History
of the
North Eastern Health Board
1971 - 2004
Stair Bhord Sláinte an Oir Thuaiscirt
Dr. Frances Carruthers, B.A., PhD.
This book was researched and written by Dr. Frances Carruthers, B.A., PhD.

for the

North Eastern Health Board, Kells, Co. Meath

Dr. Frances Carruthers

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A mother to five children, she spent fifteen years as a full time homemaker until 1990 when her youngest child began school she returned to adult education. Two years later she received a diploma in Liberal Studies, i.e. History, Philosophy and English. Determined to fulfil a life long ambition Frances undertook a full time degree course and graduated with a BA Honours in Modern History and Geography in 1995. Post graduate studies followed and she was awarded a PhD in Modern History in 2001, for her thesis on Lady Ishbel Aberdeen, Marchioness of Aberdeen and Temair 1887-1939.

She has also worked for Schizophrenia Ireland as a Facilitator and also as a Senior Workshop Supervisor/Trainer for Cheeverstown Mental Handicapped Services.

Previous research include Against All Odds Cheeverstown: One Hundred Years of Voluntary Beneficent Services 1904-2004, articles in relation to work for Schizophrenia Ireland, The Reality of Schizophrenia in Childhood 1998 and Whose Illness is it Anyway 2000 and Defining Mental Illness in Ireland 1998, Information Education and Activities on Mental Illness in Ireland.
Acknowledgements

I would like to begin by thanking Mr. Paul Robinson, Chief Executive Officer and Ms. Rosaleen Harlin, Communications Director, for giving me the opportunity to write this history of the North Eastern Health Board. Ms Harlin also gave her support and encouragement and introduced me to the individuals who were in the best position to be of assistance. I am particularly grateful for unimpeded access to all of the records, reports, files and correspondence relating to the activities of the Health Board dating back to its inaugural meeting on the 26th November, 1970, to the concluding meeting held on the 21st June, 2004. I would like to make it clear that any opinions expressed in this work are my own, supported by my research. No individual or group tried to influence the outcome of my findings, but gave me free rein in compiling this history. My special thanks go to Ms. Mary Flanagan, Secretary to the CEO, who spent many hours painstakingly editing this work.

I truly appreciate the time taken by those who made written submissions or gave personal interviews and thereby greatly added to my knowledge or the workings and personalities of those involved in the services. They include, in alphabetical order:

- Mr. Vincent Brady, former Administrator, Louth Community Services
- Mr. Micheal Casey, Finance Department, Head Office
- Mr. Eugene Caulfield, St. Davnet’s Hospital, Monaghan
- Mr. Paddy Conaty, former Board Member and former Chief Ambulance Officer
- Ms. Katherine Cregan, Communications Department, Head Office
- Mr. Billy Davey, Cavan/Monaghan Community Services (based in Monaghan)
- Mr. Geoff Day, Assistant CEO Regional Services
- Dr. Hugh Dolan, former Chairman of the Board and former Director of Community Care and Medical Officer of Health in Louth Community Services
- Mr. Sean Donohoe, Management Services Department, Head Office
- Mr. Peter Finnegan, former staff member (currently in South Eastern Health Board)
- Ms. Geraldine Fox, Dunshaughlin Healthcare Unit, Co Meath
- Ms. Anne Marie Hoey, Primary Care Services
- Ms. Dymphna Keenan, Primary Care Services, Navan
- Mr. Gerry Kelly, Regional Services, Head Office
- Mr. Sean McGeough, Louth Community Welfare Services
- Mr. Seamus Mattimoe, Technical Services Department, Head Office
- Mr. Paul McGillicty, Louth Community Welfare Services
- Mr. Tadhg O’Brien, Assistant CEO Acute Hospital Services
- Ms. Anne O’Reilly, Community Services, Head Office
- Ms. Carmel O’Rourke, Finance Department, Head Office
- Mr. John Pepper, former staff member (currently St. John of Gods, Stillorgan)
- Ms. Mary Reilly, former CEO’s office and currently Acute Hospital Services
- Ms. Mary Reilly, former CEO’s office and currently Acute Hospital Services
- Mr. James Reilly, Chief Executive Officer’s Office
- Mr. Donagh Russell, Management Services Department, Head Office
- Mr. Barry Segrave, first CEO of the Board
- Sister Isabel Smyth, Medical Alissionaries of Mary
- Ms. Amanda Tormey, Communications Department, Head Office
- Ms. Elma Tormey, Head Office

Unfortunately, it was not possible to include all of the stories and reminiscences submitted by very interesting and often entertaining individuals. The restrictions of time and space did not allow for their inclusion. Nevertheless, they gave me great insight into the work, commitment and loyalty of Board members, executive and staff to the population of the north eastern region. Finally, I wish to thank each member of the Board's staff located at the Head Office in Kells who were exceptionally helpful and made me feel very welcome in the time that I spent there.

Dr. Frances Carruthers

October 2004
Dedication

To all of those who were involved over many years and in many disciplines with the North Eastern Health Board who have now passed on but whose legacy continues to exist to the present day.

Coat of Arms

The Chief Herald of Ireland granted a Coat of Arms to the North Eastern Health Board in June 1994.

The design reflects the River Boyne as one of the most notable geographic features in the region.

One of the principal Celtic deities associated with the area was Aengus, a mythological figure particularly associated with the dun and with youth. The symbol of the clasped hands from which drops of water fall recalls the story of the death of Diarmuid na Duibhne, celebrated warrior of the Fianna. According to tradition, Diarmuid lay mortally wounded having been gashed by a wild boar, which impersonated his enemy and pursuer, Finn macCumhaill. One thing alone will save him - a drink of water from the Boyne River. Aengus is charged with carrying the life-giving water to Diarmuid but before he reaches him, the water has all dripped through his hands, and Diarmuid dies.

On the bend which represents the river, is depicted the celebrated salmon of the Boyne, the Eo Fis, "The salmon of knowledge", signifying the research and knowledge inherent in all medicine.

The essential meaning of the motto used "Slainte an Bhraoin" is that the salmon is synonymous with health.
In June 1994 the Board commissioned Desmond A Byrne, Kilkenny Handwrought Silver to make a Chain of Office for the Chairman. The Chain of Office is made from Sterling Silver with 18kt yellow gold mounts and consists of 40 link bars which are engraved with the names of the Chairmen of the Board and their Period of Office. It incorporates the Coat of Arms granted by the Chief Herald of Ireland in June 1994. The Chain of Office was sponsored by AIB Corporate Division and was presented by Mr. Donal Chambers, General Manager and Ms. Marion McCarville AIB to Dr. Hugh Dolan, Chairman, NEHB on 23rd January, 1995.

Presentation of Chain of Office by Mr. Donal Chambers, General Manager and Ms. Marion McCarville, AIB to Dr. Hugh Dolan, Chairman, NEHB on 23rd January 1995.

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FOREWORD

This short history of the North Eastern Health Board has been written to record, acknowledge and celebrate the achievements of the Board and its staff over the last 33 years. The Ireland of today is very different from that of 1971 when health boards were established. Economic growth was in its infancy, unemployment and emigration were high and infrastructure was underdeveloped. The health status of the population was significantly lower than it is today, and general standards of living were substantially below European norms.

The healthcare system which health boards took over reflected the general condition of the country. Acute care was mainly provided in small county hospitals with few specialist services and very small numbers of consultant staff by today's standards. Long stay care - for elderly, mentally ill and intellectually disabled - was provided almost exclusively in institutions, most of which had been built in the 19th century. Community services to a large extent were based on the Dispensary Doctor system.

The changes, expansion and improvements in service which have occurred in the North East since 1971 are chronicled in this history, together with an outline of some of the key changes in health status. These demonstrate the level of commitment, competence and dedication which has been shown by people - Board Members and staff of all grades and professions - down through the years and going forward into the future. We should not forget that this was achieved through the present structures, both nationally and in the North East. However, no organisation can stay static and the need for reform of the health services has been evident for some time, given the growing complexity of health care and the scale of activity which we have today.

One of the key decisions of the Health Service Reform Programme involves major rationalisation of existing health service agencies to reduce fragmentation. This includes the abolition of the existing health board/authority structures. The new health system will depend on the skill, dedication and commitment of those who are currently working for the Health Services and who will continue to work with that same dedication and commitment.

I am very grateful to the many people who have contributed to this account of the history of the North Eastern Health Board and who have given time to share their knowledge and experience.

Dr. Frances Carruthers has shown enormous skill, diligence and expertise in researching the history from Board and other relevant records, in interviewing people who contributed to the changes and developments, in sifting and editing the huge mass of information and in blending the official records and personal recollections to provide a history which succeeds in being scholarly, interesting and readable.

The project was directed by Ms. Rosaleen Harlin, Communications Director who has shown tremendous interest, dedication and commitment at a time when demands on the Communications Department were at an extremely high level.

Ms. Mary Flanagan of the CEO’s Department has contributed immensely by proofreading the various drafts and advising on style and layout.

PAUL ROBINSON
Chief Executive Officer
North Eastern Health Board

INTRODUCTION

Essential health care boded on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.

World Health Organisation

From the early years of the nineteen century and for the next one hundred years, Irish health and social services became more and more institutionalised. The Poor Law Act of 1838 had become the root of the services, beginning with the introduction of the dreaded Workhouse practice. These institutions were expected to deal with the worst of the country’s social ills, from extreme poverty to the sick, the physically and intellectually disabled, the mentally ill, disadvantaged young children and the elderly. The Great Famine was to show the shortcomings of this system and some forms of out-door relief were introduced. However, rather than trying to change the practice of using institutions to fill a societal need by the introduction of radical change, the trend was to expand the system. In order to do this, not only the State - whether under a British or Irish administration - but Catholic and Protestant philanthropic groups, whose ventures were largely denominational, played a major role in this institutionalising process. This continued to be the case well into the first seven decades of the twentieth century.

Between 1925 and 1942, the local administration of health services was undertaken by Boards of Health which were set up in each county and consisted of ten county councillors. From 1943 the provision of health services in most counties became one of the functions of the County Councils. The old Department of Local Government and Public Health was over due for reform, particularly after the Second World War, and thus the new Department of Social Welfare and the Department of Health came into existence in 1947, with Dr. James Ryan as the first Minister for Health. In 1966, the Government published a White Paper on the development of the Health Services in Ireland, which was followed by the enactment of the Health Act, 1970.

Following the Health Act of 1970, eight health boards were established under Erskine Childers as Tanaiste and Minister for Health. The membership of health boards consisted of public representatives, representatives of professional grades whose daily lives were spent in the provision of health services in one form or another, and individuals with diverse backgrounds whom the Minister appointed to the boards.

Erskine Childers addressed members of the Eastern, North Eastern, South Eastern and Midland Health Boards on the 26th November, 1970, at a luncheon held in the Metropole Ballroom in Dublin to mark the inaugural meeting of these Boards. He began by endeavouring to allay the fears expressed by some members, during the discussions which were held at the passage of the Health Bill and subsequently, that the quality of health services might suffer as a result of this administrative re-organisation. Many also expressed concern that they would not have a sufficient voice in determining policy with regard to health services in their own area.

The Minister claimed that health services under the health boards would not become impersonal and remote but would be welded into one and shaped to meet the needs of the local community.

As members of health boards, they would, he was sure, become increasingly involved in the development of community services. They would be in a position to take decisions which would influence the development of those essential services which the State could and should provide to form a basic foundation for the provision of care in the community. More importantly, however, they would be in an excellent position to encourage co-operation between those services which would be provided by health boards and the services which are provided through the many voluntary organisations which are now a feature of our society. These organisations are irreplaceable, but they are at their most effective when they are collaborating together with professionals.

If the history of the North Eastern Health Board (NEHB) is about anything, it is about two major developments which took place during its existence. Firstly, the significant improvements which were made to the existing acute hospital services, psychiatric and geriatric institutions inherited by the Board, many of
which dated back to the Poor Law days: several were renovated and lor others it was vital that they be replaced. Secondly, and arguably more importantly, the members supervised the move away from institutional to community based services thereby bringing an end to the institutionalisation of generations, housed in inadequate facilities with out-dated practices.

While thirty years is not a very long time in historical terms, the legacy ot members and management of the Health Board has been to take the health services out of its nineteenth century inheritance and into the twenty-first century. That is not to say that the NEHB leaves behind a Utopian level ot services. That would not be the case for any of the health boards, and nationally the health and social services in this country leave a lot to be desired. The purpose ot this history however is to outline the successes and failures, and the effort made to bring the services to where they stand at present. It would have been possible to write a complete and lengthy history of any one aspect ot the North Eastern Health Board’s services in great detail. However, the purpose of this publication is to give an overall portrayal of the difficult tasks undertaken by the members and executive of the Board to bring the health services in the north east from the old into the new era.

The first chapter will discuss the inauguration of the North Eastern Health Board and the change in structures throughout the 1970s. This will include the introduction of the Choice of Doctor Scheme and other measures which made primary health care services more accessible to a greater number of individuals. The following chapter will deal with the major changes which have taken place in acute hospital service provision and the difficulties and challenges which arose in this sector. The major advances in the provision of psychiatric, mental handicap and geriatric services will form a principal part of the next two chapters. Developments in maternity and childcare services will also be outlined. Finally the leading role of modern community based facilities including Doctor on Call, Community Care Teams and Community Day Care Centres will be discussed as among the most significant and lasting legacy of the former members and management of the North Eastern Health Board.

CHAPTER 1

WITHOUT FEAR OR FAVOUR

I suppose it is fair to say that it it easy to provide serviced duccecdfully when the resourced are readily available; the real test id when dome ingenuity and forbearance id needed to dt retch resourced do that all serviced continue to be available in acceptable form to those entitled to them and to whom they are necessary.


The inaugural meeting of the North Eastern Health Board was held at the Conference Room, Aras Mhic Dhiarmada in Store St. Dublin, on the 26th November, 1970. The meeting was chaired by Jerry O’Dwyer, Assistant Principal Officer with the Department of Health. The NEHB functional area incorporated counties Cavan, Louth, Monaghan and Meath, a region that covered an area of 6498 sq. kilometres and catered for a total population of approximately 237,000.1 The Board was responsible, within national guidelines, for assessing local health needs for all health services, planning and co-ordinating community care services and managing the fifteen hospitals and institutions under their supervision.

The Minister for Health, Erskine Childers, in outlining the reasons underlying the formation of larger administration units for the provision of health services, asserted that the nation would have a more efficient service if top level staff were recruited. The Minister also claimed that the career structure within the new health boards would attract such talent.2 The Board realised that this actuality would be crucial to the development of a professional team who would administer the regional health service effectively. All of the
staff working in health were given the option of joining the new body, or remaining with the County Council, and the vast majority opted to transfer to the Health Board. As new and considerably less experienced staff were to come to the NEHB over the next few years, it was those who came from the County Councils who brought essential erudition and constancy to the service.

The newly formed Board was made up of individuals from various backgrounds, political parties, professions, counties, and a number of ministerial appointees, and were expected to work together as a cohesive group from the outset. According to Erskine Childers:

A properly integrated approach to planning and determination of objectives was, therefore, eminently feasible for health boards...members...should try at all times to take an objective view on the priority which should be afforded to the various services and try at all times to keep sectional interests out of policy deliberations. *

Therefore it was essential that each member who was nominated agreed to serve the whole functional area of the Board and not be handicapped by narrow county or sectional interests. As members were senior political representatives with a wealth of experience behind them, and medical professionals - consultants, surgeons, doctors, dentists, pharmacists and nurses - totally committed to the health care, this was not impossible to demonstrate a lack of understanding as to their exact function and obligations in terms of national health legislation and by ministerial initiative. There were, nevertheless, a number of noteworthy limitations placed on them by the Health Act 1970. Section 31 stated:

1. A Health Board shall not, save with the Minister’s consent, incur expenditure for any service or purpose within any period in excess of such sum as may be specified by the Minister in respect of that period.
2. The CEO of the Health Board shall not in the performance of his functions do anything which would incur expenditure by the Board in contravention of this section.
3. If at any time the CEO of the Health Board is of the opinion that a decision of the Board would incur expenditure by the Board in contravention of this section he shall so inform the Board and the Minister.*

This section of the Act would impinge greatly upon the autonomy of health boards by conferring final authority in relation to expenditure on the Department of Health. Locally controlled and financed systems became increasingly centralised and centrally controlled. Financially the Board’s hands were in the main tied and the lack of sufficient resources to fund services would remain an ongoing struggle for over two decades. Six months after the founding of the health boards, Erskine Childers addressed the Western Health Board in Galway and came to the crux of the matter:

...an ever-increasing range of services had to be provided, with no great expectation of any spectacular increase in the overall proportion of wealth which could be devoted to these services. In the situation which exists in this and many other countries, on unlimited demands on limited resources, escalation of costs and wages, the provision of more effective services largely depended on greater efficiency...in this situation, reducing costs became a major responsibility and required constant attention from those responsible for managing the health services either as members of the Boards or as part of the Management Teams of the Boards.*

This assertion was to become the mantra of the various Ministers for Health and their Departments for decades to come. In fairness to the Department of Health, the reality was that since it had been founded in 1947 there had been a substantial and ever-escalating increase in the quantity and quality of medical expertise and technology. In the decades to the end of the 1980s, the scope for medical intervention and the treatment of disease was limited. Consequently, the cost of providing an open-ended commitment to this type of medical care was relatively small. However, with the ever-growing scientific and technological revolution that was transforming medical care, there were ever-increasing costs and a need for a more sophisticated method of managing these services.

The general population also had increased expectations of the developing medical services. According to the Report of the Commission on Health Funding published in 1989 these two factors, the transformation of medical care and raised public expectation, had combined in previous decades to produce a situation where the funding demands of the health services had posed huge problems in the Western World. The difficulties which were to arise in the coming decades for the NEHB were therefore not only a national, but an international phenomenon.
It would be some months after the establishment of the NEHB before the exact arrangements were worked out for the allocation and distribution of health board funds. For the financial year 1971/72, Jerry O’Dwyer informed the Board that it would take over the aggregated health estimates of the constituent local authorities. For future allocations, under Section 32(2) of the Health Act, 1970, finance was to come from two sources: from the Oireachtas viz the Exchequer and from local rates. The latter allocation in particular gave the Board a certain degree of independence. The spending of funding was, for the moment, at the discretion of the Board, i.e., which proportion of spending went on existing services and which on new or capital projects.

One of the first and most practical assignments for the NEHB, having visited each of the counties in turn, was to agree on the location of a headquarters and establish a base as soon as possible. Kells, Co Meath, Carrickmacross, Co Monaghan, Ardee, Co Louth and Kingscourt, Co Cavan were all proposed as suitable locations; it took five ballots before Kells was chosen. In June, 1972, the Board agreed to purchase a site adjoining the local Roman Catholic Church from Fr. Holloway, PP, for the erection of the headquarters building. Until such time as a purpose built office could be provided, all meetings were held at the Courthouse in Kells. It was the 17th May, 1974, before the Headquarters of the NEHB was put into use with approximately thirty administrative staff.

Over the coming decades, many of the old dispensary buildings with their inadequate and often antiquated services to medical card holders. The terms of the contract issued to doctors who wished to participate in the new scheme did not allow them to make a distinction between private and public patients attending their clinics. An individual who qualified for medical services could now register with any participating doctor who wished to use. This remained the situation when the NEHB took over this service and it was no longer acceptable to patients or to service users. It would however take time and investment to modernise these facilities.

During this period the Management Team was recruited, and the necessary structures put in place to provide the Board with plans and programmes for the implementation of policy decisions. The Team consisted of Dr. Patrick Quinn. Acting Programme Manager Community Care; Pat Clarke, Programme Manager Hospital Care; Denny Sheppard, Personnel Officer; Tommy Moore, Finance Officer and Tom Morris, Secretary to the Board. Between August, 1972. and March, 1973, the administrative functions, as undertaken by the County Councils, were gradually absorbed by the headquarters staff based in temporary offices in Kells. This was no easy task as their workload was such that there was little time available for the introduction of schemes for the improvement of services. Members remarked that staff were simply dealing with ad hoc problems as they came to light. It was essential therefore that a programme of regionalisation was introduced as soon as possible and the systems put in place to more efficiently manage the health services. For example, prior to April, 1971, the County Managers established standards for full eligibility for medical services within each county. The standards varied from county to county and therefore within the new region there were substantial differences between the four counties. It was imperative that a uniform standard for the region was introduced in the context of the new regulations, thereby creating a more equitable system for almost forty per cent of the population in the NEHB region.

A second major change, which was to take place in the provision of medical services under the Health Act 1970, was the abolition of the old dispensary system and the introduction of the Choice of Doctor Scheme. The former system was based on the Poor Law Acts dating back to the Workhouses. By the early twentieth century there was, linked to these state run institutions, a nation-wide dispensary service that had its origin in the Medical Charities Acts of 1851.0. The dispensary system had remained the basis of health administration since this date, with about six-hundred dispensary districts nation-wide provided by District Medical Officers. The extent of the upgrading and improvement in the service by the NEHB can be witnessed by comparison between the two systems. In the old dispensary service there were sixty-seven doctors in the region catering for an average of 1164 patients per doctor in one-hundred and fourteen centres. Under the new Choice of Doctor Scheme there were ninety-nine doctors, catering for an average of 786 persons per doctor at one-hundred and sixty two centres. In addition there were approximately fifty private medical practitioners in practice in the region.

The General Medical Services (Medical Card) Scheme was introduced in 1972 to remove the social stigma association with the public dispensary system that had remained unchanged since Victorian times. Under this scheme, contracts were entered into between general practitioners and the health boards for the provision of services to medical card holders. The terms of the contract issued to doctors who wished to participate in the new scheme did not allow them to make a distinction between private and public patients attending their clinics. An individual who qualified for medical services could now register with any participating doctor who did not have a list full to the maximum. In addition, the doctor might be assigned eligible persons by the Board, particularly in the case of persons who had unsuccessfully applied to a number of doctors for acceptance, thereby ensuring that no individual entitled to such services would be left without provision.

This remained the situation when the NEHB took over this service and it was no longer acceptable to members or to service users. It would however take time and investment to modernise these facilities.
of local members from the medical profession, the NEHB and representatives from voluntary organisations. They would consider such matters as staff numbers, staff morale, health and safety concerns, living conditions, particularly for long stay patients, and other pressing issues. They made recommendations on changes in the quality and quantity of service including action to improve physical facilities and followed up on implementation and results. Over the coming decades Visiting Committees would continue to keep the Board in close touch with conditions and standards of care provided in its institutions. In addition, medical and nursing personnel who were members of the Board each reported upon the major issues within their area of expertise.

The members of the NEHB were appalled at the level of service and the inferior environment to be found in many of the institutions that were now within their sphere of influence. Acute hospitals were often overcrowded and in an abject physical state, leading to demanding and distressing conditions under which the many of the institutions that were now within their sphere of influence. Acute hospitals were often overcrowded and in an abject physical state, leading to demanding and distressing conditions under which the members of the NEHB were appalled at the level of service and the inferior environment to be found in the Republic of Ireland. The NEHB region is adjacent to the border between the Republic and Northern Ireland in three of its four counties, Louth, Monaghan and Cavan. This fact at times led to struggles within the Health Board, some of which were minor and some of which were of greater significance.

In 1972 objections were raised by members of the Board to two doctors, living in the Northern Ireland side of the Louth and Monaghan borders, being on the Choice of Doctor Panel. Objectors claimed that as doctors in the Republic were debarred from participating in the six counties, it was unjust to allow these doctors to participate in the south. The National Health Service available to those living north of the border was perceived as providing a more than adequate financial income for doctors there.

Barry Segrave explained to members that some patients would be deprived of any service if the two doctors in question were not members of the Panel as both were necessary to provide a Choice of Doctor in the centres to which they applied. There was also no mention in the agreement made between the Department of Health and the Irish Medical Organisation that doctors from Northern Ireland should be debarred from participating in the scheme. The CEO stated that it would have been morally wrong to discriminate against the doctors who were legally admitted to the scheme. Consequently objections to the inclusion of doctors from Northern Ireland in the Choice of Doctor Scheme were withdrawn.\5

The reality of the NEHB’s close proximity to Northern Ireland was on occasions to have more serious consequences. At a meeting held on the 1st February, 1972, the Board suspended proceedings and adjourned the meeting to enable the members to condemn the tragic events which took place in Derry the previous Sunday: a tragedy which was to become known as ‘Bloody Sunday’. It was agreed as follows:

1. That the Board would back the decision taken by the Taoiseach the previous day which followed the thirteen murders in Derry on Sunday, 30th January, 1972.
2. That the Board would request the Taoiseach and members of Dail Eireann to do all in theIr power to get the British army out of Northern Ireland and that they request that United Nations troops take their place.
3. That both Mr Heath, the British Prime Minister, and Mr Wilson, the Leader of the Opposition, be requested to remove the British army from the Six Northern Counties of Ireland immediately.
4. That the sincerest sympathy of the Board be forwarded to the relatives of the people murdered in Derry by the British Forces on Sunday, 30th January, 1972.

The offices of the NEHB remained closed the next day, a Day of National Mourning, as a mark of respect. A letter was subsequently sent to the Taoiseach, Jack Lynch, which stated:

At a meeting of the NEHB which represents the Irish people of the four counties of Cavan, Sligo, Leitrim and Monaghan on the 1st February, 1972, it was unanimously agreed that the Board would back the decision taken by you yesterday which followed from the cold blooded murders which occurred in Derry on Sunday 30th January, 1972. It was further agreed that we request you and all in Dail Eireann to do all in your power to get the British army out of Northern Ireland and request that United Nations soldiers take their place.

A similar letter was sent to John Hume, MP, asking that the deepest sympathy of the NEiB be conveyed to the people of Derry.

The passionate and perhaps inappropriate language for a statutory authority was a reflection of strongly held political opinions of this generation of members of the Board. Put in context, a number of members were just old enough to remember the Civil War and had fathers, brothers or uncles who fought on both sides. For
example, Joseph Farrell TD, who was later to become Chairman of the Board, was a founder member of Fianna Fáil. All members were old enough to remember a time before there was any Northern Ireland or British troops stationed there. It was also only a few years since the 50th anniversary of the Easter Rising was celebrated in April, 1966, with pride and pageantry and the Civil Rights Movement came to prominence in Northern Ireland three years later.

The members were not alone in their condemnation of the events that had taken place in Derry in 1972 and simply reflected the outrage felt nationally. The Taoiseach, Jack Lynch, on behalf of the nation, requested that the British Government act immediately to the United Nations for the urgent dispatch of a Peace Keeping Force to the six counties. He also requested that they enter into negotiations with the Irish Government to review the present constitutional position of the six counties of Northern Ireland.

Two years later, votes of sympathy were proposed for the relatives of the Dublin and Monaghan bombings, which happened on the 17th May, 1974, the day that the new offices in Kells were opened. Again the meeting was adjourned and the language of condemnation was similar to that which attended the British government following Bloody Sunday. It would be hospitals in the NEHB region on this occasion, and later following the Dundalk bombing in January, 1976, and the Castleblayney bomb blast in March, 1976, which would have to cope with the victims of these atrocities. Over twenty years later in 1998 the Health Board sent medical staff to assist in the aftermath of the Omagh Bombing in August of that year.

Other matters came to the attention of the Board, some of which were extremely important for the provision of health services, and some of which belong to their place and time in history. For example, in 1976 the employment of married nurses within the region became a matter of concern for the NEHB. It was stated at a meeting of the Board that there were instances where the ‘husbands of such women earned upward of £100 a week’, while many school leavers were unable to obtain employment in hospitals. Members agreed that the root of the trouble was the decision of the government in 1973 to lift the marriage bar from the civil service and subsequently from local authorities and health boards. They agreed that although the Board had no objection to ‘needy’ women getting jobs it was unacceptable that many girls, ‘some with six and seven honours in their Leaving Certificate, had to be content with washing dishes in hotels’. Consequently the Board adopted a motion requesting that the Minister for Health ‘arrange more training centres so that girls possessing the Leaving Certificate could take up nursing if they so desired’.21

This patriarchal attitude is hardly remarkable as it was accepted by Irish society as a whole. Despite the establishment by the Government of the Commission on the Status of Women in 1970,22 women in all categories of employment were underpaid in relation to their male counterparts and were limited in their terms of employment. Increasingly high unemployment rates throughout the 1970s. There were many who believed that the problem of unemployment and underpayment could be solved if women would simply stay at home. However the members of the Board could also show themselves to be quite radical in terms of their attitude to women and families, when the need arose.

At the end of 1972, the Health Board faced with a dilemma: the implications of a recent Irish Medical Association resolution regarding the availability of contraception, and the responsibility of the Board in light of this situation. Dr. Terence Birkett, who brought this matter to the attention of the Board, stated that while issue would have to be modified. As a result of the lengthy discussions which took place, the majority of members agreed that while they did not endorse the wholesale importation of contraceptives to be distributed to all age groups, they should be available to married couples who wished to limit the size of their families. Consequently the following motion was forwarded to the Minister for Justice and on the seven health boards for their consideration:

That the Government be requested to amend the current Criminal Law so as to allow regulated dispensation and sale of contraceptives under stringent controls.

This particular resolution had to be worded carefully and was a courageous stand when considered in terms of the controversy surrounding this issue. Highly regarded individuals including Senator Mary Robinson, Dr. Noel Browne and Dr. John O’Connell and others had tried, since 1971, to have the 1935 Criminal Law amended in order to permit the sale of contraceptives with no success. They were up against some formidable opposition on a nation and state that remained conservative, Catholic and analogous. Successive governments had tried to introduce extremely limited Bills relative to this matter which never got past the Dail. The influential John Charles McQuaid, Archbishop of Dublin and Primate of All Ireland, had claimed in his pastoral message:

Given the proneness of our human nature to evil, given the enticement of bodily satisfaction, given the wide spread modern ideas of sexual promiscuity, it must be evident that an access, hitherto unlawful, to contraceptive devices will prove a most certain occasion of sin, especially to immature persons. Such measures would be an insult to our Faith, it would without question prove to be gravely damaging to morality, private and public, it would be and would remain a curse upon our country.24

Despite a Supreme Court Judgement made in 1973 assenting that the ban on the importation of contraceptives was contrary to the Constitution, and therefore married couples were entitled to have reasonable access to contraception, it was 1983 before reform was introduced as the Health (Family Planning) Act. In the interim, the Board agreed that the CEO should submit proposals for the setting up of Family Planning Clinics throughout the region.

Regardless of other major and minor distractions, the Board was continually brought back to the fundamental shortage of resources. Despite the recommendation that all health boards remain within the budgetary restraints imposed by the Department, at the end of 1975 the NEHB had sustained enormous bank overdrafts. This unfavourable position was due chiefly to the problem of arrears outstanding from the Department of Health for unpaid grants which had already been sanctioned. Huge interest payments were effectively reducing the finances available to the Board for the provision of services.25

Tommy Moore as Finance Officer claimed that in 1974 the NEHB overdraft was £1,913,000 while at the same time they were owed £1,050,000 in arrears of grants by the Department. A large portion of the latter figure dated back to the 1971-72 and 1972-73 phases. In his report to the Department of Health in 1975, A. O’Carroll, Principal Local Government Auditor, expressed his concern regarding the funding of the NEHB, which was forced to rely heavily on Bank overdraft accommodation. Mr O’Carroll claimed that:

Indeed one of the earliest decisions which the Board was required to make was one authorising the arrangement of such overdraft accommodation. The sums paid in respect of overdrafts interest amounted to £32,014 in 1971-72 and £38,775 in the following year. The establishment of a proper basis for funding the Board from month to month as required should be given appropriate attention.26

It had been expected when the health boards were established that the allocation of funds would be on a programme basis, i.e. that the Board would know over at least a five year period what their allocation would be, so that an orderly development of services on an agreed priority basis might be planned. This had not happened; in fact the Board was only given its allocation in January or February each year when the budget year was already underway. This problem intensified when allocations fluctuated substantially from year to year. Early advice would have enabled the Board to plan accordingly and reduce the impact of what Barry Segrave referred to as the ‘stop-go’ system in the service, and its effect on the morale of the staff.

The NEHB at its Budget Meeting in May 1975, expressed disappointment at the fact that only limited funds had been made available for capital projects in the current year. Nonetheless, in order to clarify the situation and introduce medium and long-term plans, the Management Team drew up a list of capital projects and the Board assigned a priority to each project.27 The Health Board reviewed this priority listing hereafter on an annual basis as circumstances changed. Pat Clarke as Programme Manager submitted a list of twenty one capital projects at a cost of approximately £5m. Significantly he explained that the top priority for the Board had to be the building of a new surgical hospital for Cavan.

The present Cavan Surgical Hospital was founded in 1765, and all agreed that it had reached the end of its
useful life and alternative facilities should be provided. Visiting Committees described conditions in the wards, which contained one bath, one toilet and one wash-hand basin for twenty-four patients. There were no start toilets and one wash-hand basin was shared by all staff. Other departments including theatres and radiography were described as ‘most unsatisfactory and equipment antiquated’. A Visiting Committee to Cavan Surgical Hospital explained that:

...the hospital consists of a three storey building with one staircase - wooden. The total building structure...is made of flammable material such as wooden floors, and old wooden equipment...It there was a fire in the hospital the only means of access from the various wards and rooms is through the overcrowded fire risk flammable corridors....There is no way or escaping from the third floor other than down a very old staircase.28

Within a year a number of patients and staff were transferred from the hospital ‘in light of the fire hazard and the unsuitability of the building for both patients and staff. The Dublin Regional Hospital Board and Comhairle na Ospidéal recommended that surgery in the hospital be discontinued as soon as possible.29 In consideration of such overwhelming difficulties the NEHB threatened to institute legal proceedings against the Department of Health if they delayed further in sanctioning a scheme for the improvement of Cavan Surgical Hospital. The members believed that when the County Surgeon retired at the end of that year it would be impossible to replace him, as no other doctor would work in an obsolete theatre under intolerable conditions. This would result in Cavan being deprived of any surgical services whatever. It was the opinion of the Visiting Committee that Cavan Surgical Hospital was the most serious problem facing the Board; hence the recommendation that due to its condition it would not be possible to modernise the building - a new one would have to be constructed.

The second priority on Barry Segrave’s list indicated that it was imperative that the re-wiring of Monaghan Hospital, which was at that time a fire hazard, was undertaken without delay. The Board was disturbed to hear that there were in fact fire risks in all fifteen of the NEHB hospitals, and it would cost £72,500 and fifteen to twenty months to put it right. The situation was a cause of concern and led to on-going discussion with the Fire Prevention Authorities.

It was difficult to prioritise the rest of the list. Upward of one thousand people were awaiting treatment in the Orthopaedic Unit in Navan, while Blessed Oliver Plunkett’s Hospital, providing a geriatric service, was ‘Ireland’s worst’ and was incapable of being improved structurally.30 Other considered capital projects were equally pressing. The reality was that the prospect of receiving this level of funding, in the prevailing economic climate, was non-existent. In that same year Barry Segrave and Tommy Moore had visited the Department of Health to ascertain the prospect of having a relatively minor project, a desperately needed kitchen for St. Brigid’s Hospital in Ardee, approved and funded as soon as possible. The answer from the Department was standard: at present there are no capital funds available for any new starts that the Board would wish to initiate.

By this time the Board no longer had complete control in relation to the allocation of funding received from the Department of Health. Since January 1975, finances to the NEHB had been provided by way of two separate allocations, one of existing services and a second for the provision of new services. A sum for that year amounting to £14,640,000 had been sanctioned for the former but the second, for the provision of new services, had not yet been notified. The general aim of the Department of Health was to maintain services at 1,775 levels, claiming that any further growth in the services, which had grown by over sixteen per cent in the previous three years, was simply not possible. Therefore the Board was left to assume that funds for the introduction or any new services for the year ahead would be very limited.

A further development in relation to funding came in March, 1977 when the Minister, Brendan Corish announced that the funding boards would come solely from his departmental budget and not from local rates, thereby further limiting the financial independence of the health boards. He also announced that a select committee or Dail Eireann was being set up to review generally the present system of health services. It would be asked to consider what the priority in public spending in the health services should be in the context of general economic and social development; to look at the adequacy of the existing services for the needs of the community; to review the effect of the existing organisational structures for providing the services; to review eligibility lor services and to examine and evaluate alternative ways of financing the services.31

Despite this review, the situation remained unchanged in relation to the provision and funding of the health services. The difficulty for the Department was that the overall level of expenditure approved in 1978 for health services was £365m. This had increased to £455m at the beginning of 1979 and to £570m in 1980. A considerable proportion of the additional expenditure was accounted for by pay and price increases, improvements in conditions of service for staff and provision of funds for the development of the services, for example, a regional hospital building programme. The total workforce in the health sector was now 57,500 with 6,700 additional posts being approved in the years 1977-79. A wide variety of developments was taking place in general hospitals, community care facilities, improvements in psychiatric hospitals and at centres caring for those with a mental handicap. This level of growth, while being far from extravagant, was becoming impossible to maintain.

The situation was just as difficult at a regional level. In 1980 the net expenditure of the NEHB was just over £42m, an increase of eleven per cent on the previous year’s allocation. However, this increase, at a time when inflation was rising at levels of sixteen to eighteen per cent, was a cut in the amount of money that would be available for any new services or the expansion of existing services. Barry Segrave explained:

The situation had decided that in the very difficult economic circumstances now prevailing, it is necessary to impose constraints on public expenditure generally...our allocation reflects this constraint in that it falls significantly short of what we had estimated to allow for the increases in staffing and the development of services proposed by the Board over the last two years...the allocation does not allow for any new staff, indeed economies in staff budgets will be necessary and there are no funds for any new services or the expansion of existing services. Our major task throughout the year will be to maintain the existing levels of services. 7

The CEO also pointed out the seriousness of the findings of a British firm of Accountants which had conducted a survey on the Irish economy for the Central Bank. The report indicated that inflation might go as high as nineteen per cent in the coming year. Not knowing then if they could survive within the statutory restraints imposed by the budget, the Board felt obliged to apply the test of Michael Woods, for additional funds. The Minister’s response, at a time when all of the Regional Health Boards were making similar demands, was almost a foregone conclusion: there would be no additional funds available for the foreseeable future.

The situation did not get any better between 1979-81 when Fianna Fail, under Charles Haughey, was in government. The nation’s budget deficit rose from an already high level of £522m to an excessive £802m. The Exchequer borrowing rose from 13.8% of GNP to 16.8% in the same period. The Department of Finance was forecasting a further rise to 21.5% in 1982. A number of events led to this economic crisis, not least of which was the five fold increase in oil prices after 1973. As oil prices continued to rise until 1979 it helped to precipitate a major international recession. Consequently, the Fine Gael/Labour coalition, 1982-87, under the leadership of Garret Fitzgerald, with Dick Spring as Tanaiste and Alan Dukes as Minister for Finance, undertook a number of very unpopular measures. Alan Dukes introduced draconian budgets in 1983 and again in 1984 which involved major cuts in public expenditure, accompanied by substantial rises in taxation. While such measures were extremely successful in what they set out to achieve, cutting Exchequer borrowing significantly from a threatened 21.5% of GNP in 1982 to 1.5% in 1989, they led to severe hardships in many sections of society, not least of whom were the sick, the elderly, those with psychiatric problems and those with physical or intellectual disabilities.

Therefore the health service was then, and remains, one of the most politicised areas in the economy and the public outcry over cuts in spending on health services led Dick Spring to leave the coalition government. He decided that as the Labour Leader, he could not support further significant cuts in health expenditure. Charles Haughey returned to government from 1987-92 and his Finance Minister, Ray McSharry, proceeded to implement a package that cut expenditure by £900m between 1987-89 alone. These cuts had a major impact upon the health services. Pat Clarke, as Programme Manager, Hospital Services, made the following statement:

I suppose it is fair to say that it is easy to provide services successfully when the resources are readily
The members, management and staff of the NEHB would have to use both ‘ingenuity and forbearance’ if the health services within their region were not only to survive, but to expand and develop the appropriate level of health care for those for whom they were responsible. Despite the overall increased level of expenditure approved for 1980, as compared to 1979, the conditions applying to the allocation for 1980 would impose considerable constraints on health boards, which would be faced with a very difficult task in deciding where the necessary economies must be found. Dr. Garret Fitzgerald, in his book Reflections on the Irish State explained:

Taxation issues are complex but finite. By contrast expenditure choices are virtually infinite. Very many items of public expenditure could with some advantage be given additional resources: politicians allocating scarce resources are thus forever choosing between an enormous number of different needs, having to decide how much to add each at the margin, or more rarely, to subtract: allocating scarce resources to prevent crime or ill health or to providing resources to deal with the consequences of these evils...

It is against this background that the history of the NEHB in the coming decade, with Pat Clarke as the new CEO, must be considered. It is important to begin with the very significant changes in the provision of hospital services throughout the county, which took place in this period.

REFERENCES

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3 Address by Mr Erskine Childers, Tanaiste and Minister for Health to members of the NEHB, EHB, SEHB and MHB 26th Nov. 1970.
4 McKinsey and Company advised the Minister for Health, Erskine Childers, on the organisation of the health boards and made recommendations on the role of Comhairle na nOspideal and the Regional Hospital Boards.
5 Minutes of the meeting of the NEHB. 15th Sept 1975.
6 Health Act 1970 Section 31:1 a and b
8 Address by Mr Erskine Childers, Tanaiste and Minister for Health, to WHB on the occasion of the presentation of Nursing Diplomas and prizes at Galway Regional Hospital. 4th Oct. 1971.
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13 Letter from Donal Devitt to Barry Segrave on behalf of Brendan Corish 26th June 1973
14 Report of the Consultative Council on General Medical Practice: notes presented by Dr Pat Quinn, Acting Programme Manager Community Care to NEHB on 30th May 1974.
15 Minutes of the meeting of the NEHB. 19th June 1972.
17 Minutes of the meeting of the NEHB. 3rd Feb. 1973
18 First legally recognised a month after establishment of the Republic of Ireland in 1949.
19 Minutes of the meeting of the NEHB. 21st May 1974.
20 The Argus. 30th April 1976.
21 It is interesting to note that the membership of the NEHB, like all of its counterparts, from the day of its founding until its last day of service, was totally dominated by males. Three female representatives was the highest number reached at any one time.
22 The Commission for the Status of Women was chaired by Dr Thelka Beere, the only female to be appointed secretary of a government department in Ireland.
23 Minutes of the meeting of the NEHB. Nov. 1972.
24 As quoted by Barry Desmond in Finally and in Conclusion. A Political Memoir p 227.
25 Minutes of the meeting of the NEHB 24th March 1975.
27 Minutes of NEHB Budget Meeting 13th May 1975.
28 Visiting Committee Cavan Surgical Hospital. 8th May 1973.
30 Minutes of the meeting of the NEHB. 21st March 1977.
32 Pat Clarke, Programme Manager. NEHB Budget 1980 p 20.
33 Dr. Garret Fitzgerald, Reflections on the Irish State, p xvi.
CHAPTER 2

THE ROAD TO REGIONALISATION

The 1980s were characterised by severe financial restraints in the public sector and this led to a period of rapid reduction in public beds and a closure of a range of public voluntary hospitals and a transfer of their services to larger hospitals...

Dr. Fergus O'Farrell

A White Paper on The Health Services and their Further Development published in 1966 was the first of three reports in favour of a regionalised hospital service. This was followed two years later by the report of the Consultative Council on the General Hospital Services, entitled Outline of the Future Hospital System, in which the general catchment areas for hospital development were first set out. This document was commonly known as the Fitzgerald Report, and it recommended radical changes including a single administrative system for public and voluntary hospitals. There was considerable nationwide debate following the publication of this report, and it was never fully implemented. Voluntary hospitals, which valued their independence, were particularly against the concept of a single administrative system.

Consequently the Minister for Health, Brendan Corish, issued a more wide-ranging statement in a General Hospital Development Plan in 1973, which was to become a prime policy document in respect of the Irish hospital system into the 1990s. Although the Minister was forced to admit that at the time capital was scarce, he considered it prudent to get plans ready 'for the better times to come'. The opposition and financial restraints which created difficulties for any plan put forward which involved changes in hospital services nationally, were repeated in the north eastern region.

A Working Party was established in 1973 to make recommendations regarding the regionalisation of hospital services in the NEHB area. Members included Peter McCann and John McGovern from Cavan; Dr. Hugh Dolan and Dr. Gerard Costello from Louth; Mr. William deWytt and Patrick McKenna from Meath; Dr. Rory O'Hanlon and Peter Sherry from Monaghan, together with Barry Segrave and Pat Clarke. The four representatives from the Regional Hospital Board were Senator Dennis Farrelly, Sr. Elizabeth Dooley, Thomas Hickey and James Wright. They would come under the Chairmanship of Professor Basil Chubb, with three members from Comhairle na nOspideal nominated by him. The Minister expected that a report would be on his desk by the end of December 1973, and he over-optimistically hoped to be in a position to make the necessary decisions on a national basis before the end of that financial year.

County Health Advisory Committees, each of the Board's acute institutions and Our Lady of Lourdes Hospital in Drogheda, were visited by the Working Party before they reached any conclusions. The Lourdes was a voluntary hospital and had to be consulted before any decisions were reached which would affect its service. Suggestions put forward by members of the various Local Advisory Committees for the location of general hospitals included Cavan, Drogheda, Dundalk, Navan, Cootehill and Monaghan. According to Dr. Hugh Dolan, former Chairman of the NEHB, the reality was that the system where every area had a local county hospital with one surgeon and/or one medical officer was becoming a thing of the past. It was no longer acceptable that the surgeon act in every capacity from orthopaedic surgeon to obstetrician, while transferring difficult cases to either Our Lady of Lourdes Hospital in Drogheda or to hospitals in Dublin. Enormous advances were being made in diagnostic methods, surgical procedures and medical intervention and it was not viable to provide these in every local unit. It was also proving practically impossible to find suitably qualified staff to work in isolation in small units when the trend was towards teamwork and specialisation.

In keeping with these advances the Working Party recommended that two general hospitals be located at Our Lady of Lourdes Hospital in Drogheda, and in Cavan where a large General Hospital would replace the Surgical and Medical Hospitals, and one smaller general hospital in Dundalk. The Orthopaedic Hospital in Navan, which was on the same site as Our Lady's Hospital, was identified for development as the Regional Orthopaedic Hospital. It was to become the first specialisation in the region. Members of the Board were assured that, if implemented, there was no question of closing down existing county hospitals; however they might have a different role to play in the future.
practitioners working in association with consultants from the general hospital. Patients would receive certain straightforward treatment in a hospital in their own area, and the demand on highly specialised and expensive services provided by the general hospital would be reduced. It was expected that patients finished with a course of treatment in a general hospital could be returned to the community hospital to convalesce.

This indicated, to those who wished to see acute hospital facilities retained in their communities, a complete downgrading of existing services to the level of a Cottage Hospital. Consequently two members of the Working Party, Peter Sherry and Dr. Rory O’Hanlon, moved for the rejection of the Report until the position of Monaghan County Hospital and Our Lady’s Hospital, Navan were made clear. This was not to be the case. Following lengthy discussions the NEHB adopted the recommendations of the Working Party by eighteen votes to eight and it was forwarded to the Department of Health for approval. The NEHB strategy would nevertheless prove very difficult to implement locally with any degree of objectivity.

In the coming years the Board would come under considerable condemnation for its role in the planning of hospital services in the region. Public meetings were held at which past and present members were criticised for not sufficiently pushing the case of the Monaghan and Navan hospitals on behalf of these communities. The Monaghan T.D James Leonard called for an inquiry into ‘the whole way this hospitalisation plan was handled from the beginning’\(^1\). This was not helped following a statement from Minister Brendan Corish that Monaghan County Hospital’s present status was not in accordance with the Comhairle guidelines and was against the conclusion reached by the Working Party, and approved by the NEHB. There was little consolation in the Minister’s claim that the role of community hospitals was still under consideration and that ‘there will be full consultation with your Health Board regarding the services which might be provided by Monaghan in its role as a community hospital’\(^4\). To clarify matters further a Press release was issued by the Department in October 1976, which stated:

Priorities in development must be decided so that as resources become available they can be put to use in a logical sequence. The pace of implementing the programme will be influenced by economic circumstances but these need not influence the pace for making preparation to build. It should be recognised however that the existing county hospitals will continue in their present role while the planning, development and new building work for the area are proceeding. Furthermore, it is only when the new and extended accommodation is available that the county hospitals so designated can commence to function as community hospitals.\(^3\)

It was the extremely serious issue of the future role of Monaghan County Hospital, and to a lesser extent Our Lady’s Hospital, Navan, that created major difficulties for the NEHB. It was one of the first health authorities to submit a Hospital Development Plan, but had lost ground as planning got underway. Full agreement had been reached on general hospital development in four of the other health board regions, i.e. D’etterkenny in the North Western Health Board area; Tralee in the Southern Health Board area; Castlebar in the Western Health Board area and St. James’ Hospital in the Eastern Health Board area. Therefore each had overtaken the NEHB in terms of progression. The members and management of the Board realised that further progress could not be made in its region until this matter, in relation to Monaghan in particular, was resolved.

Significantly, when giving formal approval for the building of Cavan General Hospital, Brendan Corish indicated that he was not in a position to give a firm commitment about the priority rating lor this major development, as compared to other projects, or to specify when the necessary capital monies would be made available.\(^4\) The reality was that the NEHB would have to reach an agreement in keeping with the requirements of the Department of Health: that the catchment area lor the new Cavan Hospital would be the area served by the present Cavan Surgical Hospital, the Medical Hospital at Lisdarn and most of the area served by Monaghan County Hospital. In the interim it was essential that the planning of the new hospital in Cavan was completed as soon as possible.

Both the Project and Design Teams for Cavan General Hospital had agreed that the most suitable site for the new hospital was at the south-east end of the property at Lisdarn. This site had been extended by the Board’s decision to purchase an adjacent nineteen acres from Cavan County Council. The acquisition of the additional
land was necessary to enable the appropriate scaling of this large development and to provide a campus for any expansion of the services which might be considered necessary in the years ahead. The Department had already agreed that as an integral part of the development of Cavan General Hospital, the design would allow for expansions of up to a third should the need arise. The major existing buildings on the site would be retained including the impressive frontage of the hospital. Essentially the development in Cavan would be comparable in size and services to Our Lady of Lourdes Hospital in Drogheda.

All of this planning, funding and commissioning was going to take some years, regardless of the urgency of the need for new and updated services. In the interim, conditions in the Surgical Hospital, Cavan, had deteriorated significantly. Following a visit to the hospital by representatives from Comhairle na nOspideal on the 13th January, 1978, the Board was advised to transfer surgery away from this unit because of the unacceptable condition of theatre facilities. This would be a difficult recommendation to implement as it would not be feasible for Lisdarn alone to take over this role until the new hospital was complete.

Consequently the Board prepared a scheme for the substantial renovation of the theatre in the Surgical Hospital which would enable it to continue to use the facility for the present. Arrangements were made with hospitals in Monaghan, Navan, Dundalk, Our Lady of Lourdes and Dublin to make inpatient services available ‘as liberally’ as possible until the repairs were concluded.

As is inevitably the case when major building projects such as that for Cavan General Hospital get underway, there are unexpected delays, glitches and technical difficulties to overcome. For example, in April, 1982, the CEO, Pat Clarke, reported that the Board had encountered some difficulty in obtaining planning approval for the project in Cavan. This had nothing to do with the proposals the NEHB had put forward for consideration by the planning authorities, but was related to an ongoing dispute which existed between the Fire Prevention Officers of the County Council and the County Council itself. Nevertheless, it was still hoped to have full planning permission by mid-May thereby allowing the schedule to proceed with a contractor on site by the middle of 1983. This was not to be the case as the situation deteriorated gravely in the coming months.

In 1982, under the direction of the Minister for Health, Barry Desmond, the Maternity Unit of twenty-six beds at Monaghan County Hospital was closed, and eighteen paediatric beds and surgical services were provided at a significantly reduced rate. The Department of Health also refused to sanction a number of new posts: an obstetrician/gynaecologist and anaesthetist for Monaghan, a physician and anaesthetist at Cavan and a pathologist to be shared by both hospitals.

Consequential events were to overtake both the NEHB and the Department of Health from January 1983. A High Court Action, by way of a ‘Motion for an Injunction’, was taken by Margaret Rose McMeel and Others against the Minister for Health and Social Welfare and the NEHB in relation to Minister Barry Desmond’s decisions regarding Monaghan county Hospital. The services of Mary Finlay, BL, and Anthony Kennedy, SC, were retained as Counsel for the Health Board. The case was adjourned provided the NEHB undertook, in relation to the erection of the General Hospital in Cavan:

1. Not to enter into any contract
2. Not to implement any existing contract
3. Not to authorise or carry out any site development works, building works or other construction works.

The building of the new hospital was brought to a complete standstill.

Other serious issues for the NEHB came to light in June, 1985, when an unwelcome letter was received by Pat Clarke from the Department of Health. The letter pointed out that Barry Desmond believed that it was initially intended that the Surgical Hospital in Cavan, the Medical Hospital at Lisdarn and the County Hospital in Monaghan would each close when the new hospital was commissioned. The Minister believed that if this did not happen it would result in the Monaghan/Cavan area being grossly over-provided with acute general hospital beds. He would not countenance such an over-provision, which ‘in the best of times was wasteful of public resources and would, of course, be totally intolerable in the present economic situation’. Accordingly, he found it necessary to have a firm commitment from the NEHB that the three hospitals which were to be replaced would be closed as acute hospital facilities and the Department of Health informed of the Board’s plans for the disposal of the properties.

When the news of the complete closure of Monaghan County Hospital came to the attention of the public, deputations from Monaghan, often unsuccessfully, sought further meetings with the Minister for Health. Protests were taken to the gates of Leinster House and local and national media support was sought. Public demonstrations against the proposed closure were ongoing and fervent. By way of trying to find a solution that would accommodate both sides in the dispute, the NEHB asked the Minister to offer a number of alternatives for reducing the number of beds in Cavan General Hospital, and thereby Monaghan County Hospital could be retained. A submission from the Board to the Minister stated:

That the proposed new General Hospital for Cavan would go ahead as planned with the deletion of the 65 beds which were designated for the treatment of psychiatric illness and alcoholism and this would leave a new General Hospital in Cavan of 271 beds and construction on this would start as early as possible and that the Monaghan General Hospital as we knew it would continue.

It was decided by the Board that, for the present, no decision would be made until complete and comprehensive hospital plans for the region were received from the Department of Health. The Board also had to consider the reality that out of a population of approximately 300,000, a proportion would, for geographic reasons, gravitate to Dublin for hospital facilities. With only one speciality in the region, the orthopaedic service in Navan, others were forced to avail of specialist amenities in Dublin.

The new year of 1984 was to bring renewed hope to the NEHB. In January the Minister made an application to the High Court seeking a release from any understanding, implied or given, which restrained him from proceeding with the building of Cavan General Hospital. In return Barry Desmond was prepared to enter into an undertaking to maintain the status quo at Monaghan Hospital and in the surgical services and no deletion or significant amendment would take place there, prior to the final decision of the High Court on the matter. The Minister’s application to the High Court was successful. As a result, on the 27th February, 1984, the Board was released from any undertaking in relation to the development of Cavan Hospital and within three months contracts were signed with John Sisk and Son, Ltd., and work on the project finally commenced.

Following delays and adjournments, proceedings in the High Court Action against the Department of Health and the NEHB began on the 22nd May, 1984, and the Plaintiffs Action was dismissed by Justice Keane. This did not bring an end to the matter: the Board’s legal advisors received a Notice of Appeal to the Supreme Court and this time the Plaintiffs were successful. The Supreme Court Judgement stated that the Minister for Health did not have the authority to close the maternity or paediatric services at Monaghan County Hospital.

Lengthy discussions on the Judgement and its implications led the Board to resubmit applications to Comhairle na nOspidéal for the approval of a second obstetrician/gynaecologist and a second anaesthetist for Monaghan. Pat Clarke and Joseph Farrell, Chairman of the NEHB, requested a meeting with Barry Desmond to discuss the future of acute hospital services in the region in light of the current situation. In reply to this request the Minister for Health stated that:

In consideration of the wide implications of the Supreme Court Judgement re Monaghan Hospital for my powers as Minister for Health, I have indicated my intention to amend the Health Act 1970. However, I have given further consideration to the overall position in relation to planned maternity services for the NEHB area and I would welcome your Board’s present proposals on the matter…subject to the normal planning guidelines for maternity services and taking into account the fall in the number of births in the NEHB area, your Board submitted financial implications forms for two consultant posts at Monaghan Hospital…a reply will be issued by my department in the usual way, therefore I think there would be no point in meeting with the Chairman of the Board and yourself until your Board have agreed specific proposals in these matters and forwarded them to me.
Minister Barry Desmond proposed to seek new legislation to allow him the power to close hospitals or individual wards, but this never came to fruition as the 1987 General Election brought a change of government. Former member of the NEHB, Dr. Rory O’Hanlon, became the new Minister for Health in March of that year. Within months the structural contract for Cavan Hospital was complete and the Minister was present for the ‘handing over’ ceremony. Dr. O’Hanlon informed the NEHB that the existing network of acute hospitals in the region would be largely retained, including Monaghan General Hospital and Our Lady’s Hospital Navan. Each unit would therefore continue to provide the same number of services as at present, with the addition of acute psychiatric services. It was agreed that the first phase of commissioning would take place at Cavan General Hospital in April 1989 and the level of service would increase gradually as additional funding became available. The first patients were admitted in June of that year. Finally, on Friday 24th November, 1989, fourteen years after it was first proposed, the Minister for Health, Dr. O’Hanlon, officially opened Cavan General Hospital.

Despite this undoubted achievement, the announcement of a £2.25m massive shortfall in the Board’s budget in 1989 led to renewed fears for the future of hospitals and services. The reality for the NEHB was that it was extremely difficult to maintain services with budget constraints and, just as important, shortages of nurses, consultants, anaesthetists, and several other categories of specialist and professional staff. The response from the Department of Health to all requests for additional personnel reflected the response for additional funding: the Department appreciated the difficulties imposed on health boards by the recruitment ban but there was nothing they could do. Dr. O’Hanlon acknowledged that low staff morale was directly related to the number of temporary staff; nevertheless, the restrictive embargo on Public Sector employment remained and only key posts could be filled.

The Department of Health also held that the health boards would have to work within existing allocations and those boards with accumulated arrears were expected to initiate a five year plan to eliminate these deficits. It would be necessary therefore for the NEHB to reduce costs and outgoings to compensate for the unavoidable shortfall in income. The Secretary of the Department of Health, which had the statutory status of Accounting Officer, drew attention to the fact that no agency had either the opportunity or right to overspend. He claimed that such courses of action were not acceptable or permissible and no other mandate applied.

As a result, Hospital Action Groups from Monaghan County Hospital, Louth County Hospital, Dundalk, St. Mary’s Hospital, Drogheda and Our Lady’s Hospital, Navan committed to continue to lobby for the retention and adequate provision of hospital services in their localities. Action Groups had the full support of the Urban District Councils, Chambers of Commerce, Local Councils, Trade Unions, politicians of all parties, staff from the hospitals, individual members of the Health Board and the local communities in their protest. Health care and hospitals remained one of the most politicised issues in the country.

The NEHB had already established a Budgetary Working Group in 1988 to examine and report on the financing of its acute hospital services. The members visited each unit where they had frank discussions with all of the senior staff from nursing to administration. As a result of its findings the Board agreed that a Nursing Unit of twenty to thirty beds, in each hospital, would close for a four-month period every year in an effort to retain within its budget allocation. The dates and times involved in the closure were agreed locally with senior medical staff, the matron and other relevant personnel. It was the intention of the Health Board to consults review the length of time patients occupied beds and to find ways to discharge patients, as far as £400,000 and £500,000 per annum. The potential danger involved in the decision to temporarily close acute hospital beds was brought to light in the winter of 1990. Major difficulties arose when the number of medical admissions throughout the nation percent, due to a virulent influenza epidemic. During the Christmas period when the service was normally reduced, over one hundred beds had to be put back into action and a further one hundred beds were placed understated medical conditions such as respiratory or cardiac illnesses were particularly affected. The demand for acute hospital beds was exacerbated because the illness had proved more severe than anticipated and was relatively slow to respond to conventional treatment.

As pressure on the services increased Pat Clarke gave limited consent to hospitals to engage short-term temporary staff, due to a higher level than normal of sick leave among hospital staff, as they too contracted the virus. The strain on the Health Board and its staff during this epidemic was to demonstrate clearly the extreme vulnerability of an under-resourced service. It had survived a very difficult period due only to the commitment of medical, nursing and ancillary staff to maintaining a service in crisis.

Fortunately as the new decade of the 1990s began the NEHB would enter an era of optimism and renewed development as the economic situation in Ireland changed for the better. On the 21st April, 1994, the Minister for Health, Brendan Howlin launched a significant report: Shaping a Healthier Future - A Strategy for Effective Healthcare in the 1990s. A phase of considerable expansion of all of the services the health boards provided came with the implementation of the National Health Strategy. Changes that began in 1990 accelerated in the period 1992-99, as GDP rose by 8.8% per annum. Ireland surpassed even the emerging ‘Tiger’ economies of Asia in terms of high growth rates and industrial production coupled with low inflation. Unemployment had fallen from 17% in the mid-1980s, the second highest in the EU, to 4% in June 1990. It was then 6% below the EU average. There were no longer the considerable restraints on public spending that had existed in the previous decades. As a result the overall resources of the NEHB grew by approximately 25% between 1993-95.

This significant increase was assisted by the introduction of a number of specific schemes outside of standard budget increases. For example, Brendan Howlin launched a Major Action Programme on Hospital In-Patient Waiting List in 1993 which provided a special fund of £200m specifically targeted at those areas of hospital treatment where long waiting lists were causing particular hardships. The NEHB received £671,000 including funding for equipment and necessary capital works, and for the provision of two hundred and thirty-seven additional orthopaedic procedures at Our Lady’s Hospital Navan. An additional £10m was earmarked nationally for the continuation of the initiative in 1994.

Even a cursory examination of the financial reports of the NEHB after 1992 shows a significant number of allocations beginning ‘additional funding received for’… under a variety of headings, from acute hospital services to all sections of community services. This unprecedented growth-rate led to the rapid expansion, modification and development of all of the services provided by the Board.

As economic circumstances changed for the better, it became clear to the NEHB with Dr. Hugh Dolan as Chairman, that it was necessary to deal with the legacy of the threat of closure which many leaned continued to hang over the hospitals in their area. As already stated, since the publication of the Fitzgerald Report over twenty years earlier, local communities had been fighting against hospital or ward closures. The NEHB was now faced with the problem that any proposed hospital changes it wished to initiate, regardless of how positive, were regarded with suspicion and gave rise to active resistance. For example it one hospital was being improved, other communities felt that it was being done at their expense and provided evidence of a downgrading of their service. These understandable fears had to be acknowledged and the threat of closure removed. Hence the Board agreed to adopt a policy which would secure the future of each of the existing live hospitals, Monaghan, Dundalk, Drogheda, Navan and Cavan, by guaranteeing an active role in the delivery of a comprehensive acute hospital service lor the region.

This programme was based on a report issued by the NEHB’s Hospital Services Committee in September 1993 entitled A New Direction for Acute Hospital Service in the NEHB Region. The report effectively ruled out the closure of any of the Board’s four acute hospitals and also called for new arrangements to ensure that Our Lady of Lourdes Hospital became an integral part of the region’s network. The report reiterated that it was not justifiable, nor financially viable, to develop a total comprehensive hospital service at each one of the five hospitals, nor was it possible to develop a full range of services on every site. Its key recommendation was that the hospitals in the area no longer act as individual units but become component parts of a regional service. Accordingly it was proposed to introduce a number of new initiatives:

it will be clearly necessary to ensure that the services or facilities developed at one site must be

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made available to staffs and patients on another or other sites. It will also be necessary to ensure that the specialist skills of staff on one site are made available to patients on another site or to patients from another site.63

The Hospital Services Committee recommended that for some services there would be a grouping of hospitals, with common or single departments covering a number of hospitals and posts. Departments staffed by consultants with complementary special interests would be required to deliver services to more than one hospital.

For decades it had been generally accepted nationally that the provision of a continuous general service by a single clinical consultant in a department was totally unsatisfactory. The development of specialisation within medical training and practice meant that the era when the general surgeon, the general physician or the general pathologist could deliver a comprehensive service on their own, had ended. No consultant could continue to try to give service twenty-four hours a day for fifty-two weeks of the year. The NEHB therefore agreed that the departments were to be staffed by a number of consultants with complementary special interests, in order to deliver a comprehensive service to patients. Consequently each department was expected to deliver services on more than one hospital site.74

As a beginning to this transformation of services, the Board realised that the concept of joint departments, shared posts and the easy movement of both staff and patients within groups, required very close collaboration between hospitals and between hospital staff. Thus discussions took place between the Health Board, consultants and senior staff in each hospital on the options for groupings of hospitals. In November 1993, it was unanimously decided by the Board to accept Cavan General Hospital and Monaghan General Hospital as one group, with Louth County Hospital, Our Lady of Lourdes Hospital, Drogheda and Our Lady's Hospital, Navan as another.

This application was in keeping with the government's National Health Strategy, which provided for specific catchment areas allied to joint departments. It was achieved by unifying the consultant specialist services across a number of hospitals, thereby extending the level and range of services available in a region. It was anticipated that such decisions would finally secure the future of each of the five general hospitals and guaranteed an active role in the delivery of a comprehensive acute hospital service in their catchment area. In addition it would bring an end to the uncertainties and infighting between hospitals and communities.

By the end of 1994 considerable progress had been made in putting into effect the policies on acute hospitals adopted by the Board in the autumn of 1993. The concept of hospital groups with joint departments serving specific catchment areas had become a reality. In the Cavan/Monaghan area meetings were held under the auspices of a Management Advisory Forum chaired by the Programme Manager Acute Hospital Services, Des Scully, with the participation of consultant representatives, matrons and administrators from each hospital. The creation of a joint executive between the NEHB and Our Lady of Lourdes Hospital in 1994, and a memorandum of agreement between the two agencies, would form the basis of the Louth/Meath Hospital Group in 1995. A Louth/Meath Advisory Forum was initiated in 1996. The inclusion of Our Lady's Hospital Navan led to the formation of joint departments across all consultant specialties in these hospitals.

A number of further milestones in the history of the development of acute hospital services in the NEHB region came in 1994. when Comhairle na nOspideal and the Department of Health in a way which vindicated the policy decisions taken for the development of hospital services for the region. The provision of sixteen additional consultant positions facilitated the expansion of existing services and the introduction of new specialist services across the catchment area.66 The Minister for Health, Michael Noonan, stated:

As evidence of my commitment to the Board's policy for its acute hospitals, my Department has made substantial development funding available over the past two years for the development of a wide range of services in both hospital groups.66

The Health Board submitted further detailed plans to the Department of Health in 1994 for the building up of acute hospital services in the coming year. An allocation of £1.4m of development monies was given for the purpose. All of the major hospitals in the NEHB region benefited significantly from these funds.

Pictured in the New Modular Theatre, Monaghan, Mr. Tommy Coyle, Sr. Brenda McCrudden and Mr. Kevin MoUoy

Capital development on the Monaghan site included the provision of a day hospital, additional out-patient facilities, a canteen for staff and visitors, a conference/meeting room and the relocation of the mortuary and ambulance base. The Cavan site benefited from the provision of a hospice care suite, an assessment and rehabilitation unit, vascular and respiratory laboratories and an intensive care unit. Improvements at Our Lady's Navan included new facilities at the reception area and outpatients department, refurbished surgical wards, a grieving room and an acute psychiatric unit. Louth County Hospital developments included the construction of three car parks, a new Accident and Emergency department, outpatient department, and improved facilities for medical records, the pharmacy, occupational therapy and physiotherapy services. A new intensive care unit was opened in Louth that was provided by the NEHB in conjunction with the Target 250 Fund Raising Committee.67 The considerable increases in allocations from the Department of Health finally overcame a number of the major difficulties that had resulted from the under-funding of the Health Board in the preceding two decades.

A third historical development in terms of acute hospital services in the NEHB region was to follow the announcement by the Medical Missionaries of Mary, in November 1996, of their decision to enter into formal negotiations regarding the transfer of the International Missionary Training Hospital (Our Lady of Lourdes) to the Board. The Medical Missionaries had previously been involved in negotiations with the Department of Health over the sale of the hospital. The outcome of these particular negotiations would have resulted in the hospital becoming a public voluntary hospital with its own board. The NEHB would then be in the unenviable position of having to negotiate with new management to provide services in the region, with the potential to undermine agreements made to date. The decision of the Medical Missionaries of Mary to enter into an agreement with the Health Board was warmly welcomed by the members. The transfer of ownership of Our Lady of Lourdes Hospital to the NEHB would make possible the more rapid development of services in the region, as it would further unify the hospital grouping. The result of discussions was entirely dependent on funding from the Department of Health for the purchase. Other factors which had to be agreed upon included the future status of employees and any liabilities arising out of future actions taken against the hospital.68
Therefore since 1971 the NEHB had accepted full liability for the payment of eligible patients in public wards at the hospital. However, the hospital continued to be funded directly by the Department of Health. When it formally considered general hospital developments in 1976 the Management Team produced a background report that was adopted by the Board. It stated:

In light of the fact that approximately one third of the acute hospital admissions in the area are to the International Missionary Training Hospital, discussion on this development of acute hospital services in the area must bring into consideration the role to be played by that hospital in the future. The Medical Missionaries of Mary see their contribution to the local community as being best expressed through participation in the provision of acute hospital services. It is appropriate to consider the hospital as an integral part of the acute hospital services in the area in the same light as the Board's own institutions.

The independence of the hospital was slowly being evaluated in terms of its role in the provision of hospital services and the financial support given. It was inevitable that when public funds were being provided the State would seek to supervise disbursement, and it was only one short step from supervision to control. By the end of 1989 Pat Clarke indicated to the Minister for Health:

That the role which Our Lady of Lourdes Hospital, Drogheda plays in the region, would need further and adequate definition and that the level of services which the Lourdes provides to the region on a specific basis, needs to be defined in order that the other services for the region can be examined, with a view to establishing their adequacy or otherwise.

It was agreed by the Board that further contact would be made with the Department of Health, seeking clarification of the service role which the Lourdes Hospital, in light of its public funding, played in the NEHB area.

The attitude of the NEHB to this voluntary hospital was not at all unique. Many involved in the health services, including the Department of Health and the health boards, believed that an unambiguous definition of the relationship between the statutory and non-statutory agencies would have to be drawn up. In 1986 the Department of Health's consultative statement on health policy entitled Health the Wider Dimension referred to:

The role of the non-statutory sector has evolved over a long period and these agencies are now involved not just in the delivery of services on an agency basis but also participate in the process of policy development through their pioneering work with various care groups...this non-statutory input is an important element in the health system which should be preserved. However, the problems of integration between the statutory and non-statutory sectors have arisen in the past and a future objective of the re-organisation now proposed is to introduce arrangements which will lead to greater cohesion between both sectors. The extent to which the non-statutory sector is dependent on exchequer funding lends further emphasis to the need for such cohesion.

Even more significantly, Health the Wider Dimension also refers to the traditional role played by voluntary hospitals and their prominent role in the provision of services on behalf of the health boards:

In practice most voluntary hospitals see themselves as independent providers of services with health boards having little or no say in their operation. Up to now both the Department of Health and the health boards have acquiesced to this. It is clear that such a situation can no longer be allowed to continue and the appropriate relationship between these hospitals and those responsible for the delivery of the services must now be firmly established. This is one of the questions addressed in the re-organisation proposals submitted to government.

Fergus O'Farrell outlined the extreme vulnerability of voluntary service providers in respect of this consistent policy. Quoting David McKevin, who also described the 'cut-back' phase in 1987-1988:

...that as individuals now had a Choice of Doctor they should also have a choice of hospital and a patients, with limited eligibility, availing of a public ward to any hospital in the region including Our acceptable consultant obstetrician/gynaecology service was available, that full liability be accepted Hospital to avail of public beds that the CEO be authorised to arrange with the Lourdes Hospital the provision of out-patient facilities when considered necessary.
hospitals; legally of course, the closure is the decision of the Hospital Board, as the Department of Health does not have jurisdiction in the actual closure decision. Evidence also suggests that the Department achieved some closures earlier than even they had planned. The ‘rush’ of events in 1987 overwhelmed the hospital segment and advantage was taken to achieve long-sought rationalisation proposals, for example, Dr. Steeven’s Hospital in Dublin.6

The services of a number of voluntary hospitals were transferred to larger hospitals i.e. to St. Vincent’s Hospital Elm Park, St. James Hospital, Beaumont Hospital, the Mater Hospital and the James Connolly Memorial Hospital Blanchardstown. In the late 1990s these were joined by the newly built hospital in Tallaght, which incorporated the Adelaide and Meath Hospitals and the National Children’s Hospital.

The initial independence, or at least semi-independence, of voluntary bodies was being eroded, as they became almost totally dependent on government funding. Rising costs, the end of the Irish Sweep Stake and the impossibility of finding sufficient private funding left them in a completely vulnerable position. The relationship between the Lourdes Hospital and the NEHB was undergoing a transformation and the time was now ripe for change which would be beneficial to both the Sisters and the Board.

On the 15th April, 1997, the Minister for Health, Michael Noonan, announced the Government’s decision to approve and fund the transfer of ownership of Our Lady of Lourdes Hospital to the NEHB. Confirmation of the approval of sale was given by the Commission of Charitable Bequests. On the 29th May, 1997, an ecumenical service was held at Our Lady of Lourdes Church to mark the handover of the hospital to the NEHB. The CEO, Donal O Shea, on behalf of the Health Board, expressed the appreciation of the members for the work done by the Medical Missionaries of Mary in Drogheda for almost sixty years:

This hospital comes to us with its tradition of teaching and training, with its medical training programme, its school of general nursing and midwifery, with the libraries and facilities which support this work. It comes with its commitment to community service and patient care, with standards of professional excellence across the specialities and professions. We wish to maintain all of this...I can assure you it will be in good hands...7

Neither the Board nor its management knew anything of this letter. According to Donal O Shea:

The timing was unfortunate in that it coincided with the Government’s approval and as a result was linked in the public mind with the transfer of ownership. It created the wholly erroneous impression that this Board intended to create staff and service reductions in connection with the transfer.8

The CEO also pointed out that under the Health (Amendment) Act, 1996, every health board and every hospital was required to produce a Service Plan to the Department of Health outlining the services to be provided for the coming year, based upon the Letter of Allocation received in December of that year. The Department had issued an invitation to the NEHB, with the full support of the hospital, to work with the management of the hospital in drawing up Service Plans for 1997. The Board would only do this on the basis of the following:

1. The internal letter of the 14th April 1997 is fully withdrawn and forms no part of the process.
2. All current staff contracts will be honoured in full.
3. There will be no reduction in staffing levels and clearly no lay-offs.
4. Service and activity levels will be maintained at 1996 levels.

In addition the Board seconded a General Manager and engaged financial expertise to assist the hospital and all appropriate key staff were consulted regarding the operation and development of the service. The Board was committed to continuing with the proposed expansion at the hospital, i.e. the recruitment of consultants in surgery, obstetrics/gynaecology, pathology, radiology and geriatrics and initiating further services for the Louth/Meath area.9 In 1998 these developments were followed by a further policy document on the ongoing development of acute hospital services entitled North East Hospital-The Net Five Year.- A Framework for Continuing Development, a blueprint which continues to influence the development of acute hospital services to the present day.

However, a number of major events have had a salient effect on the development of acute hospital services in the region since this time. New specialities and subspecialities are becoming increasingly interdependent and complex technologies are becoming an integral element in the delivery of services in the region. This reflected both national and international trends in acute hospital services which tended towards specialisation, development in technology, i.e. equipment, medicines and treatment. There has also been a significant move away from in-patient treatment to day services and greater than before activity in hospitals. As a result the Board has attempted to advance the process of hospital networking and to re-organise services as the pace of change has increased and the recommendations and standards set by regulatory and professional bodies developed further.
In 2001, the management's *Proposed Development of Specialist Services 2001-2006* was accepted by the Board and it was viewed as complementary to its 1993 and 1998 policies. Conversely, one of the major difficulties for the provision of acute hospital services in the region was again based on the future of Monaghan General Hospital. In 2002 the Minister for Health, Michael Martin, commissioned Kevin Bonner to report in relation to Monaghan General Hospital, following the submission of the Report of an Independent Review Panel into the events surrounding the death of Baby Bronagh Livingstone. She was a premature baby who was born in the ambulance after her mother Denise who was twenty-four weeks and six days pregnant, presented at Monaghan General Hospital with labor pains. She was subsequently transferred by ambulance to Cavan General Hospital, and gave birth en route. The baby died in Cavan General Hospital after arrival. Maternity services at Monaghan had been suspended almost two years before. (see chapter 5 'A Perilous Impace' which outlines the provision of maternity services)

The Bonner Report entitled *Monaghan General Hospital: Proposals for Further and Future Development, 2001*, referred to the change in mistrust that continued to exist between the community that the hospital serves and the NEHB. The warniness was based on the belief that it was on the Board's agenda to close or down the hospital, and there was a need, for that reason, to develop a mutually trusting relationship for the benefit of the hospital. Kevin Bonner pointed out that the first principle involved had to be an acceptance that the hospital was not going to close; on the contrary, there was a vital role for the hospital as part of the Cavan/Monaghan Hospital Group. In particular the Bonner Report proposed to strengthen the management capacity of the hospital within the Group and the central involvement of consultant staff within this structure.

Michaél Martin accepted the main recommendation of the report i.e. that Monaghan General Hospital should continue to play a vital role in the delivery of acute services to the local community. Its findings were also accepted by the NEHB. However, it was not possible for the Health Board to secure an agreement to implement the Bonner Report, Chief Executive Officer, Paul Robinson stated that:

> Despite numerous attempts at consultation through meetings and correspondence it has not been possible to progress the potential of the Group or to implement the proposals of the Bonner Report which was endorsed by the Board.

He acknowledged that the development of joint departments was an essential component in achieving progress, but in Cavan/Monaghan this had proved to be slow and hindered process. Consequently, in April, Cavan/Monaghan Hospital Group. The Directive regarded the future configuration of these hospitals, in line with the guiding principle, that both sides had a role to play in the provision of acute hospital services for the therefore each needed to devise appropriate protocols relating to service delivery in the context of responsibilities, i.e. the level of services to be provided at each site taking into account available resources and the quality of care and safe practices, including risk management.

A Steering Group was established in May, 2004, to examine service configuration issues for Cavan/Monaghan Hospital Groups in line with principles laid down in the Directive. Paul Robinson required submissions to the Steering Group. Having examined in detail the proposals from service providers and ensure the execution of these proposals an Implementation Group be established as a matter of urgency.

Furthermore, a major decision was made by the NEHB in 2000, based on the provision of safe systems of Neary, a former consultant obstetrician/gynaecologist at Our Lady of Lourdes Hospital Drogheda. The frequency of caesarian hysterectomies carried out were excessive. Dr. Neary had been placed on Hospital, and had not practiced in the hospital since that time.

As a result of these regrettable circumstances the NEHB was consequently faced with two alternatives: to regard what happened as a once-off occurrence and hope that nothing further happened; the second was to engage in a process to establish whether there were other significant causes of concern in any of its hospital sites. The Board chose the latter alternative and decided to appoint independent experts in risk management, Healthcare Risk Resources International, to assess and report on all five hospital sites. It was aware that such a strategy was not without its drawbacks: it meant being prepared to be subjected to detailed expert and independent scrutiny of all facilities and activities, clinical and non-clinical, and to have all risks identified across the five sites at the same time. This raised the possibility of the hospitals facing further major public criticism and perhaps reducing public confidence as there were no benchmarks in Ireland at that time against which results of the study could be compared.

The process involved making site visits and inspections, detailed discussions with staff of all grades, examination of records, procedures and protocols, review of practices, assessment of staffing levels and grades, facilities for study and continuous professional development, etc. Findings and recommendations were discussed at departmental and hospital levels before the reports were submitted to the CEO. The report, in summary form, was reported in public to the Health Board and the media in July 2001. Its findings were detailed and comprehensive and represented a major challenge for all hospital staff and also for the management of the hospital services. Some of the recommendations required physical changes, increases in staffing, introduction of new disciplines, review of practices and procedures etc. and these have progressed within available resources and in the context of the policy of developing hospital networks. In an effort to introduce these Paul Robinson explained that:

> A Corporate Risk plan was developed, a programme of implementation was prepared for each hospital site and a Corporate Risk Management Department was established for the Board, with Risk Advisors appointed to each hospital group. A process of incident reporting was introduced in advance of the national system which has been introduced by the State Claims Agency. All incidents are now examined, risks assessed and remedial action recommended where necessary. Arrangements are in place to ensure that improvements and learning gained in one location is transferred to others.

He also stated that the risk management reports represented the findings at a particular period of time and that situations are changing constantly. Once it was decided to adopt a risk management approach, it represented a major on-going commitment and process. The sad death of Frances Sheridan and the report completed by an independent review group had further demonstrated the need for constant review and improvement of processes and systems. It had been viewed as essential that all involved in any way in the delivery of patient care participated fully in this process in the interests of both patients and staff.

Closely linked to the development of Acute Hospital Services are the major changes which have taken place in the Ambulance Service in the north east region. At the time that the NEHB took over the service, a small number of ambulances was attached to a particular acute hospital under the direction of the Matron. There was just one untrained driver who was accompanied by a nurse. It was the Board's official policy since 1981 to have all ambulances crewed by ambulance personnel only. The role of the Matron in relation to this service was to be replaced by a Chief Ambulance Officer. As with all other objectives for the improvement of the health services, this too would take some considerable time to introduce.

The Minister for Health, Brendan Howlin, in November, 1993, launched the first *National Review of Ambulance Service*. As a result the NEHB applied for the necessary resources to develop the service, replace equipment and provide additional ambulances. In addition it set about introducing new standards for the recruitment and training of staff including in-training programmes. Two person crews were viewed as essential, particularly to a Cardiac Ambulance Service, and by 1995 two person crews were introduced to all accident and emergency vehicles in the region. However nursing staff are still made available if a situation requires it.
History of the North Eastern Health Board

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Two new frontline cardiac equipped ambulances were added to the existing fleet in 1997

As demand has risen the service now operates from five stations: Cavan General Hospital, Monaghan General Hospital, Drogheda Cottage Hospital, Louth County Hospital; the Regional Command and Control Centre is based in the grounds of Our Lady’s Hospital Navan. The Ambulance Service Training Unit is situated at Our Lady of Lourdes Hospital. The training was introduced to ensure that patients, as far as possible, are stabilised until they receive advanced medical treatment in a hospital.

The role of the Ambulance Service has changed considerably over the decades to providing twenty four hour a day comprehensive emergency or elective transport services to the people of the region. There are one hundred and eighteen staff, the vast majority of whom are directly involved in patient care or operational communications and it now operates a fleet of thirty-eight ambulances and support vehicles. The NEHB Ambulance Service serves over three hundred thousand people in an operationally difficult region with many challenges. Unfortunately, the region has the highest rate of road fatalities in Ireland.

A reflection of the various responsibilities of the Board’s Ambulance Service is demonstrated by a number of major local events, for example, services are provided at the Slane, Co. Meath ‘Rock Concert’. Six ambulances, one mobile control vehicle, and one mobile casualty unit are staffed with medical teams. This prevents local casualty departments being over-run with a large volume of patients.

Regardless of the major difficulties in the provision of acute hospital services in the region, which continue to the present day, the NEHB has developed an acute hospital service in the region which is unrecognisable to that which it had inherited over thirty years earlier. The local county hospitals, with minimum services, have been surpassed by a major regional service with an increasing number of specialties. Despite the number of difficulties which continue to face the acute hospital services in the North East region, history has demonstrated that considerable progress has been and continues to be made across both hospital networks.
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80 Kevin Bonner is former Secretary General of the Department of Enterprise and Employment.
81 This issue will be dealt with in some detail in a following chapter.
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86 Paul Robinson CEO. Hospital Services in the North East p 2.
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CHAPTER 3

A NEW BEGINNING

Since then, the values of a society that confounds its unproductive and inconvenient members to what is effectively social euthanasia have been repeatedly questioned. The psychological and social effects of living in total institutions have been well documented.

Paddy Byrne, Irish Wheelchair Association.

Two Commissions of Inquiry were formed by the Minister for Health, Sean McEntee, in 1961: the first to examine and report on issues relating to Mental Handicap; the second to Mental Illness. They took almost five years to complete but the findings were critical. Both Commissions reported on the appalling living conditions to which patients in psychiatric institutions had to endure. In speaking of the findings of the Commissions of Inquiry, Annie Ryan in her book Waifs of Silence noted:

In the years that the Commission had examined the situation the members visited each of the Mental Hospitals. They were keenly aware of the discrimination which existed towards the mental hospitals. As little as possible was spent on furniture or furnishings, or maintenance or on catering. Patients were living in primitive conditions because so little was spent on heating or sanitary facilities.

The emphasis in these hospitals was custodial. Patients were placed together in large groups in the belief of responsibility for their own actions and even their personal belongings, hence they inevitably became institutionalised.

Very few patients in the last decades of the twentieth century actually required this level of custodial care. It was the lack of alternative social services and unfortunate or unfortunate social attitudes that led many long stay residents in patients, 2,638 or 16% were in a mental handicap, and 4,668 or 29% were over sixty-five years of age; the remaining 8,367, or 58%, were long-stay psychiatric patients receiving only custodial care.

Only after the Second World War were research studies, which had linked mental handicap and psychiatric illness to every conceivable social ill, critically evaluated and found wanting. The approach to mental handicap acknowledged. In addition pressure for the abandonment of long-stay institutional care for all manner of economic grounds. Speaking in 1980, Paddy Byrne of the Irish Wheelchair Association stated:

Since then... the values of a society that confounds its unproductive and inconvenient members to what is effectively social euthanasia have been repeatedly questioned. The psychological and social effects of living in total institutions have been well documented.

In terms of psychiatric illness, changes were taking place both nationally and internationally in the pattern psychiatric institutions, in units within general hospitals, hostels and day-care facilities in special centres, where it was regarded as important that the patient maintain links with the wider community.

This transformation was made possible over the coming decades by a change in public attitudes, the approach involving medical teams and social welfare resources. An increasingly important role was played by the introduction of new methods of treatment including significant developments in drug therapies and a team clinical teams of psychologists, social workers, psychiatric nurses and other paramedical staff. According to the.

1972 Working Party Report on Psychiatric Nursing in the Health Boards:

With the development of modern treatments, together with the involvement of other trained personnel to complement the work of doctors and nurses, a complete transformation has come about in the whole concept of psychiatric care. For many people there is no longer a need to enter hospital to be treated effectively, for those who have to enter hospital, the length of stay has been shortened and there has been a quickening...of activity within the hospitals. The way has been cleared for these custodial care institutions, to become active treatment and rehabilitation centers...the large walls surrounding many of the hospitals have disappeared. These developments have in turn helped to promote a more enlightened public opinion.

Nevertheless, while welcome, change came slowly and had to await a number of societal, political and economic developments. When the NEHB took over the provision of psychiatric/intellectual disability services it was to find conditions as austere in the region as those found nationally. The two main psychiatric institutions in the region were St. Davnet's Hospital in Monaghan and St Brigid's Hospital in Ardee. St. Davnet's was a traditional District Mental Hospital, established in 1869 and provided a psychiatric service for counties Cavan/Monaghan. The wards of St. Davnet's Hospital were totally renovated through the depressed 1950s, the wards being closed one by one to facilitate this work. St. Brigid's was a relatively new hospital having opened in the 1930s and while smaller, was similar and covered the Louth/Meath region. These institutions had a pattern of patients' diagnosis very close to the national average. The Census of 1971 had indicated that of the six hundred and eighty-five patients in St. Davnet's Hospital, one hundred and thirty-five had a mental handicap, and two-hundred and two were aged sixty-five or over. Similarly, of the four hundred patients in St. Brigid's Hospital, fifty-nine had a mental handicap and one hundred and twenty-three were sixty-five years or older. At this time patients from County Meath, while residing in the NEHB region, continued to be admitted to St. Loman's Hospital, Mullingar which was part of the Midland Health Board. In 1977 there were three hundred and twenty Meath patients attending this Unit.

The conditions within these institutions were far from ideal: they included inadequate facilities, the isolation of patients and out-dated systems of care and management. The NEHB Psychiatric Hospital Visiting Committees were continually requesting additional staff, better living conditions and relief from overcrowding. In December, 1971, St. Brigid's Visiting Committee described the 'serious and dangerous' levels of overcrowding in male and female wards, the totally unsatisfactory kitchen facilities, the floors throughout the hospital which needed to be tiled, the obvious lack of sufficient chairs for both patients and visitors at both bedsides and in day-rooms, very few beds had bedside lockers, the sitting which was available was in a deplorable state' and 'should be taken outside and burned', all wards were in need of redecoration, the hospital windows were in need of repair and repainting.

A year later a Visiting Committee to St. Davnet's described 'gross over-crowding', units in need of redecoration as 'present appearance is drab and forbidding', the old kitchen unit which 'should be abolished as it is unfit for use', the dining room in the old section also needed to be abolished as it too was deemed unfit, furnishings and seating needing replacing at once. It should be noted that both the old kitchen unit and the dining room at this time were having been replaced by a bright new modern catering department and the natural conclusion was to abolish the old vacant units. Mr. Eugene Caulfield had the honour of administering their demolition in 1976. It was likewise realised that the majority of individuals within these wards were totally unsuited to the environment. While age, psychiatric illness and mental handicap are not necessarily mutually exclusive, there were few who required constant long-term institutional care. There was an immediate need in St. Davnet's, according to the Visiting Committee, lor the provision of at least live or six additional psychiatrists if patients were to receive suitable treatment and rehabilitation.

Fundamental change in the delivery of psychiatric services in the NEHB region was dependent on finding a way to implement a number of new proposals: the Report of the Working Party on Psychiatric Nursing Services of Health Boards, the Condon Report; the Report of An Bord Altranais on Psychiatric Nurse Training and the report on Proposed Regional Training Programmes for Trainee Psychiatric Nurses. All reports issued in the mid 1970s agreed on the necessity of providing regional based training programmes for psychiatric nurses.
Previously such nurses were trained mainly for their custodial role and in ‘total patient care’. In addition traditional services had placed considerable constraints on nurses’ professional development and restricted their therapeutic input. There was an acute need to move from the old concept of nursing and to educate nurses in the therapeutic concept involved in supporting patients in a new environment and the future role of nurses as part of a psychiatric team. One of the major enterprises undertaken by the NEHB in 1976, therefore, was the introduction of a new programme of training for psychiatric nurses. This was recognition that psychiatric nurses provided the backbone of services and would be central to any changes which the Board wished to initiate.

In discussion with An Bord Altranais, the NEHB agreed that a regional nurse training programme for psychiatric nurses would be developed, with St. Davnet’s Hospital designated as the principal training school. An Bord Altranais asserted that St. Brigid’s no longer fulfilled the requirements for a full training hospital although it had provided psychiatric nurse training for almost forty years. This unsuitability was due to years of neglect, resulting in chronic overcrowding and deteriorating living conditions for patients and working conditions for staff. It was also based on the fact that nurses concluded their training in St. Brigid’s they would almost invariably find employment there, and so allowing fewer opportunities for those requiring training placements.

The decision to use St. Davnet’s as the principal teaching centre was reached mainly because of the significant changes which had already taken place there. From before the NEHB had come into existence in 1971, St. Davnet’s was a progressive service under the influence of Dr. Vincent Glass. The nursing staff was open to supporting alternative levels of service for their patients; hence the hospital introduced specific care for the various categories of patients by identifying the special needs of the elderly, those with a mental handicap and those with a mental illness - thereby the hospital staff acknowledged the different requirements of each category of patient and the inappropriateness of maintaining them together. Services and departments in St. Davnet’s were therefore organised appropriately on the basis of patients’ conditions: i.e. acute mental disorder, chronic mental disorder, geriatric, social disabilities and mental handicap. However valuable these initiatives were, the service remained institutionally focussed. New circumstances and attitudes were to lead, under the direction of Dr. John Owens, Resident Medical Superintendent at St. Davnet’s, to the adoption of the emerging model of community based psychiatry services, which advocated the normalisation and communalisation, as opposed to the isolation and institutionalisation, of patients.

It was agreed by the NEHB that the regional training of psychiatric nurses would take place in five interlinked settings. The major focus of training would be at St. Davnet’s, while the practical experience in areas of community care, occupational therapy, hostel accommodation, day hospitals and day centres would be available through St. Brigid’s. Clinical experience in the field of nursing those with a mental handicap was made available through St. Mary’s, Drumcar, a unit provided by the St. John of God Brothers in Co. Louth. The Health Board would likewise assist the development of psychiatric nurse training at Our Lady of Lourdes Hospital, which already provided clinical experience in general nursing for trainee psychiatric nurses. Suitable courses in biology, microbiology, chemistry, biochemistry and maths, as laid down in the new syllabus for psychiatric nurses, were developed at the Regional College in Dundalk. This was a pilot programme, as no experimental schemes along these lines had evolved in any other health board region to date.

St. Davnet’s Hospital in 1979 was also recognised as an official Teaching Hospital for under-graduates and the psychiatric training of medical students from Queen’s University, Belfast. This complemented the existing relationship with the Department of Psychiatry at Queen’s University which had for some time contributed to the post-graduate psychiatric training programme, for registrars and house-officers at St. Davnet’s. The staff at the hospital, and the NEHB, anticipated that this relationship would continue and extend into other areas such as research.

This was to happen sooner than expected when, at the end of 1979, a Community Health Survey was carried out in the Cavan/Monaghan area for the purpose of obtaining information on living patterns and attitudes, the relationships between these two and the levels of health and liability to illness among individuals. In particular the survey was expected to provide information on the prevalence of alcoholism and depression and the association of these ailments with social and personal characteristics. It was hoped to use this information to identify causative factors, and to establish appropriate preventative measures and treatment facilities, thereby planning a more effective service. The survey was carried out by Consultant Medical Staff at St. Davnet’s in consultation with the Medico-Social Research Board and Queen’s University Department of Psychiatry. Interviews were conducted by Community Nursing Staff from St. Davnet’s and the cost of the survey was borne by the Board. In 1994, the NEHB, in conjunction with the Royal College of Surgeons in Ireland, appointed a Registrar to research epidemiological and genetic aspects of schizophrenia, one of the most grave and least understood of psychiatric illnesses.

In this period there were several categories of individuals in psychiatric hospitals for many different reasons and for a time the numbers continued to increase. In his Estimate Speech of 1976, Minister for Health, Brendan Corish claimed that psychiatric illness continued to be one of the most pressing health problems of the decade:

Psychiatrists and sociologists and others in touch with the problem are divided as to whether its actual incidence is increasing. What is certain is that more people are seeking care for it and that every year the demand on the psychiatric service grows...indeed if it were possible to identify accurately the impact of mental illness on the demand for health care as a whole there is no doubt that it would be found to be an exceedingly important one.

According to the findings of the Medico-Social Research Board, which were published in the same year, there were several factors which led to the increase in numbers of those seeking care, which were unrelated to any increase in psychosis or nervousness. Throughout Ireland there was in fact a slight fall in the numbers of first admissions for personality disorders and neurosis from 1973 to 1974. On the other hand the report noted:

First admission numbers for alcoholism continue to rise and in 1974, alcoholism was the most frequent cause of first admissions to our hospitals accounting for almost a quarter of these admissions and 196.3 per cent of all admissions in 1973...first admissions for manic-depressive psychosis have also continued to increase, 38.8% since 1965...first admissions for organic psychosis, schizophrenia, neurosis...are generally stable and predictable from year to year.

An account submitted to the Health Board by Dr. John Owens confirmed a steady increase in the number of first admissions to the hospitals in the region for alcoholism. Consequently the Rathlin, an Alcoholic Unit with ten beds to cater for both male and female patients was opened in 1974. The Rathlin was intended as a short-stay unit for the management of chronic alcoholism, and treatment was predominantly based on group therapy. By 1978 St. Davnet’s was admitting four hundred alcoholics every year, approximately forty cent of their total admission and that percentage was increasing.

Alcoholism was not the only reason behind the figures for the increased numbers admitted to psychiatric hospitals at this time. A report published under the Chairmanship of Sean Trant of the Department of Health, indicated that nearly half of the people in Ireland who suffered from mild, severe or profound mental handicap were classified as ‘misplaced persons’ They were accommodated where the available services were not appropriate for their needs: i.e. 2500 individuals continued to be admitted and maintained in the unacceptable confines of psychiatric hospitals and geriatric institutions.

The situation with regard to the numbers with intellectual disabilities in psychiatric institutions was to get worse before it got better. The decade of the 1960s had heralded, for a short time, a period of unprecedented national economic growth, particularly when compared to the stagnation of the 1950s. The increased levels of prosperity and economic optimism led to a fifty per cent increase in the marriage figures from the 1920s, breaking the unique Irish pattern of late marriages. As couples married at a younger age, the birth rate also increased producing the ‘baby-boom’ of the 1960s. The Census of 1971 registered the first increase in the population of the twenty-six counties since partition. A significant decline in the numbers who emigrated from the 1970s, added to the figures.

Unfortunately, with the increase in the birth rate, came an almost equivalent increase in the numbers of infants born with a mental handicap. This trend was to continue for some years, for example, between 1981 and 2004.
and 1994 the number of people with intellectual disabilities increased by an estimated twenty-five per cent. In addition, due to the improvement in social conditions and better health care provision, life expectancy for those with even the severest of handicaps had increased significantly.

As the children of the 1960s began to get older the increased numbers drew attention to the severe lack of services. According to Anne Byrne, of the Brothers of Charity in Clarinbridge, Co. Galway writing in 1984:

One of the biggest areas of concern in the past decade has been the lack of services for the adult handicapped. Often there have been adults within the community where no services have been available to them growing up, and they are now presenting as unmanageable at home, showing signs of severe behavioural disturbance and many have been unable to cope with the area of self-care. In view of this there have been a number of requests for admission to residential care in order that very specialised help could be given to some of these adults to train them to cope. There is also a group of adults who have been in institutions since they were children and are now being discharged back home...and parents have been given no specific help or guidelines on how to cope with these young adults on their return home. In view of this there has been an urgent need of new and modern services to be made available to these adults. 105

Nevertheless numerous misconceptions regarding mental handicap continued to lead to the confinement of many in psychiatric institutions. The misleading notions, including the belief that mental handicap was either an illness which would require constant medical care and attention, or a psychiatric illness that required institutionalisation, still lingered in the national psyche. It is only in the last twenty years that individuals with a mental handicap finally began to be viewed as having difficulties which were socio-educational, rather than medical, thereby removing the perceived need for the incarceration of such persons. Consequently rigorous pressure was placed on the State by parent and carers support groups and voluntary organisations, to integrate those with a mental handicap to the fullest degree possible into a normal life.

In the NEHB area in 1993, St. John of God Brothers, based at St. Mary’s in Drumcar Co. Louth, provided the only residential accommodation available for those with a mental handicap. While St. Mary’s had almost four hundred places for children, many of these were now occupied by adults, who had grown up from childhood there, with no alternative placements they remained and thereby impeded turnover. As early as 1973, Dr. Patrick Quinn, as Acting Programme Manager in Community Care, carried out a comprehensive study of mentally handicapped in the area which demonstrated that one of the major problems for the service arose from the fact that places built and designed for children in institutions were now occupied by adults. This continued to be a major national problem at a time when the waiting lists for children and young adults in need of support services continued to grow.

The Board reviewed its services for those with a mental handicap and decided to implement a number of major policy initiatives to overcome these difficulties, the principal aim being the development and co-ordination of these services throughout the region. In 1988 three wards of St. Davnet’s Hospital were designated for use as residential accommodation for persons with learning disability and that resource with itsordination of these services throughout the region. In 1988 three wards of St. Davnet’s Hospital were designated for use as residential accommodation for persons with learning disability and that resource was to be the foundation of the Board’s own learning disability services. In the early 1990s several premises were purchased to provide group homes, workshop facilities, respite and day care centres. The NEHB Community Care Programme undertook budgetary responsibility for the residential services in 1993 and incorporated future development into the Board’s own five year plan for mental handicap services.

In 1971 the Minister for Health, Brendan Howlin, announced a total of £12.5m was being made available which would now become part of the on-going annual funding of these services. The NEHB received £955,000 which enabled the Board to enhance and develop the residential, respite, day care and home support services to its clients even further. Over the coming decade further developments continued to take place based on the Apartment of Health’s document: The Service to Person, with a Mental Handicap/Intellectual Disability. An Assessment of Needs 1997-2001. The continued transfer of those with a mental handicap inappropriately placed in psychiatric hospitals was further progressed. Measures were also taken to improve the co-ordination of training and sheltered workshop services, including assessment, placements and linkages with external agencies. 106

Although change was anticipated for all categories of clients since the 1970s, conditions within psychiatric hospitals remained critical for almost twenty years. National industrial action taken on behalf of psychiatric nurses by the ITGWU in March 1980 was due, the Union claimed, to:

Lack of real concern for psychiatric nurses and the psychiatric services is evidenced by the deplorably bad conditions, overcrowding, understaffing and a lack of elementary facilities which continues to be massively in evidence throughout the service. 107

In St. Brigid’s Hospital, while decor and facilities had improved somewhat, there remained over-crowding in a number of wards. The Visiting Team described St. Brigid’s as having beds which were placed in rows with less than eighteen inches apart. Dr. James Wilson, Resident Medical Superintendent, pointed out that the re-allocation of patients to other less crowded wards would not be possible, as the illness of the patient determined in which wards they would receive treatment and therapy. Not all patients were considered appropriate to provide a suitable mix of individuals. He also felt that the establishment of new wards was not practical, as there would be marked cost implications due to the number of additional staff this measure would require and no significant benefit to the patient would result. The move to community care services had to take priority 108.

An Solasan, Dundalk - residential unit for patients suffering from mental health

This policy began implementation as far back as 1977 when the first psychiatric Day Care Centre in Ireland, outside of the major urban areas, was established in Cavan Town at the residence of the late County Surgeon, Paddy Moloney. The Centre introduced a number of programmes including social skills training, relaxation therapy, occupational therapy, counselling services and meals. 109 Many of those who attended came from a ten mile radius of the Centre and were provided with transport where necessary. It was a pilot project and its success acted as a blueprint for the setting up of similar day care centres throughout the region.

To initiate further change the NEHB sought to implement Planning for the Future - The National Strategy for Mental Health published in 1984. This report helped to place service development in a strategic context. It described in detail the mechanisms for the phasing out of traditional mental hospitals and placed considerable emphasis on the relocation of acute units to General Hospitals. The new services were to be founded on principles that were patient-centred with the minimum use of in-patient beds. This would involve each patient having an individual care plan, with geriatric patients being cared for by the geriatric services, and those with a mental handicap by services appropriate to their needs. 110 The Board undertook to actively support community psychiatric nurses, out-patient clinics, day hospitals, group homes, and high, medium and low support hostels.
The financing of all projects by the NEHB was always going to be an issue in terms of the provision of these services throughout the 1980s in particular. While respective Ministers were in favour of change to community-based services and other major developments, it would have to be done within the financial restrictions placed on the health boards. For example in May 1986, P.W. Flanagan, Secretary at the Department of Health stated:

First of all let me make it clear that I am satisfied that in the medium term at least there will be no significant additional money made available to the health services in this or indeed in any other European country. Secondly the expectations of the disabled are high and rightly so...we are faced with both diverting resources from other health sectors for those who clearly fall within the responsibility of the Department and ensuring that the money is specifically available for the disabled is extended to the best advantage."

Accordingly in the NEHB region, if a community house was opened, then the money was taken directly from hospital budgets. All worthwhile changes had to be achieved by the planned relocation of resources from the existing service. There were nevertheless small but significant additional allocations made by the Department of Health in an effort to overcome the difficulties associated with the changeover from institutional to community care.

As this transition was slowly taking place, a psychiatric unit was established at the Cavan General Hospital in 1990. This move created some difficulties for the NEHB and a reworking of its recommendations. The Admissions Unit in Cavan was planned as a fifty bed facility to provide for all admissions from the Cavan/Monaghan area and a changing role lor St. Davnet's. However, opposition to the closure of the Admission Unit in Monaghan resulted in a twenty-five bed unit being provided for Cavan and the retention or a twenty-five bed unit in St. Davnet's Hospital for Monaghan. Nevertheless the new Cavan/Monaghan services initiated a research programme in 1991 to assess all aspects of service delivery and the care needs of patient groups within the region based upon local research and a review of the relevant models abroad.

One of the major findings that came to light was that fewer than five per cent of service users were accounting for twenty-four per cent of admissions and sixteen per cent of bed usage. The high levels of reliance were shown to come from the ten per cent of patients attending standard psychiatric outpatient clinics with inadequate follow up procedures. Dr. Phillip Sheeran-Purcell, Psychiatric Registrar at St. Brigid’s in 1994 described the following:

The traditional "specialist" clinic is a daunting prospect in location, format and ambiance. There is generally sombre architecture, the queue to the check-in, the "sizing up" of one's fellow patients and the departure of those in front of you, one by tedious one, into the inner sanctum and the heady relief of those exiting from the other side: all this is reminiscent of those far off days of first confession. To some extent this air of sacerdotal pomp is unavoidable and is part and parcel of any manifestation of our health service institutions; however while this may be merely a source of minor anticipatory anxiety in a general surgical clinic, it may, in the context of mental health, prove to be a major barrier to those most need help."

There were also difficulties for the majority of patients who were receiving treatment for psychiatric problems at primary care level. It was evident that while existing practices were making progress, there was a need for a multidisciplinary approach as general practice sought to interface with the psychiatric service.

The NEHB consequently introduced professional education programmes in both psychiatry and general practice that emphasised multidisciplinary working skills and service models. As part of a pilot scheme student placements were shown to come from the ten per cent of patients attending standard psychiatric outpatient clinics with inadequate follow up procedures. Dr. Phillip Sheeran-Purcell, Psychiatric Registrar at St. Brigid’s in 1994 described the following:

The traditional "specialist" clinic is a daunting prospect in location, format and ambiance. There is generally sombre architecture, the queue to the check-in, the "sizing up" of one's fellow patients and the departure of those in front of you, one by tedious one, into the inner sanctum and the heady relief of those exiting from the other side: all this is reminiscent of those far off days of first confession. To some extent this air of sacerdotal pomp is unavoidable and is part and parcel of any manifestation of our health service institutions; however while this may be merely a source of minor anticipatory anxiety in a general surgical clinic, it may, in the context of mental health, prove to be a major barrier to those most need help."

According to Dr. Phillip Sheeran-Purcell, there were many advantages to this arrangement. The general practitioner could learn the latest trends in treatment while the specialist would see aspects of the patient which were smothered in the more formal clinic setting. There was also less waste of time and opportunity as about one third of new attenders might default from psychiatric clinics but far less would do so from their family doctor. Most importantly, provision of services in the general practitioners surgery, with familiar associations and staff members removed the stigma felt by many, of going to the 'clinic'.

New services for the severely mentally ill commenced in 1998 when research drew attention to the high rates of re-admissions by a core group of 'revolving door', in some cases 'whirling door' patients, whose needs were obviously not being met. They were mainly those with a severe mental illness, a range of social and personal disadvantages, high rates of non-compliance and an apparent inability to survive within their communities. This category of patient included the remaining long-stay patients at St. Davnet’s, the discharged long-stay patients in staffed hostels or group homes and the new chronically ill, whether within the hospital or community.

Difficulties for those in the long-term category, many of whom were institutionalised following long periods of inpatient care, would need huge amounts of support if this cycle was to be broken. It was found therefore that it was preferable to have the focus of care and rehabilitation programmes lor the new chronically ill based in their homes, in an effort to avoid a repetition of this situation for another generation. This intention was the impetus for the establishment of the Monaghan Community Mental Health Team in September 1998 and the Cavan Community Mental Health Team in 1999. Their aim was to provide an integrated, comprehensive, individualised system of care and support which would meet the needs of people with acute mental health problems.

The functioning of Community Services was enhanced when the necessary nursing staff were appointed to new clinical teams. The important role of community based psychiatric nurses was one of the most notable features of this development as a home based acute nursing service provided an alternative to the use of admission beds. The availability of additional nursing staff was facilitated by the closure of two long-stay wards at St. Davnet’s in 1995 and 1998. The new service led in turn to the closure of yet another ward in 2000 as intensive community services became the norm.

Ultimately the success of community care was, to a very large extent, dependent on the agreement and active support of families, carers and the wider community. In addition it was dependent on input from the service user and their involvement and empowerment in terms of the level of service provided. Individual Care Programmes, to plan service provision based on specific needs, were introduced for the benefit of both service users and carers. It was viewed as essential that the carers were provided with the knowledge, skills and support necessary to assist them and to minimise the stress associated with their role. Without this the achievement of the objective of rehabilitation and recovery would meet with little success. The alternative to this level of inclusion was simply institutionalisation and isolation in a community setting and ultimately recurring admissions to acute units.
This model for a new community mental health service was the subject of a two day national conference organised by the Board in September, 2001. A monograph was produced for the conference setting out the background, service changes and evaluation of the new service - A Model for a New Community Mental Health Service, The Cavan Monaghan Project, 2001 - North Eastern Health Board. Subsequently other services within Ireland have adopted the model to reflect the growing momentum for radical change in the mental health services. The new circumstances created by the provision of community psychiatric services and rehabilitation programmes outside the confines of large mental hospitals is a substantial legacy for the NEHB to leave to the region. Walls and barriers have been removed, not only physically, but in relation to society's attitude to mental handicap and mental health. This is reflected in the acceptance by the wider communities in the north eastern region of those who would have, in the not so very distant past, been placed in the confines of major institutions. In 2000, admissions to St Davnet's Hospital from community mental health teams were reduced by forty-one per cent, while admissions to Cavan General Hospital from Cavan Community Teams were reduced by 42%.
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CHAPTER 4

AN HONOURABLE OLD AGE

The task of providing adequate care in the community for the old and compensating for services often previously provided in an institutional setting should not be underestimated. It will provide a major challenge to our Board and will tax the initiative, ability and resourcefulness of our Community Care Teams.

When the NEHB came into existence in 1971, it inherited a number of institutions for the care of the elderly. St. Mary’s Hospital, Castleblayney provided two hundred beds; Blessed Oliver Plunkett’s Hospital; Dundalk one hundred and eighty beds; St. Felim’s Hospital, Cavan three hundred and twenty beds; Hillstop Hospital, Dundalk forty beds; St. Joseph’s Hospital, Ardee fifty-five beds; St. Mary’s Hospital, Drogheda eighty-two beds; St. Joseph’s Hospital, Trim two hundred and forty beds and the Navan Infirmary, twenty-seven beds. These figures do not include those who were catered for in St. Davnet’s and St. Brigid’s Hospitals or those who were resident in Homes supplied by voluntary organisations. The latter included the St. Vincent de Paul Society who had a Home in Ballybay, Co. Monaghan with forty-one beds and the Sisters of the Sacred Heart who ran the Home for the Aged in Crones Co. Monaghan with twenty-eight beds. The number of placements demonstrates the large number of elderly in the region who were no longer, for many reasons, able to live independently or with their families.

The majority of institutions in the keeping of the Health Board were found to be in a wretched and often unsafe state and were therefore in need of major investments or total replacement. For example, Blessed Oliver Plunkett’s had long since outlived its usefulness, was in a deplorable condition and, for good reason, was known locally as ‘The Workhouse’. A local newspaper described it as a relic from the Dickensian era. St. Mary’s in Drogheda was a three storey building and was considered by Fire Officers as a potential fire hazard and as unsatisfactory long-stay accommodation by the Department of Health. St. Felim’s, which was built in 1941 under the Poor Law Act and had provided purely geriatric services since 1962, was acknowledged as unsuitable for the elderly in terms of the design of the building and large numbers being provided with residential placements in one location. St. Joseph’s Hospital in Ardee had been converted into a geriatric home in 1959, from a surgical and maternity unit with two huts for TB patients, and was in need of further renovation. Just as significantly, it is important to note that many were confined in these institutions simply because there were so few community or day-care facilities for the elderly, and even less supports for those who wished to remain living independently in their own homes.

This situation was to change nationally in the coming decades as the widespread acceptance of institutional care as an option for the elderly was replaced by an emphasis on the concept of community care. A governmental inter-departmental report published in 1973 entitled Programme for the Care of the Aged, recommended that every elderly person should be assisted to remain in their own home for as long as possible. The report suggested that this could be achieved if every effort was made to maintain and sustain such individuals in living independently. Members of the NEHB were also well aware that hospitals, welfare homes or other institutions were not a suitable or desirable substitute for appropriate housing and autonomous living. Nevertheless until replacements were provided, and sufficient community care became an active reality, the Board would continue to over-use its institutions. The main challenge facing the NEHB was that the paradigm change which was taking place in relation to the care of the elderly had to await the financial resources to bring its objectives to fruition.

Conversely it had to be acknowledged that, realistically, there would always be a call for institutional accommodation for the elderly ill and frail and so environmental changes needed to be made in existing facilities. Further independence, privacy and an increased quality of life had to be given to those who lived in long-stay institutions. Hence a programme of maintenance designed to improve, as far as possible, both the mechanical service and the internal appearance and decor of the buildings was initiated by the Board in 1972 and continued unceasingly for very many years.
Various fire officers’ reports were considered and the principal fire hazards were eliminated in Geriatric Units by the provision of fire doors, fire extinguishers etc.\textsuperscript{113} Despite these undertakings, the NEHB believed that it was hard to justify spending such large sums of money on such archaic facilities.\textsuperscript{114} The Board noted:

...old buildings in Dundalk, Drogheda and Cavan leave much to be desired and while the service provided to patients is as good as can be expected under the circumstances the long term usefulness of these buildings must be in serious doubt. The high fire risk is a continuing source of worry, and allied to this is the high maintenance cost without a corresponding long term improvement in the quality of buildings.\textsuperscript{115}

Following this evaluation it was arranged for the major institutions to be inspected by Senior Administrative and Technical Officers from the Department of Health. These officers visited three hospitals: St. Mary’s Hospital, Drogheda, St. Felim’s Hospital, Cavan and Blessed Oliver Plunkett’s Hospital, Dundalk and found serious problems related to each unit. Their reports demonstrated that considerable changes would have to be introduced to the hospital services for the elderly, over and above simple embellishment.

It was recognised that three distinct types of institutional care services were required for the future: Acute Hospital Care, Assessment and Rehabilitation Units and Welfare Homes. Geriatric Assessment Units would be specially equipped and staffed for the full assessment of patients who were not in need of acute treatment in a general hospital. Patients having been assessed and received rehabilitation treatment where necessary, could then be assigned either back to their own homes, to a Welfare Home if they were ambulant and could not return to their own home, or to a long-stay hospital unit if they were in need of continuous nursing care. It was envisaged that Welfare Homes would provide short term care for the elderly suffering from minor illness or were convalescing, and provide respite services to carers.

It is important to note that the affirmative attitude of the health board to the elderly is found in the fact that in November 1975 members discussed the unsuitability of using the title ‘Welfare Homes’ due to the inappropriate connotations in the word ‘welfare’. Therefore in the coming years names were chosen for each facility as they opened: for example Boyne View House, Drogheda and the Dr. Jack Sullivan Memorial Home, Cavan and Oriel House in Monaghan.

One of the first nationwide programmes in relation to independent living for the elderly came to the NEHB in serious doubt. The high fire risk is a continuing source of worry, and allied to this is the high maintenance cost without a corresponding long term improvement in the quality of buildings.\textsuperscript{119}

In the process of trying to transform services for the aged, the Board worked with County Medical Officers to estimate the needs of the elderly in each community. The NEHB unanimously adopted the report of its own Working Party based on this data on the 6th April 1974, entitled Housing for the Aged. The report recommended that the change of emphasis in the provision of services for the elderly could be achieved by a number of means: the provision of special housing and day-care facilities; the expansion of the Home Help service; the provision of income supplements and practical assistance with major problems of inadequate housing; development of a consultant based geriatric service supported by adequate community care services. The principal objectives of elderly care for the NEHB were outlined as follows:

...to sustain the elderly at home in independence, comfort and contentment, and when independence begins to wane to support them by all necessary means for as long as possible.\textsuperscript{120}

The NEHB was all too aware of the difficulties that lay ahead if such propositions were to be brought to completion:

The task of providing adequate care in the community for the old and compensating for services often previously provided in an institutional setting should not be underestimated. It will provide a major challenge to our Board and will tax the initiative, ability and resourcefulness of our Community Care Teams.\textsuperscript{121}

As with all other aspects of the health services, financial constraints were always going to be a problem and hinder the aspirations of the Board to provide better services. It was essential therefore that the NEHB set about achieving its aim by using every feasible resource available to it from other statutory agencies and voluntary organisations, if it was to meet with success. On voluntary input the report Housing for the Aged stated:

There is an increasing awareness of the important contribution being made by these [voluntary] services for the aged. The Board is appreciative of these services and wishes to assist in their expansion on as uniform basis as possible by provision of grants and by assistance by the Board’s officers.\textsuperscript{122}

Numerous voluntary organisations contributed to the care of the elderly including local Community Councils, Care of the Aged Associations, Social Services Councils, Rotary Clubs, the Knights of Malta and various units of the St. Vincent de Paul Society. O'Xamam House, at Mornington Co. Meath for example, which was administered by the Society of St. Vincent de Paul, was used as a holiday home for the elderly who were not in a position to provide a holiday for themselves out of their own resources. The Society catered for individuals, married couples and family units. A very large number of those who benefited from holidays at Mornington were from the north-east area and groups from the Board’s long-stay institutions also benefited from this service. Therefore the NEHB made a considerable contribution to the project.

In October, 1979, the Sisters of Mercy offered to provide facilities for the elderly by establishing a Day Centre in Kells. The nuns proposed renovating the old girls school to cater for the elderly in the town and surrounding areas and naming it the Catherine McAuley Day Centre. The Board agreed to lease the property and pay for operational costs.

As the quantity and quality of housing for the elderly played a considerable role in the ability of any individual to remain at home, regardless of health or family circumstances, the Board made housing its highest priority. There were three separate areas that created different problems in relation to housing the aged. The requirements of the elderly who lived in isolated rural areas were inherently distinct from those encountered in villages and smaller towns, and both groups differed from the needs of those in large urban areas. In isolated areas elderly people were often living in substandard housing, which dated back, over one hundred years, to a period when the British Government built cottages for rural labourers. As the costs of renovating or rebuilding such properties were prohibitive for the NEHB, the provision of a mobile home was at times the only practical answer for those who wished to remain in their familiar surroundings.\textsuperscript{123}
Regardless of the number of major programmes introduced for the elderly, the NEHB in October 1985 acknowledged that the aspirations of the Board for the care of the aged remained notably short of its target. There existed to be a significant over-provision of extended nursing care beds, which was caused mainly by the shortage of alternative community based accommodation and shortages in terms of early intervention, increased assessment and rehabilitation and greater domiciliary supports. On a more positive note there was substantial progress made towards solving the problem of unsatisfactory geriatric hospital buildings. The old Blessed Oliver Plunkett’s Hospital and Hilltop Hospital were replaced by a hospital in Dundalk. The numbers of beds in St. Felim’s Hospital were reduced significantly thereby eliminating some of the chronic overcrowding and improving the work load for nursing staff, while adding significantly to the comfort of the patients. The phased transfer of services from St. Mary’s Hospital Drogheda to the Louth Cottage Hospital had commenced.

A valuable contribution to the quality of life for the elderly living in defective conditions throughout the country came as a result of the Government scheme entitled Special Housing Aid for the Elderly-1982. This programme was to be used to improve conditions for the aged living in unfit or unsanitary housing accommodation. The National Task Force on Housing Aid for the Elderly, under the Chairmanship of Ger Connolly TD, Minister of State at the Department of the Environment, had been allocated £1m by the Government and its allocation to the NEHB was £130,000. The scheme was to be dispensed either by the use of trainees from FAS, Ireland's National Training and Employment Authority, the direct employment of builders by the health boards or a payment of grants to applicants. Pat Clarke set up an ad hoc group to implement the project in the region, which would include officers from the relevant Housing Authorities and a representative from each of the voluntary organisations involved in the care of the elderly.29 This project enabled many housing improvements to be completed throughout the coming years.

In an effort to keep administration requirements at a minimum, applications for the upgrading of homes were made to the local offices of the Health Board by a client or, on their behalf, by a relative, a public health nurse, general practitioner, social worker or voluntary organisation. Almost anyone could approach the Board on behalf of the elderly. Environmental Health Officers carried out an examination of the house to determine the extent and type of work required. The Board operated the service as economically as possible, by providing for the cost of materials, but using labour supplied by FAS and so allowing as many as possible benefit from the programme.28 In the two years between 1992 and 1994 there was a seventy per cent increase in the amount allocated to the project. By the end of 1994 the number of jobs completed throughout the region in that period was a total of five hundred and fifty with expenditure in excess of £265,000. “1 Unfortunately, as the economy grew and the building industry expanded greatly, the scheme became increasingly difficult to operate. Over time more expensive and unsuitable methods would have to be applied.

The building in villages of sheltered housing schemes of three to six houses had many advantages, overcoming the principal problems of loneliness and isolation due to the convenience of churches and other community facilities. In larger towns the need to avoid the creation of ghettos was stressed, and it was generally agreed that the provision of units of twelve to twenty dwellings was most desirable. In villages and towns the capacity of statutory and voluntary organisations to provide important services such as medical, nursing and meals-on-wheels also increased. The inclusion of a Warden Service, financed by the Health Board, would thereby allow individuals and couples to remain independent for as long as possible, while retaining the freedom to come and go as they pleased. Sheltered housing would also provide a secure environment.

The success or failure of this policy depended on working closely in the planning and development of these projects with those who could contribute to the building programme for the region.27 The NEHB thus approached Urban District Councils, County Councils, Town Commissioners and Corporations asking them to provide such housing schemes. Following discussions with Monaghan County Council on this matter, Carrickmacross was chosen as the site for the initial scheme.28 The Local Authority built thirty houses for the elderly on the Cloghvalley site and the Board as an integral part of the service provided the Day Centre for the Aged. The Housing for the Aged report, had recommended the provision of Day Care facilities in association with suitable housing developments undertaken by the Housing Authorities. In addition to providing a social amenity for the residents of the houses, the Day Centre was operated by Carrickmacross Social Services Council and catered for the elderly from the surrounding area. Over the coming decades such arrangements in various areas were to become the norm.

By the late 1980s the network of Day Care Centres had increased with new services in Ardee, Ballybay, Blacklion, Clontibret, Drogheda and Enniskillen joining similar services operated from St. Mary’s Hospital, Castleblayney, St. Joseph’s Hospital, Trim and Oozanam House, Mornington. Patients selected for day services were collected from their homes and brought to the Centre where they were provided with a meal. Chiroprody, hairdressing and ophthalmic services and medical care were also arranged. The Board held that while the provision of day care facilities was not an end in itself, it did however make a noteworthy contribution to maintaining the elderly in their homes for a longer period and with better health.

The movement from long-term institutional care and the medical advances which offered better health and the significantly increased life expectancy for many, led to the recognition of the need for active social inclusion of the aged. Age and Opportunity, a National Organisation with core funding from the Department of Health, was thus established in 1988. Its goal was to enable and encourage older people to participate fully in the community and to create opportunities for them to use their skills and talents to the common good. The agency set out to change negative attitudes towards ageing. The range of activities involved were broad, reflecting the diversity of concerns, experience and abilities of older people. It worked in co-operation with local and national organisations, voluntary and statutory agencies. Consequently the NEHB was actively involved in Age and Opportunity since its inception. By 1996 there were three Co-ordinators for the agency in the NEHB region who instigated a number of relevant projects throughout the year. These included informaton seminars and conferences, holidays abroad, fashion shows, art and crafts exhibitions and variety concerts. There were six such groups in Cavan/Monaghan area alone.29

A significant government report was published in 1998 entitled The Year, Ahead—the Report of the Working Party on Health and Welfare Service, for the Elderly. Minister Rory O’Hanlon stated that he wanted the health boards to concentrate on the development of domiciliary services and community facilities. This report emphasised that the objective of health services for older people should be to support them in dignity and independence at home and to support those caring for them. It was viewed as a blueprint for the development of services for the aged.

In response to the government’s report, the NEHB made a number of significant recommendations, which it felt would have to be implemented if it was to become more than aspirational. The Board determined that

Opening of Gardens in St. Joseph’s Hospital, Trim, Co. Meath

History of the North Eastern Health Board

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additional resources from acute hospitals should be directed towards community based geriatric care, as the elderly accounted for more than twenty-five per cent of hospital admissions, with a considerably greater proportion of admissions being made to medical rather than surgical wards. Consequently liaison between hospital services and the community services was regarded as being of prime importance in the identification, treatment and return to the community of those patients who were clinically discharged.

It was estimated that at least twelve additional public health nurses were required to achieve the staffing ratio recommended in The Ten Year Ahead and to permit the important liaison work between the hospital and community services. The NEHB region was unique in that it was the only area without a consultant geriatrician, a matter which had been vigorously pursued with the Department of Health over many years. Taking Our Lady’s Hospital, Navan, as an example, as it housed the regional orthopaedic unit, a major part of the hospital’s workload involved dealing with the elderly, particularly with regard to hip replacements. The association of a geriatrician with an orthopaedic surgeon and a consultant in psychiatry, who had special responsibility for the development of old age psychiatry services, would mean a considerable rise in the level of care and support available to elderly patients. Therefore the Board requested the immediate appointment of a Consultant Geriatrician in each community care area. It also requested the appointment of a number of additional Public Health Nurses, Community Officers and a Co-ordinator of Services for the Elderly in each Community Care area. The members agreed that Community Care Areas should be sub-divided into districts with District Care Teams and the appointment of a District Liaison Nurse to each team was considered essential.

Other recommendations included the expansion of paramedical services; chiropody, physiotherapy and occupational therapy and an improved throughput of hip and knee replacements be maintained and a reduction of waiting time for the removal of cataracts. In addition the development of existing long-stay hospitals as community hospitals providing an extended range of services including convalescent care, respite care and hospice supports. Many of these proposals slowly became a reality.

By the end of 1989 the NEHB area was divided into three Community Care Areas: Cavan/Monaghan Community Care Area with a population of 13,970 in the over sixty-five age group; Louth Community Care Area with 9,100; and Meath Community Care Area with 8,738, a total population of 31,853. These areas were sub-divided into Districts. Relatives continued to be the most important and most numerous carers of the elderly and relied heavily on support from Community Care Teams in terms of the Public Health Nurses, Home Help services, whose numbers had increased, respite care and general practitioners still provided primary medical care.

The Programme for Economic and Social Progress, published in 1992, gave renewed impetus to all health boards for the development of services for the elderly. The Programme provided for an additional capital investment of £100m at 1990 prices, and annual expenditure of £90m in real terms on the development of community based and associated services. The Minister for Health, Dr. John O’Connell, advised the Board that the hospital’s workload involved dealing with the elderly, particularly with regard to hip replacements. The association of a geriatrician with an orthopaedic surgeon and a consultant in psychiatry, who had special responsibility for the development of old age psychiatry services, would mean a considerable rise in the level of care and support available to elderly patients. Therefore the Board requested the immediate appointment of a Consultant Geriatrician in each community care area. It also requested the appointment of a number of additional Public Health Nurses, Community Officers and a Co-ordinator of Services for the Elderly in each Community Care area. The members agreed that Community Care Areas should be sub-divided into districts with District Care Teams and the appointment of a District Liaison Nurse to each team was considered essential.

It was fitting that the NEHB should review its services in 1993 as it was designated European Year of Older People and of Solidarity Between Generations. The Board identified the need for a more responsive service, which would deal more effectively with the needs of individual clients, general practitioners and the community at large. It acknowledged that the lack of sufficient Day Hospital Services was a major gap in the provision of care for the elderly. Day Hospitals would facilitate diagnosis, assessment, treatment and rehabilitation services. They would also provide support services including the service of consultants, general practitioners, paramedical staff, occupational therapists, speech therapists and social workers. A proposal for the provision of a day hospital was incorporated in the brief for the Dunshaughlin Health Care Unit. Non-consultant day hospital services were introduced in St. Felim’s, Cavan, St. Mary’s, Castleblayney, St. Oliver’s, Dundalk, the Cottage Hospital, Drogheada and St. Joseph’s Hospital, Trim. These services continued to expand with the addition of consultant led day hospital services being provided at acute hospital sites and at the Health Care Units in Dunshaughlin and Virginia. These developments were helped, in 1996, by the appointment of two consultant geriatricians in the region, who would provide essential assessment, treatment and rehabilitation services for the elderly.

Examining services provided in 1996, the 25th anniversary of the founding of the NEHB, demonstrate the changes which have taken place in institutional care facilities from those outlined at the beginning of this chapter. St. Felim’s Hospital in Cavan, St. Joseph’s Hospital in Trim, St. Mary’s Hospital in Castleblayney, St. Oliver Plunkett’s Hospital in Dundalk and many of the other smaller units, including those attached to acute hospitals, had significantly decreased numbers of long-stay patients. Of those who were placed in residential units, between thirty-five and seventy percent were over eighty-five years of age. No unit was strictly residential as they introduced a team-based approach to provide a comprehensive range of services including Day Hospital/Day Care, respite and convalescent care. Protocols for the care of patients were developed between the acute hospitals, mental health, general practice and other community services. Within the next five years a new Health Centre was built in Virginia Co Cavan and it housed the remaining patients from St Felim’s.
Community services have become the norm; they include Home Support Services, Public Health Nursing, Special Housing Aid, Palliative Care with community based social workers, physiotherapist and occupational therapist services. As the numbers of those over retirement age continue to increase, at present 11.4%, 34,812 individuals in the north eastern region are over sixty-five years; and the number of those over seventy-five continues to increase due to the advances in medical care. In 2001 the NEHB had already developed a five year strategy for the provision of appropriate services for the elderly entitled Healthy Ageing - A Secure Future. According to the present CEO, Paul Robinson:

It is important to adopt a more comprehensive vision of aging by taking a holistic approach to the provision of health and social services for older people while promoting a positive image and awareness of aging and older life. This strategy aims to provide a comprehensive range of services necessary to support older people enjoy healthy ageing in appropriate and secure environments of their own choice.10

The NEHB continued to be aware that the development of appropriate services remained one of the major challenges facing it. These would include an increase and development of all of the aspects of the services mentioned in this chapter; particularly in relation to assessment and rehabilitation, the expansion of community based services and a significant increase in the link between community services and hospital services. The reshaping of services for the elderly achieved and envisioned by the NEHB will continue to play a major role in contributing to the quality of life for future generations of the elderly.

REFERENCES

118 Minutes of the meeting of the NEHB 21st April 1975. Blessed Oliver Plunkett's Hospital had a Fire Precaution Notice issued in January 1975 by the Dundalk Urban District Council, based on the requirements made in three separate Chief Fire Officers Reports: August 1965, May 1971 and June 1973. The Order required that the situation be remedied within 180 days.

119 The NEHB spent over £50,000 in the five years to 1977, on structural work and redecoration in Blessed Oliver Plunkett's Hospital alone. The Board continued to be concerned with the fire hazard in their existing facilities. By 1991 they had spent over £250,000 on fire precautionary work at St Mary's Hospital, Drogheda.

120 Minutes of the meeting of the NEHB July 1976.

121 Dr Jack Sullivan was a well known and respected Cavan GP.

122 Minutes of the meeting of the NEHB 16 June 1975.

123 Report Housing for the Aged April 1974.

124 Report Housing for the Aged April 1974.

125 Housing for the Aged April 1974.

130 The NEHB was at the forefront nationally in involving FAS in the operation of this scheme.
CHAPTER 5

A PERILOUS IMPASSE

...if the basic aims of ensuring safe delivery and giving the infant the best chance of optimal health and normal development are to be best achieved, every expectant mother should have ready access to care at a consultant-staffed obstetric/neonatal unit. Comhairle na nOspideal 1973.

The provision of maternity services in the north east region was arguably one of the most controversial and demanding dilemmas faced by the members and management of the NEHB. The controversies began within four weeks of the Board taking over responsibility for the health services and continued until it ceased to exist. The issues that arose for the Board in relation to the provision of maternity services were similar to those regarding acute hospitals, psychiatric, elderly and disability services. On the 29th April 1971, an impromptu meeting took place in Cavan town when over two hundred women came to voice their anxiety regarding the total lack of vital facilities at the Maternity Unit in St. Joseph's Hospital, Lisdarn. The women had every right to voice their concerns. The Chairperson of the Committee for Obstetric/Gynaecological Services was Kathleen Young; she addressed the meeting and described in detail the inadequacy of services. At that time patients requiring a caesarean section were transported, 'at tremendous risk to themselves and their unborn babies', to the local surgical hospital, after which the mother and baby were again subject to this harrowing ride with all its attendant risks back to the maternity unit. This was because the surgical hospital could not accommodate post-operative caesarean patients.

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The proposed transformations led to additional serious difficulties for the Board. A conflict arose immediately between those who wished to have obstetric facilities within reach of local communities and those who wished to see a minimum number of regional services in high technology units. The latter proposal resulted in much opposition and animosity for many years and in some cases has taken decades to accomplish. The NEHB tried to reach a compromise between the two diametrically opposite sides, by the provision of quality obstetric services in the majority of main hospitals throughout the region.

There were 5020 live births in the north east area in 1973: Our Lady of Lourdes Hospital 2484, St. Joseph's Hospital, Cavan 773, Monaghan Hospital 544, Louth County Hospital Dundalk 501, Drogheda Cottage Hospital 500 and Trim Hospital, Co. Meath 218. The conditions in most of the maternity units were such that they required either upgrading or complete closure. The 1970s over-crowding at the maternity unit in Our Lady of Lourdes, one of the biggest units in the country, was a cause of complete dissatisfaction. Members were aware that nursing staff were working under impossible conditions and the lack of support services was also causing concern. At the other end of the scale, the unit in Trim was described as totally inadequate both from a structural and service availability viewpoints. Patients had to be transferred to the Coombe Hospital in Dublin if an emergency arose, and yearly the number of births was decreasing but the number of transfers rising.

It was imperative that the NEHB began the process of modifying the maternity services throughout the region, based on the recommendations of the Department of Health and Comhairle na nOspideal. A huge involvement of existing small maternity units, which were no longer considered viable and an amalgamation of the remaining services was considered. As already demonstrated in the case of acute hospital services, one of the most difficult problems for any health board was the closure of a hospital. To close down a maternity hospital or maternity unit was particularly challenging. As expected therefore the NEHB’s proposal to discontinue the maternity services in Trim, the unit with the lowest number of births and most basic facilities, resulted in major resistance over many years.
Lengthy discussions on the Judgement and its implications led the Board to submit further applications to Comhairle na nOspideal for the approval of a second obstetrician/gynaecologist and a second anaesthetist for Monaghan in an effort to advance the service.\(^1\)

The Cavan/Monaghan area was not the only cause of concern for members in relation to the provision of maternity services in the region. The Board requested funds for the appointment of an obstetrician/gynaecologist at the Louth County Hospital Dundalk and approval to allow locum cover until such time as the appointment was made. The Consultant, Dr. Kidney wished to relinquish some of the load that was involved in providing the services with very limited medical supports. The objective of the NEHB was to provide a full obstetric/gynaecological and paediatric service at the Louth County Hospital. Anything short of this was considered to be totally unacceptable as it would only be a stopgap measure, which could be lapsed or significantly altered at any time in the future.

Knowing from experience that it would take some time to receive a reply, the NEHB felt that it had no alternative other than to proceed with a temporary appointment, as it was its statutory duty to provide safe and adequate services. Pat Clarke therefore placed an advertisement for a temporary consultant obstetrician/gynaecologist for the hospital in Dundalk with the full support of the Board. In renewing the request for formal approval for the appointment, Pat Clarke stated that he regretted it had been considered necessary to proceed without the approval of Comhairle na nOspideal and more particularly without the sanction and agreement of the Department of Health. However, on the 16th May 1983 the Minister directed that no further steps should be taken to fill this post until the position regarding funding had been clarified, agreed with the Department of Health and approved by Comhairle na nOspideal. The creation of an additional post of obstetrician/gynaecologist, with a major commitment to the provision of services at the Louth County Hospital, now seemed unlikely and another way would have to be found.

Representatives of the NEHB for that reason met with senior officials from the Department of Health in Dundalk and discussed in great detail the issues surrounding this particular service and facilities at the hospital were fully examined. The representatives also met with the Management of Our Lady of Lourdes Hospital accompanied by the officials from the Department. It was made clear to the hospital management that the only viable course of action for the Board was to have a consultant based in Dundalk but attached to the staff of the International Missionary Training Hospital. By the end of the year agreement was reached between all parties concerned in relation to the provision of maternity services at Louth County Hospital. An adequate level of neo-natal and paediatric services was provided in the context of these arrangements. The obstetrician/gynaecologist from the Lourdes Hospital would in fact cover the unit in Dundalk, and while this had some disadvantages it nonetheless offered the patients the opportunity to avail of a consultant based service.

This was not an end to the matter in terms of the provision of maternity service in this area. There had been an underutilisation of facilities in the maternity unit at Trim for many years as patients tended to go to Drogheda or Newry for their confinements in the face of inadequate support services, but the appointment of Dr. Fallon, who had resigned as obstetrician/gynaecologist at Cavan in 1984 and had taken up the appointment at the Louth County Hospital, was to introduce disparities.\(^1\) By 1986, the hospital saw an increase of over fifty per cent in the number of deliveries at a time when over the previous five years the birth rate had declined by twenty per cent. Various deficiencies in accommodation for patients in terms of overcrowding and a lack of services and staff at the unit needed urgent attention. Consequently a request was made to the Department of Health for additional funding for the hospital and the matter of re-designating lour to six beds from another unit also received careful consideration.

In 1987 the foundation stone was laid for a new maternity unit in Drogheda. At the same time the preliminary calculations on the number of hospital beds which would be required in the area, based on the current population and birth-rate trends, demonstrated that the Board had a considerable excess in bed numbers and figures indicated that two obstetric units would suffice for the area in the future. Cavan General Hospital and Our Lady of Lourdes were the recommended locations and the future of Monaghan and Louth County Hospital again became uncertain.
Nonetheless from the mid 1990s a more flexible approach was taken to the provision of antenatal and postnatal care across the region. Obstetric and gynaecology out-patient services and day surgery commenced in Navan with the recruitment of a shared consultant between the International Missionary Training Hospital and the Board. Protocols and procedures were put in place to provide services to mothers who chose to have a home birth. There were formidable challenges for the Board in attempting to develop and improve its maternity services in the context of ensuring the required medical and nursing practices, while responding to the right of women to choose their maternity services.

A consultative process in the NEHB culminated with the publication of a report entitled Report of Expert Advisory Group on Women’s Health Lamej in 1985. This report made it clear that the public expected the Health and the Board. Protocols and procedures were put in place to provide services to mothers who chose to have a home birth. There were formidable challenges for the Board in attempting to develop and improve its maternity services in the context of ensuring the required medical and nursing practices, while responding to the right of women to choose their maternity services.

A special meeting of the NEHB was held on the 5th February 2001 at which the following motion was passed:

That in order to avoid the temporary suspension of maternity services at Monaghan General and Dundalk and to seek additional approval for the immediate appointment of onsite paediatric cover at both hospitals.

As a result the Board sought Comhairle na nOspideal for the necessary temporary consultant posts. This was not to be the case as Comhairle deferred making any decision until the recommendations of its own report were considered. At the same time the Minister for Health, Micheal Martin, wrote to the NEHB stating that:

A serious and urgent issue has now arisen with regard to patient safety in maternity service delivery units in Monaghan and Dundalk. As you are aware, the levels of staffing, support services and facilities required to attain best practice at maternity delivery units have risen dramatically in recent years with the objective of securing the safety of newborn babies and their mothers. In particular, single handed obstetric units are no longer regarded as safe, because competent and qualified clinicians must always be available at the delivery of babies.

The Minister, his Department and Comhairle na nOspideal were of a similar mind in relation to the future of maternity services nationally and locally. The situation was to deteriorate further following correspondence from the Irish Public Bodies Mutual Insurances Ltd. at the end of February 2001. The letter indicated to the Board that in respect of Monaghan and Dundalk Hospitals it was withdrawing Indemnity Cover for maternity services unless appropriate measures were implemented in the immediate future. This decision led to the Board being obliged to temporarily suspend maternity services at both the Monaghan Hospital and Louth County Hospital.

Subsequent to the suspension of these maternity services on the 1st March, 2001, a re-configuration of maternity services occurred within the NEHB region. The twenty bed Maternity Unit was transferred from the Monaghan General Hospital to Cavan General Hospital creating a joint service for the Cavan/Monaghan area. Monaghan Hospital maintained out-patient obstetric/gynaecological clinics. The thirteenth bed maternity unit was transferred from the Louth County Hospital to Our Lady of Lourdes. Mearth patients used either Our Lady of Lourdes or Dublin Hospitals.

The Board had agreed the formation of a further independent review group on the 26th February, 2001, under the Chairmanship of Patrick Kinder who was formerly CEO at the Eastern Health and Social Services Board, Northern Ireland. The Kinder Report stated that all women in the NEHB must have access to a women centred quality service which is safe, accessible and sustainable. In agreement with the Condon Report, Kinder suggested units providing various levels of care from one to three, the first being a midwife led unit, and the latter providing the highest standards of consultant and technological services. The Lourdes would be given category three status and become the regional centre for maternity services with a Regional Intensive Care Unit. It also suggested that the NEHB region should be self-sufficient as far as possible by offering a comprehensive range of services. As a result of its findings a total complement of nine consultant obstetricians/gynaecologists and ten consultant paediatricians was considered as a basic requirement for the region. During the consultative process favourable and opposing views on midwifery led services were expressed to the Review Group. As a result the matter was given careful consideration involving extensive enquiries on existing services, the views of representative, midwives and review of relevant Irish nursing policy.

As a result a recommendation was made that midwifery led units should be established in the first instances as integrated units within Cavan General Hospital and Our Lady of Lourdes Hospital, Drogheda while the phased opening of units at Dundalk and Monaghan. It was further proposed that a midwifery led unit should be established at Navan Hospital as soon as judged to be necessary. The Board adopted the Kinder Report and launched a Task Force in early 2002 to implement its recommendations.

Work commenced to establish midwifery led services on a pilot basis in the context of a Research trial. Hospital accommodation has been refurbished to provide purpose designed accommodation. These services commenced on July 5th 2004 at Cavan General Hospital and Our Lady of Lourdes Hospital, Drogheda.
To date women are being provided with Antenatal Care, with births due to take place in December in both sites.

In 2001 Comhairle na nOspídeal established a committee to review maternity and related services in the NEHB area. During the Committee's consultation process with the NEHB it was drawn to Comhairle's attention that an increase in birth rates had been experienced recently due to the growing population in the region and the location of refugees/asylum seekers particularly near Drogheda. Nevertheless it had to be admitted that a significant proportion of mothers resident in the NEHB area gave birth in hospitals outside the region i.e. twenty-one percent in Dublin hospitals.

Comhairle na nOspídeal issued the Report of Committee Reviewing /Maternity and Related Serviced in the NEHB Area in July 2003. It described a trend of rationalisation that began in 1966 when there were one hundred and thirty-two maternity hospitals in the Republic of Ireland and only forty per cent of the total number of births took place in units with over 1000 births per annum. By 1982 there were seventy-three hospitals with maternity units and by 1993 there were thirty-nine hospitals with maternity units and ninety-five per cent of births took place in units with over 1000 births per annum. Better public health and medical advances, particularly in obstetrical and neonatal care, greatly reduced the infant mortality rates, from thirty per 1000 in the 1960s to six per 1000 in 1996.

In keeping with this trend the report recommended Our Lady of Lourdes as the maternity centre for the Louth/Meath Hospital Group and Cavan General Hospital as the maternity centre for the Cavan/Monaghan Hospital Group, based on the number of live births in 2002 of 1280 at the Lourdes and 1300 in Cavan. The committee advised that all babies should be delivered in these units where there is access to consultant provided twenty-four hour obstetric, paediatric and anaesthetic cover and midwifery staff. Having reviewed international literature and assessed professional advice from all of the bodies consulted, the committee was of the opinion that there was no evidence to support the establishment of midwife led maternity units in Dundalk or Monaghan as outlined in the Kinder Report. It maintained that instead an integrated model of maternity care should be provided to ensure that outreach consultants provide outpatient maternity, gynaecology and paediatric services to women and children in the Monaghan and Dundalk catchment areas.

Following the publication of three comprehensive reports in as many years the NEHB was left with two Maternity Units at Cavan General Hospital and Our Lady of Lourdes Hospital and huge public opposition to the closure of the other two units at Monaghan and Dundalk. A High Court Action was taken by four women in July 2004, who were requesting a Judicial Review of the Health Board's right to close the maternity unit in Monaghan and the return of services to their local hospital. The women had a huge amount of support from many quarters within the local community and from SIPTU which also called on the Minister for Health to restore services at Monaghan. Counsel for the Board, Gerard Hogan, maintained that there were too few births in Monaghan to secure consultant cover. This perilous impasse remains a matter to be resolved by those who have taken over the provision of health services in the north east region.
REFERENCES

1. Letter to Barry Segrave CEO from Kathleen Young, Chairman of Committee for Obstetric/Gynaecological Services for Cavan. 3rd May 1971
3. Our Lady of Lourdes Hospital was founded in 1939 and a 12 bed maternity unit was opened in 1944 when it was registered as a Midwifery Training School.
8. Letter from the Minister for Health to Pat Clarke CEO. 20th Jan 1983.
9. Minutes of the meeting of the NEHB. 21st Jan 1985
10. Minutes of the meeting of the NEHB. 21st Jan 1985
11. Minutes of the meeting of the NEHB. 21st Jan 1985
12. Minutes of the meeting of the NEHB. 21st Jan 1985
15. NEiB North East Hospitals - The Next Five Years, pp 20-21.

CHAPTER 6

THE YOUNGER GENERATION

There is currently a growing public debate about children, about their care, behaviour and aspirations and about what the future holds for them. There is increasing recognition of the richness and complexity of their lives and how that can impact both positively and negatively on the lives of others. There is an acknowledgement of past failures in meeting children's needs and the continued existence of barriers which inhibit some children from realising their full potential. There is a recognition that present challenges and past mistakes must be faced openly so that further progress can be made.

National Children's Strategy - Our Children Their Lives, 2000

The history of the development of health and social services to children in Ireland is inextricably linked with the cultural, economic, social and political history of the state. It was dominated by the constitutional primacy of the family unit and the cultural beliefs that children belonged to their parents and that state intervention only resulted when it was deemed that there was a failure of parents to provide moral and regulatory control. The Department of Education by the 1950s funded and regulated fifty-two industrial schools: thirty for girls of six to twelve years; ten for senior boys of ten to sixteen years; six for junior boys of two to ten years and three reformatories, two for girls and one lor boys.1-4 The history of many of these institutions, particularly industrial schools and reformatories, has been relatively well documented in recent years.5-8

In response to the growing criticism of industrial schools in the 1960s, the Government appointed a committee to enquire into the system which was presided over by District Justice Eileen Kennedy. The Kennedy Report of 1970 was the first of many to point the way towards today's preference for family and family based community care that are geared towards the prevention of family breakdown. It recommended the total abolition of the institutional system and its replacement by group homes with a strong rehabilitation focus.

In 1951 Meath County Council, in keeping with the national approach, had bought the Good Shepard facility in Dunboyne, for young expectant unmarried mothers. However this was to come to an end as the Status of Children Act 1987 removed discrimination in law between children born within or outside of marriage and gave each child the same succession rights. It was also no longer considered a crime to be expecting a baby and so demand for such institutional services fell. From 1990 the numbers of young unmarried mothers attending the service had declined significantly, even though numbers were not restricted to those from the north eastern region. The building reverted to the Board when it was vacated in 1991.

The Daughters of Charity,15 who were based in Drogheda, who had previously administered an industrial school at St. Vincent's, adapted to the changing patterns of child care during the 1970s and replaced the institutional facilities with family type accommodation. In 1974 the Sisters provided a hostel for older boys at Val Halla, Drogheda as a step towards them leaving residential care. Many of these boys, who had been institutionalised as children, were desperately in need of this level of support. As this particular requirement lessened over the next four years, Val Halla became a group home to cater for eight children.

In the same period the old industrial school became St Vincent's Children's Services in Drogheda for adolescents in the twelve to eighteen age group. This provided services appropriate to the needs of youth with serious behavioural problems.16 Two houses in the Priory, West Court, a relatively new housing estate were purchased by the Daughters of Charity at the end of 1990 and adapted as a group home with seven children in each, ranging in age from eight to fifteen years. As groups became smaller, children attended local schools, and remained as far as possible a part of the local community. On the 25th October, 1995, the Daughters of Charity withdrew, and their Children's Residential Services in Drogheda became part of the NEHB Child Care Services. All of the existing staff of the service became employees of the Health Board as it became an integral part of its Child Care Programme.16-17

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At the time of the publication of the Kennedy Report the NEHB fostered approximately one hundred children with families throughout the region. However members were concerned that fifty four children were still being maintained in approved schools and institutions, sometimes outside of the region. Consequently a list of children in the latter category was issued to each County Medical Officer, with a view to determine whether or not they could be fostered by relatives or other suitable families. Foster parents received a payment to contribute towards maintenance, clothing, etc., but as the allowance varied from county to county, it was both increased and regionalised in an effort to make the service more acceptable. There was some success following these measures and the position of fostered children continued to be critically reviewed by an official of the Board.

The NEHB pursued the policy that when young people had to come into the care of the state, in the first instance an alternative home would be sought with relatives of the child and failing that a foster home placement would be sought. A small number of young people continued to need care in residential settings and the Board’s policy was to develop units that were maintained as close as possible to ordinary living conditions, based in local communities close to families and friends. As with other elements of the Board’s Child Care Services, the residential services were administered in close co-operation with other agencies including local schools and the Gardaí.

Despite regular requests being made to the Department of Health for sufficient resources to provide community based services and more suitable residential places, it would be a number of years before any radical changes were to take place as funding remained in short supply.

The community care team structure in Health Boards was developed out of the Mc Kinsey report, Towards Better Health Care: Management in the Health Boards, (1971) commissioned by the Tanaiste and Minister for Health, Erskine Childers, T.D. in 1970. This envisaged a horizontally integrated approach to service delivery by the full range of community based services. The managers of those services were to be co-ordinated in the community care team under the direction of the Director of Community Care and Medical Officer of Health. Mc Kinsey described the purpose of the ‘Care of Children Sub-programme’ being:

To care for children in the community roughly between the ages of 6 weeks and 16 years. It will include the school health service, immunisations, general medical services, including identification of emotional disturbance, dental, ophthalmic and oral services, care of ‘problem children and care of handicapped children in the community’.

At the beginning of the process in terms of basic community services, in 1982 the Department of Health agreed to allocate the sum of £20,000 for pre-school facilities. The available funds did not allow the Board to meet the costs of the operation of these services, but only to supplement the resources of voluntary organisations managing such centres. The Minister for Health, Barry Desmond, asked that priority be given to groups who were concerned mainly with supporting deprived families. Grants were therefore given to those organisations managing such centres. The Minister for Health, Barry Desmond, asked that priority be given to those organisations managing such centres. The Minister for Health, Barry Desmond, asked that priority be given to those organisations managing such centres.

The Minister has now decided to allocate some of this year’s development funds for the purpose of helping young people leaving such long term residential care, so that a smooth transition to adult life might take place. In the period from the mid 1980s many families were experiencing major social, economic, cultural and demographic changes at a time when community services were being developed. According to Dr. Ambrose McLoughlin, Deputy CEO:

These changes are registered in rising separation rates, fall in marriage rates, increase in the numbers of children born outside marriage either to women on their own or co-habiting couples, and rising recorded rates of domestic violence against women, and violence against children. There are an increased number of lone parent families, composed of separated, divorced and widowed parents, as well as unmarried mothers, parents of prisoners or those in long term institutional care.

As a result of these trends, the requirements of children were escalating and becoming ever more complex. New legislation was introduced to protect children in terms of their legal rights and safety from neglect or abuse. These included the Status of Children Act 1987, the Adoption Act 1988, the Adoption Act 1991 and most importantly, the Child Care Act of 1991. The challenge for the NEHB was to provide for children and their families in need of support while attempting to enact the significant legislative changes.

A milestone in the development of Child Care Services in the NEHB region occurred as a result of the Child Care Act of 1991. The implications of the Act introduced an exigent era in the provision of child care services in Ireland. The level of assistance that the health boards were expected to provide moved far beyond medical, surgical, dental, vaccinations and all manner of paediatric services:

1. It imposes statutory duty on the health boards to promote the welfare of any child in the community who is not receiving adequate care and protection.
2. It grants the health boards new powers to provide child care and family support services.
3. It gives health boards statutory responsibilities for homeless children.
4. It introduces new legal procedures to enable the health boards and the Gardaí to intervene where children are being neglected or abused.
5. It upgrades the grounds on which children may be placed in care by the Courts.
6. It introduces new legal controls on pre-school services for children.
7. It modernises the statutory framework for the regulation of children’s residential centres.

According to Pat Clarke, its implementation would necessitate extra and better trained staff, new and improved residential and community facilities, and the development of imaginative responses to the many complex problems that exist in the provision of support to vulnerable children. The reality was that the health board did not have adequate resources given the likely expansion of the numbers of children who would now come to its attention. A sustained programme of capital investment and substantial extra resources for child care services were required. Over a third of the population of the north east consisted of children and young people to nineteen years of age, all of whom would come into contact with the health services at some-point in their lives from birth to adulthood.

The Board’s first Child Care Advisory Committee was established in 1992 to counsel the health board on the performance of its functions under the legislation. It spent a considerable amount of time reviewing the
existing services and recommending major changes which needed to be introduced over the following three to five years. The review highlighted major gaps in current service provision by confirming that there was sizeable variation in availability and accessibility to child care between areas.

Dr. McLoughlin presented a report on the Development of Child Care Services 1992-1994, which was in keeping with the recommendations of the Child Care Advisory Committee. The report placed strong emphasis on support for the family and the further development of existing community based services. The NEHB’s development of services consequently took cognisance of the demographic trends within the region and targeted requirements in appropriate geographical locations. For example, over the coming years larger towns were provided with a comprehensive range of services, centrally located and easily accessible, developed in partnership with community and voluntary organisations. The smaller urban centres were given a broad range of childcare services which were also locally developed. Particular attention was paid to children who lived in isolated rural areas and so required a different type of service delivery in order to meet their needs.

The Board was granted an additional £800,000 in 1994 as a result of the Child Care Action Plan introduced by Minister Brendan Howlin. It had three objectives:

1. To ensure that the sections of the Child Care Act currently in force were being properly operated, particularly in relation to the provision of services to homeless children and youngsters in the 16-18 year age group.
2. To enable health boards to prepare for the new statutory responsibilities to be conferred on them during 1995, e.g. new court procedures, supervision orders, new access arrangements, development of preventative services.
3. To improve arrangements for monitoring children in residential child care in anticipation of the recommendations of the Working Group on residential care...

National initiatives which resulted from this plan included the expansion of services for homeless children including extra hostels and other units; the establishment of new family resource centres and other community support projects to assist disadvantaged families; the further development of pre-school services in areas of social deprivation; support for foster care and other family placement services; increased financial support for women’s refuges and provision of additional places and services for victims of family violence. The individual health boards were asked by the Minister to expedite the putting in place of these advances.

The NEHB unanimously welcomed the developments outlined in the Action Plan for its region and three important capital projects were completed in this period: the Regional Child and Family Services Centre in Drogheda, the Child and Family Centre in Our Lady’s Hospital Navan and the Child and Family Centre in Dundalk. A wide range of services, whether on an individual or multi-disciplinary basis, were provided by psychiatrists, psychologists, social workers, counsellors, community based nurses and a Child Abuse Validation Team. This was assisted by twenty-five additional posts in the areas of family supports and child protection. The number of child care social workers in the region rose from seventeen in 1991 to thirty-five in 1994, including three new supervisory posts of Social Work Team Leaders.

Family Support Services were directly provided by many levels of community based staff from the mid 1990s. General practitioners, in addition to providing medical services, contributed to the Board’s child care training programme, the development of its child protection guidelines and information services. Child Protection Courses were also incorporated into general practitioners training programmes in the region. Public health nurses began to extend their role in terms of prevention, early detection of major difficulties within families and referrals when children were at risk. They became increasingly involved in the delivery of Primary Prevention Services and developing community based projects.

Under its 1993 Child Care Development Plan, Child Care Workers were employed by the NEHB in the community for the first time. They were part of the social work team and were expected to work intensively with families in their own homes. Family Support Workers, who had experience either raising their own families or in some form of day care or child care setting were also used to provide assistance to parents. The NEHB was among the first of the health boards to have this programme in place and used in tandem with other projects and voluntary groups it was highly successful. It is interesting to note that of those discharged from care in 1993, nationally 31% were reunited with their families; in sharp contrast, in the north east region over 81% were reunited with their families.

Following the establishment of the Board’s Child Placement Service in 1992, significant developments took place in the recruitment, assessment and training of foster parents in the region. This was viewed by the Board as a vital development as the vast majority of children cared for by the NEHB at this time were placed with foster families i.e. of the two hundred and ninety children in its care, two hundred and thirty were in foster care. In line with the Foster Care Regulations introduced by Austin Currie, Minister of State at the Department of Health, in 1995 specific training and on-going support was given to those willing to assist children who would benefit from a more intensive placement than that offered in a normal foster placement.

For those unwilling or unable to stay with their own or foster families, short-term flexible accommodation for homeless youth in the main urban centres of the region was initiated and an ‘on the street’ outreach service was aimed at those at risk. It was important that placing children in bed and breakfast accommodation, which was still used as a last resort, was superseded by alternative arrangements. There was a large number of statutory and voluntary organisations providing services in the region for young people; these included generic-youth services such as youth clubs, Foroige, the National Youth Development Organisation, and other voluntary projects. Statutory services included the probation and welfare service and the Garda juvenile liaison scheme.

One major gap in the provision of services was that there were no services provided for seriously disturbed children or those with psychiatric illnesses in the north east. This was despite the fact that Dr. John Owens had been pressing for the provision of a child psychiatric service for the region since 1983. Requests were made by the Board on a regular basis to the Department of Health for the next ten years in an effort to secure adequate funding for the scheme. A major breakthrough came when financial support was finally granted as the Child and Family Centre in Drogheda incorporated the Board’s Child Psychiatry and Child Placement Services. A Consultant Psychiatrist was appointed with additional clinical staff consisting of a senior psychologist and three social workers. After initial consultations over a period with all the services involved with children in the area, referrals were accepted by the Child Psychiatric Services from the 1st March, 1993. A second Consultant Child Psychiatrist was appointed in the mid 1990s and a third in 2000. Multi-disciplinary consultant led teams were developed in each of the local community care areas and provided assessment and treatment services to children from 0-16yrs.

Out-patient child psychiatric clinics were held in Counties Cavan, Monaghan and Meath. These included assessment and treatment, consultation service to the health care professional, paediatric liaison and consultation to the paediatric units, training of primary care professionals to deal with common disorders and preventative initiatives at primary and secondary levels. The Community Services Committee endorsed the emphasis placed on a community based response to children and adolescence with psychiatric problems.
Whether within the traditional institutions, in modern facilities or the home, one of the most important responsibilities for any agency involved in child care is the protection of children from abuse. In May, 1993, the Kilkenny Incest Inquiry Report highlighted the problem of child abuse and family violence in Irish society and made recommendations for improvements in services and procedures in order to protect children at risk. In 1994, the NEHB undertook a major initiative by producing a standardised Child Protection Guidelines Manual for the north east region. This was the first manual of its type and was both a pilot project and a developmental model for child protection services in the north east region and in the country as a whole. The guidelines were produced after consultation with agencies and professionals involved in the field of child protection throughout the region. It was followed by the measures required for the implementation of these guidelines.

A Child Abuse Prevention Team was established and a comprehensive training programme for NEHB staff and those from other relevant agencies was introduced. Specific training modules were developed for key child care agencies including the Garda, general practitioners, schools and voluntary organisations. In 1994, a working group of officers from the NEHB and the two Garda Divisions in the region was set up with a wide brief to look at working relationships between the two organisations and to develop standardised working protocols in relation to child care and child protection. Members of the Garda were also involved at senior management level and each Garda Division appointed a liaison officer to the health board to assist in these developments.176

Primary prevention measures were introduced to reduce the risk to children and support the functioning of the family. As a way to achieve this, the Board actively supported the Stay Safe Programme which was developed in the course of a two year pilot programme by representatives of the INTO in association with the Departments of Health and Education. The Programme was a teaching package which aimed to prevent child abuse by equipping parents and teachers with the knowledge and skills necessary to protect children in their care. It was introduced to Primary Schools in 1991-92 and was aimed at eight to twelve year olds. A suitably trained social worker, supported by a teacher who had a wide experience of the special needs of the primary school system, was enlisted to implement the Stay Safe Programme. Agreement was sought from local schools management of the three hundred and thirty national schools in the region. In addition it was believed that pre-school playgroups could help reduce the risk of abuse to children and raise parents’ standards of care.

Secondary Protection Services were sub-divided into three categories: Child Protection Services, Supplementary Services to Family Care and Alternative Services to Family Care. Secondary prevention addressed problems where they had actually arisen and sought to reduce their impact; the goal was to resolve the crisis in the life of the child. Interdisciplinary and interagency co-operation was viewed as central to the proper management of cases. Public health nurses, general practitioners and School Development Clinics provided an important child surveillance and abuse identification system.

Having identified the need for an increase in services to victims of domestic violence, the Board engaged in a close co-operative process with the Women’s Aid Committee, a voluntary organisation, to develop appropriate services in Dundalk. Until this time the only Women’s Aid organisation in the north east region was Meath Women’s Aid based in Navan. In 1994, the same Women’s Aid Committee, with the assistance of the Board, opened an office in the town to provide a help-line and appropriate counselling services. Increased funding enabled them to expand practical supports, including counselling and advisory services and refuge accommodation for women and children.180 These services were viewed by the Board as a model of best practice which needed to be repeated in other large towns in the region. During 1997, the Board provided funding to allow the Federation of Women’s Refuges to establish the post of Co-ordinator of Services and established an interagency co-ordinating committee to enhance the integration of services to victims of domestic violence.181 Within two years there were four refuges in the region bringing the total number of places to fifty.

The last decade (1994-2004) has seen an unprecedented level of investment, development and change in the planning and delivery of services to children and families in the Board. Again, these were underpinned by the substantial increases in the statutory responsibilities placed on the Board by the Child Care Act (1991). It was incrementally implemented by 1995 and supported by a suite of regulations to be followed latterly by National Standards of practice. Additional legislation included the Children Act, 2001, the Mental Health Act, 2001, Protection for Persons Reporting Child Abuse Act, 1998, Sex Offenders Act, 2001, Ombudsman for Children Act, 2002, Freedom of Information Act, 1997 & 2003, Data Protection Act, 2003, and the Domestic Violence Act, 1996. The Social Services Inspectorate (SSI) was established in 1999 and began its work in 2000. It was given an immediate statutory function of inspecting Health Board residential homes. All of the five residential care units in the NEHB were inspected by the SSI in 2002. Overall the SSI indicated that many of the standards were met and they found evidence of commitment to providing a quality service to children in care and examples of care staff working conscientiously to support young people and families.

In addition to increased statutory responsibilities, this period saw a significant increase in the number of national policies, guidelines, strategies, and reports which all influenced the direction and delivery of services.

In May 1996, the Board put forward a submission to Austin Currie, entitled Putting Children First - A Discussion Document on Mandatory Reporting of Child Abuse. It set out in detail the initiatives which the Minister intended to undertake with a view to improving the responsiveness of child care services to the needs of children.182 It was prepared by Dr. Ambrose McLoughlin and reflected the outcome of extensive consultations which took place with the Board’s Child Care Staff and Child Care Advisory Committee.

Children First: National Guidelines for the Protection and Welfare of Children 1999 was one of the most significant developments in the area of national guidance. The Board undertook an incremental work plan, underpinned with service plan targets to progress the implementation of the guidelines. These included the strengthening of social work services, the standardisation of the child protection process and the development of the multi-disciplinary training team to support and prepare staff to meet their additional responsibilities. Further developments included the establishment of an information and advice post in each area and the development of the Child Notification System. This progress was accompanied by the development of a supervision policy document, the development of a protocol for child protection conferences, and guidelines for file management. As a greater awareness of child abuse grew, the capacity of the Board to respond and provide services increased. The number of cases reported increased significantly. Numbers rose from 156 in 1989 to 1,500 in 1998.183 During 2000 additional key frontline staffs were appointed in each community care area to further enhance multi-disciplinary child care services.

A Regional Director of Child Care Services was put in place in 1997 to lead and give direction to the planning, quality assurance and monitoring needed to give effect to the new statutory responsibilities. In addition significant changes were made in the overall management of child care services with the appointment of child care managers in each of the community care areas in 1998 with responsibility for management of the processes of delivery of services to children and families. In addition considerable investment was made in developing social work, psychology, child care worker and allied professional departments with increased management structures to enable them to meet the legislative responsibilities. In the five years between 2000
and 2004, there was a 116% increase in the budgetary funding available to child care, from 16,312,240 in 2000 to 35,266,155 in 2004. Much of this increase went to support additional staffing (over 154 additional staff), increases in allowances for foster care services, the delivery of improved residential care services, the development of new services for children and families and the increase in grants to voluntary agencies to deliver a range of new services to vulnerable children and families, in partnership with the Board.

The Board also commissioned a number of significant reviews of its services - A Review of Residential Care Services 2000, a Review of Foster Care Services, 2002 and a Review of the Child Protection Case Conference Protocol, 2003. It also commissioned two significant research pieces into the area of child neglect, which represents almost 50% of all child abuse referrals, to learn about its practice and ensure that planning was based on evidence. Two major reports were produced, Chile

Alongside this were important developments in family support services, both within the Board and delivered by the non-statutory sector in partnership with the Board. These developments were seen as vital to balancing the intervention and crisis work with equally robust preventative and early intervention services. In 1998, funding was received for the development of two community based family support services as part of the National Springboard Family support programme. One of these projects was based in Mulehevenmore, Dundalk and the second in Navan, Co. Meath. Following participation in a National outcome evaluation project these two projects were mainstreamed in 2002.

The Board carried out an extensive review of existing child health services from birth to twelve year old age group in the year 2000. A document entitled Best Health for Children was produced in an effort to set the way forward for child health services. The underpinning of this was the importance of the role of the parent, supported by professional expertise and the need to promote children’s health and to prevent ill health. A similar review of services to be provided lor thirteen to eighteen year olds was undertaken and was made available in 2001.

The Board established the RIAN Counselling Service in 2000 to provide counselling for adults living in the NEHB area who had experienced abuse in their childhood, including those adults who had been abused within institutions and worked in conjunction with the Commission to Inquire into Child Abuse. It also acknowledged the impact on family members and partners and children of those who have been abused and seeks to provide support and counselling for the family members of those who avail of the counselling services.

Launch of Rian Counselling Services

Great concern was expressed nationally in the mid '90's about the safety of women and children and about violence against women being a serious and widespread problem in society. Eithne Fitzgerald, Minister of State at the office of the Tanaiste established a task force to review service needs service provision and service standards and they produced a Report, ‘Violence against Women’ in 1997. Arising out of this report each of the health boards were given lead responsibility to established a Regional Planning Committee for Violence Against Women. The North East Committee was established in May, 1997, whose main purpose was to build a partnership among relevant statutory and voluntary agencies in the North East, to achieve a co-ordinated proactive and effective approach to the issue of violence against women. A strong partnership between the statutory and Non Governmental Organisations sector was established with an ambitious strategy and work plan to increase services and to provide a more effective and co-ordinated approach to service delivery. In 2002, it commissioned a research project to map and evaluate the effectiveness of existing services in the North East. The report, Changing Direction, was launched in 2004 along with a detailed action plan to implement its recommendations.

Despite the recent commitment to rebalance investment in preventative and family support services, progress delivering on that agenda has been slow and needs considerable investment and focus. The numbers of referrals in relation to child abuse and neglect while they have levelled off in the last four years, still remain high. In addition, with over 400 children in the care of the Board, considerable resources are invested in the acute side of the service. Meeting the needs of the small number of very vulnerable and needy adolescents continued to challenge the Board. With the additional statutory responsibilities placed on the Board by the Children Act, 2001, the Act aims to divert children away from the juvenile justice system, into the care system. For the first time the link between a child’s offending behaviour and his/her care needs is recognised in legislation. The Board has a responsibility to provide a range of placement options, including high support and access to secure care for these very vulnerable children.

As part of the development of a continuum of services a High Support Facility, Rath na nOg was developed for young people who experienced severe difficulties with existing placements in residential or foster care. The NEHB entered into a partnership with the North Western Health Board, Western Health Board and Midland Health Board to develop this joint high support facility. A suitable site was located in Castleblaney, Co Monaghan, a purpose built centre was developed and the unit became operational in September 2002.

Rath na nOg consists of two six-bed, mixed gender units. Children who are admitted to Rath na nOg require a specific level of therapeutic and educational intervention and support to enable them to attain their full potential over an agreed period of admission.
In conclusion, the history of health and social services to children and families has been one of inheriting a historical legacy of services to very vulnerable children, mainly to children in the care of the state, when the health board was established in 1971. There was very little investment in services to children in the 1980s despite the increase in demand from vulnerable families resulting from major social, economic and cultural changes at that time. Community care services were established and services to children were part of the generic community care services provided, where available. Major changes and developments in the 1990s continued into the new millennium as a result of the increased statutory responsibilities placed on Boards by legislation and regulations. This drove the development of services for children and families in crisis and at risk of abuse or neglect without an equivalent development of family support and early intervention and universal health and welfare services to all children and families. The adoption by Ireland of the UN convention on the Rights of the Child (ratified in 1992) gave a strong focus to children’s basic human rights. This influence is reflected in The National Children’s Strategy, Our Children Their Lives, published in 2000 which emphasised a child-centred approach, giving children a voice and developing a whole-child perspective, set out an excellent strategic vision for children services into the future. This vision was further developed and customized for children and families in the North East with the publication of Leaps and Bounds: A Strategy for Children and Families in the North East, 2004. It provides a framework for ensuring that the lives of all children and young people in the region are improved and commits itself to modern, high quality, child centred services.
REFERENCES

158 p., example the TV Documentaries ‘Dear Daughter’ with Christine Buckley and ‘States of Fear’ and the publication Suffer Little Children. The Story of Ireland’s Industrial Schools by Mary Raftery and Eoin O’Sullivan and Paddy Doyle’s The God Squad.

159 The Daughters of Charity arrived in Drogheda in 1855, when they provided an evening school for girls from the local factories and made visits to the poor.


161 Financial Statements and Service Plans. NEHB February 1996.

162 Minutes of the meeting of the NEHB. 19th Nov. 1973.

163 Minutes of the meeting of the NEHB 19th April 1982.

164 Minutes of the meeting of the NEHB Pat Clarke CEO Report. 15th July 1985


166 Child Care Act. 1991 pt II section 3 (i).


171 Minutes of the meeting of the NEHB. Pat Clarke CEO Report. 28th March 1994.


174 Austin Currie was appointed as Minister of State at the Department of Health with specific responsibility for overseeing and coordinating the implementation of the Child Care Act 1991.


176 Early onset schizophrenia, depression, behavioral and personality disorders, eating disorders, reactive behaviors etc are a reality for some children.

177 Minutes Visiting Committee to St Davnet’s Hospital 5th Nov. 1990.


184 The word RIAN is an Irish word, meaning path, ‘trace’ or mark..
Community Care Services were advanced by changes which had taken place throughout the 1990s. Community Medicine and Public Health - the Future, published in 1990 at the request of the Minister for Health, Dr. Rory O’Hanlon, was very clear in its findings in relation to this:

Acute hospitals and their role in health care are being affected by various changes including new medical technology, cost containment policies and changes in the financing of hospital care. This has given rise to the need for new service delivery strategies and new strategies of care where the acute hospital is not the centre of the system but functions as one component of a closely co-ordinated range of services in a total health system. The acute hospital of the future is likely to be highly specialised and closely linked to the rest of the health system based on the principles of primary health care, where treatment will be delivered at the lowest level of complexity. It is clear that unless hospitals accept a partnership role and function in an integrated way with other services in the community a fragmented local health system will persist.1,8

There was a lot of work to do if these aspirations were to become a reality. In 1991, the NEHB had established a Sub-Committee to examine in depth the services which the Board was currently providing. The terms of reference for the Committee included: to review of the adequacy of the current services, to consider all resources available to the Board were being used effectively and efficiently, to indicate new services or changes to existing services considered necessary to provide adequate services and to make recommendations regarding optimum timetable and methods to bring about strategic changes.10

The NEHB was made aware that any effective changes in community care would have to begin with primary health care, which included health promotion, disease prevention, curative medicine and rehabilitation. It was clear that general practitioners provided a key ingredient in primary health care and the growth of general practice was viewed as essential for the expansion of primary care services. Most importantly, these developments needed to include integration into the pre-hospital care service and close linkages with hospital services.

This was a huge undertaking for the NEHB. According to Donal O Shea as CEO, there were serious difficulties in bringing general practitioners and hospital doctors/consultants together to implement agreed therapeutic regimes.11 It was essential for the Health Board to encourage and facilitate the maximum possible level of co-operation between hospital based consultants and pharmacists and general practitioners and community based pharmacists. This had already proved effective to a large extent in other aspects of the health care, outside of acute hospital services. For example, joint service development between consultants and general practitioners in mental health, the care of the elderly and child care were already well underway.

In order to make these transformations possible in the NEHB region, a number of events had to take place, based on the key role of general practitioners in primary health care. Firstly, just as it was no longer acceptable to have a single handed physician or surgeon working in isolation in local hospitals, there had to be a move away from single general practice units to joint shared practices. It was also essential that services were accessible and made available twenty-four hours a day. The Board planned to begin with the introduction of multi-centred group practices which would involve a minimum of three doctors working in full partnership and providing cross-cover in a district. It was envisaged that while each would have their own centre of practice, the group would have one central medical centre which would make equipment and facilities available to all colleagues. A facility for practice nurses and secretaries, together with access to specialist advice and support to general practitioners on the selection and introduction of computerised patient record systems, thereby improving the efficiency of the service, advising on the employment of practice support staff, information on the improvement of practice premises and the development of a new medical card system which would provide general practitioners with up-to-date and accurate information on their panel of patients.

Additionally, the General Practice Unit was effective in addressing areas of quality prescribing, by offering information on generic prescribing, cost comparisons and the options open in relation to the effectiveness of various treatment regimes. These programmes of support and education were aimed at extending the services provided by general practitioners. In 1997, the General Practice Unit changed its name to the Primary Care Unit to acknowledge the Board’s awareness of the importance of other professional groups in the delivery of primary care.12 It was all too clear that there was more to primary health care than just general practice. Health and social care professionals, i.e. nurses, midwives, dieticians, psychologists, occupational therapists, physiotherapists, social workers, speech therapists, etc., each had particular skills to bring to primary care. They needed to work together as a team in a location that was accessible to local communities.

Substantial advances at this time included a multi-General Practice Centre which was established in Navan with paramedical services including chiropody, physiotherapy and speech therapy. A minor surgery programme was organised by the Meath College of General Practitioners and the instruction of doctors in the area of palliative care. These programmes of support and education were aimed at extending the services provided by general practitioners.

The National Health Strategy of 1994 confirmed the Department of Health’s commitment to the development of General Practice. It published a strategy document which identified organisational problems in the health services and the steps to be taken to develop the service were set out in an action plan covering the period 1994-97. In its action plan, it stated that the ‘General Practitioner Service will be better organised and supported in fulfilling a wider and more integrated role in the Health Care System’. The NEHB held that the proposed developments would advance the progress of the general practitioner service in the region as the numbers of those involved in the scheme were significant.13 In 1994, the region had one hundred and twenty agreement was reached between the Department of Health and the Irish Medical Organisation, based on the Programme for Economic Progress 1991. The contract allowed for significant adjustments in the provision of scheduled general practitioner services, in terms of out-of-hours services.

The full commitment of all parties to the future development of general practice was further outlined in the Blueprint Document for the Future of General Practice in Ireland, published in 1993 which included Guidelines for the Establishment of General Practice Units in the Health Board and on an Indicative Drug Target Scheme.16 Under the latter scheme, fifty per cent of savings were made available to general practitioners to directly invest in the improvement of their practice, with the approval of the Health Board. The remaining fifty per cent of the savings achieved were used by the Board to fund the overall development of general practices in the region. It was agreed that the level of prescribing could be reduced without having an adverse effect on the quality of patient care.

The Blueprint document was to prove to be a major breakthrough in the expansion of primary care services. It gave considerable incentives to doctors to become involved as the Health Board endeavoured to move away from an unwarranted reliance on hospital services. The document indicated that priority should be given by General Practice Units to improving arrangements at local level, in particular the active promotion of amalgamations, groups and co-operative type schedules between general practitioners.

This was to prove to be a major breakthrough in the expansion of primary care services as it gave considerable incentives to doctors to become involved as the Health Board endeavoured to move away from an unwarranted reliance on hospital services. To oversee this expansion, a NEHB General Practice Unit was set up in March 1993 and was staffed by three general practitioners, one pharmacist and administrative staff who had a common commitment to a progressive future for general practice. The Unit immediately introduced a number of initiatives to encourage closer working arrangements between single handed practitioners and the establishment of informal group practices to provide improved cover arrangements between practitioners and advice and support to general practitioners on the selection and introduction of computerised patient record systems, thereby improving the efficiency of the service, advising on the employment of practice support staff, information on the improvement of practice premises and the development of a new medical card system which would provide general practitioners with up-to-date and accurate information on their panel of patients.

1 History of the North Eastern Health Board
2 192
3 193
4 1971 -2004

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two doctors and ninety two pharmacists providing services under the GMS Scheme to 123,892 eligible people, almost 40% of the population. Nationally almost 36% of the population were eligible for services under the GMS Scheme. Agreement was reached between the Department of Health and the Irish Medical Organisation in 1997/98, which allowed for major adjustments in the provision of scheduled general practitioner services, in terms of out-of-hours services. The level of integration and the essential development of a twenty four hour general practice was expanded in 1999 following the first general practice co-operative established in Ireland.

CAREDOC, Doctor on Call was set up by the South Eastern Health Board. It provided out-of-hours general practitioner services in Carlow and the surrounding area. By 2001 it had extended to Kilkenny and South Tipperary. The second pilot project co-operative was launched by the NEHB in September 2000. NEDOC: North East Doctor-On-Call. Its role was to improve the provision of out-of-hours services to the population, whether under the GMS Scheme or to private patients. The partnership between the NEHB and general practitioners in the region was subsidised by an additional allocation of funding from the Department of Health and the GMS (Payments) Board.

This was a new co-operative approach to providing out-of-hours general practice services. Patients presently continue to be given access to the service through an extensively published low cost telephone number and calls are connected to a central communications based in the grounds of St. Brigid’s Hospital in Ardee. Triage is provided centrally from Ardee at peak periods. The triage doctor provides advice or arranges for the patient to be seen by a doctor in a Primary Care Centre or through a home visit. Alternatively, in the event of an acute emergency requiring hospital attendance, the ambulance central headquarters is directly contacted. The Primary Care Centres in the region include Cavan, Castleblayney, Drogheda and Navan. The general practitioners based in each or the primary care centres also provide triage duty after midnight.

Eight fully equipped cars are supplied to transport general practitioners to home visits, local primary care centres and respond to requests to assist the ambulance service. The fleet of the NEDOC cars is monitored centrally in Ardee by way of a vehicle tracking system. The vehicles are equipped with a defibrillator, resuscitation equipment, oxygen, nebulisers and suturing kits. These cars transport general practitioners on duty in each of the four centres to satellite clinics, home visits or to the scene of an accident at the request of ambulance control.

Within a year of this co-operative system being introduced, eighty per cent of general practitioners in the region were members and sixty-five additional staff were employed by the NEHB including nurses, drivers and other support staff. Pharmacists assist in the operation of the service by providing an out-of-hours directory and an on-call rota system for pharmaceutical emergencies. NEDOC is provided on a whole population basis other than to patients of general practitioners in Dundalk and Monaghan who opted not to join the co-operative.

NEDOC is provided on a whole population basis other than to patients of general practitioners in Dundalk and Monaghan who opted not to join the co-operative. Many general practitioners in areas of North County Dublin within the Northern Area Health Board have opted to provide out-of-hours cover in partnership with NEDOC. It also arranges for services to be provided at the request of the Gardaí in accordance with the schedules as set out by the Department of Justice and Law Reform. To date, over 250,000 episodes of care have been provided by North East Doctor-on-Call.

A cardiovascular initiative in Primary Care was launched by the CEO in June 2000. The Regional Cardiovascular Implementation Committee allocated funding to support a 1. Secondary Prevention Programme within General Practice
2. Compliance / Medication Review Initiative with Community Pharmacists.

It was recognised that structured care in the community, following a cardiovascular event would greatly benefit patients. General Practitioners, who satisfied certain criteria, were encouraged to enrol patients who had suffered either a heart attack or heart surgery, in a structured care programme within the practice. Patients were offered regular reviews where their blood pressure and cholesterol levels were routinely monitored with appropriate lifestyle advice provided. Practice Nurses were an integral feature of the initiative. Intensive Training for General Practitioners and Practice Nurses was provided. The NEHB Public Health Department was involved in evaluating the initiative which was a forerunner for the National Campaign ‘Heart Watch’.

Pharmacists’ involvement within the NEHB Cardiovascular Initiative in Primary Care focused on three areas

1. Compliance: ‘Building Healthier Hearts’ the Cardiovascular Strategy had recognised ‘Non-compliance’ to medication prescribed as a contributing risk factor to coronary heart disease.
2. Identification of patients who may be suitable for aspirin.
3. Lifestyle advice and reinforcement of lifestyle messages received in other settings.

The North Eastern Health Board was the only Health Board to enrol its community pharmacists in a structured manner as part of the Cardiovascular Strategy Rollout nationally. The Pharmacy Compliance Initiative was co-funded by the Health Research Board and reported in the HRB report ‘A Picture of Health’, published in 2003.

The NEHB commenced development of a Primary Care Extranet or Web Portal project during 2002. The main aims of the project were to provide the capability to:

- Provide Healthcare information securely to Primary Care Practitioners in the NEHB region. This information may originate within the Health Board itself such as in hospitals run by the NEHB. Examples of this information include laboratory, radiology and GP Out of Hours results.
- Provide Primary Care Practitioners in the NEHB with access to a secure e-mail service and also secure access to the Internet. This facilitates the secure flow of information both between Primary Care Practitioners and also between Primary and Secondary care. Some examples would include information such as referral and discharge information.
- Provide Primary Care Practitioners with access to Hospital booking information relevant to Primary Care as part of the DAS (Direct Access Surgery) initiative.

Approx 50,000 results will be made available electronically for GPs during 2004 via the extranet web portal.

The NEHB rolled out a New Immunisation/Accentration project in early 2003. This system was developed in conjunction with key users from Primary Care, Public Health, General Practice, Community Care and Public Health Nursing.

The system provides for the capability to administer, track and report on all vaccination schemes such as Primary Childhood Immunisation, Booster, MENC, Influenza and BCG in a generic fashion. It also records child health information captured via birth notifications and information gathered by the PUN on first visit to the mother following discharge from the hospital. The NEHB was the lead development board but developed the system in partnership with the NWHB and MWHB based on a specification and project scope developed
History of the North Eastern Health Board

initially by the NEHB.

Primary Care Services developed a number of new initiatives in 2003: the NEHB 24 hour Information Line, a specimen collection service and a central storage and vaccine distribution service. These three initiatives all address a number of the key principles and recommendations contained in the Health Strategy - Quality and Fairness and also the Primary Care Strategy.

The first initiative was the development of a 24 Hour Information Line 1850 24 1850. This low call number which acts as a one stop shop enables members of the public to access information from a central location regarding the wide and varied health and social services provided by the Board. It is the first of its kind to be implemented in the country and it is supported by a comprehensive computerised data base which contains information on over 150 topics. A number of health promotion initiatives have been undertaken since the commencement of the service to make available health promotion literature and advice during targeted health promotion periods, e.g. Smoking Cessation, Continence Awareness Week, Breast Cancer Awareness Month. The Information Line has also proved to be a valuable resource to the Board in dealing with certain issues and unforeseen circumstances.

Declan Breathnach, Chairman, NEHB tries out the new Information line watched by (L-R) Anne Marie Hoey, Director Primary Care, Paul Robinson, CEO, NEHB, Geraldine Charman, Operator and Geraldine Kane, Manager at the Launch of the NEHB 24 Hour Information Line and Transport Service held in St- Brigid's Hospital, Ardee.

A specimen collection service was implemented in 2003. This service was implemented to further enhance the integration between primary care and secondary care. Laboratory samples are collected on a twice weekly basis from GP practices and are transported to the five acute hospitals in the region. This has resulted in a major quality of life gain lor the public who in the past may have had to travel long distances for a test that can be more appropriately provided in the primary care setting. Patients can now get many samples taken at general practice level, obviating the need tor them to travel to their nearest hospital. The implementation of this service also addresses the Carriage of Dangerous Goods by Road Act 2001.

A central storage and distribution sen ice for vaccines was developed in 2003. Vaccines are transported to GPs am other Health Board Immunisation providers each Friday in dedicated temperature controlled vehicles. Centralising the storage and distribution centre for vaccines has improved the overall organisational structures, policies, procedures and best practice measures to ensure the provision of a quality service to the public. It has also improved recording systems for batch numbers, thereby leading to a comprehensive system of traceability when the system is used in conjunction with the Primary Care Immunisation Claim System.

A significant year for the development of the community services structure in the region was 1993. In that year the Minister for Health, Brendan Howlin turned the sod on the site a Co. Cavan. The Community Services Department moved to the newly refurbished building on the site at Cavan General Hospital and new services were provided at Ashbourne and Dunboyne in Co. Meath. Nevertheless, the Board recognised that it had substantial ground to make up in this critical area. Deficits had been well documented. Therefore work continued throughout 1994 on the Board's policy of improving standards in health care centres.

The facilities planned lor Dunshaughlin, Co Meath, would pilot the development to enable the Board to provide multiple services. The Unit was opened in July 1998 and was specifically designed to cater lor the full health and social needs of the south Meath catchment area with a range of primary and community care professionals. It would include consultant out-patient clinics provided by acute hospital consultants, day hospital services for those with a psychiatric illness, an intellectual and/or physical disability, the elderly, child and family support services, palliative and community health services, physiotherapy, dental, general practice, social work and psychology services and restaurant facilities for the general public and staff. This important development in south Meath consists of a state-of-the-art polyclinic which was the first of its kind in Ireland. The unique amenities presently include shared facilities for a whole range of professions and disciplines.

Turning of the Sod at Site of Dunshaughlin Health Care Unit on 24th March 1994
Mr. Aidan Browne, Asst. CEO Community Services and Mr. Ivor Callely, Minister of State with responsibility for Services to Older People visit the new Virginia Health Care Unit.

The Health Board Community Ophthalmic Services Scheme (HBCOSS) commenced on 1st July, 1999 and provides for eye testing and the provision of certain spectacles and lenses to medical card holders aged 16 years and over. The introduction of the scheme has provided greater access to ophthalmic services and reduced the waiting times for treatment as those in need can now go directly to the optician/ophthalmic medical practitioner of their choice. In 1999 a total of 2,790 people availed of the scheme. In 2004 the total number of people to avail of the scheme will be in the region of 16,000.

The Dental Treatment Services Scheme (DTSS) came into operation in September 1994 and provides treatment for all medical card holders aged 16 years and over. Dentists who wish to participate in this scheme enter into a contractual agreement with the North Eastern Health Board. All eligible clients are entitled to one full course of routine treatment (above the line treatments which does not require prior Health Board approval) in any 12 month period i.e. extractions, fillings and scale and polish. Other treatments (below the line treatments which require prior Health Board approval) include, endodontics, periodontal treatment, (approved on an annual basis) radiographs, (panoramics, approved once in a four year period) and dentures (approved once in a live year period).

Primary Care Services encourage, organise and sponsor training and development for GPs and practice nurses. Over 100 Community Nurses attended educational and development programmes provided by the NEHB and National Nursing Council in 2003. Continuing professional development and educational programmes have been made available to all practice nurses and some community nurses in the NE region. This facilitated improvement in the quality of care delivered since all programmes will have a strong evidence base and be focussed on improved quality of care for patients in the Primary Care setting.

A number of study days have been held in conjunction with the ICGP for GPs in the region.

Primary Care Services became responsible for the regulation and delivery of Pharmacy Services within the region following the agreement of a new Pharmacy Contract in 1996 between the Department of Health and Children and the Irish Pharmaceutical Union. This contract recognised for the first time the professional duty of the pharmacist when dispensing medication to patients.

Recognising the importance of harnessing the complimentary skills of the healthcare professionals in the community. Primary Care Services encouraged Community Pharmacists to participate in a number of quality initiatives over the following years, particularly within the implementation of the Cardiovascular Strategy within the

For the last three years Health Promotion Services and Primary Care Services have worked together to develop and deliver a Health Promotion Training Programme, so that Community Pharmacists can be involved in a more structured manner in disseminating the core Health Promotion messages.
The Health Promotion Department in the North Eastern Health Board commenced in July 1996 with four people, Dr Nazih Eldin, Regional Health Promotion Officer, Gerry Roddy, Manager, Bernard McDonald, HEO in Schools and Aine Woods, administration.

Significant development, investment and resource provision has resulted in a comprehensive programme embracing lifestyles, topics and settings. Twenty two synergised components of the programme include Cardiovascular (Smoking, Nutrition, Physical Activity, Alcohol) Substance Misuse, Accident Prevention, Mental Health, Youth Service, Cancer, Oral Health Promotion, Healthy Cities, Hospitals, Schools, Workplace, Locality, Training and Marketing Programme.

The Health Promotion function is guided by
(a) A long-term process involving capacity building, enhancement of self-esteem and self-efficacy and attitudinal and behavioural change.
(b) A catalyst to address the broader determinants of health i.e. peace, shelter, stable eco-systems, income, social justice, equity etc.

Among the more significant achievements resulting from this department's efforts over the last years include a reduction in smoking rates over the last five years from 31% to 23% which is the lowest in the entire country. This is underpinned by a 40% reduction in young people smoking. Moreover, the smoking cessation services implemented in collaboration with Hospital Services is supporting over 2000 smokers per annum to quit and is achieving a 36% average quit rate at three months.

The Health Promotion Department provide a unique (in Ireland) service for the Department of Justice whereby young 'drug offenders' can be referred by probation to the department's addiction counselling service thus negating the need for custodial sentence in approximately 60-80 young people per annum. This is realising a saving of up to €2.5 million per annum to the exchequer.

A Youth Health website was developed at www.youthhealth.ie specifically for young people. This interactive resource allows young people access to youth health information on a 24 hour basis and again it is the only one of its kind in Ireland.

In conjunction with the Irish Heart Foundation a Happy Heart Award initiative has been developed whereby restaurants are encouraged and supported to provide healthy options on their menus. The success of this is reflected in that 44 restaurants are now involved and are reporting significant improvement in business. Again this is being considered for national roll out.

In conjunction with DKIT, DCU and Royal College of Surgeons Ireland, Health Promotion has developed a range of 3rd level academic courses including National Certificate in Health Promotion, Graduate Certificate Health Promotion in Primary Care. Graduate Diploma/MSc Prevention in Primary Care (Cancer Prevention), ami Graduate Diploma/MSc in Men's Health Studies.

The above merely profiles a small percentage of the wide range of long term and sustainable programmes which are changing the lifestyle of the many sub-population groups within the North East region.
CHAPTER 8

Looking Back - 33 years of the NEHB, 1971-2004

In 1971 eight regional health boards were established in Ireland under the Health Act, 1970. The four counties of Louth, Meath, Cavan and Monaghan formed the North Eastern Health Board (NEHB). On April 1st 1971, the NEHB took over the responsibility for running the publicly administered health and welfare services for the region to ensure that a high level of comprehensive health care was provided for the population of the area.

This chapter looks at some of the changes that have occurred in the north east since the NEHB was first established. Data on population size and structure, births, deaths, hospital beds and medical card eligibility are shown. Data from 1971 are used when available. If not available, data from the nearest available year are used.

Population Growth

From 1971 to 2002 the population of the north east has experienced considerable growth, particularly in the areas closest to Dublin.

- The population has grown by 99,386 in these years, from 245,540 in 1971 to 344,965 in 2002. The north east population accounted for 8.8% of the State population in 2002, and 8.2% in 1971.
- Since 1971 Meath has experienced an increase of 86.7% in its population, with an acceleration of growth occurring between 1996 and 2002.
- The population of Louth has risen by 35.8% since 1971.
- The populations in Cavan and Monaghan have been relatively stable, with growths of 14.1% in Monaghan and 7.2% in Cavan since 1971.

The population increase for north east counties between 1971 and 2002 is shown in Figure 1.

![Figure 1: Population comparisons between 1971 and 2002 in the north east by county](source: CSO, 1971 and 2002)

<table>
<thead>
<tr>
<th>Health Board / Authority</th>
<th>Increase in numbers</th>
<th>% Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern Regional Health Authority</td>
<td>410,823</td>
<td>42</td>
</tr>
<tr>
<td>Midland</td>
<td>46,680</td>
<td>26</td>
</tr>
<tr>
<td>Mid Western</td>
<td>70,126</td>
<td>26</td>
</tr>
<tr>
<td>North Eastern</td>
<td>99,286</td>
<td>41</td>
</tr>
<tr>
<td>North Western</td>
<td>34,397</td>
<td>18</td>
</tr>
<tr>
<td>South Eastern</td>
<td>94,936</td>
<td>29</td>
</tr>
<tr>
<td>Southern</td>
<td>114,950</td>
<td>25</td>
</tr>
<tr>
<td>Western</td>
<td>67,790</td>
<td>22</td>
</tr>
</tbody>
</table>

*Formerly Eastern Health Board

Source: CSO 1971 and 2002

Changes in Population Profile

The age profile of the population of the region has changed since 1971. All age groups have seen an increase in numbers. Figure 2 shows the changes in the age profile of residents of the north east since 1971:

- In the 0-14 age group there was a substantial rise after 1971, reaching a peak in 1986 and thereafter showing a gradual decline. A total increase of 3% occurred since 1971.
- The most dramatic population increase is seen in the 25-44 age group with a doubling of their numbers between 1971 and 2002.
- The number of people aged 45-64 began to increase during the 1990s, and showed a total increase of 40% from 1971 to 2002.
- The proportion of persons aged 65 years and over has remained relatively stable; in 2002 this age group comprised 11% of the north east population (36,471 persons) and in 1971 was 11% also.

![Figure 2: Population age profile for residents of the north east, 1971 to 2002](source: CSO 1971 and 2002)
Changes in Births

The birth rate has fallen over the period 1971 to 2002, reflecting dropping birth rates in Ireland. The proportion of births to single mothers has increased from 3% to 27% in the north east, which reflects national trends. While the birth rate has fallen in Meath along with the rest of the country, the increase in population in the county resulted in an increase in the actual number of births in Meath. Table 2 shows births occurring to mothers resident in the north east in 1971 and 2002.

| Table 2 Births occurring to mothers resident in north east counties, 1971* and 2002 |
|----------------------------------|--------|--------|--------|--------|
| Total live births                | Louth  | Meath  | Cavan  | Monaghan North East |
| 1971                            | 1,910  | 1,743  | 968    | 894    |
| 2002                            | 2,069  | 2,391  | 806    | 674    |
| Birth rate per 1,000 population | 1971: 25.5 | 24.3 | 18.4 | 19.3 |
|                                 | 2002: 16.4 | 17.8 | 14.3 | 12.8 |
| % of births to single mothers    | 1971: 18 | 3.6 | 3.5 | 2.9 |
|                                 | 2002: 34.5 | 23.8 | 23.5 | 27.0 |

* Births in private maternity homes are excluded in 1971 figures

Changes in Deaths

Death rates for the leading causes of death have fallen since 1971. Table 3 shows the number of deaths and the standardised death rate (adjusted for the age-sex profile of the population) for 1971 and 2002 for leading causes of death.

| Table 3 Number of deaths and standardised death rates* per 100,000 population for leading causes of death in the north east and Ireland, 1971 and 2002 |
|----------------------------------|--------|--------|--------|--------|
| Circulatory diseases             | Louth  | Meath  | Cavan  | Monaghan North East |
| 1971 n                          | 1,424  | 588    | 927    | 16,300 |
| 2002 n                          | 440    | 188    | 624    | 5,680  |
| Respiratory diseases             | 381    | 155    | 378    | 13,942 |
| Injury and poisoning             | 121    | 50     | 122    | 1,481  |
| All causes                       | 2,699  | 1,117  | 2,413  | 31,890 |

Changes in Infant Mortality

Infant mortality rates have steadily declined in recent years. The improvement in infant, neonatal and perinatal mortality since 1971, within the north east and Ireland, can be seen in Table A.

| Table 4 Infant, neonatal and perinatal mortality in the north east and Ireland, 1971 and 2002 |
|----------------------------------|--------|--------|--------|--------|
| Infant deaths*                   | Louth  | Meath  | Cavan  | Monaghan North East |
| 1971                            | 37.0   | 27.0   | 15.0   | 20.0   |
| 2002                            | 11.0   | 10.0   | 6.0    | 5.0    |
| Infant Mortality Rate            | 1971: 19.4 | 15.5 | 15.5 | 22.4 |
|                                 | 2002: 6.6 | 4.2   | 7.4   | 7.4    |
| Neonatal deaths<                 | 1971: 22.0 | 17.0 | 9.0   | 13.0   |
|                                 | 2002: 8.0  | 8.0 | 6.0   | 5.0    |
| Neonatal mortality rate          | 1971: 11.5 | 9.8 | 9.3   | 14.5   |
|                                 | 2002: 4.8  | 3.4 | 7.4   | 4.9    |
| Perinatal deathsQ                | 1971: 58.0 | 41.0 | 30.0  | 15.0   |
|                                 | 2002: 15.0 | 19.0 | 5.0   | 5.0    |
| Perinatal mortality rate         | 1971: 29.7 | 23.2 | 30.3  | 16.7   |
|                                 | 2002: 8.6  | 8.4 | 6.6   | 7.9    |

* Average for north east counties
*2000 data

Deaths of infants under one year of age
- Infant deaths: Deaths of infants divided by total live births, multiplied by 1,000
- Neonatal deaths: Deaths at ages under one month of live born infant.
- Neonatal mortality rate: Deaths at ages under one month of live born infant divided by total live births, multiplied by 1,000
- Perinatal deaths: Deaths of live born infants divided by total live births, multiplied by 1,000
- Perinatal mortality rate: Deaths of live born infants divided by total live births plus either late foetal deaths (1971) or stillbirths (2001), all multiplied by 1,000.

Late foetal deaths:
- Stillbirths: Stillbirths (1971) or stillbirths (2001), all multiplied by 1,000.
Changes in Hospital Bed Complement and Length of Stay

Since 1973 the number of acute hospital inpatient beds available in the north east has dropped. In 1973 the inpatient bed complement in the north east was 988 and in 2000 it was 866. Table 5 shows the bed complement in north east acute hospitals in 1973 and 2000.

Table 5 Bed complement in acute hospitals in the north east, 1973 and 2000

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Year</th>
<th>Number of inpatient beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cavan General</td>
<td>1973</td>
<td>146</td>
</tr>
<tr>
<td></td>
<td>2000</td>
<td>174</td>
</tr>
<tr>
<td>Louth County</td>
<td>1973</td>
<td>140</td>
</tr>
<tr>
<td></td>
<td>2000</td>
<td>124</td>
</tr>
<tr>
<td>Monaghan General</td>
<td>1973</td>
<td>174</td>
</tr>
<tr>
<td></td>
<td>2000</td>
<td>125</td>
</tr>
<tr>
<td>Our Lady of Lourdes</td>
<td>1973</td>
<td>333</td>
</tr>
<tr>
<td></td>
<td>2000</td>
<td>288</td>
</tr>
<tr>
<td>Our Lady's Navan</td>
<td>1973</td>
<td>195</td>
</tr>
<tr>
<td></td>
<td>2000</td>
<td>155</td>
</tr>
<tr>
<td>Total</td>
<td>1973</td>
<td>988</td>
</tr>
<tr>
<td></td>
<td>2000</td>
<td>866</td>
</tr>
</tbody>
</table>


*Bed complements are not available for later years. Average 7 or 5 day beds available have been calculated for 2003 but are not comparable.

• The average length of stay in north east hospitals for medical patients in 1973 was 14.9 and in 2002 was 7.2 days. For surgical patients in 1973 it was 10.5 and in 2002 was 5.1 days (Source: 1975 Health Estimates and HIPE).

• Day cases were not a feature in 1971. In 2000 there were 16,469 day cases performed in the north east. In 2002 there were 35,574 day cases performed on north east residents (Source: HIPE).

Changes in Medical Card Coverage

The percentage of the population covered by the General Medical Services (GMS, medical card) scheme has decreased both nationally (from 35% to 30%) and in the north east (from 39% to 30%) from 1974 to 2004. The 2004 figures include all those aged 70 years or older who are now entitled to a medical card. A comparison of GMS coverage between 1974 and 2004 is shown in Table 6.

Table 6 Percentage of population covered by the GMS, 1974 and 2004

<table>
<thead>
<tr>
<th></th>
<th>Louth</th>
<th>Meath</th>
<th>Cavan</th>
<th>Monaghan</th>
<th>North East</th>
</tr>
</thead>
<tbody>
<tr>
<td>1974</td>
<td>24,304</td>
<td>28,563</td>
<td>24,283</td>
<td>22,080</td>
<td>99,230</td>
</tr>
<tr>
<td>2004*</td>
<td>35,942</td>
<td>31,517</td>
<td>18,768</td>
<td>16,632</td>
<td>102,859</td>
</tr>
</tbody>
</table>

* January 2004 figures

Source: GMS Payments Board and CSO 2002
CHAPTER 9

IT IS THE PEOPLE THAT MATTER

During times of tumultuous change our principles may be our only constant

Dr. David McCutcheon

The Chief Executive Officers of the North Eastern Health Board 1971 - 2004:

Barry Segrave from Drogheda was the first Chief Executive Officer of the NEHB. He has been described by many as a gentleman to his fingertips. He returned from working in the United States for twelve years, including some time spent with the United States Army, to work on a one-year project for An Bord Fáilte. However, he remained with them for a second year as an Administrative Manager. He brought with him a great deal of experience to the Board.

Pat Clarke, a Meath man, was a native of the area and worked with Barry Segrave as a Programme Manager for the Hospital Services. He had a background in accounting and finance, being a dual qualified accountant. He initially returned to Ireland from England as a Management Accountant with the Department of Finance but was assigned to the Department of Health before joining the NEHB. In 1980 he took over the role of CEO from Barry Segrave and one of his crowning achievements was to deal with the very many issues surrounding the completion of Cavan General Hospital, the largest capital project in the Board's history.

Dona O'Shea was Chief Executive Officer of the Board from 1993 until 1999. During the first years of his term with the North East, he also was CEO of the North Western Health Board, a post he had held since 1974. He continued to hold the post of dual-CEO, dividing his time between the North East and the North West until 1997. In 1996, Donal was appointed by the Minister for Health to Chair the Task Force established to oversee and manage the implementation of the proposals for the establishment of the new Eastern Regional Health Authority; yet again, he was holding down two posts simultaneously. He subsequently became the first Regional Chief Executive of the ERHA in October 1999. When Donal came to the North East, he brought with him excellent managerial skills. Together with his vision, leadership qualities and easily approachable manner, he succeeded in transforming the Board and assisted in developing a number of policies for the provision of better services in the region. His contribution, dedication and commitment were enormous and helped guide the Board through remarkable changes. He was a man of high integrity and intense honesty and had a great working relationship with members and staff alike.

Dr. Ambrose McLaughlin came to the North Eastern Health Board in 1990 as Programme Manager Community Care from the Mid Western Health Board, where he had been the Principal Dental Surgeon. He has since served in the Acute Hospitals Services Programme and more recently in Governance and Strategic Planning. Ambrose has also served as Deputy Chief Executive Officer since the early 1990s, ably representing the Chief Executive Officer when duty called. He was appointed as Chief Executive Officer in 1999 following the departure of Donal O'Shea and prior to the arrival of Paul Robinson. His contribution to a wide range of services throughout the region is legendary and he has been the driving force behind many of the improvements in community and primary care services over the years. Like many of his colleagues, he still managed to have many of his ideas transformed into policy despite the many constraints under which he had to operate.

Paul Robinson was appointed to the North Eastern Health Board as Chief Executive Officer in January 2000. He came from the Mid Western Health Board where he held the post of Deputy Chief Executive Officer. He was also Assistant County Manager of Kerry County Council. Since his appointment to the Board, Paul has held many leading roles at national and international level, including Director General of CAWT (Co-operation and Working Together), representative on the SCCI (Sub Committee and Co-ordination) of HOPE (Hospitals of the European Union), Chairman of the National Ambulance Training Board, Chairman of PHECC (Pre-Hospital Emergency Care Council) and many others. He is currently the lead CEO on a number of projects under the auspices of HeBE (Health Boards Executive). Paul's period of office has certainly been eventful as he had many difficult decisions to make during his appointment, as did the Board, but his deep sense of commitment to providing the best quality service to the people of the north east has always been to the forefront. While many may not have agreed with the decisions he had to make, and these have been well documented in the media, nevertheless he still remained of the opinion that if tough decisions had to be made, then so be it if it resulted in an improved and safer service for patients and clients. During his period of office, Paul had a great working relationship with his colleagues and staff, particularly with the staff in his own office, and is deeply respected and held in the highest esteem by all.
The history of the NEHB is incomplete without mentioning at least a very representative group of those who were involved with the service from the time of its inauguration. It would prove to be a major task and perhaps impossible to write another book to give a deserved recognition to every member of the Board and every member of the executive and staff. Having had discussions with Barry Segrave and a large number of staff who have been with the service for over twenty-five years the following names, many of whom have already been mentioned in relation to their role in one aspect of the service or another, were brought to my attention.

Alary Reilly (Gillon) was the first Secretary to the Chief Executive Officer, and over the years, she and Barry Segrave had a great working relationship. Mary came to the Board in 1971 and the knowledge and experience gained by her in the local authority were of enormous benefit to her in her new role. She subsequently became Secretary to the Board until she left the Board in the late 1970s. Mary set high standards and in turn passed those down to successive staff. She returned in 1994 and is currently working in the Acute Hospital Services Office in Head Office.

Joe Torney was one of the earliest appointees to the Health Board in Kells. Joe was appointed as Caretaker but he was considered to be far more than that as his manner was quite extraordinary. He was described as being everybody’s friend showing kindness and courtesy to staff, and particularly to new staff, visitors and potential patients looking for health information. He kept the property, which was initially in poor condition. The garden around Headquarters was given a number of rewards for its high standard of excellence. There was far more to this than just completing a job. Each fully reflected the image the Board wanted to project of being caring and considerate to both those who used the service and those who worked in it. He was elected to Kells Urban Council on behalf of Fine Gael and he sometimes held unofficial clinics outside the Health Board offices. After Joe died suddenly, a memorial garden seat was placed at the front of the building in Kells by the staff, to commemorate his memory. Joe’s wife, Elma, has also worked for the NEHB for thirty years and is as highly thought of as her late husband. While Joe was tending to the gardens, Elma was making sure that staff had their “morning cuppa”. Over the years, she has kept staff on Head Office supplied with teas and coffees, as well as visitors, people who arrive for meetings and of course the Board staff, visitors and potential patients looking for health information. He kept the property, which was initially in poor condition. The garden around Headquarters was given a number of rewards for its high standard of excellence. There was far more to this than just completing a job. Each fully reflected the image the Board wanted to project of being caring and considerate to both those who used the service and those who worked in it.

Tom Morrid had been an employee of Monaghan County Council for many years and worked as a town clerk in the county. He applied for a position working with the CEO and when successful he brought with him a great deal of local government experience and knowledge of his part of the region. The Headquarters which were based in the Louth/Meath area benefited greatly from Tom’s knowledge of the Cavan/Monaghan area. He brought with him familiarity with the workings of the health services in these counties, the individuals involved and the views and history of the County Council in relation to the health services. He was described as one who had a very good intellect and this was essential to moving things forward in the early days of the NEHB.

Tommy Moore from Wicklow was the first Finance Officer in the Health Board. He had been the Finance Officer in Kerry for sixteen years and was County Accountant in Meath before moving to the Board. This background provided him with a great public service education which would assist him in making the best use of the limited financial resources available for the provision of services. His capacity as a controller of its finances and a great in-depth and practical knowledge of the costs of the various services were respected by members of the Board. He made a significant contribution to the management team as he was not only experienced but was a thoughtful man. Apart from his work with the Health Board he had a great interest in antiques and he was gifted with a great pair of hands for working on small objects. He had a particular interest in Grandfather Clocks. Barry Segrave explained that he saw him carry home a broken clock in a bag and a couple of months later it emerged as a beautiful time piece. There were times when the old fashioned accounting machinery broke down in the offices and he would repair it, often with just a nail file. He is remembered as a gentleman and man with a very pleasant personality. A tree to his memory was planted in the Headquarters grounds.

Dr. Patrick Quinn had been a Medical Officer in Cavan before being appointed firstly as a temporary Programme Manager, Community Care. Because of his level of maturity and understanding of the needs of individuals, he introduced the Choice of Doctor Scheme in the region. His relationship with the medical profession and his efforts to meet the Board’s critical objective of ensuring a widespread service availability and particularly a choice for patients, assisted in this outstanding contribution.

Paddy Mattagh, a Monaghan man, came to the Board from being a County Secretary in Clare. He filled a very important niche in the Board. He was the first permanent Programme Manager for Community Care and brought with him a great deal of experience both as a senior administrator and knowledge of the health service and a technical knowledge of the workings of local government. The first task which he carried out with distinction was the full implementation of the Choice of Doctor Scheme in the region. He has been widely described as a man of integrity and loyalty and for many years, until his retirement, he made a distinct contribution to the development of the health services. He represented the Board for many years on the General Medical Services (Payments) Board.

Dr. Hugh Dolan was the first Public Health Medical Officer representative on the Board and he brought to it a very broad understanding of the needs of individuals as well as a great in-depth knowledge of the costs of the various services. He served as a Board Member from 1973 and as Chairman from 1991-2002. Dr. Dolan’s most outstanding commitment for almost thirty years was the development of community services based on the realisation that this made up over seventy per cent of health care. He believed passionately that ‘instead of bringing the people to the hospital, bring the hospital to the people’. In this way there would be less demand on hospitals and institutions and more resources available in terms of finance and staff to help to further improve community services. All staff from hospital consultants, to physiotherapists, occupational therapists, nursing staff etc., should be available in community based out-patient units to all members of the community from infants to the elderly. In both offices he encouraged these developments. As Director of Community Services in Louth he tried to introduce this programme by way of example for the region as a whole.

Des Scally, a Galway man, served with great distinction for many years as Technical Services Officer and later as Programme Manager of Hospital Services. He was outstanding in dealing with and solving problems on the regional sites. He was joined in the Technical Services Department by Seamus Mattimore a Roscommon man, and together they made an extraordinary team. Barry Segrave remembered having a discussion with them regarding a problem at one of the county hospitals on a Monday morning. The meeting of the Management Team was adjourned to reconvene on the following morning. Within that time Des and Seamus had visited the site, drafted considerations for the Team and within twenty-four hours a resolution to the problem had been found and agreed upon by all. This is an example of how they worked.

Dennut Farrelly was a Senator and he was the first Chairman of the NEHB. In many ways he was a father figure to the Board. He was from Kilmainhamwood in Co. Meath and he brought with him a great sense of commitment to patients and a very gentle disposition. Barry Segrave stated that he never heard him raise his voice, or become angry and upset. He recalls discussions with the Senator which took place on several occasions, particularly in the summer of 1971-72, sitting at the side of the road chatting about what kind of service the NEHB could provide. The discussions would not be about individual services but about how people might be treated and about how staff might be motivated to provide a caring service. They both acknowledged that the country was in dire straights at the time, and so there was very little money around, but Dennut firmly believed that they had good people who would provide the services to the best of their ability and to always put patient needs first.

Joe Farrell the second Chairman of the NEHB was from Dundalk. With the exception of just one year, he served in this office from 1975 to 1991. He was very popular and well liked and trusted by those who served with him. By profession he was a coach builder with the Great Northern Railway who had worked in Dundalk. He was TD for Louth and was a veteran of the War of Independence and one of the founder members of Fianna Fail. He worked very closely with Frank Aiken who was Minister for Foreign Affairs at that time. Joe was a man of extraordinary integrity and forwardness, who did not understand, nor would he tolerate, any deviation from truth, fairness and total objectivity in relation to the services the Health Board provided and the patients they looked after. He has been described by those who have known him as an exceptional individual.
Peter Sherry was from Monaghan. He was a Fine Gael Councillor and was nominated to the Board by the Minister. He was a relatively elderly man who brought great wisdom, common sense and a sense of fair-play and maturity to the service. He had lived for a number of years in the United States and was one of the most far sighted representatives in that he was not parochial in his outlook. As he had patient centred viewpoint he was very practical in relation to what might be done and what could be done. He would look at the fundamentals in relation to health care and did not get carried away with anything new or fanciful. He felt that the Board should work hard at the fundamentals of providing good medical and surgical services locally and after that make the best arrangements you could for additional services.

Alary Flanagan joined the NEHB in 1977 as a clerk typist based in the Personnel Department. She commenced working in the office of the then CEO, Pat Clarke, in November, 1992. During these twelve years Mary has worked with four CEOs, has administered all of the Health Board elections, dealt with over ninety individual Board members, two Chairmen and each Management Team member. Whenever there was a query from any of these individuals, the first point of contact was more often than not Mary. She has also supervised and trained over twenty staff in her time as Board Secretary. Many of these staff have been promoted to other areas of the Health Services and all have gained great knowledge and experience of the health services through working with and learning from her wisdom. In addition she has continuously kept the office of the Chief Executive Officer up to date with modern technology and always strives to ensure that the work carried out is of the highest standards, not only in the office of the CEO, but throughout the Board. These high standards are recognised and acknowledged by many staff not only in the NEHB but in many external agencies including the Department of Health and Children.

Colum Cromwell from Skne, Co. Meath was a quite extraordinary man in that he joined the Health Board and worked in a number of areas particularly in finance. He was a very popular officer of the Board in that he brought great common sense, intellect and good judgement to the work and had a very agreeable personality. Like many of his colleagues, the essentials of the services the Health Board provided were important to him and were understood by him. He had a very distinguished career in the GAA and held many high offices in Meath County Board throughout his life. In 2001, he had a book published entitled Golden Wonder* about his experience in the public services and the GAA. His main ambition in life was in the field of the GAA as distinct from his Health Board career. However he had a very distinguished career in relation to the Finance Department where he worked very well with Tommy Aloore and the present office holder, Seomie O’Mathuna whom Colum viewed as a workaholic. Each has set standards which have prevailed over many years.

Dr. Rory O’Hanlon was a general practitioner and attended the inaugural meeting of the NEHB in November 1977. For well over thirty years Dr. O’Hanlon has been extensively involved in matters relating to the health services both locally and nationally. He remained a medical representative on the Board until 1987 when he became Minister for Health and Social Welfare. Within that time he served as Dail Deputy for Cavan/Monaghan and as Fianna Fail spokesman on Health. In 2002 he was elected as Ceann Comhairle, Dail Eireann, a position which he holds to the present time.

Dr John Orruvut came to Monaghan as the Resident Medical Superintendent in St. Davnet’s Hospital, Monaghan. He was appointed to succeed Dr. Vincent GLUM who was a legend in his own lifetime. Dr. Owens was elected as a Board member in 1974 and served a member until 1992. He not only encouraged the transformation of the NEHB Psychiatric Services, but the psychiatric services nationally. He had the unique facility of being able to relate his clinical skills to management objectives based on the strategies needed to form a coherent integrated patient care strategy for St. Davnet’s Hospital and the services in Cavan/Monaghan. His colleague, Dr Jim Wilson, the Resident Medical Superintendent from St. Brigids’ Hospital, Ardee, was an early innovator in relation to patient care within the community and made a number of the very interesting initiatives in that area.

Larry to’ubb came to the NEHB as Personnel Officer in 1981 from the Local Government Staff Negotiations Board (LGSNB). His wealth of knowledge and experience was of enormous value to the Board and the negotiations and developed in the LGSNB helped to no small way to handle many very serious and fraught situations over the years. Larry Acted as Programme Manager for Community Care, Hospital Services. Primary Care Services and indeed Mental Health Services at various stages over the years. In 2000, Larry was appointed as Assistant Chief Executive Officer and assigned the responsibility of Governance & Strategic Planning - a new Department being set up. Here again, his input and expertise was exceptional and in 2002 Larry was assigned to Acute Hospital Services where he continued to have a huge impact until his secondment at the end of 2002 to the Health Service National Partnership Forum. Larry’s most notable contribution to the Board has to be in the transfer of ownership of Our Lady of Lourdes Hospital to the Board where he demonstrated very admirably his talent in negotiating skills and his huge wealth of experience.

Jim Roche was Administrator in Meath Community Care from his appointment in 1972 until his retirement in 1992, a role he relished, having transferred to the Board from Meath County Council where he held the Health remit for County Meath. He was regarded as one of the best health executives in the country and was recognised as such by his peers. Jim had a great feeling for people, particularly those in distress, whom in his capacity as senior health official in the county Council he had helped so often, not alone with their entitlements but also with his own personal time. He had a vast and extensive knowledge of the whole of County Meath, and representatives at council level and indeed at health board level, who availed of his services on many occasions in making their representations, had nothing but the highest of praise for him. The highest tribute that could be paid to Jim is that his memory is commemorated by the Board naming a building in Railway Street, Navan, in his memory. This is known as “Jim Roche House” and primary care, public health and health promotion services are provided on the premises.

Other Administrators of Community Services who made a huge contribution to the delivery of services in the region in the formative years of the Board were:

- Paddy Mc Glynn. (RIP), who served as Administrator in Roscrea, Monaghan, from 1972 to 1980, having served with Monaghan County Council until his transfer to the Board.
- Dr. James Curran, a colleague in Cavan, who too held a similar post in Cavan Cavan Council.
- Vincent Brady held the post for Louth Community Services from 1972; again, he had served his time with Louth County Council.

Aidan Augeran’s started working in St. Brigid’s Hospital, Ardee, in 1956, left briefly to join the Gardai and returned to St. Brigid’s in 1958 where he held a variety of administrative jobs until 1974. During the next few years, he worked in Our Lady’s Hospital, Navan, and in the Personnel Department in Head Office where he gained invaluable experience in industrial relations matters. In 1977, he returned to St. Brigids’ where he held a variety of title changes until he retired in 2001. Over the years, Aidan was involved with many improvements and developments in Mental Health Services in Louth and Meath and managed the Acute Hospital Services and Services for the Elderly in Co. Cavan. Patients were Aidan’s first priority and he operated an open door system. He also applied this to the many staff who worked with him during these years and as a result had an excellent working relationship with everyone with whom he came in contact. Aidan and still is regarded in the highest esteem by all his colleagues and friends and indeed is still called upon for various assignments within the Board; he can be seen just as much around Head Office over the last couple of years as when he was working with the Board.

Dr. Sheelagh Ryan was appointed as Programme Manager in 1993 - the first female to be appointed to this position within the Board - and was assigned responsibility for Acute Hospital Services. She held this post until her appointment as Chief Executive Officer in 1997 to the Western Health Board. Again, Sheelah made history - she was the first female to be appointed as Chief Executive Officer in the country. During her period of office as Programme Manager with the Board, Sheelah managed many changes within the acute hospital sector, not least of which was the transfer of ownership of Our Lady of Lourdes Hospital, Drogheda, to the Board. Sheelah dedicated an enormous amount of time, including her own personal time, and commitment to this process, ensuring that the transition happened as smoothly as possible with little disruption to the service. Sheelah was nominated by the Department of Health to head up a Steering Group to scope out the rollout of a national programme, a project which lasted for approximately five years, and which ultimately chaired the Board of Breastcheck and oversaw the rollout of the programme to the Midland, North East and the then Eastern Health Board areas. She also oversaw the initiation of the hospital groupings within the Board and contributed in no small way to the development and expansion of consultant posts, a vis a vis specialties and sub-specialties. Sheelah made many friends while in the North East, many of whom still keep in contact with her, and is remembered for her quiet unassuming manner of getting things done.
Members of the Order of Mercy made a tremendous contribution to nursing services throughout the region, and their service, dedication and commitment has had a huge impact on the development and delivery of services in the Board. Some of these are mentioned below:-

Sr. Annucia Ceitt was appointed as Matron to Louth County Hospital, Dundalk, having transferred from the County Infirmary in Dundalk. She held the post of Matron from 1959 to 1988 when she retired after a dedicated service and enormous contribution to the hospital. She was instrumental in the establishment and fitting out of the Louth County Hospital. Her dynamic presence during the course of her career there left an indelible mark which can still be seen on the hospital itself. She is currently retired and is in Castle Lodge Nursing Home where she is visited very frequently by her former colleagues and staff members. This in itself shows the high esteem in which she was held by everyone with whom she was associated.

Sr. Carmel Oakley was Matron in St. Mary’s Hospital, Drogheda from 1968 to 1981 and was also a Staff Nurse there from 1949 to 1968. She made a very valuable contribution to the development of services in the care of the elderly in Drogheda and was instrumental in the development of Boyne View House. She had a major input in the handing over of the Convent to the Mental Health Services; this proved a very valuable acquisition as a Group Home for the Drogheda area. She was a lady held in very high esteem by all who came in contact with her and had a close working relationship with the late Dr. Costello, Medical Director for St. Mary’s and a Consultant Physician at Our Lady of Lourdes Hospital in Drogheda.

Sr. Carmel Mulligan was Staff Nurse and Assistant Matron in St. Mary’s in Drogheda for the period from 1953 to 1976. She was appointed as Matron of St. Joseph’s Hospital in Trim in 1976, a post she held until her retirement in 1993. She set very high standards for patients and staff in both locations, and is recalled with great affection by all those who came in contact with her. She was also a Board Member, representing the Nursing profession, for the period 1977 to 1982, and here again she made a huge contribution, contributing to many of the debates and not just issues which affected nursing matters.

Sr. Seohatiake Ale Rory was Matron in St. Mary’s Hospital, Castleblayney, from 1977 to 1989, having also been a Staff Nurse there from 1951. She had a major influence on the care of the elderly services in Co. Monaghan. A unique feature of St. Mary’s was its licensed premises, and is one, if not the only one, such residential centre for the elderly in the country, to boast its own licensed premises. This unique feature lent a homely atmosphere to both residents and visitors and was and still is enjoyed by all. Sr. Scholastica was held in high regard by stall and patients alike and indeed everyone with whom she came in contact.

Sr. Mercy Rooney was Matron in St. Felim’s Hospital, Cavan, from 1959 to 1981, having also been a Staff Nurse and Assistant Matron there from 1944. She was renowned for being most helpful to everyone - patients, stall and visitors alike. She had a great sense of humour, loved music and was always ready to organise and indeed to take part in any form of entertainment at the hospital. Sr. Mercy was particularly helpful to people whom she would know were in difficulty in some form or other but this was always carried out very discreetly and unofficially. She was also known to give people a start when they were down on their luck - maybe even employ them in various roles within the hospital. When people spoke of Sr. Mercy, it was always with fondness and very happy memories, and still do today.

Mr. Aidan Cunningham joined the Board in 1972 coming from the New York Fire Service. He became the face of Fire Prevention throughout the region for a period of almost three decades, be it a small Health Centre in Cavan or an Acute Hospital in Isimth or Navan. His fire lectures were full of enthusiasm as he imparted his vast knowledge of fire prevention to the staff of the NEHB. Aidan retired earlier this year and he is wished a long and happy retirement.

Niall Doherty transferred to the NEHB from the local authority service where he worked for a range of Councils. He was the first Administrator for the old acute hospitals in Cavan - St. Joseph’s, Lisdarrn (Medical and Maternity Hospital) and Cavan Surgical Hospital in the town centre. He was appointed Secretary to the Project Board for the construction and commissioning of the new Cavan General Hospital. He managed this Project manager. His role was pivotal in which the project was completed on time and on budget. The manner in which the hospital was commissioned and the protocols and procedures put in place on its opening are a major tribute to Niall. Following the opening of the Hospital, Niall moved to Services for the Elderly where again he was busy in developing the infrastructure in Cavan and Monaghan. One of his key projects was the conversion of the old Lisdarrn Acute Unit to a modern unit for the elderly. Niall's contribution to the Cavan Hospital campus is now legendary. He retired in 1999 and now enjoys the greens, hills and hollows of Cavan Golf Club which adjoins his home.

John Gillette from Monaghan was another former local authority employee who came to the Board. He was a hospital administrator in Navan and Dundalk before finally taking up a similar position in Monaghan General Hospital. He was there when Mr. Michael Maloney was Surgeon and Ms. Phyllis Owens was Matron. John was dedicated to the hospital service in Monaghan and the interest of all its patients. John was a great public servant and also contributed to national security through his membership of the FCA. He was also an active member of the IMPACT Union. John retired from the Board in 1997 and he can now pursue his main interest, golf.

Sean Keelan joined the NEHB from Meath County Council in 1971. He worked in the Community Care Service at Headquarters with Paddy Murtagh in the early years of the Board. He was the conduit through which the local office manager dealt with Head Office. Kathleen Gannon and Brenda Cheevers worked with him in Kells. Sean moved to the Hospital Services and took over as Hospital Administrator in Our Lady's Hospital, Navan, in 1978. He was there when the new general theatre, the new orthopaedic theatre and the new x-ray department were provided. He worked closely with Dr. H.F. (Roy) Devine (Consultant Radiologist) and Mr. Rory Laville (Consultant Surgeon) and indeed with the current Director of Nursing, Ms. Aileen Maguire. Sean worked overseas for a period before he retired. He managed a hospital in Saudi Arabia for a number of years where he used all the skills and experience he had built up during his career in Ireland. He retired from the Board in 1988.

Eugene Caulfield is one of the most experienced managers in the Board. He has spent most of his career in the Psychiatric service, particularly in St. Davnet’s Hospital, Monaghan. Eugene worked closely with Dr. John Owens in developing community psychiatric services in Cavan and Monaghan. He was very involved with the purchase of houses in both counties to become the new homes for patients being discharged from St. Davnet’s Hospital. This improvement in facilities and conditions for the former patients was particularly pleasing to him. Eugene also worked for a period in the Personnel Department as Head Office and was the Board’s Personnel Officer for a period. He is a keen sportsman and played senior hurling for Monaghan and is also an accomplished musician.

Seoirse ÓAodha, a Louth man, joined the Board in 1975 as its first Internal Auditor. He had previously worked with Louth County Council, the Dublin Health Authority and the Eastern Health Board. He set up the Internal Audit function in the Board. His first task was to standardise various procedures, processes and reporting systems in the four counties. This gave him a great insight into the Board’s operations and the staff involved. The dedication of staff then and since has always impressed him. He was later appointed as Financial Accountant and subsequently succeeded the late Tommy Moore as Finance Officer. He acted as Programme Manager at various stages over the years and was appointed as Head of Finance in 2003. Seoirse was responsible for introducing many new systems over the years but his most notable has to be the new SAP Financial Systems and the fact that the NEHB was the first Board in Ireland to install this state of the art system. He has also been involved in the purchase and sale of properties within the Board. Carraghbeag Farm in Ardee has certainly taken up a lot of his time - first it was sold, then it was bought back again, then it was sold again and he is now about to buy it back again! Of course there’s a story to all of this but that could take another chapter - Seoirse will be only too delighted to fill in the details for any of you interested in that saga and may even relate the story a... Gaeilge as he is also a keen Irish language enthusiast.

Tadhg O’Brien started in the Board in the early 1970s in Finance Department as a Clerical Officer and over the years has spent various spells at different levels in hospital services, primary care services and more recently back in the hospital services. He is certainly seen as the driving force behind many of the developments in the Primary Care services where he served as Director, not least of which was the introduction of the North East Doctor on Call (NEDOC). His knowledge and experience led to his...
secondment to the National Task Force on Primary Care at the request of the Department of Health where he had a huge impact at national level. Tadhg has a great rapport with people and this is certainly beneficial to him in his current role as Assistant Chief Executive Officer of Acute Hospital Services. He is widely respected locally, regionally and nationally at all levels by all who come in contact with him and is renowned for his great sense of humour.

It is important to acknowledge that there are only six remaining starl members, who started with the Head Office in Kells: Paul McGillick, (currently in Louth Community Welfare Services), who helped to move furniture down the road from John Street to the new building; Eamon O’Brien, who now serves as Director of Human Resources; Eugene Caulfield who is now in St. Davnet’s Hospital, Atchael Casey, Finance, Carnel O’Rourke presently in Accounts and Martin Neacy working in Dundalk.

These individuals and very many more like them have served wholeheartedly as members, executives and staff of the NEHB for thirty-three years. It is appropriate that the address which was made at the final informal meeting of the Board on the 21st June 2004 by Declan Breathnach, the final Chairman be used to bring a conclusion to the history of the NEHB:

We should be proud of the myriad of services provided despite the well documented restraints that have been imposed on the Board by lack of finance and difference of opinion with the Department of Health and Children about how our region should be best developed. From Primary Care, Community Care, Child, Family, Mental Health, Disability Services, Services for our Elderly, Community Welfare Services, Acute Hospitals and Central Services, Corporate Management, GPs, Pharmacists, Nurses, Dentists, all administrative staff, and by no means least the many Voluntary Care Organisations I say a job well done and hope that in the new scheme of health the sturdy foundations of the last 30 years will see your services further expand to deliver an ever greater enhancement in services for the people of our region. I earnestly hope that the many deficiencies of which we are all too aware and have recently documented will be focused on by those charged with future delivery in our complex health system...

Like the public representative it is incumbent on all stakeholders from porter to physician, from canteen staff to consultant, from nurse to neurologist to adopt within the new system of reform the role of interested participants rather than vested interests to achieve the best outcome for the patients who use the services they provide.
NORTH EASTERN HEALTH BOARD

Chairmen

1971 - 2004

Mr. Denis Farrell 1971 - 1974
Mr. Patrick Fullam R.I.P. 1982 - 1983
Dr. Hugh Dolan 1991 - 1997
Mr. Declan Breathnach 2002 - 2004

Ms. Nancy Allen 2002 - 2004
Mr. Patrick Andrews 1974 - 1985
Dr. Declan Bedford 2002 - 2004
Mr. Michael Bell 1974 - 1976
Mr. Jimmy Bellie 1976 - 1979
Mr. Thomas Bellou 1985 - 1995
Dr. Fred Bereen 1992 - 1997
Mr. Terence Birkett 1995 - 1991
Mr. Danny Brady 1985 - 1994
Mr. John Brady 1985 - 1991
Mr. Declan Breathnach 1991 - 2004
Mr. Jim Brown 1982 - 1984
Mr. Fra Browne 1979 - 1985
Mr. Patrick K. Buckley 1973 - 1974
Mr. J. H. Caffrey 1997 - 2003
Dr. Teresa Carey 1997 - 2003
Dr. Owen Clarke 1987 - 1992
Mr. Michael Coburn 1971 - 1974
Mr. David Coleman 1971 - 1974
Mr. Patrick J. Conaty 1974 - 1991
Mr. Patrick Conaty 1991 - 2004
Mr. John F. Conlan 1977 - 1999
Mr. Paudge Connolly 1997 - 2004
Dr. Fergal Connolly 1997 - 2002
Mr. John J. Connors 1979 - 1983
Mr. Sean Conway 1992 - 1995
Dr. Gerard P. Costello 1972 - 1982
Dr. J. Costello 1974 - 1977
Mr. Jim Cousins 2002 - 2004
Dr. Ellen Cowhey 1971 - 1972
Mr. Archibald Coyle 1971 - 1972
Mrs. Edith Craig 1977 - 1982
Dr. Fergus John Cronin 1997 - 2002
Dr. Patrick B. Cusack 1971 - 1977
Mr. James Deery 1979 - 1980
Mr. W. deWitt 1971 - 1977
Dr. Hugh Dolan 1972 - 2002
Mr. Seamus Dolan 1974 - 1979 1982 - 1992
Mr. Patrick S. Donegan 1971 - 1973
Sr. M. E. Dooley 1971 - 1977
Mr. AJP Dwyer 2001 - 2003
Mr. Thomas Elmore 1979 - 1985
Mr. Donal Fairlough 1971 - 1973
Mr. Aloysius Farrell 1983 - 1989
Mr. Joseph Farrell 1971 - 1991
Mr. Denis Farrell 1971 - 1974
Mr. John Farrell 1985 - 2004
Mr. Susan Faulkner 1992 - 2001
Ms. Mary P. Fay 1987 - 1992
Mr. Edward Feely 1991 - 2004
Mr. James J. Finn 1991 - 2004
Mr. Brian Fitzgerald 1979 - 1985
Mr. Jack Fitzgerald 1979 - 1985
Mr. John B. Fitzpatrick 1971 - 1974
Mr. Patrick Fullam 1975 - 1985
Dr. Eamon J. Hartmann 1992 - 1999
Mr. Raymond E. Healy 1971 - 1974
Mr. Thomas C. Hickey 1971 - 1974
Ms. Evieleen Higgins 1984 - 2004
Mr. Brendan Hughes 1985 - 2004
Mr. Daniel J. Keane 1996 - 1997
Mr. Tom Kelly 1987 - 1992
Mr. Justin Mackin 1987 - 1992
Dr. Brendan MacMahan 1987 - 1992
Mr. James Mangan 1992 - 2004
Mr. Gerry Marry 1992 - 2004
Ms. Mudge Martin 1992 - 2004
Mr. Fred Matthews 1987 - 1992
Mr. Nicholas McCabe 1992 - 2004
Dr. John McCarthy 1987 - 1992 1987 - 2004
Dr. Paul McCarthy 1987 - 2004
Mr. Finnan McCoy 2003 - 2004
Lo. Gillian Cark* Mel W 1997 - 2001
Mr. Hugh McElvany 1992 - 2004
Mr. John F. Mc Govern 1971 - 1974
Mr. Joe P. McGrath 1992 - 1997
Mr. Thomas McGrory 1995 - 2004
Mr. Richard McGuinness 1972 - 1977
Mr. Brian McKenna 2003 - 2004
Mr. P.O.F. McKenna 1971 - 1977
Mr. William McKenna 1999 - 2004
Mr. Patrick Mooney 1971 - 1979
Mr. Peter J. Moore 1971 - 1979
Sr. Carmel M. Mulligan 1971 - 1979
Mr. James Mulroy 1971 - 1979
Mr. Peter Murphy 1980 - 1985
Mr. Tommy Murphy 1989 - 1999
Mr. Gerry Murray 1989 - 2004
Dr. Alfred Nicholas 1987 - 1997
Mr. Andy O'Brien 1987 - 1997
Mrs. Maureen O'Brien 1971 - 1977
Mr. Cuimbham O'Caoimh 1999 - 2003
Dr. Michael J. O'Connell 1971 - 1972
Mr. Thomas O'Connell 1973 - 1982
Dr. Rory O'Hanlon 1971 - 1978
Dr. Patrick O'Neil 2002 - 2004
Mr. Brian O'Neill 2003 - 2004
Mr. Patrick O'Reilly 1974 - 1979
Mr. Patrick O'Reilly 1991 - 2004
Mr. Matthew O'Reilly 1971 - 1974
Dr. B. J. O'Sullivan 1972 - 1977
Dr. J. M. Owens 1977 - 1992
Dr. Martin Rahill 1971 - 1972
Dr. Mary Randie 1982 - 1987
Mr. Alan Reilly 2001 - 2002
Mr. Patrick Reilly 1974 - 1979
Mr. Reilly 1999 - 2004
Mr. Peter Savage 1996 - 2004
Mr. Tim Scanell 1992 - 1997
Mr. Peter Sherry 1971 - 1974
Mr. Michael F. Shine 1977 - 1995
Mr. Francis J. Skinnder 1977 - 1998
Mr. Michael Smith 1985 - 1991
Ms. Mary Smith 1979 - 1985
Mr. Maurice Stokes 2002 - 2004
Ms. Grainne lipping 2002 - 2004
Mr. Brendan Tool 1974 - 1977
Mr. Patsy Trenalor 2002 - 2004
Mr. James Tully 1971 - 1973
Dr. Peter Wahrab 1987 - 2001
I. O. J. Wick Wadlon-bhw b 1999 - 2002
Ms. Mary Wallace 1985 - 1991
Mr. John J. Ward 1974 - 1979
Dr. J. J. Wilson 1972 - 1979
Mr. James Wright 1971 - 1985
NORTH EASTERN HEALTH BOARD

Chief Executive Officers

1971 - 2004

Barry Segrave
1971 -1980

Pat Clarke
1980-1993

Donal 0 Shea
1993-1999

Ambrose McLoughlin
1999-2000

Paul Robinson
2000 - 2004

MANAGEMENT TEAM MEMBERS

AT
DECEMBER
2004

Paul Robinson
Chief Executive Officer

Mr. Tadhg O’Brien
Asst. CEO - Acute Hospital Services

Dr. Ambrose McLoughlin
Deputy CEO - Governance and Planning

Mr. Geoff Day
Asst. CEO - Regional and Community Services

Mr. Seoirse 0 hAodha
Head of Finance

Mr. Eamon O’Brien
Director Human Resources

Mr. Jim Curran
Technical Services Officer

Mr. Fran Thompson
Director Information Systems

Ms. Rosaleen Harlin
Communications Director

Mr. Iim Reilly
General Manager

Mr. Aidan Browne - seconded to iHSE
Mr. Larry Walsh - seconded to Health Service National Partnership Forum
Dr. Rosaleen Corcoran - seconded to HeBE

The following Senior Managers are currently seconded to other agencies:

Mr. Aidan Browne - seconded to iHSE
Mr. Larry Walsh - seconded to Health Service National Partnership Forum
Dr. Rosaleen Corcoran - seconded to HeBE
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