



Feidhmeannacht na Seirbhíse Sláinte  
Health Service Executive

## **Palliative Care Services - Five Year/Medium Term Development Framework**

## TABLE OF CONTENTS

	<b>PAGE</b>
<b>Foreword</b>	<b>3</b>
<b>Executive Summary</b>	<b>5</b>
<b>1 Introduction</b>	<b>12</b>
1.1 Palliative Care Definition	12
1.2 Objective, Scope & Approach	12
1.3 National Context	15
<b>2 Overview of the Provision of Palliative Care Services in Ireland</b>	<b>20</b>
2.1 Introduction	20
2.2 National Overview of Palliative Care Service Provision	21
2.3 Overview of Palliative Care Service Provision by Administrative Area	23
<b>3 Setting National Priorities</b>	<b>32</b>
3.1 Assumptions Underpinning National Priority Setting	32
3.2 Criteria for Selection of National Priorities	32
<b>4 National Development Framework</b>	<b>33</b>
4.1 Immediate Priorities to Address Areas of Greatest Need	34
4.2 National Priorities	36
4.3 Rationale and Analysis	41
4.4 Impact of Successful Implementation	44
<b>5 Resourcing National Priorities</b>	<b>47</b>
5.1 Total Resourcing Requirement of National Development Framework 2009 – 2013	47
5.2 Capital Cost of National Development Framework 2009 – 2013	48
5.3 Revenue Cost of National Development Framework 2009 – 2013	49
<b>6 Key Challenges and Next Steps</b>	<b>53</b>
6.1 Key Challenges and Enablers	53
6.2 Next Steps	55
<b>7 Appendices</b>	<b>57</b>
7.1 External Stakeholder Consultation	57
7.2 Area Development Committee – Terms of Reference	58
7.3 Area Consultative Committee – Terms of Reference	59
7.4 Project Steering Committee Membership	60

## FOREWORD

I am pleased to present this Framework document

The decision to undertake this plan was based on discussions between the Minister for Health & Children, the HSE and bodies such as the Irish Hospice Foundation, the Irish Cancer Society and the Irish Association of Palliative Care. The work was undertaken in partnership with all relevant stakeholders, including both the statutory and voluntary sectors

It details the required actions and initiatives necessary to address the gaps in palliative care service provision, against the recommendations set out in the 2001 report of the National Advisory Council for Palliative Care. This takes a patient centred approach and ensures that patients' particular and unique needs are addressed in a holistic manner. The national priorities selected are aligned to national healthcare policy and the HSE's Transformation Programme and Corporate Plan. This framework sets national priorities which have been agreed by all stakeholders based on solid needs analysis to ensure that services do not develop in an ad-hoc fashion and that any developments proposed in future reflect areas of greatest need. Such an approach ensures an equitable approach to service provision as well as consistency in inputs such as pay and non-pay costs as well as levels of staff. The national priorities reflect the gaps that currently exist in particular areas and services and the prioritisation reflects the largest gaps.

When this work was initiated its purpose was to provide a sound planning framework for resource utilisation. It was anticipated that funding for the agreed priorities might be achieved through a combination of reorientation and reconfiguration of existing resources and the identification of additional resource requirements when further funding might come on-stream. However, the current economic environment is not conducive to the possibility of further development funding for palliative care services certainly in the short to medium-term.

At a meeting following the completion of the report at which the Department of Health and Children, the Irish Hospice Foundation, the Irish Cancer Society and the Irish Association of Palliative Care as well as the Health Service Executive were represented, it was agreed that that the priorities identified in the Framework would not be altered despite the need to be aware of the current economic climate and that the focus for development in palliative care services should be in the context of

- reconfiguration and re-allocation of existing resources/services;
- increasing and developing capacity within existing resources,
- developing skills in community care and care of the elderly settings specifically in relation to palliative care services and
- taking the opportunity afforded by integration to identify ways of enabling the delivery of these agreed national priorities.

## PALLIATIVE CARE SERVICES FIVE YEAR/ MEDIUM TERM DEVELOPMENT FRAMEWORK

The position now as agreed with the Department of Health and Children in relation to the prioritised developments is that the Health Service Executive, in association with the Department of Health and Children and other key stakeholders will lead in the formation of a tripartite group to discuss how best to achieve the recommendations detailed in the Framework.

This group will be set up on foot of the publication of the Framework.

I am taking this opportunity to thank my colleagues in the HSE for their work and support to date in relation to this Framework, to our partners in the voluntary sector without whose tremendous co-operation and support this work could not have been done and to the Department of Health and Children for their support for the process which has culminated in this report.

**Hugh Kane**

**Assistant National Director**

**Health Services Executive**

## EXECUTIVE SUMMARY

### OBJECTIVE AND BACKGROUND

#### ***OBJECTIVE AND SCOPE OF THE NATIONAL DEVELOPMENT FRAMEWORK (2009 – 2013)***

The objective of this document is to detail the **Palliative Care Services - Five Year/Medium Term Development Framework (2009 – 2013)**. It has been developed using a holistic, system-wide, approach to addressing the level of need identified by both the **Baseline Study on the Provision of Hospice / Specialist Palliative Care Services in Ireland (2006)** as well as the **HSE Audit of Palliative Care Service Provision (2007)**. The “HSE Audit” (as it is referred to in this document) was conducted by each of the four HSE Administrative Areas, in conjunction with Area Development Committees, against the recommendations of the **Report of the National Advisory Committee on Palliative Care 2001** (the NACPC Report). Therefore, this document is grounded in the recommendations of the NACPC Report, (e.g. palliative care definition, palliative care service areas, staffing and bed number ratios), and informed by the findings of the HSE Audit.

The purpose of this document is not to replace the recommendations of the NACPC Report from a policy context, nor does it represent a new national strategy for palliative care. This document details the required actions and initiatives necessary to address the gaps in palliative care service provision, against the recommendations set out in the NACPC Report.

#### ***BACKGROUND TO THE DEVELOPMENT OF THE NATIONAL DEVELOPMENT FRAMEWORK (2009 – 2013)***

A number of initiatives relating to palliative care services were undertaken prior to the development of this Framework, including significant work completed by Area Development Committees (ADCs), which were established by the HSE based on the recommendations of the NACPC Report. The outputs of their extensive work formed the input into the development of this Framework.

In recent years, a significant number of reports, strategies, policy documents and plans have been published which have implications for the development of palliative care in Ireland, including:

- The National Cancer Strategy (1996);
- The Report of the National Advisory Committee on Palliative Care (2001);
- The Primary Care Strategy (2001);
- The Palliative Care Needs Assessment for Children (2005);
- The Baseline Study on the Provision of Hospice / Specialist Palliative Care Services in Ireland (2006);
- The Cancer Control Strategy (2006);
- The Transformation Programme (2007).

The national priorities identified for the development of palliative care service presented in this National Development Framework are aligned to national healthcare policy, as set out above, and the HSE’s Transformation Programme 2007 – 2010.

The Department of Health & Children is developing a children’s palliative care policy which aims to provide a framework for future service development. Therefore, this report does not address paediatric palliative care.

#### ***APPROACH TO THE DEVELOPMENT OF THE NATIONAL DEVELOPMENT FRAMEWORK (2009 – 2013)***

To support the development of the National Development Framework (2009 – 2013), a Project Steering Committee was established with representatives from within the HSE, comprising the National Lead for Palliative Care, the Lead Local Health Managers for Palliative Care from each Administrative Area, together with representatives from Estates, Manpower Planning, and support from the Health Atlas Ireland Team. Prospectus Strategy Consultants provided project management support throughout the process.

## PALLIATIVE CARE SERVICES FIVE YEAR/ MEDIUM TERM DEVELOPMENT FRAMEWORK

The Project Steering Committee was tasked with integrating and building on the work already completed by individual Administrative Areas and their ADCs to develop a National Development Framework that is holistic and presents a national picture.

The Project Steering Committee (which was convened for the first time on March 31<sup>st</sup>, 2008) conducted a number of working sessions (5 workshops) to consider the significant work completed at Area level and agree national palliative care priorities for the period 2009 – 2013.

The analysis of the work completed at Area level was conducted in close consultation with HSE staff at national, regional and local level (via individual meetings and teleconferences) to understand the priority need in each Area and the implementation enablers required to support those needs on a national basis. Throughout the completion of this work, the Project Steering Committee had to ensure that any need identified was grounded in the recommendations of the NACPC Report. A key challenge involved ensuring consistency of approach and assumptions used, given that national priorities were considered in the context of the priorities identified at ADC level.

The Project Steering Committee engaged with a number of key external stakeholders, such as the Irish Hospice Foundation, the Irish Cancer Society, the Irish Association for Palliative Care (IAPC) and the Hospice CEOs Group to inform the development of national priorities for palliative care. This engagement acknowledged the commitment of the voluntary sector in the provision of palliative care services, and the voluntary sector's involvement in Area Development Committees.

This report, the Palliative Care Services - Five Year/Medium Term Development Framework (2009 – 2013), represents the output from the Project Steering Committee's work.

### NATIONAL OVERVIEW OF PALLIATIVE CARE PROVISION

Based on the output of the HSE Audit (2007) by each Administrative Area, there were significant variations in the levels of specialist palliative care service provision across each service category, outlined below:

#### *SPECIALIST PALLIATIVE CARE IN-PATIENT UNITS*

- There are eight dedicated specialist palliative care in-patient units across the 4 HSE Areas.
- There is a wide regional and intra-regional variation in the availability of specialist palliative care in a specialist in-patient unit.
- Three geographic areas have no specialist in-patient units and no access to specialist in-patient beds for those patients most in need.
- Some specialist in-patient units have varying levels of the multi-disciplinary team providing the specialist palliative care service.
- Waiting lists currently exist for admission to some specialist palliative care in-patient units.

#### *SPECIALIST PALLIATIVE DAY CARE CENTRES*

- There are six specialist palliative day care services nationally across the 4 HSE Areas.
- The total number of patients accessing these services in 2006 was approximately 2,600.
- Currently, the majority of specialist palliative day care centres operate Monday to Friday, 9am – 5pm.
- There is a wide intra-regional variation in the availability of specialist palliative day care services.
- Three geographic areas have no specialist palliative day care centres. These are the same areas with no Specialist Palliative Care In-Patient Units.

#### *SPECIALIST PALLIATIVE CARE IN THE COMMUNITY*

- Almost all LHO Areas had access to Specialist Palliative Care / Home Care Teams in the community.
- Many of these services are a consultant-led multidisciplinary service. However, in some areas there continues to be a number of nurse-led services.

## PALLIATIVE CARE SERVICES FIVE YEAR/ MEDIUM TERM DEVELOPMENT FRAMEWORK

- Access to services is provided through the Specialist Palliative Care / Home Care Teams, with significant variation in service availability (e.g. hours of service delivery).
- Current home help and public health nursing capacity is often insufficient to meet the needs of patients, with additional support provided by the Irish Cancer Society and the Irish Hospice Foundation.
- Non-cancer patients, e.g. those with renal failure and heart disease, do not have the same access to night nursing services as those with advanced cancer.

### SPECIALIST PALLIATIVE CARE SERVICES IN ACUTE GENERAL HOSPITALS

- There are 50 acute general hospitals with approximately 38 of these having varying degrees of access to dedicated specialist palliative care teams.
- The majority of acute hospitals provides specialist palliative care services 5-days a week, including a 7-day / 24-hour on call Consultant in Specialist Palliative Care service in a number of hospitals.
- In a small number of acute general hospitals weekend/out of hours services are provided to the acute hospital by the Clinical Nurse Specialist in the community or the Home Care Nurse.
- There are significant variations in the staffing levels of specialist palliative care teams in acute general hospitals nationwide.

## NATIONAL DEVELOPMENT FRAMEWORK 2009 – 2013

The Project Steering Committee agreed **41 national priorities** for inclusion in the *Palliative Care Services - Five Year/Medium Term Development Framework (2009 – 2013)* that are grounded in the recommendations of the NACPC Report and address the service gaps identified by the HSE Audit.

These 41 national priorities are grouped under the following four service categories:

- Priorities Relating to *Home Care* Deficits (12);
- Priorities Relating to *Specialist In-Patient Bed* Deficits (6);
- Priorities Relating to *Capital Developments* (15);
- Priorities Relating to *Acute Hospital Support* (8).

The following criteria used to select national priorities for palliative care were set by the Project Steering Committee. They were informed by work at Area Development Committee level and discussions with external stakeholders.

National Criteria	Qualifying Questions
Needs Assessment	<ul style="list-style-type: none"> <li>• Does the priorities address a major area of need, where there is limited or no service provision, as highlighted by the HSE Audit (e.g. Midlands, South East, North East, and Wicklow)?</li> <li>• Does the priority build capacity or ensure self-sufficiency?</li> </ul>
National Policy	<ul style="list-style-type: none"> <li>• Does the priority address the recommendations set-out in the NACPC Report?</li> </ul>
Health Care Policy / Integration	<ul style="list-style-type: none"> <li>• Does the priority support wider healthcare policy, such as the Primary Care Strategy, the Transformation Programme, or the Cancer Control Programme?</li> </ul>

Using the above criteria for the selection of national priorities, the Project Steering Committee reviewed the priority actions submitted by each Area Development Committee (approximately 141). It was through this lens that the various demands on a regional basis were considered, and a national approach to priority selection applied.

## PALLIATIVE CARE SERVICES FIVE YEAR/ MEDIUM TERM DEVELOPMENT FRAMEWORK

National Priorities for Palliative Care Services 2009 – 2013		Completion Timeframe
<b>NATIONAL PRIORITIES RELATING TO HOME CARE DEFICITS</b>		
1.	<b>Address Home Care Team deficits in Wicklow LHO</b> (7 WTEs required). Currently no specialist palliative care service in Wicklow.	2009
2.	<b>Address Home Care Team deficits in Laois Offaly LHO &amp; Longford Westmeath LHO</b> (6 WTEs required) in order to meet current staffing deficits.	2009
3.	<b>Address Home Care Team deficits in Louth LHO, Meath LHO &amp; Cavan Monaghan LHO</b> (9 WTEs required). There are currently core staffing deficits within all of the Home Care Teams in HSE Dublin North East.	2009
4.	<b>Address Home Care Team deficits in Waterford LHO, Wexford LHO, South Tipperary LHO, Carlow Kilkenny LHO and North Cork LHO</b> (13.5 WTEs required) to enhance community services where no specialist IPU exists and provide consultant-led service in North Cork LHO. Voluntary services fund 62% of Home Care service.	2009
5.	<b>Address Home Care Team deficits in Galway LHO, Mayo LHO &amp; Roscommon LHO</b> (8.26 WTEs required) in order to meet current staffing deficits.	2010
6.	<b>Address Home Care Team deficits in Kildare West Wicklow LHO</b> (9 WTEs required) in order to meet current staffing deficits, with a particular emphasis on health and social care professionals.	2010
7.	<b>Address Home Care Team deficits in all LHOs in Dublin North East</b> (12 WTEs required) in order to meet current staffing deficits, with a particular emphasis on allied therapy professionals.	2011
8.	<b>Address Home Care Team deficits in North Lee LHO, South Lee LHO, West Cork LHO &amp; Kerry LHO</b> (14 WTEs required) in order to meet current staffing deficits.	2011
9.	<b>Address Home Care Team deficits in Our Lady's Hospice and Blackrock Hospice</b> (OLH 10.5 WTE, Blackrock 9 WTE) in order to meet current staffing deficits , with a particular emphasis on health and social care professionals.	2012
10.	<b>Address Home Care Team deficits in Donegal LHO, Sligo Leitrim LHO &amp; Limerick LHO</b> (12.28 WTEs required) in order to meet current staffing deficits per recommendations of the NACPC Report.	2012
11.	<b>Address Home Care Team deficits in all LHOs in Dublin North East</b> (5 WTEs required) in order to meet current staffing deficits, with a particular emphasis on clinical nurse specialists.	2013
12.	<b>Address Home Care Team deficits in South Lee LHO &amp; North Lee LHO</b> (6 WTEs required) in order to meet current staffing deficits, with a particular emphasis on allied therapy professionals.	2013
<b>NATIONAL PRIORITIES RELATING TO SPECIALIST IN-PATIENT BED DEFICITS</b>		
1.	<b>Address Specialist IPU deficits in Laois Offaly LHO &amp; Longford Westmeath LHO</b> (6 WTEs required at Athlone for 4 interim beds). No specialist in-patient services in the region.	2009
2.	<b>Address Specialist IPU deficits in Kildare West Wicklow LHO</b> (12.2 WTE required) to bring 6 beds in St. Brigid's up to Level 3 service following appointment of Consultant in 2007.	2009
3.	<b>Address Specialist IPU deficits at St. Francis Hospice, Raheny</b> (12.75 WTE required) to meet the recommendations of the NACPC Report.	2010
4.	<b>Address Daycare deficits in Sligo LHO and Galway LHO</b> (18.2 WTE required) to meet the recommendations of the NACPC Report.	2010
5.	<b>Address Specialist IPU deficits in Donegal LHO &amp; Limerick LHO</b> (16.4 WTE required) to meet the recommendations of the NACPC Report.	2011
6.	<b>Address Specialist IPU deficits at Our Lady's Hospice &amp; Blackrock Hospice</b> (20.1 WTE required). Current staff levels for 36 and 12 bed units respectively, are below minimum recommended level.	2012
<b>NATIONAL PRIORITIES RELATING TO CAPITAL DEVELOPMENTS</b>		
1.	<b>Development of 12 Bed In-patient Unit and Education &amp; Research Centre in Louth LHO</b> (Drogheda) with associated revenue and staffing implications, to serve Louth LHO & Meath LHO.	2011
2.	<b>Development of 24 Bed In-patient Unit and Day Care Unit in North West Dublin LHO</b> (Abbotstown), with associated revenue and staffing implications.	2012
3.	<b>Development of 25 Bed In-patient Unit in Laois Offaly LHO</b> with associated revenue and staffing implications, to serve Laois Offaly LHO & Longford Westmeath LHO.	2013
4.	<b>Development of 20 Bed In-patient Unit in Waterford LHO</b> (Waterford Regional Hospital) with associated revenue and staffing implications, to address specialist in-patient bed deficit in the former South Eastern Health Board.	2013
5.	<b>Development of 11 Bed In-patient Unit in Wicklow LHO</b> with associated revenue and staffing implications. Currently no in-patient beds available for population of 109,202.	2012

## PALLIATIVE CARE SERVICES FIVE YEAR/ MEDIUM TERM DEVELOPMENT FRAMEWORK

National Priorities for Palliative Care Services 2009 – 2013		Completion Timeframe
6.	Development of an additional 20 In-patient Beds at Marymount Hospice, with associated revenue and staffing implications, to address the deficit in North Lee LHO, South Lee LHO, North Cork LHO & West Cork LHO.	2011
7.	Development of 14 Bed Specialist Satellite Unit in Mayo LHO, with associated revenue and staffing implications. Current bed complement is 58 specialist in-patient beds.	2013
8.	Development of 16 Bed In-patient Unit and Day Care Unit in Cavan Monaghan LHO, with associated revenue and staffing implications. Currently no in-patient beds available for population of 200,000.	2013
9.	Development of an additional 14 In-patient Beds in Kildare West Wicklow LHO (St. Brigid's Hospice) with associated revenue and staffing implications. Currently only 6 Level 2 beds available for population of 203,327.	2013
10.	Development of 12 Bed Satellite Unit in Carlow Kilkenny LHO, with associated revenue and staffing implications. Site secured on the grounds of St Luke's General Hospital in Kilkenny.	2013
11.	Further Development of Day Care & Community Based Services in Limerick LHO (Milford Care Centre), with associated revenue and staffing implications. Includes investment in education and research.	2009
12.	Development of 4 Bed Extension to In-patient Unit in Donegal LHO with associated revenue and staffing implications.	2013
13.	Development of 14 Bed Extension to In-patient Unit and Day Care Unit in Galway LHO, with associated revenue and staffing implications. Current bed complement is 58.	2013
14.	Development of an additional 2 In-patient Beds in Sligo Leitrim LHO with associated revenue and staffing implications.	2013
15.	Development of 15 Bed Satellite Unit in Kerry LHO (Kerry General Hospital) with associated revenue and staffing implications. Part 1 of project completed with opening of Specialist Day Care in 2007.	2013
<b>NATIONAL PRIORITIES RELATING TO ACUTE HOSPITAL SUPPORT</b>		
1.	Address deficits in the provision of Support to Acute Hospitals in Laois Offaly LHO and Longford Westmeath LHO (3 WTEs required) – provision of nursing support to Portlaoise, Mullingar and Tullamore.	2011
2.	Address deficits in the provision of Support to Connolly Hospital (5.5 WTEs required). There is currently no Palliative Care Team in Connolly Hospital.	2011
3.	Address deficits in the provision of Support to Acute Hospitals in Dublin North-East (9 WTEs required). This will include 6 WTE Clinical Nurse Specialists and 3 WTE Non Consultant Hospital Doctors (NCHD) posts.	2011
4.	Address deficits in the provision of Support to Acute Hospitals in Waterford LHO, Wexford LHO, South Tipperary LHO & Carlow Kilkenny LHO (7.7 WTEs required). This will include 1.7 WTE Clinical Nurse Specialists, 4 WTE Social Workers and 2 WTE Secretarial support.	2012
5.	Address deficits in the provision of Support to Acute Hospitals in Galway LHO, Sligo LHO & Limerick LHO (10.95 WTEs required). This will include 5.81 WTE Clinical Nurse Specialists, 3.39 WTE Social Workers and 1.75 WTE Medical Secretary supports.	2012
6.	Address deficits in the provision of Support to Acute Hospitals in Dublin Mid-Leinster (14 WTEs required). This will include provision of CNS support to St. James's Hospital, St. Vincent's Hospital, St. Colmcille's Hospital, Tallaght Hospital, St. Michael's Hospital and Naas General Hospital.	2012
7.	Address deficits in the provision of Support to Acute Hospitals in Donegal LHO, Roscommon LHO & Mayo LHO (5.05 WTEs required). This will include 1.38 WTE Clinical Nurse Specialists, 2.17 WTE Social Workers and 1.5 WTE Secretary support.	2013
8.	Address deficits in the provision of Support to Acute Hospitals in North Lee LHO, South Lee LHO, North Cork LHO, West Cork LHO and Kerry LHOs (9.8 WTEs required). This will include 2.8 WTE Clinical Nurse Specialists, 4 WTE Social Workers and 3 WTE Secretarial support.	2013

During the development of a **Palliative Care Services - Five Year/Medium Term Development Framework (2009 – 2013)**, the Project Steering Committee identified a number of immediate priority actions under each of the four categories that would represent the immediate focus during the period of this plan. These priorities (highlighted in the table above) relate to the areas of greatest need identified by the NACPC Report and HSE Audit, particularly to the service provision “black-spots” where there is limited or no palliative care service provision currently. See Section 4.1 for further information.

**IN TOTAL, THE DELIVERY OF THE 41 NATIONAL PALLIATIVE CARE PRIORITIES OUTLINED ABOVE WILL REQUIRE:**

- 272.19 WTE AND
- 203 SPECIALIST IN-PATIENT BEDS (LEVEL 3).

## PALLIATIVE CARE SERVICES FIVE YEAR/ MEDIUM TERM DEVELOPMENT FRAMEWORK

As illustrated in the table below, this requirement is spread across the four service provision categories within the five-year framework:

National Actions for Palliative Care Service Provision	Completion Timeframe				
	2009	2010	2011	2012	2013
Priorities Relating to <i>Home Care Deficits</i>	▲4	▲2	▲2	▲2	▲2
Priorities Relating to <i>Specialist In-Patient Bed Deficits</i>	▲2	▲2	▲1	▲1	▲0
Priorities Relating to <i>Capital Developments</i>	▲1	▲0	▲2	▲2	▲10
Priorities Relating to <i>Acute Hospital Support</i>	▲0	▲0	▲3	▲3	▲2
<b>TOTAL</b>	<b>▲7</b>	<b>▲4</b>	<b>▲8</b>	<b>▲8</b>	<b>▲14</b>

▲ = NUMBER OF NATIONAL PALLIATIVE CARE ACTIONS PER YEAR

Please note the completion timeframe associated with each national priority above is accurate at the time of the publishing of this document. However, the Project Steering Committee recognises that the completion timeframes are indicative and subject to variation due to a range of contingencies. As a result, certain priorities listed in order of completion priority above may be subject to change.

### TOTAL RESOURCE REQUIREMENT OF NATIONAL DEVELOPMENT FRAMEWORK 2009–2013

The table below provides indicative capital and revenue costings at a national level for the national priorities identified by the Project Steering Committee. Significant investment is required between 2009 and 2013 to ensure that the deficits identified in the NACPC Report and the HSE Audit are addressed.

Total Resource Requirement of National Development Framework (2009 – 2013)	Capital Requirement	Revenue Requirement	Sub-Total
	€(m)	€(m)	€(m)
Priorities Relating to Home Care Deficits	-	10.474	10.474
Priorities Relating to Specialist In-Patient Bed Deficits	-	6.956	6.956
Priorities Relating to Capital Developments	237.340	48.020	285.360
Priorities Relating to Acute Hospital Support	-	6.035	6.035
<b>Grand Total</b>	<b>237.340</b>	<b>71.485</b>	<b>308.825</b>

Overall, the capital and revenue requirements to deliver on the 41 national actions outlined above will cost a combined **€308.825 million**. This equates to **€237.34 million capital** and **€71.485 million revenue** over the Five Year/Medium Term Framework.

## NEXT STEPS

The Project Steering Committee identified a number of follow-on actions that will be required in order to address the implementation of the national priorities outlined in this report.

### ***ADOPTING THE NATIONAL DEVELOPMENT FRAMEWORK 2009 – 2013***

This report represents a holistic **approach to addressing the level of need identified by both the NACPC Report and the HSE Audit**, informed by the detailed needs analysis completed by each Administrative Area.

This National Development Framework presents a statement of priorities and actions required to address the identified deficits in palliative care service provision, and presents a sequence of actions requiring implementation.

Government support is central to ensure the successful delivery and implementation of the national palliative care priorities 2009 – 2013. Appropriate funding will need to be made available to support the national priorities for palliative care outlined in this report. The Health Service Executive, in association with the Department of Health and Children and other stakeholders will discuss how best to achieve the recommendations detailed in the Framework. Identification of appropriate funding may be achieved through a combination of the following:

- Reorientation and reconfiguration of existing resources, to be undertaken in partnership with all relevant stakeholders, including both the statutory and voluntary sectors;
- Identification of additional resource requirements when further funding comes on-stream.

### ***PUTTING DELIVERY MECHANISMS IN PLACE***

Implementation of the national actions outlined in the National Development Framework will present a significant challenge. Formal commitment to implement these national palliative care actions will be required spanning the timeframe of the National Development Framework 2009 – 2013, including putting in place appropriate mechanisms to monitor the implementation of national actions.

### ***LOOKING AHEAD***

Overall responsibility for ensuring the delivery of the 41 national priorities identified in the National Development Framework 2009 – 2013 will rest with the HSE, supported by other stakeholders, including the Department of Health & Children and Area Development Committees.

## 1. INTRODUCTION

### 1.1 PALLIATIVE CARE DEFINITION

Palliative care is defined as “*the active holistic care of patients with advanced, progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families facing the problems associated with life-threatening illnesses through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems. Many aspects of palliative care are also applicable earlier in the course of the illness in conjunction with other treatments.*”

World Health Organisation, 2002

The goal of palliative care is the achievement of the best possible quality of life for patients and their families. Specifically, palliative care is concerned with the following:

- *Providing relief from pain and other distressing symptoms;*
- *Affirming life and regarding dying as a normal process;*
- *Neither hastening nor postponing death;*
- *Integrating the psychological and spiritual aspects of patient care;*
- *Offering a support system to help patients live as actively as possible until death;*
- *Offering a support system to help the families cope during the patient’s illness and in their own bereavement;*
- *Using a team-based approach to address the needs of patients and their families, including bereavement counselling;*
- *Enhancing quality of life and positively influencing the course of illness.*

Institutions providing in-patient palliative care as well as multidisciplinary teams providing palliative care in the home have been a long-standing tradition in Ireland. Palliative / hospice care originated in Ireland in the late 19<sup>th</sup> Century with the establishment of St. Patrick’s Hospital in Cork and Our Lady’s Hospice in Dublin.

### 1.2 OBJECTIVE, SCOPE AND APPROACH

#### 1.2.1 OBJECTIVE AND SCOPE OF THE NATIONAL DEVELOPMENT FRAMEWORK (2009 – 2013)

The objective of this document is to present the **Palliative Care Services - Five Year/Medium Term Development Framework (2009 – 2013)**. It has been developed using a holistic, system-wide, approach to addressing the level of need identified by both the **Baseline Study on the Provision of Hospice / Specialist Palliative Care Services in Ireland (2006)** as well as the **HSE Audit of Palliative Care Service Provision (2007)**. The “HSE Audit” (as it is referred to in this document) was conducted by each of the four HSE

## PALLIATIVE CARE SERVICES FIVE YEAR/ MEDIUM TERM DEVELOPMENT FRAMEWORK

Administrative Areas, in conjunction with Area Development Committees, against the recommendations of the **Report of the National Advisory Committee on Palliative Care 2001** (the NACPC Report).

Therefore, the **Palliative Care Services - Five Year/Medium Term Development Framework (2009 – 2013)** is grounded in the recommendations of the NACPC Report, (e.g. palliative care definition, palliative care service areas, staffing and bed number ratios), and informed by the findings of the HSE Audit.

The NACPC Report agreed a definition for palliative care services in Ireland, and highlighted a number of inequalities in the availability of palliative care services in all areas, including home care, day care and specialist in-patient units. The NACPC Report also made recommendations in relation to the appropriate membership of specialist palliative care teams, and made a number of specific recommendations in relation to the appropriate staffing and bed number ratios to ensure that palliative care services could be available in all care settings. A sample of these ratios include:

- *There should be at least 8 – 10 specialist palliative care beds per 100,000 population;*
- *There should be a minimum of 1 WTE specialist palliative care nurse per 25,000 population;*
- *There should be a minimum of 1 WTE specialist palliative care nurse per 150 beds in each acute general hospital.*

In 2007, the HSE conducted an audit of palliative care service provision in Ireland, measuring services on a regional basis against the staffing and bed number ratios recommended in the NACPC Report. Significantly, the HSE Audit highlighted ongoing deficits in palliative care service provision at both a national and regional level across all areas, e.g. home care, day care and specialist in-patient units.

For further details of both the NACPC Report and the HSE Audit, please refer to **Section 1.3 – National Context** of this document.

A number of initiatives relating to palliative care services was undertaken prior to the completion of the HSE Audit, including significant work completed by Area Development Committees (ADCs), which were established by the HSE based on the recommendations of the NACPC Report (see **Section 1.3 – National Context** for more details relating to other significant work completed). Area Development Committees comprise representatives from statutory agencies and voluntary organisations providing specialist palliative care services, and senior officials from the HSE (see **Section 7.2 – Area Development Committee Terms of Reference** for further information). The outputs of their extensive work formed the input into the development of this Framework. Outputs of the Area Development Committees that were not aligned to the recommendations of the NACPC Report were considered outside of the scope of this National Action Plan.

The purpose of this document is not to replace the recommendations of the NACPC Report from a policy context, nor does it represent a new national strategy for palliative care. **Palliative Care policy is determined by the Department of Health & Children and the National Council for Specialist Palliative Care.** This document details the required actions and initiatives necessary to address the gaps in palliative care service provision, against the recommendations set out in the NACPC Report.

The Department of Health & Children is developing a children's palliative care policy which aims to provide a framework for future service development. Therefore, this National Development Framework does not address paediatric palliative care.

### **1.2.2 APPROACH TO THE DEVELOPMENT OF THE NATIONAL DEVELOPMENT FRAMEWORK (2009 – 2013)**

To support the development of the National Development Framework (2009 – 2013), a Project Steering Committee was established with representatives from within the HSE, comprising the National Lead for Palliative Care, the Lead Local Health Managers for Palliative Care from each Administrative Area, together with representatives from Estates, Manpower Planning, and support from the Health Atlas Ireland Team (see **Section 7.4 – Project Steering Committee Membership**). Prospectus Strategy Consultants provided project management support to the Project Steering Committee throughout the process.

The Project Steering Committee was tasked with integrating and building on the work already completed by individual Administrative Areas and their Area Development Committees to develop a National Development Framework that is holistic and presents a national picture.

The work of the Project Steering Committee addresses commitment given in the HSE National Service Plan 2008 to develop a palliative care development framework for 2009 – 2013 following the completion of the national needs assessment (HSE Audit). Commitment was initially made under the 2007 Programme for Government to remove regional disparities in the provision and funding of palliative care services in Ireland.

The timing of this piece of work is important, as the Project Steering Committee was aware of the opportunity it had to consider in relation to the delivery of specialist palliative care services in the context of a consolidated national health service (the NACPC Report was largely focussed on the delivery of specialist palliative care services through the former Health Board structures).

The Project Steering Committee (which was convened for the first time on March 31<sup>st</sup>, 2008) conducted a number of working sessions (5 workshops) to consider the significant work completed at Area level and agree national palliative care priorities for the period 2009 – 2013.

The analysis of the work completed at Area level was conducted in close consultation with HSE staff at national, regional and local level (via individual meetings and teleconferences) to understand the priority need in each Area and the implementation enablers required to support those needs on a national basis. Throughout the completion of this project, the Project Steering Committee had to ensure that any need identified was grounded in the recommendations of the NACPC Report. A key challenge of the work involved ensuring consistency of approach and assumptions used, given that national priorities were considered in the context of priorities identified at ADC level.

During the completion of this report, the Project Steering Committee was required to make working decisions regarding data inputs and use assumptions to focus the scope of this exercise. These key assumptions are outlined in **Section 3.1 – Assumptions Underpinning National Priority Setting**.

In order to inform the development of national level priorities for palliative care for the period 2009 – 2013, the Project Steering Committee engaged with a number of key external stakeholders, such as the Irish Hospice Foundation, the Irish Cancer Society, the Irish Association for Palliative Care (IAPC) and the Hospice CEOs Group, to seek their input. This engagement acknowledged the commitment of the voluntary sector in the provision of palliative care services, and the voluntary sector's involvement in Area Development Committees. A list of the external stakeholders consulted with as part of this process can be found in the Appendices (**Section 7.1**).

This report, the Palliative Care Services - Five Year/Medium Term Development Framework (2009 – 2013), represents the output from the Project Steering Committee's work.

## 1.3 NATIONAL CONTEXT

Since the development of the first National Cancer Strategy in 1996, a significant number of reports, strategies, policy documents and plans have been published which have implications for the development of palliative care in Ireland. This section presents a brief overview of the changing national palliative care context, spanning the development of the National Cancer Strategy, through to the launch of the HSE's Transformation Programme.

The national priority actions for palliative care provision (**Section 4.2 – National Priorities**) are aligned to national healthcare policy, as set out below, and the HSE's Transformation Programme 2007 – 2010.

### 1.3.1 NATIONAL CANCER STRATEGY

One of the most important governmental interventions in the development of palliative care services in Ireland was the drawing up of the **National Cancer Strategy** (*Department of Health, 1996*). This strategy acknowledged the role palliative care plays in improving the quality of life for patients for whom disease cure was no longer possible, through the establishment of palliative care content in the curricula of education for nurses, physicians, and other allied health professionals. Another governmental initiative, the Cancer Services Forum, defined how palliative care services should be organised and structured within the country, thus providing a first step in standardising the quality of care provided.

The National Cancer Strategy also served to highlight policy deficiencies in a range of areas within cancer services, and underlined the requirement for the expansion of palliative care services in Ireland.

### 1.3.2 NATIONAL ADVISORY COMMITTEE ON PALLIATIVE CARE

The National Advisory Committee on Palliative Care was established by the Minister for Health and Children in 1999, with a view to preparing and presenting a comprehensive report on existing service provision and the future requirements of palliative care services in Ireland. **The Report of the National Advisory Committee on Palliative Care** (*Department of Health and Children 2001*) considered the historical background of palliative care service provision in Ireland, the need for specialist palliative care service provision in terms of specialist palliative care services in specialist units, acute general hospitals, community, standards, funding, accountability, planning and development and service priorities.

The NACPC Report anticipated that the need for palliative care services would increase substantially in the coming years. Disability prevalence rates and other "social" factors indicated that the number of people dying from cancer was expected to rise in future years. At the time of publishing, over 6,000 people in Ireland used hospices every year. This figure was projected to increase to 16,000 per annum by 2016.

The NACPC Report also recommended that palliative care services should be structured into three levels of ascending specialisation. These levels refer to the expertise of the health professionals delivering the palliative care services, and not the specific categorisation of beds.

- *Level One: Palliative Care Approach*

The palliative care approach should be a core skill of every clinician at hospital and community level. Many patients with progressive and advanced disease will have their care needs met without referral to specialist palliative care units or personnel.

## PALLIATIVE CARE SERVICES FIVE YEAR/ MEDIUM TERM DEVELOPMENT FRAMEWORK

- *Level Two: General Palliative Care*

At an intermediate level, patients and families benefit from the expertise of health care professionals who have had some additional training and experience in palliative care. Such intermediate level expertise may be available in hospital or community settings.

- *Level Three: Specialist Palliative Care*

Specialist palliative care services are those services whose core activity is the provision of palliative care. These services are involved in the care of patients with more complex care needs, and require a greater degree of training, staff and other resources.

The NACPC Report also highlighted the *ad hoc* nature of service provision, and inequalities in the availability of palliative care services in all areas, including home care, day care and specialist in-patient units. An overview of the principal recommendations of the NACPC Report is as follows:

- *An adequate level of public funding should be provided for the provision of palliative care services;*
- *Priorities for the development of specialist palliative care services should be based on national policy and should be decided by Health Boards at regional level. They should be based on the need for services as defined by regional needs assessments;*
- *All day-to-day expenditure should be met by the Health Boards' specialist palliative care budget. There should be a separate protected budget for specialist palliative care services at Health Board level;*
- *Health Boards should work in partnership with the voluntary service providers in their areas, with service agreements as the basis of their working relationships.*

In addition, the NACPC Report also recommended that palliative care services should be available in all care settings, and that services should allow patients to move from one care setting to another.

### **1.3.3 BASELINE STUDY ON THE PROVISION OF HOSPICE / SPECIALIST PALLIATIVE CARE SERVICES IN IRELAND**

In 2004, the Irish Hospice Foundation began an audit of palliative care service provision, benchmarking services on a regional basis against the recommendations of the NACPC Report. **The Baseline Study on the Provisions of Hospice / Specialist Palliative Care Services in Ireland** (*Irish Hospice Foundation, 2006*) highlighted continued inconsistencies and inequalities in accessing hospice services throughout the country.

The Baseline Study found that while a number of the recommendations of the NACPC Report had been implemented (including the appointment of more Medical Consultants in Specialist Palliative Medicine, the extension of home care services, and the establishment of the National Council for Specialist Palliative Care), many of the recommendations had yet to be implemented. The Baseline Study found that there was still a wide divergence in the range of services and care options available in different parts of the country, and that access to comprehensive services largely depended on the region of the country in which the patient resided.

More importantly, the Baseline Study highlighted continuing deficits in service provision across the country. This included a deficit of 254 specialist in-patient beds against the 390 specialist in-patient beds recommended by the NACPC Report.

### **1.3.4 HSE AUDIT OF SERVICE PROVISION**

## PALLIATIVE CARE SERVICES FIVE YEAR/ MEDIUM TERM DEVELOPMENT FRAMEWORK

Under the new Programme for Government (2007), commitment was made to remove the regional disparities in the provision and funding of palliative care services in Ireland, and to ensure that the needs of all those who require palliative care services are met.

Following this commitment, each of the four Administrative Areas of the HSE was tasked with the completion of an up-to-date audit of palliative care service provision against the recommendations of the NACPC Report. This initiative built upon the previous work undertaken by the Irish Hospice Foundation in the completion of their Baseline Study. In addition to addressing service provision and investment in line with the NACPC Report, the work undertaken by the four HSE Areas also sought to document palliative care services and investment in areas not dealt with in the NACPC Report, such as quality systems, ICT, support services, etc.

Each of the four HSE Administrative Areas, in association with the relevant Area Development Committee, identified the deficits in service provision and formulated a set of priority actions to be addressed over a Five Year/Medium Term period (2009 – 2013). They also completed preliminary costings (capital and revenue) associated with the implementation of these priorities.

### **1.3.5 PRIMARY CARE STRATEGY**

The Primary Care Strategy – *Primary Care: A New Direction* (Department of Health & Children, 2001) – set out a new direction for primary care as the central focus for the delivery of health and personal social services in Ireland. It envisaged that all Primary, Community and Continuing Care services will be delivered within a sector, or Social Care Network. Each sector will have within it a number of Primary Care Teams that are self-sufficient in terms of being able to provide health and community support services to meet the needs of the population. As well as the provision of domiciliary services to support patients to remain living in their own homes, quality residential care facilities will be available to provide assessment, diagnostic, rehabilitation, day care and respite services to help prevent hospitalisation and/or admission to long-stay care.

Members of the Primary Care Team / Social Care Network will include GPs, nurses/midwives, health care assistants, home helps, physiotherapists, occupational therapists, social workers and administrative personnel. The Primary Care Team/ Social Care Networks will be required to liaise directly with specialist teams (including the specialist palliative care team) in the community to improve integration of care.

### **1.3.6 NEEDS ASSESSMENT ON PALLIATIVE CARE FOR CHILDREN**

The need for a review of paediatric palliative care services in Ireland was first highlighted by the NACPC Report (2001). Following significant work conducted in conjunction with the Irish Hospice Foundation, the Department of Health & Children published *A Palliative Care Needs Assessment for Children* in 2005.

This document highlighted the need for a co-ordinated approach in the provision of services to children and adolescents with life limiting conditions. It clearly identified that services need to be inclusive of:

- *Age appropriate care;*
- *In a location of the patient's choosing;*
- *With services provided by specifically educated and trained healthcare professionals;*
- *Be capable of back-up support when required.*

Implementation of these recommendations by the Department of Health & Children represents the first step in a nationwide, cohesive and equitable palliative care service specifically for the paediatric population. There is

## PALLIATIVE CARE SERVICES FIVE YEAR/ MEDIUM TERM DEVELOPMENT FRAMEWORK

strong commitment by the Department of Health & Children and the HSE to provide appropriate access and care within this field by the development of specialist paediatric palliative care posts (medical and nursing), to spearhead the establishment of services and education.

The Department of Health & Children is currently developing a children's palliative care policy which aims to provide a framework for future service development. This National Development Framework 2009 – 2013 does not address paediatric palliative care.

### 1.3.7 THE CANCER CONTROL STRATEGY

The national Cancer Control Strategy (*A Strategy for Cancer Control in Ireland, 2006*) aims to ensure that a comprehensive and co-ordinated cancer control exists across the continuum of care involving prevention, screening, diagnosis, treatment, supportive and palliative care. Since the first National Cancer Strategy (1996) the range and capacity of cancer services in Ireland have been significantly enhanced.

The aim of the Cancer Control Strategy is to ensure that:

- *Cancer is prevented or detected early;*
- *Diagnostic, treatment, supportive and palliative services are consistent, accessible, equitable and high quality throughout the country irrespective of geography or ability to pay;*
- *Effective planning, evaluation and monitoring of performance in cancer control takes place;*
- *Ambulatory care is maximised, thereby reducing unnecessary dependency on inpatient care and patients having to spend more time than is necessary away from home;*
- *Cancer research is developed and integrates into all the activities of cancer control.*

The HSE is developing Managed Cancer Control Networks which will consist of primary, hospital, supportive and palliative care. While recognising fully that palliative care applies to patients suffering from a range of conditions, we are conscious of the opportunity which the Cancer Control Strategy presents to ensure an increasing integration of palliative care with the wider health service.

### 1.3.8 THE TRANSFORMATION PROGRAMME

The HSE's **Transformation Programme 2007 – 2010** represents our ambition for the future. The programme was prepared following staff consultation and reflects views expressed across the organisation. Specifically the Transformation Programme states the HSE's purpose – *“to enable people live healthier and more fulfilled lives”* – and provides the HSE with a shared direction and focus that will enable us achieve our ambition for the future.

Our ambition states that *“everybody will have easy access to high quality care and services that they have confidence in and staff are proud to provide.”*

One of the key priorities of the Transformation Programme (2007 – 2010) is to provide access to care in a setting that is close to the client's home. Accordingly, the HSE is now placing a greater emphasis on delivery of services locally through multi-disciplinary teams and local diagnostic services. An example of this emphasis is the fact that almost three-quarters (€109 million) of the €150 million funding package allocated to Services for Older People and Palliative Care in 2006 was committed to community care supports.

## PALLIATIVE CARE SERVICES FIVE YEAR/ MEDIUM TERM DEVELOPMENT FRAMEWORK

In prioritising elements for this Framework, the Project Steering Committee has kept a strong focus on this dimension of patient need. Recent international research from the European Society of Medical Oncology (2007) has outlined the preference of many patients to receive palliative care services in their own homes, and we have sought to reflect this in the national priorities for palliative care outlined in this document.

**THE PALLIATIVE CARE SERVICES - FIVE YEAR/MEDIUM TERM DEVELOPMENT FRAMEWORK (2009 – 2013) IS INFORMED BY THE NATIONAL HEALTHCARE POLICY CITED ABOVE, AND ALIGNED TO THE HSE'S TRANSFORMATION PROGRAMME.**

## 2 OVERVIEW OF THE PROVISION OF PALLIATIVE CARE SERVICES IN IRELAND

### 2.1 INTRODUCTION

Recent studies examining the provision of specialist palliative care services in Ireland confirm that we continue to experience wide regional variances in specialist service provision in all areas – specialist in-patient units, day care centres, acute hospitals, and community-based multidisciplinary home care.

This section of the report outlines how palliative care services are organised currently, and highlights the gaps in service provision on a national basis, categorised by the current settings of where specialist palliative care services are provided across the health system.

#### 2.1.1 PUBLIC / VOLUNTARY SECTOR INTERFACE

The Project Steering Committee recognises the important contributions of the voluntary sector to the provision of palliative care services in Ireland, and acknowledges that the flexibility and quality of services provided by the voluntary sector plays a critical role in helping to meet patient need.

The contribution of the voluntary sector is evident across all aspects of palliative care service provision, most notably in specialist palliative care in-patient units and day care facilities (with services provided on behalf of the HSE by hospices such as Our Lady’s Hospice, St. Francis Hospice, Milford Care Centre, and Marymount Hospice), and the provision of specialist palliative care in the community.

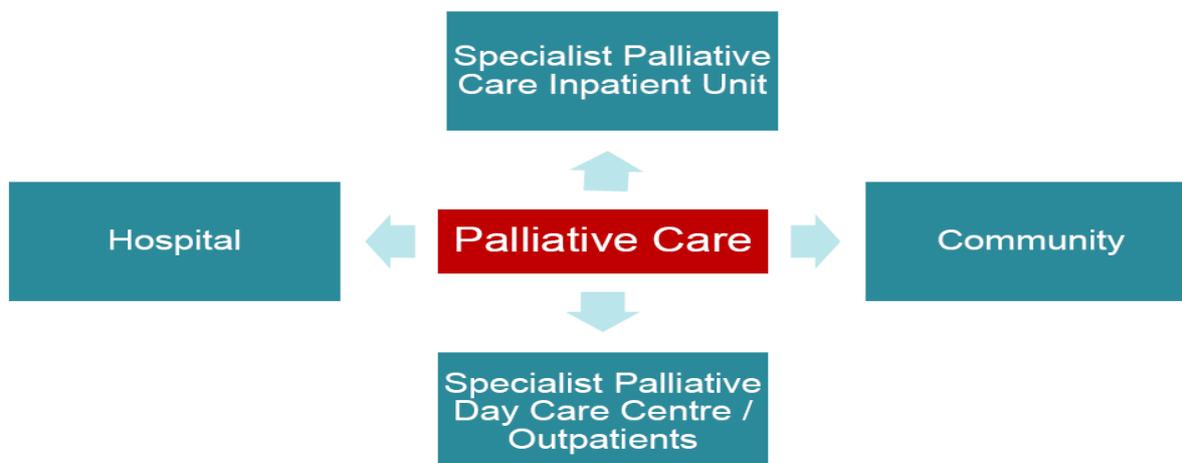
The NACPC Report identified the core role of the voluntary sector in the development of hospice and palliative care in Ireland. Subsequently, the Baseline Study (developed by the Irish Hospice Foundation, supported by funding from the HSE and Atlantic Philanthropies) outlined voluntary commitments in the provision of specialist palliative care services. Most notably, the Baseline Study indicated that local voluntary fundraising “contributes almost €14m to the funding of specialist palliative care nurses in the community.” In addition to contributing an approximate €1.8m to fund the provision of specialist palliative care staff in the community, the Irish Cancer Society also fully funds night nursing palliative care services in the community. This free service is offered to seriously ill cancer patients and is usually initiated by the home care team but can be accessed through the public health nurse, GP or hospital team. In 2006, direct costs of running the night nursing service were €1.4m, of which 97% was salary related. In 2007, this figure had risen to €1.7m, of which 95% was salary related (figures received from the Irish Cancer Society’s submission to the Project Steering Group – 15/04/08 – for the consideration of the Night Nursing Service in the Framework).

Although the night nursing service did not come under the scope of the National Development Framework 2009 – 2013, the Project Steering Committee noted that further consideration needs to be given to putting an appropriate funding mechanism in place to address the level of service provided by the Irish Cancer Society and other voluntary providers, and also the additional need in night nursing.

In working towards the commitments outlined in the Programme for Government, the importance of the active co-operation of the voluntary and statutory sectors cannot be understated. The Project Steering Committee recognises the vital role that both the voluntary and statutory sectors play in caring for those who are dying or who have a life limiting illness, and the importance of combining the respective effort of each to meet the future challenges of palliative care service provision in an efficient and effective manner.

## 2.2 NATIONAL OVERVIEW OF PALLIATIVE CARE SERVICE PROVISION

The NACPC Report (2001) established the principal settings in which both specialist and non-specialist palliative care services are currently provided across the health system. This is illustrated as follows:



The following section provides an overview of the above illustrated settings for palliative care, and provides a high level summary of the current provision of palliative care services in each setting nationally, as emerged from the HSE Audit (2007).

### 2.2.1 SPECIALIST PALLIATIVE CARE IN-PATIENT UNIT

The specialist palliative care unit is the essential core element of the specialist palliative care service, providing a wide range of specialist services to patients and families. The specialist palliative care unit should act as the focal point for the delivery of specialist palliative care services and should support and complement other service providers at hospital and community level appropriately. The unit should also act as an important resource, providing facilities for research and education.

Based on information received as an input to the HSE Audit (2007), there are eight dedicated specialist palliative care in-patient units across the four HSE Administrative Areas. There is a wide regional and intra-regional variation in the availability of specialist palliative care in a specialist in-patient unit. Nine Local Health Office areas have no specialist in-patient units and no access to specialist in-patient beds for those patients most in need:

- Cavan Monaghan LHO, Meath LHO and Louth LHO;
- Laois Offaly LHO and Longford Westmeath LHO;
- Wexford LHO, Carlow Kilkenny LHO, Waterford LHO and South Tipperary LHO.

Specialist palliative care units are also available to provide advice when needed to health care professionals caring for a specialist palliative care patient in other settings. Some specialist in-patient units have all members of the multi-disciplinary team while other units have varying levels of the team providing the specialist palliative care service. Waiting lists currently exist for admission to some specialist palliative care in-patient units.

### 2.2.2 SPECIALIST PALLIATIVE DAY CARE CENTRE / OUTPATIENTS

Specialist day care centres provide an important service to patients. Day care services attached to specialist palliative care units provide access to specialist care, a change of environment for patients, and respite for their families and carers.

Based on information received as an input to the HSE Audit (2007), there are 6 specialist palliative day care services nationally across the 4 HSE Administrative Areas. The total number of patients accessing these services in 2006 was approximately 2,600. This equated to an approximate monthly average of 215 patients. Currently, the majority of specialist palliative day care centres operate Monday to Friday, 9am – 5pm.

Similar to Specialist Palliative Care In-Patient Units, there is a wide intra-regional variation in the availability of specialist palliative care in day care centres. Nine Local Health Office areas have no specialist palliative day care centres. These are the same areas with no Specialist Palliative Care In-Patient Units:

- Cavan Monaghan LHO, Meath LHO and Louth LHO;
- Laois Offaly LHO and Longford Westmeath LHO;
- Wexford LHO, Carlow Kilkenny LHO, Waterford LHO and South Tipperary LHO.

### 2.2.3 SPECIALIST PALLIATIVE CARE IN THE COMMUNITY

The specialist palliative care team in the community, traditionally known as the “home care team”, provides specialist support and advice to patients, families and community-based health care professionals when appropriate. The specialist palliative care team working in the community may also be involved in the care of patients in palliative care support beds (e.g. Level 2 beds), when appropriate.

Based on information received as an input to the HSE Audit (2007), almost all Local Health Office (LHO) areas had access to Specialist Palliative Care / Home Care Teams in the community (*with the exception of Wicklow LHO in HSE Dublin Mid-Leinster*). The Specialist Palliative Care / Home Care Team should be accessible in the community, non-acute hospitals and nursing homes. Many are located in or have connections with the specialist palliative care in-patient units. Many of these services are a consultant-led multidisciplinary service. However, in some areas there continues to be a number of nurse-led services.

Service availability varies across the Specialist Palliative Care / Home Care Teams. A number of Specialist Palliative Care / Home Care Teams operate 7-days a week, 24-hours a day, while other teams operate 7-days a week, 9am – 5pm, while a further cohort of teams operates 5-days a week, 9am – 5pm. A small number of home care teams also have a waiting list to avail of services.

Based on information received as an input to the HSE Audit (2007), many Specialist Palliative Care / Home Care Teams do not have access to the multidisciplinary team. Current home help and public health nursing capacity is often insufficient to meet the needs of patients, and additional nursing support from the Irish Cancer Society and the Irish Hospice Foundation is time-limited to 70-hours per patient. As a result, in some situations it may become more difficult to maintain patient care in the community which ultimately results in the admission of the patient to in-patient facilities. The night nursing service provided by the Irish Cancer Society is exclusively funded by voluntary contributions. Non-cancer patients, e.g. those with renal failure and heart disease, do not have the same access to night nursing services as those with advanced cancer.

## PALLIATIVE CARE SERVICES FIVE YEAR/ MEDIUM TERM DEVELOPMENT FRAMEWORK

Overall, it was recognised that the General Practitioner and Public Health Nurse are the main providers of general palliative care in the community setting, including local community hospitals and nursing homes. This is an important consideration, in light of the Government's Primary Care Strategy, which champions the concept of Primary Care Teams, and the HSE's Transformation Programme.

### **2.2.4 SPECIALIST PALLIATIVE CARE SERVICES IN ACUTE GENERAL HOSPITALS**

Specialist Palliative Care Services are currently provided in a number of acute general hospitals throughout the country. Patients receiving the services of the specialist palliative care hospital team remain on their own wards, under the care of their referring consultant. Specialist palliative care teams in acute general hospitals work in support of, and in collaboration with, other hospital teams.

The pace of development of specialist palliative care services in the acute hospital relates to the contractual commitments of the consultant practice and accompanying palliative care staff. In Ireland, there are 50 acute general hospitals with approximately 38 of these having varying degrees of access to dedicated specialist palliative care teams. The majority of specialist palliative care services in the acute hospital provide access to services 5-days a week. In a number of acute hospitals a 7-day / 24-hour on call Consultant in specialist palliative care service is provided. In a small number of acute general hospitals weekend/out of hours services are provided to the acute hospital by the Clinical Nurse Specialist in the community or the Home Care Nurse.

Based on information received as an input to the HSE Audit (2007), there were significant variations in the staffing levels of specialist palliative care teams in acute general hospitals nationwide.

## **2.3 OVERVIEW OF PALLIATIVE CARE SERVICE PROVISION BY ADMINISTRATIVE AREA**

Building on the National Overview of Palliative Care Service Provision described above, the following section provides a high level summary of the provision of palliative care services in each of the four HSE Administrative Areas, as identified from the needs analysis exercise conducted by the ADCs in preparation for this Framework.

### **2.3.1 HSE DUBLIN MID-LEINSTER**

HSE Dublin Mid-Leinster, which incorporates Dublin city south of the River Liffey, south Dublin county and counties Wicklow, Kildare, Longford, Westmeath, Laois and Offaly, has been developing its specialist and non-specialist palliative services in all care settings. This has been achieved through collaborative working with key stakeholders including the Department of Health & Children and the range of service providers (both statutory and voluntary) who deliver services, and service users.

HSE Dublin Mid-Leinster has a total population of 1,216,848 (based on the 2006 census), covering a geographic area from Wicklow to Longford.

### **Specialist Palliative Care In-Patient Units**

## PALLIATIVE CARE SERVICES FIVE YEAR/ MEDIUM TERM DEVELOPMENT FRAMEWORK

The Administrative Area currently has two Specialist Palliative Care In-Patient Units, which offer a range of specialist palliative care services, including specialist in-patient care service, day care service and specialist home care service. Our Lady's Hospice in Harold's Cross (36 specialist in-patient beds) serves Dublin South City LHO, Dublin South West LHO and Dublin West LHO, representing a population of approximately 415,786. Blackrock Hospice (12 specialist in-patient beds), which is a satellite unit of Our Lady's Hospice, serves Dublin South LHO and Dublin South East LHO, representing a population of approximately 236,869.

There are no Specialist Palliative Care In-Patient Units in Wicklow LHO, Laois Offaly LHO or Longford Westmeath LHO, representing a combined population of approximately 312,509 across the 3 LHOs. In Kildare West Wicklow LHO, representing a population of approximately 203,327, there are no dedicated specialist in-patient beds. However, there are six Level 2 beds at St. Brigid's Hospice, which are in the process of being upgraded to Level 3.

The recommended number of specialist in-patient beds for the current population in HSE Dublin Mid-Leinster is 122 beds. At present, there are only 54 beds in the Region (including the six Level Two Beds in St. Brigid's Hospice), so **another 68 specialist in-patient beds will be needed to meet the national recommendations from the NACPC Report at current population levels.** Existing staffing / WTE deficits will also need to be addressed in order to achieve the recommendations of the NACPC Report.

### Specialist Palliative Day Care Centre / Outpatients

The Administrative Area has limited access to day care services, currently provided from Our Lady's Hospice, Harold's Cross and Blackrock Hospice. Therefore, there is **no access to specialist palliative day care facilities in Wicklow LHO, Laois Offaly LHO, Longford Westmeath LHO or Kildare West Wicklow LHO.**

### Specialist Palliative Care in the Community

Based on the current population of HSE Dublin Mid-Leinster, there are significant staff deficits in Home Care Teams in all LHO areas, most notably in Wicklow LHO. At present, many Home Care Teams do not have the resources to provide a 7-day a week 24-hour service (this mainly applies to the areas which are not served by a specialist in-patient unit). Some areas cannot provide a weekend on-call service.

The recommended number of community palliative care Clinical Nurse Specialists (CNS) for Dublin Mid-Leinster is 49. There are currently 41.5 in post or being recruited, which leaves **a current deficit of 7.5 posts.**

**There are also staffing / WTE deficits in consultant posts, and allied therapy posts,** which would be required to achieve fully functioning multidisciplinary teams, and to meet the national staffing recommendations from the NACPC Report.

### Specialist Palliative Care Services in Acute General Hospitals

The Administrative Area has a number of large acute hospitals which should be serviced by Consultant-Led Specialist Multidisciplinary Team. These include:

- St James's Hospital, Dublin 8
- Tallaght Hospital (Adelaide and Meath Hospital, incorporating the National Children's Hospital, AMNCH), Dublin 24

## PALLIATIVE CARE SERVICES FIVE YEAR/ MEDIUM TERM DEVELOPMENT FRAMEWORK

- Naas General Hospital, Co Kildare
- St Vincent's Hospital, Dublin 4
- St Columcille's Hospital, Loughlinstown
- St Michael's Hospital, Dun Laoghaire
- St Luke's Hospital, Rathgar, Dublin 6
- Midland Regional Hospital at Mullingar
- Midland Regional Hospital at Tullamore
- Midland Regional Hospital at Portlaoise.

All of the above hospitals currently have some level of consultant led specialist palliative care input.

The recommendations of the NACPC Report stated that there should be one hospital palliative care Clinical Nurse Specialist (CNS) per 150 beds in acute hospitals. Currently there are 8 hospital CNSs in post and a further 4 in the process of being recruited, so there is a **requirement for a further 12 CNS posts** in HSE Dublin Mid-Leinster. Overall, **all of the hospitals listed above have deficits in staffing levels for providing specialist services for Palliative Care within the acute sector.**

### 2.3.2 HSE DUBLIN NORTH-EAST

HSE Dublin North-East, which incorporates Dublin City north of the River Liffey, the community of Fingal county, and counties Louth, Meath, Cavan and Monaghan has been steadily developing its specialist and non-specialist palliative services in all care settings. This has been achieved through collaborative working with key stakeholders including the Department of Health & Children, the range of service providers (both statutory and voluntary) who deliver services and service users.

HSE Dublin North-East has a total population of 935,056 (based on 2006 census), covering a geographic area from Dublin to Monaghan.

#### Specialist Palliative Care In-Patient Units

The Administrative Area currently only has one Specialist In-Patient Unit, offering a range of specialist palliative care services, including specialist in-patient care service, day care service, and specialist home care service. St. Francis Hospice in Raheny (19 specialist in-patient beds) serves North West Dublin LHO, North Central Dublin LHO and North Dublin LHO, representing a population of approximately 534,233.

There are no specialist in-patient units in Cavan Monaghan LHO, Meath LHO and Louth LHO, representing a combined population of approximately 400,823 across the 3 LHOs.

The recommended number of specialist in-patient beds for the current population in HSE Dublin North-East is 93 beds. At present, there are only 19 beds in the Region, with no in-patient beds available in Cavan Monaghan LHO, Meath LHO and Louth LHO. Therefore, **74 specialist in-patient beds will be needed to meet the national recommendations from the NACPC Report at current population levels**, with the bulk of these (40 specialist palliative care in-patient beds) required in Cavan Monaghan LHO, Meath LHO and Louth LHO.

## PALLIATIVE CARE SERVICES FIVE YEAR/ MEDIUM TERM DEVELOPMENT FRAMEWORK

Existing staffing / WTE deficits will also need to be addressed in order to achieve the recommendations of the NACPC Report.

### Specialist Palliative Day Care Centre / Outpatients

The Administrative Area has limited access to day care services, currently provided from St. Francis Hospice, Raheny. Therefore, there is **no access to specialist palliative day care facilities in Cavan Monaghan LHO, Meath LHO or Louth LHO.**

### Specialist Palliative Care in the Community

Based on the current population of HSE Dublin North-East, there are significant staff deficits in Home Care Teams in all LHO areas. In particular, there are no physiotherapists or occupational therapists in North Dublin LHO, North Central Dublin LHO or North West Dublin LHO.

The recommended number of community palliative care Clinical Nurse Specialists (CNS) for HSE Dublin North-East is 37.5. There are currently 32 in post or being recruited, which **leaves a current deficit of 5.5 posts.**

In Cavan Monaghan LHO, Meath LHO and Louth LHO, staff are also required to rotate between community home care, and the provision of palliative care support to the 5 acute hospitals.

### Specialist Palliative Care Services in Acute General Hospitals

The Administrative Area has a number of large acute hospitals which should be serviced by Consultant-Led Specialist Multidisciplinary Team. These include:

- Beaumont Hospital, North Dublin
- Connolly Hospital, Blanchardstown
- Mater Hospital, Dublin
- Our Lady of Lourdes Hospital, Drogheda, Co. Meath
- Cavan General Hospital
- Louth County Hospital, Dundalk, Co. Louth
- Monaghan General Hospital
- Our Lady's Hospital, Navan, Co. Meath.

Each of the above hospitals currently has limited consultant led specialist palliative care teams.

The recommendations of the NACPC Report stated that there should be one hospital palliative care Clinical Nurse Specialist (CNS) per 150 beds in acute hospitals. Currently there are 7 hospital CNSs in post, so there is a **requirement for a further 9.8 CNS posts in HSE Dublin North-East.** Overall, **all of the hospitals listed above have deficits in staffing levels for providing specialist services** for Palliative Care within the acute sector. In particular, there is **insufficient Medical Consultant cover in the three Acute Hospitals** in Dublin North City and County.

## 2.3.3 HSE SOUTH

HSE South, which incorporates the counties Waterford, Wexford, Carlow, Kilkenny, South Tipperary, Cork and Kerry has been steadily developing its specialist and non-specialist palliative services in all the service settings. This has been achieved through collaborative working with key stakeholders including the Department of Health & Children, the range of service providers (both statutory and voluntary) who deliver services and service users.

Work has also been ongoing towards raising awareness of the principles and holistic value of palliative care to all stakeholders.

HSE South has a total population of 1,081,968 (based on the 2006 census), covering a large geographical spread extending from Kerry to Wexford.

### Specialist Palliative Care In-Patient Units

The Administrative Area currently has only one Specialist Palliative Care In-Patient Unit, which offers a range of specialist palliative care services, including specialist in-patient care service, day care service and specialist home care service. Marymount Hospice, St Patrick's Hospital, Cork (24 specialist in-patient beds) serves North Lee LHO, South Lee LHO, West Cork LHO and North Cork LHO, representing a population of approximately 481,295. Work will commence in 2008 on the construction of a 44-bed Specialist Palliative Care In-Patient Unit in Cork, increasing the LHO capacity of specialist in-patient beds by 20.

There are no Specialist Palliative Care In-Patient Units or Satellite Specialist Palliative Care Units in Waterford LHO, Wexford LHO, South Tipperary LHO and Carlow Kilkenny LHO, representing a combined population of 460,838. However, from January 2008, an additional two specialist palliative care beds were designated at Waterford Regional Hospital, serving Waterford LHO, Wexford LHO, South Tipperary LHO and Carlow Kilkenny LHO. Furthermore, there is no Satellite Specialist Palliative Care Unit in Kerry LHO. A Satellite Base would also be required to assist in the delivery of services in North Cork LHO.

The recommended number of specialist in-patient beds for the current population in HSE South is 108 beds. At present, there are only 26 beds in the Region (including the 2 designated beds in Waterford Regional Hospital), so **another 82 specialist in-patient beds will be needed to meet the national recommendations from the NACPC Report at current population levels.** Existing staffing / WTE deficits will also need to be addressed in order to achieve the recommendations of the NACPC Report.

### Specialist Palliative Day Care Centre / Outpatients

The Administrative Area has limited access to day care services. A Specialist Palliative Day Care Centre is located at Marymount Hospice. A reconfigured service is operational at St. Luke's Hospital in Kilkenny. There is also a Specialist Palliative Day Care Centre located at Kerry General Hospital, which was opened in 2007. An Out-Patient Department is also located at this site where joint out-patient clinics are held with hospital

consultants. Therefore, there is **no access to specialist palliative day care facilities in Waterford LHO, Wexford LHO, Carlow Kilkenny LHO, South Tipperary LHO, West Cork LHO or North Cork LHO.**

### Specialist Palliative Care in the Community

Based on the current population of HSE South, there are significant staff deficits in Home Care Teams in all LHO areas. In Waterford LHO, South Tipperary LHO and Carlow Kilkenny LHO, the HSE is contributing 62% towards the salary of the Clinical Nurse Specialist in Palliative Care through Service Level Agreements with voluntary providers.

The recommended number of community palliative care Clinical Nurse Specialists (CNS) for HSE South is 43. There are currently 39 in post, with **a deficit of 6 posts** in two LHO's and a deficit in funding to the voluntary committees (to resource an existing 6.5 posts) and achieve the recommendations of the NACPC Report.

While Specialist Palliative Care Services are delivered in the community, there is **a deficit in the composition of the team in some areas i.e. consultant led, allied health professionals and nurse specialists.** A Satellite Base is also required to assist in the delivery of services in North Cork LHO.

### Specialist Palliative Care Services in Acute General Hospitals

The Administrative Area has a number of acute hospitals which should be serviced by Consultant-Led Specialist Multidisciplinary Team. These include:

- Mallow General Hospital, Cork
- Kerry General Hospital
- Bantry General Hospital, Cork
- Mercy University Hospital, Cork
- South Infirmarary/Victoria University Hospital, Cork
- Cork University Hospital
- Waterford Regional Hospital
- South Tipperary General Hospital
- St. Luke's Hospital, Kilkenny
- Wexford General Hospital.

Nine of the above hospitals currently have consultant led specialist palliative care teams. These are in Cork University Hospital, South Infirmarary/Victoria University Hospital, Mercy University Hospital, Kerry General Hospital, Bantry General Hospital, Waterford Regional Hospital, South Tipperary General Hospital, St. Luke's Hospital, and Wexford General Hospital.

The recommendations of the NACPC Report stated that there should be one hospital palliative care Clinical Nurse Specialist (CNS) per 150 beds in acute hospitals. Currently there are 14 hospital CNSs in post, with a

## PALLIATIVE CARE SERVICES FIVE YEAR/ MEDIUM TERM DEVELOPMENT FRAMEWORK

**requirement for a further 7.5 CNS posts** in HSE South to meet the recommendations of the NACPC Report. Overall, **all of the hospitals listed above have deficits in staffing levels for providing specialist services for Palliative Care within the acute sector.** One acute hospital is currently not receiving a consultant led specialist palliative care service while other hospitals **have deficits in different team members.**

### 2.3.4 HSE WEST

HSE West, which incorporates counties Donegal, Sligo, Leitrim, Roscommon, Mayo, Galway, Clare, Limerick and North Tipperary has been steadily developing its specialist and non-specialist palliative services in all the service settings. This has been achieved through collaborative working with key stakeholders including the Department of Health & Children, the range of service providers (both statutory and voluntary) who deliver services and service users.

HSE West has a total population of 1,010,690 (based on 2006 census), covering a geographic area from Limerick to Donegal.

#### Specialist Palliative Care In-Patient Units

The Administrative Area currently has four Specialist Palliative Care In-Patient Units, which offer a range of specialist palliative care services, including specialist in-patient care service, day care service and specialist home care service. Donegal Hospice (8 specialist in-patient beds) serves Donegal LHO, representing a population of approximately 138,627. Northwest Hospice in Sligo (6 specialist in-patient beds) serves Sligo Leitrim LHO, South Donegal, and West Cavan, representing a population of approximately 99,690. Galway Hospice Foundation (12 specialist in-patient beds) serves Galway LHO, Mayo LHO and Roscommon LHO, representing a population of approximately 444,277. Milford Care Centre in Limerick (30 specialist in-patient beds) serves Limerick LHO, Clare LHO and North Tipperary LHO, representing a population of approximately 361,028. There are no Specialist Palliative Care In-Patient Units in Mayo LHO, Roscommon LHO, North Tipperary LHO and Clare LHO.

The recommended number of specialist in-patient beds for the current population in HSE West is 92 beds. At present, there are only 58 beds in the Administrative Area, so **another 34 specialist in-patient beds will be needed to meet the national recommendations from the NACPC Report at current population levels.** Of this deficit, Roscommon LHO, Mayo LHO and Galway LHO have a requirement for a further 28 beds. Existing staffing / WTE deficits will also need to be addressed in order to achieve the recommendations of the NACPC Report. The Baseline Study also recommended the development of an additional 9 beds in the Limerick, Clare and Tipperary area. However, in agreement with the HSE, Milford Hospice decided to defer developing these beds in favour of supporting the current development project at Milford Hospice, which is aimed at enhancing home care and day care services.

#### Specialist Palliative Day Care Centre / Outpatients

The Administrative Area has limited access to day care services, currently provided by Milford Care Centre, Galway Hospice Foundation and Donegal Hospice to their catchment areas. Milford Care Centre provides a 12-place day care centre, operating 2-days per week with transportation provided in a 15-mile radius. Galway Hospice provides a 14-place day care centre, operating 2-days per week with transportation provided in a 40-

## PALLIATIVE CARE SERVICES FIVE YEAR/ MEDIUM TERM DEVELOPMENT FRAMEWORK

mile radius. Donegal Hospice provides a 10-place day care centre, operating 1-day per week, with no transportation.

Therefore, there is **no access to specialist palliative day care facilities in Sligo Leitrim LHO, Mayo LHO, Roscommon LHO, Clare LHO or North Tipperary LHO.**

### Specialist Palliative Care in the Community

Currently in HSE West each LHO Area has a reasonably well developed consultant led specialist palliative home care service providing a full 7-day service, with reduced input at weekends in certain LHOs, with weekend cover being provided by the public health nurse service in other LHOs. Most home care teams are based in specialist palliative care centres, although the consultant-led Donegal team is based in the community rather than at the hospice. In the case of Milford Care Centre, in addition to the base in Limerick City, there are outreach bases in Ennis, Nenagh, Thurles and Newcastlewest.

Based on the current population of HSE West, there are significant staff deficits in Home Care Teams in all LHO areas, **a total staffing deficit in the area of 20.54 WTEs**, with Galway LHO, Donegal LHO, Clare LHO, Limerick LHO and North Tipperary LHO showing the greatest level of deficit in this regard.

The recommended number of community palliative care Clinical Nurse Specialists (CNS) for HSE West is 40.5. There are currently 39.7 in post or being recruited. However, there are **substantial staffing deficits for medical personnel, social workers, bereavement counsellors, care assistants, physiotherapists and occupational therapists, in order to meet the recommendations of the NACPC Report.**

### Specialist Palliative Care Services in Acute General Hospitals

The Administrative Area has a number of large acute hospitals which should be serviced by Consultant-Led Specialist Multidisciplinary Team. These include:

- Letterkenny General Hospital, Donegal
- Sligo General Hospital
- Roscommon County Hospital
- Mayo General Hospital
- University Hospital, Galway
- Merlin Park, Galway
- Portiuncula Hospital, Ballinasloe
- Ennis General Hospital
- Mid-Western Regional Hospital, Limerick
- St John's Hospital, Limerick
- Nenagh General Hospital, Tipperary.

Six of the above hospitals currently have consultant led specialist palliative care teams. These are in Donegal, Sligo, Roscommon, Mayo, Galway and Mid-Western Regional Hospital in Limerick. Consultant input is planned for Portiuncula Hospital. However, there is no consultant input to St. John's Hospital, Limerick, Ennis General Hospital or Nenagh General Hospital.

## PALLIATIVE CARE SERVICES FIVE YEAR/ MEDIUM TERM DEVELOPMENT FRAMEWORK

The recommendations of the NACPC Report stated that there should be one hospital palliative care Clinical Nurse Specialist (CNS) per 150 beds in acute hospitals. Currently there are 13 hospital CNSs in post, with a **requirement for a further 7.2 CNS posts in HSE West**. Overall, **all of the hospitals listed above have deficits in staffing levels for providing specialist services** for Palliative Care within the acute sector. In particular, Galway University Hospital, Sligo General Hospital and Letterkenny General Hospital show the greatest level of deficit.

### 3 SETTING NATIONAL PRIORITIES

To support the selection of initiatives for inclusion in the National Development Framework 2009 – 2013, the Project Steering Committee identified national priorities for the future development of palliative care provision. The Project Steering Committee considered the development of priorities as critical to its role and an essential feature of the Framework. For over a decade, repeated reports and analysis have pointed to the *ad hoc* and imbalanced development of our palliative care services. This section outlines the assumptions underpinning the setting of national priorities, and criteria used to select same.

#### 3.1 ASSUMPTIONS UNDERPINNING NATIONAL PRIORITY SETTING

The assumptions underpinning the national priorities for the development of palliative care provision are as follows:

- Specialist Palliative Care Services are defined as Specialist Palliative Care Centres (In-Patient Units & Satellites Units); Specialist Home Care Teams; Acute consultant-led teams; and associated Specialist Palliative Day Care.
- All priorities included in the palliative care priority lists submitted by the Area Development Committees from each administrative area are aligned with the recommendations of the NACPC Report 2001, with WTE figures calculated on the minimum requirements outlined.
- All priorities included in the palliative care priority lists submitted by the Area Development Committees are based on firm quantitative data, and the regional needs analysis exercise (the HSE Audit), in which a level of rigour has been applied consistently across all four HSE Administrative Areas. As such the work of the ADCs represents a response to the greatest areas of need, i.e. where the gap between the recommended position and the actual position is the widest.
- All area priorities submitted to the HSE National Lead for Palliative Care have been signed off by Area Development Committees.
- Demographic projections used in the audit of palliative care service provision recently undertaken by the Administrative Areas have been retained.
- There were a number of areas *outside the scope* of this piece of work:
  - Level 2 beds / Intermediate care beds in community hospitals;
  - Generic community care. Only specialist home care was considered;
  - Children's palliative care.
- It is recognised that Palliative Care services are currently provided by both the statutory and voluntary sectors. This National Development Framework highlights priority actions for palliative care, without prejudice to the possibility of mixed sources of funding. For given developments, there may be a range of options in how the desired service can be procured.

#### 3.2 CRITERIA FOR SELECTION OF NATIONAL PRIORITIES

## PALLIATIVE CARE SERVICES FIVE YEAR/ MEDIUM TERM DEVELOPMENT FRAMEWORK

The following criteria used to select national priorities for palliative care were set by the Project Steering Committee. They were informed by work at Area Development Committee level and discussions with external stakeholders.

National Criteria	Qualifying Questions
Needs Assessment	<ul style="list-style-type: none"><li>• Does the priority address a major area of need, where there is limited or no service provision, as highlighted by the HSE Audit (e.g. Midlands, South East, North East, and Wicklow)?</li><li>• Does the priority build capacity or ensure self-sufficiency?</li></ul>
National Policy	<ul style="list-style-type: none"><li>• Does the priority address the recommendations set out in the NACPC Report?</li></ul>
Health Care Policy / Integration	<ul style="list-style-type: none"><li>• Does the priority support wider healthcare policy, such as the Primary Care Strategy, the Transformation Programme, or the Cancer Control Programme?</li></ul>

Using the above criteria for the selection of national priorities, the Project Steering Committee reviewed the priority actions submitted by each Area Development Committee. It was through this lens that the various demands on a regional basis were considered, and a national approach to priority selection applied.

At the outset of the project, individual Area Development Committees had identified approximately 141 individual priority actions that were required to address the recommendations of the NACPC Report. Following an assessment of these individual area priorities against the above criteria, the Project Steering Committee agreed **41 individual priorities** for immediate consideration in the **Palliative Care Services - Five Year/Medium Term Development Framework (2009 – 2013)**.

These national priorities are outlined in **Section 4 – National Development Framework 2009 – 2013**, and are categorised as follows:

- Priorities Relating to *Home Care Deficits* (12);
- Priorities Relating to *Specialist In-Patient Bed Deficits* (6);
- Priorities Relating to *Capital Developments* (15);
- Priorities Relating to *Acute Hospital Support* (8).

## 4. NATIONAL DEVELOPMENT FRAMEWORK 2009 – 2013

The **primary objective** of the Project Steering Committee was **the development and presentation of a Palliative Care Services - Five Year/Medium Term/Medium Term Development Framework (2009 – 2013)**. Due to the complexity of demands for palliative care service provision, which had been previously assessed on a largely regional basis, the Project Steering Committee was tasked with integrating the work

## PALLIATIVE CARE SERVICES FIVE YEAR/ MEDIUM TERM DEVELOPMENT FRAMEWORK

completed at Area level, applying national criteria for the selection of priority actions to develop a National Development Framework that is holistic and presents a national picture.

Therefore, the National Development Framework 2009 – 2013 seeks to address the deficits identified in the HSE Audit, in the context of the recommendations of the NACPC Report, and a system wide approach to the provision of palliative care services.

This document is not a new strategy for the delivery of palliative care services in Ireland, nor does it represent a revised policy document for the delivery of palliative care services in Ireland. Palliative Care policy is determined by the Department of Health & Children and the National Council for Specialist Palliative Care.

Section	Description
Section 4.1	Presents the immediate priorities identified to address the areas of greatest need under each of the four categories of palliative care provision.
Section 4.2	Outlines the 41 national priorities to address the recommendations and service gaps outlined in the NACPC Report and HSE Audit.
Section 4.3	Examines how the national priorities agreed by the Project Steering Committee would impact on the palliative care service gap identified.
Section 4.4	Presents a graphical depiction of palliative care provision across the country if the 41 national priorities outlined in this plan were successfully completed, e.g. at the end of 2013.

Please note the completion timeframe associated with each national priority is accurate at the time of the publishing of this document. However, the Project Steering Committee recognises that the completion timeframes are indicative and subject to variation due to a range of contingencies. As a result, certain priority actions listed in order of completion priority below may be escalated (e.g. brought forward from a completion timeframe of 2013 to 2011) to take advantage of possible delays in preceding national actions.

In relation to sequencing, the decision was made to front-load priorities relating to immediate areas of need, or areas where there was an absolute absence of palliative care service provision, as identified by the HSE Audit. Actions relating to the provision of home care were prioritised to reflect the shift in service provision from an acute setting into the community. Capital developments were prioritised in recognition of the extended timescale associated with the tendering and design process.

### 4.1 IMMEDIATE PRIORITY ACTIONS TO ADDRESS AREAS OF GREATEST NEED

During the development of a **Palliative Care Services - Five Year/Medium Term/Medium Term Development Framework (2009 – 2013)**, the Project Steering Committee identified a number of immediate priorities under each of the four categories that represent the areas of greatest needs. These priorities relate to the areas of greatest need identified by the NACPC Report and HSE Audit, particularly to the service provision “black-spots” where there is limited or no palliative care service provision currently.

## PALLIATIVE CARE SERVICES FIVE YEAR/ MEDIUM TERM DEVELOPMENT FRAMEWORK

Section 4.2 outlines the full list of 41 national priorities from which the following immediate priorities for urgent implementation were agreed.

Palliative Care – Immediate Priority Actions for Completion	Completion Timeframe				
	2009	2010	2011	2012	2013
<b>Priorities Relating to Home Care Deficits</b>					
Address Home Care Team deficits in Wicklow LHO (7 WTEs required). Currently no specialist palliative care service in Wicklow (population 109,202)	▲				
Address Home Care Team deficits in Laois Offaly LHO & Longford Westmeath LHO (6 WTEs required) in order to meet current staffing deficits (population 251,664)	▲				
Address Home Care Team deficits in Louth LHO, Meath LHO & Cavan Monaghan LHO (9 WTEs required). There are currently core staffing deficits within all Home Care Teams in HSE Dublin North East.	▲				
Address Home Care Team deficits in Waterford LHO, Wexford LHO, South Tipperary LHO, Carlow Kilkenny LHO & North Cork LHO (13.5 WTEs required) to enhance community services where no specialist IPU. Voluntary services fund 62% of Home Care service.	▲				
<b>Priorities Relating to Specialist In-Patient Bed Deficits</b>					
Address Specialist IPU deficits in Laois Offaly LHO & Longford Westmeath LHO (6 WTEs required at Athlone). No specialist inpatient services in the region (population 251,664).	▲				
Address Specialist IPU deficits Kildare West Wicklow LHO (12.2 WTE required) to bring 6 beds in St. Brigid's up to Level 3 service following appointment of Consultant in 2007	▲				
Address Specialist IPU deficits at St. Francis, Raheny (12.75 WTE required) to meet the recommendations of the NACPC Report.		▲			
Address Specialist IPU deficits in Sligo LHO and Galway LHO (18.2 WTE required) to meet the recommendations of the NACPC Report.		▲			
<b>Priorities Relating to Capital Developments</b>					
Development of 12 Bed In-patient Unit in Louth LHO (including an Education and Research Centre) with associated revenue & staffing implications.			▲		
Development of 24 Bed In-patient Unit in Abbotstown with associated revenue & staffing implications to serve North West Dublin LHO				▲	
Development of 25 Bed In-patient Unit in Laois Offaly LHO with associated revenue & staffing implications to serve Laois Offaly LHO and Longford Westmeath LHO					▲
Development of 20 Bed In-patient Unit in Waterford LHO (Waterford Regional Hospital) with associated revenue & staffing implications to address specialist in-patient bed deficit in the South East					▲
Development of 11 Bed In-patient Unit in Wicklow LHO with associated revenue & staffing implications. Population of 109,202 = 11 beds. Current in-patient beds = 0				▲	
<b>Priorities Relating to Acute Hospital Support</b>					
Address deficits in the provision of Support to Acute Hospitals in Laois Offaly LHO and Longford Westmeath LHO (3 WTEs required) – provision of nursing support to Portlaoise, Mullingar & Tullamore			▲		
Address deficits in the provision of Support to Connolly Hospital (5.5 WTEs required). There is currently no Palliative Care Team in Connolly Hospital.			▲		
Address deficits in the provision of Support to Acute Hospitals in Dublin North-East (9 WTEs required). This will include 6 Clinical Nurse Specialists & 3 NCHD posts			▲		

As outlined in the above table, the Project Steering Committee identified **16 immediate priorities** which require funding to address the **areas of greatest need nationally** across the four categories:

- In total, these 16 national priorities proposed will require 102.15 WTE and 92 specialist in-patient beds (Level 3). Based on the requirements identified in **Section 4.2** below, this represents approximately

## PALLIATIVE CARE SERVICES FIVE YEAR/ MEDIUM TERM DEVELOPMENT FRAMEWORK

38% of WTE requirements (102.15 WTEs out of a proposed 272.19 WTEs) and approximately 45% of specialist in-patient bed requirements (92 beds out of a proposed 203 beds).

- 25% of immediate priorities relate to home care deficits, with all proposed to be completed in 2009, requiring 35.5 WTE.
- 25% of immediate priorities relate to the staffing of in-patient beds, with 50% of these proposed to be completed in 2009 (resulting in the requirement for 18.2 WTE), and 50% proposed to be completed in 2010 (resulting in the requirement for 30.95 WTE).
- 31.25% of immediate priorities relate to capital developments, with 20% of these proposed to be completed in 2011 (resulting in the provision of 12 beds), 40% proposed to be completed in 2012 (resulting in the provision of 35 beds), and 40% proposed to be completed in 2013 (resulting in the provision of 45 beds).
- 18.75% of immediate priorities relate to the provision of support to acute hospitals, with 100% proposed to be completed in 2011 (resulting in the requirement for 17.5 WTE).
- Of the immediate priorities that have a WTE component, all 102.15 WTEs are required by 2011, with 53% (53.7 WTE) required by 2009, 30% (30.95 WTE) required by 2010, and 17% (17.5 WTE) required by 2011.
- Overall, **50%** of immediate priorities are proposed for completion in **2009** and **2010**, with no capital developments proposed for completion in **2009** or **2010**.

### 4.2 NATIONAL PRIORITIES

Based on the criteria for selecting national priorities outlined in **Section 3.2**, the Project Steering Committee agreed **41 national priorities** for inclusion in the *Palliative Care Services - Five Year/Medium Term/Medium Term Development Framework (2009 – 2013)*. The priorities are outlined by category – *Home Care Deficits, Specialist In-Patient Bed Deficits, Capital Developments, and Acute Hospital Support*.

Please note that while these national priorities address the areas of immediate need as identified by the Project Steering Committee, they may not necessarily address *all* of the palliative care service gaps addressed in the NACPC Report and HSE Audit.

**4.2.1 PRIORITIES RELATING TO HOME CARE DEFICITS**

National Actions for Palliative Care Service Provision	Completion Timeframe				
	2009	2010	2011	2012	2013
<b>Priorities Relating to Home Care Deficits</b>					
Address Home Care Team deficits in Wicklow LHO (7 WTEs required). Currently no specialist palliative care service in Wicklow (population 109,202).	▲				
Address Home Care Team deficits in Laois Offaly LHO & Longford Westmeath LHO (6 WTEs required) in order to meet current staffing deficits (population 251,664).	▲				
Address Home Care Team deficits in Louth LHO, Meath LHO & Cavan Monaghan LHO (9 WTEs required). There are currently core staffing deficits within all Home Care Teams in HSE Dublin North East.	▲				
Address Home Care Team deficits in Waterford LHO, Wexford LHO, South Tipperary LHO, Carlow Kilkenny LHO & North Cork LHO (13.5 WTEs required) to enhance community services where no specialist IPU. Voluntary services fund 62% of Home Care service.	▲				
Address Home Care Team deficits in Galway LHO, Mayo LHO & Roscommon LHO (8.26 WTEs required) in order to meet current staffing deficits.		▲			
Address Home Care Team deficits in Kildare West Wicklow LHO (9 WTEs required) in order to meet current staffing deficits, with a particular emphasis on health & social care professionals.		▲			
Address Home Care Team deficits in all LHOs in Dublin North East (12 WTEs required) in order to meet current staffing deficits, with a particular emphasis on allied therapy professionals.			▲		
Address Home Care Team deficits in North Lee LHO, South Lee LHO, West Cork LHO & Kerry LHO (14 WTEs required) in order to meet current staffing deficits.			▲		
Address Home Care Team deficits in Our Lady's Hospice and Blackrock Hospice (OLH 10.5 WTE, Blackrock 9 WTE) in order to meet current staffing deficits, with a particular emphasis on health & social care professionals.				▲	
Address Home Care Team deficits in Donegal LHO, Sligo Leitrim LHO, and Limerick LHO (12.28 WTEs required) in order to meet current staffing deficits per recommendations of the NACPC Report.				▲	
Address Home Care Team deficits in all LHOs in Dublin North East (5 WTEs required) in order to meet current staffing deficits, with a particular emphasis on clinical nurse specialists.					▲
Address Home Care Team deficits in South Lee LHO & North Lee LHO (6 WTEs required) in order to meet current staffing deficits, with a particular emphasis on allied therapy professionals.					▲

- Wicklow LHO is identified as an area of immediate need for home care provision, where there is no provision of palliative care services in the community. Currently, there is also no specialist in-patient palliative care service provided in Wicklow.
- Other LHOs are also identified as an area of immediate need for home care provision for similar reasons, as there is no specialist palliative care service provided in the region, e.g. Laois Offaly LHO and Longford Westmeath LHO; and Louth LHO, Meath LHO and Cavan Monaghan LHO.
- Waterford LHO, Wexford LHO, Carlow Kilkenny LHO and South Tipperary LHO were also identified as areas of immediate need for home care provision due to the lack of specialist palliative care service provided in region. However, community services are currently provided in Waterford LHO and Wexford LHO – 62% of which are funded by voluntary services. This priority aims to enhance existing statutory services.

## PALLIATIVE CARE SERVICES FIVE YEAR/ MEDIUM TERM DEVELOPMENT FRAMEWORK

- A number of the priorities relating to home care team deficits seek to expand existing day care and community based services in order to support the preference of palliative care patients to be cared for at home for longer periods, while concurrently reducing in-patient admissions.

### 4.2.2 PRIORITIES RELATING TO SPECIALIST IN-PATIENT BED DEFICITS

National Actions for Palliative Care Service Provision	Completion Timeframe				
	2009	2010	2011	2012	2013
<b>Priorities Relating to Specialist In-Patient Bed Deficits</b>					
Address Specialist IPU deficits in Laois Offaly LHO & Longford Westmeath LHO (6 WTEs required at Athlone). No specialist inpatient services in the region (population 251,664).	▲				
Address Specialist IPU deficits Kildare West Wicklow LHO (12.2 WTE required) to bring 6 beds in St. Brigid's up to Level 3 service following appointment of Consultant in 2007.	▲				
Address Specialist IPU deficits at St. Francis, Raheny (12.75 WTE required) to meet the recommendations of the NACPC Report.		▲			
Address Specialist IPU deficits in Sligo LHO and Galway LHO (18.2 WTE required) to meet the recommendations of the NACPC Report.		▲			
Address Specialist IPU deficits in Donegal LHO & Limerick LHO (16.4 WTE required) to meet the recommendations of the NACPC Report.			▲		
Address Specialist IPU deficits at Our Lady's Hospice & Blackrock Hospice (20.1 WTE required). Current staff levels for 36 and 12 bed units respectively, are below minimum recommended level.				▲	

- Laois Offaly LHO and Longford Westmeath LHO were identified as areas of immediate need for in-patient staffing provision, as there is currently no active specialist in-patient palliative care service in the region. Provision of funding will provide staffing for existing interim specialist beds, pending the development of the new specialist in-patient unit.
- Kildare West Wicklow LHO is identified as an area of immediate need for in-patient staffing provision in order to bring a number of Level 2 / intermediate beds up to Level 3 service following the appointment of a Consultant in 2007.
- A number of the priorities relating to in-patient deficits seek to allow for robust clinical governance, quality and risk management. A number of priorities also seek to expand existing day care services in order to support the preference of palliative care patients to be cared for at home for longer periods.

4.2.3 PRIORITIES RELATING TO CAPITAL DEVELOPMENTS

National Actions for Palliative Care Service Provision	Completion Timeframe				
	2009	2010	2011	2012	2013
<b>Priorities Relating to Capital Developments</b>					
Development of 12 Bed In-patient Unit in Louth LHO (including an Education and Research Centre) with associated revenue & staffing implications.			▲		
Development of 24 Bed In-patient Unit in Abbotstown with associated revenue & staffing implications to serve North West Dublin LHO.				▲	
Development of 25 Bed In-patient Unit in Laois Offaly LHO with associated revenue & staffing implications to serve Laois Offaly LHO and Longford Westmeath LHO.					▲
Development of 20 Bed In-patient Unit in Waterford LHO (Waterford Regional Hospital) with associated revenue & staffing implications to address specialist in-patient bed deficit in the South East.					▲
Development of 11 Bed In-patient Unit in Wicklow LHO with associated revenue & staffing implications. Population of 109,202 = 11 beds. Current in-patient beds = 0.				▲	
Development of an additional 20 In-patient Beds at Marymount Hospice, with associated revenue & staffing implications, to address the deficit in North Lee LHO, South Lee LHO, West Cork LHO & North Cork LHO.			▲		
Development of 14 Bed Specialist Satellite Unit in Mayo LHO, with associated revenue & staffing implications. Current bed complement is 58 specialist in-patient beds.					▲
Development of 16 Bed In-patient Unit and Day Care Unit in Cavan Monaghan LHO, with associated revenue & staffing implications. Currently no in-patient beds available for population of 200,000.					▲
Development of an additional 14 In-patient Beds in Kildare West Wicklow LHO (St. Brigid's Hospice) with associated revenue & staffing implications. Currently only 6 Level 2 beds available for population of 203,327.					▲
Development of 12 Bed Satellite Unit in Carlow Kilkenny LHO, with associated revenue & staffing implications. Site secured on the grounds of St Luke's General Hospital in Kilkenny.					▲
Further Development of Day Care & Community Based Services in Limerick LHO (Milford Care Centre), with associated revenue & staffing implications. Includes investment in education and research.	▲				
Development of 4 Bed Extension to In-patient Unit in Donegal LHO with associated revenue & staffing implications.					▲
Development of 14 Bed Extension to In-patient Unit and Day Care Unit in Galway LHO, with associated revenue & staffing implications. Current bed complement is 58.					▲
Development of an additional 2 In-patient Beds in Sligo Leitrim LHO with associated revenue & staffing implications.					▲
Development of 15 Bed Satellite Unit in Kerry LHO (Kerry General Hospital) with associated revenue & staffing implications. Part 1 of project completed with opening of Specialist Day Care in 2007.					▲

- Cavan Monaghan LHO, Meath LHO and Louth LHO are identified as areas of immediate need for in-patient bed provision, as there is currently no specialist in-patient palliative care service in the region. The unit in question will address the bed deficit for Meath LHO and Louth LHO, and will also facilitate admissions from Cavan Monaghan LHO until such time as the proposed unit at Cavan Hospital comes on stream.
- Laois Offaly LHO and Longford Westmeath LHO are also identified as areas of immediate need for in-patient bed provision, as there is currently no specialist in-patient palliative care service in the region.

## PALLIATIVE CARE SERVICES FIVE YEAR/ MEDIUM TERM DEVELOPMENT FRAMEWORK

- The development of an In-Patient Unit and Day Care Centre at Abbotstown has been under proposal for a number of years, with a site having already been allocated.
- A number of the priorities relating to developments in HSE South that have been included are at advanced stages of development, some with sites secured and business cases developed (Waterford, Kilkenny and Kerry), and some already having received approval from the Department of Health & Children, with the project having already gone to tender (Cork – Marymount Hospice).
- A number of the priorities relating to in-patient bed deficits seek to expand existing day care services in order to support the preference of palliative care patients to be cared for at home for longer periods.
- Completion timeframes above are indicative and subject to variation due to a range of contingencies. As a result, certain actions listed in order of completion priority may be escalated (e.g. brought forward from a completion timeframe of 2013 to 2011) to take advantage of delays in preceding national actions.

### 4.2.4 PRIORITIES RELATING TO ACUTE HOSPITAL SUPPORT

National Actions for Palliative Care Service Provision	Completion Timeframe				
	2009	2010	2011	2012	2013
<b>Priorities Relating to Acute Hospital Support</b>					
Address deficits in the provision of Support to Acute Hospitals in Laois Offaly LHO and Longford Westmeath LHO (3 WTEs required) – provision of nursing support to Portlaoise, Mullingar & Tullamore.			▲		
Address deficits in the provision of Support to Connolly Hospital (5.5 WTEs required). There is currently no Palliative Care Team in Connolly Hospital.			▲		
Address deficits in the provision of Support to Acute Hospitals in Dublin North-East (9 WTEs required). This will include 6 Clinical Nurse Specialists & 3 NCHD posts.			▲		
Address deficits in the provision of Support to Acute Hospitals in Waterford LHO, Wexford LHO, South Tipperary LHO & Carlow Kilkenny LHO (7.7 WTEs required). This will include 1.7 WTE Clinical Nurse Specialists, 4 WTE Social Workers & 2 WTE Secretarial support.				▲	
Address deficits in the provision of Support to Acute Hospitals in Galway LHO, Sligo LHO & Limerick LHO (10.95 WTEs required). This will include 5.81 WTE Clinical Nurse Specialists, 3.39 WTE Social Workers & 1.75 WTE Medical Secretary supports.				▲	
Address deficits in the provision of Support to Acute Hospitals in Dublin Mid-Leinster (14 WTEs required). This will include provision of CNS support to St. James's Hospital, St. Vincent's Hospital, St. Colmcille's Hospital, Tallaght Hospital, St. Michael's Hospital & Naas General Hospital.				▲	
Address deficits in the provision of Support to Acute Hospitals in Donegal LHO, Roscommon LHO & Mayo LHO (5.05 WTEs required). This will include 1.38 WTE Clinical Nurse Specialists, 1.5 WTE Secretary support & 2.17 WTE Social Workers.					▲
Address deficits in the provision of Support to Acute Hospitals in North Lee LHO, South Lee LHO, North Cork LHO, West Cork LHO & Kerry LHO (9.8 WTEs required). This will include 2.8 WTE Clinical Nurse Specialists, 4 WTE Social Workers & 3 WTE Secretarial support.					▲

- Laois Offaly LHO and Longford Westmeath LHO were identified as areas of immediate need for the provision of acute support, as there are currently no specialist in-patient palliative care services in the region.
- Priorities relating to HSE Dublin North-East were identified as areas of immediate need for the provision of acute support as significant staffing deficits were identified, with limited consultant-led services being provided in each of the 8 acute general hospitals in the region. In particular, the region

## PALLIATIVE CARE SERVICES FIVE YEAR/ MEDIUM TERM DEVELOPMENT FRAMEWORK

was identified as having insufficient Medical Consultant cover, and associated deficits in Clinical Nurse Specialists, Therapy and NCHD posts.

- A number of the priorities relating to acute support deficits seek to allow for the provision of consultant-led services (Connolly Hospital, HSE West), while also providing for robust clinical governance, quality and risk management.

### 4.3 RATIONALE AND ANALYSIS

**Section 2** of this document details the gap identified by the HSE Audit at a national and regional level. The rationale behind the selection of the 41 national priorities listed above is to address the gap identified, particularly in the areas of greatest need, or where there is currently an absence of service provision. This section of the document examines how the national priorities agreed by the Project Steering Committee impact on the palliative care service gap identified.

**Section 4.4** of the National Development Framework presents a graphical depiction of palliative care provision across the country should the 41 national priorities outlined above be successfully completed e.g. at the end of 2013.

#### 4.3.1 IMPACT ON HOME CARE DEFICITS

Commitment to deliver on the 12 national priorities relating to Home Care Deficits would require 122 WTEs approximately, allowing for improvements in the level and range of palliative care service provision, and providing coverage to some LHOs where no specialist palliative care services are currently provided.

The NACPC Report made a number of specific recommendations in relation to the appropriate ratio of WTE requirements of home care team members based on the population or catchment area served. For the purpose of this analysis, we have examined the impact of these positions against the identified gap associated with these positions. Please note that this may exclude some of the WTE posts being proposed to meet the needs of the catchment area.

The relevant recommendations of the NACPC Report were as follows:

- *There should be a minimum of one WTE specialist palliative care nurse per 25,000 population.*
- *There should be a minimum of one WTE community physiotherapist specialising in palliative care per 125,000 population. This post should be based in the specialist palliative care unit.*
- *There should be a minimum of one WTE community occupational therapist specialising in palliative care per 125,000 population. This post should be based in the specialist palliative care unit.*
- *There should be a minimum of one WTE community social worker specialising in palliative care per 125,000 population. This post should be based in the specialist palliative care unit.*

The most notable impacts on the levels of home care deficits were in the following Local Health Offices identified in the NACPC Report as having limited or no home care provision:

- The provision of funding for 9 WTE Clinical Nurse Specialists, 6.5 WTE Physiotherapists, 8.5 WTE Occupational Therapists, and 6 WTE Social Workers fully addresses the level of need identified for HSE Dublin Mid-Leinster. Significantly, the provision of 7 WTEs in Wicklow LHO will allow for the

## PALLIATIVE CARE SERVICES FIVE YEAR/ MEDIUM TERM DEVELOPMENT FRAMEWORK

provision of home care services to the Wicklow area where there is currently no specialist service provided.

- There will be a notable impact on the level of need identified in HSE Dublin North-East, both in North Dublin LHO, North Central Dublin LHO, and North West Dublin LHO where there were no Physiotherapists or Occupational Therapists in particular; and in Louth LHO, Meath LHO, and Cavan Monaghan LHO. The provision of 10 WTEs across HSE Dublin North-East reduces the deficit of CNS, Physiotherapists, Occupational Therapists and Social Workers by over 50%.
- There will also be a notable impact on the level of need identified in Waterford LHO, Wexford LHO, South Tipperary LHO and Carlow Kilkenny LHO, where there are deficits in the numbers of Physiotherapists, Occupational Therapists and Social Workers. The provision of 13.5 WTE will also have an impact on the level of funding support provided by the voluntary sector, which currently accounts for 62% of existing home care services.
- Overall, the provision of 93.04 WTE CNS, Physiotherapists, Occupational Therapists and Social Workers reduces the associated deficit identified by approximately 90%.

Following the successful implementation of the above 12 national actions relating to Home Care Deficits, a number of LHOs would continue to have deficits in relation to the provision of specialist palliative home care services.

### **4.3.2 IMPACT ON SPECIALIST IN-PATIENT BED DEFICITS**

Commitment to deliver on the 15 national priorities relating to Capital Developments would require 203 beds approximately, allowing for improvements in the level and range of palliative care service provision, and providing coverage to some LHOs where no specialist palliative care services are currently provided.

The most notable impacts on the levels of in-patient bed deficits were in the regions identified in the NACPC Report as having limited or no specialist palliative care in-patient beds:

- There will be a notable impact on the level of need identified in Louth LHO, Meath LHO, and Cavan Monaghan LHO, where there were no specialist in-patient beds in operation, but with a requirement for between 31 and 40 beds. The development of 12 specialist in-patient beds in Louth LHO, and the development of 16 specialist in-patient beds in Cavan Monaghan LHO will make significant progress in addressing the bed deficit identified.
- There will also be a notable impact on the level of need identified in Waterford LHO, Wexford LHO, South Tipperary LHO and Carlow Kilkenny LHO, where currently there are no Specialist Palliative Care In-Patient Units or Satellite Specialist Palliative Care Units, and only 2 specialist in-patient beds. The development of 20 specialist in-patient beds in Waterford LHO, and the development of 12 specialist in-patient beds in Kilkenny LHO will make significant progress in addressing the deficit of 35 – 44 beds identified.
- The development of 25 specialist in-patient beds in Laois Offaly LHO fully addresses the level of need identified for Laois Offaly LHO and Longford Westmeath LHO. Based on a population of approximately 251,664, a deficit of 25 beds had been identified.
- Overall, the provision of 203 specialist in-patient beds reduces the deficit identified by approximately 80%.

## PALLIATIVE CARE SERVICES FIVE YEAR/ MEDIUM TERM DEVELOPMENT FRAMEWORK

Following the successful implementation of the above 15 national priorities relating to Capital Development, a number of LHOs would continue to have deficits in relation to the provision of specialist palliative in-patient beds.

### 4.3.3 IMPACT ON ACUTE HOSPITAL SUPPORT DEFICITS

Commitment to deliver on the 8 national priorities relating to Acute Hospital Supports would require 65 WTEs approximately, allowing for improvements in the delivery of specialist palliative care services in acute hospitals, and ensuring existing palliative care support in acute settings meets the minimum recommendations of the NACPC Report.

The NACPC Report made a number of specific recommendations in relation to the appropriate ratio of WTE requirements of specialist palliative care team members in an acute general hospital based on the number of beds. For the purpose of this analysis, we have examined the impact of these positions against the identified gap associated with these positions. Please note that this may exclude some of the WTE posts being proposed to meet the needs of the catchment area.

The relevant recommendations of the NACPC Report were as follows:

- *There should be a minimum of one WTE specialist palliative care nurse per 150 beds in each acute general hospital.*
- *The specialist palliative care team in an acute general hospital should consist of at least a consultant in palliative medicine; a specialist palliative care nurse; social worker and secretary.*

The most notable impacts on the levels of acute support deficits are as follows:

- The provision of funding for 17 WTE Clinical Nurse Specialists fully addresses the level of need identified for HSE Dublin Mid-Leinster. However, deficits continue in the provision of Social Workers and Secretaries in Specialist Palliative Care Teams.
- The provision of funding for 7.19 WTE Clinical Nurse Specialists fully addresses the level of need identified for HSE West. However, deficits continue in the provision of Social Workers and Secretaries in Specialist Palliative Care Teams, although these have been reduced significantly – by almost 60% for Social Workers (fully addressing the level of need identified for Letterkenny General Hospital, Roscommon County Hospital and Mayo General Hospital), and by almost 30% for Secretaries (fully addressing the level of need identified for Sligo General Hospital).
- There will be a notable impact on the level of need identified in HSE South. The provision of 17.5 WTEs across region (4.5 WTE CNS, 8 WTE Social Workers, and 5 WTEs Secretaries) fully addresses the level of acute support identified.
- Overall, the provision of 56.33 WTE CNS, Social Workers and Medical Secretaries reduces the associated deficit identified by approximately 73%.

Following the successful implementation of the above 8 national priorities relating to Acute Hospital Supports, a number of LHOs would continue to have deficits in relation to the staffing levels providing specialist palliative care support to acute hospitals.

## 4.4 IMPACT OF SUCCESSFUL IMPLEMENTATION

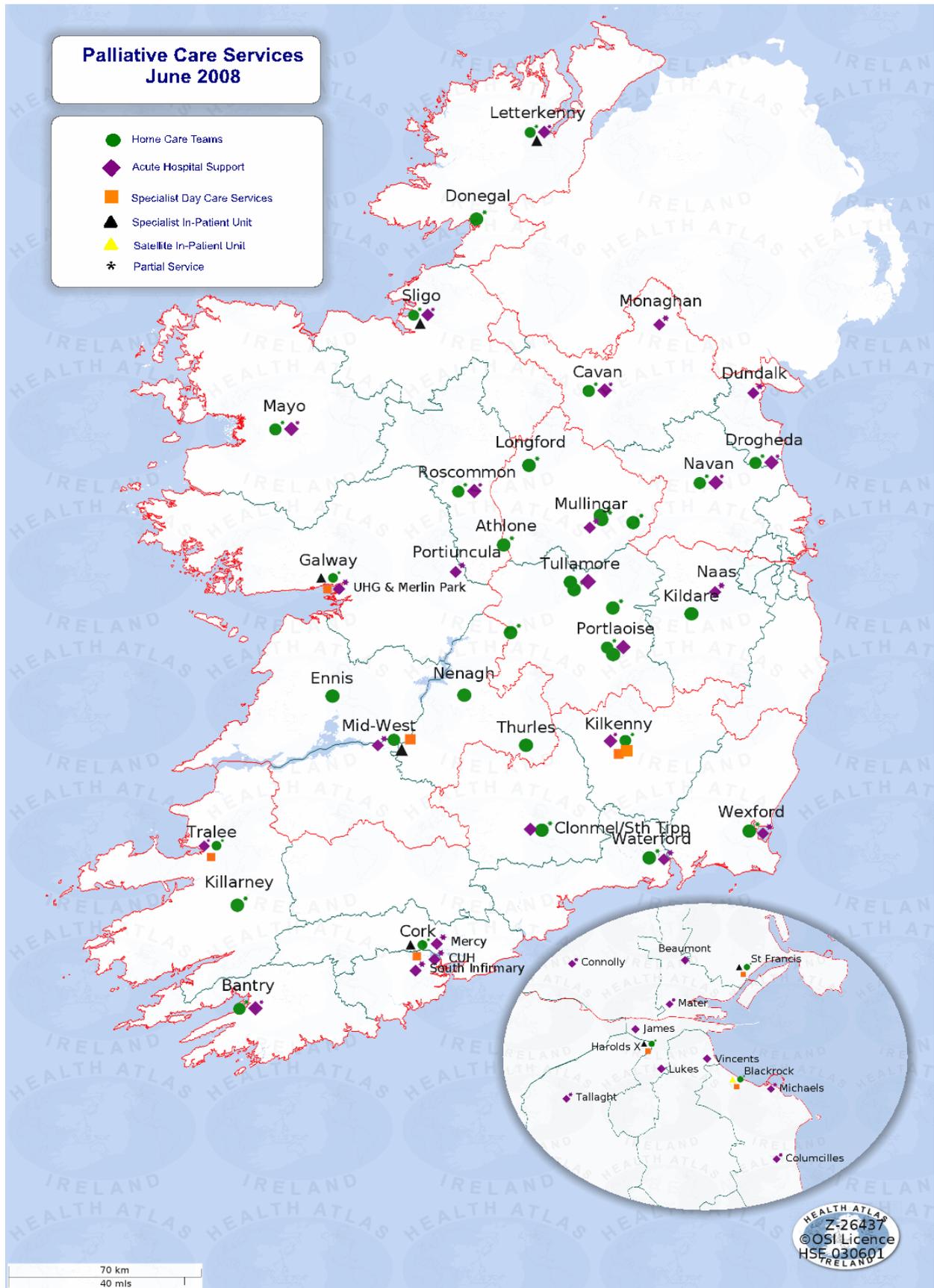
This section of the National Development Framework presents a graphical depiction of palliative care provision across the country. Section 4.4.1 presents an overview of the current provision of palliative care services in each setting nationally, as emerged from the HSE Audit (2007). Section 4.4.2 presents an overview of the future provision of palliative care services in each setting nationally upon successful completion of the 41 national actions outlined above, e.g. at the end of 2013.

This section of the National Development Framework was developed by Health Atlas Ireland.

### 4.4.1 OVERVIEW OF CURRENT PALLIATIVE CARE SERVICE PROVISION

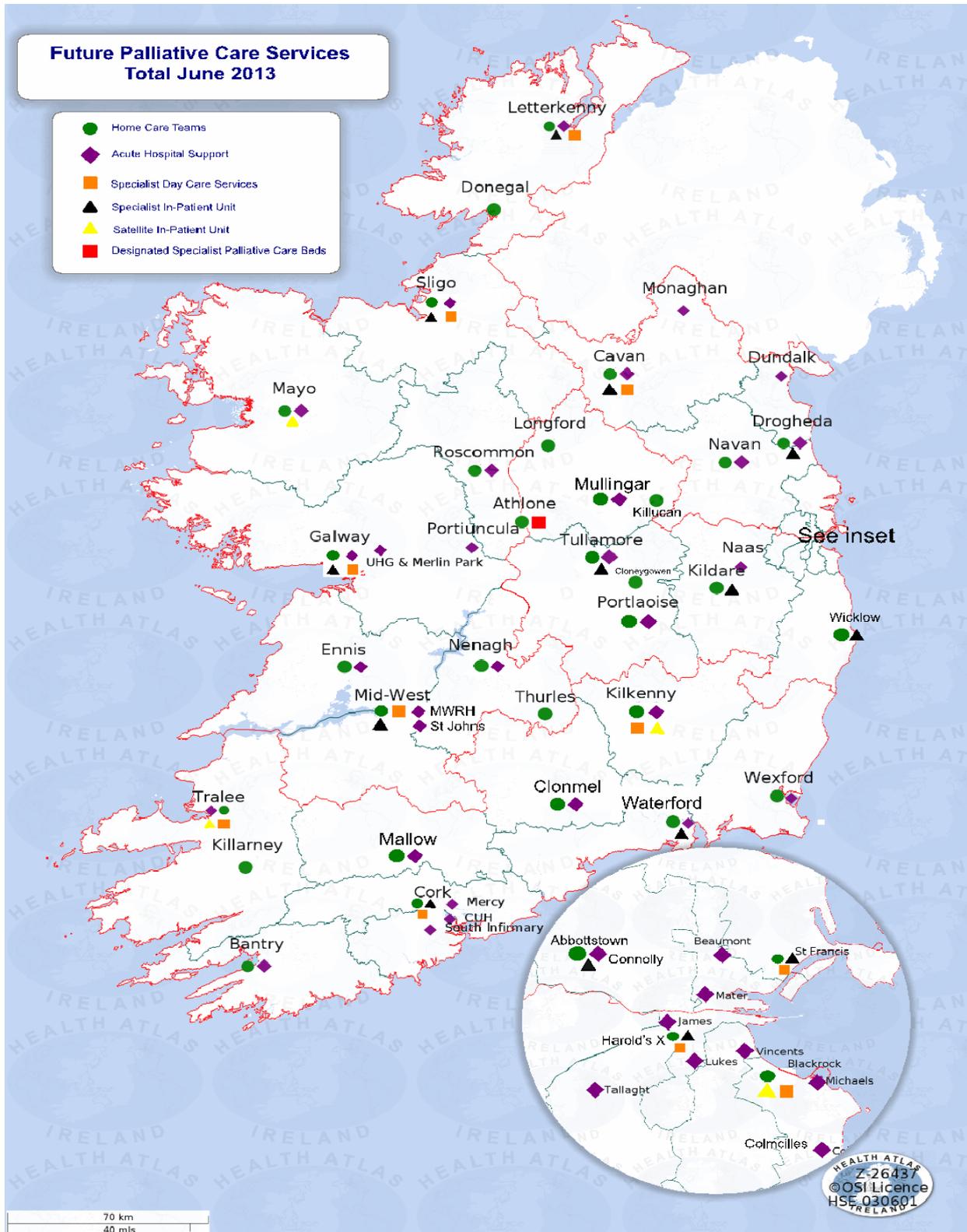
The following table presents a graphical overview of the current national provision of palliative care services, as at June 2008. Please refer back to **Section 2.3 – Overview of Palliative Care Service Provision by HSE Administrative Area** for a description of current provision of palliative care services in each of the 4 HSE Administrative Areas.

# PALLIATIVE CARE SERVICES FIVE YEAR/ MEDIUM TERM DEVELOPMENT FRAMEWORK



4.4.2 OVERVIEW OF FUTURE PALLIATIVE CARE SERVICE PROVISION

The following table presents a graphical overview of the proposed national provision of palliative care services, as at June 2013, following the successful completion of the palliative care actions outlined in the National Development Framework 2009 – 2013.



## 5. RESOURCING NATIONAL ACTIONS

This section provides an overview of some of the resource implications – both capital and revenue – to support the successful delivery of the national priorities described in **Section 4**.

**Section 5.1** presents a national summary of the capital and revenue requirements to support the implementation of the priorities identified in this Framework. **Section 5.2** presents an overview of capital and revenue requirements broken down by HSE Administrative Area.

This section of the report benefitted from significant input received from HSE Estates and Manpower Planning. Any assumptions used in the development of the following costings were based on industry best practice, and existing Department of Health & Children and HSE templates and pay scales.

### 5.1 TOTAL RESOURCING REQUIREMENT OF NATIONAL DEVELOPMENT FRAMEWORK 2009 – 2013

The following section provides indicative capital and revenue costings at a national level for the national priorities identified by the Project Steering Committee. Significant investment is required between 2009 and 2013 to ensure that the deficits identified in the NACPC Report and the HSE Audit are addressed.

Certainty of capital funding is central to the development of proposed new specialist in-patient units. The availability of revenue funding to commission the staffing required in new specialist in-patient units, as well as that required to meet the existing staffing deficits identified, is also critical and needs to be planned. Ensuring the availability of funding to cover the revenue requirement over the duration of the National Development Framework is a key challenge.

The table below outlines illustrative capital and revenue cost estimates required to deliver on the national actions identified for completion between 2009 and 2013. In calculating the illustrative cost estimates below, the Project Steering Committee utilised a number of working assumptions, which are outlined in **Section 5.2.2 – Assumptions Underpinning Capital Costs**, and **Section 5.3.2 – Assumptions Underpinning Revenue Costs**.

Total Resource Requirement of National Development Framework (2009 – 2013)	Capital Requirement	Revenue Requirement	Sub-Total
	€(m)	€(m)	€(m)
Priorities Relating to Home Care Deficits	-	10.474	10.474
Priorities Relating to Specialist In-Patient Bed Deficits	-	6.956	6.956
Priorities Relating to Capital Developments	237.340	48.020	285.360
Priorities Relating to Acute Hospital Support	-	6.035	6.035
<b>Grand Total</b>	<b>237.340</b>	<b>71.485</b>	<b>308.825</b>

Overall, the capital and revenue requirements to deliver on the 41 national priorities outlined in **Section 4.2** will cost a combined **€308.825 million**. This equates to **€237.34 million capital** and **€71.485 million revenue** over the period of the National Development Framework (2009 – 2013).

## PALLIATIVE CARE SERVICES FIVE YEAR/ MEDIUM TERM DEVELOPMENT FRAMEWORK

For further information on the breakdown of capital and revenue requirements by HSE Area, action category and year, refer to **Section 5.2 – Capital Cost of the National Action Plan**, and **Section 5.3 – Revenue Cost of the National Action Plan**.

### 5.2 CAPITAL COST OF NATIONAL DEVELOPMENT FRAMEWORK 2009 – 2013

The following section provides indicative capital costings at a national and regional level for the national priorities identified by the Project Steering Committee.

HSE Area	Total Beds	Total Capital Funding Requirement (€m)								Total (€m)
		2006	2007	2008	2009	2010	2011	2012	2013	
DML	50	-	-	-	2.00	6.10	12.50	10.00	4.00	34.60
DNE	50	-	-	1.00	5.00	20.50	19.00	8.00	0.50	54.00
South	67	0.20	3.00	10.00	22.75	27.05	20.50	15.00	4.50	103.00
West	34	-	1.00	6.00	2.50	4.00	13.20	13.10	5.94	45.74
<b>Total</b>	<b>203</b>	<b>0.20</b>	<b>4.00</b>	<b>17.00</b>	<b>32.25</b>	<b>57.65</b>	<b>65.20</b>	<b>46.10</b>	<b>14.94</b>	<b>237.34</b>

#### 5.2.1 TOTAL CAPITAL REQUIREMENTS

The Project Steering Committee has identified the following key messages from the breakdown of capital costing of national priorities:

- The table in Section 5.2 above discloses the total capital cost irrespective of source of funding. Therefore, it reflects both the statutory cost associated with capital development national actions, and it reflects where commitment has been given by the voluntary sector to contribute to the capital cost.
- Approximately 9% of the capital cost associated with national priorities will have been drawn down in advance of the commencement of this National Development Framework 2009 – 2013, e.g. in 2006, 2007 and 2008. This reflects the fact that a number of the capital developments included in the National Development Framework 2009 – 2013 commenced in years preceding the initiation of this piece of work.
- Over the period of the National Development Framework 2009 – 2013, the completion of capital developments has been phased based on current or projected phase of development, e.g. Tender, Appraisal, Design, Construction, etc.
- The above breakdown shows that just over **70% of the total capital requirement is proposed for draw-down between 2010 and 2012**. Approximately 20% of the total capital requirement will be drawn down at the commencement and completion of the National Action Plan, e.g. in 2009 and 2013.
- The completion timeframes outlined above are indicative due to extenuating circumstances and issues outside the control of the HSE. As a result, certain capital developments listed in order of completion

## PALLIATIVE CARE SERVICES FIVE YEAR/ MEDIUM TERM DEVELOPMENT FRAMEWORK

priority may be escalated (e.g. brought forward from a completion timeframe of 2013 to 2011) to take advantage of possible delays in preceding capital developments.

- Overall, the outlined total capital cost requirement of **€237.34m** for the development / extension of specialist palliative care in-patient units (incorporating day care and home care bases as appropriate) will provide an additional **203 specialist in-patient beds** (Level 3).

### 5.2.2 ASSUMPTIONS UNDERPINNING CAPITAL COSTS

The assumptions underpinning the development of capital costs associated with national priorities for the future development of palliative care provision are as follows:

- It is recognised that Palliative Care services are currently provided by both the statutory and voluntary sectors. This National Development Framework highlights priority actions for palliative care, without prejudice to the possibility of mixed sources of funding. Therefore, the capital costs outlined above are the total cost of the capital development.
- The programme for each project is based on a realistic assessment by HSE Estates locally and nationally of the current project status, the range of other developments on the same health campus, and the projected revenue impact.
- Total project costs are based on the following:
  - Design Team Estimates from developments in Abbotstown, Marymount Hospice, and Milford Care Centre;
  - Developed Design Briefs from proposed developments in Mayo, Kilkenny, and Kerry;
  - Estimated costs provided by Local Management for proposed developments in Laois Offaly LHO, Waterford LHO, and Galway LHO;
  - All costs will have to be validated when the final Design Brief is developed.

## 5.3 REVENUE COST OF NATIONAL DEVELOPMENT FRAMEWORK 2009 – 2013

The following section provides indicative revenue costings at a national and regional level for the national priorities identified by the Project Steering Committee.

### 5.3.1 TOTAL REVENUE REQUIREMENTS

The following table provides breakdown of revenue costings (both pay and non-pay) at a national and regional level to support the successful implementation of the National Development Framework (2009 – 2013).

Revenue Costing of National Priorities	Pay Costs	Non-Pay Costs	Total
<b>Home Care Deficits</b>	<b>€(m)</b>	<b>€(m)</b>	<b>€(m)</b>
2009	2.344	1.004	<b>3.348</b>
2010	0.981	0.421	<b>1.402</b>
2011	1.666	0.714	<b>2.380</b>
2012	1.627	0.697	<b>2.324</b>

## PALLIATIVE CARE SERVICES FIVE YEAR/ MEDIUM TERM DEVELOPMENT FRAMEWORK

Revenue Costing of National Priorities	Pay Costs	Non-Pay Costs	Total
2013	0.714	0.306	1.020
<b>Sub-Total</b>	<b>7.332</b>	<b>3.142</b>	<b>10.474</b>
<b>In-Patient Bed Deficits</b>	<b>€(m)</b>	<b>€(m)</b>	<b>€(m)</b>
2009	0.998	0.428	1.426
2010	1.771	0.759	2.530
2011	1.050	0.450	1.500
2012	1.050	0.450	1.500
2013	0.000	0.000	-
<b>Sub-Total</b>	<b>4.869</b>	<b>2.087</b>	<b>6.956</b>
<b>Capital Developments</b>	<b>€(m)</b>	<b>€(m)</b>	<b>€(m)</b>
2009	0.000	0.000	-
2010	0.000	0.000	-
2011	5.068	2.172	7.240
2012	6.615	2.835	9.450
2013	21.931	9.399	31.330
<b>Sub-Total</b>	<b>33.614</b>	<b>14.406</b>	<b>48.020</b>
<b>Acute Hospital Support</b>	<b>€(m)</b>	<b>€(m)</b>	<b>€(m)</b>
2009	0.000	0.000	-
2010	0.000	0.000	-
2011	1.390	0.596	1.986
2012	1.685	0.722	2.407
2013	1.149	0.493	1.642
<b>Sub-Total</b>	<b>4.225</b>	<b>1.811</b>	<b>6.035</b>
<b>Grand Total</b>	<b>50.040</b>	<b>21.466</b>	<b>71.485</b>

It is important to note that the revenue costs associated with capital developments include the provision of adequate WTE requirements to fully staff the number of specialist palliative care beds being proposed.

There are a number of important observations based on the information outlined in the table above:

- Revenue expenditure on actions relating to home care deficits has been front-loaded into 2009 to reflect the shift in palliative care provision from an acute setting into the community. Overall, 2009 revenue expenditure on actions relating to home care deficits accounts for approximately 32% of national revenue expenditure relating to home care over the course of the National Development Framework 2009 – 2013.
- **All revenue expenditure** on priorities relating to **capital developments** (100%) will be required between **2011 and 2013**, with the large majority required in 2013 (65%).

### 5.3.2 ASSUMPTIONS UNDERPINNING REVENUE COSTS

## PALLIATIVE CARE SERVICES FIVE YEAR/ MEDIUM TERM DEVELOPMENT FRAMEWORK

The assumptions underpinning the development of revenue costs associated with national priorities for the future development of palliative care provision are as follows:

- Revenue costs (pay and non pay) *associated with Capital Projects* were calculated having regard to the minimum level of staffing required as per the NACPC Report, with pay costs calculated on March 2008 rates plus relevant PRSI rates and premia as appropriate. These costings also reflect existing infrastructure where appropriate. These costs will vary depending on the level of existing service provision as well as the level of development of other services within any specific area and so costs are indicative only.
- Revenue costs (pay and non pay) *associated with service priorities* were calculated having regard to the minimum level of staffing required as per the NACPC Report, with pay costs calculated on March 2008 rates plus relevant PRSI rates and premia as appropriate.
- Pay versus Non-Pay was calculated at a ratio of 70/30.
- The core membership of Home Care Teams, Specialist Palliative Care Teams, and Acute Hospital Support are based on the recommendations of the NACPC Report.

### 5.3.3 REVENUE COST BREAKDOWN BY HSE AREA

The following tables provide indicative revenue costings broken down by HSE Area under each of the categories of national priorities identified by the Project Steering Committee.

#### HSE Dublin Mid-Leinster

Revenue Costing of National Priorities	2009	2010	2011	2012	2013	Total
<b>HSE Dublin Mid-Leinster</b>	€(m)	€(m)	€(m)	€(m)	€(m)	€(m)
Home Care Deficits	1.090	0.755	-	1.450	-	3.295
Specialist In-Patient Bed Deficits	1.426	-	-	1.500	-	2.926
Capital Developments	-	-	-	2.970	9.550	12.500
Acute Hospital Support	-	-	0.298	1.400	-	1.698
<b>Sub-Total</b>	<b>2.516</b>	<b>0.755</b>	<b>0.298</b>	<b>7.320</b>	<b>9.550</b>	<b>20.439</b>

The table for HSE Dublin Mid-Leinster shows us that:

- A large proportion of revenue expenditure is weighted towards **2012 and 2013**.
- The bulk of revenue expenditure (**61%**) is on priorities relating to **capital development**.

#### HSE Dublin North-East

Revenue Costing of National Priorities	2009	2010	2011	2012	2013	Total
<b>HSE Dublin North-East</b>	€(m)	€(m)	€(m)	€(m)	€(m)	€(m)
Home Care Deficits	0.868	-	1.090	-	0.498	2.926

## PALLIATIVE CARE SERVICES FIVE YEAR/ MEDIUM TERM DEVELOPMENT FRAMEWORK

Specialist In-Patient Bed Deficits	-	0.900	-	-	-	0.900
Capital Developments	-	-	3.240	6.480	3.200	12.920
Acute Hospital Support	-	-	1.688	-	-	1.688
<b>Sub-Total</b>	<b>0.868</b>	<b>0.900</b>	<b>6.018</b>	<b>6.480</b>	<b>3.698</b>	<b>17.964</b>

The table for HSE Dublin North-East shows us that:

- A large proportion of revenue expenditure is weighted towards **2011 and 2012**.
- The majority of revenue expenditure (**72%**) is on priorities relating to **capital development**.

### HSE South

Revenue Costing of National Priorities	2009	2010	2011	2012	2013	Total
<b>HSE South</b>	<b>€(m)</b>	<b>€(m)</b>	<b>€(m)</b>	<b>€(m)</b>	<b>€(m)</b>	<b>€(m)</b>
Home Care Deficits	1.390	-	1.290	-	0.502	3.202
Specialist In-Patient Bed Deficits	-	-	-	-	-	-
Capital Developments	-	-	4.000	-	10.800	14.800
Acute Hospital Support	-	-	-	0.553	0.720	1.273
<b>Sub-Total</b>	<b>1.390</b>	<b>0.000</b>	<b>5.290</b>	<b>0.553</b>	<b>12.042</b>	<b>19.275</b>

The table for HSE South shows us that:

- The majority of revenue expenditure (**77%**) is on priorities relating to **capital development**.

### HSE West

Revenue Costing of National Priorities	2009	2010	2011	2012	2013	Total
<b>HSE West</b>	<b>€(m)</b>	<b>€(m)</b>	<b>€(m)</b>	<b>€(m)</b>	<b>€(m)</b>	<b>€(m)</b>
Home Care Deficits	-	0.647	-	0.874	-	1.501
Specialist In-Patient Bed Deficits	-	1.630	1.500	-	-	3.130
Capital Developments	-	-	-	-	7.780	7.780
Acute Hospital Support	-	-	-	0.454	0.922	1.642
<b>Sub-Total</b>	<b>0.000</b>	<b>2.277</b>	<b>1.500</b>	<b>1.328</b>	<b>8.702</b>	<b>13.807</b>

The table for HSE West shows us that:

- There is **no revenue expenditure across each of the 4 categories in 2009**.
- Over half of revenue expenditure (**58%**) is on actions relating to **capital development**.
- The bulk of revenue expenditure in 2013 (over 89%) relates to capital developments.

## 6. KEY CHALLENGES AND NEXT STEPS

### 6.1 KEY CHALLENGES AND ENABLERS

The Project Steering Committee identified a number of key challenges and enablers that will impact on the HSE's ability to address the implementation of the national priorities outlined in this report. These are over and above the certainty of capital funding and the availability of revenue funding for the duration of this National Development Framework 2009 – 2013.

#### 6.1.1 ONGOING ENGAGEMENT OF STATUTORY AND VOLUNTARY SECTORS

The invaluable role played by the voluntary sector in the provision of palliative care services in Ireland has been widely acknowledged by the HSE and the wider healthcare sector. Voluntary and non-statutory organisations, such as the Irish Hospice Foundation and the Irish Cancer Society, have taken a significant role in identifying needs and service gaps in the community. They have also taken a lead role in responding to these identified needs, as can be seen, for example, with the provision of home care services, such as the night nursing service. Much of this development has taken place in co-operation with local statutory structures, including significant involvement with Area Development Committees.

The Project Steering Committee recognises the importance of the continuing involvement of the voluntary sector in the planning and delivery of specialist palliative care services in Ireland. Mechanisms to allow for the interface between the voluntary and statutory sectors in the planning and roll-out of National Development Framework 2009 – 2013, such as the Area Development Committees, should be strengthened and promoted.

The Project Steering Committee welcomes the commitment and support given to it by voluntary partners in the completion of this National Development Framework and in the recognition of our statutory responsibility to plan for this essential service. This ongoing collaborative engagement will be equally important in the delivery of the actions outlined in this document.

#### 6.1.2 MANPOWER PLANNING

Availability and recruitment of suitably trained staff and healthcare professionals will continue to be a challenge in addressing the level of need identified, particularly in the area of home care and in the provision of community based services. Currently, evidence exists that both the statutory and voluntary sectors have experienced difficulties in attracting suitably qualified staff in areas outside of the main urban centres.

The HSE and Department of Health & Children have recently established a Manpower Planning Group to examine staffing issues in the health service, including a number of relevant care groups, i.e. patients requiring palliative care, the older population, people with disabilities, etc.

The National Development Framework will require 272.19 WTE posts across the 4 HSE Areas. The Manpower Planning Group will need to take account of this requirement and consider the sequencing of these posts over the duration of the National Action Plan.

### **6.1.3 PROCUREMENT**

Procurement models to address the delivery of the national priorities identified in this report will need to be considered. Given the level of involvement of the voluntary sector, and the tax incentives in place for private providers, there are a number of options to be considered, not limited to development and operation by the statutory sector. Options in this regard include competitive tendering by the public and private sectors to build or operate facilities, or to provide services.

The HSE will need to engage with the market to inform the procurement model(s) to address the immediate priority needs identified, building on the experience gained through recent procurement exercises.

### **6.1.4 PRIVATE HOSPICE TAX INCENTIVES**

With the introduction of Capital Tax Incentives available to developers of private palliative care / hospice facilities, it is essential to ensure that development of new facilities and palliative care services is targeted in the areas of greatest need, to ensure that an uneven distribution does not occur. It will also be important to ensure that these units are developed in line with the published design guidelines for specialist palliative care settings.

In addition, it will be equally important to ensure that any new private development has the ability to meet the full range of needs of patients requiring palliative care.

### **6.1.5 DESIGN GUIDELINES FOR SPECIALIST PALLIATIVE CARE SETTINGS**

The NACPC Report recommended that “*an Expert Group on Design Guides for Specialist Palliative Settings should be established to inform all relevant parties and to ensure a national consistency of standards for all specialist palliative care settings*”.

In 2005, the Expert Group published guidelines for the assistance and information of those writing design briefs, on the nature, type and size of accommodation required for specialist palliative care settings, which are to be capable of supporting fully the needs of both patients and families under their care, as well as the needs of staff working within them. These guidelines do not deal with the particular palliative care needs of children, which are to be the subject of separate research and recommendations.

It is important that these guidelines are brought to bear in the roll-out of the National Development Framework 2009 – 2013.

### **6.1.6 EDUCATION AND TRAINING**

The NACPC Report stated that “*Education is a core component of specialist palliative care. The culture of continuing professional education and development should be promoted among health care professionals in all disciplines that are involved in the delivery of palliative care.*”

The Project Steering Committee would like to reinforce one of the “Education and Training” recommendations of the NACPC Report: “*There should be major public funding allocation to promote palliative care research in Ireland and to put in place the necessary infrastructure to allow this to happen.*”

### 6.1.7 QUALITY STANDARDS

To address the quality and safety standards in the health care system, the Government established the Irish Health Services Accreditation Board (IHSAB), which developed the Acute Care Accreditation Scheme (ACAS) in 2001. In 2004, IHSAB adapted these standards for Specialist Palliative Care Services called the Palliative Care Accreditation Scheme (PCAS).

The PCAS has been open on a voluntary basis to applications since July 2005. Milford Care Centre was the first facility in the country to achieve full accreditation as a Nursing Development Unit. The process to gain accreditation for Palliative Care Services aims to raise the standards of palliative care services regionally. It is anticipated that Milford Care Centre will act as a model to encourage other palliative care providers nationally to apply for accreditation.

## 6.2 NEXT STEPS

The Project Steering Committee identified a number of follow-on actions that will be required in order to address the implementation of the national priorities outlined in this report.

### 6.2.1 ADOPTING THE NATIONAL DEVELOPMENT FRAMEWORK 2009 – 2013

This report represents a holistic **approach to addressing the level of need identified by both the NACPC Report and the HSE Audit**, informed by the detailed needs analysis completed by each Administrative Area.

This National Development Framework presents a statement of validated and costed priorities required to address the identified deficits in palliative care service provision, and outlines a sequence of actions requiring implementation.

Government support is central to ensure the successful delivery and implementation of national palliative care framework 2009 – 2013. Appropriate funding will need to be made available to support the national priorities for palliative care detailed in this report. The Health Service Executive, in association with the Department of Health and Children and other stakeholders, will discuss how best to achieve the recommendations detailed in the Framework. Identification of appropriate funding may be achieved through a combination of the following:

- Reorientation and reconfiguration of existing resources, to be undertaken in partnership with all relevant stakeholders, including both the statutory and voluntary sectors;
- Identification of additional resource requirements when further funding comes on-stream.

### 6.2.2 PUTTING DELIVERY MECHANISMS IN PLACE

Implementation of the national priorities outlined in the National Development Framework will present a significant challenge. Formal commitment to implement these national palliative care priorities will be required spanning the timeframe of the National Development Framework 2009 – 2013, including putting in place appropriate mechanisms to monitor the implementation of national priorities.

### 6.2.3 LOOKING AHEAD

## PALLIATIVE CARE SERVICES FIVE YEAR/ MEDIUM TERM DEVELOPMENT FRAMEWORK

Overall responsibility for ensuring the delivery of the 41 national priorities identified in the National Development Framework 2009 – 2013 will rest with the HSE, supported by other stakeholders, including the Department of Health & Children and Area Development Committees

## 7 APPENDICES

This section of the **Palliative Care Services - Five Year/Medium Term/Medium Term Development Framework (2009 – 2013)** contains the following information:

Section	Description
Section 7.1	Consultation with Key External Stakeholders
Section 7.2	Area Development Committee – Terms of Reference
Section 7.3	Area Consultative Committee – Terms of Reference
Section 7.4	Project Steering Committee Membership

### 7.1 EXTERNAL STAKEHOLDER CONSULTATION

As part of the consultation with key external stakeholders, the Project Steering Committee met with the following individuals:

- Eugene Murray – Irish Hospice Foundation
- John McCormack – Irish Cancer Society
- Mary Ferns – Irish Cancer Society
- Dr. Dominic O’Brannagáin – Irish Association of Palliative Care
- Pat Quinlan – Milford Care Centre
- Mo Flynn – Our Lady’s Hospice, Harold’s Cross
- Kevin O’Dwyer – Marymount Hospice
- Ethel McKenna – St. Francis Hospice
- Dr. Tony O’Brien – Consultant

The focus of the consultation and the main discussion topics that we considered were as follows:

- What are the key strategic issues and challenges facing the sector that need to be considered in light of a Palliative Care Services - Five Year/Medium Term Development Framework?
- What are the key national priority areas for palliative care provision?
- What criteria should be considered when considering national priority areas?

## 7.2 AREA DEVELOPMENT COMMITTEE – TERMS OF REFERENCE

The Assistant National Director in each area should establish an Area Development Committee for Specialist Palliative Care. This Development Committee should report to the Assistant National Directors on service delivery issues.

The terms of reference of the Area Development Committee are as follows:

- *Recommend to the Assistant National Director of the Area the allocation and use of all statutory resources (capital and revenue) provided annually or multi annually.*
- *Implement the service policy guidelines issued by the HSE and the Department of Health & Children, having regard to the recommendations of the National Council and Area Consultative Committee*
- *Prepare and agree a development plan for the Area based on needs assessment and national policy.*
- *Establish such sub committees as may be required from time to time.*
- *Provide an annual commentary on Palliative Care Services to the Assistant National Director of the Area.*
- *Encourage and participate as appropriate in the evaluation of service delivery in accordance with the agreed mission statement.*

**The Area Development Committee should consist of:**

- *A maximum of three senior representatives from statutory agencies providing specialist palliative care services (clinical and professionals). Nominated by the Assistant National Director.*
- *A maximum of four senior representatives from among the voluntary organisations providing specialist palliative care services, and having a service agreement with the HSE. Invited by the Assistant National Director and nominated by individual groups.*
- *A maximum of three senior officials from the HSE. Nominations made by Assistant National Director.*

The Assistant National Director should be responsible for appointing members to the Area Development Committee from the nominations received from the organisations referred to above.

One of the senior officers of the HSE should be the person in the area who has overall lead responsibility for Specialist Palliative Care Services. This person should be the Chairperson of the Committee.

The maximum term of office will be two years with regular reviews.

The Committee should meet not less than four times each year. Secretarial support for the committee will be provided by the HSE.

### 7.3 AREA CONSULTATIVE COMMITTEE – TERMS OF REFERENCE

An Area Consultative Committee for Palliative Care should be established by the Assistant National Director in each HSE region. The Area Consultative Committee should be an advisory committee, which should provide a broadly based forum for the exchange of information and ideas on all matters pertaining to palliative care, both specialist and non-specialist in the Area.

The terms of reference of the Area Consultative Committee are as follows:

- *Advise and consult with the Area Development committee on any matters relating to the provision of palliative care services in the Area, including new developments and based on the needs assessment and national policy.*
- *Advise and consult with the Area Development Committee on strategies to maximise co-operation between patients, families, statutory authorities and service providers, both voluntary and statutory.*
- *Participate in the evaluation of services in the Area.*
- *Agree mechanisms and actively pursuing effective advocacy in relation to standards for persons who may benefit from palliative care in the Area.*
- *Establish such sub committees as may be required from time to time.*

The structure of the Area Consultative Committee will recognise that for a period of transition, membership will need to facilitate the ongoing involvement of existing consultative committee members. The committee will include as a minimum:

- *Senior officials of HSE;*
- *Representatives of specialist palliative care service providers, voluntary and statutory;*
- *A representative from Oncology Services;*
- *A representative from Acute Hospital Services;*
- *A General Practitioner representative;*
- *A Home Care Team representative;*
- *A representative of Community Hospitals;*
- *Two consumer representatives/advocates;*
- *Other persons that the Assistant National Directors may deem appropriate.*

The Assistant National Director will be responsible for appointing members to the Area Consultative Committee for a period of two years with regular reviews.

The Chairperson of this Committee will be appointed by the Assistant National Director and be a member of the Area Development Committee. The appointment will be for an agreed period of time.

Secretarial support to the Committee should be provided by the HSE. The Committee should meet not less than three times each year.

## 7.4 PROJECT STEERING COMMITTEE MEMBERSHIP

The membership of the Project Steering Committee tasked with the development of the **Palliative Care Services - Five Year/Medium Term Development Framework (2009 – 2013)** was as follows.

Name	Organisation	Title
<b>Hugh Kane</b>	HSE	Assistant National Director, Primary, Community and Continuing Care, Dublin Mid Leinster with the National Lead for Palliative Care
<b>Martina Queally</b>	HSE Dublin Mid-Leinster	Local Health Office Manager – Kildare West Wicklow
<b>Pat Dunne</b>	HSE Dublin North-East	Local Health Office Manager – North Dublin
<b>Ann Kennelly</b>	HSE South	Local Health Office Manager – North Cork
<b>Priya Prendergast</b>	HSE West	Local Health Office Manager – Galway
<b>John Browner</b>	HSE Estates	Assistant National Director (Estates)
<b>Catherine Neary</b>	HSE Manpower Planning	General Manager, Workforce Planning
<b>Frances McNamara</b>	HSE	Senior Manager, Office of the Assistant National Director

The project was supported by **Dr. Howard Johnson** and the team from **Health Atlas Ireland**.

The Project Steering Committee would like to acknowledge the significant support received from a number of individuals across all four HSE Administrative Areas in the development of this National Action Plan. These include:

Name	Organisation	Title
<b>Suzanne Creaven</b>	HSE Dublin Mid-Leinster	Grade VII, Office of the LHM – Kildare West Wicklow LHO
<b>Gerry Hanley</b>	HSE Dublin North-East	Group Services Manager – North Dublin LHO
<b>Anne O'Reilly</b>	HSE Dublin North East	Senior Executive Officer
<b>Eileen O'Leary</b>	HSE South	A/Senior Administrative Officer, Regional Support – Palliative Care
<b>Anne O'Neill</b>	HSE West	Senior Administrative Officer – Galway LHO