



Milford Care Centre

(Under the auspices of Little Company of Mary)

**HSE Mid West
Community Healthcare**



**Ospidéal OL
UL Hospitals**

Working together, caring for you

Mid-West Palliative Care Strategy (2021 – 2025)

'All services working together for persons with life limiting conditions'

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1. Foreword

CEO, Milford Care Centre (Pat Quinlan)



The focus of this Mid-West Palliative Care Strategic Plan is on ensuring ***“All services in the Mid-West working together to care for persons with life limiting conditions”***. It is based on the premise of all relevant services taking collective responsibility and collaborating together to ensure accessible, integrated and appropriate palliative care services, regardless of setting. It seeks to ensure that the care provided is always fully patient and family centred at what is a very challenging time in peoples' lives.

We are fortunate in the Mid-West that a very strong statutory/voluntary partnership has been formed between the HSE and Milford Care Centre down through the years, with the support of other key agencies/voluntary partners across the Mid-West.

This Strategy builds on the success of the 2013 to 2017 Strategic Plan which saw the completion of a new 34 bed Specialist In-patient Unit in Milford Care Centre in February 2018 to serve Clare, Limerick and North Tipperary. This also resulted in a targeted expansion of the Centre's broad range of education programmes, which are proving an invaluable resource to frontline staff across all agencies in ensuring the adoption of the palliative care approach in all clinical practice.

While it is acknowledged that the previous strategy was a success, the healthcare landscape, as seen in the analysis section of the Report, has changed and will continue to change very significantly, even in the short to medium term. This is due to the increased prevalence of chronic disease, cancer incidences and an aging population. These changes combined will present challenging circumstances and significant demands on existing palliative care services. Most of the population now live longer than ever before but increasingly more of us, as we age, will live with the consequences of higher risk of developing chronic conditions. Therefore, the provision of adequate and responsive good quality and safe palliative care is important to all of us now and into the future.

The aim of this Strategy is to develop collaborative processes and practices across all agencies and with the support of local communities, to provide an improved and evolving palliative care service that meets the needs of individuals and their carers, regardless of care setting. Its overriding and critical objective is to ensure seamless care pathways across community services, acute hospitals, the specialist palliative care in-patient unit, day care services, nursing homes and all other care settings eg. intellectual disability residential centres etc.

The focus of this strategy initiative was to:

- ***Identify the gaps that exist in the current level of service provision***
- ***Take cognisance of national and international best practice***
- ***To present a set of strategic objectives/outcomes which will drive required actions over the next five years and to seek to do so within available resources***

1. Foreword (cont'd.)

CEO, Milford Care Centre (Pat Quinlan)

In order to achieve these objectives a Working Group, with representations from HSE/MCC was appointed and assigned the task of overseeing the compilation of this Report (see *appendix 9*). In addition a Project Team was also set up to support the Working Group in its work (see *appendix 9*). I would like to take the opportunity to express my gratitude to both Groups for their commitment, efforts and high levels of enthusiasm demonstrated throughout this whole process.

The active consultation across all key services provided valuable insights about how this Strategy covering the next five years should give effect to its agreed Vision, offering guidance as to what we should prioritise as outcomes and what we should prioritise as enablers to delivery. The Strategy is built on current and predicted demographics, research and consultation and takes cognisance of service user feedback which also informed other recent national strategies.

The Strategy gives full cognisance for future planning of palliative care service provision in the Mid-West with due consideration to an aging population, a growing demand for services from persons with chronic illnesses and key to this is ensuring optimum collaboration across all services.

The implementation of this Strategy will be challenging and will require strong governance arrangements, ownership and leadership across all service providers in terms of implementing new ways of working but more importantly to ensure we are, together, delivering what our service users require. This Strategy reinforces the need to continue developing the strong partnership arrangements that already exist in the Mid-West.

It is intended that a HSE/MCC governance process e.g. Implementation Committee, will be established to ensure there is a clear line of sight from the high level strategic objectives/outcomes contained in this Strategy, right through to implementation at individual service levels. The very positive nature of engagement from the outset assisted in the formation of this Strategy and the conclusion from this interaction is that there is already widespread commitment to ensuring the successful implementation of same. However, it is also accepted that in order to achieve this, that this will require integrated planning across all services and within an appropriate governance framework.

I would like to thank all those who supported and contributed to this invaluable process which was very much appreciated. I would also like to thank my fellow Co-chair of the Working Group Ms. Kate Duggan Head of Primary Care Services for her key support and commitment to this initiative. In addition, I would like to thank Mr Joe Murphy, Chairperson and the Board of Directors at Milford Care Centre, Ms. Maria Bridgeman, Chief Officer, HSE CHO 3 and Ms Colette Cowan, CEO, UL Hospital Group, for their support and approval of this Strategy.

Arising from my upcoming retirement in April 2021, the Board of Milford Care has confirmed the appointment of Mary O'Brien as my successor. It is highly advantageous that Mary, given her former Senior Management role in CHO 3, contributed to the compilation of this Strategic Plan along the way and is already familiar with its stated vision and objectives covering the next five year period. I have no doubt that Mary will build on the strong partnership foundation built up over many years that underpins the delivery of palliative care service delivery across the Mid-West region and I wish Mary every good wish and success in her future role.

Finally, a word of acknowledgement and thanks to Seamus Woods, Projects Consultant (former Chief Projects Officer, HSE) whose leadership, expertise and commitment facilitated the development of this Strategy within the agreed timeframe. This is a most comprehensive and ambitious Report and we are most grateful to Seamus for his invaluable contribution and also the Mid-West PMO office for supporting him in its compilation.

Pat Quinlan

CEO Milford Care Centre

2. Foreword

Foreword from Chief Officer, Mid-West Community Healthcare and CEO, UL Hospital Group



HSE Mid-West delivers Health and Social Services to the people of Limerick, Clare and North Tipperary.

“All services working together for persons with life limiting conditions” is the Mid West Palliative care five year strategy for the years 2021 to 2025.

In practice this strategy will function as the “roadmap” on which initiatives over the coming years will be developed and implemented. It will underpin and give direction to operational planning and to the implementation and delivery of services until 2025.

This strategy gives concrete expression to the fundamental and shared vision for palliative care services in the Mid West which has been agreed by the key service providers. It also compliments and supports Sláintecare, the National Health Strategy and reinforces the model of care outlined by the National Clinical Programmes in its report “Adult Palliative Care Services Model of Care in Ireland 2019”.

The HSE is delighted to have partnered with Milford Care Centre to take the next steps in delivering high quality palliative care services across the mid-west. This legacy partnership approach has ensured that the people of the Mid West have access to one of the leading centres of excellence for palliative care in Ireland. This strategy will further enhance this approach and sets out a vision that emphasises the importance of:

- ***Public and Staff across all agencies understanding Palliative Care***
- ***Appropriate care being provided by responsive and competent staff***
- ***Timely access to services***
- ***Collaboration and continuity of care***
- ***Availability of a consultant led specialist palliative care service across the entire region***
- ***“Nothing about me without me” in relation to service users and families***

The focus will be on four key areas to deliver on the vision:

- *Equity of access to services across the whole of the mid-west*
- *Collaborative and collective responsibility amongst key partner agencies to ensure “joined up care”*
- *The continued pursuit of international best practice*
- *Ensuring palliative care is understood by everybody - public and all staff.*

The achievement of the vision and outcomes set out in this Strategy is based on certain assumptions and if the circumstances change in any significant way the Strategy will be reviewed and amended if that is appropriate. The advent of Covid 19 has had significant implications for the delivery of all health care services in 2020 and we face into an uncertain future in 2021. All healthcare developments will be reviewed on an ongoing basis in the context of Covid 19.

We would like to take this opportunity to thank all those involved in developing this Strategy and look forward to supporting its implementation in partnership with Milford Care Centre and many stakeholders which will build on the great work already achieved.

We would like to take this opportunity to thank all those involved in developing this Strategy and look forward to supporting its implementation in partnership with Milford Care Centre and many stakeholders which will build on the great work already achieved.

Maria Bridgeman

Chief Officer, Mid-West Community Healthcare

Colette Cowan

HSE UL Hospitals CEO

3. Introduction

3.1. Palliative Care – What is it?

The *World Health Organisation (WHO)* (2014) defines Palliative Care as “an approach that improves the quality of life of individuals and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual”.

In Ireland Palliative Care Services are organised into specialist and non-specialist services that operate in partnership as part of an integrated network of providers. Many people still think of palliative care as a care provided at the very last stage of life, around the time of death. However, in the last twenty years, the scope of palliative care has broadened to provide palliative care at an earlier stage in the disease trajectory. In this model of integrated palliative care provision palliative care is not dependent on prognosis and can be delivered at the same time as curative treatment. *National Clinical Programme for Palliative Care 2018*¹³

Palliative care, both generalist and specialist, is provided in all care settings, including the community, nursing homes, hospitals, and specialist palliative care units. In recent years, the scope of palliative care has broadened so that palliative care is now provided at an earlier stage in the trajectory of both malignant and non-malignant disease.

The key aim of the *Adult Palliative Care Services Model of Care in Ireland – The National Clinical Programme for Palliative Care*¹⁸ is that:

“Every person with a life limiting or life threatening condition can easily access a level of palliative care appropriate to their needs regardless of care setting or diagnosis to optimise quality of life.”

To realise this aim set out in the above Model of Care, the following eight foundations are expected to be in place:

- 1. People with life-limiting or life- threatening illness receive regular, standardised assessment of palliative care need and individualised care plans are co- developed to meet identified need, with the aim of optimising quality of life.**
- 2. Family and carer needs are assessed so that they receive practical, emotional, psychosocial and spiritual support, including into bereavement.**
- 3. An enabling environment is created where hospital, community and primary health care providers are supported to provide a palliative care approach as part of their normal service provision.**
- 4. Access to specialist palliative care is provided for those patients with complex needs and the capability of services is developed.**
- 5. Hospital, community, primary care and specialist palliative care providers are supported to work together to provide an integrated model of care provision.**
- 6. Effective and timely flow of information between hospitals, community, primary health care and specialist palliative care providers is in place, communication is inclusive of patients and carers, where appropriate.**
- 7. A culture of quality improvement is embedded in palliative care provision.**
- 8. A research and innovation agenda that improves the quality and value of palliative care is supported.**

3. Introduction

3.1. Palliative Care – What is it?

In essence Palliative Care should be provided with a person centred approach, respecting needs of Service users, their families and carers and moves beyond a pure clinical response to the assessment and management of symptoms and treatment and includes recognition of emotional, spiritual and psychological circumstances. This is perhaps best encapsulated by a carer of a service user in Milford Care Centre:

PERSONAL:	This is a very personal journey of illness for the patient.
ACCEPTANCE:	Your illness for now is a part of your life and accepting this is very important.
LOVE:	It can be a scary and uncertain time, but we can never underestimate the power of love, from our own family and friends, and the Palliative team.
LIFE:	We may have a life threatening, progressive illness but we still have a life, however changed it has become.
INSIGHT:	A natural deep understanding evolves on this journey. Gratitude for the life we have shared with each other and knowing that we are forever journeying in the cycle of life.
ALLOWING:	Allow yourself to just be and know you are understood.
TREATMENT:	You may have a medical treatment plan, but the emphasis on Palliative Care is a holistic and sometimes a spiritual environment, both for the patient and the family.
INFORMATIVE:	Knowledge is power and the information given to the patient is given to empower the patient, thus allowing a support system to be put in place. Recognising what support is needed by both patient and family.
VULNERABILITY:	We all feel vulnerable and afraid when dealing with illness. The family is fearful for the patient. The Palliative team approach is one of understanding and support. Recognising what is needed to strengthen this support.
EMPATHY:	To be understood and to be heard are hugely important to the patient. The holistic approach ensures you are understood, even when words cannot be found.

In the Mid-West Specialist Palliative Care Services (SPC) provided through Milford Care Centre are a valued asset in the community and has a strong reputation for its professionalism, compassion, leadership and education/training provision.

3. Introduction

3.2. Background to Strategic Plan

One of the key strengths in the Mid-West has been the genuine partnership approach between the HSE and Milford Care Centre, in conjunction with other key voluntary organisations and as a result there has been significant development in Palliative Care services across the Region. Following the success of previous joint Strategic Plans (2004 – 2011) and (2013 – 2017), Palliative Care services have for many years championed holistic approaches to care and delivered integrated services across hospital and community settings. Much impetus for this work has come from Milford Care Centre, with the development of creative partnerships with the HSE and community/voluntary sector organisations, working together to design, develop and deliver services.

As the Mid-West now moves into a new strategic phase, a number of key policy directions will guide the approach to the development of a new Palliative Care Strategy for the region.

- *The HSE's Palliative Care Services Three Year Development Framework (2017 – 2019)*⁶ continues to build on the *Report of the National Advisory Committee on Palliative Care (2001)*⁴, which has been the foundation stone for the provision of Palliative Care Services in Ireland. The Framework highlights some of the challenges facing palliative care services going forward: Ireland's ageing population, a growing demand for services, issues of access and the need to provide services close to home and to seek integration across all settings.
- The latter challenges are particularly targeted in the *Committee on the future of Healthcare - Sláintecare Report (May 2017)*⁸ which quotes the Irish Hospice Foundation "One of the main challenges is to "join the dots" – to coordinate, replicate, progress and embed innovative, evidence-based solutions to issues which arise in care of the dying and the bereaved".

- The aim of the *Adult Palliative Care Services Model of Care in Ireland – The National Clinical Programme for Palliative Care*¹⁸ is that "Every person with a life limiting or life threatening condition can easily access a level of palliative care appropriate to their needs regardless of care setting or diagnosis to optimise quality of life."
- *The National Cancer Strategy (2017-2026)*⁷ emphasises the key issue of access and the necessity to "continue to develop our national services in order to ensure that all people with cancer, who have palliative care needs, including a small cohort of children, can readily access appropriate services".
- One of the key policy developments to deliver on integrated care is the HSE's drive to set up 97 Community Health Networks (CHNs) across the country (8 in the Mid-West) which will "enable integration for all services for a local population". *Community Healthcare Organisations – Report and Recommendations of the Integrated Service Area Review Group HSE 2014*²⁰

All of the above national policy directions have informed an integrated approach to delivery in the Mid-West and are addressed in this new Strategy.

In the context of the above challenges, Mid-West Community Healthcare and Milford Care Centre agreed to jointly develop a 5 year Strategic Plan (2021 – 2025) for Palliative Care Services in the Mid-West, which will endeavour to sustain the existing focus and commitment to excellent palliative care services, but also to ensure that services can respond to the demographic challenges and to build networks and linkages across the health system so that palliative care continues to be an "active and total approach to care from the point of diagnosis through to death and beyond." *HSE Palliative Care Services Three Year Development Framework (2017 -2019)*⁶.

3. Introduction

3.2. *Background to Strategic Plan*

The challenge of continuing to improve Palliative Care services demands comprehensive responses. This Strategic Plan outlines how all service providers in the Mid-West can work together to achieve this and places huge value on the necessary collaborative partnerships to make this happen. Planning to meet the increase in demand presents a series of challenges which include the community's expectations of access to quality palliative care services, particularly for the growing population of older persons who increasingly are living alone and with fewer available family members able to provide support.

Note: It should be noted that palliative and end of life care for children is not within the scope of this strategy, given the very specialised needs in this area.

3. Introduction

3.3. Broad approach to developing strategy

The strategy planning process was led by an interagency Working Group (See Appendix 1 for membership) who were responsible for articulating the approach taken to developing the strategy, committing staff to key project team/sub groups, establishing a programme schedule and approving a draft plan.

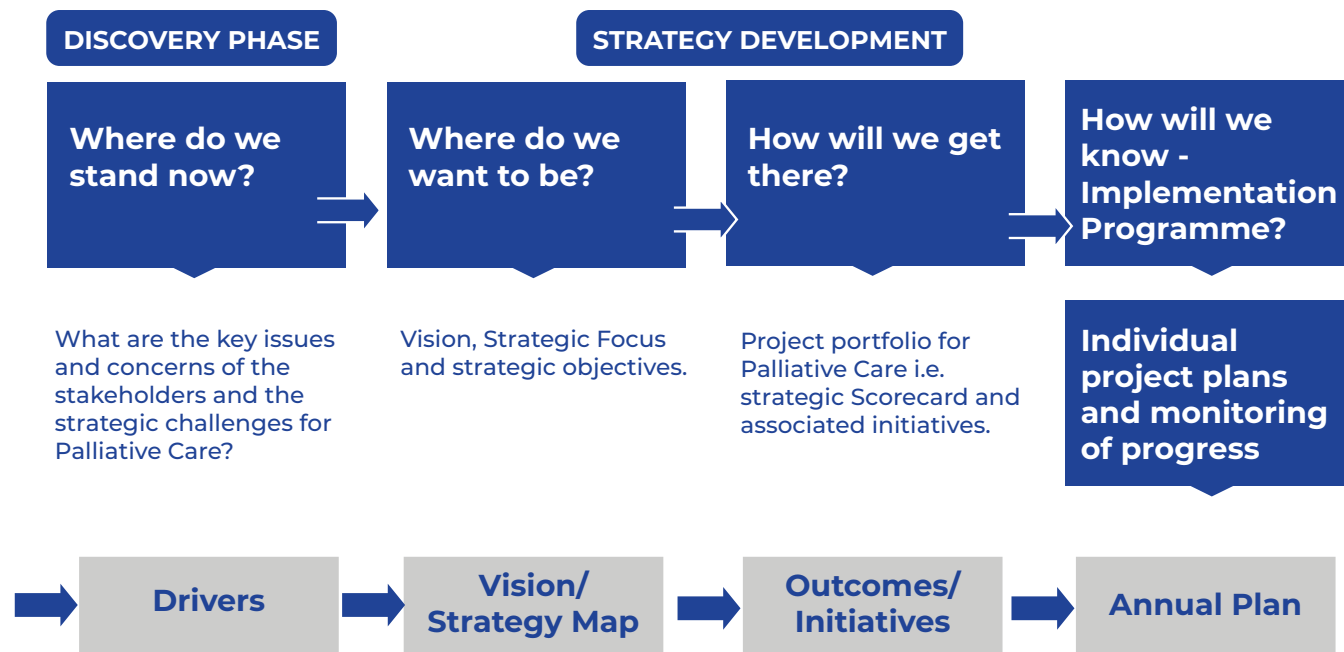
The following broad approach was agreed (see Appendix 2 for a more detailed view)

Discovery Phase

The Discovery Phase includes an examination of the current state of Palliative Care services in the Mid-West, and a consideration of the key requirements for the future, including getting key insights about the future landscape. It was carried out through comprehensive stakeholder engagement, use of environmental and data analysis tools.

The details and the conclusions of the Discovery Phase are set out in the next chapter.

MID-WEST PALLIATIVE CARE STRATEGY DEVELOPMENT PROCESS



3. Introduction

3.3. Broad approach to developing strategy

Strategy Development

The Mid-West Palliative Care Strategic Framework, set out below, is based on the original Kaplan and Norton Strategy Mapping and Balanced Scorecard work and the more recent work of the Balanced Scorecard Institute in its 2016 publication *The Institute Way*².

The figure below illustrates the major components of an Integrated Strategic Planning and Management Framework for Palliative Care for the Mid-West, based on the above methodologies. It has been used to draft a strategy to achieve a 5 year strategic vision for Palliative Care services in the Mid-West and also to translate the intent into executable and measurable actions in the form of a Strategic Plan and measureable Palliative 'score cards'.

This approach ensures a regular feedback loop by way of performance/ achievement of strategic outcomes that will facilitate a regular review of progress and opportunities to revise and revalidate the strategic direction over the 5 year period.

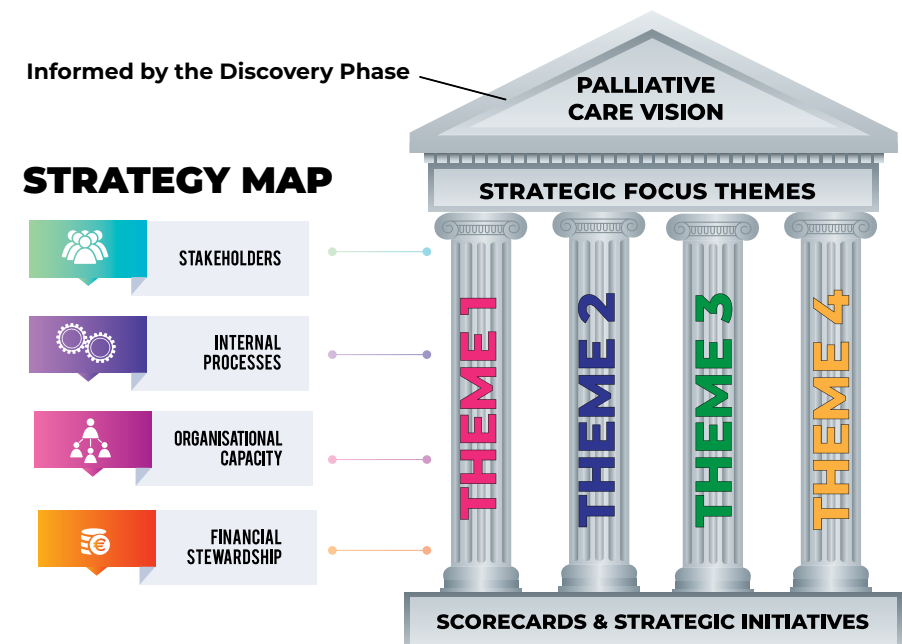
The following diagram sets out the key components of the Palliative Care Strategic Framework

- **A Palliative Care Vision** is the strategic roof of the Framework, informed by the enablers and challenges from the Discovery Phase
- **Strategic Themes** are the key focus areas and the key pillars of the strategy itself
- **The Palliative Care Strategy Map** sets out the key objectives that must be achieved to deliver on the Vision and are representative of the key perspectives of the Palliative Care services across the agencies

- **The foundation of the Framework** are a set of **scorecards/enablers** that represent success measures and initiatives that will achieve each objective of the Palliative Care Strategy Map
- **A monitoring and feedback system** to ensure that progress, when tracked will indicate whether or not there is a need to take corrective action

This step by step approach tightly aligns the Palliative Care Vision to the strategic focus areas, the themes to actionable strategic objectives and objectives to success measures and initiatives. The summary "scorecards", seen in a later chapter will show visually and logically how the outputs from each step connect to each other.

The Framework as applied to the Mid-West will be described in the next chapter.



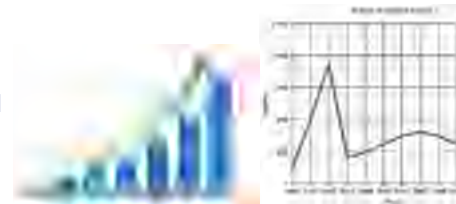
4. Discovery Phase

The Discovery Phase comprised the review and analysis of the current performance of Palliative Care services across the Mid-West. This phase was structured around a number of key steps:

- A review of data for Mid-West, including demographic and key service data.
- An environmental scan by way of a SWOT analysis and interviews with key stakeholders as it relates to the internal and external perception and consideration of what has already been implemented and works well.
- A review of National Strategies and key research papers.
- An assessment of service user/carer feedback re expectations.
- A review of the previous Mid-West Palliative Care Strategy 2013 – 2017.

In essence the Discovery Phase includes an examination of the current state of Palliative Care in the Mid-West, and a consideration of the key requirements for the future, including any key insights about the future landscape.

Data Review



Research National Strategies/Policies

SWOT Analysis Matrix

	Positives	Negatives
Internal Factors	STRENGTHS	WEAKNESSES
External Factors	OPPORTUNITIES	THREATS



Service User/Carer Feedback

4. Discovery Phase

4.1 *Conclusions from Discovery Phase*

Appendix 3 sets out the detailed summary findings from the Discovery Phase and clearly outlines that the Palliative Care needs within the Mid-West are changing and will change further. Demands on our Palliative Care Services at all levels are increasing. Therefore the way we approach Palliative Care Services must change as people are living longer, getting older and there are many more service users with a chronic disease who will require support in a palliative way. These service users will need support to manage their condition, improve their quality of life and help to live in an appropriate environment.

Providing suitable care will mean providing more proactive Palliative Care Services across community services and hospitals and enhancing services in local communities. These challenges are not unique to the Mid-West but Milford Care Centre has made much progress in Palliative Care Services over the years by working in a partnership way and there is now an opportunity for the Mid-West to take a lead role to continue to focus on tackling these challenges and work in an innovative way. People needing palliative care must be sure of having received the best possible joined up care and this needs to happen across all services in the Mid-West.

Figure A overleaf highlights a number of key issues:

- ***An increase in demand due to an ageing population and increase cancer incidences***
- ***The need to increase uptake of Palliative Care training/education for generalist staff across Hospital and Community Services***
- ***The requirement to maximise joined up care for service users, through an integrated network of services***
- ***To ensure appropriate use of Palliative Support Beds across the Mid-West***
- ***Maximise co-terminosity of services across agencies to support integration***
- ***Eliminate funding gap for Section 39 Specialists Palliative Care Providers such as Milford Care Centre***

As stated above, Appendix 3 sets out the detailed findings from the demographic/data review, SWOT Analysis, Research, Assessment of Service Users/Carer feedback and the review of the previous Mid-West Palliative Care Strategy. The following pages however highlight the key

- ***Enablers***
- ***Challenges***
- ***Lessons Learned***

that emerged during the discovery process and provided a key input into the Strategic Approach taken and the subsequent Strategy concluded by the Working Group.

4. Discovery Phase

4.1 Conclusions from Discovery Phase

HOWEVER, findings from DISCOVERY PHASE presents a compelling and shared CASE FOR CHANGE

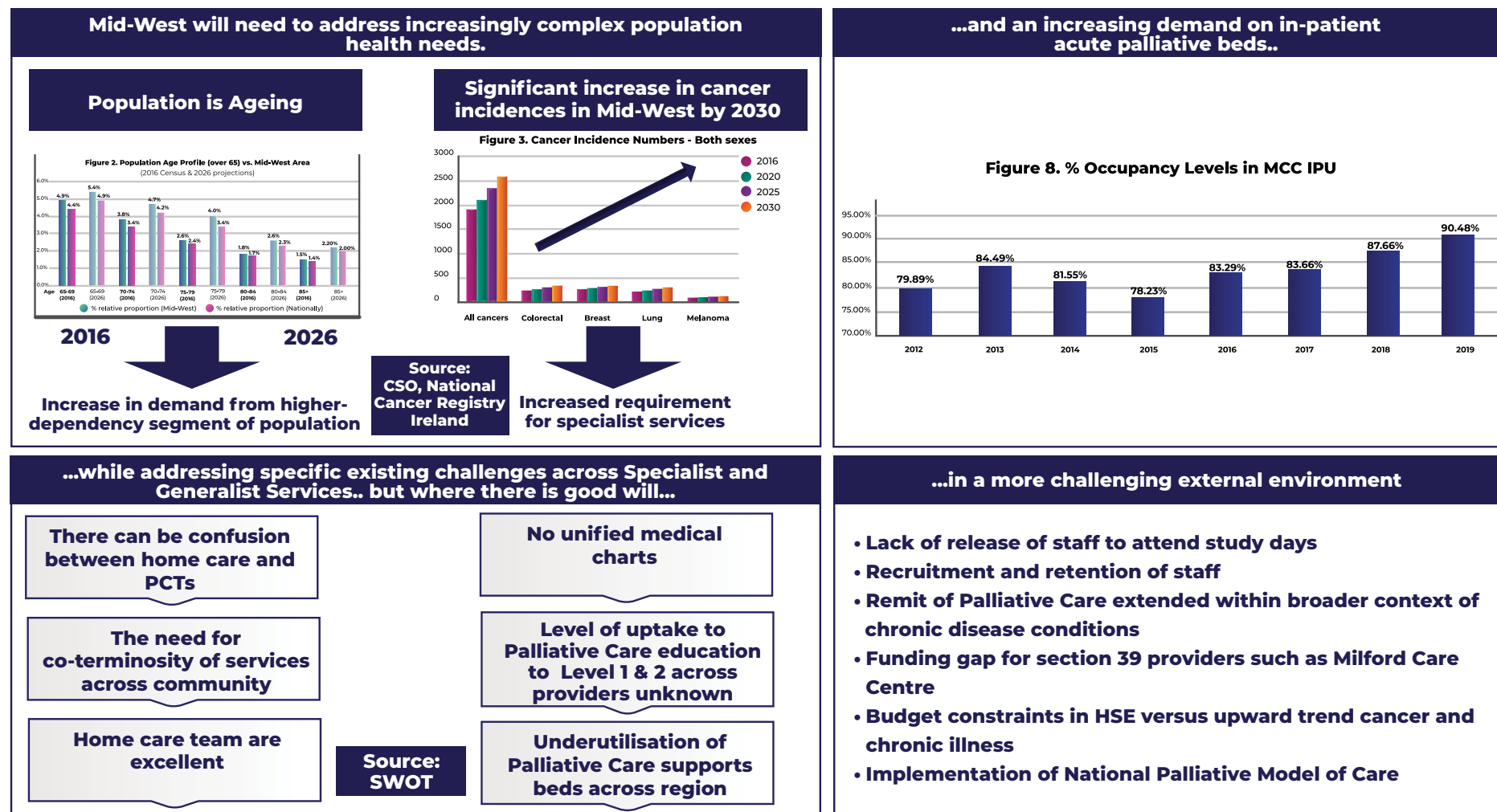


Figure A

4. Discovery Phase

4.1 *Conclusions from Discovery Phase*

ENABLERS

- Clearly the Mid-West has established a well-regarded palliative care sector. With Milford as its centre of excellence, the service has championed holistic approaches to care and working with the HSE and other agencies across “in hospital” and “out of hospital” settings to provide integrated services.
- A history in the Mid-West of strong interagency leadership and co-operation that supports strategic direction and governance
- At service level clinicians have built good relationships and provided good collaborative support to one another.
- During the stakeholders engagement process there was a clear appetite expressed across stakeholders to enhance collaborative ways of working to maximise use of existing resources at a time of growing demand and to enhance joined up care for the service users
- Milford has established itself as a lead provider in palliative care education and also as a collaborator in research
- Milford has a strong reputation for its expertise, professionalism and education support
- Sláintecare and the roll out of the National Model of Care for Adult Palliative Care services in Ireland may present opportunities to further develop approaches across the spectrum of services
- The ability to increase capacity in the IPU at Milford at an early stage (subject to funding) to meet increasing demand

4. Discovery Phase

4.1 *Conclusions from Discovery Phase*

CHALLENGES

- The remit of palliative care has been extended within the broader context of chronic disease conditions
- With people living longer, with a substantial increase in over 80's cohort of population and an increase in the prevalence of chronic disease, this will place greater demand on palliative care services. This is already been seen with an increasing demand on specialist services at inpatient unit level and on community services
- Access to services both from a geographical and service perspective will be challenging in the current and pending funding environment
- The extension of the remit of palliative care across the chronic disease spectrum has implications for the skill set of staff in the SPC services who will be dealing with a broad range of chronic diseases.
- Release of staff to do Palliative Care training/education
- The funding model for Milford (as with other hospices) as a Section 39 provider has significant implications for core funding and ability to continue developing as a leading centre of excellence in Ireland.
- The continued stigma and fear of palliative care amongst the public and communities needs to be addressed so palliative care approach is integrated at the earliest stage of diagnosis
- To achieve integration and a continuum of care across service providers in a timely fashion is critical
- An increasing regulatory framework will present new challenges going forward for service providers
- To continue to put the service user/carers/families at the centre of decision making
- There is an increasing competitive environment in recruiting staff, especially in current funding environment

4. Discovery Phase

4.1 *Conclusions from Discovery Phase*

LESSONS LEARNED

- Each service provider will have to view itself as a piece of an integrated network, with a particular role in order to maximise joined up care. Enhanced timely information sharing is required to support this, including improved hand off points
- The Mid-West needs to be in a position to manage a substantial increase in demand for quality palliative care services, given the changing demographics, especially relating to over 80's
- Given the increase in demand and scope of palliative care going forward, the current overall service model will require a refocus so that existing care services are in a position to embrace more of a palliative approach (at level 1 & 2) on a day to day basis and allow the SPC services to work with the most complex cases
- With increasing demand to provide services in the “home” or “close to home” , innovative solutions will need to be found to ensure equitable access to services across the geographical extent of the Mid-West
- There is a need to harness and enhance information and communication technology, including improving electronic literacy, to improve process and clinical integration
- Service users/carers must be central to decision making and care choices
- Service users expect continuity of care from service providers, including bereavement support / counselling, where appropriate
- Continued “joined up” leadership and governance across the agencies is vital going forward
- The value of learning from National and International research to inform best practice and initiatives to be undertaken
- Vital that Milford remains as a leading centre of excellence with the education and specialist capacity to support other providers in the Mid-West
- Co-terminosity of services to support interaction of services, including involvement with local communities
- Staff must be facilitated to attend courses to increase skill sets and competencies across all settings

5. Strategic Direction

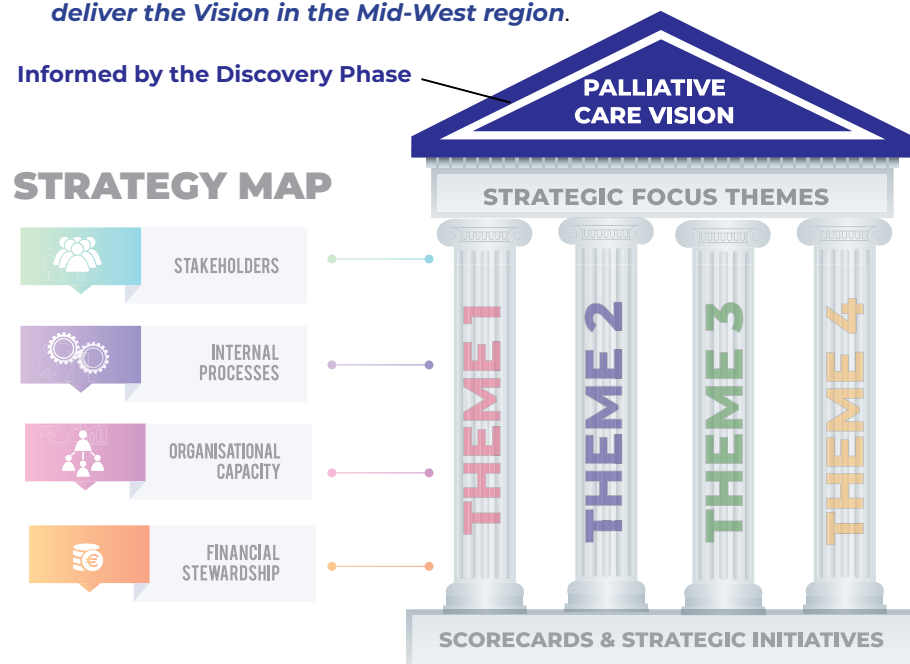
5.1 Introduction

Section 3 sets out the high level Mid-West Palliative Care Strategic Framework that was used to guide the development of the strategy. The *Institute Way*² defines the strategy as positioning choices made (the path) and actions taken (the plan) to move the organisation from its current state to some desirable future stage.

This section describes the strategic focus (the path) for the Mid-West in relation to Palliative Care Services. This “path” comprises of 2 key components:

- ***The Mid-West Palliative Care Vision***
- ***The Strategic Themes i.e. key focus areas to deliver the Vision in the Mid-West region.***

Informed by the Discovery Phase



5.2 Mid-West Palliative Care Vision

The Vision for Palliative Care Services creates a picture of a successful future through a vivid, compelling statement that creates a sense of urgency and hopes to emotionally inspire people to carry it out. It clearly strives to meet the old meaning of “Begin with the end in mind”.

Following many iterations the consultative process has teased out and given form to this Vision. This included many discussions on findings from the following:

- ***The issues arising from the SWOT***
- ***The assumptions arising from the data analysis***
- ***Analysis of trends, best practice and service user expectations***

5. Strategic Direction

5.2 Mid-West Palliative Care Vision

The Vision is framed by the following key questions:

- *What is the ideal picture of Palliative Care in the Mid-West 5 years from now?*
- *How will successful attainment affect service users and staff?*
- *How will we define success after 5 years – what will it feel like, look like etc.?*
- *How will it be measured?*

The approach taken by the Working Group was to develop a short vision statement and a longer supporting 'picture' of the future that was measurable.

This Vision is now a description of the purposes we share in the Mid-West and the expectations with which the overall strategy was formed.



5. Strategic Direction

5.3 Strategic Themes

In developing the critical strategic focus for the strategy, the Working Group set out 4 high level themes that will drive the Vision, are complimentary and reflect internal and external considerations. In essence if we are to be successful in achieving our Vision for Palliative Care in the Mid-West, what are the key areas we need to focus on.

In determining the Themes, the Working Group looked at the following:

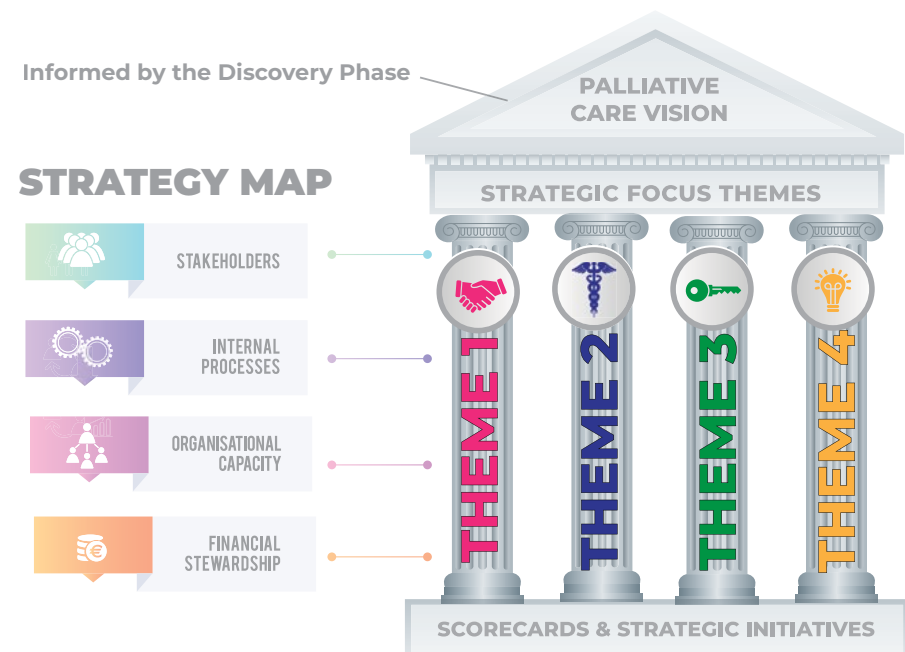
- **High level outcomes from Vision**
- **Interpretation of the Discovery phase**
(SWOT, Data, service user feedback etc.)
- **The type of relationship that service users and carers want**
- **Being cognisant of certain level of 'unknowns' in terms of funding and demand**

The Themes selected will focus effort on the key issues that matter most to deliver on the Mid-West Vision for palliative care, cognisant on the challenges and opportunities from the Discovery phase. Each Theme is a 'Pillar' of the Strategy and has its own high level outcomes that we want to achieve. In essence the Themes can be seen as the 'value gap' between the Mid-West Vision and the current reality i.e. our findings from the Discovery phase.

The 4 themes, agreed by the Working Group to drive the development of the Strategy are:

- 1. Collaboration & Collective Responsibility**
- 2. Pursue International Best Practice**
- 3. Equity of Access to Services**
- 4. Palliative Care is Understood by Everyone**

The following sets out each Strategic theme and associated high level outcomes.



5. Strategic Direction

5.3 Strategic Themes



THEME 1

COLLABORATION & COLLECTIVE RESPONSIBILITY

- Improve shared care and transition arrangements across providers to reflect complexity and overlap in responsibilities.
- With the patient at the centre, providers will work together to pro-actively manage people with palliative care needs within the appropriate setting.
- Enable patients to be discharged to a setting of their choice but appropriate to their needs.
- The establishment of more formal links between care providers so that when a service users condition becomes more complex there will be clarity on how to access specialist skills as close to the community as possible.
- Improved linkages with GPs and PHNs through Community Network Concept (CHNs).
- The capacity and potential of local people and communities to support the Palliative approach will be harnessed.



THEME 2

PURSUE INTERNATIONAL BEST PRACTICE

- Demonstrate knowledge and learning from PCOC (Palliative Care Outcome Collaborations) to improve service quality.
- Service users and public will be confident that we are practicing evidence-based care and committed to the pursuit of excellent care.
- Continuous improvement in relation to service user outcome measurement and reporting.
- Service users/carers are enabled to have a voice and are involved in the design and delivery of care ("nothing about me, without me") and to ensure that services are culturally appropriate.
- Staff will have the required competencies to work as part of SPC multidisciplinary teams.
- Continual use and prevalence of clinical decision tools (practice guidance, protocols, clinical standards) etc. based on best available evidence.
- Continuous professional development across all disciplines to support service delivery.
- Provision of formal/informal education support by SPC services will be expanded.
- Incorporation of advanced practice roles across disciplines.

5. Strategic Direction

5.3 Strategic Themes



THEME 3

**EQUITY OF
ACCESS TO
SERVICES**

- There will be a coordinated and appropriate response to urgent clinical need across settings based on patient need.
- Improved “signposting” of services and greater support for people navigating the system.
- With relevant consent, appropriate information will be visible to all care professionals involved in providing Palliative Care.
- All Community Services will be built around co-terminus local networks of circa 50k, as set out by the HSE in order to facilitate access to and “partnering” of services at a local level.
- Families will have access to bereavement supports within their local communities.
- Increase opportunity for people who want to receive end of life care at home.



THEME 4

**PALLIATIVE CARE IS
UNDERSTOOD
BY EVERYONE**

- Increase the awareness of Palliative Care amongst the public.
- The public perception of Palliative Care is acknowledged and there will be a targeted response to change and allay the mind-set of people.
- Education of the public, patients and healthcare providers will be seen as paramount by organisations in order to integrate Palliative Care at the early stages of diagnosis.
- Palliative Care teams will be seen as “advocates” for better quality of life within healthcare.
- Palliative Care will be seen as an important part of the work of healthcare professionals and they will feel confident in the core skills required of them. These skills will be available within all services.

6. Mid-West Palliative Care Strategy

6.1. Introduction

In the era of knowledge workers, strategy must be performed at all levels of the organisation or across organisations. In that context a change in strategic direction usually requires some form of behavioural change and adopting new ways of doing things. The following approach, by way of developing a Strategy map for Palliative care, allows for a set of 'cause and effect' relationships that can be made explicit and testable over time. In a way it sets out a clear picture (a 1 page strategy) that can be understood by all staff, so there is a common view of how we can further develop palliative care services in the Mid-West.

6.2. Strategy Map

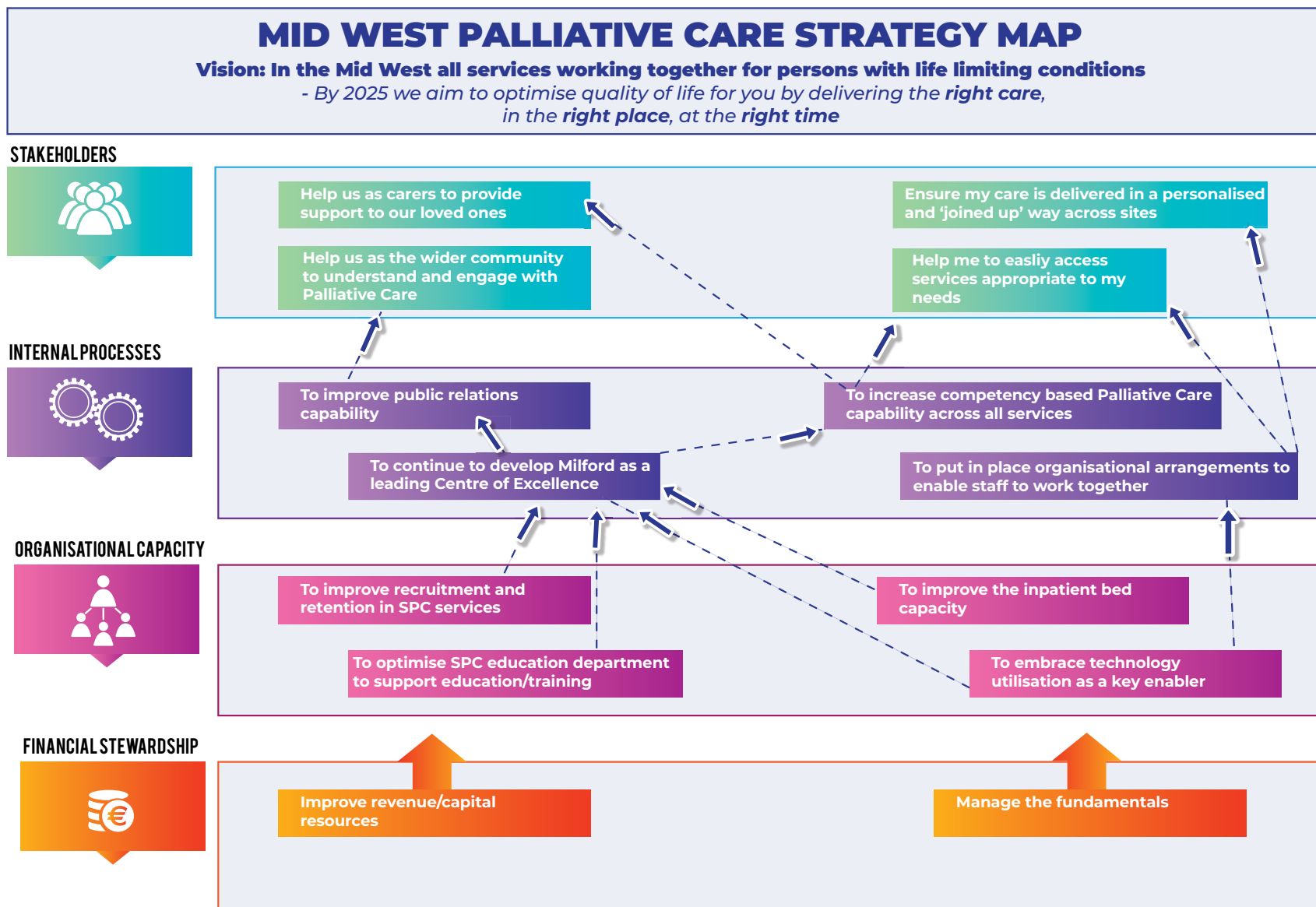
Strategic objectives make strategy actionable across the full extent of an organisation(s) and when "linked" together, as a chain of objectives form a Mid-West Strategy Map for Palliative Care.

The Strategy Map highlights the strategic objectives that will deliver on the Palliative Care Vision and become the foundation of the intent of the Strategic Themes, outlined in the previous section. The strategic objectives are the building blocks for the strategic plan, with clear outcome measures of success and actions/initiatives that can be taken forward. The objectives are set out under 4 organisational perspectives:



6. Mid-West Palliative Care Strategy

6.2. Strategy Map

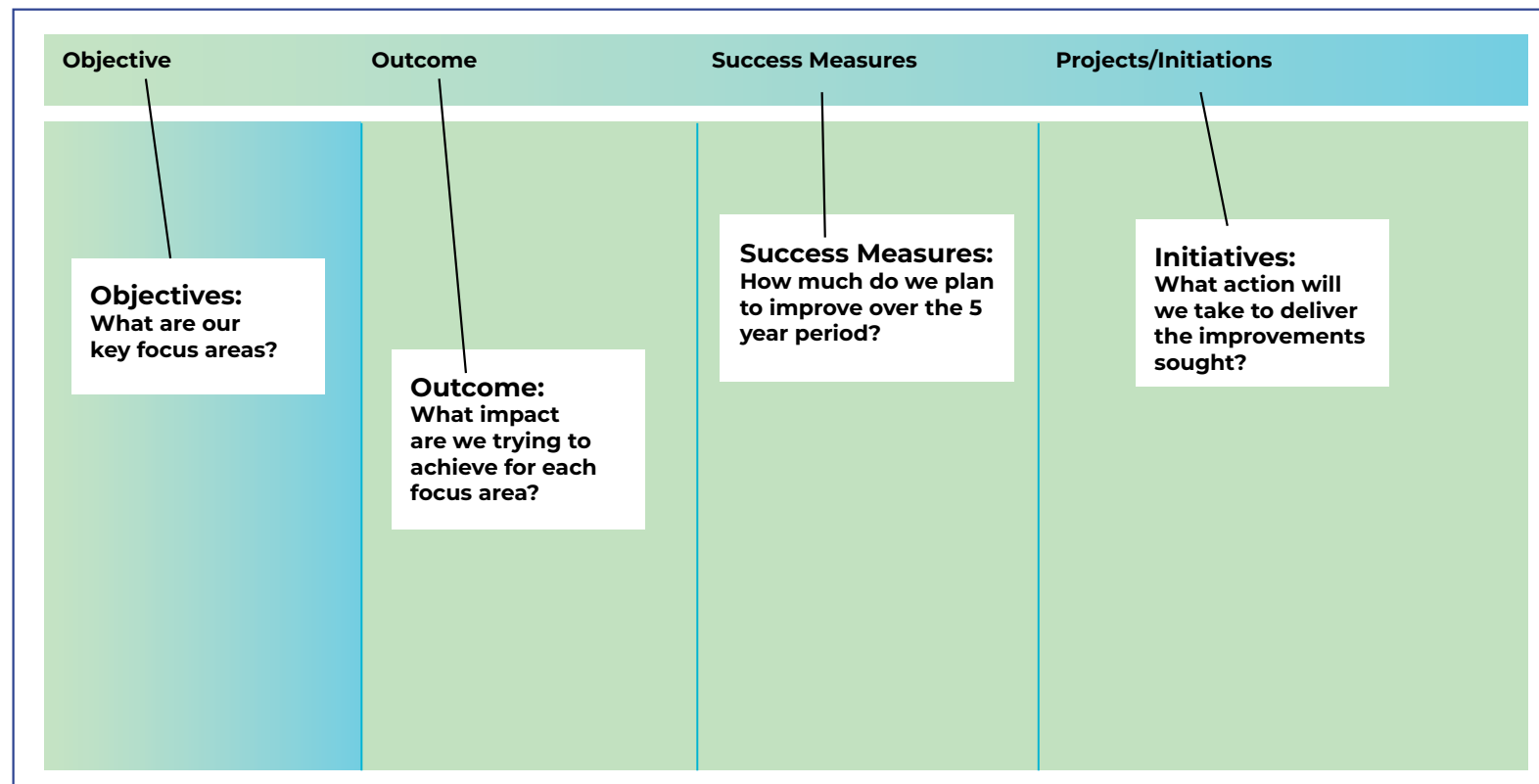


6. Mid-West Palliative Care Strategy

6.3 Palliative Care Scorecards – Outcomes/Measures of Success

In developing the required outcomes and measures of success, the Working Group sought to ensure that there is a clear “cause and effect” evidenced based relationship between the strategic objectives and the outcomes selected. This will facilitate a continued assessment of the Palliative Care strategic plan over its 5 year horizon.

The Palliative scorecard (set out below) brings the strategic objectives on the Strategy Map “to life” and to allow the identification of targets to be achieved by 2024 and to identify gaps from where we are currently.



6. Mid-West Palliative Care Strategy

6.3 Palliative Care Scorecards – Outcomes/Measures of Success

The following was considered in the completion of the scorecards.

- *For each measure a target indicator for 2021 (starting point) and 2025 (end point for plan) was identified, where possible*
- *Initiatives that may be an appropriate response to closing the 'gap' between now and 2025 were suggested*
- *The measures of success selected were checked to see if they were both necessary (without the measure would the objective still be met) and sufficient (if all the measures were achieved would the objectives still be met)*
- *For each such initiative the lead Mid-West service and/or services were identified. The following section outlines the commitments and action required to achieve the intended outcomes. It will serve as a dynamic road map to be used to guide and challenge the annual operational plan for the key service providers going forward. It will be subject to continual review and adjustment to ensure it meets the emerging need of the public and staff.*

The consultative process will continue throughout the implementation phase. The objectives and targets set out in this document, while practical and balanced, are ambitious and challenging. A monitoring/tracking process will be developed to provide regular assessment against plans and the effectiveness of our actions. This is discussed in a later chapter.

This plan will be the foundation upon which the implementation process will be based and the learning from the reality of putting the plan into action will be used to inform on an on-going basis. It is intended that the initiatives set out in the Strategic Plan will form part of Annual Stakeholder Operation plans, with relevant care services taking lead roles.

Implementation of this plan will require leadership and commitment by all care services and funded agencies to support and enhance Palliative Services in the Mid-West. The Strategic Plan is a step in the right direction for Palliative Care in the Mid-West. Whether we play a large or small role, by working together we can achieve our objectives.

Our service commitments are described in the following section, supported by expected outcomes and key actions over the next 5 years. A score card for each of the strategic objectives on the Mid-West Palliative Care Strategy map is set out in the following pages.



STAKEHOLDERS

Help me to easily access services appropriate to my needs

Outcome	Measures	Targets 2021-2025	Initiatives
Appropriate care is provided in a timely fashion	<ul style="list-style-type: none">• % of Aids & Appliances requisitions fulfilled in agreed timeline, following referral for service users with Specialist Palliative care needs and with generalist Palliative care needs• % responsiveness to SPC referrals as per National referral guidelines (Inpatient & community services)• % Hospitals with designated end of life care room & % hospitals with designated family room	<ul style="list-style-type: none">• Set baseline in 2021• Thereafter > 95% meeting timeline• Category 1 – 100% seen within 48 hours• Category 2 – 100% seen within 7 days• Category 3 – 100% seen within 14 days• Complete in UL Hospital by 2021 and set baseline for other hospitals in 2021	<ul style="list-style-type: none">• Palliative care Proofing of the Aids and Appliances pathway project• Ongoing review by MCC management team• End of life care room initiative in UL hospitals• Roll out End of life care room initiative to other hospitals



STAKEHOLDERS

Help me to easily access services appropriate to my needs

Outcome	Measures	Targets 2021-2025	Initiatives
Quicker access to prescribed drugs for Palliative Care service users	<ul style="list-style-type: none"> • % of CHNs with a pharmacy arrangement aligned to Palliative Care Pharmacy protocol • Availability of SPC registered nurse prescribing practitioners across the Mid-West community health networks 	<ul style="list-style-type: none"> • Availability within all CHNs across the MidWest • Target to be set following Evaluation of pilot initiative in 2023 	<ul style="list-style-type: none"> • Community Palliative care pharmacy initiative • Registered Nurse prescribing initiative, including evaluation
Increase in the no. of people spending more time in their preferred home environment	<ul style="list-style-type: none"> • % of CHNs with access to fully resourced specialist palliative care community teams as per the model of care • % of CHNs with access to SPC satellite bases in the Mid-West • Response times for homecare packages for 'end of life' • All CHNs have access to Level 2 beds 	<ul style="list-style-type: none"> • Gap analysis in 2021 • Satellite bases are fully functioning across all agreed sites by 2025, with baseline waiting times set • Set baseline in 2021 • Thereafter >95% meeting timeline • Newcastlewest availability in 2023 • Level 2 beds available to all CHNs by 2025 	<ul style="list-style-type: none"> • Business case to the National clinical programmes/ Sláintecare (note MCC's Health & Social Care professionals WTE levels fall below the norms recommended in the NACPC report 2001 and the Framework report 2017-2019) • Satellite Base pilot project • Satellite Base full rollout, aligned with CHNs • Palliative proofing of home care packages initiative • Newcastlewest initiative • Level 2 bed mapping & review project



Help me to easily access services appropriate to my needs

Outcome	Measures	Targets 2021-2025	Initiatives
Reduction in delayed discharges from the inpatient unit	<ul style="list-style-type: none">• Response times to referrals from SPC Inpatient Unit to Palliative care support beds• Response times to 'Fair Deal' for persons at 'end of life'	<ul style="list-style-type: none">• Set baseline for 2021• Thereafter agree an increase year on year to 2025• Set baseline for 2021• Thereafter > 95% meeting timeline	<ul style="list-style-type: none">• Implementation of the Palliative Care Support Beds admission policy• Review PIs for delayed discharges• Palliative Care proofing of 'Fair Deal'
Reduced unnecessary hospital admissions	<ul style="list-style-type: none">• Improved communications between 'out of hours' GP Co-ops and SPC services	<ul style="list-style-type: none">• Evaluation with key stakeholders in 2022 re communication between out of hours GP services & SPC services	<ul style="list-style-type: none">• Communication protocol with co-ops in 2021• Improvement plan following evaluation



STAKEHOLDERS

Help us as the wider community to understand and engage with Palliative Care

Outcome	Measures	Targets 2021-2025	Initiatives
Improved Public knowledge of Palliative Care services	<ul style="list-style-type: none">Information availabilityIncreased education in schoolsUnderstanding of Palliative Care by “hard to reach” and/or vulnerable groupsParticipation by Mid-West in annual AllHPC Palliative Care awareness campaign	<ul style="list-style-type: none">Mid-West portal available by end of 2022Evaluation of uptake of site by 2024Roll out to school learning site in 2021Further roll out to schools across 8 CHNs by 2025Roll out to ‘Men’s Shed’ Learning site in 2021Roll out to “hard to reach” groups by 2025Annual roll out plan with a “Mid West reach”	<ul style="list-style-type: none">Mid-West portal with directory of service and links to other key sitesEvaluation of siteAnnual media campaignSchool Pilot Site initiative & evaluationCHN school initiative roll-out‘Men’s Shed’ Pilot site initiative & evaluationFurther roll out following evaluationAnnual campaign initiative (co-ordinated by Mid-West PC communication group)



STAKEHOLDERS

Help us as the wider community to understand and engage with Palliative Care

Outcome	Measures	Targets 2021-2025	Initiatives
Increased community involvement	<ul style="list-style-type: none">• Uptake on health promoting Palliative Care• Increased support for bereaved in community	<ul style="list-style-type: none">• Roll out 'health promoting palliative care' in a targeted CHN by 2022• Bereavement support hub set up in a CHN by 2022• Roll out further CHN support hubs by 2025• Commence secondary school placements in SPC	<ul style="list-style-type: none">• Health promoting CHN initiative• Evaluation & further roll out• CHN pilot Bereavement initiative in partnership with the Irish Hospice Foundation• Evaluation & further roll out of bereavement hubs across the Mid-West, in partnership with the Irish Hospice Foundation• Education - Pilot bereavement/education to students and teachers in secondary schools• Experience – Transition placements in MCC following education



STAKEHOLDERS

Help us as Carers to provide support to our loved ones

Outcome	Measures	Targets 2021-2025	Initiatives
Improved ability of family carers to support service users	<ul style="list-style-type: none">• % of carers reporting that they can access the information support they need from SPCs• Improved access to respite for Carers	<ul style="list-style-type: none">• Maintain baseline figures from Famcare• Create a baseline in 2023 for respite care in MCC specialist beds and within the palliative care support bed network	<ul style="list-style-type: none">• Communication initiative around the availability of online training www.carers.thepalliativehub.com• Video training aids on Mid-West portal• Carry out review of the usage of beds in both specialist palliative care and palliative care support beds and develop appropriate policy & governance around same
Improved involvement in care planning and decision making	<ul style="list-style-type: none">• Involvement in care planning (where consent has been given by service user)• Awareness and recognition of carers	<ul style="list-style-type: none">• Famcare measurement of 80% of respondents report that they are satisfied or very satisfied• No of personal stories captured 'on line'	<ul style="list-style-type: none">• GDPR proofed protocol for carer involvement• Annual Famcare carer evaluation• Annual improvement plan following Famcare carer evaluation• Personal experience 'stories' on Mid-West portal



Ensure my care is delivered in a personalised and ‘joined-up’ way across sites

Outcome	Measures	Targets 2021-2025	Initiatives
Fewer service users having to repeat their stories	<ul style="list-style-type: none"> Transfer or shared care arrangements happen more efficiently Greater clarity of roles at case level 	<ul style="list-style-type: none"> No. of PCTs using PCNA assessments to identify appropriate referrals to SPC (1 site in 2022) and year on year increase to other PCTs To implement a tool to transfer decision making between care settings around advanced care planning Use of patient held home care records between SPC & HSE Community by 2025 Agreed pathways of care between generalist and SPC services Role delineation/overlap within disciplines & agreed scope of practice Implement a key worker approach 	<ul style="list-style-type: none"> Pilot PCT Learning site (<i>consider linkages with CHN learning site</i>) and including basic palliative care pathway Review “co-ordinate my care” and its potential applicability within the Mid-West (UK initiative since 2010) and/or “Think Ahead” IHF Pilot patient held Home Care Record in 1 CHN Roll out of all patient held Home care records initiative across all CHNs Pathway mapping initiatives, including the setting out of the number of pathways required Scope of practice initiatives Review key worker approach across generalist & specialist
A more consistent approach to the design of ‘joint care pathways etc. between SPC and generalist services	<ul style="list-style-type: none"> Coherence between various care pathways designed 	<ul style="list-style-type: none"> Interagency Design Group set up to oversee ‘joint’ clinical initiatives in 2021 and meeting at least every 6 months 	<ul style="list-style-type: none"> Set up Design Group



To put in place organisational arrangements to enable staff to work together

Outcome	Measures	Targets 2021-2025	Initiatives
Improved awareness and understanding of Palliative Care by all service providers	<ul style="list-style-type: none">• Agencies signed up to Mid-West Palliative Care charter• Improved co-terminosity of services at local level	<ul style="list-style-type: none">• Palliative Care Charter to issue 2022• % of Primary Care services aligned to CHNs• % of SPC Community services aligned to CHNs	<ul style="list-style-type: none">• PC Charter initiative, including launch (Initially create baseline re understanding by agencies of PC)• Primary Care CHN project• SPC CHN project
Improved inter agency governance	<ul style="list-style-type: none">• Improved governance around Level 2 support beds• Governance of PIs set out in strategy	<ul style="list-style-type: none">• Greater uptake and usage of Level 2 beds (2022 target is 65%)• Quarterly reporting of PIs for consideration by joint HSE/MCC Implementation Group	<ul style="list-style-type: none">• SLA and/or protocol with relevant providers• Develop reporting schedules for Implementation Group at quarterly meetings



To continue to develop Milford as a leading Centre of Excellence

Outcome	Measures	Targets 2021-2025	Initiatives
Improved quality of care	<ul style="list-style-type: none">Patients showing improvement in outcomes and quality of careHighly qualified specialist and experienced staff to provide excellent care	<ul style="list-style-type: none">% of service users showing improvement across aggregated PCOC scores (baseline to be set by end of 2021)Cumulative Famcare scores to be maintained at or above 85% of respondents reporting they are satisfied or very satisfiedNo. of SPC staff with attainment of level 3 specialisation (survey to be completed in 2021 and target for each service year on year)All new nursing staff to SPC services (who do not have a PC specific post graduate qualification) should be required to initiate the ECEPC within 12 months of starting employmentIn excess of 90% of professional clinical staff working in SPC have completed Advanced Skills Communication course by 2025	<ul style="list-style-type: none">PCOC initiative plus admin supportImprovement initiative following PCOC reportingReporting of Famcare results on annual basisQuality improvement plan to be developed in response to Famcare feedbackTraining needs analysis & Database (Level 3 specialisation attainment to be defined in 2021)Gap analysis & training plan (should embrace non-malignant illnesses)6 monthly HR reportPerformance reporting in relation to uptake of 2 day programme



To continue to develop Milford as a leading Centre of Excellence

Outcome	Measures	Targets 2021-2025	Initiatives
	<ul style="list-style-type: none">• Patient/service user voice• Right skill mix as part of multi disciplinary team	<ul style="list-style-type: none">• No. of evidenced base practice guidelines and standards for SPC disciplines (2021 target to be set)• No. of specialist staff attending programmes relevant to role (set 2021 target)• % of initiatives on Portfolio involving Service user voices• Meet National policy for minimum staffing levels for SPC• No. of advanced practice roles for nursing and Clinical Specialists for HSCPs• Pain management sessional input• Psychiatry sessional input• Psychology role in SPC services• Social worker role in UHL hospital Palliative team	<ul style="list-style-type: none">• Practice guidelines initiatives• Attendance & learning write up• Included in all Project plans• Relevant business cases to be made to HSE Mid West/Sláintecare programmes



To continue to develop Milford as a leading Centre of Excellence

Outcome	Measures	Targets 2021-2025	Initiatives
Improved out of hours services	<ul style="list-style-type: none"> • Clinical leadership and governance in all Mid-West acute hospitals • Advancement of care through research • Quality assurance programmes in place • Meeting diversity/culture challenges • Availability of CNS services in hospital • Improved access to 'Out of hours' SPC services for patients and families 	<ul style="list-style-type: none"> • % hours per week with consultant cover available in all hospitals • 0.5 academic post in place by 2025 • Review of HIQA self-assessment in 2021/2022 • Review results from user/carer feedback annually • Weekend availability of Palliative CNS at weekend • Local evaluation of the out of hours telephone advisory service—completed 2021 • Review findings of national evaluation within 6 months of its publication 	<ul style="list-style-type: none"> • Business case re consultant cover • Business case to HSE • Quality improvement programme reporting • Diversity/culture improvement programme • CNS initiative in UHL • Improvement plan following local evaluation of out of hours telephone system • Business case extending SPC 'Out of hours' following National evaluation



To increase competency based Palliative Care capability across all services

Outcome	Measures	Targets 2021-2025	Initiatives
Increase capacity of general health care staff to embrace & provide Palliative Care	<ul style="list-style-type: none"> No of hospital and community staff within service units having completed agreed level 1 specialisation i.e. palliative care approach Take up of agreed Level 1 specialisation (i.e. palliative care approach) by Professional carers No of hospital and community staff within service units having completed agreed level 2 specialisation i.e. general palliative care 	<ul style="list-style-type: none"> Create baseline target for Level 1 in 2021 (using service units as a determinant) Year on year increase on baseline target to achieve in excess of or greater than 90% Performance management of SLA for Carer service providers to achieve >90% By 2025, 25% of staff operating in the hospital or community will have completed either: <ul style="list-style-type: none"> - 2 day palliative care introduction course - Project Echo (zoom) - ECEPC (European certificate in essential Palliative Care) distance learning - Northern Ireland certificate in holistic dementia care (distance learning) 	<ul style="list-style-type: none"> Policy in hospitals and community services re attendance at Level 1 courses Monitoring and reporting on HPSA system Amendment to HSE SLA provider agreements and PI monitoring Policy in hospital and community services re attendance at Level 2 level of specialisation i.e. general palliative care



To increase competency based Palliative Care capability across all services

Outcome	Measures	Targets 2021-2025	Initiatives
Increase health literacy around advanced care planning with relevant staff in hospital and community settings	<ul style="list-style-type: none">• Health workers feel supported in facilitating conversation with service user/carer	<ul style="list-style-type: none">• Increase % of relevant staff in hospital and community settings who have completed the “what matters to me” programme or the advanced “communications skills” programme	<ul style="list-style-type: none">• Informed choices education programme for staff



To improve public relations capability

Outcome	Measures	Targets 2021-2025	Initiatives
Improved collaborative cross agency communications across the Mid-West	<ul style="list-style-type: none"> • Mid-West PC communications group established in 2021 • Communication vehicle in place • Cross agency communications plan • Clear branding strategy for Palliative Care 	<ul style="list-style-type: none"> • Communication governance established • Mid-West Portal by 2022 • Annual joint communication plans in place by 2022 • Mid-West branding strategy in place by 2022 	<ul style="list-style-type: none"> • Set up cross agency communication group • Mid-West portal • Communication and social media strategy • Annual communication plan • Branding strategy
Improved capacity to engage with Public and communities	<ul style="list-style-type: none"> • Availability of support for staff to engage with communities 	<ul style="list-style-type: none"> • Have a toolkit in place to work with local communities around Palliative care by 2023 • % of staff trained in public speaking (set baseline in 2021) 	<ul style="list-style-type: none"> • Community toolkit project • Public speaking course



To optimise SPC education department to support education/training

Outcome	Measures	Targets 2021-2025	Initiatives
Increase range of “online courses” to maximise uptake of education opportunities by HSE staff	<ul style="list-style-type: none">• Availability of courses on HSEland	<ul style="list-style-type: none">• Palliative Level 1 course on HSEland by 2022	<ul style="list-style-type: none">• Negotiate and agree with HSE re availability on HSEland and recording on HPSA• Annual publication of training schedule and course delivery
Increase development of educational role in SPC services	<ul style="list-style-type: none">• Support of staff working in residential settings and Primary care• Support of GPs	<ul style="list-style-type: none">• A minimum number of ECHO programmes over the 5 year period:<ul style="list-style-type: none">- 3 programmes for nursing staff- 2 programmes for therapy & social care staff• Provide education opportunities in a fora that GPs can access	<ul style="list-style-type: none">• Evaluation of Project ECHO• Business case for co-ordinator to support provision• GP initiative (following consultations with GPs)
Increase satisfaction of attendees at training	<ul style="list-style-type: none">• % who feel the programme provided the knowledge they needed	<ul style="list-style-type: none">• Maintain satisfaction levels above 90%	<ul style="list-style-type: none">• Survey monkey pilot in 2021• Ongoing evaluation



To optimise SPC education department to support education/training

Outcome	Measures	Targets 2021-2025	Initiatives
Increased opportunity regarding undergraduate & post graduate programmes	<ul style="list-style-type: none">• Increase no. of staff to attend post graduate programmes relating to Palliative Care	<ul style="list-style-type: none">• Annual increase of 2% per year in staff from Mid-West on the ECEPC or the NI Hospice eCertificate• Maintain the existing number of staff taking up places on post graduate programmes• All funded Masters students to publish research within 18 months of completion of programme	<ul style="list-style-type: none">• Mid-West bursary policy• Maintain existing levels of funding from the CNME Mid-West (Post Grad or Masters) Note: This may be impacted by the recent CNME policy• Performance reporting
Increased participation in practice improvement and clinical research	<ul style="list-style-type: none">• Maintaining student placements from UL• Continue to develop links with UL and enhance profile of the palliative care strategy with increased number of conferences held in Mid-West	<ul style="list-style-type: none">• No. of student placements in MCC• Provide 2 international conferences between 2021 & 2025	<ul style="list-style-type: none">• Discussions with UL/HSE• 2022 International conference• 2025 International conference



To improve inpatient bed capacity

Outcome	Measures	Targets 2021-2025	Initiatives
Improved access to Palliative care support beds	<ul style="list-style-type: none">• Beds available to all CHNs	<ul style="list-style-type: none">• Support beds in Newcastlewest in 2023	<ul style="list-style-type: none">• Mapping of support beds across CHNs• Newcastlewest initiative
Increase “inpatient” unit beds in MCC	<ul style="list-style-type: none">• All existing beds in MCC open• Explore possibility of expanding to 38 bed capacity	<ul style="list-style-type: none">• 4 bed unit open between 2021-2022• 4 extra bed unit open by 2025	<ul style="list-style-type: none">• Revenue funding project for 4 unit beds• Midterm review of bed capacity with a view to expansion of 38 beds
SPC Satellite centres available across Mid-West	<ul style="list-style-type: none">• No. of satellite centres	<ul style="list-style-type: none">• Satellite centres aligned to CHNs by 2024	<ul style="list-style-type: none">• Satellite centres capital and revenue funding project



To improve recruitment and retention in SPC services

Outcome	Measures	Targets 2021-2025	Initiatives
Increased assurance that Palliative care staff are working in accordance with the Palliative care competency framework	<ul style="list-style-type: none">• % of clinical MCC staff working in Palliative Care areas that are assessed against the Palliative Care competency Framework• Staff trained to meet their expected role	<ul style="list-style-type: none">• Create baseline 2022• Greater than 90% of staff with Performance achievement/ IDPs in place in MCC	<ul style="list-style-type: none">• Staff review against competency framework in SPC• Education/Training strategy, aligned with competency framework
Improved retention of staff	<ul style="list-style-type: none">• % Increase in staff satisfaction in working in SPC services	<ul style="list-style-type: none">• Set baseline for 2022 after initial engagement process• % increase year on year to end of Strategy	<ul style="list-style-type: none">• Staff engagement project and improvement projects
Establish MCC as employer of Choice	<ul style="list-style-type: none">• Increased no. of applications for posts• Improved employee 'well-being' within SPC services	<ul style="list-style-type: none">• Develop baseline for agreed "certain" posts• Increase contract hours of counselling services by 1 day• Annual Health screening programme Staff from 2022• Quarterly workshops on topical staff issues E.g. psychosocial	<ul style="list-style-type: none">• Recruitment drives• Counselling initiative• Health screening programme• Educational plan and roll out to staff, including consideration of initiatives such as the Schwartz rounds etc.



To embrace technology utilisation as a key enabler

Outcome	Measures	Targets 2021-2025	Initiatives
Enhanced ability of clinical staff and service users to use electronic tools to support decision making and improving health outcomes	<ul style="list-style-type: none">• No of existing processes automated	<ul style="list-style-type: none">• Develop an Information Management Strategy for the Mid-West by 2022• No of new systems commenced by 2025	<ul style="list-style-type: none">• Information Management Strategy• Information Management Implementation Plan
Enhanced utilisation of statistical information to review progress against National KPIs	<ul style="list-style-type: none">• No. and types of reports available	<ul style="list-style-type: none">• Improved availability of reports	<ul style="list-style-type: none">• Agree appropriate circulation and/or availability of reports
Faster information sharing amongst clinical staff	<ul style="list-style-type: none">• No of systems automated and /or connected	<ul style="list-style-type: none">• Use of 'out of hours' electronic information form on iCare in Mid West by 2021• Enhanced usage of iCare as a shared patient record within MCC by 2023	<ul style="list-style-type: none">• Readiness assessment and Implementation of Mid-West 'out of hours' e-information form• Implementation of iCare for patient notes for Milford Community Services & Day Unit by end of 2023 (<i>National EPR may be initiated</i>)• Evaluation/Roll out of iCare in Community Services/Day Care by mid 2022



To embrace technology utilisation as a key enabler

Outcome	Measures	Targets 2021-2025	Initiatives
Increased aptitude for digital working by MCC staff to improve Communication and 'day to day' working	<ul style="list-style-type: none"> • % of MCC staff set up on Server with an email address • % of Community Services staff competent to utilise available technology to link between MCC and bases for meetings and education sessions 	<ul style="list-style-type: none"> • 100% of MCC staff with email address on server by 2023 (subject to business case approval) • 100% of Community Services staff using available technology to link into MCC for meetings and education sessions 	<ul style="list-style-type: none"> • Development of business case to explore possibility of individualised email addresses • ICT skills initiative (following needs assessment) • Enhanced video link training sessions
MCC managers trained to meet expected role	<ul style="list-style-type: none"> • % of managers self-sufficient on TMS system to download appropriate reports e.g. rosters etc. • % of managers using available document management system to ensure policies are reviewed, updated, authorised and acknowledged in a timely manner 	<ul style="list-style-type: none"> • All managers trained on TMS system by 2021 • All managers trained on document management system by 2022 	<ul style="list-style-type: none"> • TMS training programme developed and delivered • Document management training programme developed and delivered • Bi-annual compliance audit undertaken
Secure and faster transfer of personal and sensitive personal information between healthcare providers and agencies, with integration into iCare record	<ul style="list-style-type: none"> • All iCare records updated automatically from fax messages received 	<ul style="list-style-type: none"> • Usage of e-Fax implemented by 2021 in MCC 	<ul style="list-style-type: none"> • e-Fax system initiative in MCC



Manage the Fundamentals

Outcome	Measures	Targets 2021-2025	Initiatives
Improved savings	<ul style="list-style-type: none">• Controllable expenses	<ul style="list-style-type: none">• Baselines to be set in 2021 by Milford Care Centre	<ul style="list-style-type: none">• Energy saving project• Maintenance project• Recycling project• Procurement project
Resources fairly distributed	<ul style="list-style-type: none">• Resource allocation	<ul style="list-style-type: none">• Resource allocation model applied to SPC community teams by 2024	<ul style="list-style-type: none">• Resource allocation project
Make processes more efficient	<ul style="list-style-type: none">• “Lean” proofed processes	<ul style="list-style-type: none">• No. MCC of staff trained on “lean” in 2022• No. of Lean projects carried out year on year after 2022	<ul style="list-style-type: none">• Lean projects
Improved maintenance of key assets	<ul style="list-style-type: none">• “Asset” maintenance programmes in place	<ul style="list-style-type: none">• Ongoing maintenance programme PIs in Milford Care Centre	<ul style="list-style-type: none">• Maintenance strategy
Reduced absenteeism	<ul style="list-style-type: none">• Absenteeism rates in comparison to national average	<ul style="list-style-type: none">• 2021 create baseline• yr on yr reduction	<ul style="list-style-type: none">• Managing absenteeism initiative to support MCC managers in their role
Reduced classroom hours for MCC induction of staff	<ul style="list-style-type: none">• introduction of ‘on line’ modules for induction	<ul style="list-style-type: none">• Induction framework in place by 2021	<ul style="list-style-type: none">• Induction Framework• ‘on line’ induction modules project



Improve revenue/capital resources

Outcome	Measures	Targets 2021-2025	Initiatives
Improved funding base for day to day services	<ul style="list-style-type: none">• MCC to move from Section 39 provider to Section 38• Comparison of MCC staffing against National reports	<ul style="list-style-type: none">• Achieved within strategy• Costing of workforce plan in 2021	<ul style="list-style-type: none">• National funding negotiation• Business case to HSE, (note MCC as a member of the Voluntary Hospice Group has already applied to Minister of Health for change in status from S39 to S38 provider)
Improved funding for capital projects	<ul style="list-style-type: none">• Business cases against Capital plan	<ul style="list-style-type: none">• No. of business cases completed in 2021	<ul style="list-style-type: none">• Capital plan

7. Mid-West Palliative Care Integration Network Model

7.1 Introduction

As stated earlier Palliative care integrates the psychological, physical, social and spiritual aspects of a patient's care. The goal of palliative care is the highest possible quality of life for the patient and family.

Palliative care, both generalist and specialist, is provided in all care settings, including the community, nursing homes, hospitals, and specialist palliative care units. In recent years, the scope of palliative care has broadened so that palliative care is now provided at an earlier stage in the trajectory of both malignant and non-malignant disease.

One of the key principles of *Committee on the future of Healthcare – Sláintecare report May 2017*⁸ is to “create an integrated system of care, with health professionals working closely together”. This is further supported by the recently published *Adult Palliative Care Services – Model of Care for Ireland 2019*¹⁸ which calls for the development of integrated Networks of Care in local areas, “where services work together to meet the needs of the population..... people with life limiting conditions must be able to engage easily with the level of expertise most appropriate to their needs, regardless of location, care setting or diagnosis”.

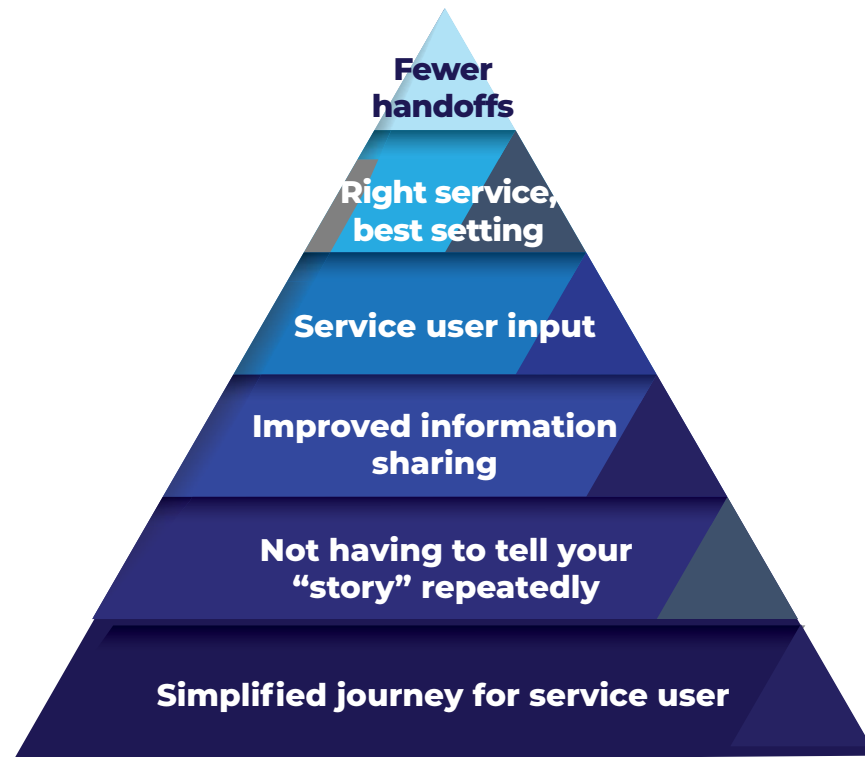
Given the history of collaboration in Palliative Care Services across the Mid-West, a key issue for stakeholders during the consultation process was the need to further develop the integration processes between providers so that consistent approaches are taken to meet the needs of service users and that there are clear shared care arrangement in place and there are clear “hand off”/transfer points, where necessary.

Creating a truly integrated care system is a key part of the Vision Statement agreed by key stakeholders for Palliative Care services across the Mid-West. The case for integrating care around the needs for service users and populations is compelling, it is underpinned by an ageing population and changing disease burden outlined earlier, which means that more people will have complex needs that brings them into contact with a variety of Health & Social care professionals. A dis-jointed response to these needs is unlikely to deliver the best possible outcomes and hence the need to develop further the integrative approach in the Mid-West. This Integration Network Model has guided some of the actions in the individual scorecards, set out in the previous chapter, but also will guide the further detailed work of the partner organisations during the implementation stages of the programme of work, by way of the principles set out herein.

7. Mid-West Palliative Care Integration Network Model

7.2 Integration Model

Integrated Care is recognised as a complex topic and there is no agreed consensus on how it can be best delivered. From experience we know that the journey towards integrated care takes commitment of time, energy and resources from all partners. The following are seen as critical integration outcomes in the literature and evidence of what's important:



Based on the feedback during the consultative process, clinical and service integration is seen as the most important integrative process required in the Mid-West.

The following key points emerged in this regard during the analysis phase:

- *Integration is happening in many pockets but not systematically*
- *Having a stable system is crucial (Mid-West has always been the Mid-West)*
- *Staff/Managers have worked in both systems*
- *Strong leadership exists in Mid-West to support integration*
- *People individually doing a great job but as a whole, families experience care that is not well co-ordinated sometimes*
- *Care groups/Divisions etc. can hinder integration*
- *Eligibility issues can hinder integration*
- *Lack of co-terminosity amongst services (Literature tells you that a sense of place in small areas is a catalyst for change)*
- *Private health system can make integration challenging*

7. Mid-West Palliative Care Integration Network Model

7.2 Integration Model

The approach to developing **Mid-West Palliative Care Integration Network Model** was to:



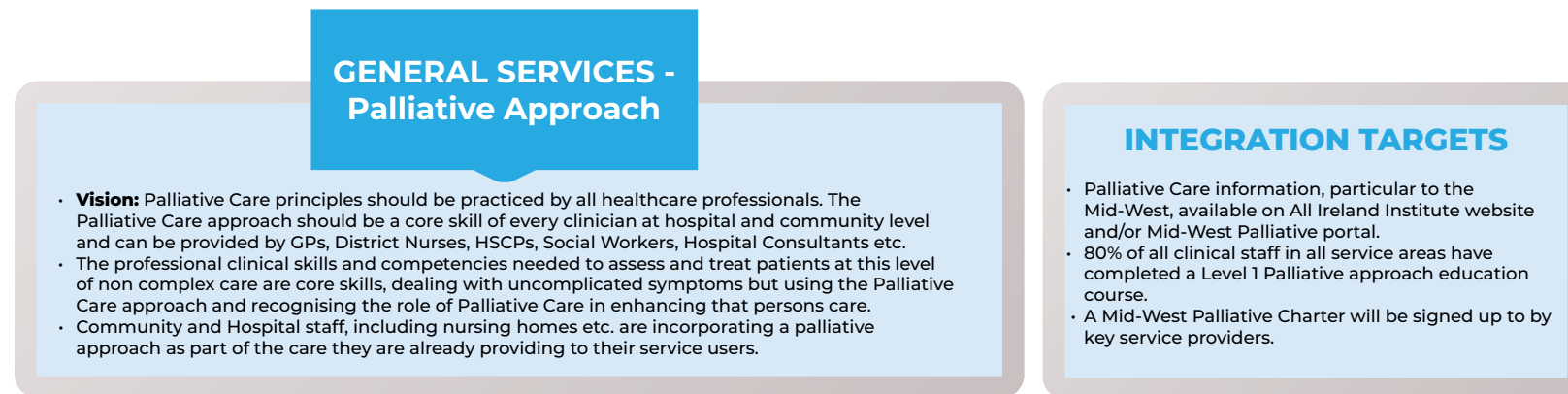
Step 1:

• Build on:

- The Palliative Care Service levels identified in *Report of the National Advisory Committee on Palliative Care 2001*⁴ which are structured according to ascending specialisation and relate to the expertise of staff providing the service
- The principles set out in the following more recent national reports:
 - *Palliative care competence framework 2014*
 - *Adult Palliative Care Service Model Of Care For Ireland 2019*
 - *Role Delineation Framework for Adult Palliative Care Services*

• Agree the Vision and level of integration that can be achieved in the Mid-West over the period of the 5 year Strategy.

The following approach has been agreed:



Note: Responsibility for care delivery remains with core service provider e.g. PCT, hospital staff, nursing home etc.

7. Mid-West Palliative Care Integration Network Model

7.2 Integration Model



Step 1 contd.

“SHARED” PALLIATIVE CARE

- **Vision:** A proportion of patients and families will benefit from the expertise of health care professionals who, although not engaged full time in Palliative Care, have had some additional training and experience in Palliative Care, perhaps to Diploma level. Such expertise may be available in hospital or community settings to deal with intermittent complex care.
- The service user continues to be managed by the community of hospital team, with additional support from the specialist Palliative Care team as required.
- Specialist Palliative Care may provide advice/guidance on a discipline to discipline basis (where the individual requires a high level of expertise and advanced competency, the specialist Palliative Care clinician may take over responsibility for that aspect of care. This may be on a continuous or an intervention basis to support the front line service. Scope of practice documents and shared protocol will need to support this).
- As a service user develops more complex problems which require the involvement of an increasing number of disciplines from the specialist Palliative Care team, a threshold may be reached where it is more practical that the specialist Palliative Care team take over the care of the person. (The National Palliative Care assessment tool will assist in this regard).

INTEGRATION TARGETS

- Each of the core service areas will have a small % of staff trained to provide a response to more complex Palliative Care cases.
- The National Palliative assessment Tool will be used at community or hospital multi-disciplinary team meetings to determine thresholds and referrals.
- A Home Care record, supported by shared Care protocol and scope of practice agreements will be initially established for shared care arrangements.

Note: Responsibility for overall co-ordination of care rests with the core service provider e.g. PCT, hospital staff, nursing home who will liaise with SPC services to ensure continuity of care

SPECIALIST PALLIATIVE CARE SERVICES

- **Vision:** Specialist Palliative Care services are those services whose core activity is limited to the provision of Palliative Care. These services are involved in the care of individuals with more complex and demanding care needs, and consequently, require a greater degree of training, staff and other resources. Specialist Palliative Care services, because of the nature of the needs they are designed to meet, are analogous to secondary or tertiary health care services.
- Specialist Palliative Care, including the IPU, will manage unresolved symptoms and more demanding care needs, including complex psychosocial, end of life and bereavement issues. This will be provided by specialist personnel from the centre of excellence, with expert knowledge, skills and competences
- Community teams, will provide specialist advice and work alongside a patient's own GP, enabling specialist care to be provided in the patient's home or care home;
- Day care, which enables patients to continue living at home while having access to day facilities will be provided by a multi-disciplinary health and social care team on an out-patient basis

INTEGRATION TARGETS

- Community Specialist Services will be aligned geographically with the HSE community teams through co-terminus networks i.e. CHNs.
- GP study/information days will be provided by SPC services.
- A Project Echo type of approach to education will be continued by SPC services and extended to PCTs in due course.

Note: Responsibility for the overall co-ordination of care rests with the Specialist Palliative Care team, who will liaise with the service users PCT as necessary to ensure continuity of care
Note: Across all three levels, clinical accountability rests with the provider of a specific service within their own clinical governance and professional structures

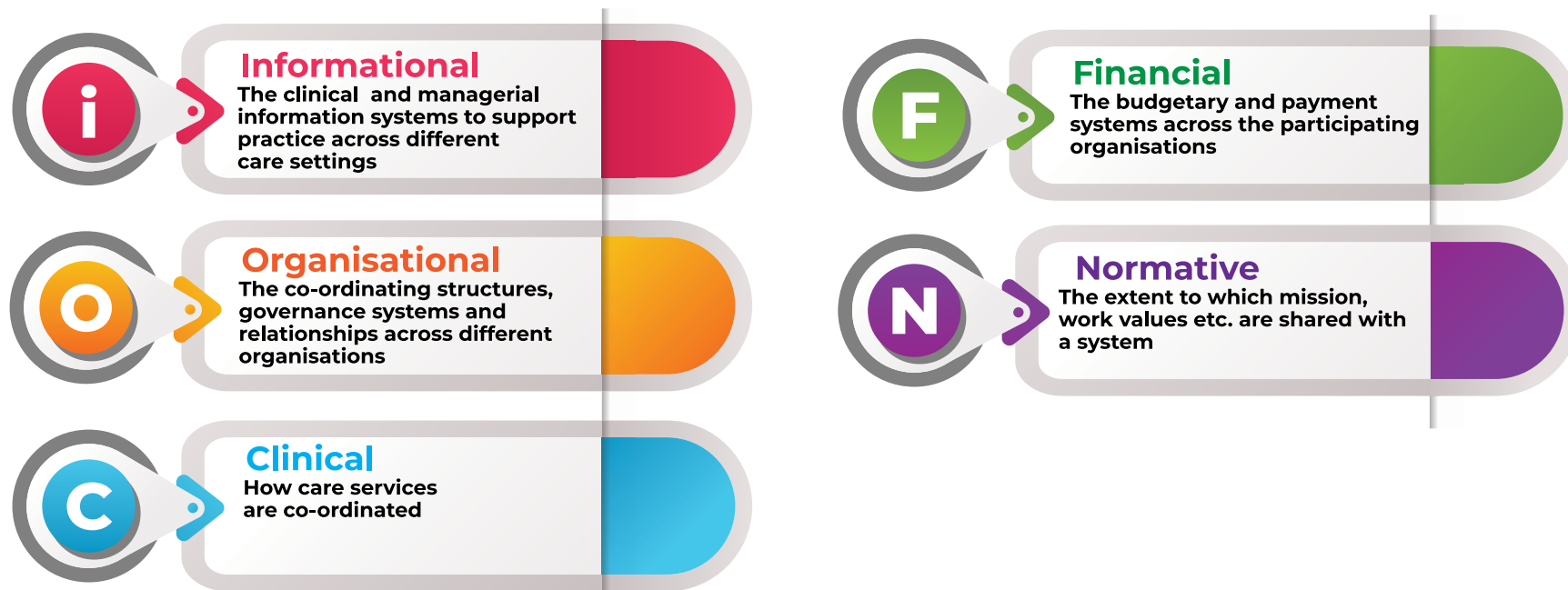
7. Mid-West Palliative Care Integration Network Model

7.2 Integration Model



Step 2: Identifying the dimensions of integration to support the Model

The following integration perspectives have been set down by the likes of Nuffield Trust, the Kings Fund, Kaiser Permanente, European Observatory etc. to drive integration across organisations and services:



7. Mid-West Palliative Care Integration Network Model

7.2 Integration Model



Step 3: Identify approaches /initiatives across each of the Service levels, using the integration perspectives from Step 2

Integration is a means towards achieving the goal of better joined up care and creates opportunities for transforming service users experience of care from being disjointed to co-ordinated and from service orientated to personalised.

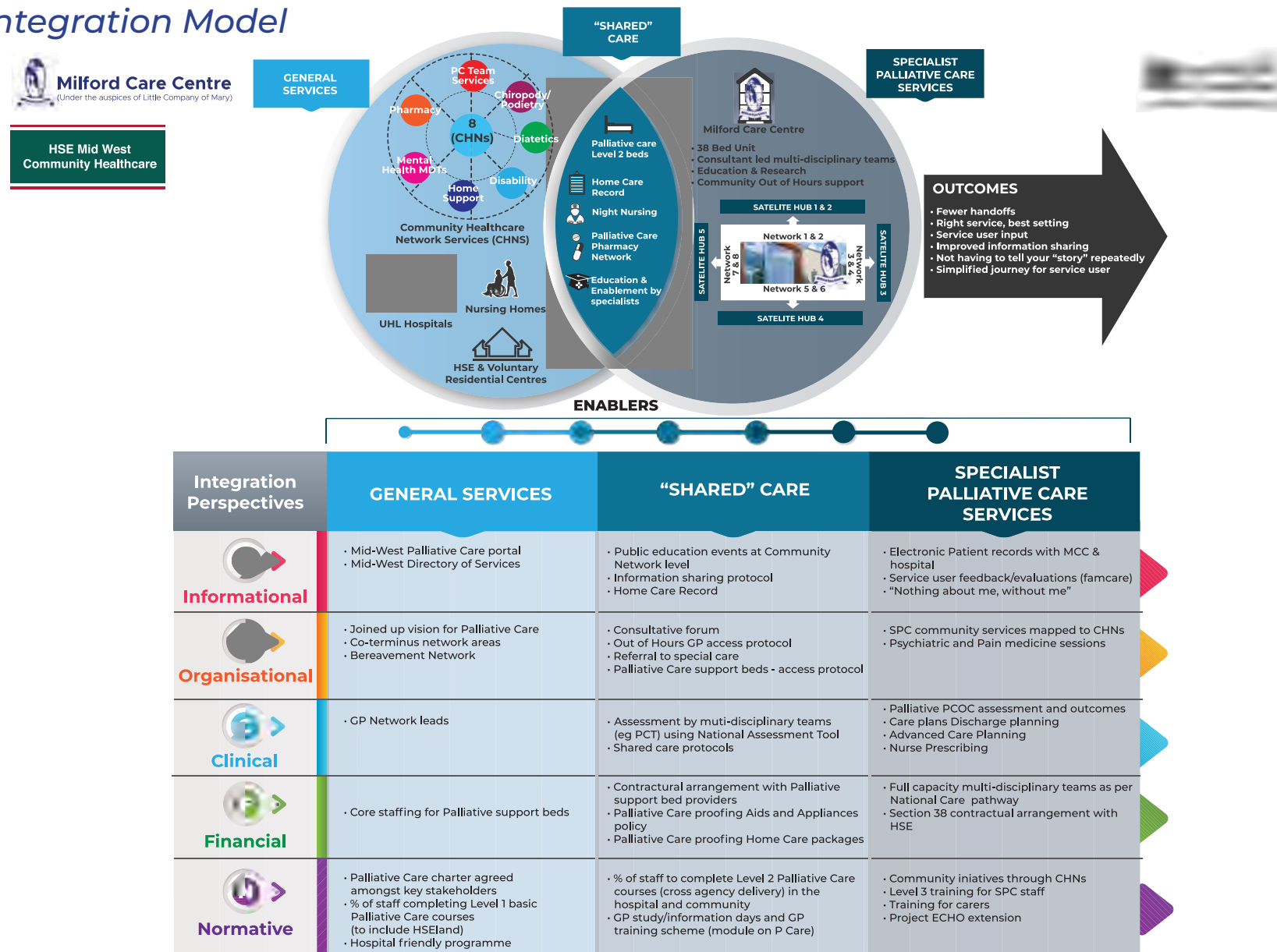
Through this Network Integration Model we envisage a 'whole system' approach to achieving integration, involving Mid-West Leaders, service providers, front line professionals and local communities. By applying the actions across the 5 Integration Perspectives from Step 2, services will be able to focus on the following key elements:

- ***The delivery of person centred co-ordinated care***
- ***The building of local care arrangements and support systems***
- ***Building Leadership that will facilitate integration***
- ***Building links with local communities***

The Palliative Care Network Model overleaf sets out the actions across each of the 5 perspectives that will support 'joined up' care between generalist hospital/ community services and specialist palliative care services.

7. Mid-West Palliative Care Integration Network Model

7.2 Integration Model



7. Mid-West Palliative Care Integration Network Model

7.2 Integration Model

Relating to the Network Model above, the following are definitions of levels of specialisation within palliative care.

Definitions of level of specialisation in Palliative Care

LEVEL 1 -

Palliative Care Approach

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

LEVEL 2 -

General Palliative Care

At an intermediate level, a proportion of patients and families will benefit from the expertise of health care professionals who, although not engaged full time in palliative care, have had some additional training and experience in palliative care, perhaps to diploma level. Such intermediate level expertise may be available in hospital or community settings

LEVEL 3 -

Specialist Palliative Care

Specialist palliative care services are those services whose core activity is limited to the provision of palliative care. These services are involved in the care of patients with more complex and demanding care needs, and consequently, require a greater degree of training, staff and other resources. Specialist palliative care services, because of the nature of the needs they are designed to meet, are analogous to secondary or tertiary health care services.

8. Implementation of Palliative Care Strategy

8.1 Introduction

The Strategic Plan described in the previous chapters draws on a whole population approach for the Mid-West and develops a sharper focus on the stakeholder and organisational outcomes relating to Palliative Care across a range of settings. The current excellent collaborative culture between the various service providers across the Mid-West will be further consolidated and enhanced over the life of the strategy. The changes inherent in the strategy will require some supported renegotiation to the roles of generalist and specialist providers.

The Strategic intent set out in this document will require executive leadership oversight and capacity in order to meet the challenges and transitions expected in such an endeavour. Service providers will need to establish processes and mechanisms to manage the implementation stage over this 5 year period.

In particular Section 6.3 sets out the key outcomes and a supporting framework of success measures that will be used to facilitate oversight of the Strategy. Each of the above initiatives listed will only produce positive change if effectively implemented, both collectively and individually, by the relevant service providers and partners. This will require discipline, planning and execution.

Good and realistic implementation planning, followed by a well sustained action is necessary if we are to realise the objectives and associated outcomes in this Strategic plan. Momentum must be established and then maintained over the next 5 years.

In this context the following are critical to implementation success:

- **FIRST 3 MONTHS** - *Over investment in implementation planning in first 3 months*
- **LEADERSHIP** - *Governance arrangements to oversee implementation*
- **PRIORITISATION** - *Phasing/Prioritisation of initiatives to maximise outcomes*
- **PROGRAMME ASSURANCE** - *Project initiation & reporting methodologies*
- **CHANGE MANAGEMENT** - *Communication*

The following sub-sections will elaborate further on each of the above Implementation success factors.

8. Implementation of Palliative Care Strategy

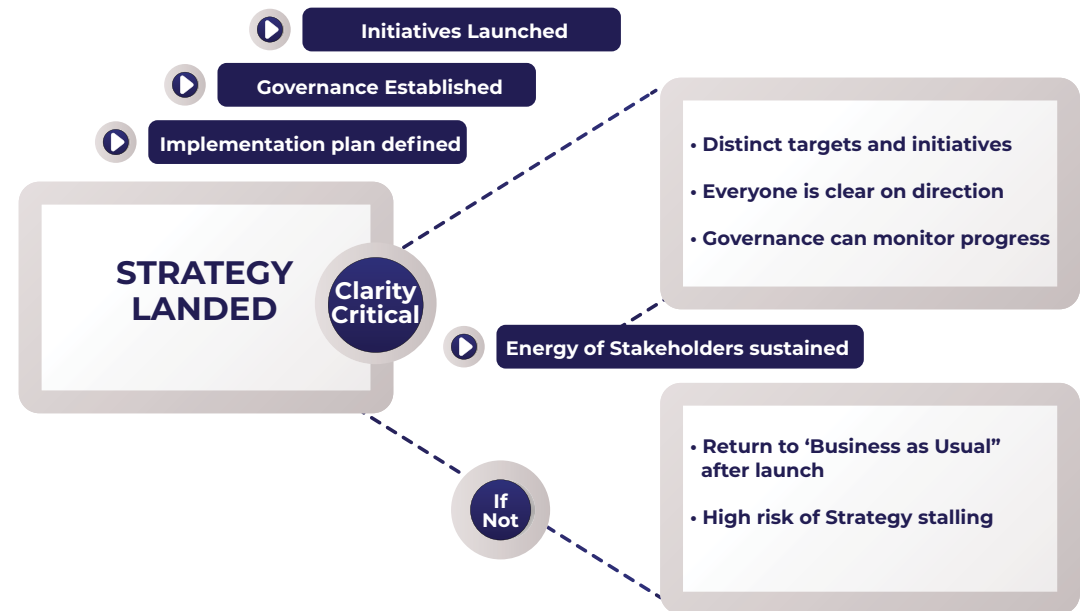
8.2 First 3 months

The first 3 months is critical to the achievement of the Strategy. Overinvesting in implementation planning in the early months of 2021 will bring clarity to prioritised initiatives and governance. This should commence immediately after the launch of the Strategy.

Key questions for the first 3 months include:

- *How should the first wave of initiatives be planned to ensure a strong start that creates energy and create a midterm state*
- *What training is required to ensure Sponsors and Project Leads are set up for success*
- *How is the Strategy story to be cascaded*
- *What is the reporting structure and reporting routine to ensure progress is on track*
- *How can the rigour of the strategy be driven through the service providers and not be seen as separate from the “day to day” business*
- *How can we ensure there is synergy between the initiatives selected in each phase*
- *What is the state of “readiness” across service providers to commence this change*

Answers to the above questions at an early stage will help develop an increasingly challenging but achievable roadmap for each implementation phase of the strategy.



8. Implementation of Palliative Care Strategy

8.3 Leadership

Developing appropriate governance arrangements to oversee the Strategy Implementation phase is critical and must be aligned to existing operational governance. HSE and Milford Care Centre will establish a joint Implementation Group at the earliest opportunity and the key roles for any such group would be to oversee prioritisation, manage issue/risks to the strategy, monitor progress and review the strategy, as required to achieve the agreed vision.

In particular the key roles will include:

- ***Set up project teams with a clear mandate to deliver a particular initiative***
- ***Agreeing mutual ownership of problems and developing solutions***
- ***Agree simplified reporting lines for the strategic initiatives***
- ***Ensure as far as possible standardisation and consistency across the programme***
- ***Providing recommendations to Service Providers on an annual agreed programme of work for the Mid-West***
- ***Manage the resolution of escalated risk and issues, making recommendation to the relevant service governance***
- ***At a minimum appoint Project Sponsors to each initiative. It is recommended that the sponsorship should be divided by way of “Strategic Objective” owners (based on the strategy map) to ensure integration across agencies and to facilitate oversight and performance regarding the outcomes associated with each of the objectives.***

- ***Carry out a regular assessment of the status of the action plan and recommending correction action where a “gap closure” relating to agreed outcome under the plan has not materialised***
- ***Consider all “integration” issues as they arise and recommend a way forward to the relevant service providers***

It is recommended that the Governance Group meet, at a minimum, on a quarterly basis. To ensure “alignment” with the relevant Governance Group and service management governance, a “Palliative change champion” approach within each key service area may need to be considered at different levels to drive the change.

8. Implementation of Palliative Care Strategy

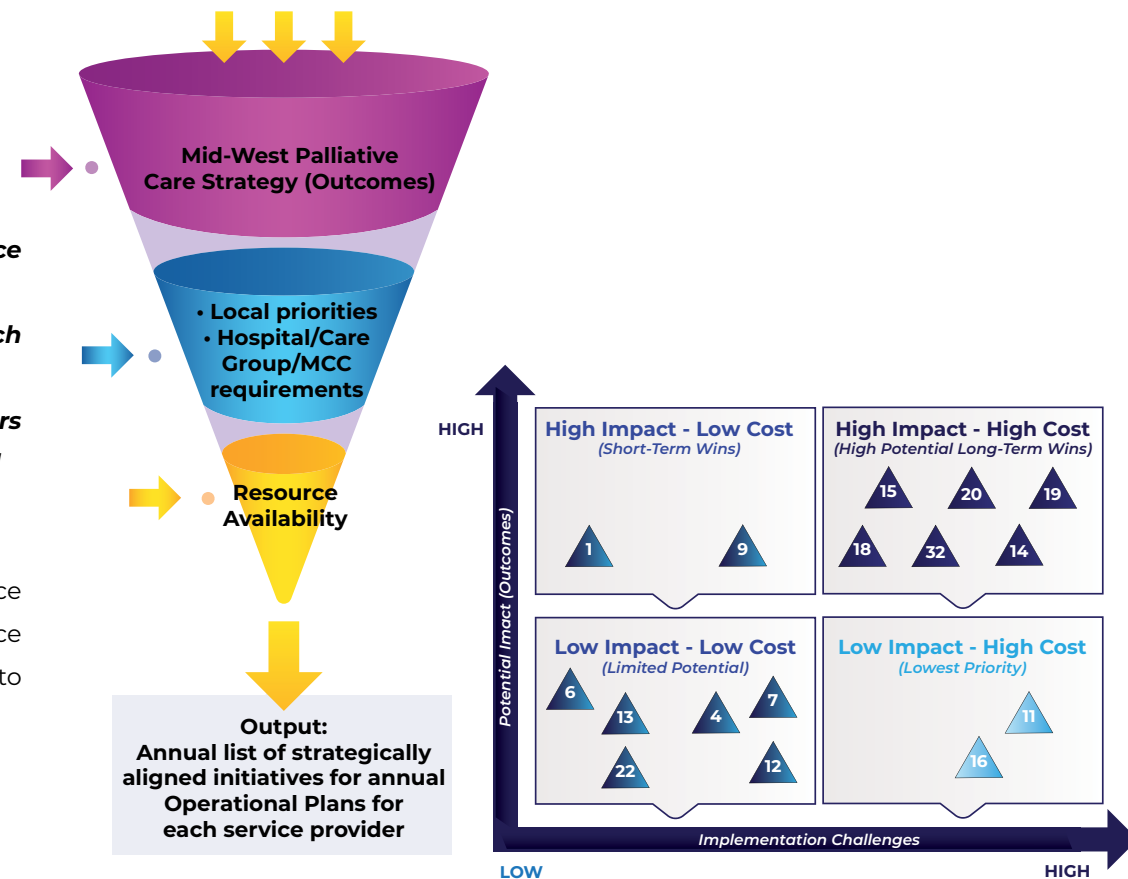
8.4 Prioritisation

As stated in the “Leadership” section there will be a need to consider a phased approach to the delivery of the strategy. Key prioritisation factors include:

- **Consideration of the value/benefit of an initiative in the context of the stated outcomes in the Strategy**
- **Priority issues for the Service Providers within their own “operational” governance**
- **Funding availability to support key initiatives**
- **“Readiness” for change at a point in time**
- **The “longitudinal” nature of certain initiatives that will need to commence at a reasonably early stage**
- **The “enabling” nature of certain initiatives to support a change approach**
- **Complexity of implementation of certain initiatives**
- **Linkages across this Strategy Map where certain objectives support others**
- **“Quick win” opportunities so that implementation can start quickly and achieve some benefits**

The following figures demonstrate an annual process that needs to take place in order to determine the key initiatives that need to be included in the service plan for each provider and also a potential tool for the governance group to prioritise initiatives. The latter tool concentrates on 2 key issues:

- **Potential benefits that can be achieved**
- **Implementability (time and investment challenges).**



8. Implementation of Palliative Care Strategy

8.4 Prioritisation

Consideration could be given to a phased approach e.g.

Phase 1	100 Day Planning (described above)
Phase 2	April 2021-November 2022

Initiatives in Phase 2 could be focused on creating immediate improvements and deciding on stabilisation initiatives that will be the foundation for Phase 3 and Phase 4 projects. For example:

- ***Develop and roll out Palliative Care Charter for Mid-West in order to “buy in” key stakeholders and create a better understanding of Palliative Care***
- ***Establish prototype Palliative Care portal to provide key information supports/videos etc.***
- ***Design and implement scope of practice agreements between SPC services and generalist services***
- ***Agree access policies (as identified in the score cards)***
- ***Provide outreach satellite bases across SPC services***
- ***Agree policy for attendance at Level 1 palliative care approach training and Level 2 general palliative care training***
- ***Palliative care approach courses on HSEland***

Phase 3 & 4 January 2023 – December 2025

The initiatives in Phase 3 should focus on those initiatives which are dependent on Phase 2 e.g.

- ***Alignment of key staffing groups to Health & Social Care Network***

8. Implementation of Palliative Care Strategy

8.5 Programme Assurance

Once the phase 1 initiatives for implementation are identified they need to be converted into formal projects.

A basic agreed methodology is required for initiating and reporting on projects within the Palliative Care Programme.

Initiation

A standardised charter template (1 page document will suffice) should be used to initiate all projects so that there is clarity on:

- **Objectives of the initiative in question**
- **The outcomes/measures to be achieved (including the “gap” to be achieved) and alignment with the strategy map**
- **The timescale for achievement**
- **The key stakeholders involved**
- **The key deliverables and milestones**
- **Assumptions/constraints**
- **Estimated cost and/or resources**

This charter should be submitted to the relevant Governance Group by the Project Lead. (It is noted as Project Leads will be coming from different service providers, the ensuing project management methodology may be different after sign off of the charter).

Reporting

Progress on project milestones

Progress reports should be sent by the Project Leads to the Project Sponsor on a bi-monthly basis. Updates will contain progress on the achievement of key milestones (agreed at outset by Project Lead and Sponsor) and any risks/issues that must be considered. Thereafter the Project Sponsor will relate progress to the Governance Group in an agreed format.

Note: It is recommended that Project Vision within the Mid-West PMO be used to support reporting across the Programme, similar to the approach used for the “Connecting for Life Programme”, which enables summary reporting on milestones/risk etc. for the relevant Governance Group.

Progress on “outcomes” set out in the Palliative Care scorecard

The above reporting relates only to the “work” of the projects. The performance data on outcomes must also become a focal point for discussions at an agreed review period e.g. (6 monthly) by the Governance Group.

Key questions for the Governance Group include:

- **Does the data over the course of the strategy confirm the cause and effect theories represented on the Strategy Map, if it doesn’t do the Strategic linkages need to be reviewed?**
- **Does the initiative help reach the intended “measure gap”? If not, does the initiative need to be enhanced?**

In relation to the gathering of data relating to “outcomes”, existing PI reporting mechanisms should be used to inform the Governance Group or else the relevant initiatives will have to consider as part of the project work, the setting up of a data source. Discussions will be required on a project by project basis in this regard. As stated earlier this process can be facilitated by “Objective Owners” from the Governance group, who will act as sponsors and who will have oversight of success or not across the relevant “objectives” by way of monitoring achievements.

8. Implementation of Palliative Care Strategy

8.6 Change Management

Organisational change management will be crucial to delivering the Mid-West Palliative Care Strategic Plan. Key stakeholders will need to support the new direction envisaged within the Strategy and a clear communication approach is required that provides the right information and guidance to help people manage the change. A communication plan will be the most integral piece of the change management process in order to create a steady, regular flow of information.

There needs to be an agreed approach across the service providers as to how to communicate the Palliative Care transformation story to key stakeholders and also to report on progress. Key communication initiatives should take place during the 100 day period.

Key work includes:

- *Developing an agreed change story i.e. case for change, rationale for specific proposals etc.*
- *Develop communication tools e.g. press material, presentations for staff*
- *Tailored engagement strategy to specific stakeholders*
- *Task Governance Group members to act as advocates and engage in their service areas*

9. Appendix 1: Working Group, Project Team & Contributors

Working Group

Kate Duggan (Co Chair)	Head of Primary Care, HSE Mid-West Community Healthcare Organisation
Pat Quinlan (Co Chair)	CEO MCC
John Bulfin	Chair of Mid-West Palliative Care Consultative Forum
Kay Chawke	Director of Nursing Therapy & Social Care, MCC
Dr Marian Conroy	Consultant in Palliative Medicine, MCC
Tom Kirby	Patient Representative
Helen McCormack	Medicine Directorate, General Manager, UL Hospital Group
Carol Murray	Head of Non-Clinical Support Services, MCC
John O'Mahony	Executive Clinical Director, Mental Health
Martina O'Reilly	Head of Education Research & Quality, MCC
Aisling Ryan	Portfolio Lead, HSE Mid-West Community Healthcare Organisation
Sheila Ryan	General Manager, Older Person's Residential Services, HSE
Seamus Woods	Project Lead (Project Management Consultant) E: seamus.woods@gmail.com

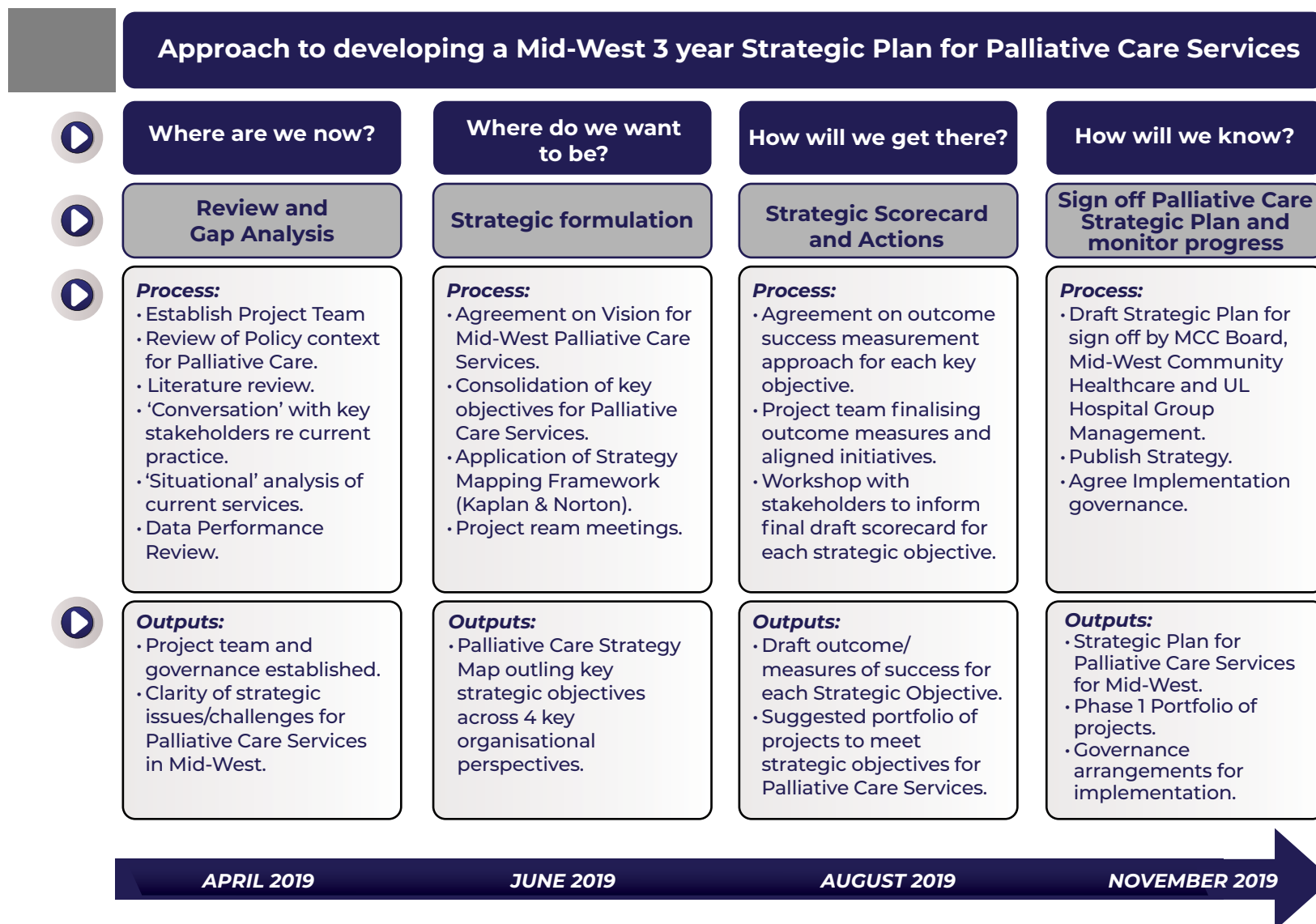
Project Team

Leonora Carey	Occupational Therapy Manager, MCC
Maria Conlon	Portfolio Management Support Officer, HSE Mid-West Community Healthcare Organisation
Ross Cullen	Programme Lead, HSE Mid-West Community Healthcare Organisation
Jacqueline Holmes	ADON Specialist Palliative Care Community Services, MCC
Noel Kennedy	Principal Social Worker, MCC
Carmel Murray	Head of Physio, HSE Mid-West Community Healthcare Organisation
Sinead O'Sullivan	ADON Inpatient Services, MCC
Breda Purcell Hartnett	Homecare Package Co-Ordinator, HSE Mid-West Community Healthcare Organisation
Shirley Real	Physiotherapy Manager, MCC
Marcella Ryan	Portfolio Management Support Officer, HSE Mid-West Community Healthcare Organisation
Marie Wrigh	Chief 11 Pharmacist, MCC

Contributions from

Noreen Spillane	Chief Operating Officer, UL Hospital Group
Mary O'Brien	Head of Social Care, HSE Mid-West Community Healthcare Organisation
Declan Deegan	HR Manager MCC
Marie Gleeson	Business Manager, Older Person's Residential Services, HSE
Howard Johnson	Health Atlas, HSE
Paul Kavanagh	Health Atlas, HSE
Mai Mannix	Department of Public Health Medicine

10. Appendix 2: Broad approach to developing Strategy



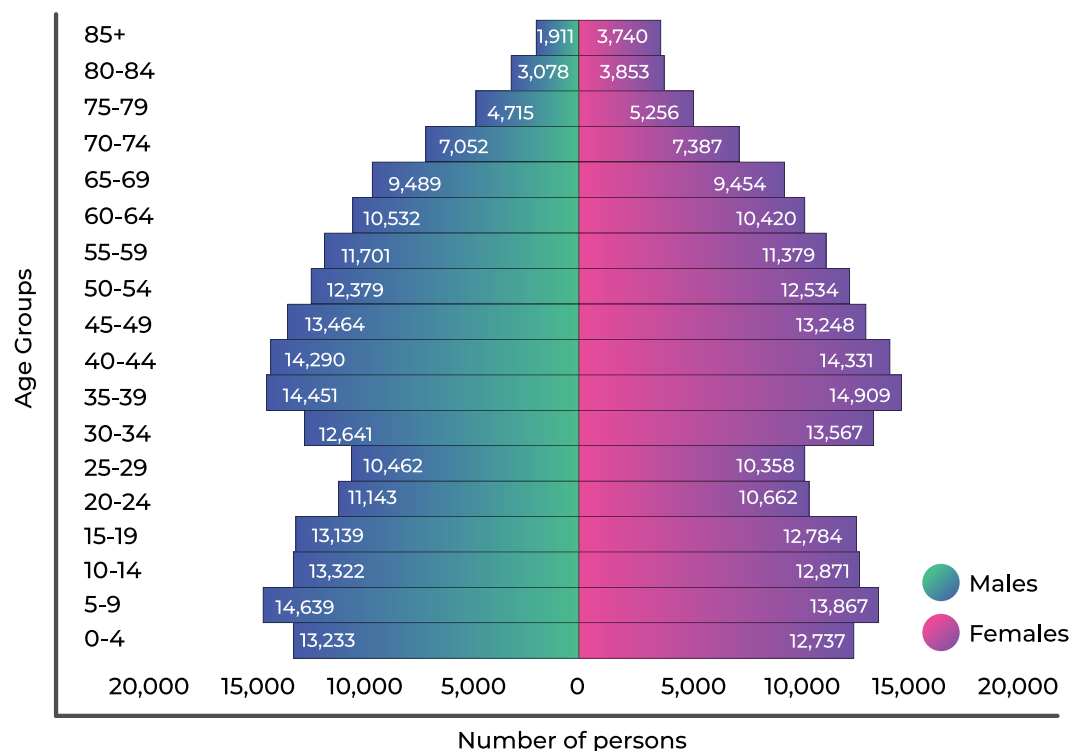
11. Appendix 3: Detailed Findings from Discovery Phase

Data: General Overview - The population is growing and ageing

The population of the Mid-West increased in size by 1.5% between 2011 and 2016, from 379,327 to 384,998 persons. Limerick had the largest population (n=194,899) in the region followed by Clare (n=118,817) and North Tipperary (n=71,282). Using Census 2016 data, figure 1 presents the population of the Mid-West by sex and age group. There were 191,641 males and 193,357 females living in the region in 2016. The 65-74 year old age group had the biggest increase (+6,186 persons)

and the 25-34 year old age group had the biggest decrease (-9,252 persons) between 2011 and 2016. The age profiles for Clare, Limerick and North Tipperary were similar in 2016, though Limerick had a slightly higher proportion of 20-34 year olds.²¹

Figure 1. Population of the Mid-West by sex and age group, 2016



11. Appendix 3: Detailed Findings from Discovery Phase

Data

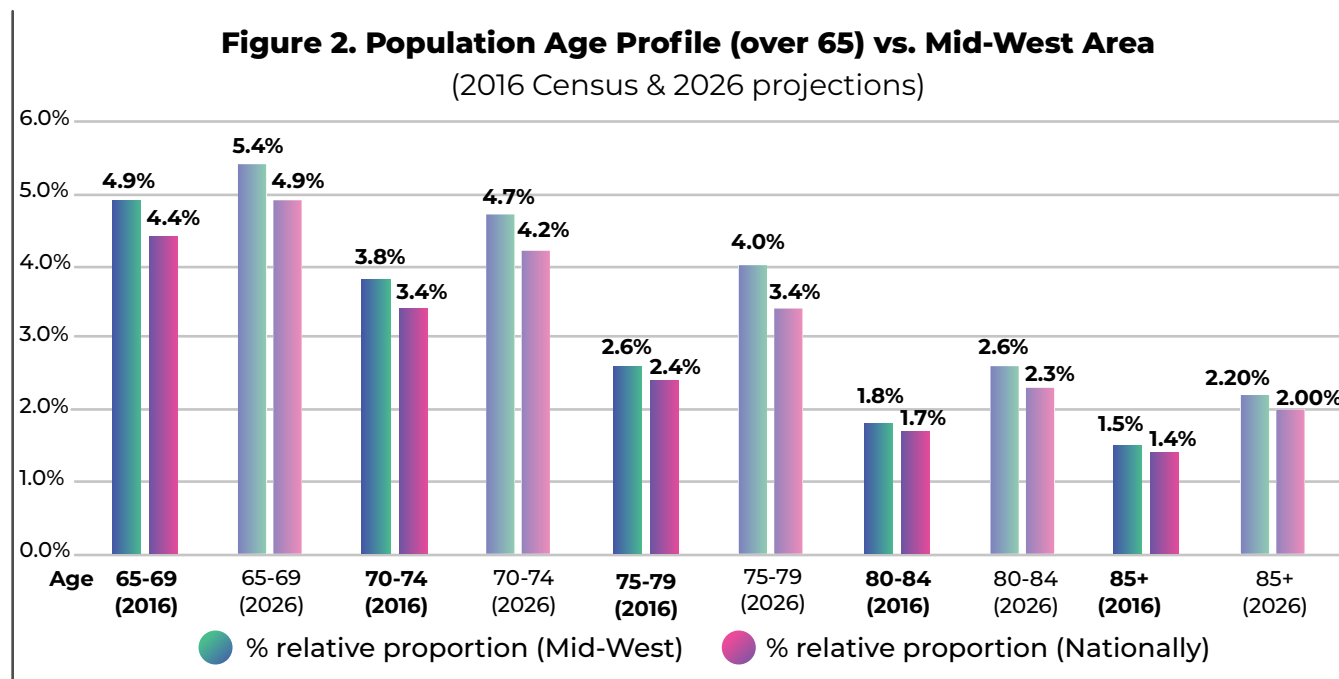
Older persons

Census 2016 highlighted that the population of Ireland is ageing. This demographic change has significant implications for the health service.²¹

The chart below sets out the relative position of the Mid-West over 65 population against the National average.

The number of people 65+ is projected to increase, and as highlighted in census 2016 and in the above chart, the population of Ireland is ageing. This demographic change has significant implications for health services, including the requirement for continued growth in Palliative Care:

- An ageing population where the average number of deaths is projected to grow steadily in Ireland (CSO estimate a 27% increase in deaths between 2011 and 2031).
- 80% of total deaths in Ireland are estimated to be associated with patients who have conditions that have Palliative Care needs. *Kane et al 2014*¹ concluded that “future Palliative Care policy decisions in Ireland must consider the rapidly ageing Irish population (Mid-West profile from chart is above national average), with the accompanying increase in deaths from cancer, dementia and neurodegenerative diseases”.
- Ireland’s ageing population driving a large increase in the number of new cancer patients over the next few decades.



11. Appendix 3: Detailed Findings from Discovery Phase

Data

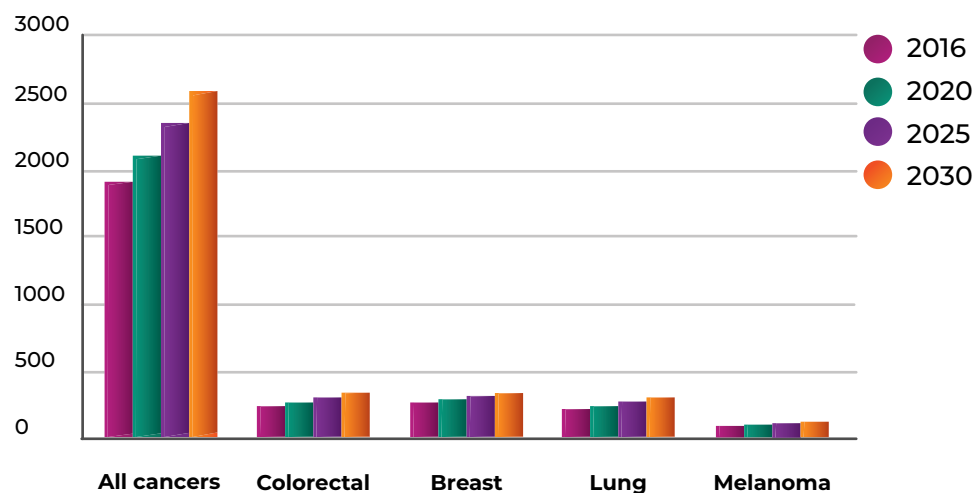
Cancer

The most recent annual statistical report of the *National Cancer Registry – Cancer incidence projections for Ireland 2020-2045*¹⁶ published in November 2018 provides a summary of projected changes in the cancer incidence burden in Ireland up to 2045. They reported that it is likely that by 2045, there will be at least a 50% increase in the numbers of cancers diagnosed. The number of cancer cases has been increasing by about 3% a year since 1994. 62% of male patients with cancer and 53% of female patients during the period of 1994 & 2014 were aged over 65 (*National Cancer Strategy 2017-2026*)¹⁷.

The following table represents the projected cancer incidence numbers for the Mid-West region from 2016-2030, as compiled by Health Atlas and based on the NCRI Cancer data.

It is obvious with the significant increase estimated in cancer incidence going forward, this will have a clear knock-on effect on the demand for Palliative Care services in the Mid-West region and beds in the IPU at Milford Care Centre.

Figure 3. Cancer Incidence Numbers - Both sexes



Both	2016	2020	2025	2030
All cancers	1918	2112	2358	2595
Colorectal	243	271	308	344
Breast	274	295	320	342
Lung	221	248	284	318
Melanoma	98	107	118	128

- Data was obtained from NCRI cancer website - incidence statistics section.
- <https://www.ncri.ie/data/incidence-statistics>.
- A profile per diagnosis was created from 2015 figures (the most recent available at present).
- Age specific rates (per 100,000 population) were recorded and applied to Health Atlas Ireland population projections for CHO3.
- Figures were rounded to the nearest

11. Appendix 3: Detailed Findings from Discovery Phase

Data

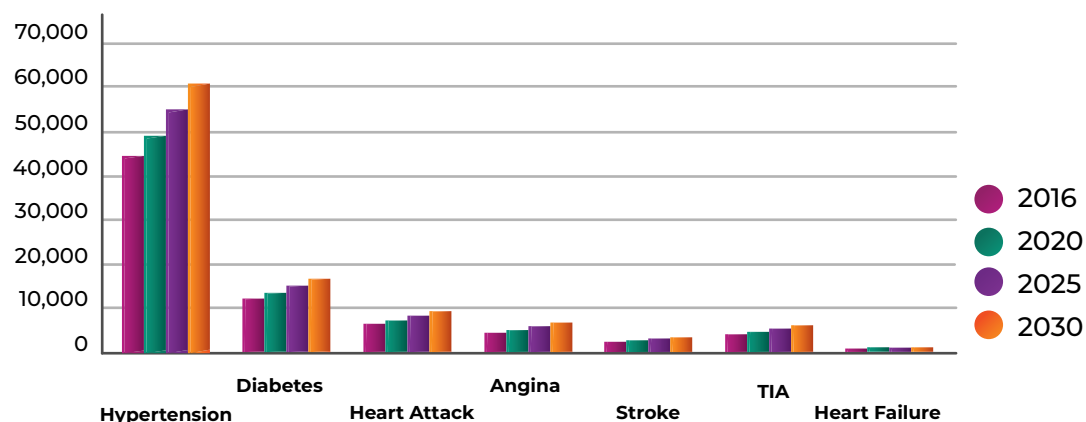
Chronic Disease

Palliative Care has been associated with caring for people with cancer, but future provision must also care for other chronic diseases such as dementia and other neurological diseases, cardiovascular, renal and respiratory diseases. Together with cancer, the prevalence of these diseases is increasing rapidly.

(*Adult Palliative Care Services Model of Care in Ireland – The National Clinical Programme for Palliative Care*¹⁸).

All	2016	2020	2025	2030
Hypertension	44615	49165	55173	61008
Diabetes	12135	13373	14991	16564
Heart Attack	6678	7437	8477	9499
Angina	4662	5267	6108	6947
Stroke	2613	2920	3342	3758
TIA	4292	4840	5604	6364
Heart Failure	1068	1178	1332	1481

Figure 4. Chronic Disease Numbers - Both sexes

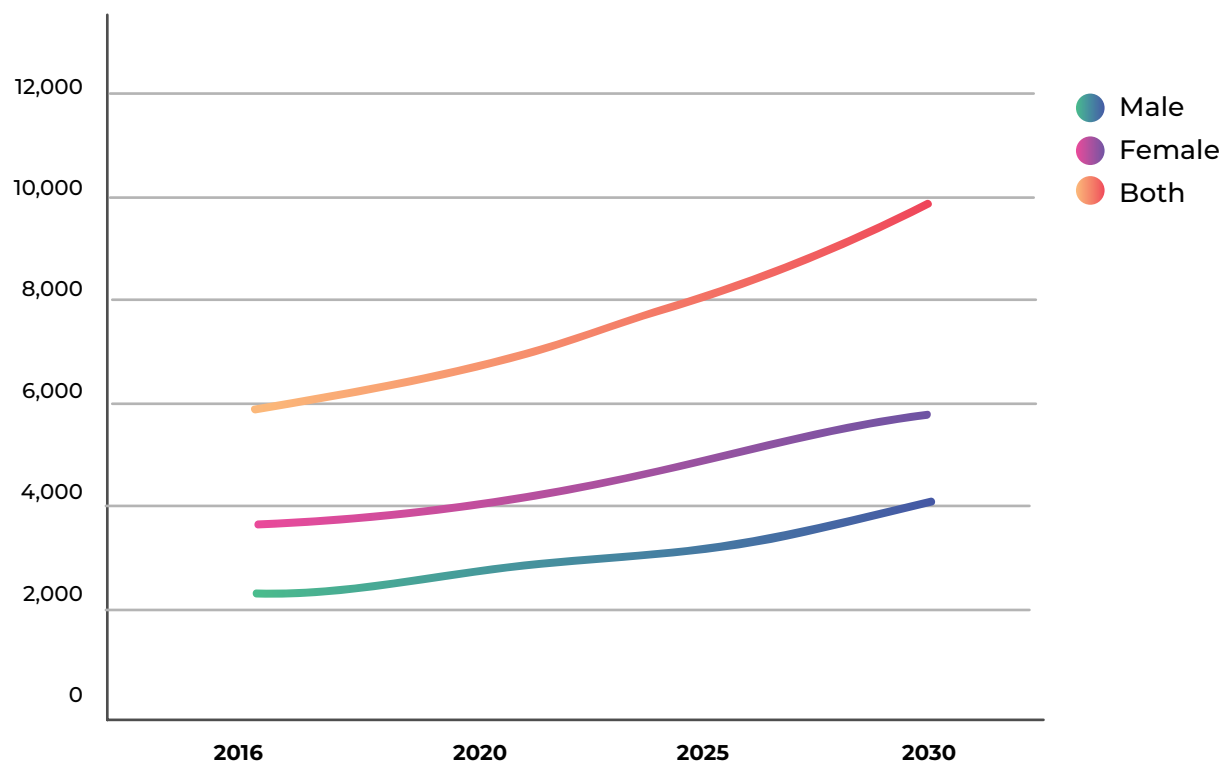


- Data was obtained from the 'Change in chronic disease prevalence and health behaviours over the first four waves of TILDA' chapter (6) from the TILDA website.
- <https://tilda.tcd.ie/publications/reports/pdf/w4-key-findings-report/Chapter%206.pdf>
- The population prevalence (%) was recorded by age group (and by age group with gender, if available).
- The age specific percentage prevalence was applied to the Health Atlas Ireland population projections for CHO3.
- Figures were rounded to the nearest whole number.

11. Appendix 3: Detailed Findings from Discovery Phase

Data

Figure 5. Dementia Numbers



	2016	2020	2025	2030
Both	5883	6743	8136	9866
Male	2250	2654	3268	3994
Female	3632	4089	4868	5872

- Data was obtained from the 'Prevalence and Projections of Dementia in Ireland, 2011 – 2046' by Dr. Maria Pierce, Prof. Suzanne Cahill and Prof. Eamon O'Shea from the Genio website.
- https://www.genio.ie/system/files/publications/Dementia_Prevalence_2011_2046.pdf
- The population prevalence (%) was recorded by age group and gender.
- The age specific percentage prevalence was applied to the CSO population projections for the Mid-West region.
- Figures were rounded to the nearest whole number.
- Male prevalence number and female prevalence numbers were added together to obtain overall prevalence numbers.

11. Appendix 3: Detailed Findings from Discovery Phase

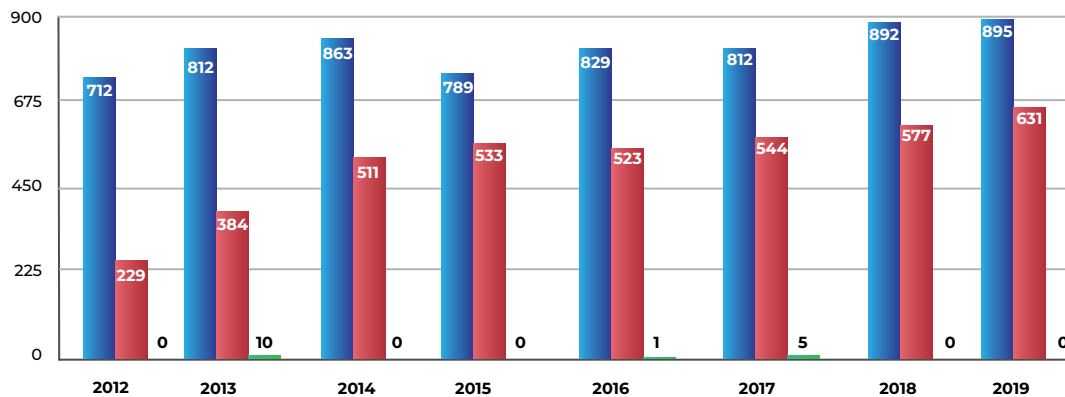
Data

Milford Care Centre – Data

The charts for the Milford Care Centre, set out below, highlight the following:

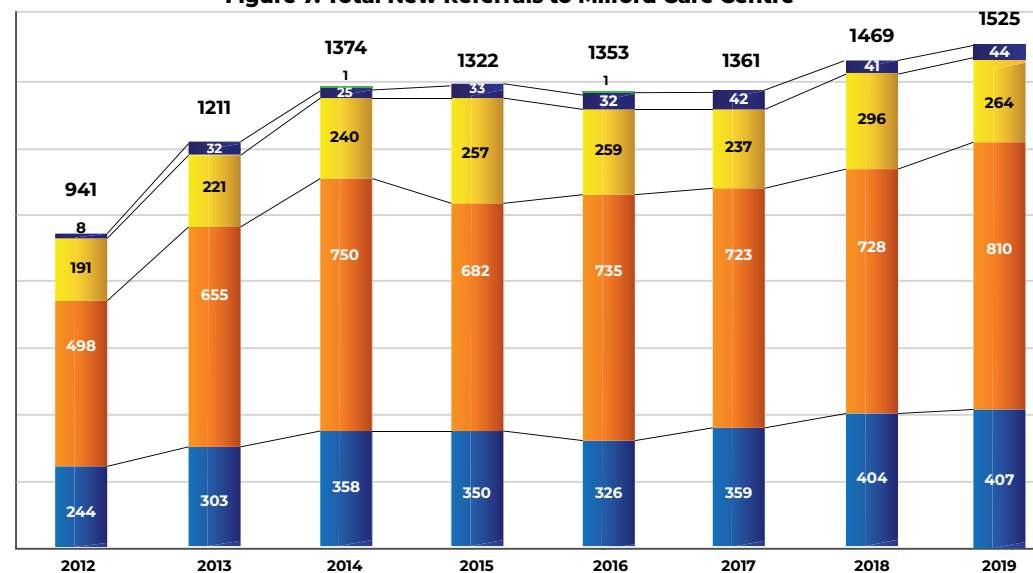
- An increase in the number of referrals to Milford Care Centre
- An increase in referrals of patients with non-malignant diseases
- An increase average occupancy in the inpatient unit
- A decrease in the number of SPC patients dying at home

Figure 6. Diagnoses by Classification



- Malignant
- Non-malignant
- Not Listed

Figure 7. Total New Referrals to Milford Care Centre



- Abroad
- Other County
- Tipperary
- Limerick
- Clare

11. Appendix 3: Detailed Findings from Discovery Phase

Data

Figure 8. % Occupancy Levels in MCC IPU

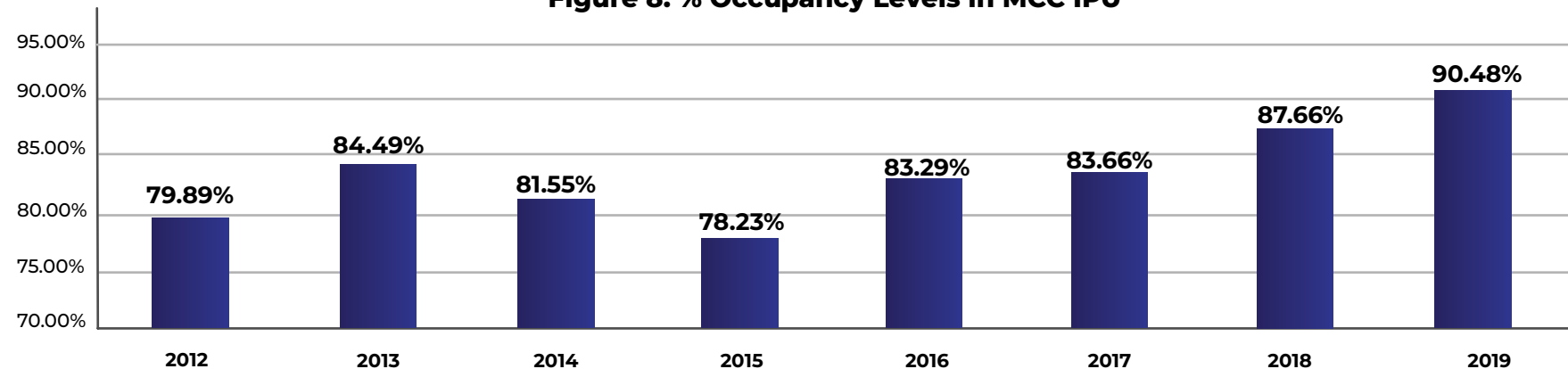
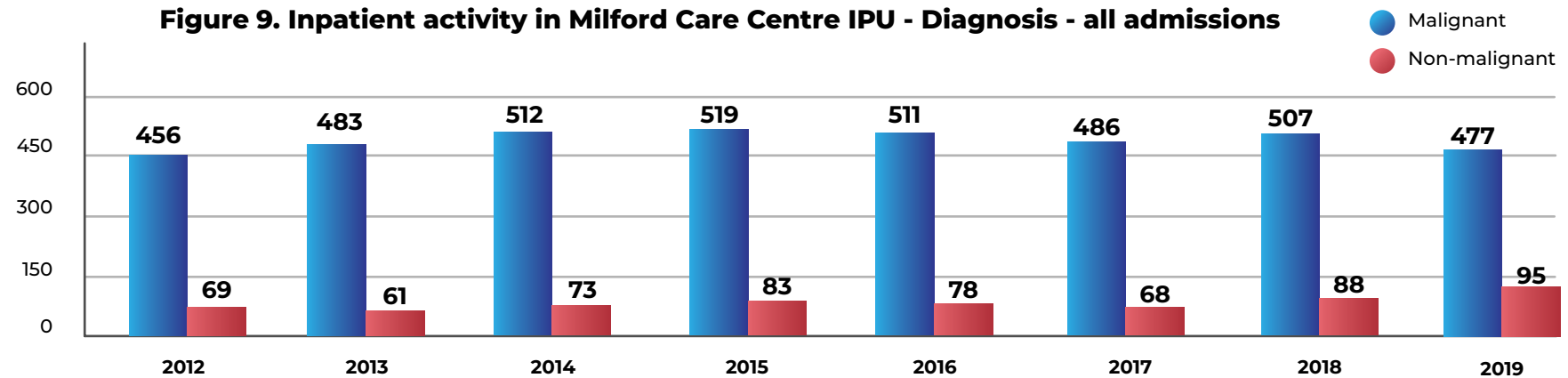


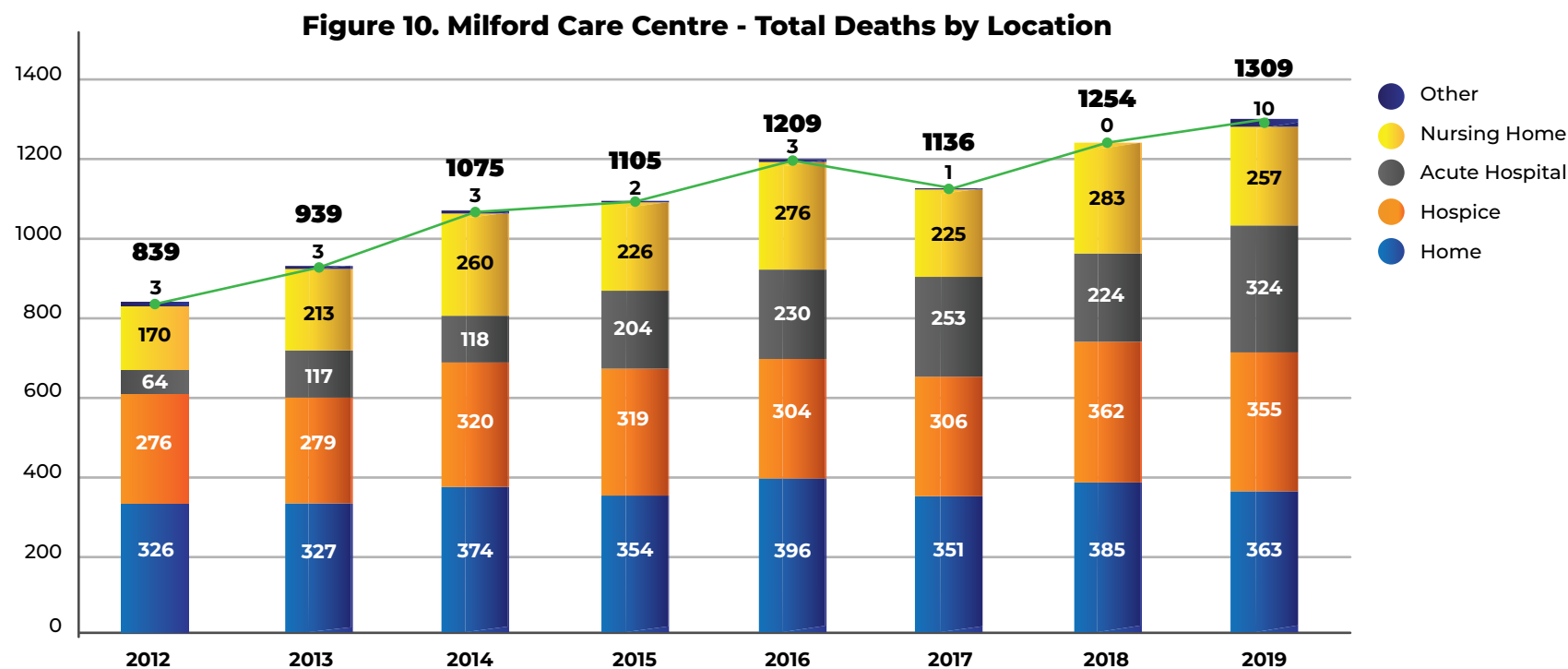
Figure 9. Inpatient activity in Milford Care Centre IPU - Diagnosis - all admissions



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Data

The growth and demand due to demographic changes, highlighted in the previous section, will require a combination of increased emphasis on community services and an increase in the number of in-patient unit beds, in line with *The Report of the National Advisory Committee on Palliative Care (2001)*⁴.



11. Appendix 3: Detailed Findings from Discovery Phase

Data

Palliative Care support beds

As set out by the National Advisory committee on Palliative Care report 2001, Palliative Care Support Beds were proposed as a means of providing an intermediate level of inpatient care for patients in a local environment, typically in designated centres for older persons. However as raised in the finding from the SWOT analysis (see next section), issues around role, governance, access and discharge planning has arisen over the past number of years and this can be seen from the chart below. This has resulted in the underutilisation of beds.

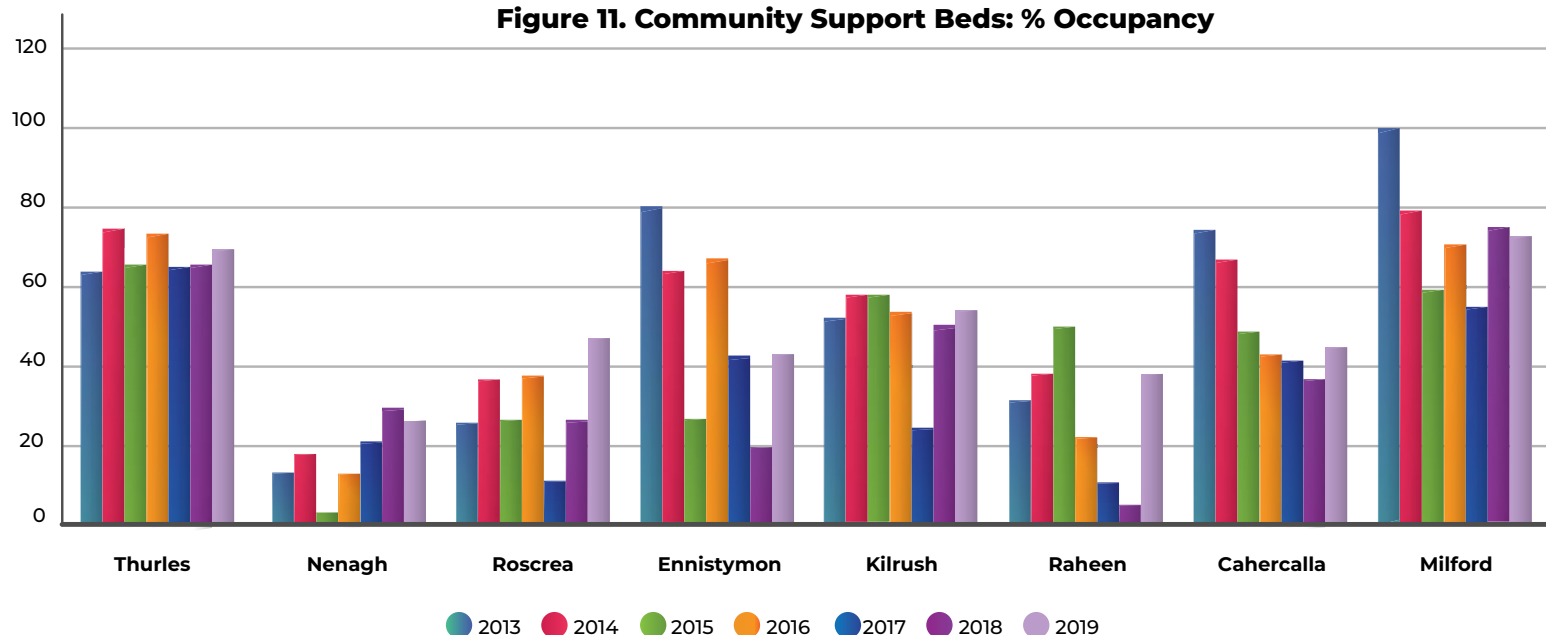
Arrangements to maximise the use of such beds currently under discussion with key stakeholders across the Mid-West, in line with the principles set out in the report of the first National Palliative Care Support Bed Review in 2014. The following chart sets out the current average occupancy level of Palliative Care support beds across the Mid-West region.

Summary of Data

Mid-West Palliative Care Services must continue to develop in order to ensure all persons who have Palliative Care needs can readily access appropriate services. With the expectant growth in need (increasing number of over 65's, increasing number of over 65's with chronic disease, increasing cancer rates) , there will be requirement to ensure:

- Adequacy of beds available in the IPU
- Appropriate use of Palliative Care support beds
- Increase capability and capacity in the community, across both generalist and SPC services

Figure 11. Community Support Beds: % Occupancy



11. Appendix 3: Detailed Findings from Discovery Phase

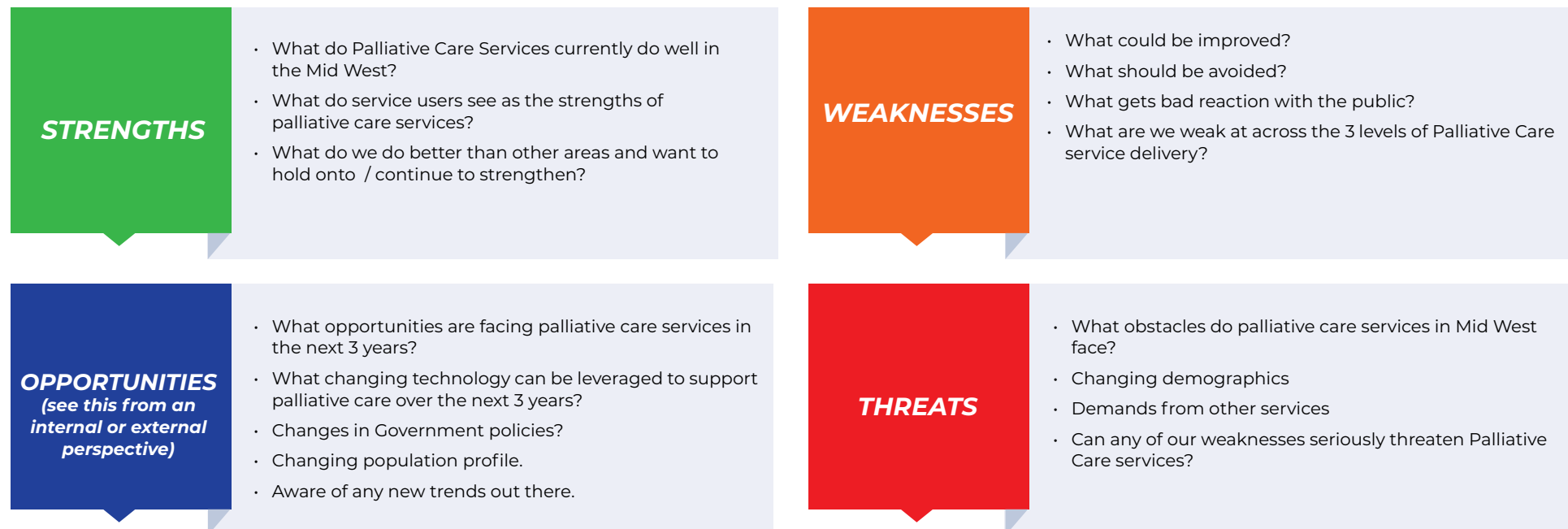
Findings from SWOT analysis and interviews

As set out in the original Project Charter, significant consultation had taken place regarding Palliative Care services in Ireland in recent years. In that context it was decided that consultation and stakeholder engagement should concentrate on the “picture” of palliative services in the Mid-West and ensure engagement with the key practitioners across the key service providers. This was seen as critical to inform and enrich the proposed actions written in the Strategic Plan.

A SWOT analysis was considered an easy way for stakeholders to communicate their thoughts and views on palliative services in the Mid-West and in effect give “a pulse check” of services and future concerns. This gave key stakeholders an opportunity to give a picture of how Palliative Care stands now in terms of its strengths, deficiencies and achievements. A “twin” approach was taken to the gathering of information in this regard:

- The Project Lead met with key stakeholders from organisations across the Mid West
- A SWOT template and guidelines were disseminated down to key front line managers across a range of organisations

The questions asked in the SWOT were as follows, with the findings and conclusions set out overleaf by way of identifying the key issues and the impact on current Palliative Care Services. (A more detailed summary of the SWOT findings is available)



11. Appendix 3: Detailed Findings from Discovery Phase

Findings from SWOT analysis and interviews

Key Message from SWOT	Impact on Palliative Care Services
The Mid-West is an ageing population with more prevalence of chronic and lifestyle diseases and with increasing cancer rates	<i>This puts pressure on existing systems, including specialist Palliative Care Services. There is an increasing demand on inpatient Palliative Care Services in Milford with an average of 90.55% occupancy of beds in 2019 compared to 87.66% in 2018</i>
Access to services <ul style="list-style-type: none"> • Some geographical inequities exist across the Mid-West e.g. level of medical cover in Nenagh hospital, lack of social worker provision in UHL, access to Level 2 beds etc. • Lack of formalised anaesthetic/pain intervention in the inpatient unit and lack of formal liaison psychiatry service to the inpatient unit 	<i>Population health needs is one of the corner stones of Sláintecare. Lack of access leads to service provision inequalities and poor health outcome for service users.</i>
No coherent view of a person's needs across the various services involved with the service user	<i>Service user can sometimes experience disjointed or duplicated services</i>
Evidence of some breakdown of working and collaboration of services within the current care pathway	<i>Strained service points, stressed providers and reduced job satisfaction</i>
Over reliance on specialist services to deliver Palliative Care, especially where skills etc. appropriate to Level 1 and Level 2 Palliative Care are not available within local services	<i>Overloaded demand on specialist Palliative care multi-disciplinary teams and inpatient unit</i>
Underutilisation of Palliative Care support beds across the Mid-West	<i>Delayed discharges from acute units and increased pressure on community services</i>
Increasing demand on the SPC community services across the geographic remit of the Mid-West	<i>Increased prioritisation on home visits and inadequate time spent with service users</i>

11. Appendix 3: Detailed Findings from Discovery Phase

Findings from SWOT analysis and interviews

Key Message from SWOT cont'd.	Impact on Palliative Care Services cont'd.
Lack of key administrative support at UHL and Milford to manage the data entry system for PCOC	<i>Delays in outcome measurement could have serious impact on clinical decision making and resource allocation</i>
Continuous stigma and fear of Palliative Care amongst the public. Palliative Care is still synonymous with death and with care in the last few weeks of life and also as an alternative to further treatment	<i>Late referrals to Palliative Care services. Loss of quality of life and less symptom control for service user.</i>
Need to continue to consolidate the Mid-West having a Centre of Excellence in Milford, with an advanced education portfolio	<i>Oversight of evidence based practice that will improve outcomes for service users.</i>
Lack of protected time for reflection and learning across services	<i>Not enough formal and informal coaching by the Specialist Palliative Care Team in order to disseminate best practice. Lack of learning/support for staff following difficult situations</i>
Limited existing medical governance available to support Level 2 support bed units	<i>Lack of clarity on clinical governance and ownership of care plans Low take up of Palliative care support beds</i>
Core underfunding for Milford	<i>Will be challenging to retain and recruit specialist staff and carry out education remit to generalist services</i>
Need to further the ICT agenda to improve clinical communication and support the integration approach	<i>Impacts joined up care, delays timely decision making and measurement of outcomes</i>
Improved availability of out of hours specialist services	<i>Would help prevent avoidable admissions and improve outcomes for service users</i>
Improved support in education for carers required	<i>Carers need further support in order to be as effective as possible</i>
Bereavement services and support needs to be addressed across the Mid-West	<i>Bereavement will continue to be inadequately addressed across the Mid-West</i>
Training/education is not widespread enough across generalist services	<i>Leads to increased demand on specialist services, reduced quality of life for services users in care settings and inappropriate A&E incidents</i>

11. Appendix 3: Detailed Findings from Discovery Phase

Themes from research

Palliative Care Services in Ireland have been guided principally over the last 18 years by the 2001 NACPC report (this policy document is due to be revised by the Department of Health in 2020). Most of its findings are as important and relevant today as they were in 2001, particularly its underpinning principles and broad model of care.

Subsequently there were further significant reports such as *Palliative Care for All - Integrating Palliative Care into Disease Management Frameworks*(2008)¹⁷ which looked at the Palliative Care needs of adults with diseases other than cancer. Also significant was the *Hospice Friendly Hospitals – the case for continued investment*, HSE Nov 2014 ¹⁴ which looked at end of life care in hospitals, in partnership with staff and interested parties such as bereaved relatives, HIQA etc. and the *Primary Palliative Care in Ireland - Irish Hospice Foundation, HSE and ICGP (2011)* ¹⁵ which looked at identifying Palliative Care initiatives that would support Primary Care teams responses to adults living with life limiting diseases in the community.

Further key reports included *The Strategic importance of Palliative Care within the Irish health service – The Irish Hospice Foundation (2013)*¹⁷ which looked at both structural and operational reforms to ensure more cost effective services. The *Palliative Care Services Three Year Development Framework (2017-2019)*⁶ was to build on the *Report of The National Advisory Committee on Palliative Care (2001)* ⁴ and more lately the HSE's National Clinical programmes published in 2019 *Adult Palliative Care Services Model of Care in Ireland – The National Clinical Programme for Palliative Care* ¹⁸ which is expected to drive best practice across the country.

The following themes have emerged from the research material (see list of research documents in Appendix 4)

Delivery models

The Committee on the future of Healthcare - Sláintecare Report⁸ reported that “the goal of the integrated model for palliative care as delivered in Ireland is to improve quality of life for both the patient and family, providing patients with relief from the symptoms, pain and stress of a serious illness, whatever the diagnosis.”

The Adult Palliative Care services Model of Care in Ireland – The National Clinical Programme for Palliative Care¹⁸ subscribed to the objective that “the aim of the Palliative Care Programme Model of Care is that ‘Every person with a life-limiting or life threatening condition can easily access a level of palliative care appropriate to their needs regardless of care setting or diagnosis to optimise quality of life’”.

Kane et al 2014¹ noted that “future palliative care policy decisions in Ireland must consider the rapidly aging Irish population with the accompanying increase in deaths from cancer, dementia and neurodegenerative disease, with associated care need, adding that new models of Palliative Care may be required to address this”.

11. Appendix 3: Detailed Findings from Discovery Phase

Themes from research

Specialist Palliative Care

The specialist palliative care inpatient unit should be the core essential element of the specialist palliative care service. It should be the “hub of the service” around which all components of specialist service revolve. ‘The SPC unit (SPCU) is regarded as the core element of the SPC service and the unit serves where activity is centred on the delivery of palliative care’.⁴ The specialist unit should act as a resource for other health professionals in the area, providing support and advice when needed. Existing specialist inpatient units should develop plans to move to all single room patient accommodation.⁶

*The Strategic importance of palliative care within the Irish health service – The Irish Hospice Foundation 2013*⁷ highlighted that “the development of specialist and generalist palliative care services is already supporting the delivery of some of the healthcare commitments made in the Programme for Government. The continued development of these services – particularly if managed strategically and with a clear overview – could contribute significantly to the achievement of the aspirations of reform”. This report also noted that “Any element of a national healthcare system that cares for a significant proportion of the population, expects client numbers to continue to grow, and commands a significant direct and indirect budget, must plan effectively for the future delivery of services. This is particularly the case with palliative care”.

Professional/Clinical Staff

The need for attracting and retaining qualified staff to the service was outlined in *The Palliative Care Services Three Year Development Framework (2017-2019)*⁶. This report acknowledged the need for continuous training, clear pathways and good working conditions for all staff. It is noted that “Specialist palliative care services have generally been successful in attracting and retaining qualified staff, and have managed to avoid the worse of the recruitment difficulties currently being experienced in the wider health services”. These can include providing career pathways for all disciplines, good workforce development processes, clear role definition, opportunities for education and research, and good working conditions, but the overall objective should be to enhance the work experience of all staff and empower them to achieve their full potential and be the best they can be. This will in turn enhance the quality of service provision and improve patient experience”.

11. Appendix 3: Detailed Findings from Discovery Phase

Themes from research

Patient Needs

Dr. Diarmuid O'Shea noted at a Joint Committee on Health debate on 7th March 2018 that "approximately 1 million people suffer from a variety of chronic illnesses, including dementia, respiratory diseases, cardiovascular diseases and diabetes. The Irish longitudinal study of ageing reports that 65% of the over 65 age cohort lives with comorbidities and multiple illnesses. The current and projected impact of chronic disease presents a major challenge not just for the health service but also for Irish society and the economy. We have more people living longer and the numbers with chronic disease and multiple comorbidities will increase. While it is very welcome that the range of investigations, tests and treatments available is increasing and improving, it comes at a cost. We must continue to implement change to meet present and future challenges and the projected demand on services in the next decade".

Annually 80% of deaths in Ireland are from conditions considered to have Palliative needs *Kane et al 2014*¹. The same report notes that Ireland is one of the countries with the highest need for Palliative Care globally because of demographic changes and also highlights the fact that multiple studies have shown that across a range of serious illnesses, Palliative Care services improve clinical and quality care outcomes and enable patients to avoid acute hospitalisation and remain safely and adequately cared for at home.

Community Based Services

The *Palliative Care Services Three Year Development Framework (2017-2019)*⁶ report noted that one of the major challenges facing the Irish Health System was "a move from predominantly hospital-centric health service delivery to deliver of care at/or close to home." It also states that "by investing in properly re-located community services care for patients with both malignant and non-malignant diseases.....leads to a reduction in inappropriate admissions, more appropriate care pathways and improved experiences for patients and their family."

Carers

The report on *Palliative Care Services Three Year Development Framework (2017-2019)*⁶ contained an action point that "An awareness of the needs of carers should be embedded in specialist palliative care culture, with a view to ensuring that those needs are identified and met".

The *Adult Palliative Care Services Model of Care in Ireland – The National Clinical Programme for Palliative Care*¹⁸ report highlighted the "lack of assessment of needs of carers and provision of supports". The report also highlighted that "caring for a person through illness and at end of life is something that is both deeply rewarding and extremely challenging. Carers deserve recognition for their work and they require support themselves in order to sustain their role". This report also highlighted the Government's plans to provide better support for carers through the National Carers Strategy.

11. Appendix 3: Detailed Findings from Discovery Phase

Themes from research

Bereavement Support

Bereavement support should be an essential part of all palliative care programmes. There is a recognition that much more work needs to be undertaken at a national and local level to improve the bereavement support available to families. *Report of The National Advisory Committee on Palliative Care (2001)* ⁴ noted that this should begin early in the process, long before the death of a patient. This report also stated that “Bereavement support should be available in all settings where specialist care is offered. This includes specialist palliative care units, general hospitals, community hospitals and within the home care setting”.

The Irish Hospice Foundation Strategic Plan 2016 – 2019 ¹⁰ stated that “Because everyone in Ireland matters right to the end of their life, we seek to create a coherent demand for better end-of-life, bereavement and palliative care services”.

Information Communication Technology

To enable Palliative Care services to work efficiently and effectively across service settings, significant and enhanced information technology and data management support is required.

The *Adult Palliative Care Services Model of Care in Ireland – The National Clinical Programme for Palliative Care* ¹⁸ in its 2019 report stated that “enhanced Information and Communication Technology (ICT) for Palliative Care is a key capability requirement for the future delivery of healthcare and a core component of the Palliative Care Model of Care. Palliative Care supports patients and their families wherever they are – at home, in hospital, in residential care or elsewhere. The ability to record and share key information on patients and carers interactions across organisations and care settings is fundamental to providing safe, effective and efficient care.”

The *Palliative Care Services Three Year Development Framework (2017-2019)* ⁶ noted that the benefits of electronic health records included “Information management, reporting and analysis which will enhance timely, reliable information and decision making support for patients, clinicians and management at both patient and healthcare system levels. This will facilitate better care, efficient service and financial planning, and clinical and financial audit”.

11. Appendix 3: Detailed Findings from Discovery Phase

Themes from research

Volunteers

It is widely acknowledged that volunteers are a very important part of palliative care services. The *Report of The National Advisory Committee on Palliative Care (2001)*⁴ stated that “Volunteers are an integral part of the specialist palliative care service, whether they are working directly with patients and their families, or giving other essential support, such as raising money”.

The *Palliative Care Services Three Year Development Framework (2017-2019)*⁶ acknowledged that “it is impossible to put an economic value on their input, because they bring a dimension to the supported organisation in terms of enthusiasm, commitment and vitality, not to mention their life skills and community links, which is immeasurable”.

Funding

The *Adult Palliative Care Services Model of Care in Ireland – The National Clinical Programme for Palliative Care*¹⁸ report noted that “Palliative Care services lead to lower cost by delivering care that is aligned to patient and family needs and that enables avoidance of unnecessary hospitalisations, diagnostic and treatment interventions and inappropriate intensive and emergency department care”.

Funding for the Palliative Care sector is not just required for day to day running of the service but also for training and education of staff and volunteers and for progressing change initiatives. The report of the 67th World Health Assembly urged members states “to ensure adequate domestic funding and allocation of human resources for palliative care initiatives, including education and training, and quality improvement initiatives”.

The *Palliative Care Services Three Year Development Framework (2017-2019)*⁶ noted that “currently the sector relies heavily on fundraising and donations to maintain services. In 2016 the provision of statutory funding to voluntary service providers ranged from 45% to 93%. In contrast, the new hospices being planned will be 100% statutory funded”.

A key recommendation also from this Report, was that all voluntary hospitals should be 100% core funded by the state.

11. Appendix 3: Detailed Findings from Discovery Phase

Themes from research

Education and Research

On-going education and research opportunities for all those working in Palliative Care are necessary to promote knowledge and ensure staff are competent to provide palliative care. Education on end of life and bereavement for staff and service users is also required.

*The Strategic importance of Palliative Care within the Irish Health Service – The Irish Hospice Foundation 2013*⁷¹ recommended that “a system of education for health and social care professionals should be developed in partnership with training bodies and health service training structures, to promote competencies, link to practice development and incorporate continuing professional development”. The report further recommended that “staff release for training must be preserved, as there is a need for a technically and socially competent workforce which can meet patient needs within a range of role remits and care settings”.

*The National Cancer Strategy 2017-2026*⁷² noted that “Cancer care, like many other areas of health care, is resource intensive. Staffing is a key part of this resource and is the major contributor to both processes and outcomes in cancer care. Without highly trained and educated staff, the significant improvements in cancer care seen in the past decade would not have occurred.”

Workforce Planning

As in all areas of health care, a highly trained and motivated staff is required throughout the services to deliver patient care.

According to the *Adult Palliative Care Services Model of Care in Ireland – The National Clinical Programme for Palliative Care*⁷³

“The HSE’s People Strategy recognises the central importance of high quality, motivated staff to the delivery of care. It commits to engaging, developing and valuing the workforce to deliver the best possible care and services to the people who depend on them. This has a particular resonance for palliative care where historical gaps in the training provided to undergraduate students mean that healthcare professionals often lack appropriate knowledge and skills to feel confident in their provision of Palliative Care. The deficit is further compounded by the fact that there is often no clear or consistent focus on ensuring competence in Palliative Care provision in continuing professional development.”

11. Appendix 3: Detailed Findings from Discovery Phase

Themes from research

Public Awareness

Apart from the need to raise awareness of bereavement support throughout the palliative care process, there is a need to raise public awareness of all aspects of palliative care, including:

- **What help is available to everyone (patient and carers)**
- **How to access hospice care and home care**
- **How the community can contribute**
- **How health care providers can help**

The *Palliative Care Services Three Year Development Framework (2017-2019)*⁶ had an action point stating “The HSE should actively support initiatives to raise public awareness and to change the culture around death and dying. Any new initiatives should build on the work done to date”.

Service User/Family/Carers Feedback

As with previous National Palliative Care reports, the more recent HSE Palliative Development Framework (2017-2019) undertook focused consultation with many stakeholder groups, including with service users representative bodies and representative organisations and also used an ‘on line’ survey tool to get feedback from health care staff and management.

In light of this it was decided not to undertake any additional research or patient consultation but to have focused ‘stakeholder’ consultations to carry out a ‘situational analysis’ of the Mid-West in the context of best practice palliative care and take on board the findings from any national and local consultation processes.

In principle the importance of seeking and receiving feedback from service users and their families cannot be underestimated. This feedback helps and contributes to improving services provided for everyone: the service user, carers and their families.

In a survey entitled *Let’s Talk About - All Ireland Institute of Hospice and Palliative Care*¹² it was noted that “the issues around living with a long-term progressive condition are complex and multi-faceted. By finding out about a high number of people’s diverse experiences it is possible to build a picture of current reality from a range of perspectives”.

The report also observed that “respondents to the Let’s Talk About survey recount both good and bad experiences of Palliative Care from health and social care services. User experience must continue to be the benchmark against which policy makers and commissioners approach the future of Palliative Care services and policy development.”

In the context of the Mid-West and as part of Milford Care Centre’s commitment to continuously strive for excellence and in recognition of the importance of evaluating the experience from the patient’s family members’ perspective, an evaluation of the specialist palliative care services was conducted *Evaluation of Specialist Palliative Care Services*⁹. The evaluation was conducted by ascertaining the retrospective views of bereaved persons who were listed as the next of kin of deceased persons who had received Specialist Palliative Care services.

11. Appendix 3: Detailed Findings from Discovery Phase

Themes from research

The findings were as follows:

- Bereaved carers highly valued the specialist Palliative Care Service received from the inpatient service. More than three quarters of respondents indicated that pain was relieved all of the time while in the Hospice, 10% reported that it was relieved partially and 10% reported it was relieved completely some of the time. Almost 90% of respondents reported that symptoms other than pain were definitely relieved or relieved to some extent.*
- With regard to communication, of those respondents who spoke with doctors and nurses 82.2%, (n = 37) of respondents reported that explanations about the patient's condition, their treatment or tests were very easy to understand, and 13.3% reported they were fairly easy.*
- With regard to respect and dignity, 95.7% reported that hospice doctors and 98% reported that nurses always treated the patient with respect and dignity. Care received from doctors was rated as either exceptional or excellent by 93.6% of respondents and care from nurses was rated as either exceptional or excellent by 96% of respondents.*
- When considering whether the patient was seen by the Hospice at Home team (now called Community specialist palliative care team) as often as was needed, 85.4% of respondents reported that the patient always saw the team when it was needed. However 12.3% of respondents reported the patient only sometimes saw the team as often as it was needed and one respondent (2.1%) felt the patient did not see the team as often as was needed. A small number of qualitative comments regarding perceived shortage of staffing levels were made by carers.*
- With regard to patient needs, the vast majority of respondents reported that emotional support needs, spiritual needs, financial concerns, symptoms other than pain and family concerns were addressed by the Hospice at Home Service.*
- The specialist palliative day unit service was attended by relatives of 15.3% n = 11 respondents and 87.5% of respondents felt the decedents always or usually benefitted by attending the service. More than 80% of respondents felt that the hospice services either definitely worked or worked well to some extent with the patient's GP and other services outside of the Hospice.*
- Of the 31% of next of kin who discussed their feelings about the decedent's illness and death with MCC staff, 30% spoke to a bereavement counsellor, 25% spoke to a nurse and 20% spoke to a social worker. Four of the respondents had spoken to a number of staff. Of note is the relatively high number of respondents (31%) who report they did not receive contact in regard to various sources of support post bereavement.*

This evaluation demonstrated that the Specialist Palliative Care Service at Milford Care Centre delivers a high quality care to the patient and to the bereaved families in many key areas and is responsive to needs of both patients and carers.

Milford Care Centre participated in a service evaluation ran from the beginning of August to end of September 2018 and relating to patients who died between 1st June 2018 and 31st August 2018. The report *Bereaved relatives' satisfaction with specialist palliative care services - A service evaluation by the Association for Palliative Medicine of Great Britain and Ireland (APM) Famcare*⁷⁹ noted the following:

11. Appendix 3: Detailed Findings from Discovery Phase

Themes from research

- *The evaluation showed in respect of Milford Care Centre that overall most bereaved families report high levels of satisfaction with care at end of life both in the Hospice Inpatient Unit and in the SPC Community Services. The “Highly Satisfied/ Satisfied” are higher for the MCC service than the “all service responses” in almost every question. This should be celebrated and highlighted to staff.*
- *However, there are a small number of areas where the Milford Care Centre specific percentages of “Dissatisfied” / “Very Dissatisfied” are higher than the percentages reported in the all services responses. Examples relating to the inpatient unit service include availability of the team to the family, attention to patient’s description of symptoms and emotional support provided to the family by the team. Examples relating to the SPC Community service relate to explanations about treatment, information giving about side-effects, emotional support provided to the patient and the family by the team.*

Out of Hours

Many of the National reports highlight the need to move towards 24/7 access to nursing including emergency visits and a multidisciplinary approach to 24/7 service, including access to specialist care medicine and pharmaceutical urgent advice.

The report of “*The National Advisory Committee on Palliative Care (2001)*”⁴ states that “specialist palliative care services should be available to all patients wherever and whenever they require them”.

The *Palliative Care Services Three Year Development Framework (2017-2019)*⁶ recommends:

- **Extension of Palliative Care community based services over a 7 day week**
- **Exploring the need for out of hours SPC services and the resource implications**

The report from the “*Adult Palliative Care services Model of Care in Ireland – The National Clinical Programme for Palliative Care*”¹⁸ recommended that “The 1-3 year objective of community specialist palliative care services should be that services are available on a 7-day basis to community palliative care patients (which includes patients in residential care)”.

11. Appendix 3: Detailed Findings from Discovery Phase

Progress from Mid-West Palliative Care Strategy 2013 – 2017



The HSE and Milford Care Centre published a Strategic Plan for Palliative Care 2013 – 2017 in July 2013 to guide specialist palliative care service development and delivery in the Mid-West Region.

Four overarching themes were identified during the consultation process:

- **Sustainability of existing services**
- **Access and integration**
- **Quality**
- **Education**

A number of key steps and actions were set out under each theme:

Sustainability of existing services

- Given the economic climate when the Strategy was being prepared a decision was taken to focus on review and consolidation to ensure current services were maintained.
- New Inpatient Unit 34-bed unit opened in February 2018. Due to resource constraints only 30 of the 34 beds opened. Negotiations continue with the HSE for funding to open the remaining 4 beds on a phased basis. Each room is a single, ensuite facility and additional overnight and day rooms have been provided for relatives.
- The formalisation of a dedicated pain management service at Milford Care Centre continues to be an outstanding recommendation for implementation from the previous HSE/MCC strategic plan (2004-2011) and as such requires priority consideration by the HSE.
- The links with Adult Mental Health services continues but we need a formal sessional commitment from the psychiatry services.
- Linkages with the UHL Group have been strengthened through the newly convened Palliative Care Clinical Operations Group.
- The service model in Palliative Day Care now offers an 8-week, patient-focused programme for each individual. The Day Care Centre has prepared an information leaflet and poster for potential referral sources.
- A review of the recommendations in *An Evaluation of the Hospice at Home Service Delivered by Milford Care Centre (December 2011)* was completed.

11. Appendix 3: Detailed Findings from Discovery Phase

Progress from Mid-West Palliative Care Strategy 2013 – 2017

MCC has, within existing available resources, strengthened its management structures for Community Services, so as to provide strong leadership, more effective management and support for specialist Palliative Care Services across the Mid-West.

- Milford Compassionate Communities Project, which included the Good Neighbour project was ceased in 2017. A number of Good Neighbours were recruited to offer voluntary support to patients with cancer, e.g. assistance with attending appointments, dog walking, companionship, etc. As this was not seen as a core activity of the Centre, a decision was taken to try and find an alternative suitable provider to agree to take on the service as funding could not be committed from MCC.
- Hospice at Home staff (now called Community specialist palliative care team) participated in the rollout of a Primary Care Network in south east Co. Limerick thus forging stronger links with local healthcare providers in the HSE and with GPs.

Access and Integration

- A Palliative Care Support Beds admission policy was developed during 2015 and reviewed in 2017 and 2019. This has now been approved by the HSE and rolled out across all Palliative Support Bed Units across the Mid-West.
- The percentage of referrals of patients with non-malignant conditions continues to increase.
- A multi-disciplinary (MDT) working group has been established to examine how the specialist palliative care needs of patient with Motor Neurone Disease can be addressed most effectively.

- The *National Specialist Palliative Care Referral Form* has been introduced to ensure that patients benefit from the optimum use of the service through timely and appropriate referrals. The Centre has also introduced a centralised triage system for all referrals to the Hospice at Home service.
- Palliative Medicine Consultants hold regular sessions in UHL, St. John's Hospital and University Hospital Ennis and liaise with other specialties to promote earlier referral to palliative care services.
- Further integration and co-ordination of the Hospice at Home multi disciplinary team has taken place with improvements in the consistency of MDT meetings including the presentation and recording of patients' management plans and the amalgamation of the Hospice at Home and Specialist Palliative Day Care Operations Groups into one Community Services Group.
- IT systems between MCC and UL and the Milford campus and the outlying bases have been improved. The Centre is now examining the feasibility of introducing the HSE's new *Healthmail* application which will facilitate the secure email transfer of clinical information between the Centre, HSE facilities and GP practices, thus reducing the need for faxing with all its attendant data protection risks. ULH has access to iCare (patient administration system) and MCC is working to get access to IPMS (UHL's system).
- Video conferencing has been introduced between MCC and all bases and can also be used for training.

11. Appendix 3: Detailed Findings from Discovery Phase

Progress from Mid-West Palliative Care Strategy 2013 – 2017

Quality

- The Centre continues its participation in the development of clinical key performance indicators at national level.
- The Quality structure developed during the IHSAB accreditation process was substantially reformed and new groups established. These are undertaking a range of tasks to address issues identified in the gap analysis of the requirements in the *National Standards for Safer Better Healthcare*. A quarterly compliance grid system aids reporting to the steering group, Management Team and Board.
- The quarterly Quality and Safety was re-introduced and a *Quality, Safety and Research Report 2013-2014* was published and is available on the website¹.
- Service user feedback has been sought via surveys in all areas, including a staff safety survey, through both a Patients and Carers link on the website and Comment Cards that are available at various locations throughout the Centre and results/feedback given to staff.

Education

- The Centre continues to lead on a range of formal and informal education programmes, both on and off site. It has implemented a number of online courses and has maintained its links with the All Ireland Institute of Hospice and Palliative Care and has received funding from it for some research projects.
- Staff have made oral and poster presentations at a number of national and international conferences which showcased the research ongoing in the Centre.
- Staff are involved in two ECHO 3 projects:
- **Involving links with nursing homes, physio and OT staff in the community.**
- **10 week video-conference programme with didactic sessions provided by our staff,**
- **Presentation on agreed topics by the external people and a question and answer session.**

12. Appendix 4: Abbreviations, Acronyms & Definitions

AIHPC	All Ireland Institute of Hospice and Palliative Care
Asst. DON	Assistant Director of Nursing
CHO	Community Healthcare Organisation
CHN	Community Health Networks in HSE (8 in Mid-West)
CNM	Clinical Nurse Manager
CNME	Centre of Nursing Midwifery Education
CNS	Clinical Nurse Specialist
CSO	Central Statistics Office
ECEPC	European Certificate in Essential Palliative Care
EPR	Electronic Patient Record
GDPR	General Data Protection Regulation
GP	General Practitioner
HIQA	Health Information & Quality Authority
HPSQ	HR Payroll Systems & Analytics
HSE	Health Services Executive
HSCP	Health and Social Care Professionals
HSEland	HSE online training tool
I Care	Patient Administration Software System
ICT	Information Communication Technology
IHF	Irish Hospice Foundation
IHSAB	Irish Health Services Accreditation Board
IPMS	Integrated Patient Management System
IPU	In patient unit (SPC)

12. Appendix 4: Abbreviations, Acronyms & Definitions

MCC	Milford Care Centre
MDT	Multi-disciplinary team
NACPC	National Advisory Committee on Palliative Care
NCRI	National Cancer Registry Ireland
OT	Occupational Therapy
PC	Palliative Care
PCNA	Palliative Care Needs Assistance
PCOC	Palliative Care Outcome Collaborations
PCT	Primary Care Team
PHN	Public Health Nurse
PI	Performance Indicator
SLA	Service Level Agreement
SPC	Specialist Palliative Care
SPCU	Specialist Palliative Care Unit
SWOT	Strengths, Weaknesses, Opportunities, Threats
TILDA	The Irish Longitudinal Study on Ageing
TMS	Time Management System
UHL	University Hospital Limerick
UL Hospitals Group	Comprises of 6 hospital sites across the Mid-West
WHO	World Health Organisation
WTE	Whole Time Equivalent

13. Appendix 5: References

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