offaly. In January 2001 a co-ordinator for the Longford/Westmeath area was appointed. Our roles are to identify the needs of Carers and endeavour to address these needs. To fulfil these objectives we are using a systematic approach.

METHODOLOGY

A mixed methodological approach, including focus groups, needs assessment, questionnaire and open forums, individual interviews are also undertaken to optimise the reliability and validity of the information provided. All care groups involved (this process is still in progress and as yet is incomplete).

FORUM OBJECTIVES

- To identify the reality of caring in the home
- To identify the needs of Caregivers at individual level
- To identify and examine resources to meet the needs of Carers
- To make recommendations to the Board and pursue the implementation of those recommendations in line with the objectives of the Carers charter
- To set up a database

FACILITATORS

Laois/Offaly	Paula Brophy Finola Colgan
Longford/Westmeath	Finola Colgan Marian Delaney-Hynes
Dates Longford/Westmeath	15th, 22nd February. 1st, 8th, 20th, 28th March. 3rd, 10th, 19th April

CONSULTATIONS NOT COMPLETE

Check with Paula for Laois/Offaly dates etc.

Longford/Westmeath Locations

Mullingar	-	St. Mary's Hospital
Longford	-	Mental Health Centre
Athlone	-	Shamrock Lodge Hotel (not Complete)

VISION OF HEALTH / HEALTH SERVICES

Including Solutions and changes that need to happen

What the Carers want

RESPITE CARE

Of all the support services for Carers a break is the one which is most essential and most appreciated by the Carer.

Traditionally Respite Care meant that the cared for person was removed from their own home to a residential setting for a short period of time to give the Carer a break.

This arrangement is not appropriate for every cared for person, particularly for a person with Alzheimer's Disease who finds change very disturbing and distressing.

Carer's Vision of a healthy Respite Service includes:

- When appropriate Respite Care would take place within the Carer's Home
- Respite care should cover reasonably long periods of time to allow the Carer to go on holiday's i.e. 2 weeks.

- Respite Care for shorter periods i.e. weekend or long respite at weekends is very necessary, as all day –care services at weekends are closed down.
- Respite Care to allow the carer the opportunity to work some hours or avail of a training programme.
- Respite services need to be more flexible, some such services are rigid, predetermined and “take it or leave it” is the attitude.
- It is necessary and essential to provide emergency respite in the event of a crisis in the home.

DAY CARE SERVICES

Currently Day Care Services are limited to opening hours nine to five and operational hours are 10.00am to 3.00pm or sometimes a lot less depending on transport and location. For a more Carer Effective Service the following changes were identified.

- Day Care Services need to open earlier and close later in order to facilitate Carer to avail of greater opportunities i.e. work, education, social events etc.

- Day Care Services need to provide adequate activities and stimulation for the people who attend in order to encourage them to continue attending, rehab services should be an integral part of all day care services.

CARER / USER FRIENDLY SERVICES

- Respite services need to be sensitive to the role and needs of the Carer

- PHN services need to incorporate a Carer Care Plan into their existing Care Plan thus recognising and acknowledging the Carers Role and creating a wholesome partnership.

- Service Providers and Professionals need to be a lot more welcoming and encouraging in attitude.

- Customer Care training in learning to use peoples names, being welcoming, courteous and helpful.

- Carers’ working in Partnership with service providers is the way forward.

INFORMATION AND INVOLVMENT

- Information and involvement are the two key factors in ensuring that an appropriate balance of power between Carers and Service Providers is achieved and maintained.
- There is often confusion between solutions and voluntary services.
- Carers often require specialist services, which they may not even know, exist, let alone know how to access.
- Help line for Carers

- To hand information for Carers should include:
  - Respite care
  - Social services
  - PHN service
  - Financial benefits and entitlements
  - Carers rights
  - Crisis support
  - Day care services
  - Carer support groups
  - Stress management programmes
  - Training in carer issues
  - Availability of equipment

- There is an onus on organisations and Health Boards to ensure that services between Carer groups are equitable
- R.R.A.S. – Rapid Responsible Accessible Services
- A National Strategy specific to Carers

STRENGTHS

- The National profile of Carer Issues is being raised

- Services are beginning to work towards greater partnership with Carers through Forum settings in the Midlands.

- The appointment of co-ordinators of services for Carers offers a great source of advocacy for Carers

- The setting up of support groups

- Provision of training and information evenings

- Carers getting the opportunity to meet face-to-face with heads of Services at Forum Settings.

WEAKNESSESS / BARRIERS

- The role of the Carer is not reflected in service provision
- Services are not seamless in order to provide support to Carers at the beginning, middle and end phases of Caring.
- No specialist services exist for young Carers.
- Practitioners are not adequately trained to work with young Carers.
- Health Care professionals do not currently have any measures in place to adopt principles of involving and encouraging Carers.
- There is currently no training strategy for Carers.
- Communication is extremely poor between members of the multidisciplinary team. Carers are increasingly frustrated having to tell their story **repeatedly** to a different Health Professional. As one Carer put it:
  "*You can't call them a team can you? I always thought that a team worked together, I am very upset by the communication between them and my daughter now aged 5 years still hasn't been diagnosed".*

ASYLUM SEEKERS AND REFUGEES

⇨ Consultation with:

Asylum Seeker Families (6)
Athlone Asylum Seekers Support group
Community Welfare Officers (1)

⇨ Facilitator(s):

- ➙ Mr. Eamonn Rodgers

⇨ Date(s):

- ➙ 25th April 2001

SERVICES FOR ASYLUM SEEKERS AND REFUGEES

A Report to the Midland Health Board in relation to the planned National Health Strategy 2001 – 2008

1. Introduction:

The Minister for Health and Children, in signalling progress on a new Health Strategy for the years 2001-2008, announced that the process will include a call for submissions and local level consultation.

The management of the Midland Health Board has assigned responsibility to a range of teams and individuals to elicit submissions and to engage in consultation with workers providing services, interest groups and users of the services themselves.

This report deals with health and personal social services ***for Asylum Seekers and Refugees.***

2. Consultative Process in Preparation of Report:

Consultation took place with the following:

- Six (6) asylum seeker families resident at the Asylum Seekers Unit, Lissywollen, Athlone (25th April,2001) **and** on 29th April with a representative of the group, when agreeing a draft record of the consultation
- Athlone Asylum Seekers Support Group, which operates under the aegis of Athlone Community Services council, (25th April,2001)
- Community Welfare Officers who have responsibility for assessment and delivery of health and personal social services to asylum seekers and refugees.(ongoing)
- Shared experiences and dialogue with professionals and colleagues from other Health Boards / Authorities (ongoing).

3. Methodology Adopted:

This was achieved through:

- Arranged meetings
- Advance notice, where feasible, to the participants of the purpose and proposed structure of the consultation(s) and the desired outcomes arising from the consultation(s)
- Facilitating, where necessary, the participants to express their views and recording those view

4.Overview of asylum Seekers and Refugees in the Midland Health Board

At 2nd April, 2001, there were 802 asylum seekers / refugees involved with the Community Welfare Service in the Midland Health Board. The breakdown on a county basis is set out at Appendix A

It will be noted from appendix A that asylum seekers / refugees may be in the private rented sector (279) or in **Direct Provision*** (523).

Asylum seekers in private rented accommodation, while not allowed to work or vote, are broadly entitled to the same rate(s)of social welfare payments and services as the indigenous population. For this reason, the remainder of the report is oriented towards asylum seekers in **Direct Provision** as it is this group that is at greater risk of exclusion or marginalisation.

Direct Provision is essentially the placement of asylum seekers in full board accommodation, with shelter, food, heat and light directly provided. The asylum seekers also receive a pocket money allowance of £15 per adult and £7.50 per child from the Community Welfare Officer. Additional needs are dealt with on a discretionary basis.

There are five (5) **Direct Provision** sites in the Midland Health Board. Appendix B gives an overview of these sites.

The Department of Social, Community and Family Affairs have issued circulars setting out rules and guidance on **Direct Provision.** These are set out at Appendix C and Appendix D.

The number of "labels and terms", often inaccurately used, that describe these newcomers to Ireland can be confusing and unhelpful. The most common terms used are:

- Asylum Seeker
- Refugee
- Programme Refugee
- EU Resident Alien

Definitions of these terms are set out at Appendix E.

5. The Six (6) Asylum Seekers Families interviewed at The Asylum Seekers Unit, Athlone, on 25th April, 2001.

The Athlone site is described at Appendix B

A profile of the families interviewed, which ensures they remain anonymous, is set out below. The families were selected at random, based on availability at the time and willingness to participate.

TABLE 1 – PROFILE OF FAMILIES INTERVIEWED

No	Country of Origin	Male Adult	Female Adult	Child	Normal Occupations of Adults	Length of Time In Ireland
1	Nigeria	1	1	2	International Relations Consultant Architect	7 months
2	Nigeria	1	1	3	Secretary Engineer	5 months
3	Kazakhstan	1	1		Driver Housewife	4 months
4	Kazakhstan	1	1		Nurse Chef	4 months
5	Czech Republic	1	1	2	Waiter Housewife	5 months
6	Czech Republic	1	1	3	Car Mechanic Waitress	7 months

The interview dealt with the asylum seekers' views on:

1. Employment
2. Accommodation and Housing
3. Food and Nutrition
4. Communications
5. Health and Personal Social Services
6. Child and Adult Education
7. Racism

The families prioritised them in this sequence, as, under current circumstances, this was their perspective of the issues affecting them.

5. The Six (6) Asylum Seekers Families interviewed at The Asylum Seekers Unit, Athlone, on 25th April, 2001. (cont'd)

5.1. Employment:

The group agreed that the government-enforced barrier on employment **was by far the biggest issue affecting their lives, health and well being.** It was further agreed that the adverse experiences and perspectives under the headings that follow would be diminished in terms of importance and severity **if only asylum seekers were allowed to work.**

The priority issues, as seen by the group, are:

- That the outcome of current government policy is that the skills, experience and qualifications of a large group of people are being lost to the economy at a time they are needed most
- That the impact of this policy is the exclusion and marginalisation of asylum seekers from society, with accrued negative implications for the physical and mental health of themselves and their families
- That there is no logic to this policy, if looked at from a cost perspective of maintaining asylum seekers on social assistance versus the economic and social value of their participation in the workforce
- The group found it difficult to understand why the government were busy advertising for and sourcing people from abroad, whilst ignoring the potential on their own doorstep.

Table 1 – Profile of families Interviewed gives some indication of the skills, experience and qualifications that may be available. The group recommended:

"that government reverse its policy of not allowing asylum seekers to work and compile an inventory of skills, qualifications and work experience of asylum seekers – this inventory to be examined and evaluated against current labour shortages in Ireland."

The group agreed that it was practical and reasonable that asylum seekers would not work for the first 6 months after coming to Ireland. This was to allow themselves and their families' time to settle, adapt and prepare for life in Ireland. It would also maintain a level of administrative order in the process.

5.2 Accommodation and Housing

The government has used a number of options to address the accommodation and housing needs of asylum seekers in **Direct Provision**. These include hotels, hostels, apartments and mobile homes. The Athlone unit is a purpose built site containing 100 mobile homes. These mobile homes currently house 118 families, which is an indicator of a significant level of accommodation- sharing by different families. There are 21 different countries of origin

5. The Six (6) Asylum Seekers Families interviewed at The Asylum Seekers Unit, Athlone, on 25th April, 2001. (cont'd)

5.2. Accommodation and Housing (cont'd)

The group were of the view:

- That **their** accommodation or any of the options described above are only suitable in the short-term
- That it is unreasonable and inequitable to keep people and families in these conditions for any extended period
- That the impacts of this policy are:
  - contributing to social exclusion of asylum seekers
  - having negative impact on their physical and mental Health
  - creating tension and confrontation between families and ethnic groups
- That the sharing of accommodation by different families was unacceptable.

The group recommended:
"that government agree and implement a time-limit for keeping people and families in Direct Provision."

5.3. Food and Nutrition

The group acknowledged and put on record their appreciation of the efforts of management and staff in seeking to meet and adapt to their needs. The difficulties in catering for many different cultures were accepted.

" We cannot expect our children to eat what they see us not eating ourselves."

"The limits of choice in what and when to eat is unacceptable."

"Eating under these conditions over an extended period of time is undignified and an intrusion on family privacy"

"We are spending a significant amount of our "pocket money" in buying food for our children"

The consensus of the group was the significance of the issue increased or decreased relative to the length of time they could expect to be in **Direct Provision.**

The group recommended:
"that, subject tot where personal cooking facilities exist on Direct Provision sites, asylum seekers be allowed the choice of eating in the canteens or being provided with or allowed to obtain the raw ingredients to do their cooking in private."

5. The Six (6) Asylum Seekers Families interviewed at The Asylum Seekers Unit, Athlone, on 25th April, 2001. (cont'd)

5.3. Communications:

The group's particular concern under this heading is **communications with the Department of Justice, Equality and Law Reform,** who process their claims for refugee status. The length of time the families are in Ireland is set out at **Table 1 – Profile of Families Interviewed.** All indicated that they had received no communication since their original applications were made. It is clear from this that the government-set targets in processing time(s) for applications are not being met.

The outcome(s) of this are:

- Continued uncertainty and stress for asylum seekers and their families regarding their futures
- Inability to begin to participate fully in the economy and society and thus integrate
- Prolonged detainment in **Direct Provision.**

5.4. Health and Personal social Services

The group expressed general satisfaction with the health services being provided by general practitioners and hospitals. They spoke of minor difficulties associated with transport. They that the statutory bodies should be more appreciative and supportive to multilingual asylum seekers who give their time voluntarily and freely to compatriots with language difficulties, when communicating on medical issues.

The group were satisfied that they were receiving their allowances in accordance with **Direct Provision rules** on a timely basis. The group did, however, speak of regional variances in some of the rules and asked that:

"Government clarify its policy regarding asylum seekers who are parents of Irish-born children, their right to leave Direct Provision and the timeframe within which they can exercise that right."

5.5. Child and Adult Education

The group expressed satisfaction with the appreciation of the educational facilities made available to their children. They were also appreciative of the language classes given to adults. **They would like to see more training and educational opportunities for adult asylum seekers.**

5.6. Racism:

The group reported no problems in this regard, either in relation to themselves or their children.

6. The Views of Athlone Asylum Seekers Support Group:

There are significant areas of consensus between the views of the asylum seekers themselves and those of Athlone Asylum Seekers Support Group. Duplication is unnecessary. The following views were expressed that embellish or are supplementary to those already made:

- That government policies and responses to the asylum seeker issue are reactionary and ill-conceived
- That these policies are inequitable and induce or exacerbate social exclusion
- That there is a lack of clarity regarding the policies themselves
- That work permits should be granted to asylum seekers after 6 months in Ireland
- That government "disposes" of its obligations to integrate asylum seekers and refugees by dispensing inadequate and inequitable* grants to voluntary groups, who are then left with this responsibility

*An example was given to support this point. National funding of £500,000 was made available to voluntary and community groups to develop integration initiatives for asylum seekers and refugees. The ratio of funding was 9 to 1 in favour of refugees. The point was made that **refugees** comprise a very small minority of these people.

- That there should be more responsible and accurate media reporting
- That there should be more recreational facilities, particularly for children, at Direct Provision sites **and** that statutory bodies should apply a minimum of bureaucracy in allowing these facilities to be developed, **thus promoting exercise and good health practices for children.**

The voluntary groups would welcome **active participation** and support from Irish citizens in integrating asylum seekers and consider that political and statutory leadership has a significant role to play in getting this message across.

7. The Views of Community Welfare Officers Providing Services:

Community Welfare Officers (CWOS) are in the front line of service provision to asylum seekers. It is mostly through CWOS that asylum seekers communicate their needs, wants and concerns. Also, it is frequently the Community Welfare Service that first gets to hear of the issues that affect other service providers.

There is significant consensus of opinion between the asylum seekers interviewed, the voluntary group interviewed and the Community Welfare Service **regarding the issues that affect asylum seekers themselves.**

However, CWOS are concerned at the lack of clear rules and regulations from a national perspective, and a consequent variation in responses and outcomes of service delivery to asylum seekers. **This service may be seen as uncaring and/or unprofessional as a result.**

CWOS often feel isolated and unsupported by colleagues within their organisation and external statutory bodies who have a mutual interest and responsibility. However this view must be balanced by an appreciation that a lack of resources may exist. The consultation with asylum seekers did not reveal any significant dissatisfaction with the Health Services. However, CWOS who interact frequently with the families involved are of the view that there are unarticulated needs, particularly in the area of social work services and psychological services.

There is a need for development of training programmes for staff who deal with asylum seekers, particularly in areas that would enhance awareness of cultural differences and how to deal with those differences.

The Health Services should also be supportive of General Practitioners, who are coping with the considerable challenge of delivery of quality healthcare to asylum seekers and their families.

The General Practitioners would welcome the development of strategies and programmes that:

- Maximise asylum seekers' awareness, appreciation and expectations of the workings of the Irish Health Services
- Facilitate asylum seekers to disclose full information of their medical histories that will assist appropriate treatment
- Address language barriers so as to optimise diagnosis and treatment and maintain the ethos of the informed consent of the patient.

8. Summary

One of the underlying themes of the 1994 Health Strategy was that of equity of **treatment of all people.** The indicators are that the proposed strategy for 2001-2008 will continue this theme and will bring the concept of **people-centred** services onto a more central platform in delivery of health and personal social services. The last decade has also seen unprecedented focus on **social inclusion** measures and **anti-poverty** strategies.

Current government policy on asylum seekers appears to be in conflict with all of these principles and concepts. In fact, the **Direct Provision** system for asylum seekers contains **in-built inequities.** However, there are factors other than equity that influence the development of such policies and the experience is that most European countries have similar programmes to ours.

- The health Services are in the business of providing quality health and personal social services **within the government policy that exists.**

- The health Boards and health Authorities may need to give greater recognition to the fact that asylum seekers and refugees are a minority disadvantaged group in danger of social exclusion.

- Arising from this, they need to engage in service provision and advocacy with other involved and empowered organisations to optimise the likelihood that asylum seekers will receive the same positive outcomes that are envisaged for everyone in the new Health Strategy.

- The empowered organisations need to adopt an enabling approach to assist service providers in achieving this.

Eamonn Rodgers
30th April, 2001

TRAVELLERS

⇨ Consultation with:

Traveller Trainees at the Senior Travelling Training Centre (25)
Staff at the Centre (2)
Traveller Women (9) consulted with (20) Traveller Families
Tullamore Traveller Movement

⇨ Facilitator(s):

- ➙ Ms. Geri Quinn
- ➙ Ms. Joan Tierney

⇨ Date:

- ➙ Late April

Health Strategy Consultation – Report
Traveller Community

Group Consulted	Traveller Trainees at the Senior Traveller Training Centre, Mullingar
Members Present	25 Traveller Women who are attending the Training Centre;- ages between 19-45. The manager of the Training Centre, Tony Barry, and the secretary, Ms. Caroline Nevin were also consulted for this report.
Methodology	Group discussion – Flip Chart with Questions
Facilitators	Ms. Geri Quinn, Ms. Joan Tierney, Health Promotion Unit.
Report	
What do you think would be a better Health Service?	- **Themes, Principles;** • Friendly welcoming services – staff listening to clients • Clearer language used by Medical and Nursing Staff. • More information on Health and Health Services especially for Male Travellers: • GP's would listen/hear what clients are saying and not rush them through – often write prescription without listening to clients (Travellers) • Mobile clinics for travellers to go out to communities and accommodation sites (Halting) • Individual clinic appointment times- instead of giving everyone the same appointment times – long waiting times in clinics. • Crèche facilities for children during clinics • Accommodation needs of Travellers; Halting Sites fully serviced, with sanitation and hygiene facilities. Transient halting sites for each town.
What are the good points of the Service now?	• Children's Services are good. • School Health Service especially good – immunisation vaccination. • Dental services good • Speech therapy for children available and good. • Flexibility around clinic times. • Traveller women report that the Ambulance Transport Service is good in Mullingar area.
What requires fixing in the current Health Service? **to use health service more** **to be more healthy?**	• The language used by Doctors and Nurses hard to understand the meaning. • Culture awareness of Travellers within the Health Services • Long waiting times for referral to consultants. • Lack of support or information available while waiting for referral. • Poor awareness of literacy issue/problems within Traveller Community. • Language difficulties – foreign staff/doctors difficult to

	understand them. • Follow-up service for clinic appointments – Postal Service not appropriate (literacy and surname duplication). • Poor Halting Sites;- Lack of Showers and Sanitation on some sites. • The long working hours and hard conditions some staff has to work. • Tired staff – not friendly or able to listen. • General public services not available to Travellers on Halting Sites i.e. Public Telephones.
What are the barriers that need to be fixed?	• Language difficulties – foreign staff and the medical words used by staff. • Culture awareness – service not friendly. • Lack of information and support service while waiting to be referred or treated. • Child care facilities in out-patient clinics • Clinic appointment system (a) times, (b) facilities (c) contact with travellers to remind them of appointments. • Lack of information available and poor advertising of the health services for traveller men. • Poor halting sites, with no hygiene facilities. • Better Accommodation • Lack of public services for travellers on Halting Sites.
How can we overcome these barriers?	• More health information and health promotion for Traveller men. • Follow up telephone calls to remind traveller of outpatient appointments • Advertise Health Services for men. • Crèche facilities for children while using the health services • Staff Training on Traveller culture. • Support and information for people waiting for treatment. • Consultation with travellers on their needs. • Accommodation appropriate for Travellers needs • Screening services- more information on service available and information on the reasons for screening.
Do you think poverty or low income affects your health?	• Healthy food more expensive and hard to feed children with healthy foods when money is scarse. • Accidents happen on poor halting sites (and are unhealthy) • Accommodation for Travellers – there should be more consultation and the services should be of a good standard

Group consulted: Travellers

Methodology: Questionnaire

Facilitation: via. The Primary Healthcare for Travellers Project, Tullamore

Report: See information returned under key questions

Key Questions

Q: What is it that people think would be a preferred health service?

A preferred Health service would be one that offers the following to Travellers:

Health Promotion – that is easily understood (given the low literacy levels) "More information about everything"

Screening – that is easily accessible to Travellers and if the screening is for Traveller women, that there would be a female doctor available.

A Health service that is "friendly, quick, open".

Appointments – A better appointment system.
Reduced waiting times for appointments.

Q: What are the strengths of the existing system?

Supportive: "They were very helpful"
"The advice given was good"

Q: What requires fixing?

Environment/Quality of care

"Need for the Health Services to be more Traveller friendly"

There are poor facilities for children in areas with long waiting times (e.g. no play areas for children in Out-Patients Departments)

Language

Language used by Health Service providers often not understood "Doctors and nurses using big words"

Lack of intercultural awareness

Travellers identified a need for Health providers to be "more understanding of Traveller culture especially the living conditions" in relation to health.

Health information and follow up

"Not being told what's wrong with me".

Poor follow up of Travellers who do not attend for appointments (especially Traveller children)

Long waiting for referral to a specialist service identified as being problematic.

Q: What are the barriers which need to be addressed in the "fixing"?

Poor access to information – current information not known or understood.

Methods used in Health Promotion – not always useful

Language used not understood – "Big Words"

Poor explanations of procedures/process –"Poor explanations or none at all"

Atmosphere – not perceived as being "Traveller friendly"

Poor understanding of Intercultural Issues

Q: How do we overcome these barriers?

Health Promotion/Information – more information that is easily understood
With more use of visual images and perhaps media (e.g. local radio, television)
"How to go about getting information for things"

Training of Health Service Providers and Travellers

Intercultural Staff Awareness training – Staff need to be "Traveller aware and friendly"
Equality proofing at organisational level

Orientation of Health Service Provision

Health services need to be "user friendly"
"Clearer explanations in a more friendly environment"
"People who understand to listen and explain in a friendly environment"

HOMELESSNESS

- **Consultation with:**
  - Homeless Men (5)
  - "Streetwise"
  - Athlone Community Information Centre
  - Management & Staff of St. Martha's Hostel
  - Community Welfare Officers
  - The Disabled Federation of Ireland

- **Facilitator:**
  - Mr. Eamonn Rodgers

- **Date:**
  - 24th – 29th April

HOMELESSNESS

A Report to the Midland Health Board in relation to the planned National Health Strategy 2001 – 2008

1. Introduction

The Minister for Health and Children, in signalling progress on a new Health Strategy for the years 2001-2008, announced that the process will include a call for submissions and local level consultation.

The management of the Midland Health Board has assigned responsibility to a range of teams and individuals to elicit submissions and to engage in consultation with workers providing services, interest groups and users of the services themselves.

This report focuses on Homelessness and the possible health impacts owing to homelessness or threatened homelessness. It also puts forward the consideration that: **" homelessness, rather than being a primary condition, is quite often an outcome or consequence of mental illness, addiction(s), social disadvantage and / or psychological disorders. "**

2. Consultative Process in Preparation of Report:

Consultation took place with the following:

- Five (5) homeless men who were staying at St. Martha's Hostel, Longford on the night of 24th April, 2001
- "Streetwise" which is an initiative set up under the auspices of Athlone Community Services Council. (25th April, 2001)
- Athlone Community Information Centre (27th April,2001)
- The management and staff of St. Martha's Hostel (24th and 29th April)
- The Community Welfare Officer who had responsibility for assessment and delivery of health and personal social services to the temporary residents of St. Martha's Hostel.(23rd April, 2001)
- The Disability Federation of Ireland, who has campaigned for the viewing of the homelessness as a condition or outcome that is frequently associated with illness and disabilities that are treatable by the Health Services (by telephone during week ended 27th April, 2001)

3. Methodology Adopted

This was achieved through:

- Arranged meetings
- Advance notice, where feasible, to the participants of the purpose and proposed structured of the consultation(s) and the desired outcomes arising from the consultation(s)

- Facilitating, where necessary, the participants to express their views and recording those views

4. The views of the five (5) Homeless Men (referred to as "the group") accommodated at St. Martha's Hostel on the night of 24th April, 2001:

St. Martha's Hostel is a hostel that was developed and is now managed by a sub-committee of St. Vincent De Paul.

Where one is homeless, it is unlikely that there will be much feedback or experiences or perspectives that are positive. The group agreed the following **fundamental** concern:

"Our strongest view is that there is a prevalent belief in society that homelessness is a self-inflicted condition. This misguided belief needs to be challenged."

4.1 The Substantive flaws of the "system":

The group felt that:

1) Procedures should be put in place to ensure that homeless people are guaranteed a percentage share of local authority dwellings, as is the case with disadvantaged groups.
2) Homeless people rarely get a mention where anti-discrimination measures are being promoted, unlike other minority ethnic groups.
3) The mortality rate for homeless people, which is reputedly the highest of all, gets no media coverage.
4) Only the voluntary bodies have a real interest in their welfare.
5) There is a lack of interest in and co-operation between statutory bodies in addressing homelessness
6) More money was being spent on administration and "jobs" than services for the **target group.**
7) Many local authority units throughout the country lie idle, while they remain homeless.

4.2 A Power to alleviate the condition of homelessness, as it exists:

The group put on record their appreciation of the facilities at St. Martha's Hostel. However, as is the case with most night shelters, the facility is only available between 8.00pm and 8.00am. The group felt that the following matters should be addressed by the Health Boards, Department of Social, Community and Family Affairs and the training / education agencies:

- The matter of access to the day centres or suitable daytime activities
- The arrangement of emergency medical cards to facilitate needed treatment

- The difficulties that a lack of fixed address can create for the receipt or transfer of social assistance payments and training, education and employment opportunities

4. The views of the five (5) Homeless Men (referred to as "the group") accommodated at St. Martha's Hostel on the night of 24th April, 2001 (cont'd)

4.3 Why homeless people find it difficult to resettle:

The group were asked for their views on why many homeless people, who get settled accommodation, take to the roads again. The following are their views on the barriers to successful resettlement:

- A lack of acceptance by host community
- An absence of rehabilitation and re-integration programmes to support their resettlement
- Loneliness

- One interesting example was given of a person, now residing in independent accommodation, who returns to the hostel at least once weekly for companionship.

The author considers that any or all of the experiences / outcomes listed in this section may be the cause of or threat to the health of a person.

5. The Views of the Voluntary and Community Bodies:

The voluntary and community bodies as listed in the introduction, put on record their appreciation of responses by organisations and personnel within organisations in providing solutions in individual circumstances. However there is a primary concern: ***"there appears to be a reluctance by statutory bodies to make full use of their powers and available responses in addressing genuine homelessness. This reluctance seems to emanate from a reservation that an innovative response may give rise to an abuse of the scheme and inappropriate expenditure."***

Arising from this primary concern, the main issues seem to be:

- Outcomes that suggest **a difference between schemes described and services delivered**
- Inappropriate use of regulations and red-tape
- Lack of information
- Adversarial approaches to homeless people by statutory bodies
- Continued lack of appropriate responses for under 18s
- The "*foisting"* of responsibility by statutory bodies of complex cases and emergencies onto voluntary bodies
- Avoidable evictions (e.g. earlier contact with M.A.B.S., An Post Easipay, partnership approaches where social problems are evident).

The Disability Federation of Ireland has demonstrated that there is a considerable link between mental illness and homelessness **(Ref: Mentally Ill and Homeless in Ireland: Facing the Reality, Finding the Solutions).** In demonstrating the Health Services' powers and obligations in this area, the author's own view is that the thinking should be extended to include:

- People with drug and alcohol addictions
- People discharged from residential care who have no experience of independent living.

The fundamental weaknesses, as seen by the Disability Federation of Ireland, are:

- The sectorisation of psychiatric services into catchment areas
- The community psychiatric services is geared to deal with **complaint** clients
- There is generally no follow-up service with patients following their discharge from in-patient care
- That there may be better outcomes if their condition was viewed from a **disability perspective** as opposed to a homeless perspective
- That there are continued problems with the discharge of mentally ill people to the community or hostels.

The author of this report considers it valuable to include a copy of the report **"Mentally Ill and Homeless in Ireland; Facing the Reality, Finding the Solutions"** to facilitate future debate on service planning in the Midland Health Board.

6. The Views of the Community Welfare officer as a Statutory Service Provider:

The Community Welfare Officer responsible for St. Martha's Hostel deals with the income maintenance needs, health service eligibility needs and information needs of homeless people presenting. Her views are:

- That the primary motivation of homeless people presenting is to address their immediate financial situation
- That the motivation of many to put down roots appears ambivalent and, perhaps, questionable
- That their transient nature is a barrier to take-up of additional services
- That other disciplines of the service, as resources permit, should positively embrace the concept of rehabilitation and re-integration of homeless people into the community
- That people involved in an outreach and follow-up approach might have to accept a **"low return on invested time and effort"** and that measured outcomes may create a perception of unviable of futile effort.

The Community Welfare Officer is aware that 1,700 bed nights were provided by St. Martha's Hostel during 2000. She is also aware of occasional overflow situations that involve the use of a local bed and breakfast premise.

The Community Welfare Officer also drew the author's attention to the existence of an independent unit on the site of St. Martha's that generally houses homeless women with children. Domestic violence situations are frequently the cause. It is not proposed to explore this aspect further in this report as it involves different issues and different consultative processes. It is further assumed that submissions on ***Families and Children*** may deal with this topic.

7. Summary

The author would have no cause to dispute or disagree with any of the following and opinions expressed in Sections 4, 5 and 6 of this report.

The statements, if accepted, should act as recommendations and should cause the Health Services to:

- Re-evaluate its perspective of its role and responsibility towards homeless people

- Prioritise the evident disabilities and disadvantages of these people as the dominant factor that contributed to homelessness occurring

- Determine what strategies it can develop and what responses it can deliver.

It is disconcerting to note that, in six government sponsored reports on mental health and related services between 1984 and 1998 (See P.4, Mentally Ill and Homeless in Ireland; Facing the Realities, Finding the Solutions) that the matter of homelessness was only once mentioned and that no recommendations were made. It is clear from this that a change of focus is required.

A recent positive development is the publication of the Government Report – **Homelessness : An Integrated Strategy** (2000). However, it is the ***implementation*** of any strategy that is the crucial factor. Resources must be provided to statutory bodies to enable them deliver on the envisaged desired outcomes. Where these resources are provided, monitoring mechanisms and performance management systems need to be in place to demonstrate the value of programmes, responses and outcomes.

Eamonn Rodgers
30th April, 2001.

FRIENDS OF THE HOSPITAL

- **Consultation with:**
  - Friends of the Hospital Portlaoise/Tullamore
- **Facilitator:**
  - Mr. Moss McCormack
- **Date:**
  - 16th May 2001

Friends of the Hospital were invited by the GM Acute Services Division to input into the Board's submission on the New Health Strategy 2001-2008. The members of the Friends were invited to participate as individuals who are well informed about health service issues because of their interaction with hospital services.

The VISION

Friends of the Hospital have developed the following vision of the future.

They see a world:

- Where people are empowered to maintain their own health status for as long as possible.

- Where a major effort is being made in promoting health and preventing disease with the objective of maintaining as many people as possible with quality of life for as long as possible.

- Where health services are rendered on the basis of need alone, not on ability to pay or geographical location and where political input into access to health service and provision is appropriate and does not involve interference with the concepts of access and service provision on the basis of need.

- Where, when aceess is gained, the services are provided equally or fairly to all. Where services are delivered with courtesy and where the dignity of the person is preserved.

- Where the public is well educated and well informed about their entitlements so that service providers can be seen to be accountable for the quality of the services they provide.

- Where service standards are published in the press/local press where they are aware of expected waiting times for services, expected length of stay in hospitals, and the package of health and social services they can expect to access to meet their needs.

- Where interventions, including: health promotion; disease prevention; diagnosis and treatment and rehabilitation and care interventions will be provided by an appropriate number of qualified professionals who will work to evidence based good practice protocols. Services will be provided in the home, in the community, in hospitals and in residential institutions as appropriate.

- Where communication is such that the public are listened to and heard where they are provided with information such that they can engage in choices about what is to happen to them.

- Where planning for delivering services to meet need will be more bottom-up to ensure it meets with the principle of consumer oriented services and delivery processes and where the public have a voice in planning services and in providing feedback about services and service delivery.

- Where resource provision matches the need for maintaining appropriate staff to population ratios, beds and facilities.

- Where services will be evaluated for improvements in health status and quality of life and mechanisms or instruments will exist that show that people/clients get a benefit from each contact with services. Members of the public as well as statutory and voluntary providers will be involved in the evaluation process and the results will be published to increase public awareness of service quality.

BARRIERS

The following are seen as barriers to achieving the vision:

- Lack of sufficient staff and beds. There is however acceptance that there will continue to be a shift towards day case work and that the use made of beds will change. Medical beds it is felt will need to be increased.

- Political interference with waiting lists and access to services is seen as a barrier and against the principle of equal access and treatment for equal need. Service provision based on formal needs assessment alone is seen as the appropriate approach.

- The unwillingness of many professionals and others to change what they do and how they do it.

- The poor communication and listening skills of professionals.

- The lack of home care, after care, step down facilities for individuals discharged, often with too much haste, from acute hospitals.

- Public to private inequality in access to the package of services and treatment.

- Lack of information about entitlements and services available.

- Lack of definition of a specified package of services available for given conditions. This makes it difficult for people to be aware of what to expect from health and social services.

- The less than desirable portfolio/package of services.

- Lack of information on: need; services available; interventions; standards and performance in terms of outputs and outcomes.

- Lack of involvement in choices about treatment and about service provision.

- Inefficient use of resources.

- The numbers of managers and administrators relative to service providers. The health services are seen as top heavy.

- The complex medical jargon used in communication.

STRATEGIES

Quality Needs Assessment and Service Planning:

- Assessing population need on a periodic basis

- Establishing structures that ensure stakeholder representation in all planning and evaluation exercises. For acute hospital services it is suggested that Hospital Boards with representation from staff, public representatives and voluntary groups would ensure better consumer orientation of planning and evaluation.

- Developing information technology and assessment instruments to support needs assessment and publishing needs to increase public awareness.

Quality Services and Service Delivery

- Defining the package of promotive, preventive, diagnostic, treatment, rehabilitative and care interventions that are available in the home, in the community, in hospital and in residential care.

- Publishing the packages of services that will be available/contracted for given conditions so that people will know what they can expect.

- Implementing Health Promotion Strategies

- Ensuring that services are user friendly with:
    - ease of access
    - simple information
    - simple language
    - simple forms

- Defining staff to workload ratios for the package of interventions and ensuring the necessary numbers and skills-mix is available and funded.

- Providing more medical beds.

- Shifting towards more day case work for surgery etc.

- Increasing the specialist services with more self sufficiency at health board level. Ophthalmology, Dermatology etc.

- Adopting the principle of timeliness – where need will be responded to at the appropriate time and not when it is too late.

- Extending the working day for appropriate parts of the services and professionals so that the package of services is actually available to meet needs.

- Providing support to Nursing Homes to ensure patients/clients have the necessary package of services including activation etc.

- Guaranteeing appropriate 24 hour GP access.

Quality Monitoring and Evaluation

- Defining service standards with appropriate resourcing and monitoring delivery against the standards.

- Evaluating the outcomes achieved for the money invested in services.

HOSPICE

- **Consultation with :**
  Each Hospice group in the region
  Health Board Personnel

- **Facilitator:**
  - Ms. Eleanor Dowling

- **Date:**
  - Late April

There are 4 Hospice Groups on a one per County basis in the M.H.B. Region. All are committee of volunteers set up primarily to Fund raise and provide a Home Care Service to patients suffering from Cancer where active treatment is no longer on option.

The M.H.B. in 1997 set up a working party to review services in the region and all the Hospice Groups were represented on this working party.

The recommendations of this Group were –

1. *The Working Party holds the strong view that a more co-ordinated approach to the delivery of the service be forged and that the service would benefit from a more consolidated financial arrangement and a sound structure, which would facilitate a smooth operational network.*

2. *That a Consultant in Palliative Care be appointed. The Consultant would head up the recommended structure, with the emphasis on localised care, if not in the patients home, then in the most appropriate facility as close to the patients home as possible.*

3. *That a regional 6-bed purpose built hospice care unit is provided at a General Hospital to serve the Midland Health Board area.*

4. *The availability of existing hospice beds should be maintained in the interests of localised care, These beds should be available to terminally ill patients in the same flexible way as heretofore.*

5. *That the structure referred to under co-ordinate and partnership sections be set in place.*

6. *The Working Party underlines the need for a 24 hour palliative care service. It recommends that 2 specialists care nurses are available to the home care service in each county within the region. These nurses should be appointed on a permanent capacity to the Board's staff.*

7. *The specialist Palliative Care Team led by a Consultant in Palliative Care and a Regional Nursing co-ordinator be set up. The team will be based in the purpose-built unit already recommended.*

   Medical support should be available to the teams from medical personnel with training and experience in the area.

   A Nurse Manager with recognised qualifications in palliative care should be appointed to each hospice unit.

   Nurses appointed to the service should have a skill mix and experience to meet the needs of the service. The number required to staff units on a 24-hour day basis is shown under staff requirement section.

8. *That the need for ongoing education of General Practitioners in updating their skills in Palliative care provided for. Local General Practitioner Primary Care Unit is well placed to facilitate the training needs.*

9. *That a sub-committee on education be set up within the recommended structure on a regional basis. The purpose of this committee would identify training needs and set up training programmes in collaboration with appropriate educational training establishments.*

10. *That a partnership approach for hospice care within the recommended structure can address the ad-hoc nature of funding arrangements, both in terms of meeting the day to day running expenses as well as accruing of funding for further development of the service. The Working Party endorses the principle referred to in other reports, that more resources be made available. The interdisciplinary thrust within the committee structure will facilitate the channelling of resources to be based on service plans compiled by each steering committee and adopted as policy by the Health Board.*

This process should address existing service needs with the acceptance of a proportionate 65:35 percentage funding from Health Board and Voluntary Sector.

All groups were critical of the inaction of the Health Board on foot of this report and were therefore somewhat cynical of this process.

Two groups provided written submissions

The following is the response to the 5 Key Questions-

1. What is that people think would be a preferred health service?

The Committee of Laois Hospice Foundation wish to see the following implemented:

A Palliative Care Unit 4/6 beds incorporated into the General Hospital, Portlaoise together with adequate staffing.

The current services for Hospice patients to be maintained in Mountmellick and Abbeyleix.

Funding
We feel that it is now time for Central Government and the Health Board to take over the funding of Hospice Services – where appropriate this could be aided by funds raised by Laois Hospice Foundation.

Finally it is our opinion that the siting of a unit needs urgent attention and that the time span taken in implementing decisions takes far too long – thence the public suffer as a result.

Bureaucracy and red tape appear to delay and hinder improvements in the Health Services at a time when money appears to be available for same.

- When people are ill they want quick access to an efficient primary care system, be assessed, treated if appropriate or referred as soon as is necessary to an efficient secondary care system and have their problems sorted out.

- That groups with special needs such as the handicapped, the elderly, the young, the terminally ill etc. should have access to structural programmes tailored to their appropriate needs at a local level if possible.

- That a proper programme in all areas of preventative medicine be put in place.

2. What are the strengths of the existing system?

- People do have access to quick primary care and are seen as soon as is required.

- A lot of the services that are required are in place to some degree.

- People who are very ill do tend to be looked after.

- The commitment and dedication of the current medical staff is very high.

- The expertise that is available is good, if thin on the ground.

3. What requires fixing?

- Primary Care: This service is stretched to the limit. It is disjointed. The pressures are increasing. There is no strategy; G.P.s are working in one building, P.H.N.s in another, there is no plan. The primary care scene is growing daily with an emphasis on keeping people in the community etc. but there is no support, thought or finance being invested in this field.

- Hospital care: Patients can not get appointments to be seen. They have to go on long waiting lists for procedures. Access to simple procedures like X-Rays, O.T., Physio. is getting slower to everybody's annoyance.

- The Health Boards with all their employees seem to be bogged down in a bureaucratic jungle.

4. What are the barriers which need to be addressed in the 'fixing'?

- The Health Boards are administrators' not medical people. They do not seem to have a feel for the problems on the ground.
- Very poor communication between administrators and medical personnel.
- Lack of trust between administrators and medical personnel.
- Medical personnel have difficulty taking direction from administrators.
- Medical manpower needs must be addressed.
- A strategy needs to be developed to overcome these.
- Suitable and adequate facilities must be put in place.

5. How do we overcome these barriers?

- More open, frank and equal co-operation between administrator and medical personnel.
- A sense of trust and better relationships be developed between both groups.
- Develop a sensible strategy, which involves all the interested parties – administrators, primary care team, secondary care team and public health section, so that all are working to a practical, sensible goal.
- Inject more money into the Health services.

COUNTY DEVELOPMENT BOARD

⇨ Consultation with:

County Development Boards from
Laois
Offaly
Longford
Westmeath

⇨ Facilitator:

➙ Ms. Sharon Foley

⇨ Date:

➙ 9th May 2001

COUNTY DEVELOPMENT BOARD

THE NATIONAL HEALTH STRATEGY

SUBMISSION TO THE MIDLAND HEALTH BOARD

MAY 2001

AUDIENCE

The audience was composed of members of the County Development Boards of

- Laois
- Offaly
- Longford
- Westmeath

METHODOLOGY

The Regional Health Promotion Manager for the Midland Health Board facilitated a participatory workshop. The group were asked to identify vision, strengths, weaknesses / Barriers to change and solutions to improve the health delivery system. At the outset, participants were asked to identify what elements affected health, so that the discussion covered both health service delivery and the wider influences on health. The participants were asked to include measures to improve the health of those living in social isolation.

The exact outcome of the consultation has been detailed below.

FACILITATOR

Sharon Foley, Regional Health Promotion Manager

DATE AND LOCATION OF CONSULTATION

Wednesday 9th May, 2001

Bridge House Hotel, Tullamore, Co Offaly

VISION OF AN IDEAL 'HEALTH' DELIVERY SYSTEM

The participant's vision of a future health service is encapsulated in the following statements/words under grouped themes:

Adequate Resources & Development of Services

- Range of quality services
- Hospital staff
- No Waiting Lists
- Care of Elderly
- Elderly – those at risk
- Respite Services – supporting carers
- Specialist services
- Counselling service back up
- Regional delivery of all specialities

More Emphasis on prevention

- Health Education – A priority particularly 'Youth'
- Co-ordination/Preventative
- Nutrition – education
- Lifestyle supports
- Healthy lifestyles
- Increased emphasis is on prevention
- Take account of such problems as:
    - Drug/alcohol addiction
    - Homelessness
    - Domestic violence
    - Poverty/un-employment

Easier and Fairer Access

- Access
- Targeted role in social exclusion
- Equality
- Access to treatment
-
- Reach out to Communities
- Affordable quality treatment
- Equitable
    - Social inclusion focus
    - Targeted initiatives
    - GMS
- Equal access for all
- Fair
- Accessible
    - Information/communication
    - Transport
    - Location of services
- Equitable access
- Access to all

More Development of Health Partnerships / Use of Consultation

- Delivered on partnership basis
    - C/VOI sector
    - Local agency interaction
    - Government department co-operation
    - Consultation - Development, Implementation, Evaluation
- Interagency co-operation

STRENGHTS OF EXISTING HEALTH SYSTEM

- Overall, good service e.g. infant mortality
- GP service is very good and very accessible
- PHN service is very good e.g. compared to USA
- Good facilities for elderly
- Overall environment is healthy
- Health system is changing and becoming more open/consultative/focused on prevention e.g. drug education
- Good interdisciplinary working/teamwork
- Innovation in service delivery e.g. PHC for Travellers
- High level of expertise
- Very caring professional overall

WEAKNESS OF EXISTING SYSTEM

Services in General

- Disability services/Mental Health Act not being tackled
- Not Enough Youth information and services
- Absence of support for carers
- Not enough forward planning for nursing and capital resources - No unit within health to deal with trends in environment (treatment and preventative) and the dynamics of a changing environment, e.g. staff shortages could have been foreseen.
- Staff (nurse) shortages
- There is a query as to whether there is always best use of resources
- Outpatient services and multiple booking – why?
- Minimum service levels not decided versus regionalisation of specialist services – the group acknowledged that some services needed to be specialised but these should be an easily accessible, locally based set of minimum emergency and non-specialist services
- Not enough services for older persons
- Not enough resources overall e.g. NDP funding was inadequate
- Respite Services
- Counselling back up
- Long waiting lists
- Children should be a priority for waiting lists – otherwise delayed developmental

Lack of Partnership and Co-ordination

- Very many government departments dealing with aspects of health e.g. medical card, psychological services – not enough collaboration e.g. minimum wage not examined for effect on medical card eligibility
- Communication skills of senior consultants can be poor

More Flexibility about services

- GP service at weekend, late at night, home visits are inadequate – co-operatives need to be developed
- Transport – need for integrated solution
- Social work service – biggest demand is at weekend/nights – 9 to 5 not adequate
- Homelessness – no services in Midlands – no one taking responsibility
- Shelter services for women – only one centre in Midland/services are inadequate

Midland Health Board Specific Weaknesses

- There is a query as to whether there is always best use of resources in rationalisation e.g. broken bones must go to Tullamore where they could be dealt with locally.
- Longford – absence of adequate local services, reflected in every consultation. Not having an equitable service - Issue for peripheral counties
- HB are not selling rationale for regionalisation and services offered

Equity and Transparency

- Is it fair? Waiting lists, disparity between rich and poor e.g. VHI
- Transparency about decisions – needs to be equitable and fair
- Public reps on HB (public representation is a strength) – Decisions should be for the good of the people, Parochialism can be difficult to ensure that decisions are 'people centred'
- How are decisions made?

Not Enough Focus on Prevention / Health Promotion

- Need for more emphasis on prevention and reaching out to communities/education
- Need to involve other agencies – sharing responsibility for health
- Education/lifeskills in school e.g. cooking skills
- Supports around drug misuse – not enough health supports for all areas

SOLUTIONS

General Services and Midland Specific Services

KEY RECOMMENDATION

REGIONAL SERVICES : Open decisions
: People Centred
: Marketed/Communicated to public on rationale

LOCAL SERVICES: Minimum level of services for life threatening/emergency services.

Establish a minimum service level - (Longford) – need to decide MSL for emergency and non specialist services (e.g. removal of casts)

- More Resources Overall for health **– increase % of GDP spent of health**
- Appoint a **Health Ombudsman** to monitor strategy
- **Innovation** needs to be developed and rewarded to meet varying demands and achieve minimum level of service. Mainstream innovative projects such as, PHC models of care e.g. lay health workers
- Health Board should **locate services to achieve minimum response** rate e.g. Longford needs locally based emergency services or innovative solutions to meet emergency needs adequately (e.g. defibrillators with GPs)
- Forward planning for staff and capital resources and demographic changes (e.g. increase in older persons)– **need for a stronger planning unit at national and regional level**
- Establish a **minimum service level** for all regions especially remote counties
- **Increase respite services and build supports for carers**
- **Improve childcare provision** (e.g. crèche)
    - Childcare committees
    - Structures should be formalised and standards set
    - Interdepartmental communication/joint working
    - Decide where the buck stops for childcare

Health Promotion Services

- **Resource and develop positive health promotion** – built into education system, more focus on physical activity, alcohol, drug abuse
- **Education for parenting**
- Need to move from 'fire brigade' approach to preventative in generic services e.g. parenting in antenatal/innovative approaches e.g. extension of PHC initiative to communities
- Develop programmes to reduce the **stigma around mental health**
- Involve other sectors in the development of **partnership approaches** to tackling determinants of health
- Ensure that all areas of the health service take a role in health promotion
- Build on current good work e.g. partnership for youth health, substance misuse work.

Solutions for Other Sectors

- State of road infrastructure and emergency services need more focus on intermediate needs
- **Transport,** especially in rural area such as the Midlands, needs to be addressed by all agencies – there is a need for a lead agency (Local Authority) to take charge of this and work proactively.
- Developing civil society – role of CDB in building communities, so that there are more social supports

Communications and Consultation

- HBs/DOHC should demonstrate **proactive communication and dialogue**
- Build on **consultative forum for older people**
- Have a **consultative forum for community**
- **Health Community Strategy** needed
    - Information to Public
    - Communications training for staff
    - Intercultural awareness training
    - Proactive 'engagement' with ethnic groups
    - Transparency about decisions
    - Marketing of Health Services
- Develop stronger **'Forward' planning units at national and regional levels** – build into consumer feedback
- **Communication training** should be built into the undergraduate training of health care staff.

Partnership

- Develop systems to **measure and reward inter agency/dept co-operation and collaboration**
- Introduce **health impact assessment** for all sectors and ensure they must work together to develop seamless services – partnerships for health at national and regional level (could try different approaches).
- **Utilise Opportunities for Health Boards to work with other agencies through CDB**
- New innovative **systems can be developed with people not just for people** – joint working/participation/consultation
- **Partnership for youth health in the MHB** – build and develop this model

Governance

- Separate 'political' gains from 'people centred' approaches by **re-examining how best health Boards should be governed.**
- Develop stronger '**Forward' planning units at national and regional levels** – build into consumer feedback
- Each Health Board needs to be able **to identify emerging critical areas** – if in existence already, **is this process working and how is it measured and evaluated** – structures to measure performance of planning.
- **Feedback mechanisms** should be developed to allow feedback to the public and contribute to transparency in Health Board decisions.

Increase Flexibility of Services

- **Social work services need to be developed with flexible access at weekend/evening**.
- Supports for children at risk/ongoing supports – how can services be preventative/easily accessed/early school learning/co-ordination between agencies/more resources
- **Extended provision of services**
    - Counselling for sub-misuse
    - Homelessness/support services
    - Domestic violence
- **Develop GP co-operatives to extend services** (24/7)
- **Develop Good family support services for older persons, disability** etc (to replace traditional family supports/to recognise diminishing family supports)
- Allow for **increased PHN visits** as these are highly regarded/useful given less contact between people

Equality of outcome – focusing on Social Exclusion and Poverty

- 2 Tier System **– look at ways to eliminate this**, should be equal waiting times for public and private
- GMS eligibility – **higher threshold, more flexibility**
- **Integrating minority groups**
    - Need to be treated equally, opportunity to address problems, specific integrated programmes
    - Looking for equality of outcome, so will **need more targeted approaches**
- **Develop Mental Health Supports** – need to develop support/supervision systems for those in the community e.g. to prevent crime, continue medication – peer support and links
- **Social exclusion and poverty** are key issues for health services
    - Need to **identify key areas for action (social exclusion zones?) and put systems in place**
    - Need to keep sight of poverty issues

OFFALY COMMUNITY FORUM

⇨ Consultation with:

Representatives from -

- **Barnardos**
- **The Irish Wheelchair Association**
- **Tullamore Youth Initiative**
- **Harbour - Bracknagh Women's Group**
- **GROW**
- **Tullamore Travellers Movement**
- **Friends of Ofalia House**

⇨ Facilitator:

➙ Ms. Sharon Foley

⇨ Date:

➙ 26th April 2001

AUDIENCE

This consultation took place with representatives of the Offaly Community Forum, with the co-operation of the Office of the Director of Community and Enterprise in County Offaly. The following members of the Forum who attended the session:

- Barnardos
- The Irish Wheelchair Association
- Tullamore Youth Initiative
- Harbour (Centre for the out of home)
- Bracknagh Women's Group
- GROW
- Tullamore Travellers Movement
- Friends of Ofalia House

METHODOLOGY

This was a small group and, consequently, the methodology adopted was that of a focus group consultation, including brainstorming and discussion of key points. A feedback mechanism has been identified and is being undertaken by the Office of the Director of Community and Enterprise.

FACILITATOR

Sharon Foley, Regional Health Promotion Manager

DATE AND LOCATION OF CONSULTATION

Thursday 26th April 2001

Office of the Director of Community and Enterprise,

Tullamore,

County Offaly.

This meeting was organised by the Office of the Director of Community and Enterprise and the Midland Health Board.

VISION OF HEALTH AND THE HEALTH SERVICES

The participant's vision of a future health service is encapsulated in the following statements/words:

- A fair system, particularly with regard to waiting lists
- A seamless service – one body/person able to authorise all aspects of applications made (particularly in relation to accommodation needs)
- Accessible
- Accountable
- Affordable housing and sensitive housing services
- Better Public Health Nurse service
- Child-centred
- Communicative
- Community-based
- Consultative
- Elimination of red-tape
- Free
- Information on childcare services
- Integration of and partnership between agencies
- Meaningful partnerships between the Health Services and the community & voluntary sector in order to provide a client-centred service
- More accessible screening service for women
- More equitable access to and wider service within the GMS system
- Needs-based
- Open
- Other agencies should health-proof their services
- Poverty and equality proofing of all services
- Proper investment so that the new strategy can be implemented in full
- User-friendly
- Well advertised

STRENGTHS

1. The fact that we have a system of healthcare was identified as being positive, as was the fact that there are now moves to consult on the development of a new Health Strategy. It was hoped that the process of consultation would be continued in the future.
2. It was also felt that the multi-disciplinary nature of the service is a strength.
3. The involvement of the community and voluntary sector was seen as pivotal the delivery of quality healthcare support in a client-centred manner. The fact that many groups now have service contracts was seen as positive.
4. Staff in the health services are perceived as being well trained, with a high level of commitment – particularly whose working in frontline services within the system.
5. The healthcare system has become increasingly responsive and innovative. The Travellers Health Unit and Primary Healthcare programmes were cited as models of best practice which should be expanded and mainstreamed in respect of other client groups.
6. Services are becoming more accessible to people with disabilities.
7. Financial support has improved, although there is still a huge funding deficit for healthcare in Ireland.

WEAKNESSES

General

1. There are problems with some of the legislation underpinning the delivery of health services. Examples quoted include the Mental Health Act and various Children's Acts. It was felt that proposed amendments to these Acts should be implemented as a matter of priority in order to ensure that services for at-risk groups are as transparent as possible.
2. Easy access to information is vital to the development of positive health attitudes within the community. At present information is available but not accessible, a major weakness within the system.
3. There are poor levels of information and awareness among the public in relation to the services offered by the Health Boards.
4. Healthcare staff have a tendency to use jargon, which alienates clients and leads to confusion in understanding their condition and its treatment.
5. Literacy has been identified as a major problem for up to 25% of the Irish population, many of whom have a functional literacy level which would not allow for them to read the

instructions on a medicine bottle properly. This needs to be addressed in the provision of information within the community, particularly disadvantaged communities.

6. Health education delivered within the school system is no longer seen as being effective.
7. The existing Medical Card scheme is inadequate and does not reflect the hardship that healthcare can inflict on people with low incomes. The need to address income limits has been exacerbated since the implementation of the National Minimum Wage.
8. There is no provision at present for community counselling and listening services at health board level. Voluntary provision can no longer cope with the demands being placed on it as stress levels increase among the population.
9. The existing Public Health Nurse service is grossly inadequate but has the potential to be a highly innovative part of our community healthcare system.
10. Public attitudes to marginal groups, such as travellers, people with disabilities, people with mental health difficulties, refugees and asylum seekers need to be addressed in order to bring equality to the system.
11. Statutory and voluntary sectors need to develop mutual respect and trust in respect of the delivery of services.
12. Hospital waiting lists are a public shame. As long as preferential treatment is given to people who can afford to pay for fast-tracking, inequalities will exist within our system. This is not desirable.
13. Application forms for Health Board grants and assistance are unwieldy and full of jargon, leaving people confused and reluctant to apply for funds.
14. Transport is a major issue in accessing healthcare services, particularly in rural and isolated areas. Currently, bus services are provided by private contractors in order for people to attend appointments. Additionally, existing roads infrastructure is in a dire state and seriously curtails the response times of the emergency services. Roads also claim the lives of hundreds of people annually.
15. There are not enough hospital beds, a situation which demands immediate attention
16. Current policy is to centralise services. This is seen as a regressive step, which further alienates people from their health service.
17. There is no choice of provider at present, which also alienates clients.
18. Consultation should be sustained and meaningful rather than rushed.

Children Childcare and Family Supports

19. Services for children who are in care and deemed to be at risk are considered to be grossly inadequate and in need of attention. Other preventative services at community level are considered to be inadequate. It was felt strongly that the current system is very reactive and needs to change to being highly proactive. Intervention is seen as much more desirable than crisis.
20. Childcare is essential, both for parents and their children. The County Childcare Strategy Committees need to become more effective at local level in addressing this problem. Childcare in Ireland requires systematic investment, expansion and development

Young People

21. Parents are in need of support, particularly young parents. There is, however, a lack of support services for parents and their children within the state.
22. Youth information on healthcare is lacking and needs to be revamped and re-targeted urgently.
23. There are few facilities, projects and information sources for young people.

Women

24. Women's health is at risk due to the cost of accessing screening systems and a dearth of information on the importance of being aware of the risks, causes, symptoms and effects of cancers and infections.

Men

25. There is no men's health strategy, a glaring omission in the current climate.

People with disabilities

26. The housing needs of people with a disability is not being appropriately addressed. The present system is cumbersome and timeconsuming.

Ethnic Minority Groups

27. Translation services are inadequate to effectively service the medical and health support needs of people whose first language is not English. This service exists in large urban centres, but is not available in rural communities.
28. Traveller Health Services do not have enough priority nationally, with GP discrimination and a lack of intercultural awareness by Healthcare staff.
29. The Traveller's Health Strategy has still not been published, a cause for concern in terms of public perception and policy.

Solutions

General

- The Department of Health and Children and the Department of Finance need to come to an agreement on the delivery of proper and adequate funding for the delivery of a quality healthcare system.
- Services need to be promoted in a user-friendly manner and literacy proofed. Preventative education is important and should be delivered in an integrated manner, with a particular emphasis on education in schools to ensure healthy practices among young people which will last for life. The co-operation of the Department of Education and Science is pivotal in the delivery of quality information to young and disadvantaged people
- Information should be more accessible and should be user-friendly, high quality, accurate and durable
- Healthcare needs to be appropriately communicated to the general public, with an emphasis on lower socio-economic groupings, which are particularly susceptible to the effects of poverty on health. A communications strategy must be put in place at every level of the healthcare system. Communications modules should be an integral part of the training of future healthcare staff.
- Literacy is a huge problem for almost one quarter of our population, many of them living in poverty and isolation and therefore at risk. Information should be literacy proofed with the help of the National Adult Literacy Agency, who can advise on the use of alternatives to written media in the development of information and resources. Healthcare providers should undergo literacy awareness training and the Department of Health and Children should explore the possibilities for co-operation in relation to the National Adult Literacy Service.

- Practice nurses should be funded in all GP surgeries. This would lead to a more efficient service within general practices and a greater ability to service general information needs.
- The GMS Scheme should be realistically extended to take account of the needs of low income households and students.
- Counselling and listening services should be widely available.
- Transport services must be provided in order to make the healthcare system accessible
- Legislation needs to be enacted, repealed or amended as appropriate. This task is of the utmost urgency, particularly in relation to people with mental health difficulties and children at risk. Constitutional amendments to ensure the rights of the child can be incorporated into legislation are an integral part of this process.
- The Strategic Management Initiative should be applied at every level within the civil service in order to improve co-ordination of services. An emphasis must be placed on proper co-ordination of services across government departments (Education, Public Enterprise, Justice Equality and Law Reform, Heritage, Gaeltacht and the Islands, Agriculture, Social Community and Family Affairs, Health and Children). Furthermore, inter-sectional communication within departments must be improved. Thought should be given to utilising further consultative committees to develop future policy and programmes.
- Service agreements are a useful tool and assist in the delivery of responsive services at community level and should continue to be used.
- Consultation must be the cornerstone of the development, implementation and delivery of the new Health Strategy. Evaluation should be an ongoing process and involve the clients of the service at every level.
- Proofing mechanisms must be applied universally for optimal effect. These should include poverty proofing, gender proofing, equality proofing, disability proofing and environmental impact assessments. Client groups can assist in proofing programmes and policies.
- In order to make effective change, the Department of Health and Children should look at international models of best practice for the long term, rather than focussing on short-term emergency measures as a solution to problems
- Evaluation of services should be independent and transparent.
- The Department of Health and Children should be aware of the provisions of the DSCFA White Paper, Supporting Voluntary Activity, and implement its recommendations as appropriate in its relationship with voluntary bodies within the healthcare system. The current use of the Community For a at county level is to be commended.

- Health Boards need to become more accountable to the public, who should have a sense of ownership over their local health services. This can only serve to strengthen relationships between service users and providers in the long-term.
- An Ombudsman should be appointed to ensure that the strategy is being implemented, is on target and is reflecting the issues raised in the consultation process. Implementation targets should be set in co-operation with the Ombudsman and reviewed at 6 monthly intervals.

Children, Childcare and Family Supports

- More co-ordination and planning of the County Childcare Committee process is necessary if the childcare difficulties currently evident nationwide are to be rectified
- A drop-in childcare service should be examined for members of the public who have short-term emergency daycare needs. The childcare needs of health service employees must also be addressed as part of a quality healthcare service. Family support services should be one of the underpinning principles of the new healthcare system
- Responsibility for family support currently rests with a number of departments. It is recommended that one department assume overall responsibility for the co-ordination of family services and the delivery of financial support in order to attain quality delivery of such services.
- The availability of nutritious meals within schools should be investigated in order to promote diet and lifestyle change in young people. Such a service need not be free, but should be affordable for all.

Young People

- Specific childcare supports should be made available to young parents who wish to access training and employment and hence improve their quality of life. Interdepartmental co-operation should be employed in delivering such services, which could be located in local health centres
- Youth counselling and information strategies should be developed in co-operation with groups active in youth work/issues.
- Preventative education is important and should be delivered in an integrated manner, with a particular emphasis on education in schools to ensure healthy practices among young people which will last for life.

- Community Care budgets should reflect the need to develop youth services in the community, particularly the development and sustainability of Neighbourhood Youth Projects and the establishment of Drop-in and Information centres for youth. These centres should integrate local agencies in the provision of a one-stop-shop service for young people which is holistic and responsive.

Women

- The Women's Health Strategy should be implemented in full and free access to cervical smear and breast check services should be made available to all women.
- Women need greater access to information on women's health, particularly in relation to the prevention of illnesses in later life, reproductive health and the importance of a healthy diet and nutrition in their lives.
- Women living in poverty and experiencing social exclusion need to be particularly targeted, and innovative ways of so doing should be explored with relevant Non-Governmental organisations at national and local level.

Men

- There is a need to develop a Men's Health Strategy in co-operation with agencies particularly concerned with men's issues. Men are less likely to engage with health systems, but have high incidences of chronic illness which could have been minimised with early diagnosis.

People with Disabilities

- Systems to deal with the housing needs of people with disabilities must be streamlined in order to ensure a speedy, efficient and effective response. The current piloting of one-stop shops under the REACH initiative is seen as pivotal in relation to this difficulty.
- As has been mentioned, transport is a vital requirement, particularly for certain client groups, which includes people with disabilities. Accessible transport is necessary in order to enable people with disabilities to participate fully in society.

Ethnic Minority Groups

- The Traveller's Health Strategy should be published and implemented as a priority.

- Interagency co-operation in the delivery of services to members of the travelling community is vital in the context of a holistic resolution to the issues of Traveller health. In particular, the accommodation needs of the Travelling Community need to be health-proofed.
- The Primary Healthcare project has been very successful and is a model of best practice. It should be extended and mainstreamed with other client groups.
- Translation services must be provided in each Health Board area. Interdepartmental co-operation on the language training needs of people whose first language is not English is necessary.

VOLUNTARY AGENCIES

⇨ Consultation with:

OAK Partnership
Laois Leader Rural Development County
Longford Community Resources Ltd.
Offaly Leader 11 Co.
Portlaoise Community Action Project
Tullamore Wider Options
Athlone Community Task Force

⇨ Facilitator:

- ➙ Mr.Bill Ebbitt

⇨ Date:

- ➙ 20th April 2001

National Health Strategy

Consultation Process – Health Board Level

Invited:

Name	***Organisation***
Pat Legoue, Manager	Oak Partnership
Aine Goodwin, Manager	Laois Leader Rural Development County
Monica O'Molloy, Manager	Longford Community Resources Ltd
Julie Scully, Manager	Mountmellick Community Development
Anton Barrett, Manager	Offaly Leader II Co.
Agnes Scully Manager	Portlaoise Community Action Project
Edward Henry, Manager	Tullamore Wider Options
Jimmy Keane, Manager	Athlone Community Taskforce
Brendan O'Loughlin, Manager	West Offaly Partnership

Present:

Name	***Organisation***
Fiona McCabe (Childcare Development Worker)	Oak Partnership
Aine Goodwin, Manager	Laois Leader Rural Development County
Monica O'Molloy, Manager	Longford Community Resources Ltd
Roisin Lennon	Offaly Leader II Co.
Anton Barrett, Manager	Offaly Leader II Co.
Agnes Scully Manager	Portlaoise Community Action Project
Edward Henry, Manager	Tullamore Wider Options
Jimmy Keane, Manager	Athlone Community Taskforce

Q. ***What is it that people think would be a preferred Health Service?***

- More holistic
- Equitable, affordable, accessibility when required
- Co-ordinated services – Internal and External
- Customer friendly information
- High quality
- Approachable, Professional staff
- Outreach services e.g. overcoming transport problem etc.,
- Proper scheduling of appointments
- Support Education Service
- Mobile Blitz – Multiple Health Services to go to areas.
- Accessibility not just rural services
- Overcoming transport problems, locally based or outreach services
- More support in the educational areas
- Openness to change from top right down.
- Certain areas of health services need to be more customers friendly.
- It may be more cost effective to provide local delivery of services.
- Partnership is maintained with relevant groups.
- Investment needs more focus via people
- Experiment with new models.
- Quality of facilities – acute – community
- Friendliness of staff/professionalism
- One that is supportive/proactive of holistic dept. of health.
- Local delivery of services
- "Equitable" a cornerstone of health provision service

- Constantly challenging itself visa versa between medical and management practices.
- Partnership orientated in delivery of public health in community.
- Advanced transport in wages from Health Service to customer.

"Strategy is what is delivered not what is written"

Q What are the strengths of the existing system?

- Resources
- Funding
- Structures in place
- Awareness of issues (somewhat especially non-traditional)
- Open to consultation – willing to collaborate
- Increased level of partnership and joint approaches
- Emphasis on prevention has grown strongly over last number of years.
- Focus is growing on lifestyle and its impact on public health from an early age.
- Willingness to engage with community sector and local development groups to plan delivery of public health and promotion of healthy lifestyles.
- Reserve of experience within system.
- Hospice and Home Care provision – key strength.
- Openness to define health in its widest sense.
- Awareness of the need to implement new management structures that respond to changing demands.

Q. ***What requires Fixing?***

- Lack of co-ordination within Health Services.
- Lack of awareness within system of own Health Board Personnel.

- Lack of public awareness of all Health Services.
- Elimination of 2-tier system.
- Need for co-ordination of Health Board with other agencies e.g. SLD, Schools, Community Childcare and Social Workers.

- Waiting Lists
- Accessibility to services in rural areas.
- Pacer responses at management level and at service delivery level.
- Improved clarity of information on range of services provided.
- Equity of service is challenged via ability to pay.
- Enhanced facilities – both active and community based.
- Stronger customer focus orientation.
- Public perception around Mental Health Services.

Q ***What are the barriers which need to be addressed in the "fixing"?***

- Co-ordination within Health Services – bring about increased targeting and other agencies.
- Awareness within Health Board and the public.
- Database of low income families
    - Funding and management of existing funds
    - Resistance to change
    - Vested interests – political and medical
    - Need to counter public disillusionment in certain sections of community (Awareness)
    - Time
    - Skills and Training
    - Strategy itself may become out of date through lack of review and assessment
    - Recruitment difficulties

- Volunteerism in decline
- Society becoming more fragmented (increased vulnerability for some sectors of society).

Q. ***How do we overcome these barriers?***

- Co-ordination – Internal and external
- Openness to change throughout service levels
- Directory of services (user friendly)
- Multi Agency targeting of vulnerable low income families (taking into account FOI)
- Protection of medical card e.g. Child Medical Card
- Pro-active support of volunteers at local level e.g. training network.
- Focussed Investment in people and infrastructure
- Top management support for broad health definition
- Use of community facilities
- Maintain partnership for to discuss and review health policy.
- Willingness to experiment with new transport and service ideas.

VEC, FAS, NTDI

- **Consultation with:**
  - **Offaly Vocational Education Committee**
  - **FAS**
  - **NTDI**
- **Facilitator:**
  - Mr. Bill Ebbitt
- **Date:**
  - 26th April 2001

National Health Strategy

Consulation Process – Health Board Level

Invited:

C.E.O. Offaly VEC
C.E.O. Westmeath VEC
C.E.O. Laois VEC
C.E.O. Longford VEC

Regional Manager, National Training and Development Institute.

Regional Manager, FAS.

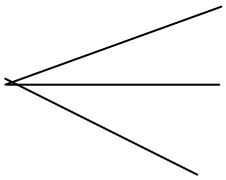
Present:

Noel Burke, Chairperson, Offaly VEC
Sheila Byrne, Training Officer, NTDI
Gerry Johnson, Regional Manager, FAS

Q: What is it that people think would be a preferred Health Service?

- Proactive/Prevention Approaches
- Flexible resources: all sectors
- Customer friendly service
- Holistic
- Standard Driven
- Supporting rural life – outreaching
- Adequate infra-structure i.e. transport
- Confidence in service provision

Q. ***What are the strengths of the existing system?***

- Access to locally based services i.e. GP's
- Quality of staff at a local level 

- Approaches of Health Board to the problems of disability services to young people.

Q. ***What requires fixing?***

- Driven – by funding of services rather than driven by real needs in this mode very hard to be people focussed.
- Lack of flexibility …..
  Lack of information leads to inaccessible services for people on the ground only the informed can access the service.
- Provision of a more holistic service. Coordination of services for patients.
- Need for para-medical services at local level. Increased staff training as opposed to buildings.
- Ambulance base at local level i.e. Edenderry/Birr.

- Severe when required – "Waiting Lists" reasonable timeframe.
- Encourage rural living – Appropriate services at local level.
- Two ter system/pubic versus private.
- Lack of competitions i.e. GP's
- All children and old people should have a free system (Medical Cards ⟶ Security).
- Income versus need related. Equity rich – Cash poor
- User friendly service – lack of criteria – accountablity
- Provision of sporting facilities in towns of Health and Fitness
- Increased Health Promotion initiatives – proactive/prevention focused
- 9am-5pm flexible

Q. ***What are the barriers which need to be addressed in the 'fixing'?***

- Transport (Rural)
- Finance
- Territory issues
- Driven by the individual (health professional) rather than the need of the service/public
- Lack of standards
- Lack of competition
- Lack of 24 hour service – innovated/creative service (childcare area)
- Education - Lack of awareness of medical issues by members of the public.
  - Value of sports/leisure
- Lack of quality criteria for monitoring services
- Lack of a structure to address what people are getting stressed about ……..

Q. ***How do we overcome these barriers?***

- Target Finance
- People centre approach
- Needs driven
- Flexibility
- Standards
- Disabilities – funding to follow client
- More information to allow for informed choice
- Information – Proactively making people aware
- Training for Health Board staff in terms of public relations

LONGFORD HEALTH SERVICES ACTION COMMITTEE

- **Consultation with:**
  Longford Health Services Action Committee

- **Facilitator:**
  - Mr. Bill Ebbitt

- **Date:**
  - 25th April 2001

National Health Strategy

Consultation Process – Health Board level

Longford Health Services Action Committee

Members present in Longford Arms Hotel on Tuesday 25th April 2001 at 8.30pm

Peggy Nolan (Chairperson)
Maureen Dunne
Annie McKenna
Margo Gearty
Matt Hynes
Brendan Fox (Secretary)
Alan Mitchell

The Longford Health Services Action Committee see our role as a Watchdog to ensure that promises made will be implemented and that the people of Longford get the health care they deserve.

Q. ***What is it that people think would be a preferred Health Service?***

- A county structure.
- Regular review of service plans with local communities
- Improve existing services. (Respond to real need as outlined in what requires fixing)
- Forget planning to meet individual needs
- Listening
- Learn by listening

Q. ***What are the strengths of the existing system?***

- Staff living locally
- Individual staff. i.e. G.P.'s
- Quality of local services which exists
- Accessible
- First class service

Q. ***What requires fixing?***

- Accessibility
  - 26 mile away from hospital
  - A & E lack of full time service
  - Doctor on call (full time?)
- Specialist – Service Provisions
- Transport
- Regional Services – Infrastructure needs to be put in place.
- Divide between Health Boards WHB/MHB. Protocol transfer activities
- The upgrading of Longford Westmeath General Hospital. To have a doctor on call solely for the Casualty Unit who will attend at the Casualty Unit when required.
- To have a Trauma Clinic in Longford patients requiring orthopaedic treatment, in Tullamore General Hospital.

- To obtain transport for Longford patients requiring orthopaedic treatment, in Tullamore General Hospital.

- To seek an improved ambulance service for Longford.

- To have a qualified midwife available for ambulance duty as and when required.

- To obtain a twenty bed step down facility for Longford.

- To improve the services for the elderly by way of additional beds and a dedicated Alzheimer's Unit in St. Joseph's Hospital.

Q. ***What are the barriers which need to be addressed in the "fixing"?***

- Not being able to appeal directly to the Minister through a local structure

- Waiting for months for Health Board members to take action.

- Lack of communication – Blocks within the system.

- Lack of openness/transparency
  - GP's - Where is the stumbling blocks.
  - Territory
  - Identify the problems

- Lack of information – one stop shop.

- Health used as political issue point scoring issue.

- Blocking/defensive attitude at Health Board level

- Local Reps. on the Health Board not allowed to voice their views at Board level

- Politicians vote in terms of how they get on to the Health Board.

- Lack of liaison between Health Board sectors.

Q. ***How do we overcome these barriers?***

- Structure for reporting back from Health Board meetings.

- Openness to learn.

- Budget for local structure to monitor service plans/strategy – county structures. "Watch dog" hold the Health Board to account.

- Require the Midland Health Board to provide accurate information on the services provided.
- Training/empowering (staff and local communities)/education.
- Co-ordination
- Communication – Accountability re: plans
- Information about local services.
- Identify real needs. Response to it …….
- Proactive rather than reactive.
- Transparency

STATUTORY SERVICE PROVIDERS

- **Consultation with:**
  Senior Probation & Welfare Officer Midlands Region
  Garda Member Laois/Offaly Division
  Sgt. Longord/Westmeath Division

- **Facilitator:**
  - Mr. Bill Ebbitt

- **Date:**
  - 25th April 2001

National Health Strategy

Consultation Process – Health Board Level

Invited:

Chief Superintendent Padraig Tansey, Longford/Westmeath Division

Chief Superintendent Kevin Donohue, Laois/Offaly Division

Dave Murray, Senior Probation & Welfare Officer, Midlands Region.

Present:

Dave Murray, Senior Probation & Welfare Officer, Midlands Region.
Sgt. Paul Cuttle for P. Tansey, Longford/Westmeath Division
Garda JLO Willie O'Grady, for K. Donohue Laois/Offaly Division

Apologies:

Superintendent Noel Carty, Laois/Offaly Division

Q. ***What is it that people think would be a preferred Health Service?***

- More accessible service with earlier interventions
- 24 hour service
- More focused towards Proactive/Preventive work.
- Infrastructure Developed for co-ordinated responses
- Clear timeframe of activities
  - Who is to do it?
  - How is it to be done?
- Holistic approach – no one service with all the answers

Q What are the strengths of the existing system?

- Deal with things at primary care G.P. services development at this level.
- Methadone Service
  - Positive impact
  - Keeping crime figures down
- Local staff with local knowledge, willing to work together (inter-agency)
- Increased coordination in the last number of years
- Joint Garda/Health Board Training Initiative (Substance Misuse)
- Contact established at local level between the agencies
- Personal Alarms Schemes for older people

Q. ***What requires fixing?***

- 24 hours service re:
  - Child Protection
  - Place of Safety
  - Type of service provided
  - Secure accommodation at a local level.

Conflict between Garda and Health Board (Hospital) due to lack of resources.

- Lack of feedback re: Reports submitted to community care (Child Protection) unsure if any action taken

- Refuse Centre – Domestic violence etc., (women and children) (Offaly)
- Personalities versus Service Provision
- Time frame of young people being seen by service providers.
- Falling through the school system – affects on health.
- Structure of communication between the agencies
- Continuity of service re: retention of staff
- Getting GP's on board in terms of the methadone service
  - Waiting list unacceptable
- Involved in times of crisis – Need to be involved in terms of proactive/prevention etc., (Inter-agency issues not just Health Board)
- Some staff inexperience in terms of difficult children (residential services)

Q. ***What are the barriers which need to be addressed in the 'fixing'?***

- **<u>Data Protection Act</u>**
  - Restricting agencies sharing information
  - Widening of scope
  - What can be discussed within a specific context?
- Lack of provision of training for staff working together
- Territorial Issues
- Services should not depend on individuals
- Lack of a communication infrastructure for senior managers to develop links between the agencies
- "Memo of Understanding" ~ Understanding of each groups culture and context.

How do we overcome these barriers?

- Appointment of key personnel within each organisation who have are responsible for feeding back within a time frame.
- Early identification within family system. " Holistic approach".
- Joint training for Health Board Staff (working with other agencies).
- Development of trust and understanding in terms of roles and responsibilities.

- Bring the services into communities i.e. Barnardos Athlone (Proactive)
- Quality of service through the system.
- Sharing of information/feedback within appropriate settings
- Review of: - How services are provided
  - Blocks
  - Alternatives
- Accessing information/help

MIDLAND HEALTH BOARD STAFF CONSULTATION

⇨ **Consultation with:**
Staff of the Midland Health Board

⇨ **Facilitator:**
- ➙ Mr. Oliver Smith

⇨ **Date:**
- ➙ 11th April - 1st May

HEALTH STRATEGY CONSULTATION WITH STAFF IN MIDLAND HEALTH BOARD

INTRODUCTION

The Midland Health Board Partnership Committee has compiled this Report, as a submission to the National Health Strategy following a consultation process with staff. The method used in this consultation process is outlined below. In the section following the main points raised in these consultations appear under a series of headings as suggested by the Project Group in the DOHC charged with gathering the information. These main points represent the frequency and importance of the issues raised in the workshops and while they are very often the individual comments uttered time and again they are for expediency sometimes an overall statement comprising a number of similar comments for that area of the service. For the full and unabridged spectrum of staff observations and for those fleeting nuggets of insight it is important to read through the appendix attached.

METHODOLOGY

The method used in the staff consultation process on the National Health Strategy was as follows:

A series of workshops were organised throughout the Board area to which staff from all backgrounds were invited to attend. Each workshop was of two hours duration and consisted of a short presentation on the New Strategy followed by two Group Workshops where staff were asked for their feedback on two topics.

The first Group Workshop asked participants to look at *their own* job and answer the following questions –

What is good about the job you do?
What does not work well?
What changes can be made to make things work better?

The second Group Workshop asked staff to look at the health service in terms of both providers and consumers of that service and answer the following questions –

Health service - What is good about it?
- What does not work well?
- What needs to be changed to make it a more effective service?

Also in this section a question was asked on "health" which obliged participants to look at the wider context outside of "illness".

What can we do to improve the health of our people?

Staff comments to all these questions were recorded on flipcharts provided. Open forum discussion followed each set of questions, led by a facilitator with feedback recorded on flipcharts. All information was retained after each workshop for the purpose of compiling this report.

In all 19 workshops were held in eight locations throughout the Board.
Over 600 staff attended with the vast number of grades/disciplines being represented.

Health Styles, promotion of best health and well being, promotion

- Integrated approach in delivery of public services where there is an impact on health and social gain e.g housing,
- Health promotion – healthy lifestyles, diet, alcohol/drugs awareness etc – with the emphasis on innovative approaches e.g making these issues more "cool" as opposed to using the didactic approach
- Increased awareness of mental health issues and society acceptance/understanding of these issues
- Screening for early detection
- Levy alcohol companies – put the money back into healthcare
- Workplace health promotion, stress management and good working conditions
- Spike bread with folic acid!

Care/service in the community

- Better planning of care from acute to community setting particularly for the elderly with the provision of adequate supports
- Consultation with the community and awareness of carers' needs
- Multicultural issues – awareness/training for same
- Greater government support for voluntary agencies. There has been a reliance by the health services on this sector to provide services and fund raising for equipment

Hospital based services

- The problems of the public/private mix came up everywhere for discussion. Problems are caused for staff who feel compromised and find they have to deal with questions raised by patients. Importantly though it felt that as things now are public patients are loosing out
- Extension of services e.g. evening clinics and out-of-hours services
- Remove the politics – have the services evidenced based/best practice.
- Triage nursing at casualty

Linkages and continuity of care/support

- Provision of IT to health professionals especially in the community setting to allow speed of access to shared data which is constantly being updated
- Continuity of care so that at all times the patients progress through the system is known

Meeting the needs of particular groups

- Services for the elderly to be prioritised in terms of tackling the many inadequacies existing there. This to include creation of more beds both long-term and respite, placement of elderly into care units appropriate to their condition, development of specialised care units e.g. Altzeimher Units, more community supports and equality in access to treatment.

Improving the experience of the public in dealing with health services

- The area of A & E drew the greatest criticism because of the delays there. Patients waiting would like to be updated from time to time on what is happening
- Raise the profile of the health service in terms of the full range of services it provides and at the same time provide comprehensive information on how these services can be accessed. Together this will provide the public with greater awareness and insight into the services

Health insurance/entitlements/eligibility for services

- Extend medical card cover for all children up to age 18

Valuing the personnel

- Recognition/acknowledgement (non-pay) of long and dedicated service by staff. They have shouldered the health services through the cutbacks and currently through manpower shortages. Many even feel they face burnout.
- Benefits to staff e.g. cheaper drugs, staff welfare services, easier access to some services such as physiotherapy
- Consultation with staff at all levels in service delivery/development and changes in the workplace. "Resource impact assessments" to be carried out when new/extended services are planned
- Family friendly policies, including crèche facilities
- A management style that is non-autocratic/bullying
- Development of good communications and information flow in every aspect – between disciplines, services, management/staff etc
- Training and development
- Training and up-skilling of attendant grades with a recognised qualification

Organisation and infrastructure

- A flexible structure to allow for consumer input

Quality

- Universal cry for more staff in all areas to deal with workload and develop services properly
- Some services need more development such as psychotherapy

WORKSHOP I – THE JOB

What works well for you in the job you do?

- Work well with one another – good colleague support.
- Teamwork
- Flexibility
- Motivation-when it happens
- Job satisfaction
- Good rapport with patients

- Communication –interdisciplinary
- Autonomy
- Education & Training good for some
- Challenge
- “Making a difference”
- Positive feedback-when it comes
- Professional responsibility is a motivator

WORKSHOP I – THE JOB

What does not work well for you in the job you do?

ATTENDANT GRADES:

- No training/development of this grade
- No promotion
- No voice (up to now)-health strategy consultation
- No staff
- Low morale
- Not enough payment for work well done
- Very slow to get pay due
- No recognition by other staff or management generally
- Work can be physically and mentally challenging

This response from a single session articulated well the widespread feeling of their grade therefore it was left intact here. Some issues raised here are of course issues among other grades such as staffing levels and morale.

- IT lack of technology
- "passing the buck" people not taking responsibility
- Need for sound proofing in delivery of some services e.g. mental health & social workers (strong feelings on this)
- Overcrowded offices

Social Workers

- Multi-disciplinary not effective →social workers(Childcare)
- Length of time it takes to get decisions made
- Stress
- Lack of foster care
- Workload not equally divided
- High service demands exceed capacity to deliver
- Communication/ information dissemination in all directions
- Safety/security issues esp. @ A&E Dept.'s and people working on their own e.g. P.H.N's
- Lack of space to work and for storage
- No time for "niceties"
- Isolation
- Mileage boundary for P.H.N's
- Valuable work done in some areas not understood/appreciated by other staff e.g. crafts with the elderly
- Processing time to fill vacant posts
- Centralising of services can lead to poorer quality
  e.g. - Laundry
  - Medical items supplies to wards form central stores may be cheaper but can be of poorer or variable quality (source changing regularly due to price)

Workshop I – The Job

What changes can be made to make things work better?

- More staff.
- Less physical work.
- Improved promotion e.g. attendant grades.
- Training (identify training needs).
- Pay.
- Staff bonuses/benefits e.g. drugs at cost, staff facilities.
- Team building.
- Support for staff (incl. Medical).
- Workspace / storage space – wards & offices everywhere.
- Investment in service.
- Improved communication in all directions.
- Consultation with staff – New equipment
  Physical changes/ design workplace
  - New services – esp. the full resourcing of same (Resource Impact Assessment).
  - Planning of services

- Crèche facilities.
- IT.
- Flexible working.
- Rewards / Recognition
- Health & Safety – security issues for staff.
- Autonomy.
- Risk management
- Realistic goals for staff/services
- Secretarial backup to some disciplines e.g. PHN's
- Standardisation of policies, procedures.
- Change agents/facilitators to assist/educate staff in change.
- Liaison Officer – staff well being.
- Clear sign posting in and around heath services buildings especially multiple building sites.
- Policy to prosecute offenders who violate staff safety
- Management style needs to change - can be autocratic, de-motivating and sometimes bullying.
- Be one Board - not isolated units
- Mobile unit for school screening
- Induction courses for new staff to the service and those changing location within the service.
- More Indians less Chiefs.

WORKSHOP 2 HEALTH SERVICE

Health Service – What is good about it?

Good A & E services ⟶ everyone gets seen.

Caring ethos.

Committed, professional, diligent staff.

Free service for eligible people.

Accessible to all.

Good Out-Patient Department services, in some areas.

On-going development and improvement of service.

Regional Specialist Services.

Increased awareness of Rights of Children.

More support for family attachment, not breaking bond.

More to be done on Mental Health Awareness issues.

Resources used properly by staff.

Psychiatry service not two tier.

Good Community Care Services in some areas ⟶ good improvement generally.

Patient Charter and complaints procedure.

Good quality care provided.

Freedom of Information Act.

WORKSHOP 2 HEALTH SERVICE

Health Service – What is not working well? (2)

Understaffed.

Underfunded, (Compared to EU countries)

Waiting lists.

N.C.H.D. hours of duty.

Free services to areas not deserving.

Communication – interdisciplinary, throughout large systems especially.

Retention ⟶ no incentive to stay.

Transport infrastructure, difficulty in getting to services e.g. duties in other towns, physio etc. especially elderly.

Legislation not matched by resourcing.

Two tier system.

Is funding always directed to right areas?

Bad planning of services at National Level.

Political influence on placing / developing of services locally, nationally.

Not a patient focused service.

Perceived to be top heavy with management grades

Career paths for clinical practitioners.

Staff facilities / space.

Multi – cultural issues / refugees.

Some individual services need attention ⟶ counselling, family planning, mental health, travellers health.

Decision making too high level.

Patient planning from the Acute to the Community Care services.

WORKSHOP 2 HEALTH SERVICE

Health Service – What is not working well? (2) (Continued).

Inappropriate use of Acute services.

Lacking Specialist services e.g. elderly people.

G.P. units ⟶ poor value for money.

Negative impact of pressure groups and power groups e.g. hospital consultants.

An Bord Altranis ⟶ not enough involvement.

Not having some services available out of hours e.g. Social Workers, psychiatric at A & E.

Reliance by health services on voluntary agencies / workers to provide services and fund raising for equipment.

Postnatal services to home are poor.

Continuity of staff care to patients through acute systems from elderly is not good.

WORKSHOP 2 HEALTH SERVICE

What would make it a more worthwhile service?

Health Service – (What can be changed to make things work better)? (3).

More Staff.

Accountability of staff and management.

Staff incentives / bonus / benefits.

Short waiting lists, especially elderly in need of operations.

More money resources.

Encourage, motivate staff.

Appraisal.

Training.

Good P.R. to promote the services to the public – all that is done and what the services offer.

Equality.

Free G.P. service for children 0 –7 or 0 – 18.

Subsidise leisure facilities for staff.

Health Boards valuing their staff → decreasing stress.

Address the issue of the two-tier system.

More consultants / specialists on the ground.

Easier access to services.

Look to outside agencies if problems in delivering services.

Look at initiatives especially G.P's to take pressure off A & E (G.P. service within hospital).

Consultation with service users.
Focus on primary care.

WORKSHOP 2 HEALTH SERVICE

What would make it a more worthwhile service?

Health Service – (What can be changed to make things work better)? (3).
(Continued).

Accountability in allocating funding.

Out of hours services, (after 5 p.m.) clinics, enquiries, payments).

Have delivery of services evidence based, out with politics.

Examine role, function of present health board structure.

More local ability to resolve problems.

Waiting lists.

Multi – cultural issues.

Need to analyse needs / black spots based on evidence, direct funding accordingly.

Day respite for the elderly ⟶ crèche type facilities.

Community supports more flexible + cost effective but not cheap options.

More effective planning and consultation with all staff.

Multi – agency involvement in social gain.

Identify eligibility ‘traps’, health needs.

Change agents / facilitators to assist / education staff in change.

Measure progress.

Nurse practitioners.

Skill mix – multi-skilling.

Close G.P. units ⟶ direct savings made to elsewhere.
Consultants – v – teams approach.
More benefits for people on low to middle income.
Night sitting service for the elderly.

WORKSHOP 2 HEALTH SERVICE

What would make it a more worthwhile service?

Health Service – (What can be changed to make things work better)? (3). (Continued).

Look after well being of health premises and staff.

Alzheimer Units.

Patients ⟶ in (appropriate) environments / units. Many patient types in elderly services.

Bring services to the elderly ⟶ consultations, diagnosis, etc. Patients going to acute elderly care centres tie up to attendant/nurse for large part of the day.

Make it more attractive for professions to work in elderly services.

Look at Canadian model.

One stop shop services on high street.

HEALTH

WHAT CAN WE DO TO IMPROVE THE HEALTH OF OUR PEOPLE?

- Health Education (from National School level upwards) Issues – smoking, alcohol/drugs, sex, exercise, diet, mental health
- Promote cycling, walking, safe cycling/walking on roads
- State funded crèches
- More work on mental health issues/awareness and integration with other services
- Workplace strategy/bullying to be tackled
- Review advertising in health promotion – more exciting, what works, feel good, not dictatorial, be age specific, link into local services e.g. food outlets to promote healthy eating/nutrition
- Funding to voluntary organisations who have a 'health' agenda
- Public awareness of health issues and preventive care
- Concentration on elderly care in the Community
- Integrate health promotion into all services/professions
- Screening for early detection
- Every government department have a 'health' responsibility – linked agendas, policies
- Spike bread with folic acid
- Levy alcohol companies – funding back into health
- Health care to prisoners/travellers
- Halting sites in all counties - cross transfer system arrangement
- Ottawa Charter
- Flexible retirement
- Look at alternatives e.g. Chinese medicine
- Physical work environment improvements
- Environmentally friendly farming practices
- Peer education in schools around specific issues
- Internal locus of control – teach people to be in charge of their lives
- Promote positive thinking as a nation
- Laughing clinics
- Address traffic problems – congestion and stress

TOWARDS THE DEVELOPMENT OF A:

Consultation with Midland Health Board, Board Members - 17th April'01.

Methodology

Special meeting convened for purpose of consultation.

CEO provided Overview of New Health Strategy development.

Presentation on key aspects of 'Shaping a Healthier Future'.

Presentation on new Health Strategy - principles, themes, key questions, issues for consideration.

Identification/affirmation of key questions

Small group discussion and feedback on each question.

Reconvening of larger group and examination of response in context of consensus/conflict.

Consideration of response in regard to omission/general discussion on issues raised.

Key Questions

What is it that people think would be a preferred health service?

What are the strengths of the existing system?

What requires fixing?

What are the barriers which need to be addressed in the 'fixing'?

How do we overcome these barriers?

In attendance:

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Facilitators: Dr. Pat Doorley, Ms. Eileen O'Neill.

VISION OF HEALTH AND HEALTH SERVICES

1. Preventative Orientation

2. Community services where support, screening, vaccination and other services are provided in a multi-diciplinary context inclusive of the G.P., with appropriate paramedical, nursing and social supports.

3. Linkages between Hospital and Community strengthened with appropriate care at appropriate time, adequate bed spaces, sufficient staff and a developed filtering system in A&E departments. Step down care developed.

4. Public/Private mix, such that it provides equity of service.

5. Access based on need.

6. Widest range of services available on regional basis.

7. Community services to be developed.

8. Emphasis on Health Promotion

9. Structures to be developed.

10. Adequate resourcing with funding on a multi-annual basis

11. Treatment available at short notice (specific reference to Mental Health Services.)

STRENGTHS

1. Staff
   - Experienced
   - Well qualified
   - Highly trained

2. Once access obtained, overall quality pretty good

3. Considerable infrastructural developments in the health services
   e.g. (1995 - 14 surgeries re-equipped)

4. Improvements identified included

- Ambulance service improved
- Health Promotion
  Cardiovascular + Women's health enhanced
- Children's Health Services improved
- Increasing emphasis on the Care of the Aged
- All Medical Card holders entitled to Dental Treatment with private practice of choice

WEAKNESSES

1. Equity

2. Poor Budgetary Planning (2/3/5 year planning)

3. Physical Infrastructure

4. Hospital Waiting Lists – problematic. Examples given were in the area of orthodontics and elective surgery. Also identified was accessing specialist opinion and treatment.

5. A & E
   - Delay
   - Quality of service
   - Lack of information – patient and relatives
   - Communication difficulties
   - Overcrowding.

6. Lack of emphasis on Community Services

7. Community - Out-of-hours service to incorporate services by
   - GPs
   - Nurses
   - Social Workers
   - Community Welfare Officers
   - Home Help

8. Structured Respite Care

9. Changing roles and expectations of staff requires a supportive work environment. Issues of stress and bullying identified.

10. Gaps in Services leading to inappropriate use of other services e.g. (services to those with alcohol problems, clogging up Casualty).

BARRIERS TO CHANGE

1. *To bring funding in line with European Average*

2. *Audit of how funding is spent*

3. *Improve communications with consumers of services*

4. *Infrastructure*
   - *Financial Input inadequate*
   - *Deficit in infrastructures*
   - *Existing projects impeded by red tape*

5. *Proper Information System*

6. *More focused health Promotion (people taking more responsibility)*

7. *Health Promotion needs to be further developed in the areas of*
   - *Lifestyle*
   - *Alcohol*
   - *Drugs*
   - *Obesity*
   - *Smoking*
   - *Road safety*

8. *Recruitment shortages*

9. *Increased beds – acute + step down*

SOLUTIONS

1. *Increase G.D.P. percentage on Health*

2. *Promote Social Responsibilities*

3. *Health Promotion needs to be further developed in the following areas of:*

- *Lifestyle*
- *Alcohol*
- *Drugs*
- *Obesity*
- *Smoking*
- *Road safety*

4. *Improve communications with consumers of service*

5. *Further develop the infrastructure to accommodate ongoing need*

6. *Develop a proper information system*

TOWARDS THE DEVELOPMENT OF A:

Consultation with MHB Corporate Team 26th March '01.

Methodology

Presentation on key aspects of ‘Shaping a Healthier Future’.

Presentation on new Health Strategy - principles, themes, key questions, issues for consideration.

Identification/affirmation of key questions

Small group discussion and feedback on each question.

Reconvening of larger group and examination of response in context of consensus/conflict.

Consideration of response in regard to omission/general discussion on issues raised.

Key Questions

What is it that people think would be a preferred health service?

What are the strengths of the existing system?

What requires fixing?

What are the barriers which need to be addressed in the ‘fixing’?

How do we overcome these barriers?

Facilitators: Dr. Pat Doorley, Ms. Eileen O’Neill.

VISION OF HEALTH and HEALTH SERVICES

- Focus on health – not just services
- Support for healthy communities
- Prevention

ACCESS:

- Similar standard regardless of where you live
- Local services where appropriate (quality considerations)
- Timely
- Needs based

EQUITY:

- Equity in health – not just services
- Target lower socio-economic groups and lower health status groups
- Single tiered system – need determines timeliness, level, quality of service
- Seen to be fair

QUALITY:

- Evidence based
- Seamless service
- Gold standard
- Person centred – holistic
- Partnerships as between the client management and professional
- Partnerships - with elements of wider system e.g. local authorities, other government departments.

ACCOUNTABILITY:

- Openess - reflected in structures
- Structures / funding should match strategy - well resourced.

EMPOWERMENT OF INDIVIDUALS AND COMMUNITIES

- Advocacy for users
- Information
- Education on maintaining health
- People should know what to expect
- Public to be more involved in planning, decisions.

STAFFING:

- Health seen as career of choice
- Good morale
- Job satisfaction
- Caring service

SERVICE SHOULD BE:

- Responsive / flexible
- Change in response to changing needs
- Anticipatory, far sighted.
- Culturally appropriate
- Choice of provider where possible and appropriate, e.g. family planning

ROLES:

- Department of Health – leadership, vision, strategic.
- Boards - strategic
- Non party political in decision making

STRENGTHS

- Overall quality appears to be good when access is gained
- Well qualified, committed workforce
- Cost effective compared to other countries
- Significantly improved accountability e.g. service planning, performance indicators. Public accountability through Boards, FOI. Accountability better than other sectors in Ireland. Development of comment, enquiry and complaints system.
- Emergency services generally good
- Improved provision of quality services locally (e.g. hospital services previously provided only in Dublin)
- Improving infrastructure through N.D.P.
- Public private mix
- Improved level and range of community services
- Since 1995 greatly improved population health focus with introduction of Department of Public Health and Health Promotion function
- High user satisfaction level (contrary to some perceptions) as indicated by independent surveys e.g. I.S.Q.A. survey
- Boards are much more open to Partnerships. In some instances they have initiated these Partnerships. Partnerships now developed in youth health, domestic violence, disabilities, mental health, health promotion, older peoples services.
- Overall health population is now improving at a faster rate than before – some credit to health service.

WEAKNESSES

- Lack of equity especially concerning access to services, as between private and public hospital patients.
- Lack of capacity, which constrains health sector from benefitting from potential, increased funding. Funding low by comparison to other developed health services. Infrastructural deficiencies such as skill shortages, shortage of acute hospital beds and in some areas longterm beds for older people. Deficiencies in health centres and other local facilities and insufficient accommodation for staff. Other infrastructural deficiency is the area of I.T.
- Waiting lists unacceptably long
- Lack of multi-annual budgeting
- Over pre-occupation with services particularly hospital services at expense of population health focus
- Lack of health status, health services information constraining needs assessment evaluation and audit
- Lack of opportunities for public involvement in planning and evaluation
- Some services fragmented e.g. as between hospitals, GPs and other community care services
- Inappropriate politicisation of some issues resulting in decisions which are not in keeping with best practice
- A blame culture, which at times inappropriately targets health sector – can demoralise staff
- System not sufficiently user friendly
- Dominance of “professional” viz a viz consumer models
- Under-developed planning function
- Relatively poor public relations

BARRIERS TO CHANGE

- Lack of strategic focus and farsightedness as evidenced in insufficient long-term planning. Lack of clarity of roles with respect to government and local health agencies.

- Lack of capacity which constrains health sector from benefiting from potential increased funding. Funding low by comparision to other developed health services. Infrastructural deficiencies such as skill shortages, shortage of acute hospital beds and in some areas longterm beds for older people, deficiencies in health centres and other local facilities and insufficient/adequate accommodation for staff. Other infrastructural deficiency is the area of I.T.

- Focus on services as opposed to population is a barrier to improving health status in the population

- Local and national politics sometimes act as a constraint to good practice

- Deficit in authority of management viz a viz their accountability. Consultants and GPs contracts are significant factors here

- Lack of involvement of Clinicians (i.e. all professionals) in management

- The perception that clinical authority is synonymous with lack of managerial accountability

- Lack of a systems approach particularly in relation to risk management and quality generally

- In some parts of the voluntary sector the piecemeal funding from various sources is a barrier to achieving a quality service and evaluation

- Level of cynicism in relation to 'new health strategy'.

- Unenlightened public attitudes towards local services for vulnerable groups –
  Children, mentally ill, intellectually disabled.

SOLUTIONS

(1) Develop a comprehensive manpower plan for all disciplines in the health services for five years and beyond so that health services can avail of improved funding and opportunities

(2) Address the area of equity through:

- Further limiting private practice in hospital medicine
- Creating general eligibility for medical card
- Further development of Health Promotion interventions for low income people and other vulnerable groups
- Health proofing of all government policies and all major projects –
  A structure to be established and chaired by the Minister for Health
- Further promotion of a Partnership approach to health

(3) Change Consultants and GPs contracts so that management has the full authority to deliver e.g. on waiting lists

(4) Clarification of clinical authority viz a viz management accountability

(5) Clinical governance structure to be put in place.

(6) General Practice and other primary care services need to be enhanced so that GPs can treat a lot of patients who currently go to hospital. This will require supports such as nutrition, therapies, psychology etc.

(7) Community services need to be developed so that some people opting for institutional care could have more confidence in community services. This development will required enhanced multidisciplinary services.

(8) Structure and fora to be established for public input.

(7) Provide for multi-annual budgeting. Strategy to identify resource requirements for strategy life-time. Representative group at national level to monitor its implementation.

(8) An explicit commitment to evidence based guidelines, protocols and needs assessment and the establishment of a national technology assessment structure

(9) Explore alternative systems of funding e.g. insurance based.

(10) Explore public, private partnership as a solution to NDP shortfalls.

(11) To create an onus on private health insurers

(a) to share data with public sector to facilitate needs assessment

(b) to develop protocols for quality and to conduct audit.

(12) The development and funding of a comprehensive information strategy for the health services to include a major upgrading of current I.T. system.

(13) The undertaking of a health technology assessment

(14) The development of new health strategy to provide: rationale for strategy, evidence of success from Shaping a Healthier Future. It should create ownership of new strategy, be explicit, have strong ministerial support and leadership and have benefits to people working in the system .