THE IRISH HOSPICE FOUNDATION

BASELINE STUDY

ON THE PROVISION OF SPECIALIST PALLIATIVE CARE SERVICES IN IRELAND

e and The Atlantic Philanthropies

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DEFINITIONS

Palliative Care

Palliative care is the continuing active total care of patients and their families, at a time when the medical expectation is no longer cure. Palliative care responds to physical, psychological, social and spiritual needs, and extends to support in bereavement. The goal of palliative care is the highest possible quality of life for both patient and family. Specialist palliative care services are those services with palliative care as their core speciality and which are provided by an inter-disciplinary team, under the direction of a consultant physician in palliative medicine.

Hospice Care

Hospice care is a term that is often used to describe the care offered to patients when the disease process is at an advanced stage. The term may be used to describe both a place of care (i.e. institution] or a philosophy of care, which may be applied in a wide range of care settings.

The terms 'hospice care' and 'palliative care' are often used interchangeably. Hospice care encompasses all aspects of palliative care.

From the Report of the National Advisory Committee on Palliative Care, Department of Health & Children, 2001

ABBREVIATIONS

AGH	Acute General Hospital
APCIP	Accelerated Palliative Care Implementation Programme
CNM	Clinical Nurse Manager
CNS	Clinical Nurse Specialist
CSO	Central Statistics Office
DoH&C	Department of Health and Children
HSE	Health Service Executive
IAPC	Irish Association for Palliative Care
MDSI	Proposed Minimum Data Sets for Specialist Palliative Care in Ireland
IHF	The Irish Hospice Foundation
SPC	Specialist Palliative Care
SPCU	Specialist Palliative Care Unit
NACPC	National Advisory Committee on Palliative Care
NCHD	Non-Consultant Hospital Doctor
NCRI	National Cancer Registry of Ireland
RGN	Registered General Nurse
WTE	Whole Time Equivalent

Health Boards:

ERHA	Eastern Regional Health Authority
MHB	Midland Health Board
MWHB	Mid-Western Health Board
NEHB	North-Eastern Health Board
NWHB	North-Western Health Board
SEHB	South-Eastern Health Board
SHB	Southern Health Board
WHB	Western Health Board

INTRODUCTION

EXECUTIVE SUMMARY

The most immediate recommendation of the NACPC report was that a needs assessment for specialist palliative care services should be undertaken in every health board area within nine months of its publication. By the close of 2004, needs assessments had been completed by the ERHA and six of the seven regional health boards. The series of regional reports derived from that exercise were taken as a starting point for the collection of data for the present Baseline Study. In essence, the Baseline Study has attempted to resolve certain methodological and comparative differences between those original needs assessments (see Chapter 2, *Methodology],* with a view to providing an accurate, composite picture of service activity and staffing levels for palliative care in Ireland, focusing for the most part on 2004.

The aims and objectives of the Baseline Study were as follows:

1. To present an up-to-date overview of the current state of service provision in hospice/specialist palliative care on a consistent basis regionally.

2. To clearly identify specific gaps in service provision relative to the recommendations of the NACPC report.

3. To provide a solid basis for assessing current and future service needs and for determining the resources required.

4. To make a significant contribution to the work of the recently established National Council for Specialist Palliative Care.

5. To provide baseline data for comparative studies to be undertaken in the future.

The study has not attempted to address all of the recommendations made in the NACPC report. It has concentrated in the main on the extent of implementation of the model for service provision outlined by the NACPC. and, integral to that, on the extent to which the recommendations for levels of staffing have been fulfilled.

The research approach adopted took into account one of the primary aims of the government's health strategy, namely to ensure the involvement of key stakeholders in the planning and development of services. From the outset, the Baseline Study sought to represent all service providers in palliative care. Furthermore, in the final phase of the research programme, all of the data collected were verified and corroborated by the key sources in the field.

In Chapter 5 *[Service Provision and Activity],* Chapter 6 *[Staffing in Hospice/Specialist Palliative Care]* and Chapter 7 *[Government Funding of Hospice/Specialist Palliative Care],* the findings of the Baseline Study are presented with respect to the NACPC report as official government policy for palliative care. Achievements over the last three years are highlighted, major deficits in service provision are outlined, and in the final chapter, some of the key challenges ahead for the full implementation of the recommendations of the NACPC *are* proposed.

Government Policy

In 2001, the Report of the National Advisory Committee on Palliative Care (Department of Health and Children) outlined the measures necessary to end the ad-hoc nature of services available to patients and their families. The present Baseline Study has tracked and quantified the gaps in the implementation of these recommendations, which are now stated government policy. Four years after its publication we find that while there has been some progress, many of the recommendations of the 2001 report remain unfulfilled.

Demand for Care

Increases in population – especially in those aged over 65 – coupled with new life-prolonging treatments, will together lead to an increase in demand for palliative care services. The number and percentage of people over the age of 65 will rise from 436,000 in 2002 (11%) to 631,000 (13%) in 2016. Additionally, as the current low level of service delivery to non-cancer patients grows, demand for services will increase further.

There were over 29,000 deaths in 2002, of which cancer accounted for over 7,000 (25.6%). An estimated 70% of cancer patients with advanced disease and 20% of non-cancer patients require access to palliative care services. It is estimated that the number of patients who required access to hospice/specialist palliative care in 2002 was 10,350. This is expected to rise to 12,500 in 2016 (see Chapter 3, *Need for Hospice/Specialist Palliative Care*).

Place of Death

Place of death is strongly influenced by the provision of access to the full range of hospice and specialist palliative care services and settings. Where comprehensive services are underdeveloped, it appears that more people die in acute general hospitals (e.g. in Waterford, Kilkenny, Offaly, Roscommon and Wicklow). Where services are more developed, there appears to be an increased incidence of death occurring in a hospice/palliative care inpatient unit or home setting (e.g. Limerick, Cork, Donegal, Sligo). Although Dublin has three inpatient units and associated services, there is still a very large shortfall in the recommended number of inpatient hospice beds, and almost 50% of people die in hospital. There is a need to collect more accurate statistics relating to place of death.

Service Provision and Activity

Hospice inpatient units

The eight specialist palliative care inpatient units dispersed across the 10 health board areas of Ireland provided care for 1,499 patients during 2004. The NACPC report recommended that there should be 8-10 inpatient beds for every 100,000 of population, with at least one inpatient unit in each of the ten health board areas. While seven health board areas have inpatient units, the remaining three (the Midlands, the North-East and the South-East], covering 12 counties, have none. Even those health board areas with existing inpatient units are experiencing hospice bed deficits. Several counties or areas where there are inpatient units in neighbouring counties have an identified need for satellite units, e.g. Cavan, Kerry, Mayo/Roscommon, Wicklow, Kildare and Dublin West.

Day care

Day care services for palliative care patients include access to medical review/treatments and a range of non-medical therapies and activities. At December 2004 there were five specialist inpatient units providing day care services. The five units together provided day care services for 538 patients (accounting for 5,961 attendances) over 2004. The absence of specialist inpatient units in the areas of the Midland, North-Eastern and South-Eastern Health Boards appears to be the main reason for the lack of day care services in those areas. The South-Eastern Health Board is developing a day care service from a hospital base.

Acute general hospitals

Acute general hospitals are the main source of referral of terminally ill patients to hospice and palliative care services (over 6,000 referrals in 2004). It is government policy that all acute general hospitals with over 150 beds should have a full, consultant-led specialist palliative care team (non-consultant doctor, specialist nurse, social worker, medical secretary). A significant number of the consultant's sessions would be in support of the local hospice inpatient unit and local home care services.

Only eight of the state's 38 acute general hospitals with over 150 beds have approved a full palliative care team. Twelve have a partial team; seven have a 'nurse-only' team and eleven hospitals have either no service or depend on external support from community-based teams.

Home care

Significant progress has been made in almost all areas in the provision of specialist palliative care nurses in the community, with a national complement of 148.5 nurses providing care to over 6.000 patients in 2004. Home care provided over 90.000 home visits in 2004.

There is wide variance in the provision of home care services:

- Service availability varies from 24 hours per day over 7 days to 8 hours per day over 5 days.
- Few home care teams are multidisciplinary - consultant-led, with nurses, social workers, pharmacist, physiotherapist, occupational therapist and bereavement support. Only one health board area has a community-based team supported by occupational therapy and physiotherapy.

In addition:

- State funding for home care services varies from location to location from 100% to 0%. In spite of government commitments to fully fund core staff, there is still a dependence on voluntary contributions for over one-third of home care staff costs.
- Night nursing is managed by the Irish Cancer Society and is almost exclusively funded by voluntary contributions. Non-cancer patients, e.g. with renal failure, pulmonary and heart disease, do not have the same access to night nursing services as those with advanced cancer.
- There has been almost universal failure to implement the agreed policy of providing care attendants to support families by assisting in the care and attention of patients.
- There is still a very low level of service delivery to non-cancer patients.

Support beds for palliative care patients

It is government policy that community hospitals should have designated beds for palliative care patients who require an intermediate level ('Level 2') of inpatient care (NACPC report, 2001). Patients may be admitted to these beds following discharge from acute general hospitals for further nursing care. They may also be admitted from the community for symptom control. Community hospitals also provide respite for patients and carers when patients are being cared for at home.

Over 50 community hospitals provided over 100 designated palliative care beds that accommodated almost 600 patients in 2004. In some regions the provision of Level 2 beds is achieved by means of contracting with private nursing homes. There are wide regional disparities in the provision of these Level 2 beds, and one in three institutions providing such beds lacks the facility of a family room.

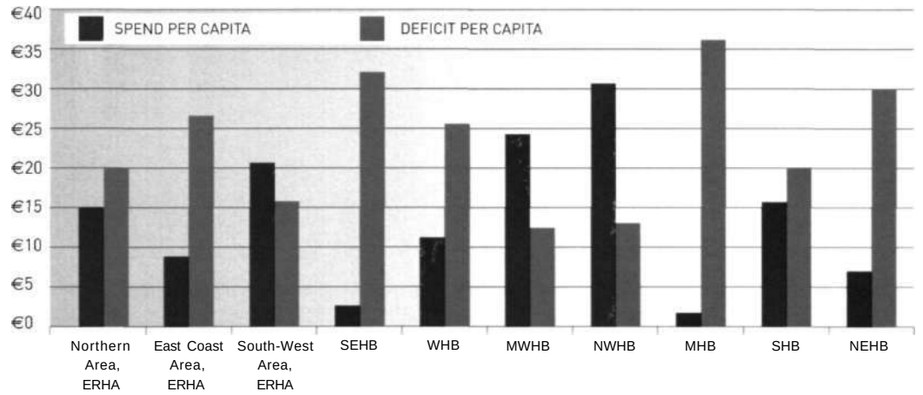
Bereavement support

Bereavement support services are also very uneven, with few designated bereavement coordinators appointed to services around the country. All areas show evidence of bereavement support service provision at each of the three levels indicated in the NACPC report. Three areas provide volunteer bereavement support services. Bereavement support training is provided for all staff in three of the eight inpatient units. Formal assessment of need for bereavement support is provided in one service.

Main Findings

The Baseline Study confirms that there are wide regional variances in the provision of hospice/specialist palliative care in all care environments - hospice/specialist inpatient units, acute hospitals, day care and community-based multidisciplinary home care. Patient and family access to comprehensive services largely depends on the region of the country in which the patient resides.

Figure ESI Palliative care staff/beds: government spend per capita by health board area.
Current position relative to the recommendations, based on current population/bed numbers, of the Report of the National Advisory Committee on Palliative Care (2001)



There are wide regional disparities in current government spending on palliative care services in all care settings. Spending *per capita* (on care staff and specialist palliative care inpatient unit beds) varies from €1.5 *per capita* in the area of the Midland Health Board to €31 *per capita* in the North-Western Health Board area.

There are major deficits in staff and bed numbers in all health board areas.

Table ES1 Cost of palliative care in Ireland: combined staffing/bed costs.
Current position relative to the NACPC recommendations, based on current population/bed numbers

	Current total	Recommended	Deficit	Annual cost including overheads	Cost deficit
Staff	**571**	**1274**	**744**	**€34.8m.**	**€51.4m.**
Beds		**390**	**259**	**€19.6m.**	**€38.8m.**

The annual cost of the care staff shortfall comes to approximately €51 m. The cost of filling the bed shortfall (excluding care staff costs) is approximately €39m. This gives a total shortfall in annual expenditure of approximately €90m.

Staffing, Financing and Key Implementation Challenges

The total cost of a fully comprehensive national palliative care service is €U4m. This accounts for less than 1.2% of the total health budget of €12 billion. Current expenditure is €54m, leaving a shortfall of €90m.

Since 2001 there has been a government commitment to spend an additional €56m over a five-year period on implementing the NACPC staffing recommendations. In the three years since publication of the NACPC's report, there has been an additional spend of less than €10m.

Education and training initiatives are key enablers in addressing staff shortages. Additionally, some mechanism will be required to overcome 'employment ceilings' where these are the sole obstacle to equitable service provision.

The new, unified Health Service Executive structure should facilitate the delivery of services on a consistent basis in each region. It is necessary at this stage to put in place an Accelerated Palliative Care Implementation Programme (APCIP) in those regions with the least developed services (see Chapter 8, *Key Implementation Challenges}.* Given that many palliative care patients are currently being cared for in inappropriate care settings, the actual additional costs of staff and beds will be partially offset by savings in other areas of the health services.

The final chapter of the Baseline Study addresses the challenges facing the development of palliative care services in Ireland. Multi-annual funding should be made available on a phased basis to meet the core running costs of all specialist palliative care services in all care settings as outlined in the NACPC report's recommendations.

CHAPTER 1

BACKGROUND TO GOVERNMENT POLICY

1.1 Introduction

Over the past ten years a significant series of reports, strategies and plans have been published which have implications for the development of palliative care in Ireland. They have all shared an unequivocal commitment to the following principles, summarised by the Council of Europe (2003):

1. The respect and protection of the dignity of a terminally ill or a dying person implies above all the provision of appropriate care in a suitable environment, enabling him or her to die with dignity.
2. Palliative care is a vital and integral part of health services. Provisions for its development and functional integration should be incorporated into national health strategies.
3. Any person who is in need of palliative care should be able to access it without undue delay, in a setting which is, as far as reasonably feasible, consistent with his or her needs and preferences.
4. Palliative care has as its objective the achievement and maintenance of the best possible quality of life for patients.
5. Palliative care seeks to address physical, psychological and spiritual issues associated with advanced disease. Therefore, it requires a coordinated input from a highly skilled and adequately resourced interdisciplinary and multi-professional team.
6. Access to palliative care should be based on need, and must not be influenced by disease type, geographical location, socio-economic status or other such factors.

Nationally, at the level of official government policy, these aspirations have been expressed in a series of strategic government reports which together represent a cumulative momentum towards supporting the development of a person-centred, high-quality and equitable palliative care service in Ireland.

1.2 Major Government Reports and Policy Statements, 1990-2005

The evolution of this series of strategic aspirations for palliative care is briefly reviewed below with reference to the following key reports:

1994 Shaping a Healthier Future – A Strategy for Effective Healthcare in the 1990s
1996 National Strategy for Cancer Services in Ireland
2001 National Health Strategy: Quality and Fairness – A Health System for You
2001 Primary Care Strategy – A New Direction
2001 Report of the National Advisory Committee on Palliative Care
2002 Sustaining Progress – Social Partnership Agreement, 2003-2005
2004 Department of Health and Children, Business Plans – Services for Older People and Palliative Care, 2004 and 2005

The 1994 Health Strategy, entitled *Shaping a Healthier Future - A Strategy for Effective Healthcare in the 1990s,* included a four-year programme for the development of palliative care services. It recognised three major causes of premature death: cancer, cardiovascular diseases and accidents. It set a number of targets for cancer care, implicit to which was the recognition of the role of palliative care: 'The important role that palliative care services play in improving the quality of life of people with a terminal illness is acknowledged, and it is intended to promote the continued development of such services in a structured manner'. The strategy also included a commitment to equity in the broadest sense, incorporating equity of access and equity of experience and specifically focused on the question of geographical equity.

The *National Strategy for Cancer Services in Ireland* was adopted in 1996. It reinforced a number of key principles related to the provision of palliative care for cancer patients. For the first time, government policy sought to promote appropriate models to address palliative care needs: '... future development of palliative services will best meet the needs and personal preferences of patients with cancer or other long-term conditions'.

In 2001, a new strategy was published, entitled *National Health Strategy: Quality and Fairness -A Health System for You.* It had as its key goal a commitment to reduce health inequalities: 'Equitable access for all categories of patient in the health system is assured ... appropriate care will be delivered in the appropriate setting'.

Also in 2001 a new Primary Care Strategy was published, entitled *Primary Care - A New Direction.* The report committed to developing an integrated, interdisciplinary, high-quality, team-based and user-friendly set of services. Specifically, it endorsed the principle that primary care should be readily available to all people regardless of: "... who they are, where they live, or what health and social problems they may have.'

By far the most important recent policy development has been the adoption by government of the recommendations of the National Advisory Committee on Palliative Care in 2001. The NACPC report highlighted the *ad hoc* and uneven nature of service provision in all areas, including home care, day care and specialist inpatient units. Since the present study has modelled its analysis and recommendations entirely within the conceptual framework and findings of the NACPC, it is worth presenting a summary of some of its principal recommendations, 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 and also taking account of advice provided by the Regional Development Committees on palliative care.
- 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 recommended that:

- Palliative care should be available in all care settings.
- Services should allow patients to move from one care setting to another.
- Research should be undertaken to examine the needs of non-cancer patients.
- Specialist palliative care services should recognise and facilitate cultural diversity.

Concerning bereavement, the NACPC made the following recommendation:

- Bereavement support should be available in all care settings.
- It should begin early in the disease process.
- It should be provided by appropriately trained personnel.
- Assessment of need should be routine in all palliative care services.

Finally, with regard to education, training and research, the NACPC report recommended the following:

- Academic departments of palliative medicine should be established in each medical faculty, with the development of interdisciplinary courses for all professionals involved in the delivery of palliative care.
- Each specialist palliative care unit should set up a nursing practice development unit to develop, implement, and monitor nursing practice in the unit. A clinical practice development coordinator should be employed in each specialist palliative care unit.
- All health care professionals working in palliative care should have the opportunity to engage in research. A number of research centres should be established, linked to academic departments of palliative medicine.
- 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.

Perhaps the spirit and ambition of the NACPC report is best encapsulated by its chairman in his opening remarks: 'I hope that this report will ensure that all health boards are in a position to provide a level and a quality of service that both reflects and defines best international practice. Our patients and their families require and deserve nothing less.' (Dr. Tony O'Brien, Consultant Physician in Palliative Medicine and Chairman of the National Advisory Committee on Palliative Care, 2001).

The government responded positively to the NACPC report and agreed to the implementation of its staff.ng recommendations over a five to seven year period at an estimated total cost of nearly €56m. Such a comm.tment would have required an additional annual expenditure over the period of approximately €10m per annum. However, in the last four years average annual additional expenditure has been less than €2m per annum.

Subsequent government policies sought to embed the recommendations of the NACPC into its global strategy on health. More recently, the Department of Health and Children's Business Plans for 2004 and 2005 have repeated previous objectives and commitments to the development of a comprehensive palliative care service. They specify the following as 'high-level' objectives:

- To provide a policy and legal framework which ensures equity for public patients and enables all patients and clients to access the services they need.
- To ensure the system has the capacity in terms of infrastructure, technology, systems and people.
- To deliver timely and appropriate services.
- To lead and guide the development of services to ensure appropriate care is being delivered in the appropriate setting with a focus on patients, clients and their families.
- To monitor and evaluate the implementation of the findings of the National Advisory Committee's Report on Palliative Care.

1.3 National Partnership Agreement

The 2002 National Partnership Agreement, entitled *Sustaining Progress - Social Partnership Agreement, 2003-2005,* contained provisions to address inequities in access to health services that were of direct relevance to the hospice/palliative care sector:

Delivering a Fair and Inclusive Society

A central theme of this Agreement is the building of a fair and inclusive society and to ensure that people have the resources and opportunities to live life with dignity and have access to quality public services.

Health and Addressing Health Inequalities

Government and social partners agree that, within the general policy framework of the National Health Strategy - *Quality and Fairness ...* to reduce the inequalities that exist. It is recognised in *Quality and Fairness* that Primary Care has a central role to play in the delivery of health and personal social services in a modern health system and that the health needs of the vast majority of people should be capable of being met by Primary Care Services. The model set out is based on multi-disciplinary team work. The Government is committed, within resource constraints, to advancing the implementation of the strategy, *Primary Care: A New Direction.*

1.4 Health Service Executive (HSE) Service Plans

Finally, *The Health Service Executive Service Plan - 2005* was formulated on the establishment in 2005 of the Health Service Executive, the new state body entrusted to operate the health services and implement government health policies:

'The overall policy framework, which governs the preparation of the Service Plan, is underpinned by a population health approach, with a particular emphasis on integration and reducing health inequalities as set out in the National Health Strategy, Quality and Fairness: A Health System for You (2001). This strategy remains the blueprint for the development of the health and social care services over the coming decade and beyond and is the benchmark against which all elements of the Service Plan have been constructed. The principles of equity, people-centredness, quality and accountability are supported in this plan and each of the actions in the plan is linked to the Strategy. **The Executive aspires to the delivery of health and social care that does not vary in quality, irrespective of geographic location, and embraces all groups in society equally.**

There are challenges ahead: capacity deficits in many sectors, historic under-funding of some services, skills shortages in nursing and other health professions, an increasing population, and clear expectations of improved performance and accountability throughout the health system. By working in collaboration and communicating with each other, building relationships, and working as true partners and teams, we, the Executive and our partners, can deliver much, much more, together. It is important to build on the acknowledged strengths within the existing system, but it is equally necessary to address the deficits.

This Service Plan aims to deliver a service that will become comprehensive, seamless and standardised across the country'

The HSE Service Plan goes on to identify a number of key objectives:

- To develop and deliver services in accordance with a population health approach
- < To promote the harmonisation and equity of all services nationally while demonstrating an improvement in access to services.
- In 2005. the Primary Community and Continuing Care Directorate will implement systems to ensure that PCCC services will continue to work closely with National Hospitals Office services m the development of integrated care, facilitating the early discharge to home of service users.'

Currents in preparahon. the HSEs Corporate Plan for the period 2005 to 2007 will map ou, the future d,rec.,on of the health and social serv.ces to be delivered through comprehensive annual Service Plans. Base on assessed needs ,, wi.l: aim to ensure egual.ty of access to h,gh-$_{Q}$ua,i,y services for the entire population, regardless of status or location.'

In short, at the level of stated government policy since 1990, there has been unequivocal support, to the point of repetition, for the development of fair and equitable, patient-centred services. More recently the National Cancer Strategy has endorsed the establishment of comprehensive specialist palliative care services. After so many years of such commitments, it is imperative that the forthcoming HSE Corporate Plan, 2005 to 2007, may finally provide an implementation roadmap for hospice/specialist palliative care.

CHAPTER 2

METHODOLOGY

2.1 Introduction

Following confirmation of support for the Baseline Study project from the Atlantic Philanthropies and the Health Service Executive, a working title was adopted; a steering committee set up; a project team appointed; objectives defined; and a methodology and time-frame agreed.

2.2 Steering Committee

The steering committee was constituted to include as wide a representation as possible of the relevant sector partners in Irish hospice/palliative care, e.g. the Irish Association for Palliative Care; the Irish Cancer Society; hospice chief executives; the Directors of Nursing of Hospices and Palliative Care Services Networking Group; the Irish Palliative Medicine Consultants' Association and the Health Service Executive (HSE), together with the Atlantic Philanthropies and the Irish Hospice Foundation.

2.3 Data Collection and Analysis

The aims and objectives of the Baseline Study have been outlined in the Introduction. Data items for collection were identified by the project team. Where possible, these items were based on key recommendations of the NACPC report and took account of the regional needs assessments for specialist palliative care which had already been carried out by the health boards over the previous three years (see 2.3.2 below). It was agreed that as far as possible the period for which data were to be collected would be the year to 31st December 2004. It was also agreed that despite its obvious importance, the collection of qualitative data was not within the scope of the present project.

2.3.1 Design of templates for data collection

Two templates - two sets of tables - were designed by the project team for completion for each health board area.

The first template. *Demographics and Service Activity,* looked primarily at the range of hospice/palliative care services in each health board area, the composition of the teams working in them and the level of serv.ce activity. It also included tables on population, mortality and morbidity. The second template, *Actual and Recommended Staffing Levels,* dealt with existing and recommended staffing levels in the full range of medical, nurs.ng. para-med.cal and support roles. The recommendations were based on the NACPC report and current population numbers for each health board area.

In the early stages of the study, the focus was on designing the templates. A format was agreed by the steenng comm.ttee and subsequently presented to a specially convened meeting of health service personnel represent.ng the different health board areas. Modifications were made and other refinements took place over time on the recommendations of individuals and groups involved in hospice/palliative care.

2.3.2 Use of existing data

A key recommendation of the NACPC report was that a needs assessment for specialist palliative care services should be undertaken in every health board area within nine months of that report's publication. By the end of 2004, needs assessments had been completed by six of the seven regional health boards and the Eastern Regional Health Authority (ERHA). The needs assessments focused on the palliative care needs of their respective adult populations and included variable amounts of data on services, activities and staffing levels.

The resulting reports were taken as a starting point for the collection of data for the Baseline Study. However, difficulties in collating and comparing the findings of the needs assessments for the various health board areas immediately became apparent.

1. While the same structure was generally adopted for the published reports, there was considerable variation in how the findings were reported on from one health board area to another.

2. Different health boards used different sources for demographic and mortality data (e.g. some population statistics were from the 2002 census and others from 1996; some mortality statistics were from the Public Health Information System and some from the National Cancer Registry of Ireland).

3. Attempts at valid comparisons were complicated by regional variations in the organisation of palliative care services.

4. The lack of standardised definitions was a problem. For example, the allocation of beds in community hospitals to palliative care was described using terms (e.g. 'designated', 'available for', 'suitable for') which were not adequately defined and which varied from report to report.

5. There was a lack of consistency between the various reports in the coverage of some matters of strategic importance.

2.3.3 Collection of data

At the outset, all relevant quantitative data and descriptive information contained in the regional needs assessments were studied and inserted into the templates as appropriate. Thereafter, the project team engaged in an intensive phase of site visits and consultation with management and clinical personnel in hospice and palliative care services in order to verify and/or update the data. These discussions also facilitated a better understanding of local issues not easily reflected in quantitative data alone. Data on activities and staffing complements were also updated where possible to 2004 levels.

2.3.4 Validation

The validation phase took place in June-July 2005. Mailing lists were drawn up of palliative care service providers and administrators in each former health board area. Key personnel were circulated with a completed set of templates for their own area. The templates were accompanied by a personal letter requesting a careful review and corroboration of the data. Nationwide, over 70 persons were consulted. The feedback from this process was used to complete the final versions of the templates.

2.3.5 Analysis of data

Using the information from the individual templates, composite tables were produced looking at each piece of data across each health board area. This allowed the generation of national statistics in some instances. Where data were missing (e.g. for the number of home care visits by a team], averages were worked out based on other services in the area (e.g. the number of home care visits per nurse in the other services in the area). These were then used to calculate visit numbers for the remaining team (average number of visits per nurse by the number of nurses in the team). Numbers based on such calculations are indicated in this report.

2.4 Calculation of Costs

Once all the data were collated, current spending estimates for each staff category in each health board area were calculated using approved salary scales, allowances and PRSI, with an adjustment of 15% for non-pay costs. The same approach was applied in estimating the cost of correcting deficits in staff resources in each region to the levels of the minimum recommendations of the NACPC report.

The NACPC report did not recommend specific figures for nursing staff in day care and education staff. For the purpose of this exercise a minimum level of two day care nurses and two education staff for each health board area was included in the calculations. This is not based on recommendations, and needs may well be in excess of these figures.

While the costs of health care staff in hospice inpatient units were included in the above exercise, the other costs associated with palliative care beds, including support staff and non-pay costs, were the subject of a separate financial calculation.

The activity-based costing calculations were derived from a specially designed Excel spreadsheet (see Appendix 1).

The cost of inpatient beds is calculated with reference to the best available financial data from existing inpatient services. After consulting with senior management in five separate inpatient units, a rate of €150,000 per bed per annum was agreed (excluding care staff). If care staff were included, the annual cost of an inpatient bed would be an additional €100,000, giving a total annual bed cost of €250,000 per annum.

2.5 Limitations of the Study

This study has a number of limitations, including:

1. The lack of uniformity in the definition of terms (e.g. what constitutes a 'home care visit', a 'designated Level 2 bed", etc.) and in the way in which activities are measured in different services, limits the comparison that can be made between services. All data should be interpreted with this in mind. Proposed Minimum Data Sets for Specialist Palliative Care in Ireland are currently being piloted as an Irish Hospice Foundation project. The MDSI defines activities and services in a standardised way.

2. The term 'NCHD' is used to describe all non-consultant medical staff. However, this does not represent a homogenous group, as some NCHDs are on specific palliative medicine training programmes and others are not. Levels of expertise and training can vary significantly from one NCHD to another.

3. Data for 2004 are reported, but in some instances new services have been developed and staffing levels have changed since the start of 2005.

A. Although the project team experienced an extremely high level of cooperation and was able to gather virtually complete data sets for each health board area, missing data for some services has resulted in the need to extrapolate from data for other services in order to produce national statistics.

5. Some of the figures in the costing tables may appear not to add up. This is because of known allowances made for specific policy issues:

   (a) It is important to note that the NACPC's staffing recommendations were minimum recommendations, and that the regional needs assessments often identified greater manpower requirements. Given this limitation, in the few cases where specific staffing levels exceeded the NACPC recommendation, it was decided not to reduce the required regional staff expenditure by the identified excess.

   (b) Given the government's commitment to fund all core staff, it was decided to transfer the current expenditure of voluntary funding on home care nurses to the expenditure deficit totals.

6. This study provides information on the structure of services and activity levels; however, these do not of themselves necessarily equate with quality.

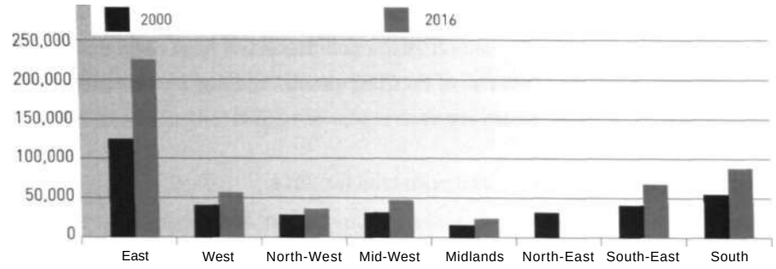
7. Education is not comprehensively explored in the study. A separate education needs assessment is currently being undertaken by the Irish Hospice Foundation.

It should finally be noted that, with its concentration on resourcing issues, the study did not seek to address all the recommendations of the NACPC report. It also did not address the issue of the capital cost of new infrastructure.

CHAPTER 3

NEED FOR HOSPICE/ SPECIALIST PALLIATIVE CARE

Figure 3.2 Population over age 65 by region: actual in 2002 and projected for 2016



Source: CSO. 2005. The North West CSO projections have been adjusted to correspond more closely with board boundaries.

As a result of the increase in age of the population, the prevalence of malignant and non-malignant diseases will also increase. As noted later in this chapter, in addition to this increased demand due to a rising proportion of the population over 65, new treatments will not only reduce mortality but in many cases will extend the period for which palliative care will be required. These factors all indicate an incremental growth in demand for specialist palliative care service provision in the future.

> The total number of new cancer cases is increasing annually. Some of this increase is as a consequence of a growth in population. However, a significant further increase can be attributed to an aging population.
>
> Department of Health and Children, 2003(a)

3.3 Mortality and Cancer

Figures from the National Cancer Registry of Ireland (NCRI) indicate that there were 7,621 cancer deaths in 2002. Table 3.1 outlines the distribution of cancer deaths by health board. There are inherent difficulties in predicting death rates for all cancers into the future; however, with a predicted increase in population of 23% by 2016, and assuming the same death rate from cancer, the number of cancer deaths would be expected to rise to approximately 9,300 for the year 2016.

Table 3.1 Total deaths, cancer deaths and percentage of cancer deaths, 2002

Health board of residence	Total deaths	Cancer deaths	% Cancer deaths
Eastern Regional Health Authority	9202	2490	27.06
Western Health Board	3368	779	23.13
North-We stern Health Board	2016	454	22.52
Mid-Western Health Board	2752	693	25.15
Midland Health Board	1866	462	24.76
North-Eastern Health Board	2456	628	25.57
South-Eastern Health Board	3298	888	26.93
Southern Health Board	4725	1228	25.99
Total	**29,683**	**7621**	**25.67**

Source: NCRI. July 2005.

3.4 Place of Death

There is a relative lack of good current epidemiological data for the place of death of those who die in Ireland. This makes it difficult to directly compare the place of death of cancer patients with that of those who die from other causes. In 2002, 42% of cancer deaths in Ireland occurred in an acute hospital setting while 14% occurred in a hospice setting. Home deaths accounted for 26%. There is considerable variation in the place of cancer death from county to county. For example, deaths in acute hospitals, recorded by county, range from a minimum of 23% (Donegal) to a maximum of 62% (Waterford). Similar variations occurred for those who died at home (from 17% to 42%) and for those who died as inpatients in hospice care (from 0% to 37%). Table 3.2 summarises the place of death of cancer patients by county of residence.

3.5.2 Non-Cancer Patients

At present in Ireland the vast majority of those who access palliative care services have a diagnosis of cancer. The report of the NACPC highlighted the need for specialist palliative care services to be available to those patients dying of non-malignant disease who have appropriate needs. Awareness of the role that specialist palliative care can play in meeting the needs of people dying from a wide range of non-malignant conditions (such as neurological diseases, cardiac and respiratory conditions] is increasing. However, despite the fact that equity of service provision based on need is a principal component of the Health Strategy in Ireland (Department of Health, 1994), only a very small minority of those dying of non-malignant conditions access palliative care services before death.

The NACPC report estimated the numbers of patients with non-malignant diagnoses who might benefit from SPC services based on research performed by Higginson *etal* in the UK (Higginson *etal,* 1997) There are approximately 6,900 deaths per year in a population of 1,000,000 due to progressive non-malignant disease, and of these one-fifth would be expected to have symptom severity comparable to the top one-third of cancer patients. Extrapolating from these figures, it has been estimated that at least 5,000 patients in Ireland annually would have a recognised period where they would be likely to benefit from specialist palliative care. With an increase of 23% expected in the population by 2016 it is estimated that at least 6,100 patients with malignant diseases who are dying would be likely to benefit from specialist palliative care.

3.5.3 Conclusion

Hence, by 2016, over 12.500 people dying annually of malignant and non-malignant diseases would be likely to benefit from specialist palliative care before death.

CHAPTER 4

SUMMARY OF CURRENT POSITION AND PLANNED DEVELOPMENTS IN HOSPICE/SPECIALIST PALLIATIVE CARE

4.1 Introduction

The Baseline Study quantifies hospice and palliative care services and activities for each of the former health board areas. This chapter contains a summary by health board area of current and planned service provision and activities. For convenience, the ten former health board areas have been grouped under the four new Health Service Executive (HSE) administrative regions to which they now belong.

4.2 HSE Dublin/North-East Region

A.2.1 Northern Area (ERHA)

The Northern Area previously formed one of three distinct health board areas within the Eastern Regional Health Authority. A Development Committee for palliative care services was established for the area in September 2002. However, prior to the establishment of that committee, a plan for the Northern Area was agreed between the then Northern Area Health Board and St Francis Hospice. The plan was submitted to the Eastern Region development team in 2001.

Northern Area (ERHA)

At December 2004 the Northern Area had one consultant in palliative medicine with eight sessions at St Francis Hospice, Raheny and three sessions at Beaumont Hospital. A second consultant post, approved and vacant over 2004. is now in the recruitment process. This second post has a commitment of four sessions at St Francis Hospice. Raheny; three sessions at Connolly Hospital, Blanchardstown; and four sessions at the Mater Misericordiae University Hospital. At December 2004 the area had five non-consultant hospital doctors: 1.5 at St Francis inpatient unit, 2.5 in St Francis home care service and one registrar at Beaumont Hospital. An additional registrar was approved in 2002. This post will be split equally between the Blanchardstown hospital and the Mater. Based on the guidelines of the NACPC report, the Northern Area requ.res at least three consultants in palliative medicine and nine non-consultant hospital doctors.

St Francis Hospice, Raheny, forms the hub for specialist palliative care in the Northern Area. Over 2004 the actual number of beds available at St Francis Hospice was 19. The *per capita* minimum recommendation of the NACPC report for the Northern Area yields a recommendation of 49 beds, i.e. a bed deficit of over 30. It has been recognised that additional beds are required in the north-west of the Northern Area, in Blanchardstown in particular. Looking to the future in terms of projected population trends, the CSO [2005][1] estimates a population of 665,000 for the Northern Area by 2016. Such a scenario would yield an NACPC-recommended bed complement of 66 for the area.

Th.s figure is **derived** from CSO/HSE populat.cn p$_{roj}$ect,ons adjusted by the IHF for the North ern Area.

There are three acute general hospitals in the Northern Area. Beaumont Hospital has a consultant-led specialist palliative care team. While Connolly Hospital, Blanchardstown, had the approved staffing resources for a full team over 2004, the vacant second consultant post mentioned above left the team without the commitment of three sessions from a consultant in palliative medicine. Over 2004 the team at the Blanchardstown hospital consisted of one clinical nurse specialist, one senior social worker and one clerical officer. In 2005 a registrar component (0.5 WTE) was approved for the team and remains vacant. The Mater Hospital had approval and funding over 2004 for three sessions derived from the second consultant post mentioned above, which has remained vacant. Over 2004 the team at the Mater Hospital consisted of one senior social worker. Over 2005, approved posts for two clinical nurse specialists and a registrar component (0.5 WTE) remained vacant.

The Northern Area has no reported community hospitals with dedicated palliative care beds.
The St Francis Hospice Home Care team provides a 24-hour, seven-day specialist palliative care service in the community. From 10.00 p.m. to 8.00 a.m., telephone support is available. Over 2004, the service cared for 749 patients and made 7,953 home visits.

4.2.2 North-Eastern Health Board Area

In the North-Eastern Health Board area, Regional Consultative and Development Committees were convened in 2002. A regional epidemiological-based needs assessment was undertaken and adopted by the NEHB in 2004. A consensus development plan has since been completed and agreed between statutory services and voluntary groups. The plan outlines short and medium-term goals for infrastructural development as well as inpatient, outpatient, and day hospital services. It also outlines plans for organisational development and the educational resources required to support those services.

North Eastern Health Board

The North-Eastern Health Board area has one consultant in palliative medicine, appointed following the publication of the NACPC report. NHO/Comhairle na nOspideal has recently sanctioned two additional consultant posts with support teams. Staffing these two posts would comply with the minimum recommendations of the NACPC on consultant numbers. There are currently four approved non-consultant hospital doctor (NCHD) posts in the area. A further two NCHD posts would be needed to meet the minimum recommendations of the NACPC report.

There are currently no specialist inpatient beds in the area. Based on 2002 population figures. 34 beds are needed to fulfil the recommendations of the NACPC report. The regional needs assessment recommends a 32-bed regional unit on the grounds of Our Lady of Lourdes (OLOL) Hospital, with a 16-bed satellite unit in Cavan General Hospital. These units form part of the development and control plan (DCP) for both hospital sites and are seen as medium-term goals. A 12-bed inpatient SPC unit in OLOL Hospital has been identified as an immediate need.

While there are five acute general hospitals, consultant-provided services are limited to OLOL Hospital and Cavan General Hospital, where specialist inpatient care and outpatient services are provided. The former health board area has a dedicated acute hospital team. Community multi-disciplinary teams provide specialist palliative care services in Cavan General Hospital, Louth County Hospital, Monaghan General Hospital and Our Lady's Hospital, Navan.

Access to Level 2 beds in the area is inadequate and inequitable. A single dedicated Level 2 bed is operational in Louth County Hospital, and two Level 2 beds are operational in St. Christopher's Unit, Cavan. The regional development plan outlines detailed proposals for the development of Level 2 beds (integrated with day hospitals) which would provide equitable access for 92% of the people of the area within a 20-minute commute of their home.

There are three multi-disciplinary community teams, each operating within designated counties (Cavan/Monaghan, Louth and Meath). These teams provide an integrated specialist palliative care service in the community and consultancy services in Louth County Hospital, Monaghan General Hospital and Our Lady's Hospital, Navan. The Cavan/Monaghan team provides cover Monday to Friday from 9.00 a.m. to 5.00 p.m. The Louth and Meath teams provide cover five days a week from 9.00 a.m. to 5.00 p.m. and a seven-day nursing service. Over 600 patients were seen by these community teams in 2004.

A comprehensive information strategy will be launched shortly by the HSE North East, aimed at developing awareness and changing perceptions amongst healthcare providers and the general public on the nature and objectives of specialist palliative care services.

4.3 HSE Dublin/Mid-Leinster Region

4.3.1 East Coast Area (ERHA)

The East Coast Area previously formed one of three distinct health board areas within the Eastern Regional Health Authority. A Development Committee for palliative care services was established for the area in September 2002. As yet. no formally agreed regional development plan has been completed, although the future service needs of the area have been well established and documented.

East Coast Area (ERHA)

At December 2004 the East Coast Area had one consultant in palliative med.c.ne, w.th two sess.ons at Blackrock Hospice and nine sessions in St Vincents Un.versity Hospital, Elm Park. In 2005. an application was made and awa.ts approval by NHO/Comha,rle na nOsp.deal for a second consultant post based at Blackrock Hosp,ce. At St Columcille's Hospital, Loughlinstown. approval has been granted or sessions from a consultant in palliative medicine with a v.ew to developing a specialist palliative care team there. At December 2004 the area had three non-consultant hosp.ta. doctors. Based on the NACPC report guidelines, the East Coast Area requires at least two consultants in pa.liative medicine and six non-consultant hospital doctors.

The Blackrock Hospice service was launched in December 2003 as a satellite unit of Our Lady's Hospice, Harold's Cross. The hospice functioned as a four-bed unit until June 2004. Since that time the actual number of beds available has increased to six. The unit has a 12-bed capacity, and funding approval was granted in May 2005 for a further six beds, bringing the service to full inpatient capacity. The *per capita* minimum recommendation of the NACPC report for the East Coast Area yields a recommendation for 33 beds, i.e. the area bed deficit over the latter half of 2004 was 27. The six beds coming on stream over 2005 will further reduce that deficit to 21. Looking to the future in terms of projected population trends, the CSO (2005) estimates a population of 456,000 for the East Coast Area by 2016. Such a scenario would yield an NACPC-recommended bed complement of 46 for the area.

There are three acute general hospitals in the East Coast Area. St Vincent's University Hospital, Elm Park, has a full, consultant-led specialist palliative care team. As noted above, St Columcille's Hospital, Loughlinstown, has had no specialist palliative care service in the past, but approval has been granted in 2005 for sessions from a consultant in palliative medicine with a view to developing a specialist palliative care team at the hospital. There is no specialist service at St Michael's Hospital, Dun Laoghaire.

The East Coast Area has two District Hospitals: Wicklow District Hospital and St Coleman's, Rathdrum. Over 2004 they provided one 'non-specialist palliative care bed' each, and together cared for approximately 20 patients. A family room was available in both hospitals for relatives and friends.

The Blackrock Hospice Home Care Team provides a weekday specialist palliative care service in the community from 8.00 a.m. to 6.30 p.m., and weekend cover from 8.00 a.m. to 4.30 p.m. Over 2004, the service cared for 234 new referrals and made 3,419 home visits. The Wicklow Home Care Team provides a weekday palliative care service in the community from 9.00 a.m. to 5.00 p.m. Over 2004, the service cared for 207 patients and made 1,345 home visits.

4.3.2 South West Area (ERHA)

The South West Area previously formed one of three distinct health board areas within the Eastern Regional Health Authority. A Development Committee for palliative care services was established for the area in September 2002. A regional development plan has been completed.

South West Area (ERHA)

At December 2004 the South West Area had 2.8 consultants in palliative medicine. The first post provides eight sessions to Our Lady's Hospice, Harold's Cross, and three sessions to the team at St James' Hospital. The second post provides seven sessions to Our Lady's Hospice and four sessions to the team at St James'. The third post provides three sessions to Our Lady's Hospice and six sessions to the team at St Luke's in Rathgar. In short, the sessional commitments over 2004 were 18 at Our Lady's Hospice; seven at St James' Hospital and six at St Luke's Hospital.

This figure is derived from CSO/HSE population projections adjusted by the IHF for the East Coast Area.

In June 2005 the area gained a fourth consultant in palliative medicine, with seven sessions at Tallaght Hospital and four sessions at Our Lady's Hospice, Harold's Cross, raising the sessional commitment there to 22. Approval has been granted for the appointment of a fifth consultant, with seven sessions at St Brigid's Hospice-Drogheda Memorial Hospital (in the Curragh), three sessions at Naas Hospital and one session at Our Lady's Hospice. Based on the NACPC report guidelines, the South West Area requires 3.6 consultants in palliative medicine and 10.8 non-consultant hospital doctors. With the appointment of the fourth consultant in June 2005, the South West Area is now in compliance with the NACPC minimum recommendations for consultant resources.

Our Lady's Hospice, Harold's Cross, is a centre of excellence in the area and plays a key educational role in the development of specialist palliative care. Over 2004 the actual number of beds available at Our Lady's Hospice was 36. The *per capita* minimum recommendation of the NACPC report for the South West Area yields a recommendation for 58 beds, i.e. a bed deficit of 22. With seven specialist consultant sessions approved for St Brigid's Hospice-Drogheda Memorial Hospital, the six beds there may develop into a satellite specialist palliative care unit, bringing the area's specialist bed numbers to 42. Looking to the future in terms of projected population trends, the CSO (2005)[3] estimates a population of 779,000 for the South West Area by 2016. Such a scenario would yield an NACPC-recommended bed complement of 78 for the health board area.

There are three acute general hospitals in the South West Area, plus St Luke's Hospital, Rathgar. St Luke's Hospital and St James' Hospital both have full, consultant-led specialist palliative care teams. While there was no specialist team at Tallaght Hospital over 2004, as mentioned above a consultant has been in post since June 2005, with seven sessions. Funding approval has been granted for one registrar, two clinical nurse specialists and a half-time secretary. Over 2004 the team at Naas General Hospital was 'nurse only'; approval has now been granted for three sessions from a consultant in palliative medicine at the hospital.

The South West Area has a community hospital at Cherry Orchard and a community nursing unit at St Brigid's Hospice-Drogheda Memorial Hospital. In the 1980s and early 1990s the 17-bed unit at Cherry Orchard Hospital provided palliative care for HIV/AIDS patients. Improvements in treatment regimes have changed the role of the unit which is now one of care for the chronically ill and the provision of respite care for relatives. Over 2004 St Brigid's Hospice-Drogheda Memorial Hospital provided six dedicated palliative care beds and cared for 60 patients. A family room was available in both hospitals for relatives and friends. As noted earlier, St. Brigid's will be developed into a specialist palliative care unit with specialist consultant provision.

Our Lady's Hospice Home Care Team provides a 24-hour, seven-day specialist palliative care service in the community with telephone support from 6.30 p.m. to 8.00 a.m. Over 2004, the service cared for 367 patients and made 7,393 home visits. St Brigid's Hospice Home Care Team consists of 5.5 clinical nurse specialists, providing a 9.00 a.m. to 5.00 p.m. weekly service and a 10.00 a.m. to 12.00 a.m. weekend service, which includes pre-booked visits. Over 2004, the service cared for 277 patients and made 1,653 home visits.

4.3.3 Midland Health Board Area

Regional Development and Consultative Committees for Palliative Care were established in 2002. A needs assessment was published in 2002 but no development plan has been completed for the area.

There is no specialist palliative care inpatient unit and no day care or dedicated teams in acute hospitals. There are no specialist palliative care medical or allied healthcare professional staff in the area. Based on the 2002 population, there is a need for at least two consultants in palliative medicine and six non-consultant hospital doctors, along with 22 specialist palliative care inpatient beds. There is a need for specialist palliative care teams at each of the three acute general hospitals in Portlaoise, Tullamore and Mullingar.

There are nine institutions offering 12 Level 2 palliative care beds (including two acute general hospitals, district hospitals, community nursing units and nursing homes). Eight of these facilities have family rooms available.

A total of 10 nurses working on two teams (Laois/Offaly and Longford/Westmeath) provide palliative care in the community (home care) for the area. It is expected that three additional nursing staff (Clinical Nurse Manager III x 1 and Clinical Nurse Specialists x 2) will be appointed to palliative care in the community in 2005. Based on the recommendations of the NACPC report there is a need for nine clinical nurse specialists in the community. The local needs assessment recommended 12 CNS and two coordinators. The service is available in Laois/Offaly from Monday to Friday (9.30 a.m. to 5.30 p.m.). A weekend telephone service, with clinical nurse specialist call-outs as needed, is provided from 9.00 a.m. to 5.30 p.m. In Longford/Westmeath the service is provided from Monday to Friday. 9.30 a.m. to 5.30 p.m. An informal weekend telephone and call-out service is provided. There were a total of 528 new referrals to the two teams in 2004. The number of visits made was 8,408.

4.4 HSE Southern Region

A.4.1 Southern Health Board Area

Regional Development and Consultative Committees were established in the Southern Health Board area in 2002. A needs assessment was published in 2003 and a regional development plan for palliative care services in Cork and Kerry was completed by the Regional Development Committee and published in August 2004.

In 2004 there were two consultants in palliative medicine in the area, one based in Cork and one in Kerry. In Cork the consultant sessional commitment was divided between the specialist palliative care inpatient unit at Marymount Hospice and Cork University Hospital. The consultant based in Kerry primarily has commitments to Kerry and Bantry General Hospitals and community teams. Since the beginning of 2005, a locum consultant in palliative medicine has been appointed in Cork, with sessions in Marymount Hospice, Mercy University and South Infirmary Victoria Hospitals. The expectation was that this arrangement would be replaced by a permanent appointment in the near future. This would bring the number of consultants in palliative medicine in the area to three. The appointment of an additional consultant to bring the complement to four has been identified as a short-term priority in the Regional Development Plan. This would be in keeping with the minimum recommendations on consultant staffing levels in the NACPC report. The needs assessment for the area recommended a consultant complement of five due to the geographical spread and the number of acute hospitals.

The three non-consultant hospital doctors in Cork are based in Marymount Hospice and offer a service to Cork University Hospital. An additional NCHD has been appointed in Cork since the beginning of 2005, and. with the locum consultant, offers a service in Mercy University and South Infirmary Victoria Hospitals. There are two approved NCHD positions in Kerry. It is a short-term priority to appoint appropriate numbers for the consultant complement (three NCHDs/consultant post). At present there are six approved NCHD posts; a further 4.5 will be needed to fulfil the recommendations of the NACPC report.
Plans are well under way for the construction of a new 44-bed regional specialist palliative care inpatient unit on a green field site to replace Marymount Hospice, which has 24 beds. Completion of this unit is expected in 2008. The total planned inpatient bed number for the area is 59 (44 in Cork and 15 in Kerry). This will prov.de approximately 10 beds/100.000 population, in keeping with the recommendations of the NACPC.

Spec.al.st palliative care day care is currently provided in Marymount Hospice. Construction of a new day care fac.l.ty on the s.te of Kerry General Hospital is expected to commence shortly, and it is expected that the facility will open in 2006. In the second phase of this project, a 15-bed inpatient unit will be constructed on the site of Kerry General Hospital.

Of the six acute general hospitals in the area, five have dedicated specialist palliative care teams. One of these - Cork University Hospital - has the full range of disciplines recommended in the NACPC report, although some posts are shared with oncology. The other four teams - in Mercy University, South Infirmary Victoria, Kerry General and Bantry General Hospitals - comprise various combinations of disciplines, but none has the full range. Currently there is no dedicated specialist palliative care team in Mallow General Hospital. There were approximately 1,500 referrals to specialist palliative care teams in acute hospitals in 2004.

There are 18 Community and District Hospitals in the area (13 in Cork, five in Kerry) providing Level 2 beds. Five of these have family rooms. The use of beds for palliative care in Community Hospitals is based on need as opposed to beds being 'designated' exclusively for palliative care purposes. In 2004 there were 125 palliative care admissions to these hospitals in the first nine months.

There are four specialist palliative care teams in the community - Marymount, West Cork satellite, North Kerry and South Kerry. The Marymount and West Cork teams both offer services seven days a week. The Kerry services operate over five days with weekend cover when 'requested and deemed appropriate'. There were 886 referrals to these teams in 2004. There are plans for the development of a North Cork satellite home care team based at the site of Mallow General Hospital.

A comprehensive information booklet for patients with palliative care needs has been published in 2005. This provides information on services, access, ancillary supports, entitlements and so on. A detailed assessment of education needs for palliative care has also been completed, following a recommendation contained in the regional needs assessment.

4.4.2 South-Eastern Health Board Area

A Regional Consultative Committee was established in 2003 followed by a Regional Development Committee in 2004. A needs assessment was published in 2003. A regional development strategy for palliative care services in the HSE South Eastern Area was completed in September 2005. In February 2005 a second consultant in palliative medicine was appointed in the area. There are currently 13 consultant sessions in Waterford Regional Hospital, and two clinical consultant sessions in each of the three other acute general hospitals in the area: St Luke's Hospital in Kilkenny, South Tipperary General Hospital and Wexford General Hospital. An additional non-consultant hospital doctor was appointed in January 2005, bringing the NCHD complement to four.

The minimum NACPC-recommended consultant complement for the area is 2.5. The appointment of a third consultant in palliative medicine has been identified as a short-term priority in the regional development strategy. A further 2.5 NCHD posts would be needed to fulfil the recommended ratio of three NCHDs to one consultant.

There are no specialist palliative care inpatient beds in the area. Based on the 2002 population, a complement of 42 specialist inpatient beds is recommended. The provision of six Level 2 specialist palliative care beds is included in the development plan for Waterford Regional Hospital. The regional development strategy has recommended that these beds be provided immediately. Appointment of nursing, care attendant and social work staff for this unit is identified as a short-term priority. The development of a 34-bed inpatient specialist palliative care unit on the grounds of Waterford Regional Hospital is a key recommendation of the strategy. The target for the opening of the unit has been set for 2009.

Recruitment is under way for staff for a new specialist palliative care day care facility on the site of St Luke's Hospital. This facility is scheduled to open in November 2005, offering a five-day service with seven places available per day. The development of day care facilities at Waterford Regional Hospital is also a short-term priority for the area.

There are dedicated specialist palliative care teams in all four acute general hospitals in the area. All teams are now consultant-led and have input from specialist palliative care nursing staff, and varying amounts of input from non-consultant hospital doctors. The appointment of four social workers, one to each of the teams, is considered a short-term priority.

At present there are seven institutions (comprising district hospitals, welfare homes and nursing homes) offering nine Level 2 beds. In addition, it is planned that five Level 2 beds will be provided at Cashel Hospital.

There are four community teams (home care] in the area, employing 17.75 WTE clinical nurse specialists in all. Each of these teams is a voluntary registered charity and the teams have traditionally received substantial funding from the voluntary sector. The South-Eastern Health Board's needs assessment reports that: Absence of service agreements between SEHB and home care teams has resulted in these interfaces being more informal than formal.' There are, however: 'current discussions on formulating service plans.' At present the Carlow/Kilkenny and South Tipperary teams provide 24-hour cover, seven days a week. Cover from 9.00 a.m. to 5.00 p.m. is provided by the Waterford team seven days a week, and the Wexford team five days a week. The appointment of 17 additional specialist palliative care nurses in the community (home care) has been identified as a short-term priority in the regional development strategy. These additional numbers are considered to be needed due to geographical spread and in order to provide a seven-day service. In 2004. 738 new patients were seen by the community teams.

4.5 HSE Western Region

4.5.1 North-Western Health Board Area

The North-Western Health Board area is currently in the process of establishing a Development Committee for palliative care services. A needs assessment is now close to completion.

At December 2004 this health board area had one consultant in palliative medicine with two sessions at Shgo Genera. Hospital, two sessions at Letterkenny General Hospital, two sessions at Northwest Hosp.ce. Shgo. and two sessions at Donegal Hospice. Letterkenny. In January 2005, a second consultant post (based at Sligo Hospice) was approved by Comhairle na nOspideal for Sligo, Leitrim South and Donegal. At December 2004 the health board area had five non-consultant hospital doctors: one based at Northwest Hospice, one at Sligo General Hospital and three at Donegal Hospice/Letterkenny General Hospital. Based on the NACPC report guidelines, the area requires at least two consultants in palliative medicine and six non-consultant hospital doctors.

Northwest Hospice, Sligo (in the grounds of Sligo Hospital), and Donegal Hospice, Letterkenny (on the site of Letterkenny General Hospital), together provide specialist inpatient palliative care for the area. In addition, Foyle Hospice in Derry provides two beds to patients from certain parts of Donegal. Over 2004 the combined number of actual beds available in the area was 18. Specifically, there were eight beds available at Northwest Hospice, eight at Donegal Hospice and two at Foyle Hospice, Derry. The North-Western Health Board area is unique in that it is serviced by two specialist inpatient units. While Northwest Hospice and Donegal Hospice have the same, relatively small numbers of beds available, the Baseline Study has identified significant differences between the two services with respect to: inpatient nursing provision (13.6 WTEs at Northwest Hospice compared to 19.6 WTEs at Donegal Hospice); physiotherapy (0.25 WTE at Northwest Hospice compared to 1 WTE at Donegal Hospice) and occupational therapy [also 0.25 WTE at Northwest Hospice compared to 1 WTE at Donegal Hospice). The *per capita* minimum recommendation of the NACPC report yields a recommendation for the North-Western Health Board area of 22 beds, i.e. the bed deficit over 2004 was four. Looking to the future in terms of projected population trends, the CSO (2005)[4] estimates a population of 265,000 for the area by 2016. Such a scenario would yield an NACPC-recommended bed complement of 26.

There are two acute general hospitals in the area and each has a consultant-led specialist palliative care team. Over 2004 the make-up of the teams at Sligo General Hospital and Letterkenny General Hospital were identical, comprising two weekly consultant sessions, one registrar and one clinical nurse specialist. The North-Western Health Board area has an extensive network of 11 community hospitals. Over 2004 the seven community hospitals with dedicated beds together provided 14 such beds, while the 11 hospitals together cared for approximately 116 patients. A family room was available in 10 of the 11 hospitals for relatives and friends.

The Northwest Hospice home care team provides a seven-day specialist palliative care service in the community with 9.00 a.m. to 5.00 p.m. cover and planned weekend visits. Over 2004. the service cared for 203 new referrals and made 2.305 home visits. The Donegal Community Services home care teams provide a five-day specialist palliative care service in the community from 9.00 a.m. to 5.30 p.m.. and plans to extend the service to include weekend cover. Over 2004. the service cared for 329 patients and made 3,757 home visits.

*** CSO populat.on projections have been adjusted to correspond more prec.sely with the North-Western Health Board boundar.es**
See Chapter 3. p. 31

4.5.2 Western Health Board Area

The Western Health Board established a Development Committee for palliative care services in September 2002. As yet a regional development plan has not been completed.

At December 2004 the West had one consultant in palliative medicine with five sessions at Galway Hospice Foundation, Renmore, and six sessions at University College Hospital, Galway. In April 2005, application was made to Comhairle na nOspideal/NHO for a second consultant in palliative medicine. This post will involve a commitment of seven sessions at Mayo General Hospital and four sessions at Galway Hospice Foundation. A further application has yet to be made for a third consultant who will have a commitment of four sessions at Portiuncula County Hospital, Ballinasloe, four sessions at Galway Hospice Foundation and three sessions at Roscommon County Hospital.

At December 2004 the area had four non-consultant hospital doctors, based for the most part at University College Hospital, Galway. Non-consultant hospital doctors also attend at Galway Hospice inpatient unit, home care and day care services. Over 2004, Mayo General Hospital had three days per week from a non-consultant hospital doctor with a special interest in palliative care. This allocation was discontinued in 2005. Roscommon County Hospital had one day per week from an NCHD (also with a special interest in palliative care). Based on the NACPC report guidelines, the former Western Health Board area requires at least two consultants in palliative medicine and six non-consultant hospital doctors.

Galway Hospice Foundation at Renmore provides the only specialist inpatient hospice care for this health board area. In the last quarter of 2004 the actual number of beds available at Galway Hospice Foundation was eight. The *per capita* minimum recommendation of the NACPC report yields a recommendation of 38 beds for the Western Health Board area, i.e. the bed deficit for the area over 2004 was 30. Looking to the future in terms of projected population trends, the CSO (2005) estimates a population of 480,000 for the West by 2016. Such a scenario would yield an NACPC-recommended bed complement of 48 for the *area.* In the longer term, there is agreement in principle for the development of a 12-bed satellite unit at Mayo General Hospital and a smaller unit at Roscommon County Hospital.

There are four acute general hospitals in the former health board area. University College Hospital, Galway. has a consultant-led team with four registrars and three clinical nurse specialists. The 2004 team composition at Mayo General also included two clinical nurse specialists, a senior social worker and a part-time medical secretary. While the hospital was provided with three days per week from an NCHD who also had a special interest in palliative care, the Regional Coordinator of Acute Services notes the allocation of one session per week from a consultant in palliative medicine since December 2004. The team at Roscommon County Hospital is nurse only', although the hospital has one day per week from an NCHD with a special interest in palliative care. The service at the hospital is supported by a community-based team of specialist nurses and a social worker. Portiuncula County Hospital had no ded.cated specialist palliative care team. The impending application for a third consultant, with a commitment of four sessions at Portiuncula County Hospital and three sessions at Roscommon County Hospital is an indication of a commitment to further develop the role of the acute hospital team for specialist palliative care in the area.

The Western Health Board area has three community hospitals, one community nursing unit and one long-stay geriatric unit which, over 2002, together provided seven "support beds' for palliative care and were availed of by approximately 26 patients. A family room was available in four of the five services for relatives and friends.

The Galway Hospice Foundation home care team provides a seven day, 9.00 a.m. to 5.00 p.m. specialist palliative care service in the community. Over 2004, the service cared for 228 patients and made 4,004 home visits. Mayo/Roscommon Hospice Services also provides a specialist palliative care services in the community on weekdays from 9.00 a.m. to 5.00 p.m. Over 2002, the service cared for 377 patients and made 5,299 home visits.

4.5.3 Mid-Western Health Board Area

A seven-year Regional Development Plan for palliative care services in the Mid-Western Health Board area was completed by the Regional Development Committee and published in December, 2004.

At December 2004 the Mid-Western Health Board area had one consultant in palliative medicine with eight sessions at Milford Care Centre and three sessions at the Mid-Western Regional Hospital. In 2005 a second consultant post has been approved with sessions distributed in the same way as the first post. Since June 2005 the Mid-Western Regional Hospital has had an additional three sessions provided by a temporary consultant in palliative medicine. At December 2004 this health board area had four non-consultant hospital doctors based for the most part at Milford Care Centre. Based on the NACPC report guidelines, the area requires two consultants in palliative medicine. The seven-year Regional Development Plan specifies a deficit of three consultants based on the Hanly' Report.

Milford Care Centre provides an integrated and comprehensive specialist palliative care service for the Mid-Western Health Board area. Over 2004, the actual number of beds available at Milford was 20. The *per capita* minimum recommendation of the NACPC report yields a recommendation for the area of 34 beds. i.e. the bed deficit at Milford over 2004 was 14. An additional 10 beds will come on-stream at Milford m the latter half of 2005. yielding an actual bed number of 30 and a deficit of four. Looking to the future m terms of projected population trends, the CSO 12005) estimates a population of 395.000 for the Mid-Western Health Board area by 2016. Such a scenario would yield an NACPC-recommended bed complement of 39/40 for the area.

The Mid-Western Health Board area was chosen as a pilot site for the so-called Hanly Report lDeparti Children. 2003b).

There are four acute general hospitals in the area and each has a specialist palliative care team. The Mid-Western Regional Hospital in Limerick has a consultant-led team with three clinical nurse specialists and input from a specialist registrar. The three other teams at Nenagh, Ennis and St John's Hospital, Limerick, are 'nurse only', with one CNS each.

The area also has seven community hospitals, which, over 2001, together provided 20 dedicated beds for palliative care which were availed of by approximately 190 patients. A family room was available in six of the seven hospitals for relatives and friends.

Milford Care Centre's home care team provides a seven-day specialist palliative care service in the community, with bases away from the Milford campus at Ennis, Newcastle West, Nenagh and Thurles. The service cared for 573 patients and made 10,365 home visits over 2004.

CHAPTER 5

SERVICE PROVISION AND ACTIVITY

5.1 Specialist Palliative Care in Inpatient Units

Table 5.1 summarises the activity of the eight specialist palliative care inpatient units dispersed across the 10 health board areas of Ireland that provided care for 1,499 patients during 2004. Almost 80% of the admitted patients died in the care of these specialist inpatient units. Overall, on a national basis, this accounts for nearly 15.52% of cancer deaths for 2004. The average bed occupancy for the eight inpatient units was 79%, while the average length of stay for the individual patient was 17 days.

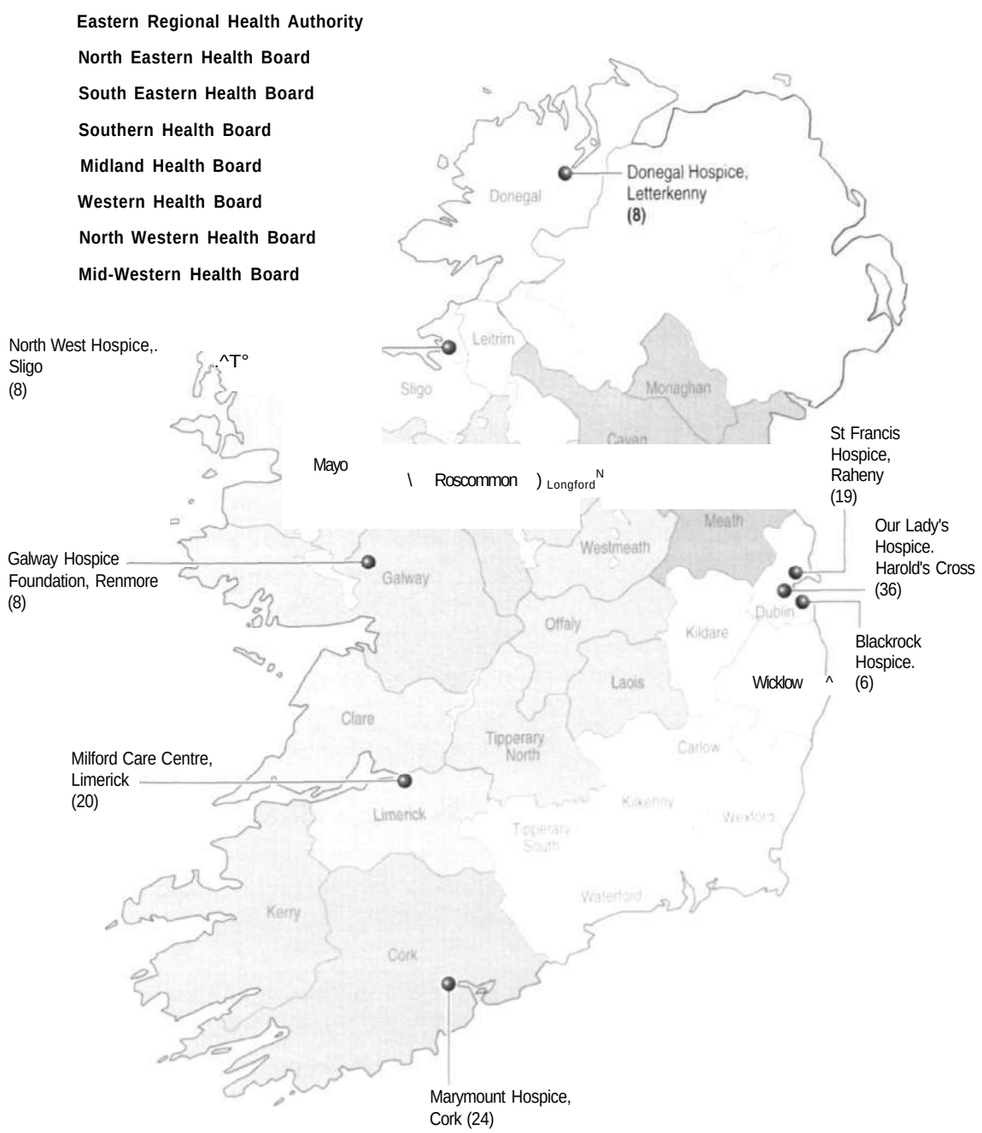
Table 5.1 Hospice/specialist palliative care inpatient units: activity, 2004

Unit and year of activity	Number of patients	Number of admissions	Number of discharges	Number of inpatient deaths	Average length of stay	Bed occupancy (%)
Our Lady"s Hospice, Harold's Cross	332	399	112	285	21 days	84%
Blackrock Hospice	97	97	25	69	19.5 days	**85.6%**
St Francis Hospice, Raheny	239	272	68	203	20 days	82%
Galway Hospice Foundation. Renmore	40	42	16	20	6 days*	35%*
Northwest Hospice, Sligo	80	129	76	55	17 days	63%
Donegal Hospice. Letterkenny	111	111	59	52	12 days	88%
Milford Care Centre. Limerick	245	407	215	175	14 days	71%
Marymount Hospice. Cork	355	456	129	307	15 days**	**79.3%**
Total	**1,499**	1,913	700	1,166	17	79%

* Average length of stay and bed occupancy at Galway Hospice Foundation were recorded from September to December 2004 and do not reflect a typical pattern of service activity for that period. The data has therefore been omitted from the calculation of average length of stay and percentage bed occupancy for inpatient activity, 2004.

The NACPC report recommended that 'there should be a minimum of 8 to 10 specialist palliative care beds per 100,000 population.' Based on the various regional needs assessments and population projections, we have chosen the upper figure as a guideline for the Baseline Study. The report also stated that 'there should be at least one specialist palliative care inpatient unit in each health board area.'

Hospice / specialist palliative care units: Locations and bed numbers, 2004



In Table 5.2, the actual number of beds are compared to the recommended number of beds to illustrate the bed deficit by health board area.

Table 5.2 Hospice/specialist palliative care inpatient units: actual number of beds for 2004 and NACPC (2001) recommended bed numbers by health board area.

Health board area	Number of inpatient units	Recommended number of beds	Actual number of beds	Deficit	% Deficit
East Coast Area (ERHA)	1	33	6*	27	82%
South West Area (ERHA)	1	58	36	22	38%
Midland Health Board	0	22	0	22	100%
HSE Dublin/Mid-Leinster Region Sub-total	**2**	**113**	**42**	**71**	**63%**
North-Western Health Board	2	22	18	4	18%
Mid-Western Health Board	1	34	20*	14	41%
Western Health Board	1	38	8	30	79%
HSE Western Region Sub-total	**4**	**94**	**46**	**48**	**51%**
Northern Area, ERHA	1	49	19	30	61%
North-Eastern Health Board	0	34	0*	34	100%
HSE Dublin/North-East Region Sub-total	**1**	**83**	**19**	**64**	**77%**
South-Eastern Health Board	0	42	0*	42	100%
Southern Health Board	1	58	24*	34	59%
Southern Region Sub-total	**1**	**100**	**24**	**76**	**76%**
National total	**8**	**390**	**131**	**259**	**66.5%**

* Additional beds at planning/implementation stage

The national bed deficit is 259 beds (66.5%) of the total recommended bed complement. In the areas with access to inpatient units there is an existing bed deficit of 157 beds (53.8% of the total recommended bed complement).

5.1.1 Hospice Inpatient Units - Regional Summary

In the South West Area (ERHA) over 2004 Our Lady's Hospice at Harold's Cross had 36 beds available. The six-bed unit at St Brigid's Hospice (Drogheda Memorial Hospital, Kildare) is shortly due for development as a specialist palliative care unit, bringing the area's specialist bed numbers to 42. The combined bed numbers of Our Lady's Hospice and St Brigid's Hospice leaves the area just 16 beds short of the NACPC minimum recommendation of 58.

In the Northern Area (ERHA) over 2004, St Francis Hospice in Raheny had 19 beds available. With a NACPC minimum recommendation of 49 beds for the area, there remains a significant requirement for 30 more beds. It has been acknowledged that additional beds are required in the northwest of the Northern Area, in Blanchardstown in particular.

In the Mid-Western Health Board area, Milford Care Centre provided 20 beds over 2004. While the minimum NACPC recommendation of 34 beds yields an area deficit of 14, an additional 10 beds coming on-stream in the latter half of 2005 will reduce the deficit to four, bringing the area close to compliance.

In the former Southern Health Board area, plans are under way for the construction of a new 44-bed regional SPC inpatient unit to replace Marymount Hospice, which has 24 beds. The total planned inpatient bed number for the area is 59. The planned construction of a 15-bed inpatient unit on the site of Kerry General Hospital combined with the new 44-bed hospice in Cork should bring the area into compliance with NACPC recommendations by 2008.

The North-Western Health Board area is serviced by Northwest Hospice (Sligo) and Donegal Hospice (Letterkenny) with eight beds each over 2004. The NACPC minimum recommendation of 22 beds yields a regional deficit of four (taking into account the availability of a further two beds at the Foyle Hospice, Derry).

In the Western Health Board area, Galway Hospice Foundation (Renmore) provided eight beds over the last quarter of 2004. There is agreement in principle for the development of a 12-bed satellite unit at Mayo General Hospital and a smaller unit at Roscommon County Hospital, which would make some impact on the significant bed deficit of 30 for the area currently.

The East Coast Area (ERHA) launched the Blackrock Hospice service in December 2003 as a satellite unit of Our Lady's Hospice, Harold's Cross. The hospice opened as a four-bed unit and increased to six beds in July 2004. The unit has a 12-bed capacity, and has approval now for a further six beds, bringing the service to full inpatient capacity. The NACPC minimum recommendation for 33 beds yields a deficit of 27 which will reduce to 21 when the additional six beds come on stream over 2005.

There are currently no specialist inpatient beds in the HSE. North East. Based on 2002 population figures. 34 beds are required to fulfil minimum NACPC recommendations. The regional needs assessment has recommended a 32-bed regional unit on the grounds of Our Lady of Lourdes Hospital with a 16-bed satellite unit in Cavan General Hospital.

There are no specialist palliative care inpatient beds in the South-Eastern Health Board area. The NACPC guidelines indicate a complement of 42 inpatient beds for the area. The Waterford Regional Hospital Development Plan includes the immediate provision of six specialist palliative care beds. The Regional Development Plan also includes the development of a 34-bed inpatient unit on the grounds of Waterford Regional Hospital by 2009.

There is no SPC inpatient unit in the Midland Health Board area and currently no plans for the development of specialist palliative care inpatient services.

5.1.2 Hospice Inpatient Units – National Summary

In short, despite the NACPC recommendation that there should be at least one specialist palliative care unit in each health board area and a minimum of eight to 10 specialist palliative care beds per 100,000 population, there are no inpatient units in more than half the country (see map, p. 53). The national bed deficit is 259.

Although all of the inpatient units have cared for a small percentage of patients with a non-cancer diagnosis, the Baseline Study identified a limited availability of hospice/palliative care for such patients.

Currently none of the former health board areas are in full compliance with the NACPC recommendations concerning specialist inpatient bed numbers. In the case of the South West Area (ERHA), the Mid-Western Health Board and the Southern Health Board, their development plans will, in the short to medium term, bring them into compliance with the minimum level of service envisaged.

Furthermore, there are those areas such as the East Coast Area (ERHA) and the Western Health Board area, which have established specialist palliative care units but whose current development plans do not address the NACPC minimum recommendations in the foreseeable future.

Remaining are those former health boards such as the North East and the South East which, although they may currently lack a specialist palliative care unit, have initiated advanced and ambitious plans for their development. And finally, the Midland Health Board lacks both an inpatient unit and a plan to develop one.

In conclusion, the needs assessments identified a need for additional beds in all former health board areas. There is a need to establish new inpatient units in the Midland, North-Eastern and South-Eastern Health Board areas. Satellite units are required in North West Dublin, Wicklow, Kildare, Kerry, Mayo and Roscommon.

5.2 Day Care Provision, 2004

One of the goals of specialist palliative care is to provide care for patients in the most appropriate setting. As patients and relatives often express a choice for care at home, there has been a shift in focus to community-based services. The evolution of day care can be seen in relation to the overall development of services in the community.

The NACPC has recommended that all specialist palliative care units should provide day care facilities for patients and carers.

At December 2004 there were five specialist inpatient units providing day care services. These were St Francis Hospice in the Northern Area (ERHA); Our Lady's Hospice in the South West Area of the ERHA; the Galway Hospice Foundation at Renmore; Milford Care Centre, Limerick and Marymount Hospice, Cork (see map, p. 58). Each unit provided an average of three day care days per week, typically accommodating around 11 patients per day. The five units together provided day care services for 538 patients, accounting for 5,961 attendees, over 2004 (see Table 5.3). It is notable that all of these existing day care services are associated with established specialist palliative care inpatient units. However, there will be an exception to this rule in Kilkenny where, despite the absence of a specialist inpatient unit in the area, a day care service is expected to commence in late 2005.

Table 5.3 Specialist palliative care: day care activity nationally, 2004

Number of units offering day care services	Average number of days per week	Average number of places per day	Number of patients annually	Number of day care attendees annually
5	3.2	11.4	538	5961

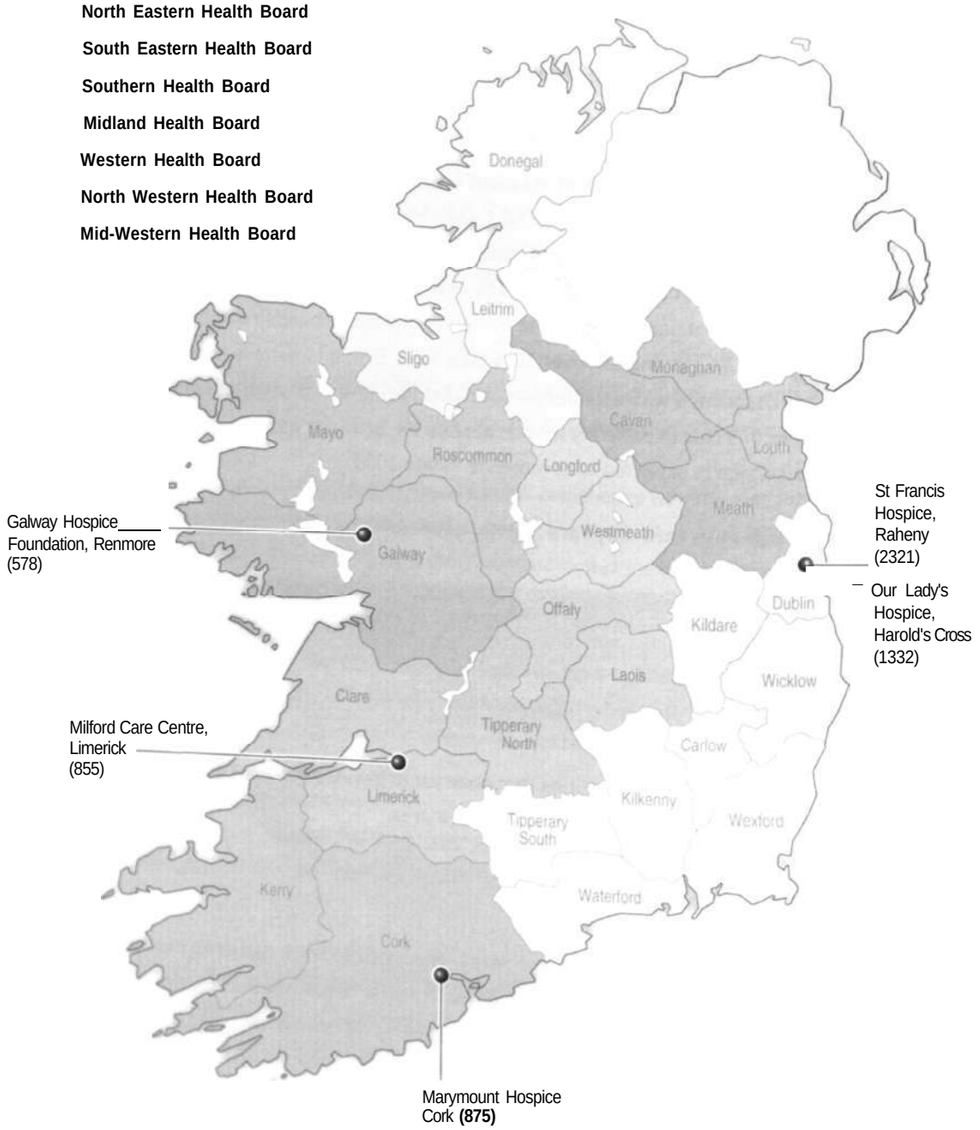
Those areas with specialist inpatient facilities that have yet to develop day care provision are the East Coast Area (ERHA) and the North-Western Health Board area.

5.2.1 Range of day care services

During the data collection phase of the Baseline Study, descriptions were gathered from each of the specialist inpatient units providing day care services, with a view to gaining a picture of the range of services available within their day care provision. This approach acknowledges that there is a range of models of day care in operation across the country. The diverse descriptions offered here are only a first glance' and in no way obviate the need for more rigorous qualitative and quantitative research into the evolution of day care services in the field of palliative care in Ireland.

Specialist palliative care:
Day care service locations and number of attendances, 2004

Eastern Regional Health Authority
North Eastern Health Board
South Eastern Health Board
Southern Health Board
Midland Health Board
Western Health Board
North Western Health Board
Mid-Western Health Board



Our Lady's Hospice, Harold's Cross

The day care service at Our Lady's Hospice has changed following a recent review. Based on the review, a predominantly social model of care has now moved to a model of care which is rehabilitative in approach. The aim is to provide support and enhance independence and quality of life for patients and their carers. The multidisciplinary day care team includes:

- nursing
- occupational therapy
- physiotherapy
- complementary, artistic and supportive therapy (CAST)
- secretarial support
- volunteers

Medical Clinics are also held in the Day Hospice. The service is open five days a week. Patients may attend for individual appointments with Occupational Therapy, Physiotherapy or CAST from Monday to Friday. Patients may attend for a full day [10.45 a.m. to 3.00 p.m.] on a Tuesday. Wednesday or Thursday when the nursing team is available. Each patient has an individual programme of care created to meet their needs.

St Francis Hospice, Raheny

The day care service at St Francis Hospice was expanded in 2004 to include complementary therapy services. Patients can avail of the following range of services:

- nursing and medical assessment
- nursing care
- complementary therapies e.g. aromatherapy, reflexology
- hairdressing/beauty therapy
- social activities
- refreshments and a midday meal
- pastoral care
- recreational art
- outings and day trips.

The service operates for four days each week, accommodating 16 attendees per **day.**

Galway Hospice Foundation, Renmore

The service at Galway Hospice offers:

- medical review/treatments
- nursing care

- creative arts therapies
- complementary therapies
- physiotherapy
- dietetics.

The service operates for two days each week, accommodating seven attendees per day. Pastoral care, chaplaincy and social work services are also available as required. Patients can avail of chiropody, hair care, assisted bathing, Jacuzzi, group and individual games.

Milford Care Centre, Limerick

The range of services available at Milford's day care facility include:

- nursing assessment and care
- physiotherapy
- occupational therapy
- complementary therapies
- hairdressing/beauty therapy
- social activities
- art and music therapy
- pastoral care
- personal care
- recreational art
- horticulture therapy.

The complementary therapies include aromatherapy, Reiki and reflexology. The service operates two days each week, accommodating 12 attendees per day.

Marymount Hospice, Cork

- medical assessment and interventions
- nursing care, physiotherapy
- pastoral care
- social work support
- chiropody
- hairdressing
- arts and crafts.

5.2.2 Future day care service development plans

The NACPC report recommended that all specialist palliative care inpatient units should provide day care to patients and families. A specialist palliative care day care service is currently being developed in Blackrock Hospice and is expected to be operational before the end of 2005. The Northwest Hospice, Sligo, has access to medical assessment and interventions, nursing care and physiotherapy for only a small number of cases. The hospice has noted that the formal introduction of day care will involve employment of new staff and a capital programme: their service agreement has a clause agreeing to discuss the development of day care services within the coming three years. There are plans at Kerry General Hospital for the development of a specialist palliative care day care service to start in 2006. This will precede the development of a planned specialist inpatient unit in the same location. In the former South-Eastern Health Board area, where no inpatient unit currently exists, there are advanced plans to commence a day care service in St Luke's Hospital, Kilkenny by the end of 2005.

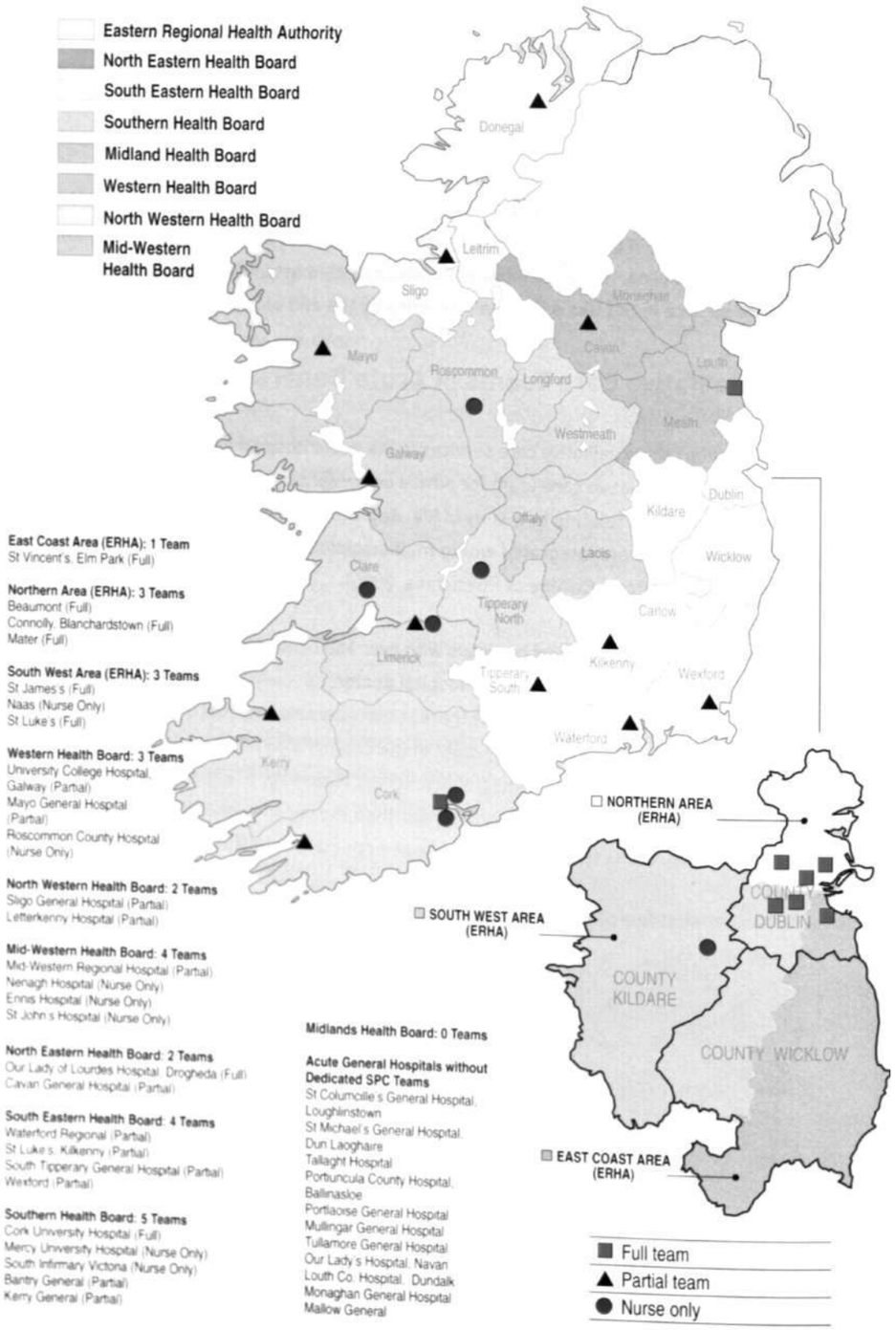
5.3 Specialist Palliative Care Teams in Acute General Hospitals

There were over 6.000[1] referrals to palliative care services in the acute hospital sector over 2004. Patients are referred to the specialist palliative care team for advice on symptom control, psychosocial support, discharge planning and problems relating to quality of life. Appropriate referral is more likely when specialist palliative care services are integrated within multidisciplinary cancer treatment centres (Joint Collegiate Council of the Royal College of Physicians, 2000).

It is government policy that all acute general hospitals with over 150 beds should have a full, consultant-led specialist palliative care team (non-consultant hospital doctor, specialist nurse, social worker, medical secretary). The Baseline Study shows that there is considerable regional variation in specialist palliative care services available in hospitals. Only eight of the country's 38 acute general hospitals have approved palliative care teams with the full range of disciplines (see map. p. 62). Not all of these full teams' have a full staff complement (e.g. some have fewer than the recommended one WTE SPC nurse/150 beds). In the main, areas that have well developed specialist units also have comprehensive teams in hospitals.

This figure does not include data on activity in the NEHB and the SEHB and therefore underestimates the level of activity i 2004.

Specialist palliative care teams in acute general hospitals: Locations and team type, 2004



There are clear differences in terms of the range of disciplines where services exist. They vary from a full range of disciplines to services consisting of a single discipline, usually a clinical nurse specialist. Twelve hospitals have a partial team, seven have a 'nurse only' service and eleven hospitals have either no service in terms of a dedicated palliative care team or depend on external support from community-based teams.

Table 5.4 Specialist palliative care (SPC) teams in acute general hospitals (AGHs)

Health board area	Number of acute general hospitals	Number of AGHs with full SPC team	Number of AGHs with partial SPC team	Number of AGHs with CNS SPC team	Number of AGHs with no dedicated SPC team
East Coast Area ERHA	3	1	-	-	2
Northern Area ERHA	3	3	-	-	-
South West Area ERHA	4*	2*	-	1	1
Western HB	4	-	2	1	1
North-Western HB	2	-	2	-	-
Mid-Western HB	4	-	1	3	-
Midland HB	3	-	-	-	3
North-Eastern HB**	5	1	1	-	3
South-Eastern HB	4	-	4	-	-
Southern HB	6	1	2	2	1
Totals	**38**	**8** (21%)	**12** (18.5%)	**7** (31.5%)	**11** (29%)

* Including a full team based at St Luke's, Rathgar, which does not strictly belong to the Western Region.

** Our Lady's Hospital, Navan, Louth County Hospital and Monaghan General Hospital have a full team and a community-based SPC team.

Again, comparing the state of development of the specialist palliative care team in the acute general hospital from one former health board area to another, the entire spectrum has been recorded: from those close to full compliance with NACPC recommendations (for example in Dublin's Northern Area where all of the acute general hospitals have approval for a full-scale specialist palliative care team) to those former health board areas where many acute hospitals have no dedicated specialist palliative care team. Overall, the Baseline Study has established that only 21% of acute general hospitals have the minimum recommended level of specialist palliative care in place.

5.3.1 Joint Outpatient Clinics

The NACPC report called for integrated outpatient services and sought to promote this concept through the establishment of joint outpatient clinics where: 'patients would attend their consultant, surgeon or physician and the specialist care team at the same time.' With a view to ensuring a timely exchange of information between service providers and to allow the patient access to a range of services in one visit, the NACPC made the following key recommendation:

> Joint outpatient clinics should be established in acute general hospitals, allowing the specialist palliative care team to become involved in patient care at an early stage in the disease process.
>
> NACPC Report, 2001

The Baseline Study has established that among the eight full specialist palliative care teams and the 12 partially constituted specialist palliative care teams, there are only five teams involved in joint outpatient clinics in the way recommended by the NACPC. Leaving aside those acute general hospitals without dedicated teams, this finding suggests that having an SPC team at an acute general hospital is of itself no guarantee that the sort of integration of services envisaged by the NACPC will be made available to patients. The Baseline Study made no systematic analysis of the barriers to this form of service integration. Further research could combine a fuller analysis of the question of joint outpatient clinics with another important, related and unexamined recommendation of the NACPC: that: 'arrangements should be made to fast-track' outpatient appointments for patients receiving palliative care.'

5.4 Specialist Palliative Care in the Community - Home Care

> One of the main principles of the Cancer Strategy is to provide palliative care services to patients in a setting of their choice. The development of community-based palliative care services is vital in the future development of palliative care services in order to best meet the needs and personal preferences of patients with cancer or progressive life-threatening disease. Specialist pall.at.ve care services should be available to all palliative care patients living in the community - be it at home, in a nursing home, or in a community hospital.
>
> NACPC Report, 2001

The role of the palliative care nurse is to provide information, advice and support to primary care providers, patients and families; it also extends to bereavement support where appropriate following the death of a patient. The Baseline Study indicates a high level of diversity in specialist palliative care teams in the community. The report of the NACPC outlines an interdisciplinary consultant-led team based in, or with formal links to, the specialist palliative care unit. Only one former health board approaches a fully compliant service. Services are not consultant-led in the main. Most services are 'nurse only'. Some services have medical and or social work input. Key staffing deficits are identified in the areas of physiotherapy, occupational therapy and social work.

Services which are not consultant-led do not usually have formal links with other elements of the palliative care services within their health board area.

Also, while the NACPC recommended that adequate and equitable state funding should be made available to meet the core running costs of all specialist palliative care services, 50% of home care services remain dependent on voluntary support to some degree - one entirely so.

The total number of patients in 2004 who accessed palliative care services within the community was over 6,000, with a total number of home visits of almost 92,000 (see Table 5.5 on p. 66). There are currently 22 home care services employing 148.5 nurses.

The NACPC report made two recommendations applicable to the funding of home care:

1. Adequate and equitable statutory funding should be made available on a phased basis to meet the core running costs of all specialist palliative care services.

2. All day-to-day expenditure should be met by the health board specialist palliative care budget.

From Table 5.6 on page 67, it is clear that neither equity nor full funding of core day-to-day expenditure is being addressed. It is estimated that local voluntary fundraising contributes almost €4m to the funding of specialist palliative care nurses in the community. Additionally, the Irish Cancer Society - the national charity for cancer care - contributed €884.000 to fund staff in this area in 2004. The Irish Cancer Society also 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 publ.c health nurse. GP or hospital team. All night nurses are registered with An Bord Altrana.s and are employees of the Society. In 2004. 1.225 patients availed of this serv.ce. wh.ch prov.ded 4.945 n.ghts of care. The cost of running the service in 2004 was €1 3m.

Table 5.5 Home care/SPC community services: annual patient numbers and annual number of visits 12004)*

Home care team	Number of patients	Number of visits
Our Lady's Hospice, Harold's Cross	367	7,393
Blackrock Hospice	234	3,419
Wicklow Home Care Service	207	1,345
St. Francis Hospice, Raheny (two teams)	749	7,953
St. Brigid's Hospice Home Care Service, West Wicklow.	227	1653
Galway Hospice Foundation Home Care	228	4,004
Mayo/Roscommon Hospice Services (two teams)	420	9,057
Northwest Hospice Home Care Team	203	2,305
Donegal Home Care Team	329	3,757
Longford/Westmeath	294	4,992
Laois/Offaly	231	3,416
Milford Care Centre (three teams)	573	10,365
Cavan/Monaghan	129	1,594
Meath	214	2,518
Louth	278	3,527
Carlow/Kilkenny	176	3371**
South Tipperary	170	4,006
Waterford	162	2,678
Wexford	230	3,430
Marymount	488	6545
Marymount West Cork Satellite Team	117	1246
Kerry Service (two teams)	260	3042
Total	6,286	91,616

-srrteddaafor,hewh„,esefv,ce,n others by individuals

Table 5.6 Home care **teams and funding sources, 2004**

Home care team	State funding (%)	Voluntary funding (%)
Our Lady's Hospice, Harold's Cross	100%	
Blackrock Hospice	100%	
Wicklow Home Care Service*	100%	
St. Francis Hospice, Raheny	33%	67%
St Brigid's Hospice Home Care, West Wicklow*	100%	
Galway Hospice Foundation Home Care (2004)		100%
Mayo/Roscommon Hospice Foundation	30%	70%
Northwest Hospice Home Care Team	80%	20%
Donegal Community Services Home Care Team	60%	40%
Milford Care Centre	85%	15%
Cavan/Monaghan	92.8 %	7.2%
Longford/Westmeath	50%	50%
Laois/Offaly	50%	50%
Meath	83.9 %	16.1 %
Louth	94.6 %	5.4 %
Carlow/ Kilkenny	20%	80%
South Tipperary	20%	80%
Waterford	20%	80%
Wexford	20%	80%
Marymount	95%	5%
Marymount West Cork Satellite (Bantry)	100%	
Kerry (includes North Kerry & South Kerry teams)*	100%	

m tl

The Baseline Study also revealed substantial regional variations in hours o. cover. w„h only two services offering 24-hour. 7-day cover. The remainder offer variations on weekday coverage and reduced weekend support (see Table 5.7 on p. 68).

Table 5.7 Home care teams and extent of cover

Home care team	Days per week	Hours of cover
Our Lady's Hospice, Harold's Cross	Monday-Sunday	24-hour Daytime visits: 8.00 a.m.-6.30 p.m. Telephone cover: 6.30 p.m.-8.00 a.m.
Blackrock Hospice	Monday-Friday Saturday-Sunday	8.00 a.m.-6.30 p.m. 8.00 a.m.-4.30 p.m.
Wicklow Home Care Service	Monday-Friday	9.00 a.m.-5.00 p.m.
St Francis Hospice, Raheny	Monday-Sunday	24-hour. Telephone service after 11.00 p.m.
St Brigid's Hospice Home Care Service, West Wicklow	Monday-Friday Saturday-Sunday	9.00 a.m.-5.00 p.m. 10.00-12.00 a.m. plus pre-booked visits
Galway Hospice Foundation	Monday-Sunday (7-day cover)	9.00 a.m.-5.00 p.m.
Mayo/ Roscommon Hospice	Monday-Friday	9.00 a.m.-5.00 p.m.
Northwest Hospice	Monday-Sunday	9.00 a.m.-5.00 p.m. (planned weekend visits)
Donegal Community Services	Monday-Friday	9.30 a.m.-5.30 p.m.
Milford Care Centre	Monday-Sunday (weekends: reduced cover)	9.00 a.m.-5.30 p.m. (phone access to inpatient unit outside of those hours!
Cavan/Monaghan	7 days for nursing cover Monday-Friday for MDT*	9.00 a.m.-5.00 p.m.
Meath	7 days for nursing cover Monday-Friday for MDT*	9.00 a.m.-5.00 p.m.
Louth	7 days for nursing cover Monday-Friday for MDT*	9.00 a.m.-5.00 p.m.
Carlow/Kilkenny	Monday-Sunday	24-hour cover
South Tipperary	Monday-Sunday	24-hour cover
Waterford	Monday-Sunday	9.00 a.m.-5.00 p.m.
Wexford	Monday-Friday	9.00 a.m.-5.00 p.m.

.CONTINUED from previous page

Home care team	Days per **week**	Hours of cover
Marymount	Monday-Sunday	Monday-Saturday 8.00 a.m.-6.30 p.m. Telephone cover 6.30 p.m.-8.00 a.m. Sundays/bank holidays 8.30-5.00 p.m.
Kerry General Hospital (North Kerry Team)	Monday-Friday	Weekend cover provided when requested and deemed appropriate
Killarney District Hospital (South Kerry Team)	Monday-Friday	Weekend cover provided when requested and deemed appropriate

* Multidisaplinary team

5.5 Palliative Care in Community and other 'Level 2' Hospitals

A key recommendation of the report of the NACPC was the designation of a number of palliative care beds in community hospitals. The benefits for the patient and family are clear: excellent services can be delivered closer to the patient's own home and often by the patient's primary care team.

> Support beds for palliative care patients are provided in a number of community hospitals around the country. Patients may be admitted to these beds following discharge from acute general hospitals for further nursing care. They may also be admitted from the community for symptom control. Community hospitals also provide respite for patients and carers, when patients are being cared for at home.
>
> The National Advisory Committee recommends that commun.ty hospitals should have designated beds for palliative care patients who require an intermediate level of inpatient care. Facilities in local community hospitals should be upgraded, w.th prov.s.on made for privacy for patients and their families, when required.
>
> NACPC Report. 2001

There are more than 116 support beds available (or patients **needing** palliative care in vanous commun.ty hospitals located throughout the country Isee map. p. 701. These beds catered for over 540 paben.s ,n 2004. Some areas did not return data on the level of adm.ss.ons to palbabve care beds in commundy hospitals. I, is likely therefore that palliative care delivered by commundy-based teams serv.ng community hospitals and nursing homes is at a higher level than the figures auuve. Level / facilities can should pay greater attention to this area of activity. respite care, given that they are generally dispersed more locally. For patients who require Level 2 palliative care input, the option of receiving such care locally may nmu or <e specialist units or acute hospitals.

Palliative care in community, district and general hospitals: Reported designated beds and health board areas*

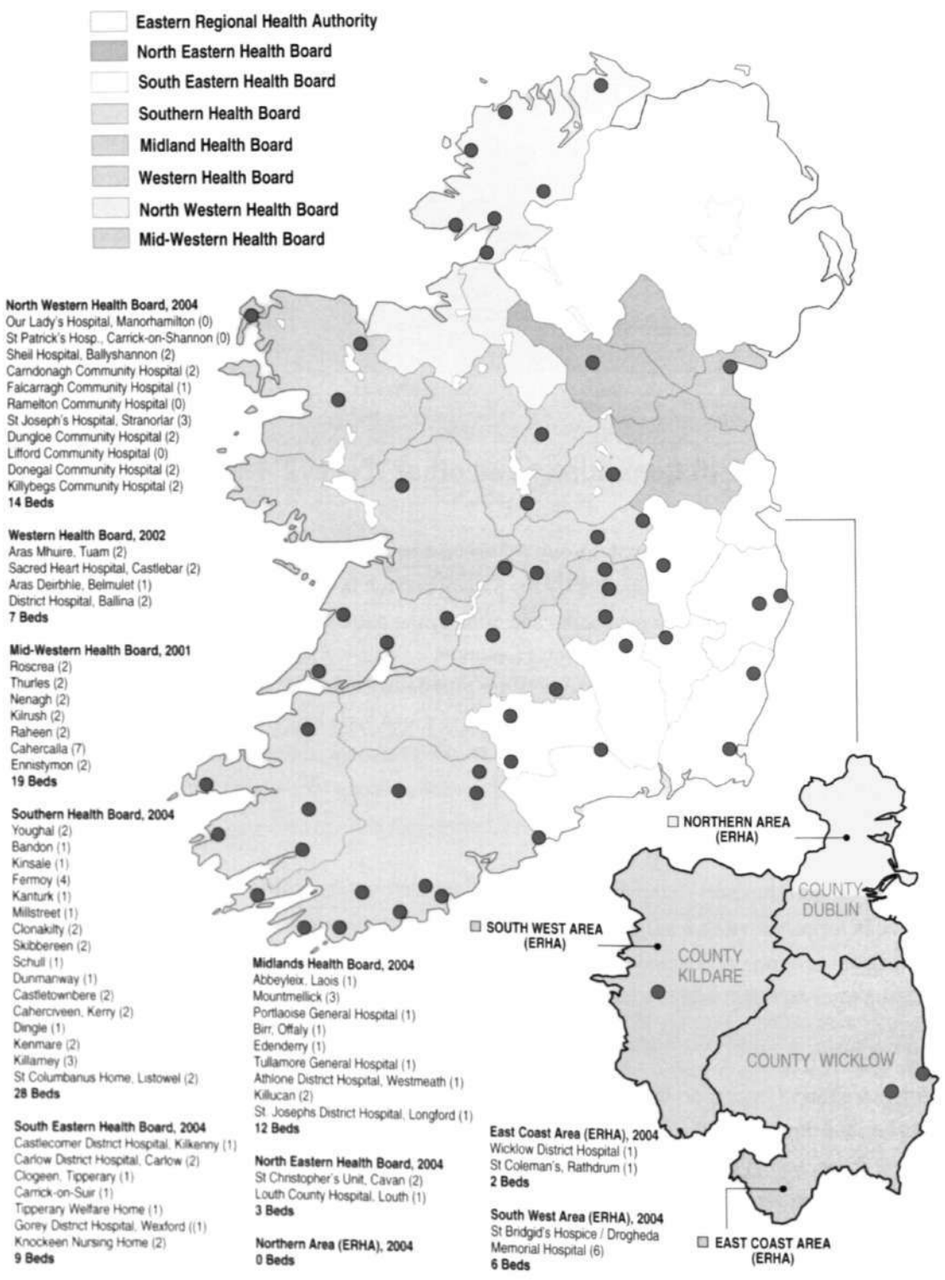


Table 5.8 Reported 'Level 2' palliative care beds* and health board area

Number and type of institutions reporting Level 2 palliative care beds	Year	Total number of reported Level 2 palliative care beds in area	Number of institutions with family rooms	Approximate number of Level 2 patients over a single specified year**
East Coast Area, ERHA 2 District Hospitals	2004	2	2	20
Northern Area, ERHA	2004	0	-	-
South West Area, ERHA 1 Level 2 unit	2004	6	1	62
Western Health Board 1 Community Nursing Unit 1 Long-stay Geriatric Hospital 2 Community Hospitals	2002	7	4	28
North-Western Health Board 11 Community Hospitals	2004	14	10	116
Mid-Western Health Board 7 Community Hospitals	2001	19	6	114
Midland Health Board 1 District Hospital 3 Care Centres 2 General Hospitals 2 Community Nursing Units 1 Nursing Home	2004	12	8	89
North-Eastern Health Board 1 Unit 1 County Hospital	2004	3	0	8
South-Eastern Health Board 5 District Hospitals 1 Welfare Home 1 Nursing Home	2004	9	5	24
Southern Health Board 18 Community Hospitals	2004	28	5	167

* The way in which patients access these beds varies from region to region

** The number of admissions alone should not be treated as an accurate indicator of service activity, since thos figures would need to be combined with figures for 'length of stay' to provide a true picture

The **way** in wh.ch patients access these beds varies from reg.on to region.

The Baseline Study did show significant variation in the availability of such beds. Those areas that already have a specialist palliative care inpatient unit in operation also have a higher proportion of Level 2 facilities and activity. The presence of the specialist palliative inpatient units in these areas seems to be a catalyst for the further development of palliative care services. The one exception to this is the former Midland Health Board which has a significant network of Level 2 beds, but no specialist inpatient unit (see map, p. 70).

There appeared to be an absence of Level 2 beds in cities, particularly in the area of the Eastern Regional Health Authority. This is significant as it will limit the transfer options of patients from other care settings, i.e. acute hospitals and specialist inpatient units.

On a national basis, the ratio of institutions *with* family rooms to those without is 2:1. This essentially means that one in three Level 2 institutions providing palliative care lacks the facility of a family room. The Baseline Study highlighted an anomaly in relation to terminology. While there was clarity in some of the former health board areas as regards the definition of Level 2 beds, in many cases beds in community hospitals are not exclusively designated for patients with palliative care needs. A more detailed quantitative and qualitative analysis of this area is required in the future.

Collecting data on beds available for palliative care in community hospitals proved more difficult than data acquisition from other care settings.

5.5.1 Links between Community Hospitals and Specialist Palliative Care Teams

> Formal links should be established between community hospitals and the specialist palliative care teams in the area. Staff members of community hospitals should be enabled to undertake some formal training in palliative care, such as a diploma in palliative care. This should be funded by the relevant health authority. Specialist palliative care units should recognise the training needs of staff in community hospitals, and offer support when required.
>
> NACPC Report, 2001

Access to Level 2 beds is generally through the Director of Nursing at the community hospital. Only in some cases do the specialist palliative care team have an input in assessing the suitability of the setting to the needs of the patient. Direct involvement of the specialist palliative care team would facilitate greater integration with the other elements of the specialist palliative care service for patients and family.

5.5.2 Equity of Access to Level 2 Care

In order to ensure equitable access to this level of care there is a need to increase the geographic spread and ava.lab.l.ty of dedicated support beds within community and district hospitals.

There is variation on policy relat.ng to who has access to these beds [in terms of healthcare professionals and patients), how access is granted, how the individual hospitals define palliative care patients, how the beds are used, e.g. short-stay respite versus long stay for someone who happens to have a malignancy that is not currently life limiting but who has need of a long-stay bed, etc. These variations are noted to highlight the shortcomings in adding figures together from different hospitals and areas when it is often not possible to compare like with like.

Ordinarily admission to a community hospital is restricted to persons over 65 years of age. In many cases this is extended to 60 years for patients with palliative care needs. Many designated beds are accessible to younger adults. However, the appropriateness of this care setting for younger adults is questionable.

The benefits of Level 2 beds can only be fully reaped if these beds are readily available and may be accessed in a straightforward way.

5.6 Bereavement Support

The report of the NACPC recommends that bereavement support should be an essential part of all specialist palliative care programmes and should be offered in all specialist palliative care settings. All health board areas show evidence of bereavement support service provision at each of the three levels indicated in the report of NACPC, i.e., follow-up, counselling and access to specialist support. The description of bereavement services across these Levels 1, 2 and 3 imposed a framework which was not employed locally in each service and which was not evident in needs assessment documents.

The Baseline Study assessed (a) whether the three levels of bereavement support specified in the NACPC report were offered through specialist inpatient units; (b) whether trained bereavement support volunteers provided bereavement support through the unit; and (c) whether these services were available on an unrestricted basis.

Some data were recorded for areas with no inpatient unit. In these cases aggregate regional data may not reflect local service variation.

Bereavement support was available in all locations, and most services could access support at each of the three levels (see Table 5.9). All offered a form of Level 1 support (information, follow-up. visits, social support). Similarly, all had access to counselling (Level 2). and most to psychotherapy services (Level 3) as appropriate It is important to note that the baseline assessment asked about the existence of such services and did not assess their adequacy in terms of either availability, waiting times or quality. As mentioned above, the framework of "Levels 1. 2 and 3' was not familiar to all services.

Only three of the areas provided a volunteer-based bereavement support service, while one service (Northwest Hospice) was planning to introduce a befriending service. These are detailed m Table 5 9

Table 5. 9 Bereavement support and bereavement support volunteers, by specialist inpatient unit and area

Location	Provides or has access to bereavement support at Levels 1, 2 and 3	Trained bereavement support volunteers	Number of trained bereavement support volunteers
Specialist inpatient units:			
Our Lady's Hospice, Harold's Cross (Dublin)	1, 2 and 3	Yes	25
Blackrock Hospice (Dublin)	1 and 2	No	NA
St Francis Hospice, Raheny (Dublin)	1,2 and 3	Yes	12
Galway Hospice Foundation	1,2 and 3	No	NA
Northwest Hospice, Sligo	1,2 and 3	No	NA
Donegal Hospice, Letterkenny	1,2 and 3	No	NA
Milford Care Centre, Limerick	1,2 and 3	Yes, 8	
Marymount Hospice, Cork	1 and 2	No	NA
Regional services:			
North East	1,2 and 3	No	NA
South East	1 and 2	No	NA
Midlands	1 and 2	No	NA
Western Health Board-Mayo/Roscomon	1, 2 and 3	No	No

Since the publication of the NACPC report there have been two evidence-based reviews on bereavement support which advocate a tiered approach to describing and providing appropriate bereavement support (NICE, 2004; Centre for the Advancement of Health, 2004). Significantly, both of these reports place more emphasis on reinforcing 'natural' supports such as information provision and family support, supplemented by volunteer and community services, with only a small minority of people requiring specialist counselling or psychotherapy.

5.6.1 Restrictions

Some services made explicit the fact that the bereavement support offered was restricted, in that it was only available to the family of patients receiving specialist palliative care services, for example:'... only significant others of patients who were receiving SPCS in the region' (NEHB); 'support groups only available to relatives of patients who were cared for by specialist palliative care team' (SHB).

Within the constituency of relatives of patients receiving specialist palliative care services, most services indicated that there were no restrictions on who could access bereavement services, although three centres did not answer this question.

Other restrictions referred to were the limited resources available to the palliative care team in-house (SEHB); the 'serious issues of availability' of bereavement counselling (NWHB: Northwest Hospice) and limited access to counselling' (Donegal Hospice).

Finally, specialist counselling services for medical card/non-fee paying clients are not as available as in the private sector.

5.6.2 Bereavement Services Coordinators and Staff Training

> Bereavement support should be provided by appropriately trained personnel from the available pool of staff in each service.
>
> NACPC Report. 2001

The Baseline Study assessed whether a bereavement services coordinator was employed in specialist palliative care services (Table 5.10) and whether all specialist palliative care staff received training in bereavement support (Table 5.11).

Three of the areas had designated bereavement service coordinators and the professional background of all three was social work. Three further services indicated that they had posts which involved a significant bereavement workload.

Bereavement support 'should begin early in the disease process, long before the death of the patient'; should be incorporated into all specialist palliative care programmes and should be prov.ded by appropriately trained staff, according to the NACPC report. Some provision for the training of palliative care staff in bereavement support was evident. Three services said training was provided for all staff, while two services encouraged training for all staff.

Table 5.10 Designated bereavement services coordinator, by specialist inpatient unit/region

Location	Designated coordinator	No designated coordinator but posts with significant bereavement workload	No bereavement services coordinator
Specialist inpatient units:			
Our Lady's Hospice, Harold's Cross		✓	
Blackrock Hospice			✓
St Francis Hospice Raheny	✓		
Galway Hospice Foundation		✓	
Northwest Hospice, Sligo			✓
Donegal Hospice, Letterkenny			✓
Milford Care Centre, Limerick	✓		
Marymount Hospice, Cork	✓		
Regional/community services:			
North East		✓	
South East			✓
Midlands			✓
Mayo/Roscommon			✓

Table 5.11 Bereavement training for all specialist palliative care staff, by specialist inpatient unit and region

Location	Yes	Encouraged	No
Specialist inpatient units:			
Our Lady's Hospice, Harold's Cross			✓
Blackrock Hospice			✓
St Francis Hospice Raheny	✓		
Galway Hospice Foundation	✓		
Northwest Hospice, Sligo			✓
Donegal Hospice, Letterkenny		✓	
Milford Care Centre, Limerick	✓		
Marymount Hospice, Cork		✓	
Regional services:			
North East			✓
South East			✓
Midlands			No answer
Mayo/Roscommon Hospice		✓	

5.6.3 Assessment of Need for Bereavement Support

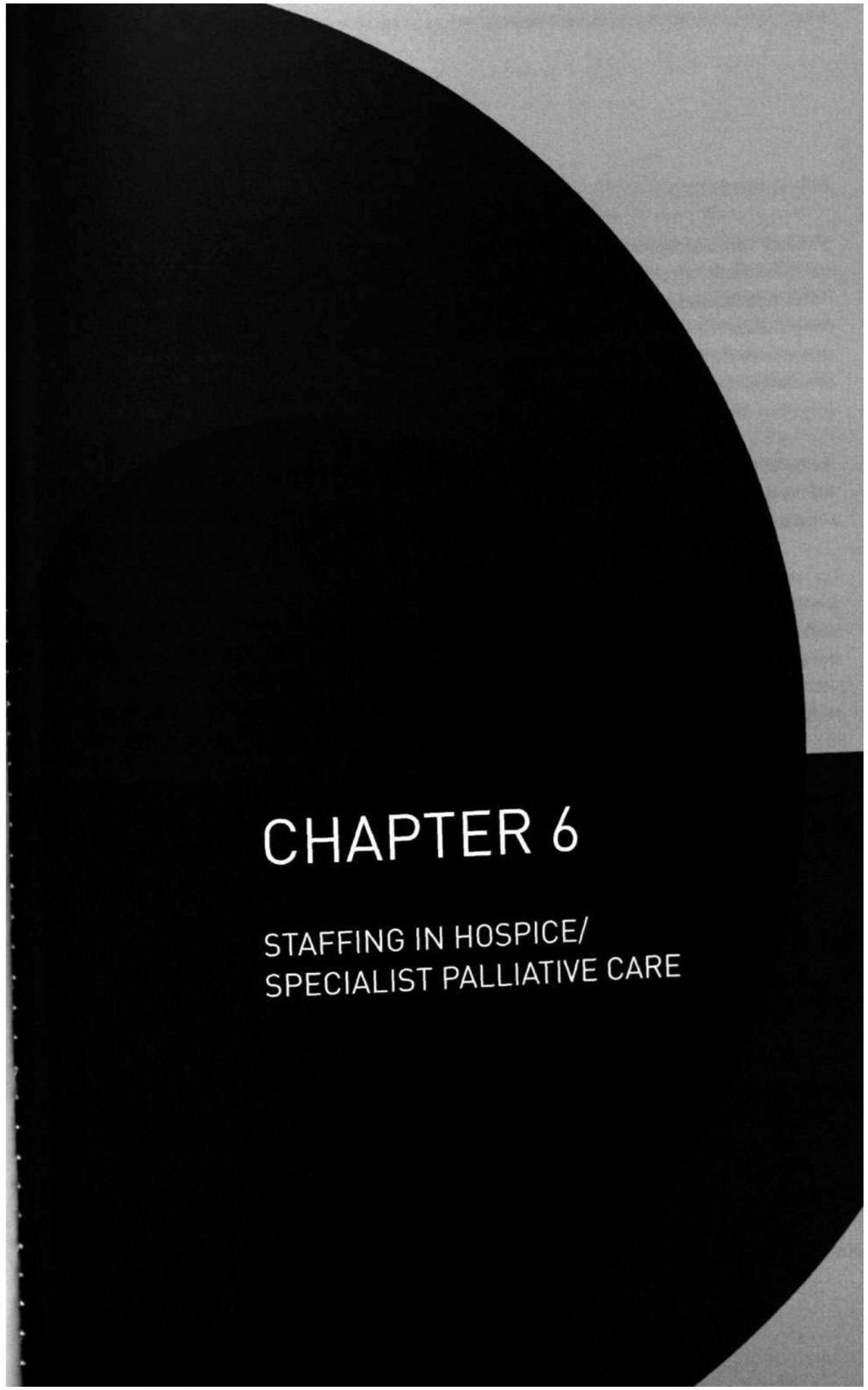
> Assessment of need for bereavement support should be routine in all specialist palliative care services.
>
> NACPC Report, 2001

The report of the NACPC recommends that assessment of need for bereavement support should be routine in all specialist palliative care units. In this study only one service had a formal procedure for assessing need in order to match it to bereavement support. In addition, only three services had specifically designated staff members who acted as 'bereavement coordinators'. These organisational and planning facets of bereavement care in the palliative care context need to be addressed.

Finally, in terms of bereavement, it is important to note that among the recommendations of the NACPC report are programmes requiring national initiatives, e.g. the development of a system to accredit and regulate bereavement counselling. These policy-related recommendations are outside of the remit of the Baseline Study.

5.6.4 Bereavement Support Services - Summary

- All areas show evidence of bereavement support service provision at each of the three levels indicated in the NACPC report.
- Three of the areas provide volunteer bereavement support services; the majority does not train bereavement support volunteers.
- Bereavement support training is provided for all staff in three centres.
- The NACPC report recommends that assessment of need for bereavement support should be routine in all specialist palliative care centres. Only one area has a formal procedure for assessing need in order to match it to the bereavement support service.
- The NACPC report recommends that an appropriate member of staff should be nominated as bereavement services coordinator. Only three areas had roles which could be described as bereavement services coordinators.
- Finally, among the bereavement-related recommendations in the report are national initiatives which have not been addressed in the Baseline Study: for example, the recommendation for the development of a system to accredit and regulate bereavement counselling.



6.1 Introduction

'Palliative Care demands a higher level of professional skills from trained professionals and a high staff/patient ratio,' according to the UK National Council for Hospice and Specialist Palliative Care Services (1995). A palliative care team comprises several varying but ultimately complementary healthcare professionals. These include consultants, non-consultant hospital doctors, nurses, care attendants, physiotherapists, occupational therapists, social workers, psychologists, professional counsellors, spiritual care-givers, speech and language therapists, clinical nutritionists, pharmacists, complementary and supportive therapists and volunteers.

The diversity in the make-up of specialist palliative care teams revolves around the underpinning principle that the best palliative care service will be provided by a multidisciplinary, consultant-led group operating with a collaborative and cooperative approach.

The role of the team is to facilitate collectively the best possible care of the patient and family, given their needs, in the appropriate care setting. The NACPC report recommended that all core staff should be funded by the state: 'All day-to-day expenditure should be met by the health boards' specialist palliative care budget.' The report clearly recognised that there would be different patterns of development in each health board area: 'It is important to recognise that different health boards are at different stages in the development of their specialist palliative care services ... and some may take a longer time scale than others to achieve these requirements.'

In some of the tables in this chapter the current staffing/deficit totals may appear not to add up because in certain staff categories in some health board areas, current staff numbers may exceed the NACPC's minimum recommendations due to local circumstances. In these cases the deficit is set at zero.

6.2 Medical Staff

6.2.1 Consultants in Palliative Medicine

One of the primary recommendations of the NACPC report is that 'all specialist palliative care services should have at least one doctor who holds a recognised Comhairle na nOspidéal approved consultant in palliative medicine post and who practices principally in this speciality.' The regional needs assessments considered the requirements for consultants in palliative medicine with 'due regard to local needs and circumstance', so that a comprehensive and equitable service to patients could be provided in each area. There is clear evidence to suggest that the appointment of a consultant to an area brings with it a critical mass of other palliative care personnel in all care settings and a strategic focus for the future development of services.

The NACPC report recommended that there should be one consultant in palliative medicine per 160,000 of population, with a minimum of two consultants in each health board area. Applying this formula to each health board area would give rise to a national need for 25 consultants in palliative medicine. There were seven consultants in post at the time of the publication of the NACPC report. The staffing level recorded in December 2004 was 12 (see map, p. 82), indicating a remaining deficit of 13. At December 2004 there were a further nine posts either approved or in the process of recruitment. This study has not established the potential impact of imposed recruitment ceilings on the filling of such posts. When these posts are filled, the remaining deficit will be four posts. However it should be noted that the Hanly Report (Department of Health and Children, 2003b) recommended that there should be one consultant in palliative medicine per 87,000 of population. The regional needs assessments recognised the realities of the Hanly conclusions, and in some cases have recommended higher levels of consultant staffing due to geographical spread and numbers of regional and satellite units. However, the Hanly Report also suggested that the increased number of consultants implied by the development of a consultant-delivered service, would be accompanied by a reduced need for non consultant hospital doctors.

Regional fulfilment of the recommended levels of consultant posts vary from health board areas that just require one additional post to the area of the Midland Health Board which has no consultant in palliative medicine to guide the development of specialist palliative care services. None of the three acute hospitals in this health board area has any dedicated specialist palliative care staff. All other areas have at least one of their recommended consultants in place but none have wholly satisfied the guideline specific to their areas.

Consultants in palliative medicine: Staffing levels and health board areas at December 2004

Eastern Regional Health Authority
North Eastern Health Board
South Eastern Health Board
Southern Health Board
Midland Health Board
Western Health Board
North Western Health Board
Mid-Western Health Board

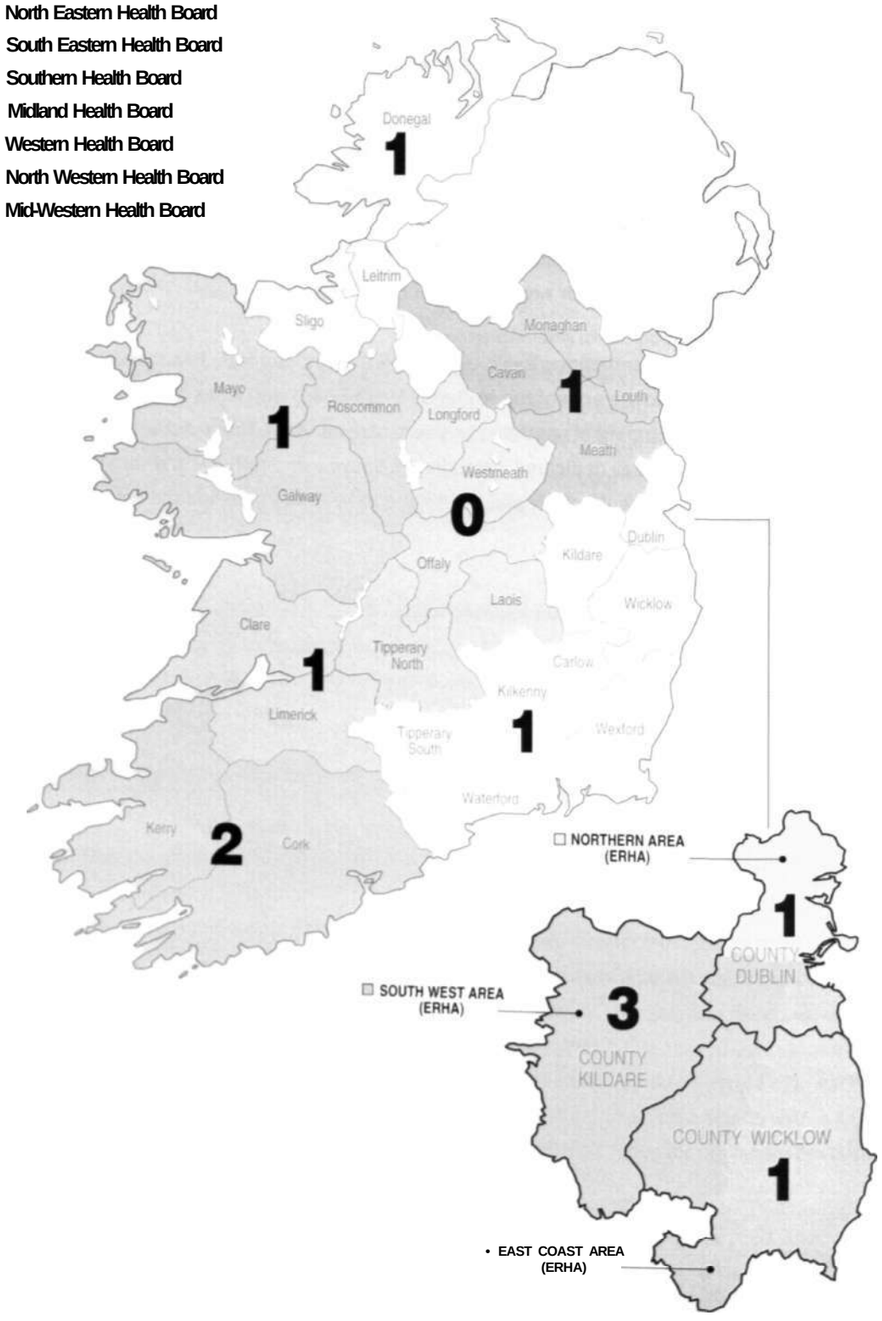


Table 6.1 Consultants in palliative medicine: current and recommended staffing levels by health board area, December 2004

Health board area	Current staffing levels	Approved or in recruitment process	Recommendation, based on one per 160,000 of population	Deficit
East Coast Area, ERHA	1	1	2	1
Northern Area, ERHA	1	1	3	2
South West Area, ERHA	3	1	4	1
WHB	1	1	2	1
NWHB	1	1	2	1
MWHB	1	1	2	1
MHB	0	0	2	2
NEHB	1	1	2	1
SEHB	1	2	2.5	1.5
SHB	2	0	3.5	1.5
National total	**12**	**9**	**25**	**13**

It is estimated that to fund this national deficit of consultants [including those currently approved or in the process of recruitment] would cost in the region **of** €3.4m annually.

6.2.2 Non-Consultant Hospital Doctors in Palliative Medicine

The NACPC report recommends that for each consultant in palliative medicine, there should be at least three non-consultant hospital doctors (NCHDs). Given this guideline, there should be 75 NCHDs working on a national basis in specialist palliative care. There were 37.5 NCHDs serving in December 2004. Once again there are wide regional variations in the deployment availability of NCHDs in palliative care services.

Table 6.2 Non-consultant hospital doctors: current and recommended staffing levels by health board area, December 2004

Health board area	Current staffing levels	Approved or in recruitment process	Recommendation, based on three NCHDs per consultant	Deficit
East Coast Area, ERHA	3	0	6	3
Northern Area, ERHA	5	1	9	4
South West Area, ERHA	7.5	1	12	4.5
WHB	4	0	6	2
NWHB	5	0	6	1
MWHB	4	1	6	2
MHB	0	0	6	6
NEHB	1	3	6	5
SEHB	3	1	7.5	4.5
SHB	5	0	10.5	5.5
National total	**37.5**	**7**	**75**	**37.5**

It is estimated that it would cost approximately €4.2m to fund this national deficit in the number of **serving** non-consultant hospital doctors in palliative medicine. There have been some difficulties in some areas in recruiting NCHDs.

6.3 Palliative Care Nursing

> 'A dynamic team of highly trained, motivated and skilled nursing personnel is an essential component of any specialist palliative care facility.'
>
> NACPC Report, 2001

There have been a number of developments in nursing practice and policy since the publication of the 2001 report. New posts have emerged: Clinical Nurse Specialist, Infection Control Nurse, Practice Development Coordinator and Advanced Nurse Practitioner. These developments have not been considered by the present study.

6.3.1 Palliative Care Nurses in Specialist Inpatient Units

The recommendation is that in an inpatient unit the overall WTE palliative care nurse to bed ratio should not be less than 1:1. Where inpatient units exist, staffing levels are generally adequate. There are currently 149.5 palliative care nurses covering the existing complement of 131 beds in specialist inpatient units. However, as referred to earlier in Table 5.2 on p.54 there is a deficit of 259 inpatient beds, with many areas having no access to an inpatient unit.

The national deficit in palliative care nurses in specialist inpatient units of 251.5 correlates closely with the national inpatient bed deficit of 259.

Table 6.3 Palliative care nurses in specialist inpatient units: current and recommended staffing levels by health board area, December 2004

Health board area	Current staffing (bed) levels	Approved or in recruitment process	Recommendation based on recommended bed numbers	Deficit based on recommended bed numbers
East Coast Area, ERHA	6.5(6)		33	26.5
Northern Area, ERHA	21 (19)		49	28
South West Area, ERHA	23.5 (36)		58	34.5
WHB	14.5(8]		38	23.5
NWHB	33(18)		22	
WHB	28(20)		34	
MHB	0(0)		22	22
EHB	0(0)		34	34
SEHB	0(0)		42	42
SHB	23 (24)		58	
National total	149.5(131		390	251.5

To fund the addit.onal nurs.ng posts to accompany the additional beds would require an additional national annual budget of €15.6m for nurses in inpatient units. Additionally, day care facilities attached to inpatient un.ts are currently underdeveloped. When there is a full complement of inpatient units offering day care services, there will be a need for at least an additional 12 nurses at a cost of €600,000.

6.3.2 Specialist Palliative Care Nurses in the Community

The NACPC recommendation is that there should be a minimum of one WTE specialist palliative care nurse m the community per 25.000 population. This amounts to a total recommended number of nursing staff m the commun.ty of 156. S.gnif.cant progress has been made in almost all areas in the provis.on of specialist pa.hat.ve care nurses in the community with a national complement of 148.5 prov.d.ng care to over 6.000 patients in 2004.

Table 6.4 Specialist palliative care nurses in the community: actual and recommended staffing levels by health board area, December 2004

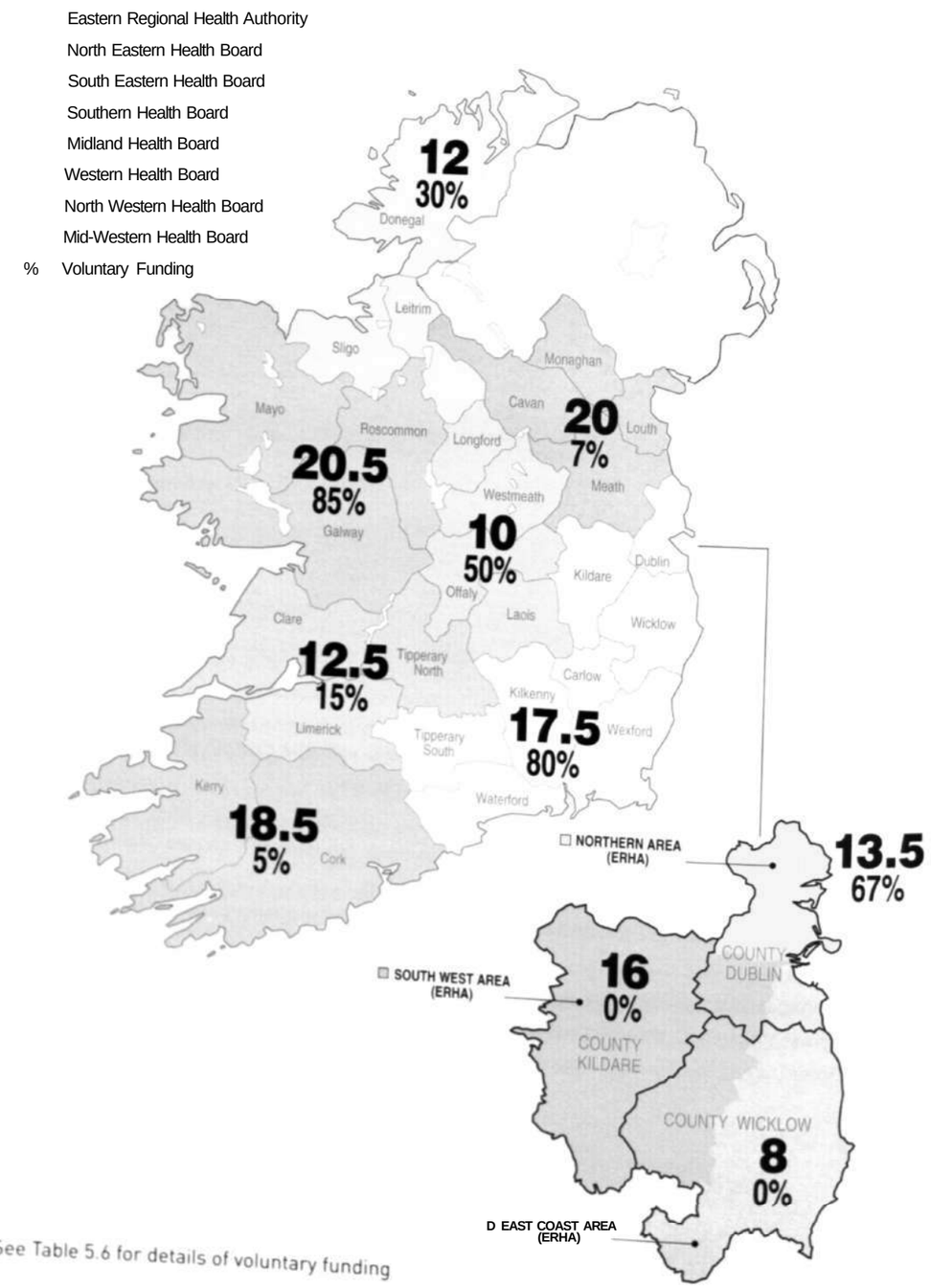
Health board area	Current staffing levels	Approved or in recruitment process	Recommendation, based on one per 25,000 of population	Def,c,tbasedon, current population/or inpatient bed numbers
East Coast Area, ERHA	8	2	13	5
Northern Area, ERHA	13.5	0	19.5	6
South West Area, ERHA	16	0	23	7
WHB	20.5	0	15	0
NWHB	12	0	9	0
MWHB	12.5	0.5	13.5	1
MHB	10	3	9	0
NEHB	20	0	14	0
SEHB	**17.5**	0	17	0
SHB	18.5	0	**23**	4.5
National total	148.5	5.5	156	23.5

There is however the issue of the source of funding for specialist palliative care nurses in the community. The NACPC report made two key recommendations in this regard:

1. Adequate and equitable statutory funding should be made available on a phased bas.s to meet the core running costs of all specialist palliative care services.
2. All day-to-day expenditure should be me, by the health board specialist palliative care budget.

The deficit for specialist palliative care nurses in the community stands a. 23 5 and many areas have plans to address this deficit. When account is taken o, the state commitment to fully fund home care nurses, the cost of funding the deficit comes to €5.3m.

Specialist palliative care nurses in the community:
Staffing levels, percentage voluntary funding and health board areas, 2004



See Table 5.6 for details of voluntary funding

6.3.3 Specialist Palliative Care Nurses in Acute General Hospitals

Table 6.5 Specialist palliative care nurses in acute general hospital teams, December 2004

Health board area	Current staffing levels	Approved or in recruitment process	Recommendation based on one per 150 beds	Deficit
East Coast Area, ERHA	2	0	5	3
Northern Area, ERHA	*k*	2	11	7
South West Area, ERHA	6	2	11.5	5.5
WHB	6	0	10	*k*
NWHB	2	0	*U*	*2*
MWHB	6	0	5	0
MHB	0	0	3	3
I*..... NEHB	2	0	5	3
SEHB	*I>*	0	7	3
SHB	*6*	0	11	5
National total	38	*k*	72.5	35.5

The NACPC recommendation is that there should be a minimum of one WTE specialist palhative care nurse per 150 beds in each acute general hospital. This guideline suggests an overall recommended number of 72.5. The number employed nationally is 38, thus the debet is 35.5. To fund t t a debet would cost in excess of €2.2m per annum.

Table 6.6 Specialist palliative care nurses: current and recommended national staffing levels

Care setting	Current staffing levels	Approved or in recruitment process	Recommendation based on current population/inpatient bed numbers	Deficit* based on current population/ inpatient bed numbers
Specialist inpatient units	149.5	3	390	251.5
Day care	10	3	20	12
Community	148.5	5.5	156	23.5
Hospitals	38	4	72.5	35.5
Total	346	15.5	638.5	322.5

;at the figures do not add up to the national deficit numbers indicated is explained by the fact that local circumstances in certain regions have resulted in staffing levels in excess of the 2001 recommendations m some staff categories.

The overall shortfall in hospice and palliative care nursing staff nationally is 322.5 at a cost of €23.2m per annum (includes cost of full state funding for all nurses).

6.4 Physiotherapists

> Physiotherapy has a vital role to play in the rehabilitation of palliative care patients and in the palliation of symptoms. Physiotherapists are an integral part of the inter-disciplinary team. They offer a wide range of services to patients requiring palliative care. Physiotherapy should be provided in a range of settings.
>
> NACPC Report. 2001

6.4.1 Physiotherapists in Specialist Palliative Care Inpatient Units

The NACPC recommendahon is that there should be at least one WTE ₚhys,otheraₚist per 10 beds in the specahst palliative care inpatient unit, with a minimum of one physiotherapist in each unit.

On the basis of this guideline, there should be 36.5 phys.otherap.sts available on a national bas,s in specialist inpatient units.

Table 6.7 Physiotherapists in specialist inpatient units: current and recommended staffing levels by health board area, December 2004

Health board area	Current staffing levels	Approved or in recruitment process	Recommendation based on one per 10 beds	Deficit
East Coast Area, ERHA	0.5	0.5	3.5	3
Northern Area, ERHA	0.5	0	2	1.5
South West Area, ERHA	3	0	6	3
WHB	0	0	4	4
NWHB	1	0	2	1
MWHB	2.5	0	3.5	1
MHB	0	0	2	2
NEHB	0	0	3.5	3.5
SEHB	0	0	4	4
SHB	3	0	6	3
National total	10.5	0.5	36.5	26

For the recommendations to be achieved on a national basis an additional €1.6m would need to be allocated.

6.4.2 Physiotherapists in the Community

The recommendat.on for this setting is that there should be a m,n,mum of one WTE community physiotherapist specialising in palliative care per 125,000 population.

This has not been fulfilled. The recommended number nationally is 31, while only two are in place, leaving a deficit of 29 at a cost of €1.9m.

Table 6.8 Physiotherapists in the community: actual and recommended staffing levels by health board area, December 2004

Health board area	Current staffing levels	Approved or in recruitment process	Recommendation, based on one per 125,000 population	Deficit
East Coast Area, ERHA	0	0	2.5	2.5
Northern Area, ERHA	0	0	4	4
South West Area, ERHA	0	0	4.5	4.5
WHB	0	0	3	3
NWHB	0	0	2	2
MWHB	0	2.5	2.5	2.5
MHB	0	0	2	2
NEHB	2	1	3	1
5EHB	0	0	3.5	3.5
5HB	0	0	4	4
National total	2	1	31	29

Table 6.9 Physiotherapists in palliative care: current and recommended national staffing levels, December 2004

Health board area	Staffing levels	Approved or in recruitment process	Recommendation based on population/inpatient bed numbers	Deficit
Specialist inpatient unit	10.5	0.5	36.5	26
Community	2		31	29
Total	12.5	1.5	67.5	55

6.5 Occupational Therapists

> Occupational therapy involves the restoration or maintenance of optimal levels of functional independence in the areas of self-care, productivity and leisure activities. Increasing demand for palliative care in non-malignant degenerative conditions, especially Motor Neurone Disease, has increased the need for specialist occupational therapy intervention.
>
> NACPC Report, 2001

6.5.1 Occupational Therapists in Specialist Inpatient Units

The key recommendation emerging from the NACPC report was that there should be at least one WTE occupational therapist per 10 beds in the specialist palliative care unit, with a minimum of one occupational therapist in each unit. Thus, the optimal level of occupational therapy staffing is in the region of 36.5. The current staffing level is only 6.5, implying a deficit of 30.

Table 6.10 Occupational therapists in specialist inpatient units, December 2004

Health board area	Current staffing levels	Approved or in recruitment process	Recommendation, based on one per 10 beds	Deficit based on or inpatient bed numbers
East Coast Area, ERHA	0	0	3.5	3.5
Northern Area, ERHA	0.5	0	2	1.5
South West Area, ERHA	2.5	0	6	3.5
WHB	0	0	4	4
NWHB	1	0	2	1
MWHB	2.5	0	3.5	1
MHB	0	0	2	2
NEHB	0	0	3.5	3.5
SEHB	0	0	4	4
SHB	0	0	6	6
National total	6.5	0	36.5	30

Six of the former health board areas failed to report any occupational therapists employed, while the average fulfilment of the remaining four areas in terms of the recommendation on occupational therapists is ,us, over 50%. To remedy this shortcoming over €1 8m would need to be made available annually

6.5.2 Occupational Therapists in the Community

The recommendation to emerge for this setting was that there should be a minimum of one WTE community occupational therapist specialising in palliative care per 125,000 population, and that this post should be based in the specialist palliative care unit. Thus the recommended staffing level is 31 occupational therapists; however, there were only two in place, leaving a deficit of 29.

Table 6.11 Occupational therapists in the community: current and recommended staffing levels by health board area, December 2004

Health board area	Current staffing levels	Approved or in recruitment process	Recommendation, based on one per 125,000 population	Deficit based on current population or inpatient bed numbers
East Coast Area, ERHA	0	0	2.5	2.5
Northern Area, ERHA	0	0	4	4
South West Area, ERHA	0	0	4.5	4.5
WHB	0	0	3	3
NWHB	0	0	2	2
MWHB	0	0	2.5	2.5
MHB	0	0	2	2
NEHB	2	1	3	1
SEHB	0	0	3.5	3.5
SHB	0	0	4	4
National total	2	1	31	29

My the North-Eastern Health Board area reported any ₖ,nd of current staffing ,eve, for ,h,s care se.hng. **The res, consistently reported zero. „ is dear tha, occupahonal therapy has** no, been g.ven adequate attention in the provision of palliative care.

The funds necessary to overcome this ambivalence and tn inctaii u.vdience ana to install a convincing national complement of **occupat.ona. therap.sts** in **palhative** care would be approximately €2m.

Table 6.12 Occupational therapists in palliative care: current and recommended national staffing levels, December 2004

Care setting	Current staffing levels	Approved or in recruitment process	^commendation based on current population or inpatient bed numbers	Deficit based on current population or inpatient bed numbers
Specialist inpatient units	**6.5**	**0**	36.5	**30**
Community	**2**	**1**	**31**	**29**
Total	**8.5**	**1**	**67.5**	**59**

6.6 Social Workers

> Medical social workers address the psychological and social issues that arise when a patient and family are faced with a progressive, life-threatening condition. The social worker also consults and liaises with outside agencies, such as general hospital teams, primary care providers, and voluntary agencies.
>
> NACPC Report, 2001

6.6.1 Social Workers in Specialist Inpatient Units

The recommendation is that there should be at least one WTE social worker employed per 10 beds in the specialist palliative care unit, with a minimum of one social worker in each unit. The total nat.onal staffing level recommended is 36.5; however, there were only 10.5 employed at December 2004. indicating a deficit of 26.

The cost to eradicate the deficit so that staffing would be in line with the guidelines of the NACPC report would be approximately €1.6m.

Table 6.13 Social workers in specialist inpatient units: current and recommended staffing levels by health board area, December 2004

Health board area	Current staffing levels	Approved or in recruitment process	Recommendation, based on one per 10 beds	Deficit based on current population or inpatient bed numbers
East Coast Area, ERHA	0.5	0.5	3.5	3
Northern Area, ERHA	2	0	2	0
South West Area, ERHA	2	0	6	4
WHB	1.5	0	4	2.5
NWHB	0	0	2	2
MWHB	2.5	0	3.5	1
MHB	0	0	2	2
NEHB	0	0	3.5	3.5
SEHB	0	0	4	4
SHB	2	0	6	4
National total	**10.5**	**0.5**	**36.5**	**26**

6.6.2 Social Workers in the Community

The recommendation is that there should be a minimum of one WTE community social worker special.sing in palliative care per 125.000 of the population and that this post should be based in the specialist palliative care unit.

Th.s means at a national level there should be 31 social workers employed in the community setting. The current staffing level is at 11.5, leaving a deficit of 19.5 (see map. p.97 and Table 6.14. **p.98).**

Social workers in the community: Staffing levels and health board areas, 2004

- Eastern Regional Health Authority
- North Eastern Health Board
- South Eastern Health Board
- Southern Health Board
- Midland Health Board
- Western Health Board
- North Western Health Board
- Mid-Western Health Board

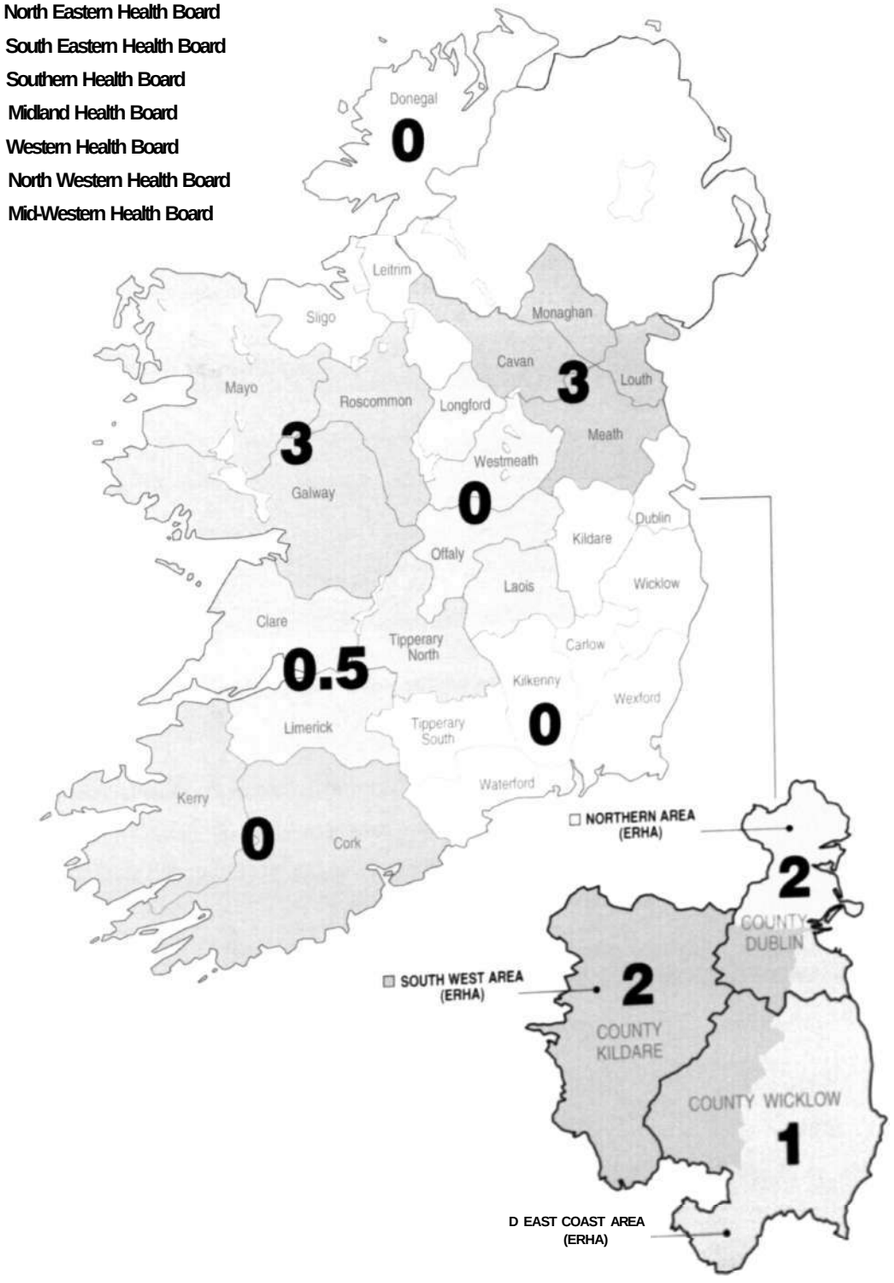


Table 6.14 Social workers in the community: current and recommended staffing by health board area, December 2004

Health board area	Current staffing levels	Approved or in recruitment process	Recommendation based on one per 125,000 population	Deficit
East Coast Area, ERHA	1	0	2.5	1.5
Northern Area, ERHA	2	0	4	2
South West Area, ERHA	2	0	4.5	2.5
WHB	3	0	3	0
NWHB	0	0	2	2
MWHB	0.5	0	2.5	2
MHB	0	0	2	2
NEHB	3	1	3	0
SEHB	0	0	3.5	3.5
SHB	0	0	4	4
National total	**11.5**	**1**	**31**	**19.5**

The total cost of funding the deficit is €1.3m.

6.6.3 Social Workers in Acute General Hospitals

There should be at least one WTE specialising in palliative care in those hospitals which have specialist palliative care teams. This guideline has not been achieved. While the recommended staffing level is 35, only 8.5 are in place.

Table 6.15 Social workers in acute general hospitals: current and recommended staffing levels by health board area, December 2004

Health board area	Current staffing levels	Approved or in recruitment process	Recommendation based on one per hospital with 150 beds	Deficit
East Coast Area, ERHA	1	0	3	2
Northern Area, ERHA	3	1	3	0
South West Area, ERHA	1	0	4	3
WHB	1	0	3	2
NWHB	0	0	2	2
MWHB	1	0	4	3
MHB	0	3	3	
NEHB	0	0	4	4
SEHB	0	0	4	4
SHB	1.5	0	5	3.5
National total	**8.5**	**1**	**35**	**26.5**

To fill the deficit of 26.5 social workers in this setting would cost €1.7m.

Table 6.16 Social workers in palliative care: current and recommended national staffing levels, December 2004

Care setting	Current staffing levels	Approved or in recruitment process	Recommendation based on current population or inpatient bed numbers	Deficit based on current population or inpatient bed numbers
Specialist inpatient units	10.5	0.5	36.5	26
Community	11.5	1	31	19.5
Acute general hospitals	8.5	1	35	26.5
Total	**30.5**	**2.5**	**102.5**	**72**

The total cost of funding the deficit in the number of soc.a workers in all care settings is €4.6m.

6.7 Spiritual Carers

> Palliative care takes a holistic view of the patient and family. This includes addressing the spiritual needs of patients, particularly at the later stages of disease, when death is imminent. Fear of dying, anxiety about the after-life, denial of impending death, concerns about family and finances, or a search for meaning within personal suffering are just a few of the common psychological and spiritual issues reported by the dying.
>
> The Committee recommends that there should be a minimum of two suitably trained chaplains available in each specialist palliative care unit to provide a 24-hour service to patients and families.
>
> NACPC Report, 2001

There should be 16 trained chaplains at the specialist inpatient units which currently exist around the country. Currently there are 11.5, leaving a deficit of 5.5 trained chaplains.

However if the country was to have an equitable distribution of specialist palliative care inpatient units, there would be a need for at least eleven extra chaplains to serve new inpatient units. This would cost an additional €450,000.

6.8 Speech and Language Therapists

> Two important measures of quality of life are the ability to communicate and to enjoy eating and drinking. Speech and language therapists are specialists in the treatment of both communication and swallowing disorders. A speech and language therapy service can greatly improve the quality of life for palliative care patients.
>
> NACPC Report, 2001

The recommendation is that there should be regular speech and language therapy sessions in each specialist palliative care unit, with a minimum of one session per week. However, this service is consistently available in only two of the eight existing inpatient units. If one takes into account the national recommendations for inpatient units, the cost to rectify this would be €63,500.

6.9 Clinical Nutritionists

> The advice of a clinical nutritionist on dietary matters is very valuable to patients, and is an important factor in improving their quality of life.
>
> NACPC Report, 2001

It was recommended that there should be at least one clinical nutritionist session in each specialist palliative care unit per week. There are five specialist inpatient units without any regular dedicated sessions on a weekly basis. Again, a national solution would cost €45,000.

6.10 Pharmacists

> It is recommended that all specialist palliative care units should have a fully trained pharmacist, who should work and function as part of the inter-disciplinary team. The pharmacist should work closely with the medical and nursing staff, offering advice and information on the most appropriate use of medications.
>
> NACPC Report, 2001

The recommendation on a national level requires pharmacists to be employed in each of the specialist palliative care units across the country. However there are only 2.5 in place, with some inpatient units without any allocated pharmacist and three with only 0.5 pharmacists available to them. There is a need for an additional 7.5 pharmacists nationally, at a cost of just over €.5m.

6.11 Care Attendants

> In each specialist palliative care unit, care attendants are required to assist in the care and attention of patients. Care attendants should also be provided to support carers of palliative care patients in the community. Care attendants should be properly selected, trained and supervised in their role... The care attendant to bed ratio in specialist palliative care units should not be less than 0.5:1.
>
> NACPC Report, 2001

The current national staffing level of care attendants is 79.5. The total national level recommended in inpatient units is 195. Thus the current deficit is 116. The cost to eliminate the deficit is approximately €4.6m. The NACPC report also recommended that families of palliative care patients in the community should have the support of care attendants. However, there are no specific recommendations on numbers in this care setting.

6.12 Library and Education Personnel

The NACPC report recommended that in fulfilling its role as the 'hub' of the service, each regional inpatient unit should have library and education personnel. Only four of the ten former health board areas currently have staff working in these fields. In December 2004 there were 10 personnel employed. On the assumption that there is a requirement for an absolute minimum of two personnel in each inpatient unit nationally, it is estimated that there is a requirement for 11.5 additional appointments at a cost of €600,000.

6.13 Volunteers

> Volunteers do not take the place of staff, but work alongside them in a complementary way. The services they provide include befriending patients and families; providing social outlets through the medium of music, art and crafts; transporting sick people to and from places of care; supporting bereaved families and friends; offering home visits and assisting at day care centres. Volunteers should be carefully selected, trained, and supervised. Every specialist palliative care unit should have a volunteer co-ordinator, who should be responsible for the selection, training and placement of volunteers and policy.
>
> NACPC Report, 2001

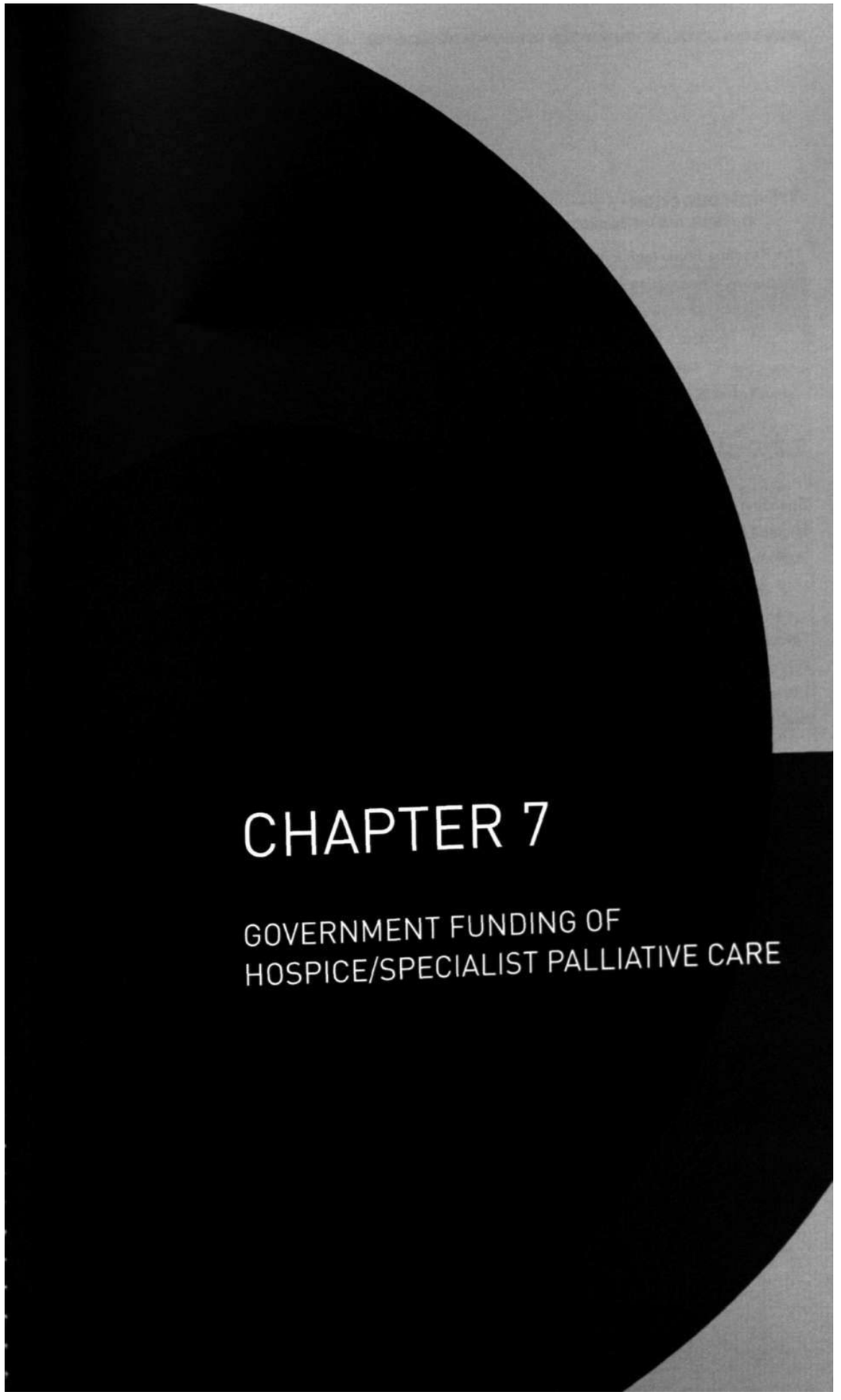
Nationally there should be 11 volunteer coordinators available to specialist inpatient units. Currently there are five, but four specialist palliative care inpatient units are without volunteer coordinators. The additional cost would be €320,000.

6.H Medical Secretaries in Acute Hospitals

The NACPC report recommended that there should be at least one medical secretary for every SPC team in an acute hospital. Currently there are 7.5, leaving a national deficit of 29.5. The cost of rectifying this deficit would be €1.2m.

6.15 Conclusion

The current cost of the 570 care staff amounts to an estimated €34.7m. It would be necessary to recruit an additional *1UU* staff in order to meet the staffing levels recommended by the NACPC. This staffing cover for a fully comprehensive service would cost an additional €51 m.



7.1 Introduction

The Baseline Study highlights a number of issues in the way in which specialist palliative care services are funded by government:

- There are wide regional disparities in current government spending on palliative care services in all care settings.
- There are significant shortfalls in the level of funding provided nationally.

7.2 Costs, Current Spending and Deficits

Spending *per capita* (on care staff and specialist palliative care inpatient unit beds) varies from €1.5 in the Midland Health Board area to €31 in the North-Western Health Board area. The annual cost of the care staff shortfall comes to approximately €51 m. The annual cost of fulfilling the bed shortfall (excluding care staff costs) is approx. €38.8m. This gives a total shortfall in annual expenditure of approximately €90m.

The current spending estimates for each staff category in each health board area were calculated using approved salary scales (at 1 st June 2005), allowances and PRSI, with an adjustment of 15% for overheads. The same approach was applied in estimating the cost of correcting deficits in staff resources in each health board area.

al staff costs (i.e. medical and other care staff), including overheads, currently stand at approximately 5m, of which an estimated €17.3m is spent on staff in community-based home care services. Thirty- percent of home care nursing costs are funded by voluntary contributions.

Table 7.1 Palliative care in Ireland: estimated financial totals - staff (2004). Current position relative to the NACPC report's recommendations based on current population/bed numbers

Health board area	Total staff	2004 staff deficit	Current cost, including overheads	Cost deficit	2004 spend per capita	Required spend per capita	2004 deficit per capita
Northern Area, ERHA	78.0	72.7	€4,324,846	€5,585,720	€8.85	€20.29	€11.43
East Coast Area, ERHA	27.0	80.7	€2,016,779	€5,006,338	€6.04	€21.04	€14.99
South West Area ERHA	95.0	91.7	€6,537,021	€5,968,995	€11.26	€21.54	€10.28
South-Eastern Health Board	27.5	108.7	€1,187,348	€7,712,051	€2.75	€20.57	€17.83
Western Health Board	64.7	69.1	€3,106,600	€5,481,148	€8.17	€22.58	€14.41
Mid-Western Health Board	88.7	29.1	€5,317,576	€2,193,760	€15.66	€22.12	€6.46
North-Western Health Board	61.7	34.7	€3,982,491	€2,409,081	€17.97	€28.85	€10.87
Midland Health Board	10.0	70.2	€345,000	€5,056,651	€1.53	€23.94	€22.42
Southern Health Board	83.0	102.2	€5,482,906	€6,641,208	€9.45	€20.89	€11.44
North-Eastern Health Board	35.0	85.6	€2,471,767	€5,377,766	€7.17	€22.75	€15.59
Totals	**570.6**	**744.7**	**€34,772,333**	**€51,432,717**			

Table 7.2 Palliative care in Ireland : financial totals - beds (2004). Current position relative to the NACPC's recommendations based on current population/bed numbers

Health board area	Total beds	Minimum recommended beds	Bed deficit	Cost including overheads	Cost deficit	Spend per capita	Required spend per capita	Deficit per capita
Northern Area ERHA	19	49	30	€2,850,000	€4,500,000	€6	€15	€9
East Coast Area ERHA	6	33	27	€900,000	€4,050,000	€3	€15	€12
South West Area ERHA	36	58	22	€5,400,000	€3,300,000	€9	€15	€6
South-Eastern Health Board	0	42	42	€0	€6,300,000	€0	€15	€15
Western Health Board	8	38	30	€1,200,000	€4,500,000	€3	€15	€12
Mid-Western Health Board	20	34	14	€3,000,000	€2,100,000	€9	€15	€6
North-Western Health Board	18	22	4	€2,700,000	€600,000	€12	€15	€3
Midlands Health Board	0	22	22	€0	€3,300,000	€0	€15	€15
Southern Health Board	24	58	34	€3,600,000	€5,100,000	€6	€15	€9
North-Eastern Health Board	0	34	34	€0	€5,100,000	€0	€15	€15
Totals	**131**	**390**	**259**	**€19,650,000**	**€38,850,000**			

laff in inpatient units. These cost s are included in Table 7.1

While the costs of care staff in hospice ,npa„en, units were included in the general staffing costs in Table . .the other costs associated with palliative care beds liable 7.21 were the subject o, a separate financial calculation.

The cost of inpatient beds was calculated with reference to the best available financial data from existing voluntary inpatient services. Following consultation with senior management in five separate inpatient units, a rate of €150,000 per bed per annum was agreed (excluding care staff). If care staff were included, the annual cost of an inpatient bed would be an additional €100,000, *giving a total estimated annual bed* cost of €250.000 per annum.

The total costs, including care staff, of the current 131 beds is estimated at €36.5m, of which an estimated €16.5m is for care staff and €20m is for other costs.

The estimated total expenditure on palliative care services in all care settings in Ireland in 2004 was €54.4m. This cost is roughly broken down as follows:

- Home care: €11.0m
- Inpatient care: €36.5m
- Acute hospital care: €05.5m
- Day care: €00.7m
- Inpatient unit library/education: €00.7m

7.3 Implications of Additional Funding

If the agreed NACPC resource recommendations were made available to the regional palliative care development committees, they could put in place a comprehensive range of specialist palliative care services. This would facilitate earlier discharge from intensive care settings in acute hospitals and would also satisfy patient preferences for community-based care. Given that many palliative care patients are currently being cared for in inappropriate care settings, the actual additional costs of staff and beds will be partially offset by savings in other areas of the health services.

In 2001 the NACPC recommended total expenditure of €70.5m on care staff in all care settings. The 2005 costs of this recommended staffing level is €86.2m. Current care staff expenditure by the state is estimated at €34.7m, leaving a shortfall of €51.5m.

The NACPC report did not estimate the total costs (excluding care staff) of providing the recommended number of hospice inpatient beds (8-10 beds per 100,000 of population). Based on a review of these costs with most current service providers, the estimated cost per bed is €150,000 per annum. Using this agreed formula, it is estimated that the cost of the current bed provision (131 beds) is almost €20m. The estimated cost of meeting the bed deficit (259 beds) is €38.8m.

The adoption of the NACPC report as policy represented an implied government commitment to spend an additional €56m over a five-year period in order to implement its recommendations. In the three years since the report's publication, there has been an additional spend of less than€10m. The present Baseline Study has identified that the current additional cost of implementing the agreed policy is €90m (€51m on care staff plus €39m in bed costs).

The estimated total cost of a fully comprehensive national palliative care service, at €144m, would account for less than 1.2% of the total health budget of €12 billion. The provision of comprehensive regional palliative care services similar to that outlined in the NACPC report has been found in other countries to be cost efficient (Bruera, Neumann *et al*, 1999). In addition, such programmes have been found to increase the number of patients accessing palliative care.

7.4 Planning and Budgeting

The recently established National Council for Specialist Palliative Care will have a key role in advising government on how to address resource deficits.

It is now policy that all regions address service deficits by producing a plan and an implementation timeframe, to ensure regional equity in service provision. Only four of the ten former health board areas are currently at this advanced planning stage. A paradox exists in that the most developed areas have the most developed plans. In these circumstances the uneven pace of development may be further reinforced. The new unified Health Service Executive structure should facilitate the delivery of services on a consistent basis in each region.

The NACPC report recommended that there should be a separate protected budget for specialist palliative care services in each Health Service Executive area. To date this recommendation has not been implemented in some areas.

In conducting this Baseline Study, it became clear that an activity-based total budget process was not the norm in planning future service provision. The absence of a transparent total budget process in some areas is a hindrance to proper planning.

It is hoped that the Health Service Executive will engage in implementing this and other aspects of the NACPC report's recommendations.

CHAPTER 8

KEY IMPLEMENTATION CHALLENGES

8.1 Introduction

This chapter gives an overview of the key implementation challenges ahead in order to achieve the goals set out by the NACPC in 2001.

The sections within this report dealing with service provision and activity (Chapter 5) and staffing (Chapter 6) present findings which provide a quantitative overview of the state of service development. The following section will focus on developments since the adoption of the NACPC report as government policy and the current challenges for the full implementation of key government policies in the area of palliative care. Throughout the commentary, particular attention will be paid to the two central questions of service inequity and service gaps.

8.2 The Baseline Study: Main Findings

There have been a number of positive developments since the publication of the NACPC report. Most notable is the expansion in the numbers of consultants in palliative medicine appointed. In many cases, however, these appointments have not been accompanied by an expansion of hospital-based teams. There has also been an expansion in the provision of home care services.

However, the most compelling overall impression from the information gathered is one of inequity in terms of capacity and access to services for people needing specialist palliative care. Access to specialist palliative care remains far too dependent on where a person lives rather than on medical need. This reality is contrary to the central philosophy of government policy.

Four years on from the findings and recommendations of the NACPC there remains a wide regional divergence in the range of services and care options available. The Baseline Study has identified some key features as follows:

- Serious inequities remain concerning access to inpatient units in the state.
- Three former health board areas have no inpatient units.
- The former MHB area appears to have a network of Level 2 inpatient beds whereas the former NEHB and SEHB have major deficits in patient beds of any description.
- Home care services are provided in all of the former health boards but there are significant regional variations in the composition of the teams, their organisational structure and in how they integrate with other elements of SPC service provision within their area.
- There is considerable inter and intra-regional variability in the existence and composition of specialist teams within hospitals.
- Day care services are provided by five of the eight specialist inpatient units. For those areas without such units, day care palliative care facilities have yet to be developed.
- Adequate and equitable statutory funding to meet the core running costs of all specialist palliative care services was a key recommendation of the NACPC report. Less than half of the home care services nationally have mainly statutory funding: the remainder are heavily or totally reliant on voluntary funding.

The Baseline Study did not collect data on education, research or support and advisory services.

8.3 Manpower Planning and Implementation of the NACPC Report

It is implicit in the report of the NACPC that all persons providing palliative care should be trained to the level of care they are providing. It is unreasonable to expect that the numbers of suitably trained staff required to comply with the minimum recommendations of the report will be available for recruitment in the short term. The deficits are too great.

A number of key issues will need to be addressed to meet this need, including, in the short term, the recruitment of suitable staff who may be trained into their new roles. There is also a need to facilitate the re-training of existing healthcare staff, as part of a professional development programme, to create a supply of personnel to fill specialist palliative care roles.

In the medium term, there will be a need for a national programme looking at staff development across all health professions. A *numerus dausus'* currently exists for all of the health sciences in palliative care in Ireland. Therefore any national change to the entry level of undergraduates will take 8-U years to have an effect on the output of fully trained specialist staff.

The Baseline Study upholds the principle of devolved regional responsibility for the future planning and implementation of palliative care services, which will now be organised in the context of the four new regions of the HSE. Furthermore, the recent establishment of the National Council for Specialist Palliative Care, which will advise on the ongoing development and implementation of a policy on pall.at.ve care services in Ireland, is most welcome. Nonetheless, it may be useful to identify here certain obvious features of service development which the HSE and other agencies working within the framework of the NACPC would need to address in order to close the gap between government policy and the current s.tuation.

The Baseline Study has revealed dramatic regional differences in the development of palliative care services. The spectrum of these differences ranges from those former health board areas where serv.ce development will match the model outlined by the NACPC in the short to med.um term, to those former health board areas where the bas.c elements required for hospice/specialist pall.at.ve care serv,ces.have yet to be established. Between these two extremes are health board areas which have establ.shed a number of service elements within the NACPC b.uepr.nt, but wh.ch st... requ.re sign.f.cant service planning and development to achieve the full model of serv.ce requ.red.

Fixed maximum number of entrants to academic programmes.

8.4 Accelerated Palliative Care Implementation Programme

A field of care characterised by such large regional disparities calls for creative planning and development in order to ensure that regional gaps are closed rather than widened. The concept of an *Accelerated Palliative Care Implementation Programme* (APCIP) is proposed as a strategic planning and development tool aimed precisely at addressing the question of regional inequity and the pace of change. It is notable that those regions where palliative care services are at an earlier stage of development are also at an earlier stage in terms of the planning for the future. They are therefore at something of a double disadvantage, lacking both service capacity and advanced plans for the development of palliative care services.

The central *raison d'etre* of an APCIP is to make available the considerable existing knowledge base for planning and development of specialist palliative care services to those regions which require the greatest assistance. In short, the APCIP is proposed as an 'extra-ordinary' form of assistance to those regions who by definition have 'the greatest distance to travel' with respect to equalising access to palliative care services for their respective populations. The APCIP is envisaged as a positive planning and development resource, so that those areas requiring such significant service development can combine sophisticated, NACPC-compliant regional development plans with the resources required to implement them.

An APCIP seeks to make available planning and development expertise regarding specialist palliative care services to the key personnel responsible for that area of service development within each division of the HSE. The knowledge base available from an APCIP will encompass expertise on each aspect of service development including the development of SPCUs, SPC teams in acute general hospitals, community-based services and palliative care in community and district hospitals (Level 2).

In relation to governance it is proposed that the establishment and coordination of APCIPs should fall within the remit of the National Council for Specialist Palliative Care.

8.5 Challenges

The Baseline Study has identified the following key implementation challenges:

1. Those former health board areas that are close to compliance with the minimum bed numbers required for inpatient care should be supported in the implementation of their plans to meet such marginal shortfalls in capacity in the immediate term.

2. Those former health board areas with an established degree of specialist inpatient care that nonetheless falls significantly short of the recommended level should be supported to develop sufficiently ambitious plans for the expansion of inpatient capacity, taking into account the geographical distribution of the population within a given region.

3. Those former health board areas currently without specialist inpatient care services should be supported and the appropriate resources made available for the implementation of plans to provide a minimum level of such inpatient care in the immediate term.

4. Those former health board areas that have yet to develop implementation plans for palliative care should have access to additional support and planning expertise in the form of an *Accelerated Palliative Care Implementation Programme* (APCIP).

5. Those SPC teams attached to acute general hospitals with the full complement of recommended disciplines should ensure that there is wholetime equivalence within each discipline for the scale of hospital activity.

6. Those SPC teams attached to acute general hospitals which are partially constituted, lacking either one or a number of the recommended disciplinary elements, should be supported and the appropriate resources made available so that they can meet the minimum requirement of a full team in the immediate term.

7. Joint outpatient clinics should be established in each acute general hospital currently serviced by full or partial teams.

8. Those former health board areas that are at an early stage in the development of SPC teams within their acute general hospital services, and those which have as yet to develop implementation plans for this aspect of palliative care for their populations, should have access to additional support and planning expertise in the form of an APCIP.

9. Those SPC teams in the community which are consultant-led should be supported in developing the full range of recommended disciplines, including social work, occupational therapy and physiotherapy.

10. Those SPC teams in the community which currently rely exclusively on clinical nurse specialists should be encouraged and supported to develop into interdisciplinary consultant-led teams as recommended.

11. The question of sufficiently resourced banks of equipment which are equally accessible to all patients for their care in the community has been established by the Baseline Study as an ongoing difficulty, requiring an immediate, more detailed analysis in the form of a national audit.

12. Those existing day care services which currently serve the function of social support for the patient should also make available a range of appropriate clinical supports to facilitate and maintain care in the community.

13. Day care services are currently unavailable to the majority of patients in receipt of palliative care in the state. A national strategy for the development of day care services is required where implementation is not entirely contingent on the development of inpatient units.

14. Those community hospitals without designated palliative care beds should be supported and the appropriate resources provided to make available an appropriate number of such beds.

15. Those community hospitals without dedicated rooms for relatives and friends of palliative care patients should be supported and the appropriate resources provided to make such facilities available in the immediate term.

16. Appropriate education and training should be made available to support the professional development of staff in all care settings providing Level 2 palliative care services.

17. Those former health board areas where the Level 2 aspect of palliative care service provision is absent or at an early stage of development should be encouraged to develop plans and should be supported with appropriate resources.

18. The individual patient's preferences and needs should be prioritised by providing specialist palliative care in all settings, whether in a specialist inpatient unit, in the community, in an acute general hospital or in a day care centre.

19. The planning and budgeting process for the four new regional divisions should consider each of their development plans and implementation frameworks in the light of the regional inequities identified by the local needs assessments and the Baseline Study.

20. Accelerated service development programmes should be made available for those regions where significant service deficits have been identified, with a view to speedily addressing the most salient inequities in service provision.

21. The wide disparity in the current spend *per capita* between regions should be addressed. The *per capita* spend ranges from €1.50 in the Midlands to €31 in the North West.

8.6 Conclusion

As regards implementation of the NACPC recommendations, the Baseline Study has revealed a significant shortfall in government funding and a consequent lack of progress in the development of specialist palliative care services. Some of the former health board areas have advanced significantly in terms of structural implementation, and are close to compliance in some areas of service provision. Others fall short in many aspects of the NACPC requirements, but can demonstrate compelling regional development plans that will bring them within reach of compliance in the short to medium term. Finally, there are populations within the state for whom an extra-ordinary' and concentrated planning and development programme will be required before they can benefit from a level of service already available to many of their fellow citizens in other regions of the state.

In general, it might be said of the 'state of the field' that there are certainly signs of movement in the direction of stated government policy since 2001. However, the pace of change has been hugely varied, with the effect of prolonging care inequities well beyond the schedule of implementation recommended by the NACPC report and agreed by Government.

Appropriate and full funding of palliative care services nationally will enable services to be developed in a coherent, planned and pro-active manner, rather than relying on individual local initiatives that might not be in keeping with the recommendations of the NACPC report.

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APPENDIX 1

ACTIVITY BASED COSTING ANALYSIS

Activity Based Costing Methodology

Current spending estimates (December 2004) for each staff category in each health board area were calculated using approved salary scales, allowances and PRSI, with an adjustment of 15% for non-pay costs. The same approach was applied in estimating the costs of correcting deficits in staff resources in each region to the levels of the minimum recommendations of the NACPC report.

The NACPC report did not recommend specific figures for nursing staff in day care and education staff. For the purpose of this exercise a minimum level of two day care nurses and two education staff for each health board area was included in the calculations. This is not based on recommendations and needs may well be in excess of these figures.

While the costs of health care staff in hospice inpatient units were included in the above exercise, the other costs associated with palliative care beds, including support staff and non-pay costs, were the subject of a separate financial calculation.

The cost of inpatient beds is calculated with reference to the best available financial data from existing inpatient services. After consulting with senior management in five separate voluntary inpatient units, a rate of €150,000 per bed per annum was agreed (excluding care staff). If care staff were included, the annual cost of an inpatient bed would be an additional €100,000, giving a total annual bed cost of €250,000 per annum.

Some of the figures in the costing tables may appear not to add up. This is because of known allowances made for specific policy issues. It is important to note that the NACPC staffing recommendations were a minimum recommendation and that the regional needs assessments often identified greater manpower requirements. Given this limitation, in the few cases where specific staffing levels exceeded the NACPC recommendation, it was decided not to reduce the required regional staff expenditure by the identified excess.

Given the governments commitment to fund all core staff, it was decided to transfer the current expenditure of voluntary funding on home care nurses to the expenditure deficit totals.

This study provides information on the structure of serv.ces and activity levels; however, this information in itself does not equate with quality.

With its concentration on resourcing issues, the study did not seek to address *all* the recommendations of the NACPC report. It did not address the issue of the capital cost of new infrastructure.

Palliative Care in Ireland : Staffing / Bed Totals

Implications of current position relative to the recommendations* of the Report of the National Advisory Committee on Palliative Care (2001)
(* based on current population / bed numbers)

	Cost	Current Levels	Approved / in Recruitment	Recommendation	Deficit	Current Costing	Cost of Funding Deficit
1. Medical Staff							
(a) At least one WTE (whole time equivalent) Consultant in Palliative Medicine per 160,000 of the population, with a minimum of two consultants in each Health Board Area)	**€265,000**	12.0	9.0	25.0	-13.0	€3,180,000	-€3.445.000
(b) For each of the above consultants, at least three non-consultant hospital doctors	**€112,500**	37.5	7.0	75.0	-37.5	€4,218,750	-€4.218.750
Total		49.5	16.0	100.0	-50.5	**€7,398,750**	-€7.663.750
2. Specialist Palliative Care Nurses							
(a) In *specialist in-patient unit*: Not less than 1 WTE per bed	**€62,100**	149.5	3.0	390.0	-251.5	€9,283,950	-€15.618.150
(b) *In the Community*: Minimum 1 WTE per 25,000 of population	**€69,000**	148.5	5.5	156.0	-23.5	€6,609,510	-€5.314.035
(c) In acute general hospital team: Minimum 1 (hospital based) per 150 beds	**€62,658**	38.0	4.0	72.5	-35.5	€2,381,004	-€2.224.359
(d) In *day-care centre*: Minimum 1 per 7 daily attendees	**€51,750**	10.0	3.0	20.0	-12.0	€517,500	-€621.000
Total		346.0	15.5	638.5	-322.5	**€18,791,964**	-€23.777.544
3. Physiotherapists							
(a) In specialist in-patient unit: At least 1 WTE per 10 beds, with a minimum of 1 per unit	**€63,250**	10.5	0.5	36.5	-26.0	€664,125	-€1.644.500
(b) *Community*: At least 1 WTE specialising in palliative care per 125,000 of population, based in specialist palliative care unit	**€58,267**	2.0	1.0	31.0	-29.0	€133,400	-€1.934.300
Total		12.5	1.5	67.5	-55.0	**€797,525**	-€3.578.800
4. Occupational Therapists							
(a) *In specialist unit*: At least 1 WTE per 10 beds, with a minimum of one per unit	**€63,250**	6.5	0.0	36.5	-30.0	€411,125	-€1.897.500
(b) *Community*: At least 1 WTE specialising in palliative care per 125,000 of population, based in specialist palliative care unit	**€58,267**	2.0	1.0	31.0	-29.0	€133,400	-€1.934.300
Total		8.5	1.0	67.5	-59.0	**€544,525**	-€3.831.800
5. Social Workers							
(a) *Specialist unit*: At least 1 WTE per 10 beds, with a minimum of 1 per unit	**€63,250**	10.5	0.5	36.5	-26.0	€664,125	-€1.644.500
(b) *Community*: At least 1 WTE specialising in palliative care per 125,000 of population, based in specialist palliative care unit	**€66,700**	11.5	1.0	31.0	-19.5	€767,050	-€1.300.650
(c) *Acute general hospitals*: At least 1 WTE specialising in palliative care in those hospitals which have specialist PC team	**€63,250**	8.5	1.0	35.0	-26.5	€541,125	-€1.686.625
Total		30.5	2.5	102.5	-72.0	**€1,972,300**	-€4.631.775
6. Spiritual Care							
(a) At least 2 suitably trained chaplains to meet needs of patients/families in each specialist palliative care unit. Service should be available 24/7.	**€37,294**	11.5	3.0	22.0	-12.0	€450,646	-€447.528
Total		11.5	3.0	22.0	-12.0	**€450,646**	-€447.528
7. Speech and Language Therapy							
Regular speech/language therapy sessions in each specialist palliative care unit, with minimum 1 session per week	**€63,250**	0.1	0.0	1.1	-1.0	€6,325	-€63.595
Total		0.1	0.0	1.1	-1.0	**€6,325**	-€63.595
8. Clinical Nutritionists							
At least 1 session per week in each specialist palliative care unit	**€63,250**	1.5	0.0	1.1	-0.7	€94,875	-€44.620
Total		1.5	0.0	1.1	-0.7	**€94,875**	-€44.620
9. Pharmacists							
At least 1 WTE in each specialist palliative care unit	**€77,141**	3.5	1.0	11.0	-7.5	€259,553	-€578.558
Total		3.5	1.0	11.0	-7.5	**€259,553**	-€578.558
10. Care Attendants							
(a) Not less that 0.5 WTE per bed in specialist palliative care unit.	**€40,250**	79.5	4.0	195.0	-116.5	€3,199,875	-€4.689.125
(b) Care attendants, including night sitters, should be available to support families of palliative care patients in the community	**€40,250**	5.0	0.0	0.0	0.0	€201,250	€0
Total		84.5	4.0	195.0	-116.5	**€3,401,125**	-€4.689.125
11. Volunteers							
Every specialist palliative care unit should have volunteer coordinator	**€46,000**	5.0	0.0	11.0	-7.0	€230,000	-€322.000
Total		5.0	0.0	11.0	-7.0	**€230,000**	-€322.000
12. Librarian/education Personnel							
Specialist palliative care services should have a librarian and education personnel	**€51,750**	10.0	1.0	20.0	-11.5	€517,500	-€595.125
Total		10.0	1.0	20.0	-11.5	**€517,500**	-€595.125
13. Medical Secretaries in Acute Hospitals							
At least 1 WTE in those hospitals which have specialist PC team	**€40,966**	7.5	0.0	37.0	-29.5	€307,245	-€1.208.497
Total		7.5	0.0	37.0	-29.5	**€307,245**	-€1.208.497
14. Bed Totals							
There should be 1 bed per 100,000 of population	**€150,000**	131.0	0.0	390.0	-259.0	€19,650,000	-€38.850.000
Total		131.0	0.0	390.0	-259.0	**€19,650,000**	-€38.850.000

Palliative Care in Ireland : Financial Totals (Staff)

Implications of current position relative to the recommendations* of the Report of the National Advisory Committee on Palliative Care (2001)
(* based on current population / bed numbers)

	Total Staff	Total Approved Staff	Recommended Staff	Staff Deficit	Current Cost inc. overheads	Cost Deficit	Current Spend Per Capita	Required Spend Per Capita	Current Deficit Per Capita
North, Eastern Region H.A.	780	5.0	148.2	-72 7	€4,324,846	-€5.585,720	€8 85	€20 29	-€11 43
East, Eastern Region H.A.	27.0	120	107.7	-80 7	€2,016,779	-€5,006.338	€6 04	€2104	-€14 99
South West, Eastern Region HA.	95.0	5.0	185.2	-91 7	€6.537,021	-€5.968 995	€11.26	€2154	-€10 28
South East Health Board	27.5	4.0	135.7	-108 7	€1,187.348	-€7.712.051	€275	€20.57	-€17 83
Western Health Board	64.7	3.0	126.2	-69 1	€3,106,600	-€5.481.148	€8.17	€22 58	-€14 41
Mid West Health Board	88.7	2.5	111.7	-29 1	€5,317,576	-€2,193.760	€15.66	€2212	-€6 46
North West Health Board	61.7	1.0	82.4	-34,7	€3,982,491	-€2.409.081	€17 97	€28 85	-€10 87
Midlands Health Board	10.0	3.0	792	-70 2	€345,000	-€5.056.651	€153	€23 94	-€22 42
Southern Health Board	830	00	184.2	-102 2	€5,482,906	-€6,641.208	€9 45	€20 89	-€11 44
North East Health Board	35.0	10.0	113.7	-85 6	€2,471,767	-€5.377 766	€7.17	€22 75	-€15 59
Staff Totals	570.6	45.5	1274.2	-744.7	€34,772,333	-€51,432,717			

Palliative Care in Ireland : Financial Totals (Beds)

Implications of current position relative to the recommendations* of the Report of the National Advisory Committee on Palliative Care (2001)
(* booed on current population / bed numbers)

	Total Beds	Total Approved Beds	Recommended Beds	Bed Deficit	Current Cost inc. overheads	Cost Deficit	Current Spend Per Capita	Required Spend Per Capita	Current Deficit Per Capita
North, Eastern Region H.A.	19.0	0.0	490	-30 0	€2.850.000	-€4.500 000	€5 83	€1505	-€9 21
East Eastern Region H.A	6.0	0.0	33.0	-27 0	€900.000	-€4.050 000	€2 70	€14 83	
South West, Eastern Region HA	36.0	0.0	58.0	-22 0	€5.400.000	-€3300 000	€9 30	€14 98	45 66
South East Health Board	0.0	0.0	42.0	-42 0	€0	-€6.300 000	€0 00	€14 57	-€14 57
Western Health Board	8.0	0.0	38.0		€1.200.000	-€4.500.000	€316	€14 99	-€1183
Mid West Health Board	20 0	0.0	34.0	-14 0	€3.000.000	-€2.100 000	€8 83	€1502	435 18
North West Health Board	18.0	00	220	-4 0	**€2.700.000**	-€600 000	€12 19	€14 8S	
Midlands Health Board	00	0.0	22.0	-22.0	**€0**	-€3300 000	€0 00	€14 63	**€14 < 1**
Southern Health Board	**24.0**	00	58.0	-34 0	€3.600.000	**-€5 100 000**	**€6 20**	**€14 99**	-€6 79
North East Health Board	**0.0**	0.0	34.0	-34 0	€0	**-€5 100 000**	**€0 00**	**€14 78**	
Bed Totals	131.0	0.0	390.0	-259.0	€19.650,000	-08.850.000			

Palliative Care in Ireland : Totals

Implications of current position relative to the recommendations* of the Report of the National Advisory Committee on Palliative Care (2001)
(* based on current population / bed numbers)

	Total	Total Approved	Recommended	Deficit	Current Cost inc. overheads	Cost Deficit	Current + Deficit Total
Staff	570.6	45.5	1274.2	-744 7	€34,772,333	-€51 432 717	€86.205.049
Beds	131.0	00	390.0	-259 0	€19.650.000	-€38 850 000	€58.500 000
Totals					**€54,422,333**	-€90,282,717	**€144,795,049**

Specialist Palliative Care in the South West Area of the Eastern Regional Health Authority

Implications of current position relative to the minimum recommendations* of the Report of the National Advisory Committee on Palliative Care (2001)

(* based on current population / bed numbers)

NACPC Minimum Recommendations	Costs inc. overheads	Current Levels (As of Dec' 04)	Approved / in Recruitment	Recommendation	Deficit	Current Costing	Cost of Funding Deficit	Current Cost + Cost of Funding Deficit
1. Medical Staff								
(a) At least one WTE (whole time equivalent) Consultant in Palliative Medicine per 160,000 of the population, with a minimum of two consultants in each Health Board Area)	€265,000	3	1	4	-1	€795,000	-€265,000	€1,060,000
(b) For each of the above consultants, at least three non-consultant hospital doctors	€112,500	7.5	1	12	-4.5	€843,750	-€506,250	€1,350,000
2. Specialist Palliative Care Nurses								
(a) In *specialist in-patient unit*: Not less than 1 WTE per bed	€62,100	23.5	0	58	-34.5	€1,459,350	-€2,142,450	€3,601,800
(b) *In the Community*: Minimum 1 WTE per 25,000 of population	€71,415	16	0	23	-7	€1,142,640	-€499,905	€1,642,545
(c) In acute general hospital team: Minimum 1 (hospital based) per 150 beds	€62,658	6	2	11.5	-5.5	€375,948	-€344,619	€720,567
(d) In *day-care centre*: Minimum 1 per 7 daily attendees	€51,750	2	0	2	0	€103,500	€0	€103,500
3. Physiotherapists								
(a) In specialist in-patient unit: At least 1 WTE per 10 beds, with a minimum of 1 per unit	€63,250	3	0	6	-3	€189,750	-€189,750	€379,500
(b) *Community*: At least 1 WTE specialising in palliative care per 125,000 of population, based in specialist palliative care unit	€66,700	0	0	4.5	-4.5	€0	-€300,150	€300,150
4. Occupational Therapists								
(a) *In specialist unit*: At least 1 WTE per 10 beds, with a minimum of one per unit	€63,250	2.5	0	6	-3.5	€158,125	-€221,375	€379,500
(b) *Community*: At least 1 WTE specialising in palliative care per 125,000 of population, based in specialist palliative care unit	€66,700	0	0	4.5	-4.5	€0	-€300,150	€300,150
5. Social Workers								
(a) *Specialist unit*: At least 1 WTE per 10 beds, with a minimum of 1 per unit	€63,250	2	0	6	-4	€126,500	-€253,000	€379,500
(b) *Community*: At least 1 WTE specialising in palliative care per 125,000 of population, based in specialist palliative care unit	€66,700	2	0	4.5	-2.5	€133,400	-€166,750	€300,150
(c) *Acute general hospitals*: At least 1 WTE specialising in palliative care in those hospitals which have specialist PC team	€66,750	1	0	4	-3	€66,750	-€200,250	€267,000
6. Spiritual Care								
(a) At least 2 suitably trained chaplains to meet needs of patients/families in each specialist palliative care unit. Service should be available 24/7	€46,000	2.5	0	2	0	€115,000	€0	€115,000
7. Speech and Language Therapy								
Regular speech/language therapy sessions in each specialist palliative care unit, with minimum 1 session per week	€66,700	0	0	0.1	-0.1	€0	-€6,670	€6,670
8. Clinical Nutritionists								
At least 1 session per week in each specialist palliative care unit	€66,700	0	0	0.1	-0.1	€0	-€6,670	€6,670
9. Pharmacists								
At least 1 WTE in each specialist palliative care unit	€66,700	1	0	1	0	€66,700	€0	€66,700
10. Care Attendants								
(a) Not less that 0 j \\ TE per bed in specialist palliative care unit.	€40,250	18.5	0	29		€744,625		€1,167.250
(b) Care attendants, including night sitters, should be available to support families of palliative care patients in the community	€40,250	0	0	0	0	€0	€0	€0
11. Volunteers / Co-ordinators								
Every specialist palliative care unit should have volunteer coordinator	€46,000	2	0	1	0	€92,000	€0	€92,000
12. Librarian / Education Personnel								
Specialist palliative care services should have a librarian and education personnel	€51,750	2	1	2	0	€103,500	€0	€103,500
13. Medical Secretaries in Acute Hospitals								
At least 1 WTE in those hospitals which have specialist PC team	€40,966	0.5	0	4		€20,483		**€163.864**
14. Bed Totals								
There should be 10 beds per 100,000 of population	€150,000	36	0	58		€5,400.000		**€8.700.000**

Staff Totals		Bed Totals		Region Totals	
Total Current Staffing Levels	95.0	Total Current Beds	36		
Total Approved Staffing Levels	5.0	Total Approved Beds	0		
Recommendation based on current pop.	185.2	Recommended Beds	58		
Staffing Level Deficit	-91.7	Bed Deficit	-22		
Current Costing	€6,537,021	Current Costing	€5,400,000	Current Costing	€11,937,021
Cost of Funding Deficit	-€5,968,995	Cost of Funding Deficit	-€3,300,000	Cost of Funding Deficit	-€9,268,995
Current Spend per Cap.	€11.26	Current Spend per Cap.	€9.30	Current Spend per Cap.	€20.56
Required Spend per Cap.	€21.54	Required Spend per Cap.	€14.95	Required Spend per Cap.	€36.52
Deficit per Cap.	-€10.28	Deficit per Cap.	-€5.65	Deficit per Cap.	-€15.96

Note: Where the actual number of staff is greater than the recommended number of staff, **the** deficit **defaults to zero.**

Note: NACPC recommended staffing levels are calculated based on the following data :

Population Size	**580,634**
Source	CSO Census 2002
Date	25th July 2005

Specialist Palliative Care in the Northern Area of the Eastern Regional Health Authority

Implications of current position relative to the minimum recommendations* of the Report of the National Advisory Committee on Palliative Care (2001)

(* based on current population / bed numbers)

NACPC Minimum Recommendations	Costs inc. overheads	Current Levels (As of Dec' 04)	Approved / in Recruitment	Recommendation	Deficit	Current Costing	Cost of Funding Deficit	Current Cost + Cost of Funding Deficit
1. Medical Staff								
(a) At least one WTE (whole time equivalent) Consultant in Palliative Medicine per 160,000 of the population, with a minimum of two consultants in each Health Board Area)	€265,000	1	1	3	-2	€265,000	-€530.000	€795,000
(b) For each of the above consultants, at least three non-consultant hospital doctors	€112,500	5	1	9	-4	€562,500	-€450.000	€1,012,500
2. Specialist Palliative Care Nurses								
(a) In *specialist in-patient unit*: Not less than 1 WTE per bed	€62,100	21	0	49	-28	€1,304,100	-€1.738.800	€3,042,900
(b) *In the Community*: Minimum 1 WTE per 25,000 of population	€69.000	13.5	0	19.5	-6	€307,395	-€1.038.105	€1,345,500
(c) In acute general hospital team: Minimum 1 (hospital based) per 150 beds	€62,658	4	2	11	-7	€250,632	-€438.606	€689,238
(d) In *day-care centre*: Minimum 1 per 7 daily attendees	€51,750	4	0	2	0	€207,000	€0	€207,000
3. Physiotherapists								
(a) In specialist in-patient unit: At least 1 WTE per 10 beds, with a minimum of 1 per unit	€63,250	0.5	0	2	-1.5	€31,625	-€94,875	€126,500
(b) *Community*: At least 1 WTE specialising in palliative care per 125,000 of population, based in specialist palliative care unit	€66,700	0	0	4	-4	€0	-€266,800	€266,800
4. Occupational Therapists								
(a) *In specialist unit*: At least 1 WTE per 10 beds, with a minimum of one per unit	€63,250	0.5	0	2	-1.5	€31,625	-€94,875	€126,500
(b) *Community*: At least 1 WTE specialising in palliative care per 125,000 of population, based in specialist palliative care unit	€66,700	0	0	4	-4	€0	-€266,800	€266,800
5. Social Workers								
(a) *Specialist unit*: At least 1 WTE per 10 beds, with a minimum of 1 per unit	€63,250	2	0	2	0	€126,500	€0	€126,500
(b) *Community*: At least 1 WTE specialising in palliative care per 125,000 of population, based in specialist palliative care unit	€66,700	2	0	4	-2	€133,400	-€133.400	€266,800
(c) *Acute general hospitals*: At least 1 WTE specialising in palliative care in those hospitals which have specialist PC team	€63,250	3	1	3	0	€189,750	€0	€189,750
6. Spiritual Care								
(a) At least 2 suitably trained chaplains to meet needs of patients/families in each specialist palliative care unit. Service should be available 24/7	€37,294	1.5	0	2	-0.5	€55,941	-€18,647	€74,588
7. Speech and Language Therapy								
Regular speech/language therapy sessions in each specialist palliative care unit, with minimum 1 session per week	€63,250	0	0	0.1	-0.1	€0	-€6.325	€6,325
8. Clinical Nutritionists								
At least 1 session per week in each specialist palliative care unit	€63,250	0	0	0.1	-0.1	€0	-€6.325	€6,325
9. Pharmacists								
At least 1 WTE in each specialist palliative care unit	€77,141	0.5	0	1	-0.5	€38,571	-€38.571	€77,141
10. Care Attendants								
(a) Nol less thai 0.5 W'l L per bed in specialist palliative care unit.	€40,250	14	0	24.5	-105	€563,500	-€422.625	€986,125
(b) Care attendants, including night sitters, should be available to support families of palliative care patients in the community	€40,250	0	0	0	0	€0	€0	€0
11. Volunteers / Co-ordinators								
Every specialist palliative care unit should have volunteer coordinator	€46,000	1	0	1	0	€46,000	€0	€46.000
12. Librarian / Education Personnel								
Specialist palliative care services should have a librarian and education personnel	€51,750	2.5	0	2	0	€129.375	**€0**	€129.375
13. Medical Secretaries in Acute Hospitals								
At least 1 WTE in those hospitals which have specialist PC team	€40,966	2	0	3		€81.932		€122.898
14. Bed Totals								
There should be 10 beds per 100,000 of population	€150,000	19	0	49		€2.850,000	-€4 50	€7.350.000

Staff Totals		Bed Totals		Region Totals	
Total Current Staffing Levels	78.0	Total Current Beds	19		
Total Approved Staffing Levels	5.0	Total Approved Beds	0		
Recommendation based on current pop.	148.2	Recommended Beds	49		
Staffing Level Deficit		Bed Deficit	-30		
Current Costing	€4,324,846	Current Costing	€2.850,000	Current Costing	€7.174.841
Cost of Funding Deficit		Cost of Funding Deficit		Coat of Funding Deficit	
Current Spend per Cap.	€8.85	Current Spend per Cap.	€5.83	Current Spend per Cap.	CUM
Required Spend per Cap.	€20.29	Required Spend per Cap.	€15 05	Required Spend per Cap.	CM»
Deficit per Cap.	-€11.43	Deficit per Cap.		Deficit per Cap	

Note: Where the actual number of staff is greater than the recommended number of staff, the deficit defaults

Note: NACPC recommended staffing levels are calculated based on the following data :

Population Size **488,500**

Source CSO Census 2002

Date 25th July 2005

Specialist Palliative Care in the East Coast Area of the Eastern Regional Health Authority

Implications of current position relative to the minimum recommendations* of the Report of the National Advisory Committee on Palliative Care (2001)
(* based on current population / bed numbers)

NACPC Minimum Recommendations	Costs inc. overheads	Current Levels (As of Dec' 04)	Approved / in Recruitment	Recommendation	Deficit	Current Costing	Cost of Funding Deficit	Current Cost + Cost of Funding Deficit
1. Medical Staff								
(a) At least one WTE (whole time equivalent) Consultant in Palliative Medicine per 160,000 of the population, with a minimum of two consultants in each Health Board Area)	€265,000	1	1	2	-1	€265,000	-€265,000	€530,000
(b) For each of the above consultants, at least three non-consultant hospital doctors	€112,500	3	0	6	-3	€337,500	-€337,500	€675,000
2. Specialist Palliative Care Nurses								
(a) In *specialist in-patient unit*: Not less than 1 WTE per bed	€62,100	6.5	3	33	-26.5	€403,650	-€1,645,650	€2,049,300
(b) *In the Community*: Minimum 1 WTE per 25,000 of population	€69,000	8	2	13	-5	€552,000	-€345,000	€897,000
(c) In acute general hospital team: Minimum 1 (hospital based) per 150 beds	€62,658	2	0	5	-3	€125,316	-€187,974	€313,290
(d) In *day-care centre*: Minimum 1 per 7 daily attendees	€51,750	0	1	2	-2	€0	-€103,500	€103,500
3. Physiotherapists								
(a) In specialist in-patient unit: At least 1 WTE per 10 beds, with a minimum of 1 per unit	€63,250	0.5	0.5	3.5	-3	€31,625	-€189,750	€221,375
(b) *Community*: At least 1 WTE specialising in palliative care per 125,000 of population, based in specialist palliative care unit	€66,700	0	0	2.5	-2.5	€0	-€166,750	€166,750
4. Occupational Therapists								
(a) *In specialist unit*: At least 1 WTE per 10 beds, with a minimum of one per unit	€63,250	0	0	3.5	-3.5	€0	-€221,375	€221,375
(b) *Community*: At least 1 WTE specialising in palliative care per 125,000 of population, based in specialist palliative care unit	€66,700	0	0	2.5	-2.5	€0	-€166,750	€166,750
5. Social Workers								
(a) *Specialist unit*: At least 1 WTE per 10 beds, with a minimum of 1 per unit	€63,250	0.5	0.5	3.5	-3	€31,625	-€189,750	€221,375
(b) *Community*: At least 1 WTE specialising in palliative care per 125,000 of population, based in specialist palliative care unit	€66,700	1	0	2.5	-1.5	€66,700	-€100,050	€166,750
(c) *Acute general hospitals*: At least 1 WTE specialising in palliative care in those hospitals which have specialist PC team	€63,250	1	0	3	-2	€63,250	-€126,500	€189,750
6. Spiritual Care								
(a) At least 2 suitably trained chaplains to meet needs of patients/families in each specialist palliative care unit. Service should be available 24/7	€37,294	0.5	0	2	-1.5	€18,647	-€55,941	€74,588
7. Speech and Language Therapy								
Regular speech/language therapy sessions in each specialist palliative care unit, with minimum 1 session per week	€63,250	0	0	0.1	-0.1	€0	-€6,325	€6,325
8. Clinical Nutritionists								
At least 1 session per week in each specialist palliative care unit	€63,250	0	0	0.1	-0.1	€0	-€6,325	€6,325
9. Pharmacists								
At least 1 WTE in each specialist palliative care unit	€77,141	0	0	1	-1	€0	-€77,141	€77,141

10. Care Attendants								
(a) Not less that 0.5 WTE per bed in specialist palliative care unit.	€40,250	2	4	16.5	-14.5	€80,500	-€583.625	€664,125
(b) Care attendants, including night sitters, should be available to support families of palliative care patients in the community	€40,250	0	0	0	0	€0	€0	€0
11. Volunteers / Co-ordinators								
Every' specialist palliative care unit should have volunteer coordinator	€46,000	0	0	**1**		€0		€46,000
12. Librarian / Education Personnel								
Specialist palliative care services should have a librarian and education personnel	€51,750	0	0	2	-2	€0		€103,500
13. Medical Secretaries in Acute Hospitals								
At least 1 WTE in those hospitals which have specialist PC team	€40,966	1	0	3		€40,966		€122,898
14. Bed Totals								
There should be 10 beds per 100,000 of population	€150,000	6	0	33		€900,000		€4,950,000

Staff Totals		Bed Totals		Region Totals	
Total Current Staffing Levels	27.0	Total Current Beds	6		
Total Approved Staffing Levels	12.0	Total Approved Beds	0		
Recommendation based on current pop.	107.7	Recommended Beds	33		
Staffing Level Deficit		Bed Deficit			
Current Costing	€2,016,771	Current Costing	€900,0OC	Currant Costing	€2,»16.771
Cost of Funding Deficit	< 5 006.338	Cost of Funding Deficit		Cost of Funding Deficit	
Current Spend per Cap.	€6.04	Current Spend per Cap.	C27C	Current Spend per Cap.	CS.74
Required Spend per Cap.	€21.04	Required Spend par Cap.	€14 83	Required Spend per Cap	C36.M
Deficit per Cap.		Deficit per Cap.		Deficit per Cap	

Note: Where the actual number of staff is greater than the recommended number of staff, the deficit defaults to zero.

Note: NACPC recommended staffing levels are calculated based on the following data :

Population Size 333,873
Source CSO Census 2002
Date 25th July 2005

Specialist Palliative Care in the North-Eastern Health Board

Implications of current position relative to the minimum recommendations* of the Report of the National Advisory Committee on Palliative Care (2001)

(* based on current population / bed numbers)

Shortcuts

NACPC Minimum Recommendations	Costs inc. overheads	Current Levels (As of Dec' 04)	Approved / in Recruitment	Recommendation	Deficit	Current Costing	Cost of Funding Deficit	Current Cost + Cost of Funding Deficit
1. Medical Staff								
(a) At least one WTE (whole time equivalent) Consultant in Palliative Medicine per 160,000 of the population, with a minimum of two consultants in each Health Board Area)	€265,000	1	2	2	-1	€265,000	-€265,000	€530,000
(b) For each of the above consultants, at least three non-consultant hospital doctors	€112,500	1	3	6	-5	€112,500	-€562,500	€675,000
2. Specialist Palliative Care Nurses								
(a) In *specialist in-patient unit*: Not less than 1 WTE per bed	€62,100	0	0	34	-34	€0	-€2,111,400	€2,111,400
(b) *In the Community*: Minimum 1 WTE per 25,000 of population	€69,000	20	0	14	0	€1,283,400	-€96,600	€1,380,000
(c) In acute general hospital team: Minimum 1 (hospital based) per 150 beds	€62,658	2	0	5	-3	€125,316	-€187,974	€313,290
(d) In *day-care centre*: Minimum 1 per 7 daily attendees	€51,750	0	0	2	-2	€0	-€103,500	€103,500
3. Physiotherapists								
(a) In specialist in-patient unit: At least 1 WTE per 10 beds, with a minimum of 1 per unit	€63,250	0	0	3.5	-3.5	€0	-€221,375	€221,375
(b) *Community*: At least 1 WTE specialising in palliative care per 125,000 of population, based in specialist palliative care unit	€66,700	2	1	3	-1	€133,400	-€66,700	€200,100
4. Occupational Therapists								
(a) *In specialist unit*: At least 1 WTE per 10 beds, with a minimum of one per unit	€63,250	0	0	3.5	-3.5	€0	-€221,375	€221,375
(b) *Community*: At least 1 WTE specialising in palliative care per 125,000 of population, based in specialist palliative care unit	€66,700	2	1	3	-1	€133,400	-€66,700	€200,100
5. Social Workers								
(a) *Specialist unit*: At least 1 WTE per 10 beds, with a minimum of 1 per unit	€63,250	0	0	3.5	-3.5	€0	-€221,375	€221,375
(b) *Community*: At least 1 WTE specialising in palliative care per 125,000 of population, based in specialist palliative care unit	€66,700	3	1	3	0	€200,100	€0	€200,100
(c) *Acute general hospitals*: At least 1 WTE specialising in palliative care in those hospitals which have specialist PC team	€63,250	0	0	4	-4	€0	-€253,000	€253,000
6. Spiritual Care								
(a) At least 2 suitably trained chaplains to meet needs of patients/families in each specialist palliative care unit. Service should be available 24/7.	€37,294	1	2	2	-1	€37,294	-€37,294	€74,588
7. Speech and Language Therapy								
Regular speech/language therapy sessions in each specialist palliative care unit, with minimum 1 session per week	€63,250	0	0	0.1	-0.1	€0	-€6,325	€6,325
8. Clinical Nutritionists								
At least 1 session per week in each specialist palliative care unit	€63,250	1	0	0.1	0	€63,250	€0	€63,250
9. Pharmacists								
At least 1 WTE in each specialist palliative care unit	€77,141	1	0	1	0	€77,141	€0	€77,141
10. Care Attendants								
(a) Not less that 0.5 WTE per bed in specialist palliative care unit.	€40,250	0	0	17	-17	€0	-€684,250	€684,250
(b) Care attendants, including night sitters, should be available to support families of palliative care patients in the community	€40,250	0	0	0	0	€0	€0	€0
11. Volunteers / Co-ordinators								
Every specialist palliative care unit should have volunteer coordinator	€46,000	0	0	1	-1	€0	-€46,000	€46,000
12. Librarian / Education Personnel								
Specialist palliative care services should have a librarian and education personnel	€51,750	0	0	2	-2	€0	-€103,500	€103,500
13. Medical Secretaries in Acute Hospitals								
At least 1 WTE in those hospitals which have specialist PC team	€40,966	1	0	4	-3	€40,966	-€122,898	€163,864
14. Bed Totals								
There should be 10 beds per 100,000 of population	€150,000	0	0	34	-34	€0	-€5,100,000	€5,100,000

Staff Totals		Bed Totals		Region Totals	
Total Current Staffing Levels	35.0	Total Current Beds	0		
Total Approved Staffing Levels	10.0	Total Approved Beds	0		
Recommendation based on current pop.	113.7	Recommended Beds	34		
Staffing Level Deficit	-85.6	Bed Deficit	-34		
Current Costing	€2,471,767	Current Costing	€0	Current Costing	€2,471,767
Cost of Funding Deficit	-€5,377,766	Cost of Funding Deficit	-€5,100,000	Cost of Funding Deficit	-€10,477,766
Current Spend per Cap.	€7.17	Current Spend per Cap.	€0.00	Current Spend per Cap.	€7.17
Required Spend per Cap.	€22.75	Required Spend per Cap.	€14.78	Required Spend per Cap.	€37.54
Deficit per Cap.	-€15.59	Deficit per Cap.	-€14.78	Deficit per Cap.	-€30.37

Note: Where the actual number of staff is greater than the recommended number of staff, the deficit defaults to zero.

Note: NACPC recommended staffing levels are calculated based on the following data :

Population Size **344,965**

Source CSO Census 2002

Date 25th July 2005

Specialist Palliative Care in the Midland Health Board

Implications of current position relative to the minimum recommendations* of the Report of the National Advisory Committee on Palliative Care (2001)

(* based on current population / bed numbers)

NACPC Minimum Recommendations	Costs inc. overheads	Current Levels (As of Dec' 04)	Approved / In Recruitment	Recommendation	Deficit	Current Costing	Cost of Funding Deficit	Current Cost + Cost of Funding Deficit
1. Medical Staff								
(a) At least one WTE (whole time equivalent) Consultant in Palliative Medicine per 160,000 of the population, with a minimum of two consultants in each Health Board Area)	€265,000	0	0	2	-2	€0	-€530,000	€530,000
(b) For each of the above consultants, at least three non-consultant hospital doctors	€112,500	0	0	6	-6	€0	-€675,000	€675,000
2. Specialist Palliative Care Nurses								
(a) In *specialist in-patient unit*: Not less than 1 WTE per bed	€62,100	0	0	22	-22	€0	-€1,366,200	€1,366,200
(b) *In the Community*: Minimum 1 WTE per 25,000 of population	€69,000	10	3	9	0	€345,000	-€345,000	€690,000
(c) In acute general hospital team: Minimum 1 (hospital based) per 150 beds	€62,658	0	0	3	-3	€0	-€187,974	€187,974
(d) In *day-care centre*: Minimum 1 per 7 daily attendees	€51,750	0	0	2	-2	€0	-€103,500	€103,500
3. Physiotherapists								
(a) In specialist in-patient unit: At least 1 WTE per 10 beds, with a minimum of 1 per unit	€63,250	0	0	2	-2	€0	-€126,500	€126,500
(b) *Community*: At least 1 WTE specialising in palliative care per 125,000 of population, based in specialist palliative care unit	€66,700	0	0	2	-2	€0	-€133,400	€133,400
4. Occupational Therapists								
(a) *In specialist unit*: At least 1 WTE per 10 beds, with a minimum of one per unit	€63,250	0	0	2	-2	€0	-€126,500	€126,500
(b) *Community*: At least 1 WTE specialising in palliative care per 125,000 of population, based in specialist palliative care unit	€66,700	0	0	2	-2	€0	-€133,400	€133,400
5. Social Workers								
(a) *Specialist unit*: At least 1 WTE per 10 beds, with a minimum of 1 per unit	€63,250	0	0	2	-2	€0	-€126,500	€126,500
(b) *Community*: At least 1 WTE specialising in palliative care per 125,000 of population, based in specialist palliative care unit	€66,700	0	0	2	-2	€0	-€133,400	€133,400
(c) *Acute general hospitals*: At least 1 WTE specialising in palliative care in those hospitals which have specialist PC team	€63,250	0	0	3	-3	€0	-€189,750	€189,750
6. Spiritual Care								
(a) At least 2 suitably trained chaplains to meet needs of patients/families in each specialist palliative care unit. Service should be available 24/7.	€37,294	0	0	2	-2	€0	-€74,588	€74,588
7. Speech and Language Therapy								
Regular speech/language therapy sessions in each specialist palliative care unit, with minimum 1 session per week	€63,250	0	0	0.1	-0.1	€0	-€6,325	€6,325
8. Clinical Nutritionists								
At least 1 session per week in each specialist palliative care unit	€63,250	0	0	0.1	-0.1	€0	-€6,325	€6,325
9. Pharmacists								
At least 1 WTE in each specialist palliative care unit	€77,141	0	0	1	-1	€0	-€77,141	€77,141
10. Care Attendants								
(a) Not less that 0.5 W IB per bed in specialist palliative care unit.	€40,250	0	0	11	-11	€0	-€442 750	€442,750
(b) Care attendants, including night sitters, should be available to support families of palliative care patients in the community	€40,250	0	0	0	0	€0	€0	€0
11. Volunteers / Co-ordinators								
Ever)' specialist palliative care unit should have volunteer coordinator	€46,000	0	0	1	-1	€0	-€46 000	€46.000
12. Librarian / Education Personnel								
Specialist palliative care services should have a librarian and education personnel	€51,750	0	0	2	-2	€0		€103,500
13. Medical Secretaries in Acute Hospitals								
At least 1 WTE in those hospitals	€40,966	0	0	3		€0		€122.898
14. Bed Totals								
There should be 10 beds per 100.000 of population	€150,000	0	0	22	-u	€0		€3,300,000

Staff Totals		Bed Totals		Region Totals	
Total Current Staffing Levels	10.0	Total Current Beds	0		
Total Approved Staffing Levels	3.0	Total Approved Beds	0		
Recommendation based on current pop.	79.2	Recommended Beds	22		
Staffing Level Deficit	-70.2	Bed Deficit	-22		
Current Costing	€345,000	Current Costing	€0	Current Costing	€345,000
Cost of Funding Deficit	-€5,056,651	Cost of Funding Deficit	-€3,300,000	Cost of Funding Deficit	-€8,356,651
Current Spend per Cap.	€1.53	Current Spend per Cap.	€0.00	Current Spend per Cap.	€1.53
Required Spend per Cap.	€23.94	Required Spend per Cap.	€14.63	Required Spend per Cap.	€38.57
Deficit per Cap.	-€22.42	Deficit per Cap.	-€14.63	Deficit per Cap.	-€37.04

Note: Where the actua. number of staff is greater than the recommended number of staff, the deficit **deuulu** to **zero.**

Note: NACPC recommended staffing levels are calculated based on the following dau :

Population Size **225388**

Source CSO Census 2002

Date 25th July 2005

Specialist Palliative Care in the Mid-Western Health Board

Implications of current position relative to the minimum recommendations* of the Report of the National Advisory Committee on Palliative Care (2001)

(* based on current population / bed numbers)

NACPC Minimum Recommendations	Costs inc. overheads	Current Levels (As of Dec' 04)	Approved / in Recruitment	Recommendation	Deficit	Current Costing	Cost of Funding Deficit	Current Cost + Cost of Funding Deficit
1. Medical Staff								
(a) At least one WTE (whole time equivalent) Consultant in Palliative Medicine per 160,000 of the population, with a minimum of two consultants in each Health Board Area)	€265,000	1	1	2	-1	€265,000	-€265,000	€530,000
(b) For each of the above consultants, at least three non-consultant hospital doctors	€112,500	4	1	6	-2	€450,000	-€225,000	€675,000
2. Specialist Palliative Care Nurses								
(a) In *specialist in-patient unit*: Not less than 1 WTE per bed	€62,100	28	0	34	-6	€1,738,800	-€372,600	€2,111,400
(b) *In the Community*: Minimum 1 WTE per 25,000 of population	€69,000	12.5	0.5	13.5	-1	€733,125	-€198,375	€931,500
(c) In acute general hospital team: Minimum 1 (hospital based) per 150 beds	€62,658	6	0	5	0	€375,948	€0	€375,948
(d) In *day-care centre*: Minimum 1 per 7 daily attendees	€51,750	1	0	2	-1	€51,750	-€51,750	€103,500
3. Physiotherapists								
(a) In specialist in-patient unit: At least 1 WTE per 10 beds, with a minimum of 1 per unit	€63,250	2.5	0	3.5	-1	€158,125	-€63,250	€221,375
(b) *Community*: At least 1 WTE specialising in palliative care per 125,000 of population, based in specialist palliative care unit	€66,700	0	0	2.5	-2.5	€0	-€166,750	€166,750
4. Occupational Therapists								
(a) *In specialist unit*: At least 1 WTE per 10 beds, with a minimum of one per unit	€63,250	2.5	0	3.5	-1	€158,125	-€63,250	€221,375
(b) *Community*: At least 1 WTE specialising in palliative care per 125,000 of population, based in specialist palliative care unit	€66,700	0	0	2.5	-2.5	€0	-€166,750	€166,750
5. Social Workers								
(a) *Specialist unit*: At least 1 WTE per 10 beds, with a minimum of 1 per unit	€63,250	2.5	0	3.5	-1	€158,125	-€63,250	€221,375
(b) *Community*: At least 1 WTE specialising in palliative care per 125,000 of population, based in specialist palliative care unit	€66,700	0.5	0	2.5	-2	€33,350	-€133,400	€166,750
(c) *Acute general hospitals*: At least 1 WTE specialising in palliative care in those hospitals which have specialist PC team	€63,250	1	0	4	-3	€63,250	-€189,750	€253,000
6. Spiritual Care								
(a) At least 2 suitably trained chaplains to meet needs of patients/families in each specialist palliative care unit. Service should be available 24/7	€37,294	3	0	2	0	€111,882	€0	€111,882
7. Speech and Language Therapy								
Regular speech/language therapy sessions in each specialist palliative care unit, with minimum 1 session per week	€63,250	0	0	0.1	-0.1	€0	-€6,325	€6,325
8. Clinical Nutritionists								
At least 1 session per week in each specialist palliative care unit	€63,250	0.2	0	0.1	0	€12,650	€0	€12,650
9. Pharmacists								
At least 1 WTE in each specialist palliative care unit	€77,141	0.5	0	1	-0.5	€38,571	-€38,571	€77,141
10. Care Attendants								
(a) Not less that 0.5 WTE per bed in specialist palliative care unit.	€40,250	18	0	17	0	€724,500	€0	€724,500
(b) Care attendants, including night sitters, should be available to support families of palliative care patients in the community	€40,250	3	0	0	0	€120,750	€0	€120,750
11. Volunteers / Co-ordinators								
Every specialist palliative care unit should have volunteer coordinator	€46,000	1	0	1	0	€46,000	CO	€46,000
12. Librarian / Education Personnel								
Specialist palliative care services should have a librarian and education personnel	€51,750	1.5	0	2	-0.5	€77,625		€103.500
13. Medical Secretaries in Acute Hospitals								
At least 1 WTE in those hospitals	€40,966	0	0	4	-4	€0		€163.864
14. Bed Totals								
There should be 10 beds per 100.000 of population	€150,0OC	20	0	34	-14	€3,000,000		€5.100.000

Staff Totals

Total Current Staffing Levels

Total Approved Staffing Levels

Recommendation based on current pop.

Staffing Level Deficit

Current Costing €5,317,5761

Cost of Funding Deficit -€2,19:

Current Spend per Cap.

Required Spend per Cap.

Deficit per Cap.

Bed Totals

Total Current Beds

Total Approved Beds

Recommended Beds

Bed Deficit

Current Costing €3,000,00d

Cost of Funding Deficit

Current Spend per Cap.

Required Spend per Cap.

Deficit per Cap.

Region **Totals**

Current Costing 0.117.57*

Cost of Funding Deficit

Current Spend per Cap.

Required Spend per Cap

Deficit per Cap

Noœ:Where the ac.ua. number of staffTis greater than the recommended number of staff, the deficit default, to zero.

Note: NACPC recommended staffing levels are calculated based on the following data

Population Size 339,591

Source CSO Census 2002

Date 25th July 2005

Specialist Palliative Care in the North-Western Health Board

Implications of current position relative to the minimum recommendations* of the Report of the National Advisory Committee on Palliative Care (2001)
(* based on current population / bed numbers)

NACPC Minimum Recommendations	Costs inc. overheads	Current Levels (As of Dec' 04)	Approved / in Recruitment	Recommendation	Deficit	Current Costing	Cost of Funding Deficit	Current Cost + Cost of Funding Deficit
1. Medical Staff								
(a) At least one WTE (whole time equivalent) Consultant in Palliative Medicine per 160,000 of the population, with a minimum of two consultants in each Health Board Area)	€265,000	1	1	2	-1	€265,000	-€265,000	€530,000
(b) For each of the above consultants, at least three non-consultant hospital doctors	€112,500	5	0	6	-1	€562,500	-€112,500	€675,000
2. Specialist Palliative Care Nurses								
(a) In *specialist in-patient unit*: Not less than 1 WTE per bed	€62,100	33	0	22	0	€2,049,300	€0	€2,049,300
(b) *In the Community*: Minimum 1 WTE per 25,000 of population	€69,000	12	0	9	0	€579,600	-€248,400	€828,000
(c) In acute general hospital team: Minimum 1 (hospital based) per 150 beds	€62,658	2	0	4	-2	€125,316	-€125,316	€250,632
(d) In *day-care centre*: Minimum 1 per 7 daily attendees	€51,750	0	0	2	-2	€0	-€103,500	€103,500
3. Physiotherapists								
(a) In specialist in-patient unit: At least 1 WTE per 10 beds, with a minimum of 1 per unit	€63,250	1	0	2	-1	€63,250	-€63,250	€126,500
(b) *Community*: At least 1 WTE specialising in palliative care per 125,000 of population, based in specialist palliative care unit	€66,700	0	0	2	-2	€0	-€133,400	€133,400
4. Occupational Therapists								
(a) *In specialist unit*: At least 1 WTE per 10 beds, with a minimum of one per unit	€63,250	1	0	2	-1	€63,250	-€63,250	€126,500
(b) *Community*: At least 1 WTE specialising in palliative care per 125,000 of population, based in specialist palliative care unit	€66,700	0	0	2	-2	€0	-€133,400	€133,400
5. Social Workers								
(a) *Specialist unit*: At least 1 WTE per 10 beds, with a minimum of 1 per unit	€63,250	0	0	2	-2	€0	-€126,500	€126,500
(b) *Community*: At least 1 WTE specialising in palliative care per 125,000 of population, based in specialist palliative care unit	€66,700	0	0	2	-2	€0	-€133,400	€133,400
(c) *Acute general hospitals*: At least 1 WTE specialising in palliative care in those hospitals which have specialist PC team	€63,250	0	0	2	-2	€0	-€126,500	€126,500
6. Spiritual Care								
(a) At least 2 suitably trained chaplains to meet needs of patients/families in each specialist palliative care unit. Service should be available 24/7	€37,294	0	0	4	-4	€0	-€149,176	€149,176
7. Speech and Language Therapy								
Regular speech/language therapy sessions in each specialist palliative care unit, with minimum 1 session per week	€63,250	0.1	0	0.2	-0.1	€6,325	-€6,325	€12,650
8. Clinical Nutritionists								
At least 1 session per week in each specialist palliative care unit	€63,250	0.1	0	0.2	-0.1	€6,325	-€6,325	€12,650
9. Pharmacists								
At least 1 WTE in each specialist palliative care unit	€77,141	0	0	2	-2	€0	-€154,282	€154,282
10. Care Attendants								
(a) Not less that 0.5 WTE per bed in specialist palliative care unit.	€40,250	6.5	0	11	-4.5	€261,625	-€181,125	€442,750
(b) Care attendants, including night sitters, should be available to support families of palliative care patients in the community	€40,250	0	0	0	0	€0	€0	€0
11. Volunteers / Co-ordinators								
Every specialist palliative care unit should have volunteer coordinator	€46,000	0	0	2	-2	€0	-€92,000	€92,000
12. Librarian / Education Personnel								
Specialist palliative care services should have a librarian and education personnel	€51,750	0	0	2	-2	€0	-€103,500	€103,500
13. Medical Secretaries in Acute Hospitals								
At least 1 WTE in those hospitals which have specialist PC team	€40,966	0	0	2	-2	€0	-€81,932	€81,932
14. Bed Totals								
There should be 10 beds per 100,000 of population	€150,000	18	0	22	-4	€2,700,000	-€600,000	€3,300,000

Staff Totals

Total Current Staffing Levels	
Total Approved Staffing Levels	
Recommendation based on current pop.	
Staffing Level Deficit	
Current Costing	€3,982,491
Cost of Funding Deficit	
Current Spend per Cap.	€17.971
Required Spend per Cap.	€28.89
Deficit per Cap.	

Bed Totals

Total Current Beds	
Total Approved Beds	
Recommended Beds	
Bed Deficit	
Current Costing	€2,700,000]
Cost of Funding Deficit	
Current Spend per Cap.	
Required Spend per Cap.	
Deficit per Cap	

Region Totals

Current Costing	(6 U 2 4B1
Cost of Funding Deficit	
Current Spend per Cap	
Required Spend per Cap	C41.74
Deficit per Cap	

NotetWhere the actual number of staff is greater man the recommended number of staff the deficit defaults to zero.

Note: NACPC recommended staffing levels are calculated based on the following data :

Population Size **221,574**
Source CSO Census 2002
Date 25th July 2005

Specialist Palliative Care in the South-Eastern Health Board

Implications of current position relative to the minimum recommendations* of the Report of the National Advisory Committee on Palliative Care (2001)

(* based on current population / bed numbers)

NACPC Minimum Recommendations	Costs inc. overheads	Current Levels (As of Dec' 04)	Approved / in Recruitment	Recommendation	Deficit	Current Costing	Cost of Funding Deficit	Current Cost + Cost of Funding Deficit
1. Medical Staff								
(a) At least one WTE (whole time equivalent) Consultant in Palliative Medicine per 160,000 of the population, with a minimum of two consultants in each Health Board Area)	€265,000	1	1	2.5	-1.5	€265,000	-€397,500	€662,500
(b) For each of the above consultants, at least three non-consultant hospital doctors	€112,500	3	1	7.5	-4.5	€337,500	-€506,250	€843,750
2. Specialist Palliative Care Nurses								
(a) In *specialist in-patient unit*: Not less than 1 WTE per bed	€62,100	0	0	42	-42	€0	-€2,608,200	€2,608,200
(b) *In the Community*: Minimum 1 WTE per 25,000 of population	€69,000	17.5	0	17	0	€241,500	-€966,000	€1,207,500
(c) In acute general hospital team: Minimum 1 (hospital based) per 150 beds	€62,658	4	0	7	-3	€250,632	-€187,974	€438,606
(d) In *day-care centre*: Minimum 1 per 7 daily attendees	€51,750	0	2	2	-2	€0	-€103,500	€103,500
3. Physiotherapists								
(a) In specialist in-patient unit: At least 1 WTE per 10 beds, with a minimum of 1 per unit	€63,250	0	0	4	-4	€0	-€253,000	€253,000
(b) *Community*: At least 1 WTE specialising in palliative care per 125,000 of population, based in specialist palliative care unit	€66,700	0	0	3.5	-3.5	€0	-€233,450	€233,450
4. Occupational Therapists								
(a) *In specialist unit*: At least 1 WTE per 10 beds, with a minimum of one per unit	€63,250	0	0	4	-4	€0	-€253,000	€253,000
(b) *Community*: At least 1 WTE specialising in palliative care per 125,000 of population, based in specialist palliative care unit	€66,700	0	0	3.5	-3.5	€0	-€233,450	€233,450
5. Social Workers								
(a) *Specialist unit*: At least 1 WTE per 10 beds, with a minimum of 1 per unit	€63,250	0	0	4	-4	€0	-€253,000	€253,000
(b) *Community*: At least 1 WTE specialising in palliative care per 125,000 of population, based in specialist palliative care unit	€66,700	0	0	3.5	-3.5	€0	-€233,450	€233,450
(c) *Acute general hospitals*: At least 1 WTE specialising in palliative care in those hospitals which have specialist PC team	€63,250	0	0	4	-4	€0	-€253,000	€253,000
6. Spiritual Care								
(a) At least 2 suitably trained chaplains to meet needs of patients/families in each specialist palliative care unit. Service should be available 24/7	€37,294	0	0	2	-2	€0	-€74,588	€74,588
7. Speech and Language Therapy								
Regular speech/language therapy sessions in each specialist palliative care unit, with minimum 1 session per week	€63,250	0	0	0.1	-0.1	€0	-€6,325	€6,325
8. Clinical Nutritionists								
At least 1 session per week in each specialist palliative care unit	€63,250	0	0	0.1	-0.1	€0	-€6,325	€6,325
9. Pharmacists								
At least 1 WTE in each specialist palliative care unit	€77,141	0	0	1	-1	€0	-€77,141	€77,141
10. Care Attendants								
(a) Not less that 0.5 WTE per bed in specialist palliative care unit.	€40,250	0	0	21	-21	€0	-€845,250	€845,250
(b) Care attendants, including night sitters, should be available to support families of palliative care patients in the community	€40,250	0	0	0	0	€0	€0	€0
11. Volunteers / Co-ordinators								
Every specialist palliative care unit should have volunteer coordinator	€46,000	0	0	1	-1	€0	-€46,000	€46,000
12. Librarian / Education Personnel								
Specialist palliative care services should have a librarian and education personnel	€51,750	1	0	2	-1	€51,750	-€51,750	€103,500
13. Medical Secretaries in Acute Hospitals								
At least 1 WTE in those hospitals which have specialist PC team	€40,966	1	0	4	-3	€40,966	-€122,898	€163,864
14. Bed Totals								
There should be 10 beds per 100,000 of population	€150,000	0	0	42	-42	€0	-€6,300,000	€6,300,000

Staff Totals		Bed Totals		Region Totals	
Total Current Staffing Levels	27.5	Total Current Beds	0		
Total Approved Staffing Levels	4.0	Total Approved Beds	0		
Recommendation based on current pop.	135.7	Recommended Beds	42		
Staffing Level Deficit	-108.7	Bed Deficit	-42		
Current Costing	€1,187,348	Current Costing	€0	Current Costing	€1,187,348
Cost of Funding Deficit	-€7,712,051	Cost of Funding Deficit	-€6,300,000	Cost of Funding Deficit	-€14,012,051
Current Spend per Cap.	€2.75	Current Spend per Cap.	€0.00	Current Spend per Cap.	€2.75
Required Spend per Cap.	€20.57	Required Spend per Cap.	€14.57	Required Spend per Cap.	€35.14
Deficit per Cap.	-€17.83	Deficit per Cap.	-€14.57	Deficit per Cap.	-€32.39

Note: Where the actual number of staff is greater than the recommended number of staff, the deficit defaults to zero.

Note: NACPC recommended staffing levels are calculated based on the following data :

Population Size **432,540**

Source CSO Census 2002

Date 25th July 2005

Specialist Palliative Care in the Southern Health Board

Implications of current position relative to the minimum recommendations* of the Report of the National Advisory Committee on Palliative Care (2001)

(* based on current population / bed numbers)

NACPC Minimum Recommendations	Costs inc. overheads	Current Levels (As of Dec' 04)	Approved / in Recruitment	Recommendation	Deficit	Current Costing	Cost of Funding Deficit	Current Cost + Cost of Funding Deficit
1. Medical Staff								
(a) At least one WTE (whole time equivalent) Consultant in Palliative Medicine per 160,000 of the population, with a minimum of two consultants in each Health Board Area)	€265,000	2	0	3.5	-1.5	€530,000	-€397,500	€927,500
(b) For each of the above consultants, at least three non-consultant hospital doctors	€112,500	5	0	10.5	-5.5	€562,500	-€618,750	€1,181,250
2. Specialist Palliative Care Nurses								
(a) In *specialist in-patient unit*: Not less than 1 WTE per bed	€62,100	23	0	58	-35	€1,428,300	-€2,173,500	€3,601,800
(b) *In the Community*: Minimum 1 WTE per 25,000 of population	€69,000	18.5	0	23	-4.5	€1,212,675	-€374,325	€1,587,000
(c) In acute general hospital team: Minimum 1 (hospital based) per 150 beds	€62,658	6	0	11	-5	€375,948	-€313,290	€689,238
(d) In *day-care centre*: Minimum 1 per 7 daily attendees	€51,750	2	0	2	0	€103,500	€0	€103,500
3. Physiotherapists								
(a) In specialist in-patient unit: At least 1 WTE per 10 beds, with a minimum of 1 per unit	€63,250	3	0	6	-3	€189,750	-€189,750	€379,500
(b) *Community*: At least 1 WTE specialising in palliative care per 125,000 of population, based in specialist palliative care unit	€66,700	0	0	4	-4	€0	-€266,800	€266,800
4. Occupational Therapists								
(a) *In specialist unit*: At least 1 WTE per 10 beds, with a minimum of one per unit	€63,250	0	0	6	-6	€0	-€379,500	€379,500
(b) *Community*: At least 1 WTE specialising in palliative care per 125,000 of population, based in specialist palliative care unit	€66,700	0	0	4	-4	€0	-€266,800	€266,800
5. Social Workers								
(a) *Specialist unit*: At least 1 WTE per 10 beds, with a minimum of 1 per unit	€63,250	2	0	6	-4	€126,500	-€253,000	€379,500
(b) *Community*: At least 1 WTE specialising in palliative care per 125,000 of population, based in specialist palliative care unit	€66,700	0	0	4	-4	€0	-€266,800	€266,800
(c) *Acute general hospitals*: At least 1 WTE specialising in palliative care in those hospitals which have specialist PC team	€63,250	1.5	0	5	-3.5	€94,875	-€221,375	€316,250
6. Spiritual Care								
(a) At least 2 suitably trained chaplains to meet needs of patients/families in each specialist palliative care unit. Service should be available 24/7	€37,294	2	0	2	0	€74,588	€0	€74,588
7. Speech and Language Therapy								
Regular speech/language therapy sessions in each specialist palliative care unit, with minimum 1 session per week	€63,250	0	0	0.1	-0.1	€0	-€6,325	€6,325
8. Clinical Nutritionists								
At least 1 session per week in each specialist palliative care unit	€63,250	0	0	0.1	-0.1	€0	-€6,325	€6,325
9. Pharmacists								
At least 1 WTE in each specialist palliative care unit	€77,141	0.5	0	1	-0.5	€38,571	-€38,571	€77,141
10. Care Attendants								
(a) Not less that 0.5 WTE per bed in specialist palliative care unit.	€40,250	12	0	29	-17	€483,000	-€684,250	€1,167,250
(b) Care attendants, including night sitters, should be available to support families of palliative care patients in the community	€40,250	0	0	0	0	€0	€0	€0
11. Volunteers / Co-ordinators								
Every specialist palliative care unit should have volunteer coordinator	€46,000	1	0	1	0	€46,000	€0	€46,000
12. Librarian / Education Personnel								
Specialist palliative care services should have a librarian and education personnel	€51,750	3	0	2	0	€155,250	€0	€155,250
13. Medical Secretaries in Acute Hospitals								
At least 1 WTE in those hospitals which have specialist PC team	€40,966	1.5	0	6	-4.5	€61,449	-€184,347	€245,796
14. Bed Totals								
There should be 1 bed per 100,000 of population	€150,000	24	0	58	-34	€3,600,000	-€5,100,000	€8,700,000

Staff Totals		Bed Totals		Region Totals	
Total Current Staffing Levels	83.0	Total Current Beds	24		
Total Approved Staffing Levels	0.0	Total Approved Beds	0		
Recommendation based on current pop.	184.2	Recommended Beds	58		
Staffing Level Deficit	-102.2	Bed Deficit	-34		
Current Costing	€5,482,906	Current Costing	€3,600,000	Current Costing	€9,082,906
Cost of Funding Deficit	-€6,641,208	Cost of Funding Deficit	-€5,100,000	Cost of Funding Deficit	-€11,741,208
Current Spend per Cap.	€9.45	Current Spend per Cap.	€6.20	Current Spend per Cap.	€15.65
Required Spend per Cap.	€20.89	Required Spend per Cap.	€14.99	Required Spend per Cap.	€35.88
Deficit per Cap.	-€11.44	Deficit per Cap.	-€8.79	Deficit per Cap.	-€20.23

Note: Where the actual number of staff is greater than the recommended number of staff, the deficit defaults to zero.

Note: NACPC recommended staffing levels are calculated based on the following data :

Population Size **580,356**

Source CSO Census 2002

Date 25th July 2005

Specialist Palliative Care in the Western Health Board

Implications of current position relative to the minimum recommendations* of the Report of the National Advisory Committee on Palliative Care (2001)

(* based on current population / bed numbers)

NACPC Minimum Recommendations	Costs inc. overheads	Current Levels (As of Dec' 04)	Approved / in Recruitment	Recommendation	Deficit	Current Costing	Cost of Funding Deficit	Current Cost + Cost of Funding Deficit
1. Medical Staff								
(a) At least one WTE (whole time equivalent) Consultant in Palliative Medicine per 160,000 of the population, with a minimum of two consultants in each Health Board Area)	€265,000	1	1	2	-1	€265,000	-€265,000	€530,000
(b) For each of the above consultants, at least three non-consultant hospital doctors	€112,500	4	0	6	-2	€450,000	-€225,000	€675,000
2. Specialist Palliative Care Nurses								
(a) In *specialist in-patient unit*: Not less than 1 WTE per bed	€62,100	14.5	0	38	-23.5	€900,450	-€1,459,350	€2,359,800
(b) *In the Community*: Minimum 1 WTE per 25,000 of population	€69,000	20.5	0	15	0	€212,175	-€1,202,325	€1,414,500
(c) In acute general hospital team: Minimum 1 (hospital based) per 150 beds	€62,658	6	0	10	-4	€375,948	-€250,632	€626,580
(d) In *day-care centre*: Minimum 1 per 7 daily attendees	€51,750	1	0	2	-1	€51,750	-€51,750	€103,500
3. Physiotherapists								
(a) In specialist in-patient unit: At least 1 WTE per 10 beds, with a minimum of 1 per unit	€63,250	0	0	4	-4	€0	-€253,000	€253,000
(b) *Community*: At least 1 WTE specialising in palliative care per 125,000 of population, based in specialist palliative care unit	€66,700	0	0	3	-3	€0	-€200,100	€200,100
4. Occupational Therapists								
(a) *In specialist unit*: At least 1 WTE per 10 beds, with a minimum of one per unit	€63,250	0	0	4	-4	€0	-€253,000	€253,000
(b) *Community*: At least 1 WTE specialising in palliative care per 125,000 of population, based in specialist palliative care unit	€66,700	0	0	3	-3	€0	-€200,100	€200,100
5. Social Workers								
(a) *Specialist unit*: At least 1 WTE per 10 beds, with a minimum of 1 per unit	€63,250	1.5	0	4	-2.5	€94,875	-€158,125	€253,000
(b) *Community*: At least 1 WTE specialising in palliative care per 125,000 of population, based in specialist palliative care unit	€66,700	3	0	3	0	€200,100	€0	€200,100
(c) *Acute general hospitals*: At least 1 WTE specialising in palliative care in those hospitals which have specialist PC team	€63,250	1	0	3	-2	€63,250	-€126,500	€189,750
6. Spiritual Care								
(a) At least 2 suitably trained chaplains to meet needs of patients/families in each specialist palliative care unit. Service should be available 24/7.	€37,294	1	1	2	-1	€37,294	-€37,294	€74,588
7. Speech and Language Therapy								
Regular speech language therapy sessions in each specialist palliative care unit, with minimum 1 session per week	€63,250	0	0	0.1	-0.1	€0	-€6,325	€6,325
8. Clinical Nutritionists								
At least 1 session per week in each specialist palliative care unit	€63,250	0.2		0.1	0	€12,650	€0	€12,650
9. Pharmacists								
At least 1 WTE in each specialist palliative care unit	€77,141	0	1	1	-1	€0	-€77,141	€77,141
10. Care Attendants								
(a) Not less that 0.5 WTE per bed in specialist palliative care unit.	€40,250	8.5	0	19	-10.5	€342,125	-€422,625	€764,750
(b) Care attendants, including night sitters, should be available to support families of palliative care patients in the community	€40,250	2	0	0	0	€80,500	€0	€80,500
11. Volunteers / Co-ordinators								
Every specialist palliative care unit should have volunteer coordinator	€46,000	0	0	1	-1	€0	-€46,000	€46,000
12. Librarian / Education Personnel								
Specialist palliative care services should have a librarian and education personnel	€51,750	0	0	2	-2	€0	-€103,500	€103,500
13. Medical Secretaries in Acute Hospitals								
At least 1 WTE in those hospitals which have specialist PC team	€40,966	0.5	0	4	-3.5	€20,483	-€143,381	€163,864
14. Beds								
There should be 1 bed per 100,000 of population	€150,000	8	0	38	-30	€1,200,000	-€4,500,000	€5,700,000

Staff Totals		Bed Totals		Region Totals	
Total Current Staffing Levels	64.7	Total Current Beds	8		
Total Approved Staffing Levels	3.0	Total Approved Beds	0		
Recommendation based on current pop.	126.2	Recommended Beds	38		
Staffing Level Deficit	-69.1	Bed Deficit	-30		
Current Costing	€3,106,600	Current Costing	€1,200,000	Current Costing	€4,306,600
Cost of Funding Deficit	-€5,481,148	Cost of Funding Deficit	-€4,500,000	Cost of Funding Deficit	-€9,981,148
Current Spend per Cap.	€8.17	Current Spend per Cap.	€3.16	Current Spend per Cap.	€11.32
Required Spend per Cap.	€22.58	Required Spend per Cap.	€14.99	Required Spend per Cap.	€37.57
Deficit per Cap.	-€14.41	Deficit per Cap.	-€11.83	Deficit per Cap.	-€26.25

Note: Where the actual number of staff is greater than the recommended number of staff, the deficit defaults to zero.

Note: NACPC recommended staffing levels are calculated based on the following data :

Population Size **380,297**

Source CSO Census 2002

Date 25th July 2005

Staff and Bed Costs - Including Overhead Costs

1. Medical Staff

(a) At least one WTE *(whole time equivalent)* Consultant in Palliative Medicine per 160,000 of the population, with a minimum of two consultants in each Health Board Area)	€265,000
(b) For each of the above consultants, at least three non-consultant hospital doctors	€112,500

2. Specialist Palliative Care Nurses

(a) *In specialist in-patient unit:* Not less than 1 WTE per bed	€62,100
(b)In the Community: Minimum 1 WTE per 25,000 of population	€69,000
(c) *In acute general hospital team:* Minimum 1 (hospital based) per 150 beds	€62,658
(d)/n *day-care centre:* Minimum 1 per 7 daily attendees	€51,750

3. Physiotherapists

(a) *In specialist in-patient unit:* At least 1 WTE per 10 beds, with a minimum of 1 per unit	€63,250
(b) *Community.* At least 1 WTE specialising in palliative care per 125,000 of population, based in specialist palliative care unit	€66,700

4. Occupational Therapists

(a) *In specialist unit:* At least 1 WTE per 10 beds, with a minimum of one per unit	€63,250
(b) *Community:* At least 1 WTE specialising in palliative care per 125,000 of population, based in specialist palliative care unit	€66,700

5. Social Workers

(a) *Specialist unit:* At least I WTE per 10 beds, with a minimum of 1 per unit	€63,250
(b) *Community-* At least I WTE specialising in palliative care per 125,000 of population based in specialist palliative care unit	€66,700
(c) *Acute general hospitals:* At least 1 WTE specialising in palliative care in those hospitals which have specialist PC team	**€63,250**

6. Spiritual Care

(a) At least 2 suitably trained chaplains to meet needs of patients/families in each specialist palliative care unit. Service should be available 24/7.	€37,294

7. Speech and Language Therapy

Regular speech/language therapy sessions in each specialist palliative care unit, with minimum 1 session per week	€63,250

8. Clinical Nutritionists

At least 1 session per week in each specialist palliative care unit	€63,250

9. Pharmacists

At least 1 WTE in each specialist palliative care unit	€77,141

10. Care Attendants

(a) Not less that 0.5 WTE per bed in specialist palliative care unit.	€40,250
(b) Care attendants, including night sitters, should be available to support families of palliative care patients in the community	

11. Volunteer Co-ordinators

Every specialist palliative care unit should have volunteer coordinator	€46,000

12. Librarian/education Personnel

Specialist palliative care services should have a librarian and education personnel	€51,750

13. Medical Secretaries in Acute Hospitals

At least 1 WTE in those hospitals which have specialist PC team	€40,966

14. Inpatient Beds

There should be 10 beds per 100,000 of population	€150,000

APPENDIX 2

COMPOSITION AND SCALE OF SPECIALIST PALLIATIVE CARE TEAMS IN ACUTE GENERAL HOSPITALS 2004

Appendix 2

Composition and scale of specialist palliative care teams in acute general hospitals, 2004

Acute general hospital	Team composition	Team scale
St Vincent's University Hospital, Elm Park	Consultant in Palliative Medicine Registrar in Palliative Medicine 2WTECNSS 1 Senior Social Worker 1 WTE Administrative Secretary	**Full**
St Columcille*s Hospital, Loughlinstown	No dedicated team	
St Michael's Hospital, Dun Laoghaire	No dedicated team	
Beaumont Hospital	Consultant in Palliative Medicine 1 Junior Registrar 3 Clinical Nurse Specialists 1 Senior Social Worker 1 Grade 3 Clerical Officer	Full
Connolly Hospital	Consultant in Palliative Medicine (Vacant) 0.5 Registrar (Vacant] 1 WTE Clinical Nurse Specialist 1 Senior Social Worker (Vacant) 1 Grade 3 Clerical Officer	Full
Mater Misericordiae Hospital	Consultant in Palliative Medicine (Vacant) 0.5 Registrar (Vacant) 2 WTE CNSs (Vacant) 1 Social Worker	Full
St James' Hospital	2 Consultants in Palliative Medicine 1 Registrar in Palliative Care Medicine 3 Clinical Nurse Specialists 1 WTE Social Worker Secretary (Half-Time)	Full

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Acute general hospital	Team composition	Team scale
St Luke's Hospital	Consultant in Palliative Medicine Specialist Registrar in Palliative Medicine (8 sessions per week) 2 WTE CNSs Clinical Psycho-Oncologist Access to Physiotherapy, Social Workers, Pastoral Care Also access to Aromatherapy/Complementary Therapy and Dietician	Full
Naas Hospital	1 WTE Clinical Nurse Specialist	Nurse Only
Tallaght Hospital	No dedicated team	
University College Hospital, Galway	Consultant in Palliative Medicine Senior Registrar 3 Registrars 3 WTE CNSs	Partial
Mayo General Hospital	1 Senior Registrar 2 WTE CNSs 1 Senior Social Worker 1 Medical Secretary (Part Time)	Partial
Roscommon County Hospital	1 WTE Clinical Nurse Specialist	Nurse Only
Portiuncula County Hospital	No dedicated team	
Sligo General Hospital	Consultant in Palliative Medicine 1 Registrar 1 WTE Clinical Nurse Specialist	Partial
Letterkenny General Hospital	Consultant in Palliative Medicine 1 Registrar 1 WTE Clinical Nurse Specialist	Partial
Mid-Western Regional Hospital	Consultant in Palliative Medicine (3 sessions) Specialist Registrar input Registrar input 3 WTE CNSs	Partial
Nenagh Hospital	1 WTE Clinical Nurse Specialist	Nurse Only
Ennis Hospital	1 WTE Clinical Nurse Specialist	Nurse Only
St John's Hospital, Limerick	1 WTE Clinical Nurse Specialist	Nurse Only
Portlaoise General Hospital	No dedicated team	
Mullingar General Hospital	No dedicated team	

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Acute general hospital	Team composition	Team scale
Tullamore General Hospital	No dedicated team	
Our Lady of Lourdes, Drogheda	Consultant in Palliative Medicine 2 Clinical Nurse Specialists 1 SHO 1 Administrator Shared Medical Social Worker from HCT	Full
Cavan General Hospital	Consultant in Palliative Medicine 0.5 WTE Clinical Nurse Specialist	Partial
Louth County Hospital, Dundalk	No dedicated team	
Monaghan General Hospital	No dedicated team	
Our Lady's Hospital, Navan	No dedicated team	
Waterford Regional	Consultant in Palliative Medicine 1 SHO 1 Registrar CNS 1 WTE 1 Secretary	Partial
St Luke's Hospital, Kilkenny	Consultant in Palliative Medicine 1 Registrar CNS 1 WTE	Partial
South Tipperary General Hospital, Clonmel	Consultant 1 day/month CNS 1WTE	Partial
Wexford Hospital	Consultant 1 day/month CNS 1 WTE 1 Specialist Registrar	Partial
Cork University Hospital	Consultant in Palliative Medicine 3 WTE Clinical Nurse Specialists Social Worker (Shared) 1/3 WTE Secretary	Full
Mercy University Hospital, Cork	1 WTE Clinical Nurse Specialist	Nurse Only
South Infirmary Victoria, Cork	1 WTE Clinical Nurse Specialist	Nurse Only
Bantry General	Consultant in Palliative Medicine 1 WTE Clinical Nurse Specialist	Partial
Kerry General	Consultant in Palliative Medicine 2 NCHDs 1 Social worker 1 Physiotherapist	Partial
Mallow General	No dedicated team	

APPENDIX 3

OVERVIEW OF BEDS AVAILABLE FOR PALLIATIVE CARE IN COMMUNITY HOSPITALS AND OTHER INSTITUTIONS ('LEVEL 2 BEDS')

Appendix 3

Overview of beds available for palliative care in community hospitals and other institutions (Level 2' beds).

Institution name, location and health board area summary	Category and total number of level 2 institutions	Family room?	Number of dedicated beds for palliative care	Number of palliative care patients 2004
Wicklow District Hospital	District Hospital	Yes	1	10
St Coleman's, Rathdrum	District Hospital	Yes	1	10
East Coast Area (ERHA), 2004	2	Yes : 2 No: 0	2	20
0	0	n/a	n/a	a/a
Northern Area (ERHA), 2004	0	n/a	n/a	n/a
St Brigid's Hospice/Drogheda Memorial Hospital, Kildare	Hospice Unit	Yes	6	62
South West Area (ERHA), 2004	1	Yes: 1 No: 0	6	62
Aras Mhuire, Tuam	Community Nursing Unit	Yes	2	0
Sacred Heart Hospital, Castlebar	Long-stay Geriatric	Yes	2	0
Aras Deirbhle, Belmullet	Community Hospital	Yes	1	2
District Hospital, Ballina	Community Hospital	Yes	2	26
Western Health Board, 2002	4	Yes: 4 No: 0	7	28
Our Lady's Hospital, Manorhamilton	Community	Yes	0	24
St Patrick's Hospital, Carrick-on-Shannon	Community	Yes	0	6
Sheil Hospital, Ballyshannon	Community	Yes	2	5
Carndonagh Community Hospital	Community	Yes	2	15
Falcarragh Community Hospital	Community	Yes	1	6
Ramelton Community Hospital	Community	No	0	10
St Joseph's Hospital, Stranorlar	Community	Yes	3	2
Dungloe Community Hospital	Community	Yes	2	22
Lifford Community Hospital	Community	Yes	0	1

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Institution name, location and health board area summary	Category and total number of level 2 institutions	Family room?	Number of dedicated beds for palliative care	Number of palliative care patients 2004
Donegal Community Hospital	Community	Yes	2	7
Killybegs Community Hospital	Community	Yes	2	18
North-Western Health Board, 2004	11	Yes: 10 No: 1	14	116
Roscrea	Community	Yes	2	31
Thurles	Community	Yes	2	14
Nenagh	Community	Yes	2	5
Kilrush	Community	Yes	2	0
Raheen	Community	Yes	2	0
Cahercalla	Community	No	7	56
Ennistymon	Community	Yes	2	8
Mid-Western Health Board, 2001	7	Yes: 6 No: 1	19	114
Abbeyleix (Care Centre)	District Hospital	No	1	5
Mountmellick	Hospital (Care Centre)	Yes	3	25
Portlaoise	General Hospital	Yes	1	0
Birr	Community Nursing Unit	Yes	1	9
Edenderry	Community Nursing Unit	Yes	1	14
Tullamore	General Hospital	Yes	1	0
Athlone District Hospital	Care Centre	Yes	1	9
Killucan	Nursing Home	Yes	2	10
Longford: St. Josephs District Hospital	Care Centre	Yes	1	17
Midland Health Board, 2004	9	Yes: 8 No: 1	12	89
Cavan: St Christopher's Unit	Hospice	No	2	No data
Louth	County Hospital	No	1	8
North-Eastern Health Board, 2004	2	Yes: 0 No: 2	3	8

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Institution name, location and health board area summary	Category and total number of level 2 institutions	Family room?	Number of dedicated beds for palliative care	Number of palliative care patients 2004
Castlecomer	**District Hospital**	Yes	1	No data
Carlow	**District Hospital**	**Yes**	2	No data
Tipperary: Clogeen	**District Hospital**	No data	1	No data
Carrick-on-Suir	**District Hospital**	**Yes**	1	**No** data
Tipperary Welfare Home	**Welfare** Home	**Yes**	1	No data
Gorey	**District Hospital**	**Yes**	1	No data
Knockeen Nursing Home	Nursing Home	No data	2	24
South-Eastern **Health Board, 2004**	**No data: 2**			
Middleton	**Community Hospital**	**No**	**0**	3
Youghal	**Community Hospital**	**No**	**2**	16
Macroom	**Community Hospital**	**Yes**	**0**	1
Bandon	**Community Hospital**	**No**	**1**	1
Kinsale	**Community Hospital**	**No**	**1**	3
Fermoy	**Community Hospital**	**Yes**	**4**	7
Kanturk	**Community Hospital**	**Yes**	**1**	9
Millstreet	**Community Hospital**	**No**	**1**	1
Clonakilty	**Community Hospital**	**No**	**2**	1
Skibbereen	**Community Hospital**	**No**	**2**	9
Schull	**Community Hospital**	**No**	**1**	2
Dunmanway	**Community Hospital**	**No**	**1**	0
Castletownbere	**Community Hospital**	**No**	**2**	7
Caherciveen	**Community Hospital**	**Yes**	**2**	8
Dingle	**Community Hospital**	**Yes**	**1**	9
Kenmare	**Community Hospital**	**No**	**2**	15
Killarney	**Community Hospital**	**No**	**3**	28
Listoweh St Columbanus Home	**Community Hospital**	**No**	**2**	5
Southern Health Board, 2004	**18**	**Yes: 5 No: 13**	**27**	**167**

The Irish Hospice Foundation 1986-2006

The Irish Hospice Foundation's (IHF) vision is that no one should have to face death or bereavement without appropriate care and support. Its mission is to promote the hospice philosophy and support the development of hospice/palliative care throughout Ireland. Over the past 20 years, the IHF has engaged in a wide range of activities. It initially supported service development by providing funding for an Education Centre at Our Lady's Hospice, Harold's Cross, and for the establishment of St Francis Hospice in Raheny. It also supported the introduction of palliative care services in general hospitals in Dublin and Cork.

Bereavement

Work in the area of bereavement is a core activity. Today, the Foundation supports bereavement services in four regions of the country. Its Education & Bereavement Resource Centre, which opened in 2003, includes a specialist reference library in this area. Practical training is provided in the form of workshops and seminars.

Education and Research

IHF education programmes include an NUI-accredited Higher Diploma in Bereavement Studies and a Certificate in Children and Loss, both in association with the Royal College of Surgeons in Ireland. In 2005, the Foundation appointed a Visiting Professor in Hospice Studies in association with UCD and Trinity College Dublin. It also funds and supports academic and professional research.

Development

The IHF undertakes development projects to enhance service provision in different care settings. An example is the *Care for People Dying in Hospitals* project, which was developed together with the Health Service Executive- North Eastern Area. The aim of this flagship project, piloted in Our Lady of Lourdes Hospital in Drogheda, is to enhance the culture of care and organisation around dying, death and bereavement in the general hospital setting. The next step will be a national roll-out of the Hospice-friendly Hospital' programme, currently at planning stage.

Children's Services

The Foundation's work for children has included financing the establishment of the Oncology Nursing Liaison Service at Our Lady's Hospital for Sick Children in Crumlin. It also funds Ireland's first specialist children's palliative care nurse. Following the publication in September 2005 of the report. *A Palliative Care Needs Assessment for Children* (the result of a research project co-funded with the Department of Health and Children), the Foundation is to fund a number of palliative care nursing posts in the community as well as in the new children's hospice being developed at the Children's Sunshine Home in Leopardstown.

Advocacy

Advocacy is an important element of the IHF's role. The organisation works to influence decision makers to implement policies that will deliver hospice services equitably on the basis of need, irrespective of diagnosis or geography. Advocacy means representing people's interests and views: to this end, the Foundation conducted the first ever nationwide public opinion survey on death and dying in Ireland in 2004. In order to support an evidence-based approach to service development and advocacy, the Baseline Study was undertaken in 2005.

Fundraising

The IHF supports the fundraising work of local voluntary hospice groups. It coordinates two of Ireland's best-known annual hospice fundraising events - *Ireland's Biggest Coffee Morning* and *Sunflower Days* It was also instrumental in Tesco Ireland's adoption of hospice services nationwide for its Chanty of the Year' fundraising programme in 2005. Unique fundraising initiatives developed by the Foundation and its supporters on its own behalf have included the popular *Whoseday Book, Art-.pack* and the *Peter and The Wolf bookCV.*

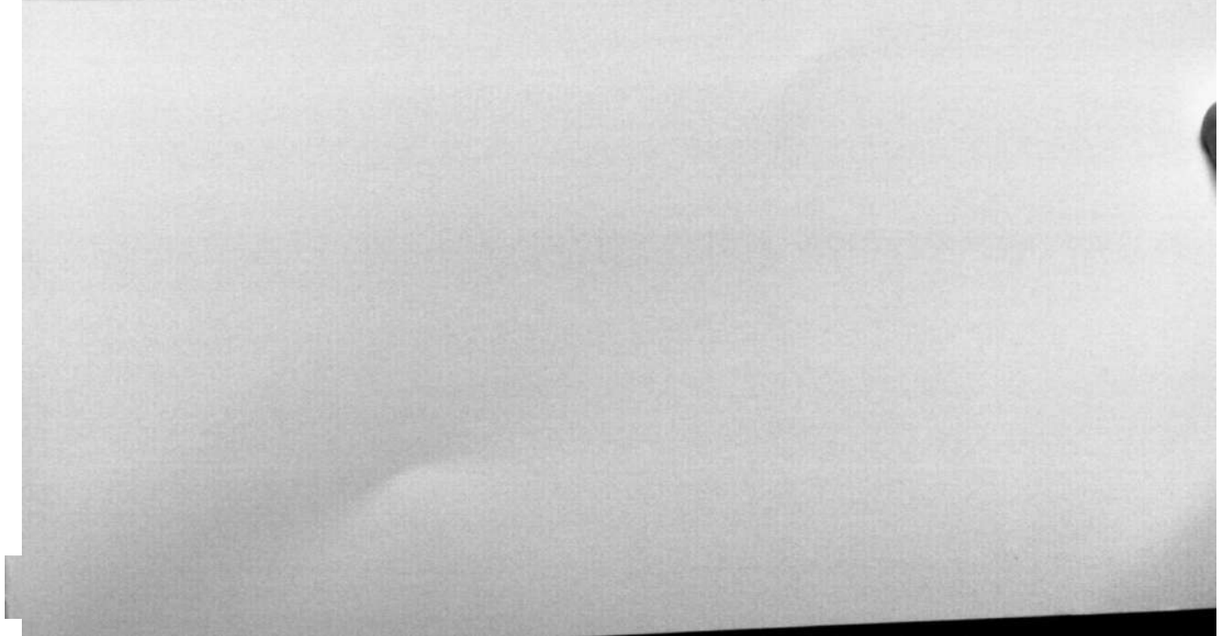
THE IRISH HOSPICE FOUNDATION

A BASELINE STUDY

ON THE PROVISION OF

HOSPICE/SPECIALIST PALLIATIVE CARE SERVICES

IN IRELAND



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