Interim Cancer Plan

Eastern Health Board

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Executive Summary

This is the first cancer plan for the Eastern Health Board. It should be seen as an interim plan and the first step of a continuous planning cycle. With the development of regional cancer committees, further consultation and research, more focused and definitive plans will evolve.

This interim plan was produced in consultation with the major service stakeholders i.e. The Regional Cancer Directors, Hospital Cancer Co-ordinators, Irish College of General Practitioners, National Cancer Registry, Palliative Care Consultants, Specialist Cancer Nurses, Voluntary Groups, Eastern Health Board Public Health Department and Management Team. It is intended that consultation with consumers of the service will form an integral part of its implementation and the identification of priorities.

This Plan is patient centred and focused on achieving measurable health and social gain. The quality of life of patients and their families is emphasised in every aspect of the Plan.

The plan addresses seven main areas:

- **information:** the further enhancement of information systems to determine outcome of treatment and patient survival is paramount
- **health promotion and prevention: P**revention, early diagnosis and appropriate treatment are the only strategies for reducing the burden of cancer in the future. The elimination of smoking is recognised as the primary factor in reducing cancer incidence. This Plan contains definite recommendations for the avoidance and cessation of smoking.
- **primary health care and early diagnosis:** The role of the general practitioner as the primary carer is emphasised as are practical developments necessary to support the care of patients in the primary care setting.
- **hospital treatment:** Definite recommendations are made regarding best practice, patient centred care and appropriate treatment. The development of best practice protocols is paramount.
- **Palliative care:** Recommendations are given which will further add to the quality of the palliative care service being offered in the EHB area
- **Counselling and voluntary group support:** this issue requires an in-depth assessment to identify counselling requirements. The Plan includes details of a 'Needs Assessment' of cancer counselling which should be undertaken.
- **Consumer views:** This Plan would be incomplete if the views of consumers were not considered and acted upon. In-depth research will be undertaken in order to identify and meet the expectations of consumers.

Next Steps

The specific plans of the three Areas of the Eastern Health Board are outlined as are the priorities for developing cancer services and enhancing patient care. Consequently the practical next steps are:

1. Implementation of the Plan by the Regional Committees of the three EHB areas
2. Liaison with the National Cancer Registry, HIPE system and Health Information Unit of the EHB regarding the implementation of the information system plan
3. The health promotion aspect of this Plan is incorporated into the EHB Health Promotion Service Plan. Steps will now be taken to implement it.
4. Liaison with Primary Care representatives regarding fulfilling the enclosed objectives including computerisation
5. The development of 'best practice, evidence-based' protocols
6. A review of counselling requirements
7. Determination of the 'Needs' for palliative care services and their development
8. Involvement of patients in planning and implementation
9. Audit of services

1. Introduction

The National Health Strategy, 'Shaping a healthier future', states that the Irish mortality rate from cancer is higher than the EU average, at 273 per 100,000 population (EU average 245 per 100,000). Cancer accounts for one-third of all premature deaths in Ireland. It is the second most common cause of death. The number of cases is expected to increase as our population is ageing.

The National Cancer Strategy (Department of Health, November 1996) states that one in three Irish people develop cancer at some time in their lives and that one in four die from it. However, the risk of developing cancer varies with age i.e. the risk of developing cancer before:

55 years is 1 in 10
65 years is 1 in 5
75 years is 1 in 3.

The first Report of the National Cancer Registry was published in July, 1997. This shows that in 1994 there were 19,316 new cases of cancer diagnosed and 7,391 deaths due to cancer in Ireland. Over the past five years there have been approximately 2,500 deaths due to cancer per annum in the Eastern Health Board Region. Cancer of the skin, colon & rectum, breast, cervix, lung and prostate accounted for 70% of all newly diagnosed cancers. Cancers of the colon & rectum, breast, lung and prostate accounted for 48% of all cancer deaths. It highlighted regional variations in the incidence of some cancers. Overall Dublin had a higher than expected incidence of cancer. Specifically cancer of the breast, lung and cervix were higher than expected in Dublin.

Resulting from the National Cancer Strategy three Regional Directors were appointed for the Eastern Health Board region.

- Professor D. Bouchier-Hayes is the Regional Director for the Northern region of the Board
- Mr. J. Hyland is the Regional Director for the South East region of the Board
- Mr J. Reynolds is the Regional Director for the South West region of the Board.

One of the functions of the Regional Directors is to develop a cancer plan for the region.

This is the first cancer plan for the Eastern Health Board region. The main priorities are to focus on prevention, outline patient and provider needs, document current service provision, identify gaps in services and make recommendations to narrow those gaps. As such, this plan is health gain focused, people centred and resource effective.

An incremental approach must be taken to planning, providing and auditing cancer services. This initial plan cannot identify, address or solve all the issues. Rather, it should be seen as the first part of a planning cycle i.e. the start of a continuous effort to build on existing cancer services. It will be updated in the light of new information, consultation and research findings. It requires a partnership approach with patients and all service providers.

Within this plan the priorities for information systems, health promotion, prevention, primary care and community services are addressed. The specific needs of hospitals in the North, South-East and South-West regions of the Eastern Health Board are identified as are the needs for palliative care services.

The single biggest cause of cancer is smoking. The Health Promotion component of this plan focuses heavily on the prevention and cessation of smoking and on the various strategies that can be employed to this end. **Patient advice and support to quit smoking should be widely available in hospitals as well as in the community. It is strongly recommended that all health care facilities develop and implement strict smoking policies.**

Patients resident outside the Eastern Health Board area require to attend many Dublin hospitals for treatment. Therefore, this plan also reflects the needs of Dublin hospitals in serving all patients who attend there for treatment. **Tertiary referrals have a major impact on hospital services in the Eastern Health Board. Up to two-thirds of Irish patients with cancer receive treatment in Dublin hospitals.** While one of the principles of the Cancer Strategy is for patients to be treated as close to their home as possible, it is evident that Dublin hospitals will continue to play a very significant role in

the provision of a tertiary referral service especially for complex cancer cases. This pattern of referral has resource implications. Discussions are required with other health boards to forecast and quantify the demands for tertiary referral of patients with cancer.

It should be noted that, as there are national committees developing structured cervical and breast screening programmes, this plan does not specifically focus on these matters. These National Committees and the National Cancer Forum should liaise with the Regional Directors and inform them of relevant developments at national level.

2. Objectives of the Cancer Plan

The objectives of this cancer plan are to ensure:

- ***Health gain and social gain of patients. All service developments are for the good of patients and their families. Services should be easily accessible and equitable***
- ***The provision of the highest quality cancer service i.e. prevention, early detection, treatment and care***
- ***Full integration and co-ordination of all service components i.e. primary care, hospital services, counselling / supports and palliative care***
- ***A 15% reduction in deaths from cancer in the under 65 age group by the year 2004***
- ***A reduction in the incidence of some cancers particularly in the under 65 age group, especially preventable and smoking related cancers.***

3. Cancer Statistics

3.1 Cancer Incidence

Appendix 2a gives incidence data for cancers in Ireland and in the Eastern Health Board region for 1994. It shows that approximately one-third of cancers in Ireland occur in the EHB region. The most commonly occurring cancers are skin, colon/rectum/anus, breast, lung, cervix and prostate.

Appendices 2b, 2c and 2d give 1994 cancer incidence data for Dublin, Kildare and Wicklow by sex. Expected and observed incidence is given together with standardised incidence rates and 95% confidence intervals.

In interpreting or making assumptions from these data it should be remembered that they represent one year only. Where numbers of a particular cancer are small, a relatively small change in these numbers can lead to a large change in rates. Therefore, data from subsequent years are required to obtain a clearer picture of cancer incidence rates. There data should be interpreted with caution until data from other years are available.

For Dublin in 1994 the standardised incidence for all cancer sites combined was higher than expected. For males this was mainly due to a higher than expected incidence of cancer of the lung, bladder, stomach, larynx and skin. For females, cancers with a higher than expected rate were stomach, lung, skin, breast and cervix.

The overall cancer incidence in Kildare in 1994 for males and females fell within expected values. Furthermore, the incidence rates for specific cancers in males and females were not higher than expected.

In Wicklow for 1994 the overall incidence and the site specific incidence rates of cancer in males was not higher than expected. For females that overall rate was slightly higher than expected; this was mainly due to a higher than expected rate of colon cancer. However, as the overall numbers are small, data from other years are required to determine whether this is an isolated finding.

3.2 Hospital Inpatient Enquiry System (HIPE) data for cancer

The following data in Tables 1-4 represent in-patient hospital utilisation by cancer patients for 1996 rather than incidence or prevalence rates. It is clear from these tables that cancers which require many hospital admissions are over represented e.g. Table 8 shows that 'lymphoma' was the third most common cancer admitted to hospital for EHB residents. Such patients require repeated hospital admissions for courses of chemotherapy. However, 'lymphoma' is not the third most commonly occurring cancer in the population. **It is also evident that, though one-third of cancer incidence is in the EHB area, approximately two-thirds of patients with cancer in the country are managed in Dublin hospitals.**

With improved technology and expertise it is now possible to provide some cancer treatments on an out-patient basis. As medical information systems in out-patient departments are underdeveloped, no data on out-patient activity are available. This weakness should be addressed.

Table 1 shows that approximately one-third of all cancers treated in hospitals within the EHB region are for persons living outside the EHB region, an indication of the high degree of specialisation of many Dublin hospitals.

Table 1 Number (%) of cancer discharges from hospitals in the EHB region by patient address	
EHB	20735 (64.7)
SEHB	2533 (7.9)
NEHB	2272 (7.1)
MHB	2003 (6.2)
NWHB	1441 (4.5)
MWHB	1401 (4.4)
WHB	1142 (3.6)
SHB	453 (1.4)
Non health board	38 (0.1)
No fixed abode	35 (0.1)

Tables 2 shows in-patient hospital activity for radiotherapy. This highlights the high level of tertiary referrals for this specialist service to St. Luke's hospital. It is probable that patients with an EHB address were more likely to receive radiotherapy as an out-patient; these statistics are not represented here.

Table 2 Number (%) discharges for radiotherapy treatment provided in Dublin by patient address	
EHB	266 (15.5)
SEHB	279 (16.3)
SHB	11 (0.6)
MWHB	243 (14.2)
WHB	327 (19.1)
MHB	165 (9.6)
NWHB	244 (14.3)
NEHB	176 (10.3)
Non health board	1 (0.1)

Table 3 shows the health board addresses of children with cancer who were hospitalised in Dublin in 1996; 49.5% resided in the EHB.

Table 3 Number (%) of children (0-14 years) treated in hospitals in the EHB by patient address				
	Age Group No. (%)			
Health Board Address	**0-4**	**5-9**	**10-14**	**Total**
EHB	341(49.6)	427 (49.3)	311 (49.7)	1079 (49.5)
SEHB	116(16.8)	203 (23.4)	31(5.0)	350 (16.0)
SHB	13(1.9)	28(3.2)	40(6.4)	81 (3.7)
MWHB	60(8.7)	72(8.3)	24(3.8)	156 (7.2)
WHB	1 (0.2)	38(4.4)	34(5.4)	73 (3.3)
MHB	71(10.3)	34(3.9)	104(16.6)	209 (9.6)
NWHB	20(2.9)	40(4.6)	43(6.9)	103 (4.8)
NEHB	66(9.6)	24(2.8)	39(6.2)	129 (5.9)
Non Health Board	-	1 (0.1)	-	1(-)
Total	688 (100)	867 (100)	626 (100)	2181 (100)

Table 4 gives the top 10 discharges for patients hospitalised for cancer in the EHB by patient address. For both EHB and non-EHB residents the greatest number of discharges was for breast cancer. These data reflect hospital activity and not incidence nor prevalence of disease.

Table 4 Top 10 Cancer discharges for cancer from hospitals in the EHB region for patients resident in the EHB and in other health boards in 1996		
	EHB residents	**Non EHB residents**
Colon/Rectum/Anus	3426	600
Breast	2945	1751
Lymphoma	1545	967
Lung	1529	581
Skin	1405	612
Lymphoid Leukaemia	1232	915
Myeloid leukaemia	827	461
Uterine adnexa	817	430
Prostate	604	-
Brain	-	381
Other sites	-	371

3.3 Mortality data

Table 5 gives five year cumulated mortality data for some cancers for the EHB and Ireland. For some cancers, particularly trachea / bronchus / lung, the standardised death rates are higher in the EHB than the national average.

Table 5 Mortality due to Selected Cancers in the EHB compared with national figures (cumulated data 1991-1995)

	Ireland		EHB	
Cancer Site	**Deaths**	**SDR (95%CI)**	**Deaths**	**SDR (95% CI)**
All sites	37157	217 (214-219)	12422	237 (232-240)
Oesophagus	1448	8.4 (8.0-8.9)	475	9.1 (8.3-9.9)
Stomach	2188	12.6 (12.1-13.2)	719	13.7 (12.7-14.7)
Colon	3475	19.9 (19.3-20.6)	1144	21.7 (20.4-23.0)
Rectum	1177	6.9 (6.5-7.3)	414	8.0 (7.2-8.8)
Pancreas	1778	10.3 (9.8-10.8)	566	10.7 (9.8-11.6)
Trachea/bronchus/lung	7718	45.3 (44.3-46.4)	2992	57.7 (55.6-59.8)
Melanoma	284	1.7 (1.5-1.9)	112	2.0 (1.7-2.4)
Other skin	215	1.2 (1.0-1.4)	56	1.0 (0.8-1.3)
Bladder	801	4.4 (4.1-4.7)	255	4.7 (4.1-5.3)
All lymphatic and haemopoeitic	2868	16.7 (15.9-17.2)	860	16.1 (15.0-18.5)
Leukaemia	1055	5.9 (5.5-6.3)	305	5.5 (4.9-6.1)
Hodgkins	130	0.8 (0.7-0.9)	48	0.9 (0.6-1.2)

4. Summary of Components of the Plan

The plan has seven main components. Fulfilling objectives in each of the components is contingent on allocation of additional resources.

1. **Health information systems**: information systems will be developed and maintained by the EHB to monitor the health status of the population, utilisation of service, resource use and outcomes of interventions. The success of these information systems are dependant on the collection of relevant data.

   1998 Health Information Cost £62,500

2. **Health Promotion**: health promotion initiatives will be communicated to all sections in society, particularly to high risk groups. This will be undertaken using an intersectoral approach. All initiatives will reflect needs and be monitored and evaluated.

   1998 Health Promotion Cost £80,000

3. **Primary Care and early detection:** skilled primary care teams are crucial to the early recognition and management of patients with cancers. Co-ordinated collaboration between GPs and hospitals will be cultivated to ensure service equity and maintenance of standards. Protocols for referral and for the management of cancers will be developed by the Regional Directors in consultation with hospital consultants and GPs.

   1998 Primary Care Cost £330,000

4. **Hospital services:** Patients with cancer receive treatments from a number of different hospitals and organisations. A seamless service will be provided and all services will be co-ordinated to meet patients' needs. Care of patients and their families is often multi-disciplinary in nature. A integrated approach to specialist nursing services, counselling supports, rehabilitation and continuing care in the community will be promoted.

   1998 Priorities for developments in hospitals Cost £645,000

The proposals from individual hospitals within the areas of the three Regional Cancer Directors are also detailed in this plan. Each of the Cancer Directors are continuing consultation with the hospitals in relation to their proposals, having regard to the overall needs of their areas.

5. **Palliative care:** Palliative care services receive major support from charitable donations. Palliative care is a developing and expanding service. A 'needs assessment' of palliative care in the Eastern Health Board should be undertaken to ensure needs are identified and met.

   Palliative care Cost 1998 £584,000

6. **Voluntary and Support groups:** The work undertaken and the value of these groups must be recognised. On-going quality training will be offered to volunteers to enable them to undertake their roles with maximum effectiveness.

   Voluntary and Support Groups Cost 1998 £210,000

7. **The client / patient perspective:** Peoples needs and expectations must be considered when planning services. In many ways clients of the service have valuable insights into the delivery of the service. It is intended to consult with client groups to obtain their views and recommendations for service planning and development.

   Client Research Cost 1998 £10,000

The seven components of the plan (detailed below) describe and analyse existing cancer services. Recommendations for improving services are made in a tabular format. In each case, objectives and targets are outlined in terms of the key players involved, priority of each objective, time-scale for effecting change, expected outcome and resources required to meet the target. The purpose of producing this plan was discussed in detail with providers of cancer services. Separate meetings were held them and some made written submissions.

Specific components of the plan

4.1 Information Systems

Description and evaluation of the current situation

Routine national information on cancer is (since 1997) supplied by the National Cancer Registry starting with analysis of the year 1994. The Central Statistics Office supplies quarterly and yearly mortality statistics. Routine hospital utilisation data on cancer are not published.

1. **Cancer Registry Information:** The Cancer Registry gives valuable data on numbers and rates of incident cancers by site and county. In time, more information may be available e.g.

- survival rates by site of cancer
- cancer stage at diagnosis
- total patient numbers by site of cancer
- total patient numbers by geographic area
- forecasts of patient numbers with different types of cancer
- place of surgery
- more complete data on the range and combination of therapies being given for the different cancers
- outcome of treatment
- outcome of treatment depending on the type of treatment given and cancer stage at diagnosis.

2. **Hospital Inpatient Enquiry data (HIPE):** HIPE data are not routinely available to the EHB for each specific hospital, rather the Health Information Unit of the EHB receives pooled data for the region as a whole. This creates difficulty for examining outcomes, in assessing best practice and in evaluating services. This limitation must be overcome. HIPE data are episode based rather than patient based. This makes it difficult to determine the types of treatment being offered to patients e.g. a patient may attend more than one hospital for different treatments.

3. **Mortality Data:** Mortality data are routinely produced on a quarterly and yearly basis by Central Statistics Office.

Requirements for Development of Information Systems

Effective information on cancer depends on the outputs of the Cancer Registry, HIPE system, EHB Health Information Unit and individual hospitals.

The main requirements for developing and improving information on cancer within the EHB are for statistical support and surveillance, see table 6. This needs resourcing from the point of view of personnel and technological investment. It is recommended that information on cancer be available for small geographic areas to aid in the investigation of cancer clusters and to identify geographic areas with higher than expected incidences of certain cancers.

Outcome indicators are required on cancer treatments and survival especially for large bowel, breast, lung, gynaecological and haematological sites. The benefits of better information, outcome measurement and the setting of targets include the development and maintenance of best practice and a quality service for all patients.

Collaboration with the National Cancer Registry will be undertaken with an aim to produce data on 1 year and 5 year survival, pre-existing morbidity, staging and small area analysis. Discussions are required with the Department of Health regarding greater availability of HIPE data.

Costs

The main additional resources required to develop information systems, as outlined, are for the Health Information Unit of the Eastern Health Board:

•statistical support	£37,500 p.a.
•clerical assistance (half time grade III)	£ 8,000 p.a.
•Additional computer hardware and software (1998)	£15,000
•Computer hardware and software in subsequent years	£5,000 p.a.
•Overheads	£1,000 p.a.
•Office equipment	£1,000 once off cost

Cost to EHB for 1998: £62,500; Costs for subsequent years (at 1997 prices): £51,500.

Table 6 Plan for Information on Cancer

Action / target	Key players	Time scale	Priority 1-3	Expected Benefit / Outcome	Requirements and costs
Determine cancer incidence: by numbers and standardised rates for: age group under and over 65 years cancer type and site sex address (DED) social class (in the future)	Cancer Registry Regional Cancer Directors Public Health Department	To be undertaken on a yearly basis Data on DEDs may not be available from the National Cancer Registry for 4-5 years Data on social class is dependant on hospitals documenting social class data in patients' charts	1	Improve monitoring Identify 'at risk' groups Conduct trend analysis Make comparisons nationally and internationally Greater understanding of cancer aetiology	see para 4.1 Consider undertaking surveys of specific cancers for social class on a pilot basis (as social class data is not routinely available at present) Standardise coding and reporting of cancer information between hospitals Develop best practice protocols for coding of information e.g. a basic oncology data set
Develop estimate and forecasts of total patients with cancers in the EHB by age, sex , cancer site (and eventually by social class) and place of surgery	Cancer Registry Regional Directors Department of Public Health HIPE data	Jan 1999	2	Indicator of service needs Evaluation of service provision Development of quality indicators and quality assurance	see para 4.1

Table 6 Information (continued)

Action / target	Those involved	Time scale	Priority 1-3	Expected Benefit / Outcome	Requirements and costs for the health board
Determine hospital utilisation by age, sex, cancer type and site time for: length of stay throughput % day cases therapies received by cancer type i.e. surgery, chemotherapy, and radiotherapy	Department of. Health (HIPE) Regional Cancer Directors Cancer Registry Public Health Department Hospitals Hospital Information Systems Hospital co-ordinators	Every year	1	Indicators of treatment procedures and outcome Analysis and recommendations regarding case loads Monitoring of illness in terms of best practice, procedures, staging and treatment	HIPE data to be available by hospital within the EHB Statistical support required (see para 4.1) Define day case accurately especially for chemotherapy and radiotherapy Identify and implement agreed standards of care within and between hospitals Agree and implement a standardised system for clinical staging and pathology reporting
Survival analysis at 1 and 5 years: by cancer type and site age group sex	Cancer Registry Department of Public Health Hospital Co-ordinators	will be available from the year 2000	2	Indicator of outcome of treatment and early detection	Statistical support

Table 6 Information (continued)

Action / target	**Those involved**	**Time scale**	**Priority 1-3**	**Expected Benefit / Outcome**	**Requirements and costs for the health board**
Monitor mortality by: numbers and standardised rates cancer site sex age group DEDs	Public health Department Central Statistics Office Cancer Registry	Yearly	1 DED coding requires additional input	Indicators of outcome Trend analysis Comparisons	Statistical support (see below)

4.2 Health Promotion

The Current Situation

The Health Promotion Strategy of the Eastern Health Board aims to reflect the direction provided by significant health promotion policy developments such as:

- The World Health Organisation's Health for All 2000 plan and the subsequent establishment of targets for the European region of WHO
- The Ottawa Charter for Health Promotion, 1986
- The Health Promotion Strategy, 1995, published by the Department of Health.

The Eastern Health Board is developing a new health promotion section which will operate across Programmes. A Director of Health Promotion has recently been appointed and will commence duty in the near future.

At present a Steering Committee identifies priorities for action in health promotion while a Central Committee, with representatives from each community care area, develops and implements specific action plans. The Dublin Healthy Cities Initiative is a key player in implementing health promotion initiatives. Joint initiatives with the Irish Cancer Society, e.g. Smoke-busters and Cancer Awareness Week, facilitate a multidisciplinary approach to health promotion. In addition many local initiatives take place at community care level.

Priority Area The Scourge of Smoking

It will be difficult to lessen the burden of cancer in the EHB in the absence of reducing smoking prevalence. Consequently for 1998 the focus is on smoking prevention and cessation. Other matters appropriate for health promotion attention e.g. alcohol, diet, sun, viral illnesses and healthy lifestyles will be addressed.

Smoking is the most important single preventable cause of death in Ireland. Apart from respiratory and cardiovascular disease, it is responsible for 35% of all cancers and 90% of all lung cancers. It is associated with cancer of the lung, larynx, pharynx, oesophagus, head and neck, pancreas and bladder. Passive or involuntary smoking causes lung cancer and other diseases in healthy non-smokers and respiratory problems in children. Smoking in pregnancy is a risk factor for low birth weight, sudden infant death syndrome and other serious conditions. Our priority must be to eliminate smoking by persuading young people not to start and by helping smokers to quit.

The approach to smoking avoidance and cessation is multi-faceted. It involves the development and use of educational materials and surveillance of the problem among different groups, including school children, students and in the workplace. It requires the provision of smoking cessation facilities for those who wish to quit, policy development and legislation. Statutory and voluntary groups together have an important role to play in the reduction of smoking.

Requirements for development

The specific objectives and targets for health promotion in the prevention of cancer are documented in Table 7. To meet the objectives it is recommended that a health promotion /education officer with specific responsibility for cancer prevention be appointed. This officer will report to the Director of Health Promotion, who will have a cross programme remit.

One of the key priorities of this officer in relation to cancer avoidance would be the:

- development of a co-ordinated approach to health promotion in relation to cancer prevention throughout the Board
- on-going identification of priorities, best practice and the implementation of programmes to meet the needs of groups in the EHB
- development of focused health promotion materials to target specific groups and the use of the media for this purpose
- evaluation of all initiatives.

It is also essential that health promotion initiatives for people with, or with a past history of , cancer be developed. Persons undergoing treatment for cancer should have information on their condition and its treatment. The health promotion officer should assist in developing these materials in association with other key players.

Costs

The main additional requirements for the implementation of this health promotion strategy relate to the availability of a health promotion/ education officer, researcher assistance and education / training materials. The total cost per year of implementing the health promotion aspect of this plan is:

•health promotion officer for cancer	£31,000
•research assistance and evaluation	£19,000
•development and production of materials	£25,000
•health promotion for EHB staff	£5,000
Total	**£80,000**

Table 7 Plan for Health Promotion

Action / Target	Key players	Time scale	Priority 1-3	Expected Benefit / Outcome	Requirements and estimated costs for the health board
Surveillance: Establish smoking prevalence in the EHB region among adults and young people: i) by analysing trends from media surveys ii) by examining point prevalence of smoking in population adult life style studies iii) by reviewing available data on smoking prevalence among school children	Department of Public Health, EHB Health promotion officer Department of Health (Health Promotion Unit) Liaison with Department of Health Promotion in UCG	1998-1999	1	Procurement of baseline data 'Statement of the extent of the problem'	Research support Statistical and information systems support
Establish smoking prevalence and lifestyle factors in GP practices	GP unit (EHB) GP practices ICGP	1998-1999	1	Profiles of lifestyle factors in general practice.	GP practice computerisation (on-going)

Table 7 Health Promotion (continued)

Action / Target	Key players	Time scale	Priority 1-3	Expected Benefit / Outcome	Requirements and estimated costs for the health board
Legislation /Policy issues: Implement smoking control regulations in all public buildings and places i.e. schools, hospitals, all state, local government , health board, hospital , educational facilities, restaurants and transport facilities. Support restrictions on all forms of cigarette advertising, marketing and sponsorship. Enforcement of legislation on cigarette sales to minors.	Relevant Government departments Health Boards Environmental Health Officers Dublin Healthy Cities Project Senior managers in state, semi-state, local government and health institutions Occupational Health Units Faculty of Occupational Health Faculty of Public Health Trade unions Garda Siochana Politicians Hospitals .Health promoting hospitals Health promoting schools network.	This is on-going	1	Health agencies providing models of good practice Changed attitudes to smoking Reduction in young people starting to smoke Less exposure of people to passive smoking Implementation of existing legislation	Research support Health promotion / education officer to implement health education programmes

Table 7 Health Promotion (continued)

Action / Target	Key players	Time scale	Priority 1-3	Expected Benefit / Outcome	Requirements and estimated costs for the health board
Occupational Health Describe, evaluate and re-define EHB workplace policy on smoking (including hospitals). Assessment of smoking prevalence among health board staff.	EHB departments of Public Health and Occupational Health Hospital co-ordinators Trade unions GPs Personnel Department.	1998	1	Revised EHB and hospital policies Recommendations for other health care establishments and local government agencies	Department of Public Health in association with other health board departments to undertake.
Evaluation of interventions: Evaluate baseline health service approaches to support smoking cessation Evaluate the effectiveness of stop-smoking clinics and interventions and the implementation of best practice in this area.	EHB Community health services Public Health Nursing Health Promotion Officer Department of Public Health Medicine Health promoting schools Local communities Parents GPs Department of Education Health Promotion Unit (Dept Health)	1998	1	Development of relevant training and smoking cessation materials	Health promotion officer and research support. Resources required can be reassessed following the evaluation of baseline smoking activities and provision of services.

Table 7 Health promotion (continued)

Action / Target	Key players	Time scale	Priority 1-3	Expected Benefit / Outcome	Requirements and estimated costs for the health board
Education and Awareness Development of educational materials for adults and children which are relevant, informative and appealing, including peer led initiatives. Best practice bench-marking assessment for educational programmes Publicise controls and awareness among the private sector. Extension of smoke-busters to a greater number of primary schools Develop a form of smoke-busters to secondary schools as a pilot	Health Promotion Unit, Department of Health Department of Public Health Department of Education EHB community services Public Health Nurses Private sector business interests Department of Enterprise and Trade	mid-1998	1	Improved awareness and knowledge of the risks and dangers of smoking. Consumer and provider views on action required to persuade young people not to start smoking	Health promotion officer Development of educational materials
Support Health Promotion activities for example European Week against cancer, Passive smoking initiatives etc. Greater dissemination of the Europe against cancer code.	Health Promotion Officer EHB Community Services Dept. Public Health Dept. Occupational Health Media (newspapers, magazines etc.)	1998 (ongoing)	1	Greater awareness of healthier choices	Advertising Educational Activities and programmes

Table 7 Health promotion (continued)

Action / Target	Key players	Time scale	Priority 1-3	Expected Benefit / Outcome	Requirements and estimated costs for the health board
Advise and assist in adopting a healthier lifestyle among ante-natal women	Maternity hospitals GPs Public health nurses Health promotion officer	on -going	1	Reduction of smoking and healthier lifestyles for young families	to be determined with maternity hospitals
Establish the smoking rate during pregnancy and the number of women who stop smoking during pregnancy and do not restart after 1 year post-delivery	Maternity hospitals Dept. Public Health Medicine	1998	2	Healthier mothers, babies and families	Part of an EU study (if accepted) Part-time senior area medical officer (depending on study being sanctioned).
Continued support for healthy eating, safe sex, sun awareness, moderation in alcohol consumption	GPs Health promotion officer Health promotion Unit Dept. Public Health Medicine Dept. Occupational Health Hospitals Voluntary organisations.	on-going	1	Greater health awareness. Healthier behaviours	Health Promotion officer.
Health promotion initiatives for patients with, or with a past history of cancer	Health promotion officer Hospitals GPs Voluntary organisations Public Health Nurses	1998	1	Healthier behaviours among this group	Educational materials and development of specific health promotion activities

4.3 The treatment and management of cancer

The management of patients with cancer involves most areas of the health service, primary care, hospitals, specialist services and palliative care. The main priorities for providing a service to meet the aims of the National Cancer Strategy are outlined below. By continuing consultation with all the key players a more detailed plan will evolve in 1998. On-going structured collaboration between service providers is being established to ensure best practice in all cancer treatments and appropriate, accessible therapies for patients.

4.3.1 Primary Care

Primary health care is the starting point of cancer services. Primary care services encompass health promotion activities, screening and early detection; community based care, rehabilitation and palliative care.

General practice

The part played by general practitioners in prevention, screening, early diagnosis and continuing care of cancer patients is paramount. In addition to diagnosis and treatment of individual patients they have an important role in identifying patients at greater risk for different forms of cancer and for arranging selective screening and counselling.

General practitioners provide primary care services, in conjunction with other community health services.

These include:

Nursing services (public health nurse and palliative care nursing)
Social services
Voluntary groups (counselling, health promotion and self help groups).

These services are pivotal to ensuring that patients are properly informed, educated and encouraged to take responsibility for their own health.

Primary care services need to be co-ordinated towards treatment of disease, relief of symptoms and social support.

It is essential for primary care services to have close links with hospital-based services to ensure speedy diagnosis and referral, co-ordinated, integrated cancer treatment and community-based rehabilitation. Unambiguous protocols for referral of people with possible symptoms of cancer must be agreed. The transfer of patients between hospitals and community needs careful planning and must be audited regularly. Prompt communication is critical in this context, in the form of prompt discharge summaries and informing GPs of the patients' awareness of their diagnosis and treatment.

Postgraduate education is also necessary for primary care service providers and this must be encouraged and facilitated.

Public Health Nursing

The public health nurse plays a key role in the continuing care of patients with cancer. This role includes prevention, curative and palliative components. Public health nurses are familiar with patients in their own environment and are often the first people to become aware of the patient's illness. Continuing medical education and updating of skills is necessary for the public health nurse and must be encouraged and facilitated. Liaison and communication between all members of the primary care team is a priority. Linkage between all primary healthcare services must be strengthened.

Details of the primary care plan are documented in table 8. This was complied with the Irish College of General Practitioners. The views of public health nursing representatives of the Eastern Health Board are contained in many parts of this Cancer Plan.

It outlines priorities for:

- Early diagnosis and referral
- Hospital/ Community liaison and communication (referral, management and discharge)
- Identification and monitoring of high risk patients within GP practices
- Information of disease processes and progression
- Accessing services in the community and in the hospital
- Continuing education and training
- Protocols for referral and management of specific conditions.

Costs

The main additional costs required to provide a more effective primary care service for patients with cancer are in relation to:

1. GP participation in multidisciplinary work with hospitals. This will include the development of protocols for referral, discharge and 'best-practice' management of cancers.

£30,000

2. Provision of a hospital / community liaison service. This service would be situated within hospitals and would probably be in the form of providing nurse specialists. This liaison facility was stated by GPs, public health nurses and hospitals in the region as the major priority to ensure continuity of care and patient support. **Costed under hospital section**

3. Identification of high risk patients and patients with cancer in GP practices. This requires the introduction and utilisation of computer systems, recording and monitoring of practice profiles. The purpose of this development is to target high risk patients and to ensure prevention and early intervention. This system should be piloted in approximately 12 practices within the EHB in 1998 and outcomes evaluated. The funding requirements are for clerical support for these practices, GP training and for one project manager to oversee it, ensure quality and evaluate.

Project manager (total costs)	£40,000
Secretarial and overheads	£120,000
Hardware and software	£60,000
Total	**£220,000**

4. Funding for continuing medical education for GPs and community health service personnel, including palliative care training. **£30,000**

5. Counselling of cancer patients in primary care (pilot). **£50,000**

As patients with worrying symptoms regularly attend GPs for treatment and support, it is desirable that trained counsellors be available at this level. The details and procedures for establishing this service needs discussion with GPs. As an initial step a pilot initiative in a number of practices will be undertaken, monitored and evaluated.

Total Cost: £330,000

Table 8 General Practice and Primary Care

Action / Target	Key players	Time scale	Priority 1-3	Expected Benefit / Outcome	Requirements and estimated costs for the health board
Establish multi-disciplinary committees within each region to ensure collaboration between all providers	Hospital co-ordinators GP faculty representatives Public Health Nursing Regional Directors Palliative care Voluntary groups (as relevant)	Jan. 1998	1	Implement procedures to agree best practice, outcomes and supports for patients	Funding GPs to take part in this work e.g. locum cover Cost: £30,000
Develop protocols for screening, referral, management and discharge of patients	GP faculty representatives Hospital co-ordinators Regional Directors Hospital and community pharmacists Public Health Nursing Palliative care (as relevant)	by June 1998	1	Full integration and collaboration of patient care and services. Relevant standardised protocols for each region. Provider & patient satisfaction.	Funding as above
Each hospital to provide a liaison service	Hospital co-ordinators EHB community services Public Health Nursing GP representatives	by June 1998	1	GPs are up-to-date with patient management. GPs can meet day-to-day needs of such patients	Appointment of a liaison service between bigger hospitals and community
Establish clear procedures to ensure rapid referral of patients to hospital by GPs	GPs Hospital co-ordinators Regional Directors	by June 1998	1	Prompt management of urgent cases	Facilitate key personnel to carry out this work. Cost above.
Hospitals to notify patients and GPs of public health nurse names and names of voluntary supports on their discharge	Hospital co-ordinators GPs Public health nurses Voluntary supports	January 1998	1	Ensuring supports and continuity of care are in place at the time of discharge	Cost: above

Table 8 General Practice and Primary Care(continued)

Action / Target	**Key players**	**Time scale**	**Priority 1-3**	**Expected Benefit / Outcome**	**Requirements and estimated costs for the health board**
On going training in palliative care for GPs	Palliative care teams GP representatives	on-going	1	GPs are competent in providing palliative care	Funding for courses Cost : £30,000
Develop guidelines for symptom control	GP faculty representatives Palliative Care	by June 1998	1	Implementation of best practice in GP delivery of palliative care	Nil extra
Greater access to a palliative care consultant opinion by GPs	Palliative care GP representatives	on going	1	GP can manage a wide range of palliative care problems with consultant advice	(See palliative care section)
GP computer systems to develop a profile of their patients with cancer, high risk factors and those who would benefit from screening	GP practices GP unit, EHB	begin to develop in 1998	1	GPs can: i) identify high risk patients & intervene accordingly ii)recommend timely appropriate screening iii)monitor patients and their needs	Computer requirements being undertaken by GP unit. Resources required to develop and monitor systems £220,000
Establish targets for cervical screening uptake in the relevant population	National Cervical Screening committee GPs	in line with work of National Committee	1	Pick up pathology at pre-invasive stage Reduction in numbers of cervical cancer	GPs require remuneration for cervical screening Request that this be discussed by national committee
Counselling for patients with cancer	GPs EHB	Discuss 1998	1	Appropriate counselling at GP level	Pilot counselling service at Primary Care level Cost: £50,000

5 Palliative Care

Introduction
Despite advances in the treatment of cancer the reality is that some patients with cancer will not be cured. Palliative care is therefore an essential element of cancer treatment.

Palliative care is defined as the continuing active total care of patients and their families by a multi-professional team at a time when medical expectation is not cure and the primary aim of treatment is no longer to prolong life for both patient and family.

It should not be limited to patients in the last few weeks of life; it has much to offer at the earlier stages of illness, both for the patient and his/her family.

The National Health Strategy identified the development of Palliative care Services as a priority and it recommended the promotion of palliative care services in a structured manner. The Cancer Strategy also recognised the importance of palliative care in the provision of cancer services and set down guidelines for their development. It stated that in developing palliative care services, the following principles should be adopted:

- patients should be enabled and encouraged to express their preference about where they wish to be cared for and where they wish to spend the last period of their life
- services should be sufficiently flexible and integrated as to allow movement of patients from one care setting to another depending on their clinical situation and personal preferences; and
- the ultimate aim should be for all patients to have access to specialist palliative care services where these are required. It is recognised that patients with advanced progressive disease will not be able to travel long distances for services.

The need for palliative cancer care
In the Eastern Health Board region (population 1.3 million) about 2500 people die from cancer each year. The incidence of cancer is increasing as the population is ageing and most people who die from cancer are over 75 years old. This puts demands on older frailer carers, and many patients with no family member to care for them. Not all of these patients are in need of specialist palliative care services, but based on service utilisation figures from the UK, between 15 - 25% of them (546 to 910 patients) need in-patient hospice care, and between 25 - 65% (910 to 2371) need the help of a support team, whether that is in hospital or at home. Currently the 2 in-patient units in the EHB admit about 700 patients for care annually, and the home care/hospital support teams are providing services for over 1000 patients.

There are two other considerations in the EHB Region. Many units in hospitals in the region are tertiary referral centres and the complexity of the cases seen may give rise to the need for more Specialist Palliative Care input. Also it is recognised that Specialist Palliative Care Services are appropriate to a wide range of conditions and that over time other conditions will take an increasing amount of the time of the specialist palliative care team and this needs to be factored into estimates of need. Currently non cancer related specialist palliative care accounts for about 8% of referrals.

Current Provision
Specialist Palliative care services in the region are provided by a mix of home care/day care services, in-patient hospice care and specialist palliative care services within acute hospitals. The different types of specialist palliative care units all have strong links with each other, thus facilitating easy movement of patients from one part of the service to another. However the links between primary care and consultants in Palliative Medicine need to be strengthened as currently there is no means of direct access to a consultant from primary care. The introduction of outpatient clinics one day a week as a pilot scheme in Our Lady's Hospice in Harold's Cross is a welcome development and consideration should be given to introduction of such clinics in other facilities in the region.

In-patient units
There are 2 in-patient units in the region providing a total of 59 in-patient beds for a population of 1.3 million. These units provide multidisciplinary specialist care to the patients in their care.

Table: In-patient units/beds in the Eastern Health Board Region

Unit	No Beds	Day centre
St Francis, Raheny	19	3 days/week
Our Lady's Hospice	36	2 days/week
Total	59	

In Our Lady's Hospice, Harold's Cross Palliative Care Unit, 428 patients were admitted in one year. Of these, 362 died in the unit and 165 were discharged. In St Francis Raheny, the number of beds increased in mid 1997 and so the figures are changing. They estimate that they will have 280 admissions in 1998. Each in-patient unit also provides day care and in one unit, an outpatients clinic on one half day a week has been introduced on a pilot project basis.

Home care services
Home care is available to all patients in the region. However, in some teams the nurse is working single handed, and without the benefit of specialist palliative care medical support. This is the case in the East Wicklow and in parts of Kildare. Funding arrangements for home care services vary throughout the region, with some services being totally state funded whereas others have to rely on voluntary sources for the majority of their funding. Regarding home care services Our lady's Hospice gets 100% state funding, St Francis' hospice receives 25% funding from the Eastern Health Board, East Wicklow gets 100% funding and Kildare, West Wicklow gets funding for 1 nurse while one and a half nurses are paid for by voluntary funds. Consequently home care services funding sources vary throughout the region

Specialist Palliative care services in hospitals
Specialist Palliative Care Services in acute hospitals are poorly developed in the region, with major gaps in provision evident. There is a service in St Vincent's hospital, in St James' Hospital and in Beaumont hospital. In three major acute hospitals however there is currently no service (Mater, Tallaght, James Connolly Memorial), and in St Luke's hospital, a designated cancer treatment hospital, there is also no specialist palliative care service available. This service is of great benefit to the hospitals where it is available. For example, in St James's hospital 328 patients were referred in a one year period. This inequity in provision of specialist palliative care services in an acute hospital means that for about 1200 acute hospital beds in the region, no service is provided. This clearly is a priority area for development.

Current funding for in-patient care
1. Acute hospital based palliative care nurses are all funded by the Irish Hospice Foundation with in some instances the promise of statutory funding following voluntary pump priming
2. Our Lady's Hospice is 100% funded, whereas St Francis, Raheny receives 90% state funding

Priority areas for development of Specialist Palliative care services

1. Urgent provision of a consultant led specialist palliative care service in the major acute hospitals in the region with no service This should be organised on a geographical basis that covers the proposed new regions of the Eastern Health Authority.

The Eastern Health Board is due to be reorganised into three regions, and it seems sensible to organise a comprehensive service based around these regions. For the Northern region, which includes Beaumont hospital, the Mater hospital and James Connolly Memorial hospital, a second consultant led service in the Mater hospital with links to St Francis in-patient unit should be set up. For the South Western region, a consultant led service should be set up in Tallaght/Naas. In addition, a specialist service should be provided based at St Luke's' hospital (with links to Our Lady's Hospital, Crumlin)

St Michael's Dun Laoghaire, and St Collumcille's Loughlinstown should be included in the service provided in the South East region. In each region there should be two specialist led palliative care teams, designed so that close links are maintained between the hospital, home care and hospice services.

As part of the remit of these new posts, specialist palliative care outpatient clinics should be set up, as these will strengthen the links between primary care and specialist palliative care services, which need to be improved.

Costs

1. Consultant in Palliative Medicine consultant x 3 £270,000
Hospital based palliative care nurse (salaries plus associated costs) £ 82,000

Acute hospitals in the Area should consider setting aside 1-2 rooms / studios for palliative care services. This facility could be used, in a flexible way, by patients and close family members.

2. The further development of home care teams so that no single handed home care teams exist as is the case in East Wicklow and in Kildare. This requires two nurses to support home care teams. £ 82,000

3. Need for strengthening of current specialist palliative care teams

This is particularly important in the areas of :

- Community occupational therapy
- Bereavement counselling
- general support in the home e.g. home help services.

Bereavement counselling is provided by teams of trained volunteers with psychological backup but in the acute hospital setting the service available is inadequate. Supportive therapies form an important part of improving quality of life for patients and urgently need to be further developed.

£150,000

4. Statutory funding of current specialist palliative care services.

A mechanism for the provision of statutory funding of palliative care nurses working both in hospitals and as part of home care teams should be considered in 1998 as part of the collaboration between the Cancer Regional Directors and the palliative care service.

The significant voluntary monies saved by not having to invest in staff can then be used for investing in teaching and research.

5. Promotion of education and research

At the two in-patient units there is a requirement to develop educational facilities. In addition the appointment of medical tutors in each in-patient unit and a research fellow shared between the units is a necessary development, as there has been little Irish research in this important area and the findings of services elsewhere are not always applicable in the Irish situation.

Total Costs: £584,000

6 Voluntary and Support Groups

Voluntary organisations regularly provide valuable support to patients and their families at various stages of treatment, whether by visiting in hospital, organising self-help groups or counselling. Some voluntary organisations have a local focus while others adopt a national role. The main voluntary organisations available for the Eastern Health Board region include:

- **The Irish Cancer Society,** which has many sub-groups e.g.
  Cancer Plus
  CanTeen
  Colostomy and Ileostomy Welfare Support Group,
  Hodgkins United Group
  Laryngectomy Society of Ireland
  Reach to recovery (Breast Cancer)
- **ARC**
- **Brain Tumour Support Group**
- **Bone Marrow Transplant Support Group**
- **Ileostomy, Colostomy and Pouch Association**
- **Slanu Cancer support Group**
- **St. Luke's Hospital**
- **Beaumont Hospital Laryngectomy Group**
- **C.H.A.T.**
- **Greystones Cancer Support**
- **Bray Cancer Support Group**
- **Arklow Cancer Support Group**

In addition there may be support groups in operation in the EHB region which are unknown to the EHB.

It was recommended in the Cancer Strategy that:
'hospitals will be requested to notify patients of the names of voluntary organisations and other appropriate contacts on discharge from hospital so that they are fully aware of the type of support available to them'.

While one of the strengths of voluntary groups is their independence and this should be maintained. Nevertheless, in the interest of providing a quality service, voluntary organisations for cancer and their members should be more integrated with the health service. Volunteers require on-going training in order to:

- develop and maintain their knowledge and skills, including counselling skills
- keep up to date with advances in treatment and care
- maintain the confidence of clients and the health service.

Action Plan for 1998

- Voluntary groups should be registered and regulated. Those in receipt of state funding should agree with the health service on use of funds, be accountable for them and services should be audited
- Criteria will be developed and used by the EHB for funding voluntary groups. All voluntary groups, funded by the Health Board, should be well structured and have a sound financial footing
- Criteria for the training of volunteers be drawn up by the EHB, specialist services and voluntary groups and training will be offered.
- **It is recommended that a review of cancer counselling services in the Area be undertaken specifically to examine the types of counselling available, gaps in services, training needs, effectiveness of these services and to make recommendations on policy. A researcher should be appointed to undertake this task in association with the Public Health Department.**

Funding for voluntary groups to include training and development £180,000
Funding for 'Review of Counselling Services and Needs' £ 30,000 Total £210,00

Table 9 Voluntary and Support Groups

Action / Target	Key players	Time scale	Priority 1-3	Expected Benefit / Outcome	Requirements and estimated costs for the health board
Greater involvement and integration with the statutory service e.g. GPs and specialist staff in hospitals, EHB community services On going training for volunteers Voluntary groups which receive health service funding to be accountable for these funds and to agree with the health service on their use	Voluntary groups EHB community services hospitals Specialist nurses Regional directors	1999	2	Greater recognition of the role of volunteers and voluntary groups Better estimate of contribution being made by voluntary groups to patients	**Total £180,000**
Review of counselling services	Department of Health EHB and Public Health Department Regional Directors Voluntary groups Specialist cancer services	up to 1 year	1	Identify availability of counselling gaps in service training requirements make recommendations on policy and service	**£30,000**

7 Consumer Views

One of the principles of the National Cancer Strategy is that cancer services be patient centred, easily accessible, flexible and capable of responding effectively to the needs of patients and their families.

In order to put the principles of the National Cancer Strategy into action, it is proposed to involve consumers in identifying issues relevant to the delivery of the cancer service. Initially, qualitative research methods will be used by establishing focus groups and conducting in-depth interviews with patients and families. In the first instance consumers of the breast cancer service will be involved. Hopefully, other major users of the service will also be included e.g. bowel cancer and families of children with cancer.

Consumers /patients of the service have valuable insights into service delivery. Clients of cancer services in the EHB will incorporated as partners in the planning and evaluation of services.

Consumers / patients deserve the highest quality service. Every effort should be made to meet their expectations. Consumer satisfaction is increasingly recognised as an important indicator of service performance. Consumer satisfaction and consumer involvement will be a central part of the implementation of this cancer plan. The involvement of consumers is being piloted in 1998, however, it is anticipated that their role and participation will expand in the future.

Cost for 1998: £10,000

Table 10 Consumer views

Action / Target	Key players	Time scale	Priority 1-3	Expected Benefit / Outcome	Requirements and estimated costs for the health board
Identify patients met and unmet needs by undertaking qualitative research on patients with breast cancer, initially. This will involve in-depth interviews and focus group work. The ultimate aim is to undertake additional qualitative research on other patients with cancer e.g. colon cancer.	Patients Healthcare personnel Department of Public Health Hospitals GPs	Every year to encourage regular review of cancer service provision from the patient's point of view	1	To identify the unmet needs of patients in relation to the cancer journey. To make the cancer service more patient centred and to involve patients in the planning and evaluation of the cancer services. To encourage audit and monitoring of cancer service provision.	1-2 part-time researchers

8. Hospital Plans for Each Area of the Eastern Health Board

8.1 General Issues

The following priorities for developing cancer services in hospitals in the EHB region were agreed by the regional cancer directors and the individual hospital cancer coordinators following their consultation with the other clinicians.

The implementation of the Cancer Strategy within hospitals in the EHB area is influenced by general health care demands e.g.

- **Access to in-patient beds and day case facilities by cancer patients**. A system for prioritising bed and theatre space for patients with cancer should be developed within hospitals

- **The demands placed on hospital beds by Accident and Emergency Department activity.** There should be continuous efforts to control activity in A&E departments.

- **The impact of tertiary referrals on planning and providing services in major teaching hospitals, availability of services and patient choice.**

- **The provision of long stay facilities to reduce unnecessary hospital bed utilisation by patients who have completed their acute care**.

8.2 Priorities common to hospitals in the EHB

While each hospital has specific short term and medium term requirements for development, it is clear that most of the hospitals had the same common priorities i.e.

1. <u>Development of 'best practice' protocols / guidelines</u>

It is agreed that 'best practice' protocols be developed and used in the diagnosis and management of cancers, specifically cancers of the lung, breast, large bowel, prostate, testis, melanoma, ovary and urological tract. It is proposed that these protocols be developed by individual professional medical and surgical societies. These societies have been requested to produce them. The Regional Directors of the EHB will be involved in developing protocols for the area. as these will be used to facilitate audit of services provided. (Costed under the section on Primary Care at £30,000).

2. <u>Data and information procurement and utilisation by hospitals</u>

There is a need for greater involvement by clinicians with data on cancers treated in their hospital i.e. involvement in how and what data are collected , using data to conduct research and audit within the hospital, developing greater links with The National Cancer Registry and HIPE. It is recommended that data / information development would require the availability of a data manager within a hospital. The role of the data manager would be to liaise with the Cancer Registry Nurse, identify information needs in association with clinicians, collate hospital data, produce hospital reports, identify areas for audit and research and ensure standardisation of cancer staging and quality of data capture. Such a development in each hospital in the EHB would have resource implications, nevertheless its merit should be considered.

It is recommended that the provision of a data manager be piloted in one hospital in each of the three Areas of the EHB and evaluated prior to expansion. Costs also include hardware and software requirements.

Cost for 1998 £135,000

3. Specialist Nursing and Liaison with Primary Care

Each hospital stressed the need for greater collaboration with GPs, community health services / support groups and for the provision of a specialist nursing service for the major cancer specialties within a hospital. The role of a specialist nurse would include supporting and providing expertise to patients and liaising with other strands of the health service. This would ensure greater continuity of care for patients. It is of note that improved liaison arrangements were a top priority for GPs and public health nurses also. The number and type of specialist nurse in a hospital would depend on the specialties being provided and patient throughput e.g. breast, upper GI, lower GI, urology and head / neck.

Cost for 1998 £300,000

4. Training of nurses and support staff

It is essential that all health care personnel are fully up to date with treatments, in terms of both educational theory and the practical application of skills. This is particularly important with respect to chemotherapy nurses, who require supervision in the administration as part of their training.

Cost for 1998 £30,000

5. Palliative care facilities in acute hospitals

There was general agreement that all acute hospitals should have access to a consultant led palliative care service.

Costed under section on Palliative Care

6. Cancer counselling services

There should be greater availability of counselling supports for patients with cancer. This could be provided , in part, by specialist nurses but also requires trained counsellors and involvement by voluntary support groups.

The provision of a cancer counselling service should be piloted and evaluated.

Cost 1998 £90,000

7. Pathology

The specialised nature of oncological pathology, with increased workload per individual patient, suggests that the manpower requirements of this discipline should be urgently evaluated. This could be achieved by reassessing workloads according to agreed international equivalents e.g. The Canadian System.

A needs assessment is required.

8. Genetic Counselling

It is apparent that some patients have a genetic predisposition to some cancers. The familial association with cancer is becoming increasingly recognised.

The need for genetic counselling services will be examined.

Table 11 Hospital Care - General issues

Action / Target	Key players	Time scale	Priority 1-3	Expected Benefit / Outcome	Requirements and estimated costs for the health board
Each hospital to appoint a cancer co-ordinator	Regional Directors Acute Hospitals Hospital Co-ordinators GPs Community Health Services	Implemented	1	Standardisation of procedures and to ensure planned programmes of care. Greater cohesion of the service. Greater collaboration with GPs and other relevant groups. Recommendations for future resource allocation.	nil extra
Ongoing analysis of current activity in all acute hospitals in the EHB to be undertaken	Regional Directors Hospital co-ordinators Department of Public Health	1997 data collected	1	Outline of the current situation Reach a consensus on standardisation, places for treatment of different cancers Discussion and agreement on patient throughput per hospital	Research and statistical supports (included in information section cost)
Evaluation of treatment outcomes	Regional Directors Hospital clinicians HIPE data Cancer Registry data	1998-2000	1	Quality assurance mechanism Prospective audit	Information and Surveillance (included in information section cost)

Table 11 Hospital Care - General Issues (continued)

Action / Target	Key players	Time scale	Priority 1-3	Expected Benefit / Outcome	Requirements and estimated costs for the health board
Development of 'best practice' protocols for the diagnosis and management of cancer of: Lung Breast Large bowel Prostate Testis Melanoma Ovary Urological tract	Relevant clinicians Relevant faculties and professional societies Hospital co-ordinators GPs to receive summaries of these protocols Regional Directors	1998	1	Standardisation of treatment Delivery of appropriate treatment and best practice Better monitoring of procedures and quality Improvement in survival	£30,000 (costed under primary care section)
Establish protocols for referral to palliative care	Hospital clinicians Hospital co-ordinators Palliative care specialty Regional Directors	1998	1	Delivery of timely palliative care	

Table 12 Hospital Care - Chemotherapy

Action / Target	Key players	Time scale	Priority 1-3	Expected Benefit / Outcome	Requirements and estimated costs for the health board
All nurses who administer chemotherapy to have theoretical and practical training before working unsupervised in this area (practical training involves working under the supervision of a fully trained chemotherapy nurse in a chemotherapy centre)	Regional Directors Hospital Management Hospital directors of nursing Nursing associations	Immediate and on-going	1	All nurses who administer chemotherapy will be fully trained in this area Greater competencies among nurses Better quality of patient care Better patient outcomes Fewer complications Better management of complications	Cost of releasing nurses for theoretical and practical training Cost included in £30,000 for all forms of nurse training
Junior medical personnel who prescribe chemotherapy to be supervised and to receive training	Hospital clinicians Junior doctors Regional Directors	Immediate and on-going	1	Greater competencies among junior medical personnel Better patient outcomes	
New National Guidelines for the Safe Administration of chemotherapy (published by the Department of Health) to be followed in all hospitals These guidelines to be audited	Regional Directors Hospital management, clinicians and nursing personnel Hospital pharmacy	immediate	1	Standardisation of procedures Implementation and audit of best practice	
Patients who receive chemotherapy to be fully informed of all aspects of this treatment	Hospital clinicians Nursing and pharmacy personnel	immediate and on-going	1	Quality of patient care. Ensuring patient / family understanding of treatment	Production of patient information leaflets

8.3 Proposals for South East Area of the EHB

Regional Director **Mr. John Hyland**
Consultant Surgeon
St. Vincent's Hospital
Dublin 4.

There are ten hospitals in the south-east Area of the EHB. St. Luke's/St Anne's Hospital is also in the region but it is considered to be a national specialty hospital and will be repesented on the committees of each of the areas.

The Regional Committee will comprise all Hospital Co-ordinators, Public Health Specialists, Nursing, General Practice and Palliative Care representatives. The main aim will be to co-ordinate a plan for the Region.

Table 13 Hospitals in the South East region and Cancer Co-ordinators

Hospital	Type of hospital	Cancer Co-ordinator
St. Vincent's Hospital	General/ Specialist services	Dr. D. O Donoghue
St. Vincent's Private Hospital	General/Specialist/Private	Dr. D. O Donoghue
St. Colmcille's, Loughlinstown	General	Mr. D. Magee
St. Michael's Hospital Dun Laoghaire	General	Dr. A. Mc Cormick
St. Michael's Hospital Dun Laoghaire (Private)	General/Private	Dr. J. Crown
National Maternity Hospital, Holles Street	Obstetrics and Gynaecology	Dr. G. Flannelly
Royal Victoria Eye and Ear	ENT, Ophthalmology	Prof. C. Timon
Blackrock Clinic	General/Specialist/Private	Dr. J. Crown
Mount Carmel Private Hospital	General and Obstetrics and Gynaecology	Dr. M. Moriarty/ Dr. B. Nolan
Hume Street	Skin	Dr. P. Collins

Together with the main general priorities outlined in para. 8.2 above, the need for specific developments were highlighted by each hospital. While some of these developments can be implemented with minimal resources others require feasibility studies, cost analysis and consideration in the light of overall hospital plans.

Table 14 Consultants with a special interest in cancer and priorities for developing cancer services by hospital (South-East)

Hospital	No. of consultants specialising in cancer treatment	No. of specialist nurses	Priorities for development
St. Vincent's Hospital	2 Medical oncologists 1 upper GI surgeon 1 lower GI surgeon 1 general GI surgeon 2 Breast surgeons 1 Haematologist 2 urologists 3 GI physicians 4 Orthopaedic surgeons 1 Cardiothoracic 1 Radiotherapist 4 Respiratory physicians	9 oncology nurses 2 breast nurses 1colo-proctology nurse (+ 1 part-time researcher) ***{both privately funded}*** 2 palliative care nurses (+ 1 in training)	**Protected bed access and theatre space** **Cardiothoracic, review of needs**: ICU beds and high dependence beds, dedicated registrar **Gynaecology:** review of services in south-east with a view to centralisation, Colposcopy service **Statutory funding of speciality nurses and research post** **Endoscopy:** development of daily bronchoscopy service and C- arm fluoroscopy service Incorporate **radiotherapy** facilities in SVPH for public patients **Cancer counsellors** **2 additional nurse specialists**
St. Michael's hospital Dun Laoghaire	1 ENT surgeon 1 Gynaecologist 1 ophthalmologist 4 physicians 3 general surgeons	none	**Colonoscope:** To improve service for detection and prevention of colon cancer £18,000 **Nasal Endoscope:** to improve facilities for the diagnosis and treatment of ENT cancers £7,000 **Prospective study of the needs of elderly patients with cancer £2,000** **Laparoscope / monitor:** to improve evaluation of patients with intra-abdominal malignancy **One additional nurse specialist**

Table 14 (continued) **Consultants with a special interest in cancer and priorities for developing cancer services by hospital (South-East)**

Hospital	No. of consultants specialising in cancer treatment	No. of specialist nurses	Priorities for development as given by each hospital
Royal Victoria Eye and Ear	11 Ophthalmic surgeons 4 ENT	None	**Medical Equipment needs for head and neck cancer:** Endoscopy and camera equipment **Additional Specialist / Liaison nurse:** especially for laryngectomy patients
National Maternity Hospital, Holles Street	12 gynaecologists 1 visiting medical oncologist	2 specialist oncology nurses	**Information management:** minimum dataset and database for oncology, theatre, colposcopy Data manager and computer, computerisation of chemotherapy. **Access to radiologist and oncologist.** **Evolution of multidisciplinary clinics.** **Greater chemotherapy facilities.** **Additional pathology services**. **Formalise links with palliative care & GP/ liaison group** **Increased psychosexual counselling facilities.** Long term plan to apply for special interest training within the hospital or in conjunction with other allied units.
St Colmcille's, Loughlinstown	2 GI Surgeons 1 General Physician 1 Geriatrician		**Sessions from palliative care physician.** **Cancer liaison nurse.** **Counsellors.** **Improved data management and data manager.**

Table 14 (continued) **Consultants with a special interest in cancer and priorities for developing cancer services by hospital (South-East)**

Hospital	No. of consultants specialising in cancer treatment	No. of specialist nurses	Priorities for development as given by each hospital
St. Vincent's Private	1 haematologist 2 medical oncologists 1 radiation oncologist	1 nurse specialist in palliative care	Funding for a **linear accelerator** in the radiotherapy department. Funding for an **Integrated Oncology Management System** for Cancer Patients
Mount Carmel			**Accurate computerisation /standardisation data collection and disease staging** **Counselling and psychotherapy**

The following were also requested by St. Vincent's hospital (see enclosure)

- **Staffing review:** medical, paramedical staff and laboratory. This includes nurse specialists and cancer registry nurse co-ordinator.
- **Equipment review:** for diagnosis and staging of cancers i.e. CT Scan, MRI, PET, upper GI and intrarectal ultrasonography and laboratory equipment for haematology, biochemistry, pathology and tumour markers
- **Space**: Laboratory (storing blood stem cells and bone marrow stem cells), treatment and diagnostic facilities (X-ray)
- **Single rooms:** with filtered air for management of haematological and oncological patients, suite for neutropaenia patients
- **Prostate cancer** detection clinic "one stop shop"
- **Cancer pain service** and vascular access procedures in terms of specialist nurse and theatre facilities
- **Review of rehabilitation services** (occupational therapy and physiotherapy)
- **Review of radiotherapy services**
- **Development of staff education programmes.**

8.4 Proposals for the Northern Area of the EHB

Regional Director Professor David Bouchier-Hayes
Consultant Surgeon
Beaumont Hospital Dublin 9.

There are eight hospitals in the Northern Area of the EHB.

Table 15 Hospitals in the Northern region and Cancer Co-ordinators

Hospital	Type of hospital	Cancer Co-ordinator
Mater	General / Specialist	Mr. T O Dwyer
Mater Private	General / Specialist /Private	Dr. D. Carney
Beaumont	General / Specialist	Mr. P. Broe
James Connolly Memorial	General / Specialist	Mr. B. Lane
Rotunda	Obstetrics/ Gynaecology	Dr. P. Mc Kenna
Children's hospital, Temple Street	Children	Dr. M King
Cappagh	Orthopaedic	Mr. Hurson
Bons Secours, Glasnevin	Private	not appointed

Together with the main general priorities outlined in para. 8.2 above, the need for specific developments were highlighted by each hospital. While some of these developments can be implemented with minimal resources others require feasibility studies, cost analysis and consideration in the light of overall hospital plans.

Table 16 Consultants with a special interest in cancer and priorities for developing cancer services by hospital (Northern Region)

Hospital	No. of consultants specialising in cancer treatment	No. of specialist nurses	Priorities for development as given by each hospital
Beaumont	5 neurosurgeons 4 urologists 2 respiratory physicians 1 general thoracic surgeon 2 gynaecologists 1 haematologist 1 locum radiotherapist 2 GI physicians 1 Palliative care consultant (sessions) Surgeons: 4 GI	1 Palliative care specialist nurse	**Medical oncologist** with the appropriate infrastructure, systems and funding (+ associated developments in pharmacy and nursing) **Permanent radiotherapist** (minimum of 4 sessions to Beaumont). This is urgent given the unique requirements of Beaumont re neurosurgery and ENT **Palliative care** structure and system including the appointment of a second palliative care nurse, social worker and NCHD **Counselling** **Nurse specialists for major specialties** and liaison systems with primary and community care **Information systems and data management** **Endoscopic ultrasound** for upper and lower GI

Table 16 (continued) **Consultants with a special interest in cancer and priorities for developing cancer services by hospital (South-East)**

Hospital	No. of consultants specialising in cancer treatment	No. of specialist nurses	Priorities for development as given by each hospital
Mater	**Surgeons:** 2 breast, 3 GI (including hepato-biliary) 2 gynaecologists, 2 cardiothoracic 2 urologists 2 ENT 2 Plastic **Physicians:** 3 dermatologists 1 haematologist 3 GI 3 pancreas 1 respiratory 1 medical oncologist	7 specialist oncology nurses 1 colo-proctology nurse	**Data management systems for hospital including for theatre and to ensure completion of pathology staging** **Specialist nurses for GI, GU, Lung, Breast and head/neck also to liaise with Primary Care** **Medical oncologist appointment and support staff** **Sessions from a palliative care consultant and 2 palliative care nurses**
James Connolly Memorial	1 upper GI 1 lower GI 1 breast Specialist urologist Gynaecologist		Oncologist service (3 sessions per week for multidisciplinary patient management and OPD service Links with a radiotherapist for multidisciplinary patient management Sessions from palliative care consultant
Rotunda	11 consultants all do diagnostic / therapeutic work 4 specialise in ovarian cancer		**Rationalisation of ovarian cancer management:** by the 4 gynaecologists to general hospitals **Development of cervical screening for patients attending Rotunda** **Nurse specialist** to co-ordinate and support cancer patients and to ensure continuity of care
The Children's Hospital, Temple street	1 Maxillo facial surgeon 1 ENT surgeon 1 eye surgeon 1 general paediatic surgeon 1 paediatric neurologist 2 paediatric oncologists		Considered under paediatric services section, also **Dedicated paediatric palliative care nurse specialist** **Access to MRI** **Nurse liaison with primary care** **Data management**
Cappagh	1 specialist orthopaedic surgeon manages bone tumours		**Evaluation of need for support systems** **Evaluation of needs and systems for the management of soft tissue sarcoma**

8.5 Proposals for the South West Region of the EHB

Regional Director — Mr. John V. Reynolds, Consultant Surgeon, St. James's Hospital

At present there are six hospitals in the south-west Area of the EHB. For the purpose of this cancer plan, The Meath, Adelaide and National Children's Hospital, Harcourt Street, are considered as one hospital given their imminent move to Tallaght. When the new hospital opens in Tallaght there will be four acute hospitals in the south-west Area of the EHB.

A Cancer Strategy Group has been established in the South-west area of the EHB. Representatives from all the hospitals and major disciplines are included. This part of the interim plan outlines the major capital requirements to correct the major deficiencies in the Area. An Action Plan will be developed over the next two years. It build on this interim plan and will focus on all aspects of cancer relevant to the population in the south-west Area

With consideration of the above I requested that representatives from St.James's Hospital, Tallaght, The Coombe Women's Hospital and Naas General Hospital complete a situation report using guidelines suggested by Professor Fennelly. I requested a supplementary statement of up to 4 major capital requirements for cancer service provision within their hospital(s). This situation report encompasses these responses. I have also considered non hospital-specific requirements for research, education and audit , although the capital requirement involved, particularly with respect to primary care and public health issues must await comprehensive analysis before future strategy can be developed, re-structured and budgeted.

Table 17 Hospitals in the South-West Region and cancer co-ordinators

Hospital	Type of Hospital	Cancer Co-ordinator
Adelaide, Meath, incorporating National Children's Hospital	General/Specialist/Children's	Dr. H. Enright
Coombe Women's Hospital	Obstetrics/Gynaecology	Dr. N. Gleeson
General Hospital, Naas	General	Mr. B. Hargan
St. James's	General/Specialist	Mr. J. Reynolds

Together with the main general priorities outlined in para. 8.2 above, the need for specific developments were highlighted by each hospital. While some of these developments can be implemented with minimal resources others require feasibility studies, cost analysis and consideration in the light of overall hospital plans.

Table 18 Consultants with a special interest in cancer and priorities for developing cancer services by hospital (South-West)

Hospital	No. Consultants specialising in cancer treatment	No. of specialist nurses	Priorities for development as given by each hospital
Adelaide/ Meath incorporating The National Children's	Surgeons: 1 upper GI 1 lower GI 1 breast 4 genito-urinary 1 head and neck 3 gynaecology 1 haematologist 1 radiation oncologist 1 microbiology/ infectious disease	1 GU	**(1) Medical Oncology Post** *Revenue and Capital Requirements:* WTE requirements: 1 consultant, 3 NCHDs Annual Revenue: £200k Capital Total: £900k **(2) One-Stop Breast Clinic** *Revenue and Capital Requirements*: Equipment: Stereotactic mammographic biopsy/cytology; £120k WTE requirements: breast nurse specialist Annual Revenue: pay; £20k; non-pay £20k Capital Total: £140k **(3) Radio-immunoguided Surgery** *Revenue and Capital Requirements*: Equipment: Hand-held gamma-counter; £20k WTE requirements: cancer nurse specialist Annual Revenue: pay; £20k; non-pay £20k Capital Total: £60k
Coombe Women's Hospital	14 Gynaecologists		**(1) Oncology Nurses** *Revenue and Capital Requirements* WTE requirements: 1.5 nurse specialists Annual Revenue: pay; £30k; non-pay £20k Capital Total: £60k **(2) Laparoscopic Equipment** *Revenue and Capital Requirements* Equipment: Laparoscopic equipment; £10,105 Outpatient hysteroscope £14,468 Camera system £32,636 Disposables £7,700 CO2 laser £89,196 Capital Total: £200k (**3) Fixed -Session Medical Oncology**[2] **(4) Expanded Cancer Pathology service**[2] [2]: These services to be linked to St.James's Hospital and Tallaght in the Regional Action Plan. The costs of this have yet to be quantified.

Table 18 (cont.) Consultants with a special interest in cancer and priorities for developing cancer services by hospital (South-West)

Hospital	No. Consultants specialising in cancer treatment	No. of specialist nurses	Priorities for development as given by each hospital
Naas General Hospital	1 general surgeon 1 general/respiratory physician 1 Geriatrician		**(1) General Surgeons with Subspecialty Interest (linked to Tallaght)** *Revenue and Capital Requirements*: WTE Requirements: 2 consultants, 2 NCHDs Annual Revenue: pay: £350k; non-pay £50k Capital Total: £750k **(2) Specialist Nurses and Counsellors** *Revenue and Capital Requirements*: WTE Requirements: 1 specialist oncology nurse; 1 counsellor Annual Revenue: pay; £46k Capital Total; £56k **(3) Medical and Radiation Oncology Clinic (linked to St. James and Tallaght hospitals)**

Table 18 (cont.) Consultants with a special interest in cancer and priorities for developing cancer services by hospital (South-West)

Hospital	No. Consultants specialising in cancer treatment	No. of specialist nurses	Priorities for development as given by each hospital
St. James's	**Surgeons:** 2 upper GI 2 lower GI 1 breast 2 GU 2 Respiratory 3 head and neck 4 plastic/reconstruct. 4 gynaecologists 2 medical oncology 1 oncology (radiation) 2 [1]/2 haematologists/ oncology 2 microbiologists/ infectious disease 4 gastroenterologists 2 respiratory	20	**(1) Diagnostic Imaging Service Needs** *Equipment*: Helical CT scanner Magnetic Resonance imaging Mammography Unit (* commitment explicit in the Action Plan to install MRI at SJH within 3 years) *Staff*: Recruitment of specialist MRI and breast consultant post 2 additional radiography posts for mammography and CT 2 additional secretarial staff *Revenue and Capital Requirements*: WTE Requirements: 1 consultant, 2 radiographers, 2 A/C III CT scanner; £600k; Mammography; £70k Annual Revenue: pay; £147k; non-pay £35k Capital Total: £1478k **(2) Laboratory for the Molecular Diagnosis of Malignant Disorders [1]** *Revenue and Capital Requirements*: WTE Requirements: 1 Principal Biochemist, 4 laboratory technicians Annual Revenue: pay: £140k; non-pay £20k Capital Total: £152k **(3) Specialist Nurses for Multidisciplinary Clinics** *Revenue and Capital Requirements:* WTE requirements: 4 specialist oncology nurses Annual revenue: pay; £92k Capital Total: £92k **(4) Cytology and Histopathology Services [1]** *Revenue and Capital Requirements:* WTE requirements: 2 laboratory technicians Annual revenue: pay: £50k; non-pay £10k Capital Total: £94k **(5) Evaluation of the management and outcome of sarcoma and the development of protocols for management** A collaborative study with surgeons and pathogolists. Cost: £15,000 1 These proposals are linked in a regional plan and are not specific to St.James's Hospital

8.6 Paediatric Cancer Services

This section refers to Our Lady's Hospital, Crumlin and Temple Street Hospitals. The specific plan for the National Children's Hospital is encompassed in the Enclosure for the South-west area which includes the Tallaght hospital development

Childhood cancer is not common. In 1994 in Ireland it represented 0.6% of all cancers i.e. 118 new cases. Our Lady's Hospital, Crumlin is the National Centre for the treatment of childhood cancer. In 1996 there were 2,495 discharges (in-patient and day-cases) from Our Lady's Hospital for treatment of cancer. This figure represents hospital activity rather than incidence or prevalence. All children diagnosed with cancer are managed by a multi-disciplinary team and all are entered into European trials. Cancer services are audited on a monthly basis. The hospital takes part in numerous research projects. Children who require Total Body Irradiation are referred to Belfast and to Glasgow for this procedure (approx. 15 per year). It was strongly recommended by Our Lady's Hospital that TBI be available in Dublin.

Table 19 Personnel who provide cancer services in Our Lady's Hospital include:

Personnel	**Number**
Surgeon	3 (including 1 paediatric neurosurgeon)
Paediatric oncologist	2
Haemotologist	1
Oncology registrars	2
SHOs	2
Radiotherapist	1(2 sessions temporary)
Ward sister	3
Liaison nurse	3
Specialist nursing staff	3
Palliative care nurse	3
Staff Nurse	30
Other nurse	3
Social worker	2
Pharmacist	2
Psychologist	1
Dietician	1
School teacher	1
Administration	3

Cancer services at The Children's Hospital, Temple Street are gradually being phased out. At present the hospital has 43 oncology patients, none of whom are on active treatment. Outpatient services are provided by personnel from Our Lady's hospital.

There is agreement that all eye tumours in the country will be treated by one surgeon. Another surgeon will be involved in the management of head and neck tumours and in reconstructive surgery following radiotherapy. A different surgeon will be involved in the management of soft tissue sarcoma.

The main priorities for developing childhood cancer services are:

<u>Our Lady's Hospital</u>

1. **Palliative care**

Access to specialist palliative care consultant with an interest in childhood cancers (already costed under Palliative care section)

2. Additional liaison nurse

This is to liaise with hospitals in other parts of the country in developing shared care and to link with GPs. **£30,000**

3. Psychologist/counsellor

The psychological needs of children and their families is described as being 'enormous'. This need would greatly benefit from the services of an additional psychologist and social worker**. £60,000**

4. **Pharmacy building:** Consideration to be given to providing a dedicated pharmacy building in place of the existing prefabricated unit. **Decision and cost: to be determined**

5. **Examine the feasibility of establishing a TBI facility in Dublin Study to be undertaken**

6. **Access to MRI facilities**

7. **Consideration to providing an additional paediatric oncologist**

<u>The Children's Hospital, Temple Street</u>

1. To continue 'the long term /late effects clinic' at the hospital.

Immediate costs for 1988: £90,000

Additional costs may arise depending future policy developments and the outcome research outlined at 5 above.

8.7 St Luke's/St Anne's Hospital

St Luke's/St Anne's hospital is a tertiary referral specialist radiotherapy hospital. The main requirements outlined by the hospital for further developing cancer services are given in the table 20.

Table 20 The Main requirements for St. Luke's/St Anne's Hospital

Hospital	**No. of consultants specialising in cancer treatment**	**No. of specialist nurses**	**Priorities for development as given by each hospital**
St Luke's/St Anne's hospital Rathgar	6 Radiation Oncologists	6 Specialist Nurses	**A flexible information system and qualified personnel to enter and edit data** **More radiation oncologists** **Computerisation of chemotherapy activities** **Development of Cancer registry** **Consultant in Palliative Care linked to the hospital**

Appendix 1

Population of the three areas covered by the Regional Cancer Directors

Northern Area	**454,088**
South West Area	**515,568**
South East Area	**324,328**

Percentage of persons per Area by epidemiological age groups

Age Group	**<1**	**1-4**	**5-14**	**15-24**	**25-44**	**45-64**	**65+**
Northern Area	1.5	6.1	17.5	19.2	28.2	18.2	9.2
South West Area	1.6	6.6	19.2	18.1	30.2	15.8	8.5
South East Area	1.4	5.4	15.7	18.9	28.4	18.9	11.3
Total	1.5	6.1	17.7	18.7	29.0	17.4	9.4

Appendix 2a Cancer Incidence in Ireland compared with EHB in 1994

Site	Number Ireland	Number EHB	% EHB
Skin	6408	2038	31.8
Breast	1557	602	38.7
Lung	1455	565	38.8
Colon	1151	381	33.1
Colon/Rectum/Anus	1785	602	33.7
Cervix	1061	498	46.9
Prostate	1000	301	30.1
Unknown primary	678	237	35.0
Blood/marrow/spleen	671	357	53.2
Bladder	509	206	40.5
Melanoma	480	178	37.1
Stomach	476	186	39.1
Rectum	453	136	30.0
Lymph nodes	297	100	33.6
Oesophagus	295	105	35.6
Pancreas	284	79	27.8
Ovary	260	95	36.5
Brain	255	85	33.3
Kidney	182	71	39.0
Corpus uteri	156	61	39.1
Rectosigmoid	115	55	47.8

(Source: National Cancer Registry)

Appendix 2b Cancer Incidence Data for Dublin 1994

	Male				Female			
Site	***Expected***	***Observed***	***SIR***	***95% CI***	***Expected***	***Observed***	***SIR***	***95% CI***
All Sites	2134	2642	121	116-126	2839	3334	117	113-122
All sites except skin	1420	1661	117	111-123	1978	2223	112	108-117
Oesophagus	29	41	108	76-148	35	42	119	86-162
Stomach	70	94	134	108-164	47	66	130	108-177
Colon	137	161	118	100-133	158	160	102	87-119
Rectosigmoid	22	27	124	82-181	17	18	105	62-167
Rectum	66	68	99	77-126	44	45	103	75-137
Rectum & rectosigmoid	90	95	105	85-129	61	63	103	79-132
Pancreas	32	27	84	66-122	33	41	105	76-143
Larynx	22	34	151	105-212	6	6	106	38-231
Lung	229	332	146	130-162	130	163	126	107-147
Blood/marrow	84	75	89	70-112	88	90	102	82-126
Skin	764	581	126	121-137	861	1111	129	122-137
Melanoma	40	48	115	84-154	92	104	113	92-137
Breast	3	3	102	19-303	451	510	113	103-123
Kidney	34	41	122	33-166	22	22	98	62-149
Bladder	78	114	148	121-176	46	60	109	81-144
Brain	35	39	104	74-142	32	36	111	78-154
Thyroid	6	4	74	19-192	14	15	108	80-179
Unknown primary	86	98	115	94-140	87	102	117	96-142
Lymphoma	60	52	86	64-113	60	73	122	98-154
Prostate	216	245	114	100-129				
Testis	19	15	77	43-127				
Cervix					338	418	124	112-136
Corpus uteri					53	53	101	75-132
Ovary					81	73	90	70-113

Source: National Cancer Registry

[SIR= Observed incidence divided by expected incidence times 100].

Appendix 2c	Cancer Incidence Data for Kildare 1994							
	Male				Female			
Site	***Expected***	***Observed***	***SIR***	***95% CI***	***Expected***	***Observed***	***SIR***	***95% CI***
All Sites	230	242	105	92-119	267	273	108	94-120
All sites except skin	150	160	107	91-124	186	186	100	86-116
Oesophagus	4	2	50	6-183	3	6	207	76-454
Stomach	7	12	163	84-286	4	2	51	5-188
Colon	14	10	70	33-129	13	7	53	21-110
Rectosigmoid	2	6	282	94-674	1	0	0	0-219
Rectum	7	9	127	66-242	4	2	55	5-203
Pancreas	3	4	119	31-308	3	2	63	6-233
Larynx	2	1	43	0-248	0	0		
Lung	24	27	114	75-166	11	10	92	44-170
Blood/marrow	9	6	66	24-145	8	8	103	44-204
Skin	80	82	103	82-127	72	88	122	98-151
Melanoma	4	5	116	36-272	9	9	104	47-198
Breast	0	0			42	46	109	80-145
Kidney	4	2	57	5-208	2	2	102	10-376
Bladder	8	8	74	27-182	4	4	105	27-271
Brain	4	5	114	36-287	3	2	61	6-226
Thyroid	1	0			1	1	79	0-453
Unknown primary	9	9	101	46-192	7	8	110	47-217
Rectum & rectosigmoid	9	15	160	89-226	5	2	40	4-147
Lymphoma	7	12	175	90-307	5	6	110	40-241
Prostate	22	25	112	72-166				
Testis	2	3	127	24-376				
Cervix					39	38	98	69-126
Corpus uteri					4	8	111	35-262
Ovary					8	10	132	63-243

Source: National Cancer Registry
[SIR= Observed incidence divided by expected incidence times 100].

Appendix 2d **Cancer Incidence Data for Wicklow 1994**

	Male				Female			
Site	***Expected***	***Observed***	***SIR***	***95% CI***	***Expected***	***Observed***	***SIR***	***95% CI***
All Sites	230	253	110	97-124	259	300	116	103-130
All sites except skin	149	156	111	94-129	179	212	118	103-135
Oesophagus	4	6	147	83-321	3	8	245	105-486
Stomach	7	8	108	46-214	4	4	90	23-234
Colon	14	17	118	89-159	14	26	176	114-260
Rectosigmoid	2	2	86	8-317	2	2	130	12-477
Rectum	7	9	126	57-240	4	3	76	14-223
Pancreas	3	2	58	5-213	4	3	83	18-246
Larynx	2	2	87	6-319	1	1	100	
Lung	24	24	101	64-150	12	9	77	35-146
Blood/marrow	9	5	68	24-149	8	3	37	7-111
Skin	81	88	106	87-134	80	88	111	89-136
Melanoma	4	4	97	25-252	8	8	72	26-158
Breast	0	0			41	43	105	76-142
Kidney	3	3	88	17-269	2	1	48	0-283
Bladder	8	12	144	74-252	4	8	141	51-310
Brain	4	1	27	0-163	3	2	67	6-245
Thyroid	1	0			1	2	165	16-607
Unknown primary	9	14	157	56-264	8	12	160	77-263
Rectum & rectosigmoid	9	11	115	68-208	6	6	91	29-213
Lymphoma	8	9	147	67-281	6	8	150	64-297
Prostate	24	31	130	88-185				
Testis	2	4	226	59-583				
Cervix					30	42	139	100-188
Corpus uteri					5	5	107	34-251
Ovary					7	12	163	54-288

Source: National Cancer Registry
[SIR= Observed incidence divided by expected incidence times 100].