

Response ID [REDACTED]

Submitted to Review of access to palliative care services - Organisations/Health professionals

Submitted on 2024-11-12 11:34:41

Consent

1 The Committee for Health would like your permission to publish your response as part of the survey results. Please indicate your preference.

Consent:

Publish response.

Who are you?

2 What is your name?

Name:

Dr Martin Eatock

3 What is your email address?

Email:

4 Are you a healthcare professional? If yes, what is your role? If no, what is your interest in palliative care services:

Yes

1500 Characters:

I am a Consultant Medical Oncologist with a clinical interest in the treatment of gastro-oesophageal cancer, liver and biliary tract cancers and pancreatic cancer. A high proportion of patients with these malignancies have incurable disease and need to have access to high quality palliative and end of life care.

5 What is your organisation?

Organisation:

Belfast Health and Social Care Trust

6 Do you currently work in palliative care services? If Yes, in what capacity?

No

1500 characters:

current state of palliative care services

7 In your view what is the current state of palliative care services in Northern Ireland?

Good

8 Do you think there is an understanding by the public of what palliative care is? If no, what are the main barriers to the public understanding palliative care?

No

1500 Characters:

The overwhelming perception is that palliative care equates to end-of-life care rather than supportive care focussed on symptom control.

This is often as a result of palliative care only being suggested once active treatment options directed at the cancer have been exhausted or are no longer appropriate resulting in patients often receiving palliative care in the last few weeks of their life.

Early discussions about the role of palliative care team at the time of diagnosis and also during ongoing active anticancer treatment may help to change some of this perception

Access to services

9 Are palliative care services equally accessible to all who need them?

No

10 From your experience where are the gaps in the provision of service?

1500 characters:

Huge gaps in the provision of palliative care for non-malignant conditions such as cardiac failure or end-stage respiratory disease.

Provision of community palliative care services is also patchy and overstretched and patients are often discharged from community palliative care follow up if their symptom burden is low even if it is expected that they have a very limited life expectancy

11 Do you believe barriers exist that prevent equitable access to these services? If yes, please provide examples in the box provided.

Yes

1500 characters:

see above

12 What additional services could/should be provided?

1500 Characters:

Provision of palliative and end-of life support for non malignant conditions.

Incorporation of palliative/supportive care clinics alongside clinics delivering anti-cancer treatment (model already being developed elsewhere in UK (i.e. the Christie in Manchester).

Lack of provision is in part due to the funding model of palliative care services which is heavily dependent on charitable donations. The HSC only contributes around 1/3 of their costs and this leads to huge variability in the ability to deliver comprehensive palliative care services.

Integration of Services

13 How well are palliative care services integrated across the health system, through primary, secondary and specialist care?

1500 characters:

This is very variable.

Specialist hospital palliative care is available in all 5 HSC Trusts, however not in all hospitals in all Trusts.

Community services are provided by nursing teams based in the Hospices and I don't have a clear understanding of how well integrated they are with primary care

14 Should palliative care be a regional service? Please outline your reasons in the box provided.

Yes

1500 characters:

It should be a regional service with core funding from the Department of Health. This will ensure greater equity of access and standardised working and access arrangements. It will be difficult to achieve for the Hospices however which are currently run by charities.

15 What can be done to improve integration?

1500 characters:

Unsure

Best Practice

16 Do you have any examples of good practice or pilots in palliative care that are meeting the needs of patients and families/carers? If so, is this best practice happening widely across Northern Ireland?

1500 Characters:

17 Do you think that families receive sufficient support when accessing services? Please outline your reasons in the box provided.

No

1500 Characters:

Limited information available in hospital clinics. As already mentioned palliative care often only introduced at a time of transition from active treatment to supportive care which can lead to misunderstanding. Earlier integration of palliative/supportive care could overcome this

Funding and Strategy

18 Do you think the current funding for palliative care is sufficient? Please outline your reasons in the box provided.

No

1500 characters:

As already mentioned we are only really scratching the surface of what is required and many patients with incurable conditions other than cancer never have access to palliative care services. Reliance on charitable funding leaves the palliative care service vulnerable.

19 Is the current model for the funding of hospices, including hospice at home/community care/rapid response support, sustainable and sufficient to meet needs now and in the future? Please outline your reasons in the box provided.

No

1500 characters:

Should be core funded by the NHS - it is an extremely valuable service which provides compassionate care and should not be viewed as peripheral to the NHS

20 Is there a need for a new Palliative Care Strategy for Northern Ireland? If yes, what should it include? If no, why not? Please outline your reasons in the box provided

Yes

1500 characters:

Funding model

Types of condition where palliative care should be involve

Role of palliative care alongside conventional oncologic care for patients with incurable cancers.

Integration with primary care in the provision of community palliative care services.

Integration with other AHP services such as dietetics, physiotherapy and occupational therapy, particularly in the community

Any other comments

21 Any other comments

1500 characters: