Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

NDTP
National Doctors Training & Planning

REVIEW OF THE **PALLIATIVE MEDICINE WORKFORCE** IN IRELAND

2017

Human Resources
Leaders in People Services

"Investing in the career development of doctors"

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1 – INTRODUCTION TO REPORT AND OVERVIEW OF THE PALLIATIVE MEDICINE WORKFORCE

1.1 INTRODUCTION

The HSE National Doctors Training and Planning (NDTP) Unit is positioned within the HSE National Directorate for Human Resources, and has statutory roles in:

- medical education and training,
- medical workforce planning, and
- the consultant post approval process.

Within its medical workforce planning remit, NDTP predicts and proposes on an annual basis the number of interns and medical trainees required for each specialty, as well as projecting the future medical workforce requirements for each speciality. This information then feeds into the medical education and training aspect of NDTP via the commissioning and funding of medical training required to meet workforce needs, ensuring that the training content and delivery is responsive to the changing needs of the Irish healthcare system, and supporting the retention of doctors upon completion of their training.

The main objective of NDTP is to ensure that, at all times, the Irish health service is provided with the appropriate number of specialists, who possess the required skills and competencies to deliver high quality and safe care, and whose training is matched to the model of healthcare delivery in Ireland, regardless of location.

1.2 BACKGROUND TO SPECIALTY-SPECIFIC REVIEWS

In 2014, NDTP published "Population Based Ratios of Specialists in Ireland and Internationally: An Information Source to Support Medical Workforce Planning", which was a benchmarking exercise conducted across all medical specialties, comparing specialist numbers against international examples. Included in this benchmarking exercise were the projected number of specialists required per specialty in ten years' time (2024). Data and contextual information were requested from individual postgraduate medical training bodies and associated national clinical programmes, which were considered in the development of each specialty-specific chapter.

As a follow-up to this exercise, it is timely to provide a review of each medical specialty based on current available data and input again from the postgraduate training bodies and clinical programmes. These reviews are high-level and are a companion to the more in-depth specialty specific reports which are published by NDTP (i.e. "Future Demand for General Practitioners 2015-2025", published in 2015, with equivalent reports in Paediatrics and Emergency Medicine in development). These reviews will be a useful reference for those with an interest in data on the medical workforce and medical workforce planning, comprising a live repository that will be continuously updated as each review is completed. Where a review has yet to be completed, the chapter from the benchmarking exercise in 2014 will be available for reference.

1.3 DATA USED AND LIMITATIONS

The data utilised in the analysis of the medical workforce in each speciality for these reviews are drawn from multiple sources:

- HSE NDTP Doctors Integrated Management E-System (DIME), which receives data from the postgraduate medical training bodies, the Medical Council of Ireland and each clinical site that employs doctors in the public health system in Ireland
- HSE Workforce Planning, Analysis and Informatics Unit (WPAI)
- The Postgraduate Medical Training Bodies
- The Medical Council of Ireland
- The National Clinical Programme linked to each specialty
- International medical training bodies (UK and Australia)
- International medical workforce datasets
- International health research groups

Variations between datasets are not unexpected and therefore the results from the different sources in the reviews are not identical. These limitations of the datasets are due to variations in the time-point of data collection, differences in the variables collected (i.e. whole-time equivalents (WTE) versus headcounts), differences in the definitions of some variables (e.g. less than full-time versus part-time), absence of variable values (i.e. missing data) in datasets, and varying quality of data between sources.
The weaknesses of benchmarking domestic data against international data are known and include:

(i) a lack of contextual consideration;
(ii) assumptions that the international standard is best practice; and
(iii) potential complacency should the domestic value equal that of the international value.

However, there is merit in this kind of comparison as these ratios are interesting in terms of contextualising the demand for consultants across international healthcare systems with similar training and healthcare delivery infrastructures to those in Ireland. Further, it provides an international baseline for comparison and can help identify areas for improvement. Irish doctors traditionally migrate to countries like the UK and Australia and so benchmarking against these countries is a useful exercise.

Should you require any further information on the reviews, please contact NDTP at doctors@hse.ie

1.4 OVERVIEW OF THE PALLIATIVE MEDICINE WORKFORCE IN IRELAND

1.4.1 The Context of Palliative Medicine in the Irish Health Service

Palliative Medicine is the branch of medicine involved in the treatment of patients with life-limiting disease for whom the focus of care is optimising quality of life. Palliative care is a multidisciplinary approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual (WHO, 2017). The management of patients with cancer is a key part of palliative care, however, the role of Palliative Medicine in caring for patients with non-malignant conditions is increasingly recognised, and is expanding rapidly.

Palliative care has a long history in Ireland and this continues to influence the delivery of services. Services originated in the voluntary sector with the establishment by religious orders of St. Patrick's Hospital in Cork and Our Lady's Hospice in Dublin as centres for the dying in the late 19th century (HSE, 2009). There have been significant advances in the provision of palliative care services in Ireland since 1995 when it became the second country in Europe to recognise Palliative Medicine as a distinct medical speciality. The voluntary sector contributes significantly to all aspects of palliative care in Ireland.

1.4.2 Model of service delivery

In Ireland, palliative care services are structured in three levels of ascending specialisation, as recommended by the National Advisory Committee on Palliative Care (2001). These levels refer to the expertise of the staff providing the service. The competencies of staff practicing at each of the levels of care are described in the National Palliative Care Competence Framework (HSE, 2014):

- Level one – Palliative Care Approach: Palliative care principles are appropriately applied by all health care professionals.
- Level two – General Palliative Care: At an intermediate level, a proportion of patients and families will benefit from the expertise of healthcare professionals who, although not engaged fulltime in palliative care, have had some additional training and experience in palliative care.
- Level three – Specialist Palliative Care (SPC): Specialist palliative care services are those services whose core activity is limited to the provision of palliative care.

Most community SPC teams are consultant-led, multidisciplinary services, but in some areas they are nurse-led. Service availability varies from seven days a week, twenty four hours per day to office hours only. Many community SPC teams do not have the full complement of staff for a multidisciplinary team. Home help and public health nursing capacity is often insufficient to meet the needs of patients and can make it difficult to maintain patient care in the community, resulting in in-patient admission.

SPC teams in acute hospitals support and collaborate with other hospital teams. Patients receiving SPC hospital team services usually remain on their own wards under the care of the referring consultant. Most SPC hospital teams provide services five days a week. However, large variations exist in the staffing levels of SPC teams in acute hospitals.

In terms of place of death, although 67% of Irish people express a preference to die at home, in reality only 26% of the circa 28,000 deaths that occur in Ireland each year take place in the home, and 43% occur in hospital. In contrast, 40% of all patients cared for by hospice home care teams die at home.

1.4.3 Specialist palliative care services - Adults

The following provides an overview of specialist palliative care services for adults in Ireland in 2016, with the total number of these services across Ireland provided for information.

- **Specialist palliative care unit:** regarded as the core element of the SPC service, each unit serves as a centre for co-ordinating the delivery of SPC services in all care settings, including hospitals and the community. There are currently 10 of these units in Ireland. Specialist palliative care units should ideally comprise each of the following components of care- in-patient beds ('hospice beds'); day hospice services; community palliative care services; out patient and bereavement services. Specialist palliative care units are, however, variably resourced across the country and not all units offer each component of care.

- **Community palliative care teams** operate across each Local Health Office (LHO) in the country. In areas where a specialist palliative care unit exists, the community palliative are team functions as part of that service. In other areas, the community palliative care team functions as an independent, standalone service. There are 26 community palliative care teams across Ireland. SPC in the community (i.e. the home care team) provides specialist support and advice to patients, families and community-based professionals. The teams may also be involved in the care of patients in palliative care support beds.
- **Hospital-based consultant-led specialist** palliative care teams and hospital-based nurse-led specialist palliative care services: SPC teams in acute hospitals support and collaborate with other hospital teams. This is the same model of care as that provided in the community. There are 36 consultant-led and one nurse-led hospital based palliative care services in Ireland currently.

1.4.4 Specialist palliative care services – Children

The following provides an overview of specialist palliative care services for children in Ireland in 2016:

- LauraLynn Children's Hospice is the only provider in Ireland of specialist palliative care beds for children, of which there are eight.

- There are a total of 10 outreach nurses operating across the country.

- There is 1 hospital-based consultant-led specialist palliative care service in Ireland

- There is a further 1 consultant-only palliative care service

- Each of the Each of the 26 community palliative care teams provides care for children at home when required. care for children at home, when required.

2 - CURRENT WORKFORCE

2.1 INTRODUCTION

Specialists in Palliative Medicine may work in a hospital setting, in the community and in specialist palliative care units. The population of doctors working in Palliative Medicine in Ireland is made up of Consultants in Palliative Medicine, specialists in another area of medicine (e.g. GP) and Non-consultant Hospital Doctors (NCHDs). This section of the report will provide a breakdown of the data currently available on the number of doctors working in specialist palliative care services in the public and private sector.

2.2 SOURCES OF DATA

The major sources of data utilised in the analysis of the current medical workforce include:

- Medical Council Workforce Intelligence data from 2015/16 registrations (MCI); based on both registrations and an optional survey attached to the registration process
- HSE Workforce Planning, Analysis and Informatics Unit (HSE- WPAI)
- HSE National Doctors Training and Planning Unit (HSE-NDTP)

Examination of the available data has allowed for a breakdown of the Palliative Medicine workforce by consultants, specialists and NCHDs working in the public and private sector. It has allowed for further detailed analysis of those doctors actively participating in the medical workforce in Ireland by gender, working patterns, registration type, contract type, where doctors received their basic medical training, and the age profile of doctors. The ratios of NCHDs to consultants are also considered.

The first section outlines the consultant/specialist workforce in Palliative Medicine, followed by an analysis of NCHDs.

2.3 THE NUMBER OF SPECIALISTS WORKING IN THE IRISH HEALTHCARE SYSTEM

2.3.1 The Number of HSE Approved Consultant Posts

In 2017, there were 36 approved consultant posts in palliative medicine recorded by the NDTP Consultants Division (table 1).

TABLE 1: HSE Number of Approved Consultant Posts

Approved Consultant Posts as at January 2017		
	HC	WTE
Palliative Medicine*	36	35

*1 of these posts for Paediatric Palliative Medicine

2.3.2 MEDICAL COUNCIL DATA

Medical Council (MC) data record 53 doctors practicing Palliative Medicine who hold specialist registration. Of these, 42 are registered specialists in Palliative Medicine, 10 in General Practice and 1 in General Internal Medicine (GIM), see Table 2. Two specialists work exclusively in the private sector.

TABLE 2: Number of Doctors on the Specialist Register of the Medical Council

Specialist registered doctors actively practicing Palliative Medicine in 2015	
	Total
Specialist registered doctors (total public & private)	53*
Specialist registered doctors (private only)	2*
Total specialist registered doctors	53*

*Source, MC ARAF (2016)

2.3.3 Country of Basic Medical Qualification

Of the 42 specialists in Palliative Medicine referred to in Section 2.3.2 above, 38 qualified in a medical school in Ireland, 3 qualified elsewhere in the EU and 1 qualified outside the EU (see Table 3).

TABLE 3: Country of Basic Medical Qualifications – Specialist Register

Country of Basic Medical Qualification		
Qualified in Ireland	Qualified in the EU	Qualified outside the EU
38	3	1

2.3.4 HSE Workforce Planning Analysis and Informatics

According to data from the HSE staff census, in 2015/16 there were 38 consultants (34 WTEs) in Palliative Medicine working in publicly funded services (WPAI, 2016), with a small proportion working less than full-time.

TABLE 4: Number of Consultants - Publicly Funded Services

Consultants - Publicly Funded Services in Ireland (WPAI, 2016)		
	HC	WTE
Consultant Palliative Medicine	38	34

2.4 PARTICIPATION OF CONSULTANTS / SPECIALISTS IN THE MEDICAL WORKFORCE IN IRELAND

2.4.1 Gender and Working Patterns

GENDER

Of the 38 consultants working in publicly funded services 13 were male and 25 were female. The gender breakdown for WPAI data is closely aligned with that of the MC (2016) data which indicate that, of the 53 doctors on a specialist register and actively working in Palliative Medicine in 2015, 15 were male and 38 were female. Palliative Medicine has a higher proportion of specialists who are female in comparison to other specialities.

TABLE 5: Gender Breakdown of Consultants/Specialists

Consultants/Specialists Working in Ireland in 2016					
Source	Male %	Male HC	Female %	Female HC	Total HC
WPAI 2016	34%	13	66%	25	38
MC 2016	28%	15	72%	38	53

WORKING PATTERNS

Of the consultants working in HSE funded services approximately 92% (35) were working on a full-time basis. full-time basis, see Table 6 below. Working patterns of those doctors on the specialist register and working in Palliative Medicine in the previous 12 months, as per MC data, indicate that approximately 92% of specialists (49) worked full-time and 9% of specialists (4) worked less than full-time. As already stated, part time working infers an approximate WTE rate of less than 80% for MC data. For WPAI Data, part-time working is defined as a WTE rate of less than 100%. The overall WTE rate for WPAI data is 90% approximately.

Although the majority of consultants in Ireland currently work full-time, it is likely that part-time working will become more common in the future. The survey conducted by the National Clinical Programme for Palliative Care indicated that 60% of respondents would like to work less than full-time in the future if the opportunity presented itself. This preference is in keeping with trends noted in the UK.

TABLE 6: Working Patterns of Consultants/Specialists

Working Patterns of Consultants/Specialists 2016								
Source	HC	HC Full-time	% HC Full-Time	HC Part-time	% HC Part-Time	WTE Full-Time	WTE Part-time	Overall WTE
WPAI 2016	38	35	92%	3	8%	32.8	1.68	34
MC 2016	53	49	92%	4	8%			

2.4.2 Permanent/Temporary Status of Consultant Contract

Of the 38 consultants working in HSE funded services 31 held a permanent contract. The remaining 7 held non-permanent contracts and were typically in locum posts and specified purpose contracts. See Table 7 below.

TABLE 7: Permanent/Temporary Status of Consultant Contract

Permanent / Temporary Status of Consultant Contract 2016					
	HC	Permanent	% Permanent	Non-Permanent	% Non-Permanent
WPAI 2016	38	31	82%	7	18%

2.4.6 Age Profile of Specialists in Palliative Medicine

Of the specialists actively working in Palliative Medicine and registered with the MC in 2015, 4% were under the age of 35, 51% were between the ages of 35 and 44, 24% were between the ages of 45 and 54 and 21% were over the age of 55 years (MC, 2016). These data indicate that over the next 10 years approximately 11 Consultants in Palliative Medicine, representing 21% of the workforce, are likely to exit the workforce due to retirement (representing all doctors over 55 years).

FIGURE 1: Age Profile of Specialists

2.5 THE NUMBER OF NCHDS WORKING IN THE IRISH HEALTHCARE SYSTEM

As with all medical specialties, Palliative Medicine is dependent on both NCHDs in training and not in training programmes to support service delivery. Table 8 below outlines the number of NCHDs who retained registration in 2015 and worked in Ireland in Palliative Medicine in the previous 12 months. Of the 61 NCHDs in Palliative Medicine, 23 were on the Trainee Devision of the register, 38 were on the General Devision and there were no doctors on the Supervised Division.

TABLE 8 NCHDs by Division of the Medical Register

NCHDs practicing in Palliative Medicine in the previous 12 months				
	General Division	Supervised Division	Trainee Division	Total
Palliative Medicine	38	0	23*	61

*Includes BST GIM and HST PM

2.5.1 TRAINING POSTS

Higher Specialist Training in Palliative Medicine is four years in duration. Training is spent in hospice, communityand hospital settings. Applicants for Higher Specialist Training (HST) in Palliative Medicine must have a certificate of completion in Basic Specialist Training (BST) in General Internal Medicine and obtained the MRCPI or equivalent. As of September 2016, there were 15 NCHDs in Higher Speciality Training in Palliative Medicine. While all trainees working in Palliative Medicine are included in Table 8 above, only those on the HST programme for Palliative Medicine are included in Table 9 below.

TABLE 9: Palliative Medicine HST Training Posts

Palliative Medicine HST Training Posts							
	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Total
Palliative Medicine	4	4	5	2	0	0	15

2.5.2 Expected Training Programme Exits

After satisfactory completion of four years of HST training candidates are eligible for inclusion on the Specialist Register of the Medical Council of Ireland and are eligible to apply for permanent consultant posts in Palliative Medicine. An analysis of the number of doctors in HST training currently infers that between two and four trainees will complete their training and be eligible for specialist registration over each of the next 5 years (see Table 10).

TABLE 10: Expected Training Programme Exits

Expected Training Programme Exits By Year and Gender					
	2017	2018	2019	2020	2021
Male	1	0	0	1	1
Female	1	4	4	3	3
Total	2	4	4	4	4

2.5.3 NCHDS NOT IN TRAINING POSTS

As mentioned in Section 2.5 above, of the NCHDs who retained registration in Palliative Medicine in 2015, 38 were on the General Division and there were no doctors on the Supervised Division. This compares with data from HSE NDTP (Table 11) which records 25 NCHDs in non-training posts (2016). Of these, 3 were SHOs and 22 were Registrars. Again, HSE data refers to HSE funded posts only.

TABLE 11: NCHDs Not in Training Posts

Palliative Medicine NCHD Non-Training DIME Data					
	SHO	Registrar	Lecturer	Research	Total
Palliative Medicine	3	22	0	0	25

2.6 PARTICIPATION OF NCHDS IN THE MEDICAL WORKFORCE IN IRELAND

2.6.1 Gender and Working Patterns

GENDER

According to the MC (2016), 77% of NCHDs registered in 2015 and practicing Palliative Medicine in Ireland in the previous 12 months were female, while 23% were male. See Table 12 below.

TABLE 12: NCHD Gender Breakdown by Division of the Medical Register

NCHDs Palliative Medicine - Medical Council					
	Female (N)	Female (%)	Male (N)	Male (%)	Total
NCHDs Gender	47	77%	14	23%	61

2.6.1.2 Working Patterns

According to the MC (2016), 92% of NCHDs registered in 2015 and practicing Palliative Medicine in Ireland in the previous 12 months worked full-time. Of those doctors registered on the General Division, 16% stated that they worked less than full-time, while 9% of trainee doctors stated that they worked on a less than full-time basis. See Table 13 below.

TABLE 13: NCHD Working Patterns by Division of the Medical Register

NCHDs Palliative Medicine - Medical Council					
	Less than full-time (N)	Less than full-time (%)	Full-time (N)	Full-time (%)	Total
General Division	6	16%	32	84%	38
Trainee Specialist Division	2	9%	21	91%	23
Overall Total	5	8%	56	92%	61

2.6.2 Country of Basic Medical Qualification

Of the total number of NCHDs working in Palliative Medicine in 2015, 72% qualified at undergraduate level in Ireland, 10% qualified in the EU and 18% qualified outside the EU. See Table 14 below. Approximately 63% of all non-training NCHDs qualified in Ireland.

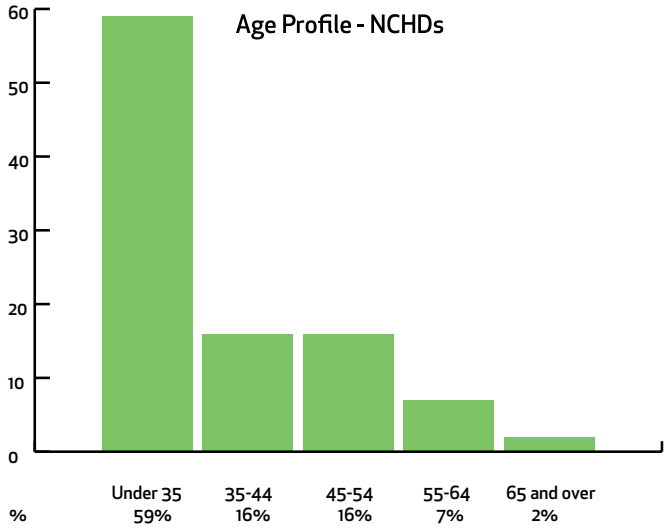
TABLE 14: Country of Basic Medical Qualifications - NCHDs

BMQ for NCHDs			
	Ireland N (%)	EU N (%)	Non-EU N (%)
General Division	24 (63%)	4 (11%)	10 (26%)
Trainee Specialist Division	20 (87%)	2 (9%)	1 (4%)
Total NCHDs	44 (72%)	6 (10%)	11 (18%)

2.6.3 Age profile of NCHDs

Of the 61 NCHDs working in Palliative Medicine, 59% were under the age of 35, 16% were between the ages of 35 and 44, 16% were between the ages of 45 and 54, and 9% were over the age of 55 years (MC, 2016). The majority of NCHDs (59%) were under 35 years (as per Figure 2). Based on these data, approximately 6 NCHDs will retire from the medical workforce over the next 10 years.

FIGURE 2: Age profile of NCHDs working in Palliative Medicine



2.7 RATIO OF NCHDS TO CONSULTANTS

The ratio of NCHDs in training, to NCHDs not in training, was 0.6: 1, while the ratio of NCHDs (training & non-training) to consultants was 1.1: 1.

These ratios are derived from data indicating that there are 38 HC (34 WTE) consultants in Palliative Medicine working in the HSE as of November 2016 HSE, WPAI, 2016; 23 NCHDs in training posts, to include those at BST and HST level and 25 NCHDs not in training posts .

As per Table 15 below, it can be seen that the ratio of NCHDs (in training only and not in training only) to consultants in publicly funded services only is approximately 0.7:1. The ratio of all NCHDs in Palliative Medicine to consultants in publicly funded services is 1.3:1.

TABLE 15 Ratios of NCHDs : Consultant Ratios in Publicly Funded Services HC

Total NCHD Posts	N	NCHD : Consultant
Total Training – HST and BST	23	0.6:1
Non-training posts	25	0.7:1
Total NCHDs	50	1.3:1

2.8 SUMMARY OF CURRENT CONFIGURATION OF PALLIATIVE MEDICINE SPECIALIST WORKFORCE 2016/17

The following table provides a summary of the current configuration of the Palliative Medicine workforce including NCHDs, for use in further workforce planning activity.

TABLE 16: Current Configuration of the Palliative Medicine Specialist Workforce

Stocktake of the Palliative Medicine Specialist Workforce		
Assumption	Value	Source
Number of consultants working in HSE funded services – permanent and temporary	38 HC / 34 WTE	HSE Workforce Planning, Analytics, & Informatics, Nov 2016
Full time consultants in HSE funded services	35 HC / 32.8 WTE	HSE Workforce Planning, Analytics, & Informatics, Nov 2016
Part time consultants in HSE funded services	3 HC / 1.7 WTE	HSE Workforce Planning, Analytics, & Informatics, Nov 2016
Estimated number of private sector only consultants as per Medical Council data	2	Medical Council (2016)
Number of approved consultant posts for HSE funded services	36 HC	HSE Consultants Division 2016
Share of females in consultant employment stock for HSE funded services	66%	HSE Workforce Planning, Analytics, & Informatics, Nov 2016
Share of males in consultant employment stock for HSE funded services	34%	HSE Workforce Planning, Analytics, & Informatics, Nov 2016
Overall WTE rate for consultants in HSE funded services	0.9	HSE Workforce Planning, Analytics, & Informatics, Nov 2016
Exits from MC Specialist Register	2	Medical Council (2016)
% consultants / specialists over 55 years	21%	Medical Council (2016)
% Non-training NCHDs over 55 years	9%	Medical Council (2016)
Total HST	15	Royal College of Physicians(2016)
Total Non-training NCHDs	25	NDTP DIME (2016)

3 - ESTIMATION OF THE CURRENT UNDERSUPPLY OF DOCTORS IN THE PALLIATIVE MEDICINE WORKFORCE

3.1 AVAILABILITY OF SPECIALIST PALLIATIVE CARE SERVICES IN IRELAND

There are wide variations in the availability of Specialist Palliative Care (SPC) services in Ireland. While all areas have access to specialist community palliative care/home care teams, not all have access to a SPC in-patient unit, specialist palliative day care centres, or outpatient clinics attached to SPC units. There are also variations in how services are structured and resourced. The Irish Hospice Foundation (IHF, 2013) highlighted that wide regional variation persisted at that time in the provision of hospice beds, resulting in significant inequity in access to services.

Nationally, there are only two regions which could be considered close to fulfilling government policy of one hospice bed per 10,000 of the population. These two regions include the Mid-West and North West regions, which are almost fully compliant with the recommendations of the report of the National Advisory Committee on Palliative Care (NACPC, 2001), adopted as national policy in 2001. The IHF (2013) report estimated that because of regional inequity in resource allocation, approximately 2,470 patients are denied admission to hospice beds and specialist care appropriate to their needs in Ireland each year.

Regions which are close to compliance with national policy in the provision of hospice beds show a significant reduction in the number of deaths occurring in acute hospitals (Brick et al., 2015).

3.2 ESTIMATION OF CURRENT UNDERSUPPLY OF PALLIATIVE MEDICINE SPECIALISTS

The National Clinical Programme for Palliative Care (2017) has indicated that there is evidence of a deficit of consultants in Palliative Medicine in Ireland. This is reflected by the following:

- Persistence of a number of single-handed posts,
- Onerous on call rotas (65% of consultants providing on call cover to in-patient units are on 1:1-1:3 rotas),
- Dependence on non-training NCHD posts,
- Lack of availability of holiday and maternity locum cover,
- Absence of 5/7 consultant presence in hospitals,
- Absence of 5/7 consultant presence in community palliative care services,
- Reports of 'care left undone'. For example, in the NCPPC survey, 73% of consultants, report that in the last week of their hospital practice they delegated patient reviews to other team members due to workload, where they felt that the task would have been better carried out by a consultant (65% response rate to question)
- Less than 10% of doctors work part-time despite NCPPC survey findings indicating that 60% of respondents would like to work flexibly if the opportunity presented itself

The current model of palliative care in Ireland is one where consultant input into the management of patients with specialist palliative care needs is largely focused on patients admitted to in-patient units. Other settings i.e. hospital, community, day hospice and out-patient services, receive extremely limited input from consultants in Palliative Medicine. The consultant commitment to care can be broken down as follows:

- Acute hospital setting: Typically, one-third of consultant sessions are allocated to hospitals where a consultation service only is provided. At current levels of staffing this means that the majority of patients see a consultant in Palliative Medicine on one occasion only. A significant number are not viewed by a consultant. However, they are seen by clinical nurse specialists in palliative care.
- Community Palliative Care: Consultants in Palliative Medicine attend community palliative care weekly MDTs. Ordinarily, patients in the community are not seen individually by consultants in Palliative Medicine.
- Day hospice: Consultant input into day hospice is limited to attendance at weekly MDT meetings or review of patients on request by nursing staff.
- Outpatient services: An extremely limited outpatient service is provided by consultants in Palliative Medicine with fewer than 12 consultant-led outpatient clinics provided nationally.

3.3 KEY DRIVERS OF CHANGE TO THE FUTURE OF THE PALLIATIVE MEDICINE WORKFORCE

The major drivers of change to the future Palliative Medicine workforce are reconfiguration of services, population ageing and the future burden of disease (both cancer and non-cancer related).

RECONFIGURATION OF SERVICES:

Planned service delivery changes, as outlined in the new Model of Care for Palliative Care in Ireland, propose extending consultant input to community and hospital settings in order to address unmet need. This should secure earlier integration of palliative care into the patient journey and will facilitate care in the patient's preferred location by ensuring access to consultants in community settings as well as facilitating discharge from hospital.

POPULATION AGING AND THE FUTURE BURDEN OF DISEASE:

Figures show that in 2010, 6,733 deaths in Ireland were supported by specialist palliative care. This accounted for 25% of all deaths and 72% of all cancer deaths. A population that is both increasing and ageing means that the numbers requiring end-of-life and palliative care are set to rise in the coming years.

People are also surviving longer with life-limiting conditions and with multiple morbidities. In-patient hospice/specialist palliative care services traditionally evolved largely around the needs of people with cancer, but there is a growing demand for these services for other life-limiting conditions, for example diseases of the circulatory system such as heart failure. If more services were to be provided to those with non-cancer diagnoses, this would increase the demand for specialists in Palliative Medicine. In 2015, the National Cancer Registry Ireland (NCRI) produced a set of projections of future cancer cases (2015-2040). The total number of new invasive cancer cases (including non-melanoma skin cancer) is projected to increase by 84% for females and 107% for males between 2010 and 2040, based only on changes in population size and age distribution.

The NCRI models project an increase of about 50% in cancer cases by 2025, and treatment numbers are expected to increase correspondingly. While some cancers are being cured, the reality is that most cancer treatments prolong life rather than cure. As advances in new treatments for cancer will reduce mortality, these will also extend the period during which palliative care will be required, while a rising population over the age of 65 is likely to also increase demand. Therefore, it is likely that there will be a concurrent increase in the demand for specialist palliative care services.

In addition, the recent Oireachtas Committee on Future Healthcare (2017) recommended that universal palliative care be introduced in the first five years of the health plan. This has the potential to put increase demand even further.

4 - VIEWS ON PALLIATIVE MEDICINE WORKFORCE PLANNING

The following section outlines the recommendations on Palliative Medicine workforce planning provided in a submission received by NDTP in 2017 from the National Clinical Programme for palliative care. These recommendations are the views of the National Clinical Programme and do not necessarily represent those of the HSE or Department of Health. However, these views have been sought in order to inform future workforce planning for the speciality.

THE NATIONAL CLINICAL PROGRAMME FOR PALLIATIVE CARE WORKFORCE PLANNING RECOMMENDATIONS

There are multiple factors that impact on the demand for Palliative Medicine services. For the purpose of this exercise, focus is given to three major variables including:

- Population change;
- Proportion of the population that will avail of specialist palliative care input, as a reflection of Government policy;
- Utilisation based on population-based needs assessment.

In order to estimate the demand for Palliative Medicine services over the next 10 years, a number of potential future scenarios are used to make different supply and demand focused workforce projections. The scenarios are stakeholder-informed and based on recommendations from the international literature, the RCPI and the National Clinical Programme for Palliative Care, as well as on Government Policy. The WTE figures derived in this modelling for all scenarios are based on the assumption that 20% of consultants will work Less than Full-time (LTFT).

SCENARIO 1

The following parameters have guided the development of this scenario:

- Maintaining the current ratio of Palliative Medicine consultant consultations to the population, accounting for population growth and demographic change and increased flexible working (20% of posts, less than full-time),
- Meeting unmet demand in a minimal manner by accounting for con sultant cover for the opening of additional specialist palliative care in-patient unit beds,
- But not accounting for estimated unmet demand for Palliative Medicine consultants in acute hospital, out-patient and community services.

In Scenario 1, 17 WTE new consultant posts in Palliative Medicine are required by 2026 to meet increasing service demand. In terms of projected total headcount in 2026, incorporating these new posts would equate to a requirement for 55 consultants (46.6 WTE) in Palliative Medicine.

SCENARIO 2

The following parameters have guided the development of this scenario:

- Increasing the ratio of Palliative Medicine consultant consultations to the population, accounting for population growth and demographic change
    - Meeting unmet demand in a partial manner by accounting for consultant cover for the planned opening of additional specialist palliative care in-patient unit beds; by extending Palliative Medicine consultant cover to model 4 hospitals on a 5/7 day basis; by extending Palliative Medicine consultant cover to community services on a limited basis only,
- But not accounting comprehensively for estimated unmet demand for Palliative Medicine consultants in acute hospital and community services.
- But not developing academic Palliative Medicine.

In Scenario 2, 35 WTE new consultant posts in Palliative Medicine are required by 2026 to meet increasing service demand. In terms of projected total headcount in 2026, incorporating these new posts would equate to a requirement for 77 consultants (64.6 WTE) in Palliative Medicine.

SCENARIO 3

The following parameters have guided the development of this scenario:

- Increasing the ratio of Palliative Medicine consultant consultations to the population while accounting for population growth, demographic change and increased flexible working (20% of posts, less than full-time),
- Meeting unmet demand in a comprehensive manner by accounting for consultant cover for the planned opening of additional specialist palliative care in-patient unit beds; by extending Palliative Medicine consultant cover to all hospitals to a 5/7 day basis; and by extending Palliative Medicine consultant cover to the community on a 5/7 day basis.
- But not developing academic Palliative Medicine.

In Scenario 3, 46.4 WTE new consultant posts in Palliative Medicine are required by 2026 to meet increasing service demand. In terms of projected total headcount in 2026, incorporating these new posts would equate to a requirement for 91 consultants (76 WTE) in Palliative Medicine.

SCENARIO 4

- Increasing the ratio of Palliative Medicine consultant consultations to the population while accounting for population growth and demographic change and increased flexible working,
- Meeting unmet demand in a comprehensive manner by accounting for consultant cover for the planned opening of additional specialist palliative care in-patient unit beds; by extending Palliative Medicine consultant cover to all hospitals to a 5/7 day basis; and by extending Palliative Medicine consultant cover to the community on a 5/7 day basis.
- Developing academic Palliative Medicine.

In Scenario 4, 61.4 WTE new consultant posts in Palliative Medicine are required by 2026 to meet increasing service demand. In terms of projected total headcount in 2026, incorporating these new posts would equate to a requirement for 109 consultants (91 WTE) in Palliative Medicine.

SUMMARY

Based on the four scenarios, with population projections to 2026, this would equate to a ratio (headcount) of between 1.1-2.2: 100,000 population. The following table is derived from the above scenarios as proposed by the NCPPC.

TABLE 17: Palliative Medicine NCPPC Workforce Planning Projections

Palliative Medicine NCPPC Workforce Planning Projections				
	2026	2026	2026	2026
	Scenario 1	**Scenario 2**	**Scenario 3**	**Scenario 4**
Headcount Ratio	1.1	1.5	1.8	2.2
WTE Ratio	0.9	1.3	1.5	1.8
Consultants (Headcount)	55	77	91	109
Consultants (WTE)	46.6	64.6	76	91
Population	5,042,096	5,042,096	5,042,096	5,042,096

5 – A COMPARATIVE ANALYSIS OF THE PALLIATIVE MEDICINE WORKFORCE IN IRELAND, THE UK AND AUSTRALIA

5.1 IRELAND

Ireland's actual ratio of Palliative Medicine specialists per 100,000 of the population has been calculated using WPAI data of 38 HC and private sector data of 2 HC, giving a total of 40 HC. This equates to an actual ratio of 0.8: 100,000 of the population, HC (see Table 18).

The National Clinical Programme for Palliative Care (NCPPC) recommends that Ireland should ultimately increase the number of Palliative Medicine consultants to reflect scenario 4 above. This equates to 109 HC or a ratio of 2.2:100,000 of the population. Taking all Scenarios outlined by the NCPPC and the associated 10 year projections, then the recommended ratio for 2026 would be between 1.1 and 2.2 consultants per 100,000 of the population. The current day recommendation would be 1 consultant: 100,000 of the population.

TABLE 18: Actual & Recommended Ratio per 100,000 - Ireland

Ireland Actual & Recommended Ratio per 100,000			
	Actual	Recommended (2017)	Recommended (2026)
Palliative Medicine	0.8: 100,000 (HC)	1:100,000 (HC)	1.1-2.2:100,000

5.2 UNITED KINGDOM

The UK Association of Palliative Medicine (2016) note that, as a medical speciality, Palliative Medicine has the highest % of female consultants at 74%; in addition, 61% of consultants are working (LTFT,) rising each year. This report refers to Specialist Advisory Committee (SAC) data from 2015, which indicates that the number of consultants in Palliative Medicine is 609 (471 FTE) in the UK. This compares to a figure of 555 (454 FTE) in 2014 and is due to more accurate data collection. The current ratio is 0.9: 100,000 (HC) and 0.7: 100,000 (WTE), representing similar actual ratios for Ireland. Current estimate of need for the UK based on 2.5 FTE per 250,000 population is 646 FTE (838 headcount). This equates to a recommended ratio of 1.3: 100,000 (HC) and 1: 100,000 (WTE).

TABLE 19: Actual & Recommended Ratio per 100,000 – United Kingdom

United Kingdom Actual & Recommended Ratio per 100,000		
	Actual	Recommended
Palliative Medicine	0.9: 100,000 (HC)	1.3: 100,000 (HC)

5.3 AUSTRALIA

From the National Health Workforce Dataset (NHWDS) shows that there were 228 specialists in Palliative Medicine in 2015. With a population of 23,490,736 this equates to an actual ratio of 1: 100,000. In terms of recommendations, the Australian and New Zealand Society of Palliative Medicine believe that Palliative Medicine Specialists are integral to the functioning of a Specialist Palliative Care (SPC) Service. The ratio of 1 (WTE): 100,000 population represents the minimum number of Palliative Medicine Specialists required for a reasonable provision of service.

In terms of industry benchmarks for the Palliative Medicine workforce, Palliative Care Australia (PCA) recommends 1.5 (WTE): 100,000 population, which equates to a ratio of 1.6 (HC): 100.

TABLE 20: Actual & Recommended Ratio per 100,000 - Australia

Australian Actual & Recommended Ratio per 100,000		
	Actual	Recommended
Palliative Medicine	1: 100,000 (HC)	1.6: 100,000 (HC)

6 – SUMMARY

6.1 CURRENT PALLIATIVE MEDICINE WORKFORCE

- HSE approved consultant posts: in the public health system there were 36 approved posts (Jan 2017).
- There were 38 consultants (34 WTEs) in Palliative Medicine employed in publicly funded services.
- There were 53 doctors actively working in Palliative Medicine in 2015 and on the Specialist Register of the Medical Council.
- There were 4 Palliative Medicine specialist entrants on to the Specialist Register in 2015 and 2 exits.
- There were 61 NCHDS working in the specialty
- Permanent/temporary status of consultant contract: In HSE funded services, 82% held a permanent contract, while the remaining 18% held non-permanent contracts.
- Working patterns: For specialists, 92% were working on a full-time basis, while 92% of NCHDs worked full-time.
- Gender: For specialists, 28% were male and 72% were female, while for NCHDs 23% were male and 77% were female.
- Age: For specialists, the majority were between the ages of 35 and 44 (51%) and 24% were between the ages of 45 and 54, 21% were over the age of 55 years. For NCHDs, the majority (59%) were under the age of 35, while 16% were between the ages of 35 and 44, 25% were over the age of 45 years.
- Country of BMQ: For specialists, 90% qualified in a medical school in Ireland, 7% qualified elsewhere in the EU and 3% qualified outside the EU, while for NCHDs, 72% qualified in a medical school in Ireland, 10% qualified elsewhere in the EU and 18% qualified outside the EU.
- Private practice: two specialist registered doctors in Palliative Medicine and two NCHDs were working exclusively in the private sector.
- Expected training programme exits: Between two and four trainees will complete HST in Palliative Medicine and be eligible for specialist registration in each of the next 5 years.

6.3 KEY DRIVERS OF CHANGE TO PALLIATIVE MEDICINE WORKFORCE

A NUMBER OF FACTORS THAT MAY INFLUENCE FUTURE WORKFORCE SUPPLY AND DEMAND:

- Wide variations in the availability of specialist palliative care services in Ireland: while all areas have access to specialist community palliative care/home care teams, not all have access to a SPC in-patient unit, to specialist palliative day care centres or outpatient clinics attached to SPC units.
- Planned service delivery changes as outlined by the new Model of Care for Palliative Care in Ireland: extending consultant input to community and hospital to address unmet needs.
- Population change: a population that is both increasing and ageing means that the numbers requiring end-of-life and palliative care are set to rise in the coming years. People are also living longer with life-limiting conditions and with multiple morbidities, and will have experienced a period of significant ill-health and palliative care need prior to death.
- The future burden of cancer: as advances in new treatments for cancer will reduce mortality, these will also extend the period during which palliative care will be required
- Increased palliative care needs for patients with non-cancer diagnoses: growing demand for palliative care services for other life-limiting conditions, for example diseases of the circulatory system such as heart failure. If more services were to be provided to those with non-cancer diagnoses, this would increase the demand for Specialists in Palliative Medicine.
- Proportion of the population that will avail of specialist palliative care input, as a reflection of Govern ment policy: the recent Oireachtas Committee on Future Healthcare (2017) recommends that universal palliative care be introduced in the first five years of the plan.

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ISBN: 978-1-78602-017-8