

Staffing Levels in Specialist Palliative Care in Ireland, 2007

A Baseline Study Review

Introduction

In October 2001 the Department of Health and Children published the *Report of the National Advisory Committee on Palliative Care* (NACPC). This report's recommendations were subsequently adopted by Government as national policy for palliative care services in Ireland.

The NACPC report recommended staffing levels for palliative care services that were based on the best available international evidence and a population health approach. These staffing recommendations were based on the former health boards and were as follows:

- 10 inpatient hospice beds per 100,000 of the population, with at least one inpatient unit per (former) health board area, with:
 - 1 nurse per bed
 - .5 care attendants per bed
 - 1 physiotherapist per 10 beds
 - 1 occupational therapist per 10 beds
 - 1 social worker per 10 beds
 - 2 spiritual care chaplains per hospice
 - 1 pharmacist per hospice
- At least one consultant in palliative medicine per 160,000 of the population, with at least 2 consultants in each former health board area.
- At least 3 or more non-consultant doctors per palliative medicine consultant.
- A consultant-led multidisciplinary team in each acute hospital with 150 beds or more (to include nursing, social work, non-consultant doctors).
- A minimum of 1 specialist palliative care nurse in the community per 25,000 of the population.
- At least 1 physiotherapist, occupational therapist and social worker in the community per 125,000 of the population.

The Health Service Executive (HSE), charged with the overall management of health services in Ireland, have since put in place structures at regional and national level to oversee the implementation of the NACPC's recommendations and monitor progress.

The first systematic nationwide review of the state of palliative care services in Ireland was conducted in 2005. Launched by the Minister for Health and Children early the following year, the *Baseline Study on the Provision of Hospice/ Specialist Palliative Care Services in Ireland* (Irish Hospice Foundation, 2005) was compiled based on data as at December 2004.

At the launch of the Baseline Study, the Tánaiste acknowledged the need to double the budget for hospice services.

The key deficits identified at December 2004 were as follows:

- Three health board areas – representing 12 counties - have no inpatient unit.
- There is a national deficit of 258 palliative care beds.
- There is a national deficit of 744 palliative care staff
- A wide disparity exists in the current spend between regions, from €1.50 per capita in the Midlands to €31 per capita in the North West,
- State funding for homecare services varies from 100% to 0%.
- There is no multidisciplinary support for most homecare teams.
- Only two of the country's 22 homecare teams are available on a 24-hour basis.
- Some 11 of the country's 38 acute general hospitals with over 150 beds have no palliative care team.
- Non-cancer patients do not have the same access to services.

Recent Government strategy documents

Four recently published key national strategy documents have prioritised investment in the development of a comprehensive hospice/palliative care service.

1. Towards 2016: Ten-Year Framework Social Partnership Agreement, 2006-2015

Provision has been made in the new Social Partnership Agreement to prioritise hospice care over the next three years by:

... “further developing palliative care throughout Ireland, with particular reference to the Baseline Study on the Provision of Hospice/Specialist Palliative Care Services”.

2. A Strategy for Cancer Control in Ireland (National Forum, 2006), issued by the Department of Health and Children, makes the following significant reference to palliative care.

“The HSE should ensure that each Managed Cancer Control Network has a comprehensive specialist palliative care service to meet the needs of patients and families. This will enable a range of benefits including the incorporation of palliative care into patient care plans at an appropriate stage in the management of their disease; an enhancement of the palliative care capacity of primary care; integrated care pathways and multidisciplinary teams that incorporate palliative care services.”

3. The National Development Plan 2007-2013: Transforming Ireland includes a commitment to developing palliative care services around the country. The Plan specifically states:

“Support will be provided to develop specialist palliative care beds in-patient units, palliative care community support beds, day services and ancillary supports. [...] The HSE has worked with key stakeholders to prioritise capital projects for palliative care. These projects will be progressed in the context of overall funding for Services for Older People and Palliative Care.”

4. Programme for Government (June 2007)

“The Government will ensure that the needs of all people who require palliative care are met, whether this is needed at home, in the community or in a specialised hospice.... We are committed, within the next five years, to removing the regional disparities in the provision and funding of palliative care.”

In December 2006, then Taoiseach, Bertie Ahern, T.D. stated:

“The Baseline Study has provided the evidence to underpin the investment and could be viewed as a ‘roadmap’ of where we want to go and how we are going to get there. This will require the involvement of all the stakeholders, including the statutory and voluntary organisations, who each play a vital role in caring for those who are dying or who have a life limiting illness.”

Increased resources of €13 million were allocated to specialist palliative care under the package for new services for older people in the 2006 budget. A further €5m was allocated in the budget of 2007.

The present review has updated the original Baseline Study information (staffing and beds) as at December 2007, and establishes what progress has been made in the intervening three years. One of the key objectives of undertaking the original Baseline Study was to establish a mechanism for tracking regional and national progress over time in the development of palliative care services. Among the primary findings of that study was the level of regional variation in service development. Much progress has been made in some areas in the intervening period. Given the commitment given by Government to address those regional variations, the present update on staffing levels in specialist palliative care provision is most timely.

In the original study, the collection of data was based on the 10 Health Board areas within the former health service structure. For simplicity and consistency, the present review used data collection templates equivalent to those developed for the original exercise, one for each former Health Board area. Once an updated picture for staffing levels had been obtained and validated for each Health Board area, the information was then collated and presented according to the current, four-region HSE structure.

The objective was to update the data on staffing in hospice/specialist palliative care, in all care settings. To achieve this we communicated with all relevant medical personnel, hospice managers and HSE service planners. We hope this review may also serve as an opportunity for cross-validation with a recent HSE exercise as regards the accuracy of the data collection.

Study method

In December 2007, respondents were sent the completed template used in 2004 to calculate the cost of fulfilling the staffing recommendations of the 2001 *Report of the National Advisory Committee on Palliative Care* within their former Health Board area. They also received a blank version of the same document. They were asked to complete this data sheet with updated figures on staffing as at December 2007.

In order to ensure the most accurate figure for total staffing and budget provision up to December 2007, in the column relating to posts ‘*Approved/In recruitment*’, respondents were asked to include only those posts where a budget-line had been approved. They were asked to note posts where a budget existed but a WTE had not been allocated. (This represents a difference from the methodology used in 2004, when posts which were ‘*Approved/In recruitment*’ were not included in the total staffing numbers.) The emergence of evidence that funds and ‘whole time equivalent’ posts (WTEs) which were funded in 2006-07 have been diverted elsewhere suggests that including posts ‘in the process of recruitment’ in the total staff numbers may lead to an overestimate in total staff numbers in this updated study.

In recording nursing provision in specialist palliative care units, the methodology was consistent with the original Baseline Study. Specifically, the number of nurses was combined with the number of clinical nurse managers (CNMs) at Grade 1 in each hospice/specialist palliative care unit. CNMs at Grades 2 and 3 were excluded, their costs being included in the ‘overheads’ element of salaries, spread across all staff.

The recommended staffing levels based on population in the original study were calculated using the CSO 2002 Census. The present study has not reviewed those population-based recommendations with reference to the 2006 Census. Thus, the deficits in staffing are understated in this updated study.

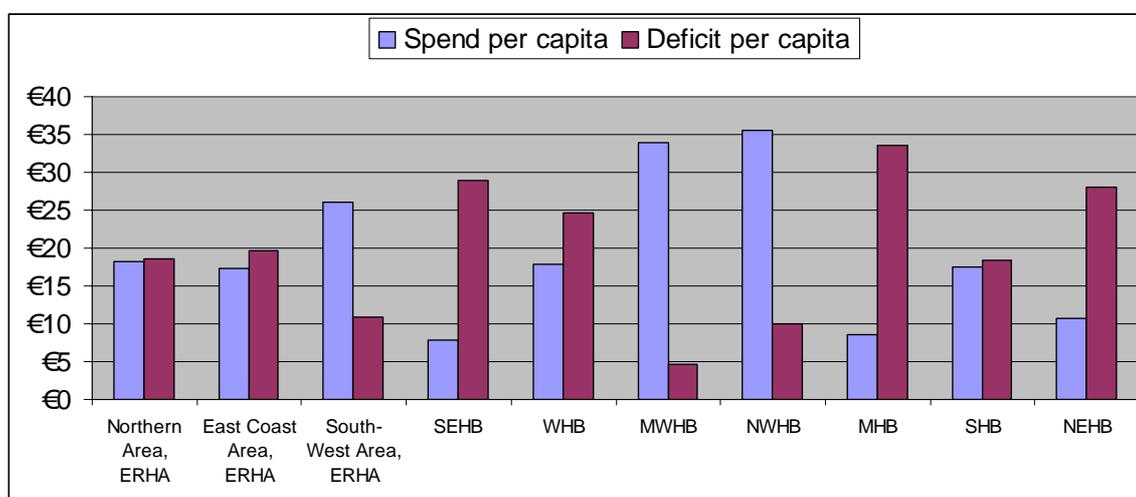
Updated information on specialist palliative care staffing was collected over January and February 2008. The data-gathering phase was successfully concluded on 15th February 2008. In the latter part of February the data sets for each of the former Health Board areas were circulated to key personnel for the purpose of validation.

Main Findings

In this section, changes in staffing levels for specialist palliative care provision both nationally and in each of the former Health Board areas is presented. The data has been structured to allow for direct comparison between December 2004 and December 2007 for each of the former Health Board areas. An amalgamated picture for each of the four current HSE regions is also presented.

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

Figure 1 **Government spend per capita on palliative care staff/beds, by former health board area**
Current position relative to the recommendations of the NACPC report, 2001, and based on CSO 2002 population figures and current bed numbers



There are wide regional disparities in current government spending on palliative care services in all care settings. Spending on care staff and beds in specialist palliative care inpatient units varies from €7.9 per capita in the area of the former South Eastern Health Board to €35 per capita in the former North-Western Health Board area.

Major deficits in staff and bed numbers remain in all former health board areas.

Hospice/palliative care staff numbers have increased from 570 to 686, an increase of 116 (20%) between 2004 and 2007. Expenditure on staff has increased from €4.7m. to €2.5m., an increase of €7.8m. (51%). Specialist inpatient bed numbers have increased from 131 to 153, an increase of 22 (17%): 10 in Limerick, six in Blackrock and six in Kildare. Spending on all inpatient beds (excluding the cost of care staff) has increased from €19m. to €23m., an increase of €4m. (21%). Despite these welcome additions in resources, much remains to be done to achieve the staffing levels and specialist inpatient services consistent with agreed national policy.

Table 1. *Cost of palliative care in Ireland: combined staffing/bed costs. Current position relative to NACPC recommendations, based on CSO 2002 population figures and December 2007 bed numbers*

	Current total	Recommended	Deficit	Annual cost including overheads	Cost deficit
Staff	686	1274	610	€2.5m	€40m
Beds	153	390	237	€23m	€35.5m
TOTAL				€75.5m	€75.5m

The annual cost of the care staff shortfall comes to approximately €40m, down from €51m in December 2004. The cost of filling the bed shortfall (excluding care staff costs) is approximately €35.5m, down from €39m. This gives a total shortfall in annual expenditure of approximately €75.5m, down from €90m.

The staff deficit of 610, at a cost of €40m, can be broken down as follows:

- 72% of the shortfall (444 staff) arises from the deficit in bed numbers of 237.
- The staff deficit in existing hospices, acute hospitals and community care amounts to 166, or 28% of the total deficit, at an approximate cost of €1.2m.

Half of this deficit - 83 staff - occurs in the provision of multidisciplinary staff support (occupational therapists, physiotherapists and social workers) for the nursing and medical teams in existing care settings.

- The deficit in nursing staff (41) occurs across community, acute hospital and day care settings. The medical staffing shortfall of 20 is predominantly in the area of non-consultant doctors (18.5).

When the recommended level of inpatient units/beds are put in place, the following care staff will be required to support those units/beds.

Nurses	222
Physiotherapists	24
Occupational therapists	24
Social workers	24
Care attendants	112
Other staff *	<u>38</u>
TOTAL	444

* *Pharmacists; spiritual carers; librarians; volunteer coordinators.*

Table 2 *Staffing numbers in palliative care in Ireland, 2004 and 2007*

Staff category	2004	2007	Difference	% increase
Medical staff	49.5	79.2	29.5	59%
Specialist palliative care nurses	346	405.7	60	17%
Physiotherapists	12.5	18	5.5	44%
Occupational therapists	8.5	14.5	6	70%
Social workers	30	34.5	4.5	15%
Spiritual care	11.5	14	2.5	21%
Speech & language therapists	.1	0.2	.1	100%
Clinical nutritionists	1.5	2	.5	33%
Pharmacists	3.5	4.5	1	28%
Care attendants	84	85.5	1.5	1.8%
Volunteer coordinators	5	5.5	.5	10%
Library/education staff	10	9.0	-1	-10%
Medical secretaries in acute hospitals	7.5	13	5.5	73%
Staff totals	570	686	116	20%

REGIONAL SUMMARIES

HSE Dublin/North-East Region

This region comprises the former Northern Area of the former Eastern Regional Health Authority (ERHA), taking in Dublin North; and the former North-Eastern Health Board area, taking in Counties Monaghan, Cavan, Louth and Meath.

Former Northern Area, ERHA (*For statistical analyses, see Appendices 1 and 1a on pages A1-A4*)

DECEMBER 2004

In December 2004, specialist inpatient/hospice care in the former Northern Area consisted of 19 beds at St Francis Hospice, Raheny. There was a deficit at that time of 30 beds. In acute general hospitals, there were three full specialist palliative care teams established at Beaumont Hospital, Connolly Hospital and the Mater Hospital respectively ('full' here indicates teams with the full *range* of recommended disciplines but not necessarily with the recommended level of provision).

Community-based services in the area consisted of consultant-led teams with 13.5 clinical nurse specialists and 2 social workers. Levels of staffing in 2004 indicated a significant deficit in meeting the blueprint for services outlined in the NACPC Report (2001). Specifically, there was a total of 78 specialist staff in post, and a staffing deficit of 72.7. The spend per capita was €14.69, based on the 2004 data.

DECEMBER 2007

By December 2007 total staffing levels had increased by 5.5 to 83.5, thus reducing the deficit to 64.7 (*see Appendix 1a*). Specialist inpatient bed numbers remained unchanged at 19, therefore maintaining a deficit of 30 beds. The spend *per capita* has increased from €14.69 to €18.21, leaving a deficit per capita of 18.61

Provision for medical staffing has increased significantly since the original study, with two consultants now in post and a third consultant post approved for recruitment. An additional non-consultant hospital doctor (NCHD) has also been secured, bringing the total to six in post.

The Baseline Study had already indicated staffing levels at St Francis Hospice that were compliant with the NACPC recommendations in most categories and commensurate with the operation of 19 beds. Since the hospice has maintained bed numbers at 19, significant increases in staffing levels were not indicated, as this review confirms. Nonetheless, specialist staffing at the hospice has been enhanced in a number of disciplines, such as nursing, physiotherapy, occupational therapy and spiritual care.

Specialist community-based nursing has also been marginally enhanced (from 13.5 to 14 clinical nurse specialists), although the teams still lack the support of recommended disciplines such as physiotherapy and occupational therapy.

Levels of specialist nursing, social work and administrative support have been maintained among the acute general hospitals in the former Northern Area along with enhanced levels of medical support for the hospital-based teams.

Plans for a new satellite hospice inpatient unit and day care service in Blanchardstown are well advanced, although funding has not yet been approved.

Former North-Eastern Health Board area (*For statistical analyses, see Appendices 2 and 2a, pages A5-A8*)

DECEMBER 2004

In 2004 there were no specialist inpatient/hospice beds in the former North-Eastern Health Board area, resulting in a bed deficit of 34. This deficit still exists, although there are plans for specialist inpatient beds in Drogheda and Cavan. In the acute general hospitals there were two specialist palliative care teams established: one full team at Our Lady of Lourdes Hospital, Drogheda, and a partial team at Cavan General Hospital. Community-based services consisted of consultant-led teams, with 20 clinical nurse specialists, two physiotherapists, two occupational therapists, three social workers, one spiritual carer, one clinical nutritionist and one pharmacist.

In 2004, this region had the most developed multidisciplinary hospice home care service. Staffing levels at that time in the former North-Eastern Health Board area indicated a significant deficit in meeting the blueprint for services outlined in the NACPC Report. Specifically, there was a total of 35 specialist staff in post and a staffing deficit of 85.6. The spend per capita was €7.17.

DECEMBER 2007

By December 2007, in spite of approval for over 20 additional staff in the region, the only additions had been in the area of medical personnel. Total staffing levels had increased by only six medical posts to 41, thus maintaining a significant staffing deficit of 72.6 with regard to the NACPC's minimum recommendations. Since there are as yet no specialist inpatient hospice beds in the region, the bed deficit remained at 34. This deficit still exists, although plans are in place for specialist inpatient beds in Drogheda and Cavan. Between 2004 and 2007, the spend per capita increased from €7.17 to €11.08, leaving a current deficit per capita of €27.80

The absence of an inpatient hospice facility in the region does account for a significant proportion of the staffing deficit. However, other than medical staffing, there are indications of considerable recruitment efforts during 2007 for specialist staff in other care settings, which did not result in filled positions. These recruitment objectives included one community-based physiotherapist, one community-based occupational therapist, one community-based social worker and two spiritual carers.

The present review indicates that the community-based specialist palliative teams serving the area have retained their multidisciplinary range, incorporating physiotherapy, occupational therapy and social work components. They have also managed to incorporate support elements more traditionally associated with inpatient services, such as spiritual care, a clinical nutritionist and a pharmacist.

Levels of staffing for hospital-based specialist palliative care teams serving the four counties have remained unchanged since December 2004. In order to meet with minimum NACPC recommendations, these would require an additional three clinical nurse specialists, one social worker and two medical secretaries.

HSE Dublin/Mid-Leinster Region

This region comprises the former East Coast and South West Areas of the former Eastern Regional Health Authority (ERHA); along with the former Midland Health Board area, taking in Counties Longford, Westmeath, Laois and Offaly.

Former East Coast Area, ERHA (See Appendices 3 and 3a, pages A9-A12)

DECEMBER 2004

In 2004 specialist inpatient/hospice care in the former East Coast Area of the ERHA consisted of six beds at the Blackrock Hospice in South County Dublin. The bed deficit at that time was 27. In the acute general hospitals there was one full specialist palliative care team established at St Vincent's University Hospital. The community-based services in the area consisted of consultant-led teams with eight clinical nurse specialists and one social worker. The staffing levels at December 2004 in the former East Coast Area indicated a significant deficit with regard to meeting the blueprint for services outlined in the NACPC Report (2001). There was a total of 27 specialist staff in post and a staffing deficit of 80.7. The spend per capita was €8.74 (Baseline Study, 2004 data).

DECEMBER 2007

By December 2007 total staffing levels had increased by 23.2 to 50.2, reducing the deficit to 58.2 (see Appendix 3a, pp. A11-A12). Specialist inpatient bed numbers have doubled from six to 12, thus reducing the total bed deficit to 21. The spend per capita has increased from €8.74 to €17.45, leaving a deficit of €19.72.

If this area were to put in place two additional non-consultant hospital doctors it would reach compliance with minimum NACPC recommendations for medical staffing. These posts have yet to be approved and progressed to the recruitment phase.

The most significant service developments have occurred in the inpatient/hospice care setting. Since December 2004 Blackrock Hospice has doubled its bed numbers from six to 12, and over the same period has succeeded in increasing specialist staff levels (in nursing, physiotherapy, occupational therapy and care attendant provision) in line

with the increased bed capacity and NACPC recommendations. There are plans to further increase bed numbers in Blackrock Hospice to 24, and to provide 12 inpatient beds in Co. Wicklow. These projects are not yet funded.

Community-based services have also achieved significant increases in staffing levels for clinical nurse specialists in particular (from eight in 2004 to 15.5 posts currently). This represents full compliance with the recommendations for community-based nursing. The community-based teams have yet to gain access to the required levels of support from allied disciplines, such as specialist physiotherapy, occupational therapy and social work. The four community nursing posts which are funded in Wicklow are currently all vacant, leaving the county with the most underfunded community service in the country.

Provision of specialist palliative care nursing among the acute general hospitals of the former ERHA's East Coast Area has remained unchanged at two posts. A third such post was approved in 2007. A further two nursing posts are required to meet minimum recommendations. Two additional hospital-based social workers are also required but as yet have not been approved for recruitment.

Former South West Area, ERHA (*For statistical analyses, see Appendices 4 and 4a, pages A13-A16*)

DECEMBER 2004

In 2004, specialist inpatient hospice care in the former South West Area of the ERHA consisted of 36 beds at Our Lady's Hospice, Harold's Cross. The bed deficit at that time was 22. In the acute general hospitals there were three specialist palliative care teams established. These consisted of two full teams at St James's Hospital and St Luke's and one 'nurse-only' team at Naas Hospital. The community-based services in the area consisted of consultant-led teams with 16 clinical nurse specialists and two social workers. Levels of staffing at that time in the former ERHA's South West Area indicated about half the required number in place for meeting the blueprint for services outlined in the NACPC report. Specifically, there was a total of 95 specialist staff in post and a staffing deficit of 91.7. The spend *per capita* was €20.56.

DECEMBER 2007

By December 2007 total staffing levels had increased by 14.5 to 114.5, thus reducing the deficit to 66.2. (*see Appendix 4a, pp. A15-16*). Specialist inpatient bed numbers have increased from 36 to 42, reducing the bed deficit to 16. The spend per capita had increased from €20.56 to €26.01, leaving a per capita spending deficit of €10.9. While the current staffing deficit remains high, significant progress has been made with regard to levels of medical staffing and towards reaching the recommended number of inpatient hospice beds for the population of the area.

Provision for medical staffing has increased significantly since the original study, with five consultants and 12 non-consultant hospital doctors now in post. This brings the region into compliance with minimum NACPC recommendations.

The Baseline Study's 2004 data indicated that staffing levels at Our Lady's Hospice, Harold's Cross, were compliant with the NACPC recommendations and, with the exception of nursing provision, commensurate with the operation of 36 beds. Since then the hospice has maintained bed numbers at 36, and levels of nursing provision have been enhanced significantly from 23.5 to 33.5. Social work provision has also increased, from two to three filled posts. At the same time a trend can be discerned towards marginal decreases across a number of areas of specialist provision at Our Lady's Hospice, including daycare nursing (from two to 1.5 staff), physiotherapy (from three to two); pharmacists (from one to 0.5) and care attendants (from 18.5 to 18 staff).

With the opening of an additional six beds at St Brigid's in Kildare, the number of Level 3 inpatient beds in the region has increased to 42. The unit at St Brigid's has combined medical supervision with the provision of two clinical nurse specialists. Other disciplines associated with the fully formed specialist inpatient unit, such as physiotherapy, occupational therapy and social work, have yet to come on-stream.

Specialist community-based nursing has also achieved significant increases in provision (from 16 to 19.5 clinical nurse specialists) while levels of social work provision have remained unchanged at 2 WTEs. The community-based teams have yet to establish their full, multidisciplinary range and remain without dedicated

specialist physiotherapy and occupational therapy support. However, approval was granted for the recruitment of a physiotherapist (0.5 WTE) and an occupational therapist (0.5 WTE) in 2007.

Levels of specialist nursing and social work among the acute general hospitals in the former ERHA South West Area have remained unchanged. An additional 5.5 clinical nurse specialists, three social workers and three medical secretaries are required to meet with minimum NACPC recommendations.

Former Midland Health Board (*For statistical analyses, see Appendices 5 and 5a, pages A17-A20*).

DECEMBER 2004

In 2004, there were no specialist inpatient/hospice beds in the former Midland Health Board area, resulting in a deficit of 22 beds. There were no specialist palliative care teams established at any of the region's three acute general hospitals, in Tullamore, Portlaoise and Mullingar. Community-based services in the area consisted of 10 clinical nurse specialists, who were 80% funded by voluntary contributions. Staffing levels at that time in the former Midland Health Board area indicated a significant deficit. Specifically, there was a total of 10 specialist staff in post, and a staffing deficit of 70.2. The spend *per capita* was €1.53, the lowest in the country.

DECEMBER 2007

By December 2007 total staffing levels had increased by 8 to 18, reducing the deficit to 67 (*see Appendix 5a, pp. A19-A20*). Since there are as yet no specialist inpatient hospice beds in the region, the deficit of 22 beds has remained unchanged. The spend per capita has increased from €1.53 to €3.62, leaving a deficit of €3.65.

The absence of inpatient hospice facilities and specialist teams in acute general hospitals to serve the populations of Longford/Westmeath and Laois/Offaly accounts for a large proportion of the ongoing specialist staffing deficit. There are plans for a 22-bed inpatient unit in Tullamore, but these are as yet unfunded.

While in 2004 the Midlands was identified as the only former Health Board area lacking a consultant in palliative medicine, it now has one in post. At December 2007, there was approval for the recruitment of one non-consultant hospital doctor to support the work of the consultant.

The most significant service developments have occurred in the community care setting. In 2004 the 10 community-based clinical nurse specialists were attempting to meet the needs of patients from within the discipline of nursing alone. In the past three years the number of nursing posts has increased to 13 and the recommended multidisciplinary approach has begun to take shape, with the addition of two community-based physiotherapists; approval for the recruitment of two community-based occupational therapists; and one community-based social worker now in post. Statutory funding of the home care team has increased from 20% to 55%.

As noted above, the original Baseline Study highlighted the lack of specialist palliative care teams in the three acute general hospitals in the area. This situation has remained unchanged, with no clinical nurse specialists (CNS) or specialist social workers in post in Mullingar, Tullamore or Portlaoise General Hospitals. However, at December 2007, three CNSs were approved for recruitment, one for each hospital.

HSE Southern Region

This region comprises the former Southern Health Board area, taking in Counties Cork and Kerry; along with the former South-Eastern Health Board area, taking in Counties Carlow, Kilkenny, Waterford and Wexford, as well as South Tipperary.

Former Southern Health Board (*For statistical analyses, see Appendices 6 and 6a on pages A21-A24*)

DECEMBER 2004

In 2004 specialist inpatient hospice care in the former Southern Health Board area consisted of 24 beds at Marymount Hospice, Cork. The bed deficit at that time was 34. In acute general hospitals there were five specialist palliative care teams: one full team at Cork University Hospital; two 'nurse-only' teams at Mercy University

Hospital and South Infirmery Victoria Hospital; and two partial teams at Bantry and Kerry General Hospitals. Community-based services in Cork and Kerry consisted of consultant-led teams with 18.5 clinical nurse specialists. Levels of staffing at that time in the former Southern Health Board area indicated a significant deficit in meeting the blueprint for services outlined in the NACPC's report. Specifically, there was a total of 81 specialist staff in post and a staffing deficit of 104.2. The spend per capita was €15.65.

DECEMBER 2007

By December 2007 total staffing levels had increased by 7.7 to 88.7, thus reducing the deficit marginally to 90.5. (see Appendix 6a, pp. A23-24). The number of specialist inpatient beds has remained unchanged at 24, therefore maintaining a deficit of 34 beds. The spend *per capita* has increased from €15.65 to €17.54, leaving a deficit of €18.46.

Significant progress has been made in the provision of medical staffing. Currently there are three consultants and seven non-consultant hospital doctors in post. With reference to the CSO Census 2002, on which the original study was based, a further 0.5 WTE consultant post and 3.5 non-consultant hospital doctors are required before medical staffing meets with the NACPC's minimum recommendations.

Much of the required recruitment activity in Cork and Kerry has been contingent on the structural development of inpatient hospice services, and in particular, the re-development of the Cork-based service at Marymount Hospice. The original Baseline Study had already indicated staffing levels at Marymount Hospice that were commensurate in most categories with NACPC recommendations for the operation of 24 beds. Since then the hospice has maintained bed numbers at 24, so that significant increases in staffing levels were not indicated as the present review confirms. There is, however, an approved capital project to build a 44-bedded hospice which is scheduled for completion in 2010.

Since 2004, the specialist community-based teams have further consolidated the nursing component of the service (from 18.5 clinical nurse specialists to 20.2). An additional clinical nurse specialist post was approved for recruitment in 2007.

Although consultant-led, the community-based teams in the region have remained uni-disciplinary, lacking physiotherapy, occupational therapy and social work components. A community-based occupational therapist was approved for recruitment in 2007.

There has also been progress with regard to the levels of specialist nursing available in the acute general hospital setting. The number of nurses in post has increased from six to nine, and a further two posts were approved for recruitment in 2007. An additional four social workers are required for the hospital-based teams, and of these posts, one has already been approved for recruitment in 2007.

Former South-Eastern Health Board (*For statistical analyses, see Appendices 7 and 7a, pages A25-28.*)

DECEMBER 2004

In 2004 there were no specialist inpatient hospice beds in the former South-Eastern Health Board area, resulting in a deficit of 42 beds. There was a partially constituted specialist palliative care team established at each of the region's four acute general hospitals (Waterford Regional; St Luke's, Kilkenny; South Tipperary General; and Wexford). Community-based services in the area consisted of consultant-led teams made-up of 17.5 clinical nurse specialists. Staffing levels at that time in the former South-Eastern Health Board indicated a significant deficit in meeting the blueprint for services outlined in the NACPC Report. Specifically, there was a total of 27.5 specialist staff in post and a staffing deficit of 108.7. The spend per capita was €2.75.

DECEMBER 2007

By December 2007 total staffing levels had marginally increased from 27.5 to 36.5, reducing the deficit to 97.7 (see Appendix 7a, pp. A27-A28). Since there are as yet no specialist inpatient hospice beds in the region the deficit of 42 beds has remained unchanged. The spend per capita has increased from €2.75 to €7.90.

With a second consultant now in post, this former Health Board area remains 0.5 WTEs short of the recommended consultant cover for the population (CSO Census 2002), although a third, full consultant post was approved for recruitment in 2007.

Non-consultant hospital doctor provision has also improved, but remains 3.5 WTEs short of the 7.5 WTEs required to support the minimum requirement for 2.5 consultant posts.

There have been some modest achievements in the development of community-based services. Nursing provision has been enhanced and the disciplinary range of the teams has been expanded with the recruitment of two occupational therapists and one social worker. As yet there is no community-based physiotherapy provision and no indication of such posts having entered the approval/recruitment process during 2007.

As with the community-based services, there have been some marginal improvements in specialist provision in the acute general hospital setting: one additional nurse has been recruited along with a further 1.5 WTEs for secretarial support. However, despite a requirement for at least four specialist social workers to be appointed for the hospital-based teams, there has been no progress in filling such posts since December 2004. There is no indication of such posts in the approval/recruitment process during 2007.

As with the former Midland and North-Eastern Health Board areas, the absence of inpatient hospice facilities to serve the populations of Carlow, Kilkenny, Wexford, Waterford and South Tipperary accounts for a large proportion of the specialist staffing deficit. There are plans to build an inpatient unit (35 single rooms) in the grounds of Waterford Regional Hospital and a satellite unit (12 beds) in the grounds of Kilkenny Hospital. These units have yet to be approved for funding.

HSE Western Region

This region comprises the former North-Western Health Board area, taking in Counties Donegal, Sligo and Leitrim; the former Western Health Board area, taking in Counties Galway, Mayo and Roscommon, and the former Mid-Western Health Board area, taking in Counties Clare and Limerick along with North Tipperary.

Former North-Western Health Board (*For statistical analyses, see Appendices 8 and 8a, pages A29-A32*)

DECEMBER 2004

In 2004 specialist inpatient/hospice care in the former North-Western Health Board area consisted of 16 beds: eight at Northwest Hospice, Sligo, and eight at Donegal Hospice, Letterkenny. Taking into account a further two beds available at Foyle Hospice in Derry, the bed deficit at that time was four. In the acute general hospitals there were two partially constituted specialist palliative care teams, one at Sligo General Hospital and one at Letterkenny General Hospital. Community-based services in the area consisted of consultant-led teams with 12 clinical nurse specialists. Levels of specialist provision at that time indicated a total of 61.7 staff in post and, based on NACPC minimum recommendations, a staffing deficit of 34.7. The spend per capita was €30.16, with a per capita deficit of €13.58.

DECEMBER 2007

By December 2007 total staffing levels had increased marginally from 61.7 to 69.7, reducing that deficit to 24.7. (see Appendix 8a, pp. A21-32). Specialist inpatient bed numbers have remained unchanged, maintaining a deficit of four beds. The spend per capita on staffing for specialist palliative care has increased from €30.16 to €35.60.

The increases in staffing provision have tended to be in those sectors where a level of provision had already been established, and for the main part related to inpatient hospice services. In the original study the North-Western area was unusual to the extent that it lacked social work provision in all specialist care settings. The present review finds this still to be the case, with no specialist social workers to be found in the two inpatient/hospice units, in the community-based teams or attached to the two acute general hospitals.

With two consultants and 5.5 non-consultant hospital doctors in post, medical staffing in the former North-Western Health Board is only 0.5 WTEs short of achieving a level of provision that meets with the NACPC minimum recommendations.

Since 2004, staffing levels within the two inpatient hospice services in the region have increased incrementally in a number of disciplines including nursing (from 33 to 33.5), physiotherapy (from 1 to 1.5), occupational therapy (from 1 to 1.5), spiritual care (from 0 to 2) and care attendants (from 6.5 to 8.5). The absence of inpatient social work support has already been noted above. The region is also unusual in having developed inpatient hospice provision without day care services as part of the overall care options available for patients.

While the level of provision for community-based nursing has decreased slightly from 12 to 11.5 WTEs, at December 2007 there were two posts approved for recruitment, which would constitute an increase relative to the original Baseline Study findings. In terms of their multidisciplinary make-up, the community-based teams have managed to acquire one physiotherapist, but still lack any occupational therapy or social work provision.

The increased level of medical staffing in the North West has enhanced the development of specialist multidisciplinary teams in the region's two acute general hospitals. However, aside from the recruitment of a half-time medical secretary, the resourcing of the hospital-based teams has remained unchanged since 2004, with one clinical nurse specialist in post in each acute general hospital. A further two clinical nurse specialists, two social workers and 1.5 medical secretaries are required to meet with minimum NACPC recommendations.

Former Western Health Board (*For statistical analyses, see Appendices 9 and 9a, pages A33-A36*))

DECEMBER 2004

In 2004 specialist inpatient hospice care in the former Western Health Board area consisted of eight beds at Galway Hospice Foundation in Renmore. The bed deficit at that time was 30. In acute general hospitals there were three specialist palliative care teams established. These consisted of two partial teams: one at University College Hospital, Galway, and the other at Mayo General Hospital; and one 'nurse-only' team at Roscommon County Hospital. Community-based services in the area consisted of

consultant-led teams with 20.5 clinical nurse specialists and three social workers. Overall levels of staffing at that time in the former Western Health Board area indicated a significant deficit in meeting the blueprint for services outlined in the NACPC Report. Specifically, there was a total of 64.7 specialist staff in post and a staffing deficit of 69.1. The spend per capita was €11.32.

DECEMBER 2007

By December 2007 total staffing levels had increased from 64.7 to 73.2, reducing the deficit to 59.9 (see Appendix 9a, pp. A35-A36). Specialist inpatient bed numbers have remained unchanged, maintaining a deficit of 30 beds. The spend per capita has increased from €11.32 to €17.86. It is planned to provide four new beds in Galway in the first quarter of 2008. There are further plans for additional beds in Galway and a hospice inpatient unit, with 12 single rooms, in Castlebar. There are also plans for non-specialist beds in Roscommon. These plans have yet to be funded.

The staff increases in the Western Health Board area have tended to be in areas where a level of provision was already established (medical, inpatient hospice nursing, community-based nursing and medical secretarial support) rather than in those areas which were already identified in the original Baseline Study as lacking provision: community-based physiotherapists and occupational therapists, an inpatient hospice pharmacist and inpatient occupational therapy support. However, the greatest proportion of the staffing deficit can be accounted for by the relatively small number of inpatient hospice beds available to serve the populations of Galway, Mayo and Roscommon.

With two consultants and five non-hospital doctors in post, and with one additional consultant and non-consultant hospital doctor approved for recruitment, medical staffing in the former Western Health Board area is close to achieving a level of provision that meets with the minimum recommendations.

Since the original Baseline Study, the number of beds *available* at Galway Hospice Foundation has remained unchanged at eight. Twelve beds are now in place and funding has been provided to open the new beds, but medical and support staff have yet to be recruited. Small increases in staffing levels have occurred at the hospice in

relation to nursing and care attendant provision. An element of physiotherapy support has also been introduced. However, the hospice remains without provision in a number of key areas identified in the original study, such as occupational therapy, speech and language therapy, clinical nutritionist support and dedicated pharmaceutical provision.

Since 2004 the nursing component of the specialist community-based teams has been further consolidated (from 20.5 clinical nurse specialists to 24.5). Levels of community-based social work provision have been maintained in line with minimum recommendations. The disciplinary expansion of the community-based teams towards including physiotherapy and occupational therapy has yet to be achieved. The Galway Hospice home care team continues to be 100% funded by voluntary contributions. This is at variance with the almost universal practice in other regions, where voluntary funding of such teams is less than 20% and statutory funding is in excess of 80%. Likewise, in Mayo and Roscommon, voluntary contributions are still the primary source of funding for home care services, at 20%.

While increases in the levels of medical staffing across the three counties has no doubt enhanced the development of specialist multidisciplinary teams in the region's acute general hospitals, such teams have achieved only quite modest advances towards achieving minimum levels of provision. In December 2004 there were six hospital-based clinical nurse specialists. The current review indicates seven in post, out of the 10 required. Social work provision has remained unchanged, with one social worker in post out of the three required, and medical secretarial provision has increased from 0.5 to 1.5.

Former Mid-Western Health Board (*For statistical analyses, see Appendices 10 and 10a, pages A37-A40.*)

DECEMBER 2004

In 2004 specialist inpatient/hospice care in the former Mid-Western Health Board area consisted of 20 beds at Milford Care Centre in Limerick. The bed deficit at that time was 14. In the acute general hospitals there were four specialist palliative care teams

established: one partial team at the Mid-Western Regional Hospital and three ‘nurse-only’ teams at Nenagh, Ennis and St John’s Hospital. Community-based services in the area consisted of consultant-led teams with 12.5 clinical nurse specialists, a social worker (0.5 WTE) and three care attendants. Levels of staffing by that time in the former Mid-Western Health Board area had already demonstrated significant progress towards meeting the blueprint for services outlined in the NACPC report. Specifically, there was a total of 88.7 specialist staff in post and a staffing deficit of 29.1. The spend per capita was €24.49.

DECEMBER 2007

By December 2007 total staffing levels had increased from 88.7 to 110.6, thus reducing the deficit to just 14 posts short of full compliance with NACPC recommendations (see Appendix 10a, pp. A39-A40). Specialist inpatient bed numbers have increased from 20 to 30, reducing the bed deficit to four. Regional plans indicate that future bed provision should focus on non-specialist beds in community care settings. The spend per capita has increased from €24.49 to €29.90, leaving a per capita deficit of €10.10.

With two consultants and six non-consultant hospital doctors in post, medical staffing in the Mid-West has now achieved a level of provision that meets with the minimum recommendations.

While enhancement of staffing levels has occurred in almost all care settings in the region, the most significant developments have occurred in the inpatient hospice services where bed numbers have increased from 20 in 2004 to a current provision of 30 beds. Milford Care Centre has also ensured that specialist staffing levels in all relevant categories have increased proportionally to meet the demands of those additional 10 beds.

Since 2004 the specialist community-based teams have been further consolidated (from 12.5 clinical nurse specialist to 16) and have also expanded the range of disciplines available. The teams now include one physiotherapist and one occupational therapist. The region is unique in having developed and maintained to

some degree the availability of community-based care attendants, a form of support traditionally exclusive to the inpatient unit.

Levels of specialist nursing have been maintained among the acute general hospitals of the Mid-West although direct administrative and social work support for hospital-based teams has yet to come on-stream.

Note: *The total staffing requirement for the region in 2004 was 111.7. Since by 2007 there were 110.6 staff in post, it would seem on the face of it that the region was just 1.1 WTE short of full compliance. However, because staffing levels in certain categories were marginally above minimum NACPC recommendations, while in other categories of specialist provision they were still below minimum recommendations, there was an actual current deficit, albeit a small one, of 14.*