

Hospice Friendly Hospitals Annual Conference – 19th May 2010
Opening Address
Denis Doherty. Chair Irish Hospice Foundation

I believe that today is a significant day in the development of end-of-life care in Ireland. Back in 1996, the late Therese Brady encouraged the then board of the Irish Hospice Foundation to broaden its focus to include those who die in hospitals. The term Hospice Friendly Hospital was coined at that time. In retrospect it seems strange that it should have been necessary to prompt an organisation concerned with end-of-life care that they should take a greater interest in the way in which end of life care was then being provided for the majority of people. However, 14 years ago, the concerns were to increase the number of hospice buildings to provide in-patient care and to develop outreach services to provide care in people's homes.

In 1994 the National Health Strategy recognised the important role of palliative care services in improving quality of life and in 2001 the report of the National Advisory Committee on Palliative Care recommended that all acute general hospitals should have a specialist palliative care service provided by a multi-disciplinary team led by a consultant in palliative medicine. It recommended that in smaller general hospitals, where it may not be feasible to employ a full-time specialist palliative care team, patients in the hospital should receive a service from the specialist palliative care team serving the community. It stated that 'hospital admission policies should be sensitive to the needs of patients with advanced disease', that there should be 'minimum delays in waiting for a hospital bed', and that there should be one point of entry to hospital services for patients attending for palliative care.

Nine years later, we are here to learn about the first ever National Audit of End-of-Life Care in Hospitals and to launch Quality Standards for End-of-Life Care in Hospitals. We will be hearing today that practically every second death now occurs in an acute hospital and that if we add in community hospitals the great majority of people are now dying in a hospital of one sort or another. It is timely therefore that we use this opportunity not just to repeat what we believe is the right of people to die in a place of their choice but to ask some searching questions as to why we are not making more progress in our efforts to ensure that it happens.

Questions such as:

Why do we still have such significant regional deficits in hospice services despite having a unified health service?

Why are we not re-allocating available resources so that more people can access comprehensive hospice services in their community?

How can the economic argument that hospice care is more cost effective and delivers better quality of care than other forms of care be more persuasively employed in a time of severe economic difficulty?

How can we get hospitality back into the language and practice of hospitals so that our hospitals become more like hotels than airports?

Can we succeed in developing hospice friendly hospitals when occupancy rates are way above European norms and our healthcare infrastructure has been judged by Prof. Roger Ulrich as among the worst in the developed world?

How can we bring end-of-life care in from the margins to the mainstream of hospital planning and care provision? This is the key theme of this conference.

On May 14th 2007 President McAleese launched the Hospice Friendly Hospitals Programme in St Mary's Hospital in the Phoenix Park. She described the programme then as 'one of the best ideas for a very long time'. Three years later I think we have reason to be proud that from a position where there were just three hospitals with small committees looking at some end-of-life issues, mainly concerned with mortuaries, we have moved to a point where three-quarters of acute hospitals are involved in some way with the programme and an increasing number of community hospitals are also becoming engaged with the development process.

I have spoken of my impatience that end of life care in Ireland has not progressed further than it has but I want to acknowledge also that Ireland is a leader in learning what would constitute good end of life care from the perspectives of patients, service providers and relatives. This morning we will hear about the results of a unique and complex audit, of international significance, which allows us to compare the differing perspectives of nurses, doctors and bereaved relatives and to hear the voice of ward staff and a sample of staff across each participating hospital. Unfortunately, it does not allow us to hear the voice of the people who were spending their last week of life in these hospitals. Neither does it allow us to hear the voice of the other patients on the wards where people died. For all that, it is a powerful piece of work which is likely to become a landmark in the process of improving end-of-life care in hospitals.

An audit, of necessity, has to tell it like it is, and, while there are many good things indicated in the audit it is fair to say that there are many issues which will give us cause for concern. These will all be addressed today as we get the perspectives of the Ombudsman, Emily O'Reilly, a hospital manager, Liam Duffy, a hospital staff member Eileen Whelan and a bereaved relative, Catriona Crowe. What is most important in raising issues of concern is that we continue to offer leadership and support to all who are striving towards realising our vision of a society in which no one dies in pain or without the support they and their relatives require at that difficult time in their lives. We undertook to develop a sense of direction and some pointers so that hospitals will know when they are doing well and when they are underachieving. This we have done by developing Quality Standards for End-of-Life Care in hospitals which the Minister for Health and Children will launch this afternoon.