

PLACE OF DEATH AND PLACE OF CARE

There is substantial evidence to show that most people would prefer to be cared for at home and to die at home. However, across England as a whole, most people die in places other than their home. In a joint publication of the National Council for Palliative Care and the Cicely Saunders Foundation (July 2003) entitled *Priorities and Preferences for End of Life Care in England, Wales and Scotland* the following findings were reported from a national telephone survey.

Table 5

Preferences versus reality – where people want to be cared for and where they actually die

Place of death	Preferred place of death	Actual place of death – all causes	Actual place of death – cancer principal cause
Home	56%	20%	25%
Hospice	24%	4%	17%
Hospital	11%	56%	47%
Care Home	4%	20%	12%

Data about place of death in the Network has been obtained from two sources:

- In respect of all deaths from ONS – Table 19 Deaths: area of usual residence and sex, by place of occurrence, numbers and percentages 2002
- In respect of deaths where cancer was the principal cause – from the Cancer Network Office.

The ONS data on place of occurrence of all deaths where Hampshire and Isle of Wight SHA was the area of usual residence is as follows:

Place of Occurrence	Numbers of Deaths	Percentage
NHS Hospitals	9890	56.0%
Hospice	821	4.6%
Home	3243	18.4%
Elsewhere (Including care homes)	3705	20.1%
TOTAL	17659	100%

Note: These figures do not include place of death of persons whose usual area of residence is Western Sussex PCT or South Wiltshire PCT which lie outside the SHA area.

It will be noted that the percentages for all places of death are very similar to the national figures reproduced in Table 5 from the National Council publication.

Table 6**Place of death by PCT of residence (where cancer was the principal cause)**

PCT	Home	NHS Acute Trust	NHS Hospital (District Community)	Nursing Home	Hospice	Elsewhere
Blackwater Valley & Hart						
East Hampshire	22%	41%	10%	8%	19%	1%
Eastleigh & Test Valley	21%	39%	7%	13%	19%	1%
Fareham & Gosport	20%	37%	18%	7%	17%	1%
Isle of Wight	17%	30%	1%	12%	39%	1%
Mid Hampshire	24%	32%	7%	12%	25%	1%
New Forest	18%	34%	18%	9%	19%	2%
North Hampshire	23%	37%	12%	7%	19%	2%
Portsmouth	19%	52%	2%	10%	16%	1%
Southampton	22%	44%	4%	5%	24%	1%
South Wiltshire	19%	61%	3%	15%	2%	1%
Western Sussex						
NETWORK	20%	40%	8%	10%	21%	1%

Note:

- 1. Data was provided by the Network Office but was not available for Blackwater Valley & Hart and Western Sussex PCTs*
- 2. Deaths that occur in the Salisbury Hospice appear to have been regarded as occurring in the hospital. Given that 124 deaths are recorded as occurring in the hospice (see Table 20) and that 80% of new patient admissions are of people resident in South Wiltshire (see Table 22), it would suggest that after taking this into account, the percentage of deaths occurring in hospital should be reduced to 29% and the percentage occurring in a hospice should be increased to 35%. The Network percentages would also need to be adjusted to 38% for deaths in hospital and 23% for deaths in hospices.*
- 3. The following interpretation of the data takes into account these adjustments for South Wiltshire.*

Interpretation/Assessment of the Data

Overall, the percentage of deaths occurring in hospitals and in nursing homes and elsewhere are similar to the national figures reported in Table 5 above. However, there are some wide variations within the Network. The overall percentages of deaths occurring at home and in hospices show significant variation from the national picture. There are also wide variations between PCTs.

- Deaths at home vary from 17% in the Isle of Wight up to 24% in Mid Hampshire. All of the percentages fall below the national average of 25%

home deaths. The influencing factors may be due to whether there are hospice beds available locally and how much support there may be for people to die at home if that is their preference.

- Deaths in hospital range from 31% in the Isle of Wight up to 54% in Portsmouth and 55% in Fareham & Gosport. However, it may be that deaths occurring in the specialist unit in Salisbury have been recorded as occurring in hospital and not hospice. That would account for the high percentage of hospital deaths and low percentage of hospice deaths.
- Deaths in hospice range from 16% in Portsmouth up to 39% in the Isle of Wight. The percentages of hospice deaths are either at or well above the national average. The Network average is 23% which is 6 percentage points higher than the national average.
- Deaths in care homes and other places vary from 6% in Southampton up to 16% in South Wiltshire. Care homes are the last choice of place of death for most people. The variations may therefore be due to whether other services are available i.e. hospice beds, support for people at home. However, that general conclusion may not be applicable to Isle of Wight where 39% of deaths occur in hospital and yet 13% occur in nursing homes and elsewhere.

The overall conclusion from this set of data is that given the variations in actual place of death from what people say that they would prefer, it is unlikely that patient choice about place of death (particularly death at home) is currently being achieved for all in the Network.

AGE STRUCTURE OF THE POPULATION

For palliative care the key factor is likely to be the numbers of people who are aged 60 and over and how that may vary across the PCT populations within the Network and how that compares with other populations in England.

Primary Care Trust	% over 60
Blackwater Valley & Hart	17.5%
East Hampshire	24.3%
Eastleigh & Test Valley South	20.2%
Fareham & Gosport	22.9%
Isle of Wight	28.6%
Mid Hampshire	21.8%
New Forest	28.9%
North Hampshire	18.1%
Portsmouth	19.8%
Southampton	18.2%
South Wiltshire	24.5%
Western Sussex	29.5%
Network	22.6%
England	20.9%

Data sources: Office of National Statistics (2001 Census) and Department of Health (GP lists in ADS 2003)

Interpretation/Assessment of the Data

It can be seen that the population of the Network is overall a little older than the average for England. Most of the PCT populations are within two or three percentage points of the average. There are however some significant variations from that.

Western Sussex has the highest proportion of people aged 60 and over. At 29.5% it has nearly 70% more people over 60 as a proportion of its population than does Blackwater Valley & Hart. New Forest and Isle of Wight also have high proportions of older people. These differences are reflected in the annual incidence of deaths due to cancer and other causes (see Table 2 above). They will have a significant effect on the level of resources required to meet palliative care needs.

NUMBERS OF MALES AND FEMALES

The proportions of males and females in the Network population according to GP lists in ADS 2003 are 48.3% male and 51.7% female. It is however important to establish whether there are any significant differences in the proportions for older people.

The proportions are normally quite different for those aged 60 and over and the Local Authority populations within the Network conform to that. The proportion of males in each PCT population varies from 42% to 44% and for females the variation is from 56% to 58%.

The proportions for those aged 75 and above are even more markedly different. The proportion of males in PCT populations varies from 36% to 38% and for females the variation is from 62% to 64%.

It is therefore much more likely in marriages and other partnerships that the female will survive the male to live alone and ultimately to be cared for. This is reflected in the fact that females are much more likely than males to die in institutional care than at home. ONS data on place of occurrence of death and usual area of residence shows that, in Hampshire & Isle of Wight SHA area in 2002, 21.8% of male deaths occurred at home but only 15.3% of female deaths. This may be an important consideration in developing home support services.

ETHNIC COMPOSITION AND RELIGION OF THE POPULATION

It is important to establish whether the ethnic composition of a Network's population varies significantly from that of England as a whole. If it does then there may be implications for the level of resources needed. For example, in populations with a high proportion of ethnic minorities, there may be a need for large numbers of interpreters for those whose first language is not English. There may also be additional education and training requirements in that the workforce should be able to deliver palliative care within an understanding of the different approaches taken by different cultures to end of life issues.

Table 7**Ethnic Group**

PCT	White	Mixed	Asian	Black	Other
Blackwater & Hart	96.6%	0.9%	1.3%	0.5%	0.8%
East Hampshire	98.5%	0.6%	0.4%	0.2%	0.3%
Eastleigh & Test Valley	97.4%	0.7%	1.2%	0.2%	0.5%
Fareham & Gosport	98.3%	0.6%	0.5%	0.2%	0.5%
Isle of Wight	98.7%	0.5%	0.3%	0.2%	0.2%
Mid Hampshire	97.9%	0.6%	0.6%	0.2%	0.6%
New Forest	98.9%	0.5%	0.2%	0.1%	0.3%
North Hampshire	97.1%	0.9%	1.0%	0.5%	0.5%
Portsmouth	94.7%	1.0%	2.4%	0.5%	1.3%
Southampton	92.4%	1.5%	3.8%	1.0%	1.3%
South Wiltshire	98.7%	0.6%	0.3%	0.1%	0.3%
Western Sussex	98.3%	0.6%	0.4%	0.2%	0.5%
ENGLAND	90.9%	1.3%	4.6%	2.1%	0.9%

Interpretation/Assessment of the Data

It is apparent from the above Table that the Asian Group is numerically significant in Southampton and Portsmouth and to a lesser extent in Eastleigh & Test Valley, Blackwater Valley & Hart and North Hampshire. The Black Group is not numerically significant except in Southampton. It is also worth noting that in Portsmouth and Southampton the proportions of mixed race and of other ethnic minority groups are numerically significant.

In consequence there may be some additional resource implications arising. However, they are likely to be marginal to the educational and training provision for the Network as a whole. That provision would need to include a programme to ensure that services are prepared to provide appropriate care to members of ethnic groups even if such need occurs only rarely in some PCTs. The data source for this Table and Table 8 on religion is the 2001 Census: Neighbourhood Statistics at ONS.

Table 8

Religion

PCT	Christian	Buddhist	Hindu	Jewish	Muslim	Sikh	Other	None	Not stated
Blackwater & Hart	75.0%	0.3%	0.5%	0.1%	0.6%	0.1%	0.3%	16.0%	7.2%
East Hampshire	74.6%	0.2%	0.1%	0.1%	0.2%	0.1%	0.3%	16.8%	7.5%
Eastleigh & Test Valley	76.9%	0.2%	0.3%	0.1%	0.3%	0.5%	0.3%	15.0%	6.3%
Fareham & Gosport	76.9%	0.1%	0.2%	0.1%	0.3%	0.1%	0.3%	15.2%	6.8%
Isle of Wight	73.7%	0.2%	0.1%	0.1%	0.3%		0.4%	17.3%	7.9%
Mid Hampshire	77.0%	0.1%	0.2%	0.1%	0.3%	0.1%	0.4%	15.2%	6.6%
New Forest	78.3%	0.1%	0.1%	0.1%	0.2%		0.3%	14.0%	6.9%
North Hampshire	75.0%	0.2%	0.3%	0.1%	0.4%	0.1%	0.3%	16.5%	7.0%
Portsmouth	68.1%	0.4%	0.4%	0.1%	2.2%	0.2%	0.4%	20.0%	8.3%
Southampton	65.6%	0.3%	0.7%	0.1%	1.9%	1.3%	0.4%	21.6%	8.0%
South Wiltshire	78.3%	0.2%	0.1%	0.1%	0.2%		0.3%	13.6%	7.2%
Western Sussex	77.1%	0.2%	0.1%	0.2%	0.3%		0.4%	14.4%	7.3%
ENGLAND	71.8%	0.3%	1.1%	0.5%	3.0%	0.6%	0.3%	14.8%	7.7%

LIVING IN HOUSEHOLDS

If people are to be cared for at home during the last year of life then they need not only good professional support but also support from informal carers. If the individual is living alone then informal support may be more difficult to provide. The analysis of males and females in the population (see above) demonstrates that older people living alone are more likely to be female than male.

Data about the proportion of single person households in each PCT may help in understanding the relative difficulty of enabling people to be cared for and die at home.

Table 9

Single person and all pensioner households

Primary Care Trust	Single Person Households	Pensioners living alone	Other all pensioner households
Blackwater & Hart	23.7%	11.2%	7.8%
East Hampshire	26.4%	14.6%	12.2%
Eastleigh & Test Valley	25.2%	12.7%	9.9%
Fareham & Gosport	25.4%	13.8%	11.5%
Isle of Wight	31.4%	18.4%	13.2%
Mid Hampshire	26.9%	14.5%	10.4%
New Forest	27.7%	17.3%	15.1%
North Hampshire	24.7%	11.3%	8.7%
Portsmouth	32.9%	15.4%	8.0%
Southampton	34.5%	14.7%	7.8%
South Wiltshire	28.3%	15.1%	11.6%
Western Sussex	30.7%	18.9%	14.5%
ENGLAND	30.0%	14.4%	9.4%

Data Source: 2001 Census – Neighbourhood Statistics, ONS

Interpretation/Assessment of the Data

It will be noted that in respect of the proportion of total single person households the PCTs are around or below the England average except for Southampton and to a lesser extent Portsmouth. This is a common characteristic of large cities where there is a higher proportion of younger people who tend to live as single persons.

The proportion of single pensioner households is around or below the national average except in Isle of Wight, New Forest, Portsmouth and Western Sussex where it is highest (about 30% higher as a proportion than the England average).

As far as other pensioner households are concerned, the PCTs with proportions well above average are East Hampshire, Isle of Wight, Western Sussex and New Forest where it is highest (about 60% higher as a proportion than the England average).

These kinds of results are mainly reflections of the different age structures of PCT populations – some are relatively young and others are relatively old. PCTs that have significantly higher than average proportions of single pensioner households may need higher levels of community palliative care services.

THE SOCIO-ECONOMIC APPROACH

Indices of Deprivation

There is probably a consensus of professional opinion that caring for people in the most deprived areas does require more resources than in the most affluent areas. There is also some evidence to show that the level of palliative care resources required to support people in the most deprived areas may be up to twice the level required in the most affluent areas. In consequence it is considered that, after the annual incidence of deaths, this is the most important factor affecting palliative care resource need in a population.

There are several possible choices of an Index for the measurement of relative deprivation that would assist in the assessment of deprivation on palliative care need. The one selected for purposes of this needs assessment is the Index of Multiple Deprivation 2004 (IMD2000) that was published in 2004 by the Office of the Deputy Prime Minister. It is based on data at Super Output Area (SOA) level. SOAs are areas having populations around 1500 i.e. much smaller than most electoral wards. The Index is made up of seven Domain Indices. These domains comprise Income, Employment, Health Deprivation and Disability, Education Skills and Training, Barriers to Housing and Services, Crime and Living Environment. The scores for the separate domains are combined into an overall index at several levels – Local Authority, Primary Care Trust and SOA level.

There are 32,482 SOAs in England. They can be compared according to the average of their scores for each domain. The SOA ranked 1 has the highest average score and has therefore the highest level of deprivation and that ranked 32482 the lowest score and the least deprivation. The Table below shows the number of the most deprived and least deprived wards for the PCTs in the Network.

Table 10 Indices of deprivation – Super Output Area ranks

PCTs		Most	Deprived		Least	Deprived	
	No. of SOAs in PCT	SOAs in top 10%	SOAs in top 10 to 20%	SOAs in top 20 to 30%	SOAs in bottom 20 to 30%	SOAs in bottom 10 to 20%	SOAs in bottom 10%
Blackwater & Hart	112	0	2	1	14	21	55
East Hampshire	113	4	15	8	15	22	13
Eastleigh & Test Valley	104	0	0	2	20	19	36
Fareham & Gosport	126	0	5	7	15	21	23
Isle of Wight	89	0	8	20	6	1	0
Mid Hampshire	110	0	0	1	15	25	47
North Hampshire	143	0	0	1	17	27	52
New Forest	114	0	2	1	18	28	17
Portsmouth	123	11	16	15	3	2	2
Southampton	146	9	21	24	11	8	4
South Wiltshire	73	0	1	3	5	12	22
Western Sussex	134	0	3	3	23	27	20
TOTALS	1387	24	73	86	162	213	291

Data source: IMD 2004

Interpretation/Assessment of the Data

The Table above demonstrates that the Network population as a whole does not suffer socio-economic deprivation. Only 13% of all SOAs fall into the 30% of most deprived SOAs in England, about 40% have relatively average deprivation and nearly 50% have relatively little deprivation. The overall picture is therefore of comparative affluence but there are some significant variations from that.

- The most acute deprivation is concentrated in Portsmouth, Southampton, the Havant part of East Hampshire PCT and the Isle of Wight. Over 80% of all the SOAs that fall into the most deprived 30% are in these PCT populations.
- East Hampshire PCT population is one of sharp contrasts from the acutely deprived parts of Havant to some of the least deprived areas of the country.
- Fareham & Gosport and Western Sussex have pockets of deprivation but the overall tendency is one of relatively little deprivation.
- Deprivation is not a factor in Eastleigh & Test Valley South, Blackwater Valley & Hart, Mid Hampshire, North Hampshire, New Forest or South Wiltshire.

These variations in deprivation will be important factors in determining the differential palliative care resource needs of the different PCT populations.

Measuring the Relative Deprivation of Large Populations

There are two potential ways of measuring the relative deprivation of populations larger than SOAs. Both give similar results in this Cancer Network. The first is to use an average of the SOA ranks weighted for population to take account of the fact that SOA population can vary significantly. Ranking of local authority or PCT populations according to the average of SOA ranks can then be undertaken. The second way is to use weighted average scores for SOAs across local authority populations. This method has been used in Table 11 below. The scores presented at PCT level have been taken from a table available on the website of the Eastern Region Public Health Observatory.

Table 11

Indices of Deprivation – Average of SOA scores Presented at Primary Care Trust Level

Primary Care Trust	Average of SOA Scores	Rank of PCT out of 304
Blackwater Valley & Hart	7.406	292
East Hampshire	16.102	192
Eastleigh & Test Valley	8.247	286
Fareham & Gosport	11.309	251
Isle of Wight	21.097	135
Mid Hampshire	8.187	287
New Forest	10.375	261
North Hampshire	8.793	282
Portsmouth City	24.874	103
Southampton City	23.761	106
South Wiltshire	11.707	246
Western Sussex	12.289	238

Note: The PCT with the highest average score is North Manchester (58.675) and that with the lowest is Wokingham (5.094). North Manchester is ranked 1 and Wokingham is ranked 304.

Interpretation/Assessment of the data

The average of SOA scores for PCT populations shows that Portsmouth, Southampton and Isle of Wight PCTs constitute the most deprived areas in the Network. However in national terms the scores for these PCTs represent average levels of deprivation. Blackwater Valley & Hart is the least deprived area together with Eastleigh & Test Valley South and Mid Hampshire. In national terms these are some of the least deprived populations in England. These results are confirmation of the overall picture obtained from Table 10 above. As in most Cancer Networks there is significant variation in deprivation which will be important in its effect on palliative care resource need.

THE BENCHMARKING APPROACH

There are two aspects of benchmarking. Firstly it is necessary to compare the palliative care needs of this Network with all the other Networks. Secondly it is necessary to compare the palliative care needs of each PCT population one with another within the Network.

Comparison with other Networks

Appendix 1 to this report is an Index of Palliative Care Resource Need for people with cancer for each of the 34 Cancer Networks. As stated in the Appendix the Index is based on an index of annual incidence of cancer deaths modified to take account of relative deprivation. The technique for doing that contains the following steps.

Step 1 Express the annual incidence of cancer deaths as the annual rate per 100,000 population

Step 2 Ascribe an index value to that rate per 100,000 that is relative to the highest rate for any Cancer Network

Step 3 Derive a 'deprivation modifier' from the Index of Multiple Deprivation. The modifier represents the relative position of the population between the highest level of deprivation (this would be represented by a modifier of 2) and the lowest level of deprivation (this would be represented by a modifier of 1). The relative position is calculated from the average of ward ranks for the 354 local authority populations.

Step 4 The modified index value is the product of the index value and the deprivation modifier.

It can be seen from the Index in Appendix 1 that Central South Coast Cancer Network is calculated to have an Index Value of 109 for cancer and is ranked 27. In Appendix 2 the Index for all diagnoses indicates an Index Value of 110 and a rank of 25. These values would indicate a need for palliative care resources per head of population of between 10% and 15% below that of the average Network. However, in the calculation of the Index, the whole of Arun Local Authority population had been allocated to Sussex Cancer Network whereas two thirds of it is included in Central South Coast. Given that this population has an incidence of deaths well above the national average it is estimated that the overall Network need is closer to 10% below average than 15%.

Comparisons within the Network

Similar techniques are employed to estimate the comparative needs of the PCT populations within the Network. Tables 12 and 13 below provide such estimates for people with cancer and for people with other diagnoses.

Table 12

Index of comparative need for PCT populations – for people with cancer

PCT	Cancer deaths per 100,000	Index Value	Deprivation score	Deprivation modifier	Modified index value	Network need index value	Effect on resource need
Blackwater & Hart	205	61.5	7.406	1.04	64.1	100.0	+0%
East Hampshire	254	76.1	16.102	1.20	91.7	143.0	+43%
Eastleigh & Test Valley	221	66.3	8.247	1.06	70.2	109.4	+9%
Fareham & Gosport	239	71.7	11.309	1.12	80.1	124.8	+25%
Isle of Wight	316	94.7	21.097	1.30	123.0	191.8	+92%
Mid Hampshire	239	71.4	8.187	1.06	75.6	117.8	+18%
New Forest	304	91.0	10.375	1.10	100.0	155.9	+56%
North Hampshire	215	64.4	8.793	1.07	68.9	107.4	+7%
Portsmouth	281	84.2	24.874	1.37	115.3	179.8	+80%
Southampton	233	69.9	23.761	1.35	94.3	147.	+47%
South Wiltshire	248	74.5	11.707	1.12	83.7	130.5	+30%
Western Sussex	334	100	12.289	1.13	113.4	176.8	+77%

Table 13

Index of comparative need for PCT populations – for people with non cancer diagnoses

PCT	2/3 non cancer deaths	Population	Deaths per 100,000 population	Index value	Modified index value	Network need index value	Effect on resource need
Blackwater & Hart	647	167079	387	55	57.2	100	+0%
East Hampshire	922	168876	546	78	93.6	164	+64%
Eastleigh & Test Valley	689	161727	426	61	64.7	113	+13%
Fareham & Gosport	937	179545	522	75	84.0	147	+47%
Isle of Wight	919	133427	689	98	127.4	223	+123%
Mid Hampshire	857	170212	503	72	76.3	133	+33%
New Forest	1047	169486	618	88	96.8	169	+69%
North Hampshire	822	206411	398	57	60.0	105	+5%
Portsmouth	1035	182100	568	81	110.0	192	+92%
Southampton	1038	221019	469	67	90.5	158	+58%
South Wiltshire	617	111352	554	79	88.5	155	+55%
Western Sussex	1451	207262	700	100	113	198	+98%

Interpretation of the Tables

Blackwater Valley & Hart PCT is estimated to have the least palliative care resource need per head of population for cancer and for other diagnoses. Isle of Wight PCT is

estimated to have a resource need per head of population that is 92% greater than Blackwater Valley & Hart for people with cancer and 123% greater for people with other diagnoses. These are very large variations and the variations as a whole need to be reflected in the estimates of the volumes of core service components that may be required for each PCT population. They also need to be reflected in access to both current and planned services.

The following two Tables provide estimates of the ideal share of resources and access to them that would reflect the differential needs of the PCT populations as set out in Tables 12 and 13 above.

Table 14

Ideal share of resources and access to them for people with cancer

PCT	Population	Variation in resource need	Weighted population	% of total weighted population	Ideal share of resources & access
Blackwater & Hart	167079	1.00	167079	5.7%	5.7%
East Hampshire	168876	1.43	241493	8.3%	8.3%
Eastleigh & Test Valley	161727	1.09	176282	6.0%	6.0%
Fareham & Gosport	179545	1.24	222636	7.6%	7.6%
Isle of Wight	133427	1.92	256180	8.8%	8.8%
Mid Hampshire	170212	1.18	200850	6.9%	6.9%
New Forest	169486	1.56	264398	9.1%	9.1%
North Hampshire	206411	1.07	220860	7.6%	7.6%
Portsmouth	182100	1.80	327780	11.2%	11.2%
Southampton	221019	1.47	324898	11.1%	11.1%
South Wiltshire	111352	1.30	144757	5.0%	5.0%
Western Sussex	207262	1.77	366854	12.6%	12.6%
NETWORK	2078946		2914067	100%	

Table 15

Ideal share of resources and access to them for people with diagnoses other than cancer

PCT	Population	Variation in resource need	Weighted population	% of total weighted population	Ideal share of resources & access
Blackwater & Hart	167079	1.00	167079	5.2%	5.2%
East Hampshire	168876	1.64	276956	8.7%	8.7%
Eastleigh & Test Valley	161727	1.13	182752	5.7%	5.7%
Fareham & Gosport	179545	1.47	263931	8.2%	8.2%
Isle of Wight	133427	2.23	297542	9.3%	9.3%
Mid Hampshire	170212	1.33	226382	7.1%	7.1%
New Forest	169486	1.69	286431	9.0%	9.0%
North Hampshire	206411	1.05	216732	6.8%	6.8%
Portsmouth	182100	1.92	349632	10.9%	10.9%
Southampton	221019	1.58	349210	10.9%	10.9%
South Wiltshire	111352	1.55	172596	5.4%	5.4%
Western Sussex	207262	1.98	410379	12.8%	12.8%
NETWORK	2078946		3199622	100%	

Note: The figures in the column headed 'variation in resource need' are taken from the final column in Tables 12 and 13. The weighted population is the product of the actual population and the variation in resource need.

Interpretation/Assessment of the Tables 14 and 15

The percentages in the final column can be used to decide upon the appropriate share of Network palliative care resources to each PCT population. That is to say that they can be used to help determine what should be provided and also to monitor whether access to available resources reflects the differential needs of each PCT population. For example if the Network had 100 specialist palliative care beds for cancer then Portsmouth could expect to have access to 11 of those beds.

This method of determining provision and monitoring of access is appropriate for all specialist palliative care services except hospital support teams where different criteria need to be applied.

OVERALL ASSESSMENT OF PALLIATIVE CARE NEED IN THE NETWORK

This section summarises the principal conclusions drawn from the analysis of epidemiological, demographic and socio-economic data. These conclusions will be employed in estimating the volumes of specialist palliative care services that may be required for the Network as a whole and for the individual PCT populations within the Network.

1. The overall Network need for palliative care resources per head of population is around 10% lower than the need of the average Cancer Network.
2. The level of need is partly a reflection of a slightly lower than average incidence of deaths per 100,000 population than the England average. The average does however disguise a large variation between very high incidence in Western Sussex, Isle of Wight and New Forest and very low incidence particularly in the north of Hampshire.
3. The level of deprivation is a key factor. Generally across the Network the level of deprivation is very low. In north and central Hampshire deprivation levels are some of the lowest in England. However, in Portsmouth, Southampton, Havant and Isle of Wight the levels are around average overall and with pockets of acute deprivation.
4. These differences in incidence of deaths and deprivation account for very large variations in resource need as between the 12 PCT populations within the Network i.e. for cancer there is estimated to be a 92% difference in need between the PCT with the lowest need and that with the highest need. For other disease groups the variation is even greater i.e. 123% difference in need between the PCT with the lowest and that with the greatest need.
5. These variations should be reflected in service provision and access to it.
6. Patient choice over place of care and death for people with cancer is unlikely to be met currently for all – only 20% of cancer deaths occur at home compared with the England average of 25%.
7. Ethnicity is not a major influencing factor in most of the Network. There may however be a greater resource need in Portsmouth and Southampton. This would however be marginal and has been taken into account in the overall assessment of around 10% less than average Cancer Network need.

PART 2 – ASSESSMENT OF THE CORE SERVICE COMPONENTS REQUIRED TO MEET THE ASSESSED NEEDS

THE NICE GUIDANCE ON IMPROVING SUPPORTIVE AND PALLIATIVE CARE FOR ADULTS WITH CANCER

The final version of the Guidance that was published in March 2004 contains the following key recommendations:

General Palliative Care Services, including Care of Dying Patients

Key Recommendation 12: *Mechanisms need to be implemented within each locality to ensure that medical and nursing services are available for patients with advanced cancer on a 24 hour, seven days a week basis, and that equipment can be provided without delay. Those providing generalist medical and nursing services should have access to specialist advice at all times.*

Key Recommendation 13: *Primary care teams should institute mechanisms to ensure that the needs of patients with advanced cancer are assessed, and that the information is communicated within the team and with other professionals as appropriate. The Gold Standards Framework provides one mechanism for achieving this.*

Key recommendation 14: *In all locations, the particular needs of patients who are dying from cancer should be identified and addressed. The Liverpool Care Pathway for the Dying Patient provides one mechanism for achieving this.*

Specialist Palliative Care Services

Key Recommendation 15: *Commissioners and providers, working through Cancer Networks, should ensure that they have an appropriate range and volume of specialist palliative care services to meet the needs of the local population, based on local calculations. These services should at a minimum include specialist palliative care in-patient facilities and hospital and community teams. Specialist palliative care advice should be available on a 24 hour, seven days a week basis. Community teams should be available to provide support to patients in their own homes, community hospitals and care homes.*

GENERAL PALLIATIVE CARE – SERVICE REQUIREMENTS

In view of the fact that these services should be provided by all health and social care professionals as a routine, integrated part of their normal professional practice, there are no separately identifiable 'core service components' for general palliative care. The availability of these general palliative care services is not therefore dependent on the assessed level of need in a population as set out in Part One of this report. Quite simply all health and social care professionals who contribute to the assessment, treatment and care of all those with advanced disease (not just cancer) should be able to:

- Assess the palliative care needs of each patient and their family across the domains of physical, psychological, social, spiritual and information needs
- Meet those needs within the limits of their palliative care knowledge, skills and competence
- Know when and how to seek advice from or refer to specialist palliative care services

In addition each primary care team should have:

- Introduced the *Gold Standards Framework* into the team's practice, or introduced an alternative mechanism that can produce similar benefits for patients and families

In addition each primary care team and each hospital team (in all specialties) should have:

- Introduced the *Liverpool Care Pathway for the Dying Patient*, or introduced an alternative mechanism that can produce similar benefits for patients and families.

These requirements have now been reinforced by the Department of Health's End of Life Care Initiative. In addition to GSF and LCP services are being encouraged to introduce the tool for ensuring *Preferred Place of Care*.

SPECIALIST PALLIATIVE CARE SERVICES

While the NICE Guidance is explicit about what minimum range of services should be provided for any given population, it does not offer specific guidance about the volume of services that may be required.

In paragraphs 9.18 to 9.19 the Guidance states that:

'There is a lack of evidence to support specified levels of service provision, such as the number of specialist in-patient beds required per million population. Commissioners should plan services flexibly around the needs of patients, recognising that this can be achieved in more than one way.'

The levels and nature of provision will depend on a number of factors, including:

- *Local demography (such as age, levels of social deprivation and ethnicity)*
- *The number of cancer deaths*
- *The views of local service users*
- *The nature, extent and distribution of existing services*

Volumes of service are interdependent: for example an increase in the resources of a community specialist palliative care team may lessen the need for in-patient care. In addition to comparing local services with national averages and services elsewhere, Cancer Networks should carry out needs assessments, including audits of patients who meet eligibility criteria but are unable to access services. These data may provide the strongest case for service expansion.'

While it is recognised that there are not (and probably cannot be) any national norms of provision, it is also recognised that nevertheless decisions do have to be made about service volumes. The following sections provide some advice that may help with such decisions. This advice is based on a number of sources including national averages and the work undertaken by the Sheffield School of Health and Related Research (ScHARR) for its report to the Department of Health on *Modelling the Costs of Specialist Palliative Care*.

ASSESSMENT OF CORE SERVICE VOLUMES

SPECIALIST PALLIATIVE CARE BEDS

The Palliative Care Survey 1999 showed that the then average provision was 51 beds per million population. Following the investment of the additional £50 million for specialist palliative care services that average is likely to have increased to about 52/53. However, according to the MDS data collection for 2002/03, 95% of access to that provision is by people with cancer. The National Council publication *Palliative Care 2000* suggested that the needs of non cancer patients for specialist palliative care beds were at minimum 50% of the needs of cancer patients.

This would suggest that provision for the Central South Coast Cancer Network that reflected national averages, the guidance in *Palliative Care 2000* and the needs assessment conclusions summarised on page 23 should be estimated as follows:

For cancer patients – $((52.5 \times 0.95) \times 0.90) \times 2,078,496 = \mathbf{93 \text{ beds}}$. This adjusts for 5% usage by people with diagnoses other than cancer, reflects the Network's 10% lower need than the average Cancer Network and the population of 2,078,496.

For non-cancer patients the tentative estimate is **46 beds** i.e. 50% of the estimate for cancer.

The total estimated requirement for specialist palliative care beds is 139 (93 for cancer and 46 for other diagnoses).

Access to beds by patients from each PCT would need to be in proportion to the ideal share of access as set out in Tables 14 and 15 above.

Table 16

Estimated share of bed numbers for each PCT population

PCT	% share of cancer beds	Share of cancer beds	% share of non cancer beds	Share of non cancer Beds	Share of total beds
Blackwater & Hart	5.7	5	5.2	2	7 (5.0%)
East Hampshire	8.3	8	8.7	4	12 (8.6%)
Eastleigh & Test Valley	6.0	6	5.7	3	9 (6.5%)
Fareham & Gosport	7.6	7	8.2	4	11 (7.9%)
Isle of Wight	8.8	8	9.3	4	12 (8.6%)
Mid Hampshire	6.9	6	7.1	3	9 (6.5%)
New Forest	9.1	9	9.0	4	13 (9.4%)
North Hampshire	7.6	7	6.8	3	10 (7.2%)
Portsmouth	11.2	10	10.9	5	15 (10.8%)
Southampton	11.1	10	10.9	5	15 (10.8%)
South Wiltshire	5.0	5	5.4	3	8 (5.8%)
Western Sussex	12.6	12	12.8	6	18 (12.9%)
TOTAL	100%	93	100%	46	139 (100%)

The SchARR researchers have estimated that the medical staff input required is 3 sessions per week per consultant per 10 beds and one WTE other medical staff per 10 beds. The new consultant contract limits the number of clinical sessions per week to 7.5. Taking that into account, for this Network for cancer that would amount to **3.7 consultants and 9.3 other medical staff**. For non cancer that would amount to **1.8 consultants and 4.6 other medical staff**.

SPECIALIST PALLIATIVE COMMUNITY CARE

The Palliative Care Survey 1999 showed that the then average provision was around 21 per million community based clinical nurse specialists in palliative care. The additional planned investment from the extra £50 million was due to increase that to 22/23 per million.

The SchARR researchers assumed that to provide 24 hour telephone advice and 9-5 availability on 7 days per week would require 1 CNS per 43,500 population i.e. 23 per million. But this provision was for cancer only whereas the 21 per million reported in the 1999 survey was 95% cancer and 5% non cancer.

There is no comprehensive data available for other professional members of the team. However, the MDS data for 2002/03 reveals that 79% of all community visits to patients/families was by clinical nurse specialists, a further 11% by other

nursing staff, 2% by doctors and 3 % by AHPs. This would suggest that the total professional input into community specialist palliative care is around 27/28 WTE per million of which 24 are nurses, 1 is an AHP, a half is a doctor and the remaining 1.5 are unknown.

The Cameron Report in Wales made a range of recommendations about the required input from social workers, physiotherapists and occupational therapists. The ScHARR researchers took account of these and also the need for pharmacist, dietician and chaplain input. There is however no source of guidance available for estimating the numbers of those able to provide psychological support at Levels 3 and 4 of the model recommended in Chapter 5 of the NICE Guidance.

Taking into account all of the available data as well as ScHARR and Cameron Report recommendations, it is suggested that the following provision would need to be made **at a minimum**. The numbers of each profession are expressed as WTE required. The numbers are for cancer patients only. The estimated numbers for the Network take into account its population size and that its overall needs are about 10% below average. There is also an underlying assumption that the district nursing service is of an appropriate size and that it is available to patients outside normal hours.

Table 17

Minimum professional resources for specialist palliative community care – cancer only

Profession	Number per million	Number for Central South Coast Cancer Network
Consultants	2	3.75
Nurses	23	43
Social Workers	0.8	1.5
Physio/OT	0.8	1.5
Pharmacist/Dietician	0.8	1.5
Chaplain	0.6	1.2

In order to ensure that at least 5% of access was for people with diagnoses other than cancer the number of nurses would need to rise to 45. Currently there is no further guidance about what other resource should be provided for non cancer.

The number of nurses would need to be distributed in accordance with the differential needs of the 12 PCTs as follows:

- Blackwater & Hart 3
- East Hampshire 4
- Eastleigh & Test Valley 3
- Fareham & Gosport 3.5
- Isle of Wight 4
- Mid Hampshire 3

• New Forest	4
• North Hampshire	3.5
• Portsmouth	5
• Southampton	5
• South Wiltshire	2
• Western Sussex	5
• TOTAL	45

SPECIALIST PALLIATIVE DAY THERAPY

The NICE Guidance does not recommend day therapy facilities as an essential core service. It does however acknowledge that such facilities can offer opportunities for assessment and review of patients' needs. The Guidance goes on to say that:

'Although many of these services can be provided on an individual basis elsewhere, specialist day therapy enables them to be brought together in one setting. It also brings patients together, providing social support and access to facilities, and can offer respite to carers. While research suggests that patients appreciate the social contact provided by day therapy, there is insufficient evidence for the adoption of a particular model (or models). For example interventions might be offered to patients during the course of attendance at a dedicated day facility or at a more formally arranged clinic (which might be located in a hospital, hospice or dedicated day therapy facility).'

Given that NICE does not state any preference for a particular model, it is not easy to offer any advice about what volumes of day therapy facilities might be required or what the composition of the multi-professional might be. However, given that these kinds of facilities are available very widely and that decisions do have to be made locally about whether to sustain and/or develop them, some advice, no matter how tentative, may be helpful.

The Palliative Care Survey 1999 revealed that there were around 13,000 day care places per million per year on average across England. For the Network population of 2.078 million, and taking into account its 10% lower than average need, it could be expected that about 24,500 places per year should be available. That is the equivalent of about 500 places per week. This would allow about 6% of places to be available to people with non cancer.

In line with the NICE Guidance, the Network should agree the objectives of service provision and the type of interventions to be offered through this volume of day care places. Access to these places should reflect the differential needs of the 12 PCT populations as follows.

• Blackwater & Hart	30 places per week
• East Hampshire	40 places per week
• Eastleigh & Test Valley	30 places per week
• Fareham & Gosport	40 places per week
• Isle of Wight	45 places per week

- Mid Hampshire 35 places per week
- New Forest 45 places per week
- North Hampshire 40 places per week
- Portsmouth 55 places per week
- Southampton 55 places per week
- South Wiltshire 25 places per week
- Western Sussex 60 places per week
- TOTAL 500 places per week

The SchARR model assumes a day care service that includes elements of both clinical and social care and that the optimal size of a unit would be 20 places. For 500 places per week this would mean 5 dedicated facilities operating 5 days per week.

The advice that can be offered about the professional composition of the day therapy team is limited, since that would depend upon the type of model (or models) preferred by the Network. It can however be expected that any model would need to include the following:

- Nursing staff including at least one clinical nurse specialist
- Medical staff including 0.2 consultants and 0.5 other medical staff per 20 place unit
- Social workers
- Physiotherapists
- Occupational therapists
- Dietician
- Pharmacist
- Chaplain
- Staff providing recreational activities
- Staff providing complementary therapies

SPECIALIST PALLIATIVE CARE HOSPITAL SUPPORT

The NICE Guidance has set out clearly what the professional composition of these specialist palliative care hospital support teams should be. It has not however given any indication of what their size might be nor of what the proportions of each profession should be in the total mix of professions. It is therefore anticipated that the availability of some advice on these two factors would be useful.

The Size of Teams

The principal factors affecting the size of teams are as follows:

- The size of the hospital – number of beds
- The number of in-patient episodes of care for cancer and other principal life-threatening illnesses
- The annual number of deaths occurring in the hospital

There are 7 acute hospital trusts within the Network. Data has been collected in respect of available beds as follows. The data in respect of the other data items is not yet complete.

	Available Beds	
	Total	Acute
Isle of Wight Healthcare	499	307
North Hampshire Hospitals	458	403
Portsmouth Hospitals	1129	1024
Salisbury Healthcare	573	458
Southampton University Hospitals	1394	1212
Winchester & Eastleigh	538	364
Royal West Sussex	533	498

The ScHARR researchers made some fairly crude assumptions about the staff resources needed by Cancer Centres and Cancer Units. This differentiation appears now to have fallen into disuse. However it may still be useful to set out the ScHARR recommendations which are intended to be sufficient to achieve 9 to 5 working 7 days per week and to provide telephone advice 24 hours per day.

Cancer Centres

5 specialist nurses with a mix of H and G grades
 1.5 Consultants in Palliative Medicine
 1 WTE junior medical staff
 1 WTE social worker
 0.5 WTE physiotherapist
 0.5 WTE dietician
 0.5 WTE occupational therapist
 0.25 WTE pharmacist
 0.25 WTE chaplain

Cancer Units

2 specialist nurses at H grade with less than 600 beds (3 nurses for units with more than 600 beds)
 0.5 WTE consultant in palliative medicine
 0.5 WTE junior medical staff
 0.5 WTE social worker
 0.25 WTE physiotherapist
 0.25 WTE dietician
 0.25 WTE occupational therapist
 0.1 WTE pharmacist
 0.1 WTE chaplain

In this Network it may be sensible to staff the two larger hospitals as 'cancer centres' and the smaller hospitals as 'cancer units'. The outcome of that in staffing required would be as set out in the Table below.

Table 18**Specialist palliative care hospital support teams – estimated staffing requirements**

Profession	Isle of Wight	North Hampshire	Portsmouth	Salisbury	Southampton	Winchester	Royal West Sussex	TOTAL
Specialist Nurses	2	2	5	2	5	2	2	20
Consultants	0.5	0.5	1.5	0.5	1.5	0.5	0.5	5.5
Other medical	0.5	0.5	1	0.5	1	0.5	0.5	4.5
Social worker	0.5	0.5	1	0.5	1	0.5	0.5	4.5
Physiotherapist	0.25	0.25	0.5	0.25	0.5	0.25	0.25	2.25
Dietician	0.25	0.25	0.5	0.25	0.5	0.25	0.25	2.25
Occupational therapist	0.25	0.25	0.5	0.25	0.5	0.25	0.25	2.25
Pharmacist	0.1	0.1	0.25	0.1	0.25	0.1	0.1	1
Chaplain	0.1	0.1	0.25	0.1	0.25	0.1	0.1	1

Note: There is no available guidance for estimating the numbers of those who can provide psychological support at level 3 and above of the model recommended in Chapter 5 of the NICE Guidance.

SUMMARY OF MEDICAL STAFF REQUIREMENTS FOR ALL CORE SERVICE COMPONENTS FOR PEOPLE WITH CANCER

It may be useful to provide a summary of the medical staff requirements for the whole Network. Data from Tables 16, 17 and 18 has been amalgamated together with data from the section on Day Therapy.

Table 19**Network medical staff requirements**

Medical Staff	In-patient	Community	Day Therapy	Hospital Support	TOTAL
Consultant	3.7	3.75	1.0	5.5	13.95
Other medical	9.3	-	2.5	4.5	16.30
TOTAL	13.0	3.75	3.5	10.0	30.25

CORE SERVICES FOR PEOPLE WITH DIAGNOSES OTHER THAN CANCER

Table 4 provides estimates of the prevalence of problems in patients with progressive non-malignant disease within the Network. The estimated number of people with each problem ranges from about the same number as people with cancer to well over twice as many. Yet nationally only about 5% of all access to specialist palliative care services is by people with non-malignant disease. It is therefore probable that any expansion of services to provide increased access would be justified. On the other hand it would be grossly simplistic to argue that

the current core services for people with cancer should be doubled in size to allow access for the non-cancer group at a level comparable with that for cancer. There is currently little agreement, let alone evidence, about what models of service would be appropriate for the other principal disease or patient groups.

The best advice may in consequence be along the following lines:

- At least sustain current levels of access to services by people with non-malignant disease
- Develop ways of enhancing the palliative care knowledge and skills of the general health and social care workforce e.g. through implementing the Gold Standards Framework for other disease groups and introducing the Liverpool Care Pathway for the Dying Patient in all care settings
- Develop any discrete services incrementally in collaboration with other specialties e.g. cardiology, respiratory medicine

SUMMARY OF CORE SERVICE NEEDS

The core service needs are as follows:

1. A health and social care workforce that is knowledgeable and skilled in general palliative care.
2. The Gold Standards Framework or equivalent mechanism is operational in primary care across the Network
3. The Liverpool Care Pathway for the Dying Patient or equivalent mechanism is operational across the Network in all care settings.
4. The Preferred Place of Care model or equivalent is introduced into all care settings.
5. 93 specialist palliative care beds for people with cancer.
6. 46 specialist palliative care beds for people with non-malignant disease (this is a tentative assessment).
7. 45 community based clinical nurse specialists (this includes 2.5 WTE equivalent for non-cancer)
8. 500 day care places per week (this includes about 6% for non-cancer)
9. 13.95 consultants in palliative medicine together with 16.3 other medical staff
10. 20 clinical nurse specialists for hospital teams
11. A full range of other professional staff for each team for each core service as detailed in the NICE Guidance and reflected in the advice above.
12. Access to specialist beds, community teams and day therapy facilities reflects the differential needs of the 12 PCT populations.

PART 3 – MAPPING OF CURRENT SERVICES

INTRODUCTION

The mapping data about current specialist palliative care services has been obtained from the specialist providers through the Cancer Network Office. The data was collected onto a standard template and covers in-patient, community, day care and hospital support services.

In any data collection exercise several common problems arise. Some providers find it difficult to extract data from their records with the result that incomplete data is provided. Sometimes there is misinterpretation of the data item with the result that data from one provider may not be on the same basis as others. There may also be issues around data quality. To some degree all these problems have been present in this Network data collection. As a result a second round of verification of data was initiated with the agreement of the Network Palliative Care Group. Two providers have not yet completed this and consequently some problems remain. In cases where they do and where they may affect overall conclusions, this is highlighted in the text.

SCOPE OF THE MAPPING SURVEY

The survey has been restricted to the services that are the subject of assessments of need in Part 2 of this report i.e. specialist palliative care beds, specialist palliative community care, specialist palliative day care/therapy and specialist palliative hospital support. The survey has therefore excluded other discrete services such as out-patients and bereavement support. The Network will need to decide whether, at some stage, it wishes to undertake a mapping of such services as an adjunct to the survey contained in this report. In making such a decision it will need to take into account the fact that there is currently no guidance available on what volumes of these other services may be needed relative to population.

SPECIALIST PALLIATIVE CARE BEDS

There are 9 in-patient facilities in the Network that are listed in the Hospice Directory 2004 as providing specialist palliative care beds. They are:

- Countess of Mountbatten House in Southampton with 25 beds
- Oakhaven Hospice in Lymington with 8 beds
- St. Michael's Hospice in Basingstoke with 10 beds
- St. Wilfrid's Hospice in Chichester with 15 beds
- Macmillan Service in Midhurst with 12 beds (9 beds available to this Network)
- Salisbury Hospice in Salisbury with 9 beds (reduced to 6 beds Jul to Sep 2004) and (8.5 beds available to this Network)
- The Rowans in Waterlooville with 19 beds
- Earl Mountbatten Hospice on the Isle of Wight with 14 beds
- Countess of Brecknock House at Andover with 6 beds

The population of the New Forest PCT also has access to beds at the Macmillan Unit in Christchurch. The current access amounts to around 1.5 beds. There are therefore 119.5 beds in total with 116 available to this Network. In addition it is understood that the population of Blackwater Valley & Hart PCT also has access to beds located outside the Network in Surrey although this has not been quantified in this assessment.

The patient activity data is in respect of the most recent year for which data is available.

The Table overleaf summarises the data provided for each unit.

Table 20

Patient activity data – Specialist palliative care beds

	Countess Mountbatten	Oakhaven	St. Michael's	St. Wilfrid's	Macmillan Midhurst	Salisbury	The Rowans	Earl Mountbatten	Countess of Brecknock	TOTALS
Available beds	25	8	10	15	9	9	19	14	6	115
New admissions	457	153	140	265	135	156	?	?		?
Repeat admissions	142	52	40	104	111	72	?	?		?
Total admissions	599	205	180	369	246	228	458	471		2756
Ratio new to total	0.76	0.75	0.78	0.72	0.55	0.68	?	?		?
Length of stay in days	13.0	11.2	13.4	13.1	11.6	10.0	9.0	8.2		
Bed occupancy	86%	76%	72%	87%	86%	80%	70%	75%		
Admission ending in death	308	111	115	182	95	124	269	192		1396
Admission ending in discharge	301	85	66	170	147	103	192	275		1335
Death to discharge ratio	1.02	1.30	1.74	1.07	0.65	1.20	1.40	0.70		1.05
Age under 65	151(33%)	47(31%)	45(32%)	58(22%)	37(27%)	61(39%)	?152(34%)	?		551
Age 65 and over	306(67%)	106(69%)	95(68%)	194(78%)	98(73%)	95(61%)	?290(66%)	?		1184
Cancer diagnosis	457(100%)	148(97%)	133(95%)	245(97%)	122(90%)	155(99%)	?	440(96%)		1700(96%)
Other diagnosis	0(0%)	5(3%)	7(5%)	7(3%)	13(10%)	1(1%)	?	31(7%)		64(4%)

Notes to Table 20:

1. Earl Mountbatten Hospice and The Rowans have not provided data in respect of new patients
2. The Rowans Hospice data on age of new patients appears to be in respect of all patients..
3. The data for Midhurst is in respect of the 9 beds (out of 12) that are available to this Network
4. The data for Salisbury Hospice is in respect of 9 beds available and does include therefore the work undertaken for patients out of the area (about the equivalent of 0.5 of a bed)

General Comments

- The ratio of new to repeat admissions is fairly consistent for 5 of the units around 70:30. The national average is 73:27. The ratio for Midhurst at 55:45 is very much out of line and it will be important to discover the reasons for that.
- Length of stay varies by over 60% as between Earl Mountbatten Hospice at 8.2 days and 13.4 days at St. Michael's Hospice. It would be important to establish the reasons for this variation. The national average is 12.7 days.
- Bed occupancy at The Rowans (70%) and at St. Michael's Hospice (72%) appears low. The national average is around 75% and most observers would think that at least 80% should be achievable. Four of the Network's providers achieve that or a higher occupancy.
- Nationally around 52% of admissions end in death. The percentages for St. Michael's Hospice (64%) and The Rowans (58%) appear high and those at the Macmillan Service at Midhurst (39%) and Earl Mountbatten Hospice (41%) appear low by comparison. It may be important to establish the reasons for that e.g. is there a difference in casemix?.
- About two thirds of all patients admitted are aged over 65 which is line with the national average of 68%. However the proportions at St. Wilfrid's (78%) is particularly high
- Around 96% of access is by people with cancer which is line with the national average. However, access to Countess Mountbatten House is restricted to people with cancer, at Salisbury access by people with non malignant disease is less than 1% but at Midhurst access is at 10%.

STAFFING

The NICE Guidance on Supportive and Palliative Care made recommendations about the professional composition of the specialist palliative care team for in-patient care. The Table below shows how far the teams in the 9 in-patient units comply with those recommendations. The Table also provides details of the medical staff numbers (consultants and others) although it is not clear in some instances whether the level of consultant input stated is exclusive to in-patient care or not. The Table also gives the total numbers of nursing staff available as a ratio to available beds.

Table 21**Staffing – Specialist palliative care beds**

	Countess Mountbatten	Oakhaven	St. Michael's	St. Wilfrid's	Macmillan Midhurst	Salisbury	The Rowans	Earl Mountbatten	Countess of Brecknock	TOTALS
Consultants	1.6	0.36		1.4	0.6	0.4	1.0	1.0		6.36
Other medical	3.9	1.12	0.5	0.4	1.0	1.0	2.6	2.45		12.97
Nurses	33.39	13.02	16.8	26.48	18.4	15.91	32.6	26.8		183.40
Ratio of nurses to beds	1.34	1.62	1.68	1.77	1.53	1.78	1.72	1.91		1.66
O/Ts	Yes		Yes	Yes	Yes	Yes	Yes	Yes		
Physiotherapists	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		
Dieticians			Yes			Yes				
Pharmacists			Yes							
Social workers	Yes		Yes	Yes	Yes	Yes	Yes	Yes		
Chaplains	Yes		Yes	Yes		Yes	Yes	Yes		
Complementary therapists	Yes		Yes	Yes	Yes	Yes	Yes	Yes		
Admin support	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		

Note:

1. No information was sought from the providers about pharmacist input
2. It is common for some providers to be able to access professional support from the local hospital e.g. St. Michael's Hospice has access to Pharmacist, Social Worker & Dietician from North Hampshire Hospital, Salisbury Hospice receives dietician & chaplain cover from the hospital
3. Oakhaven states that although it does not employ dieticians, pharmacists, social workers, occupational therapists or chaplains, it does have access to them. There is however no indication of the source of that access or whether it is adequate.

4. Midhurst receives chaplain cover from the hospital
5. All of the providers benefit from volunteer support

General Comments

- Overall most units have access to most of the professions and therefore are reasonably close to compliance with the NICE Guidance. However, that should not be taken to mean that the volume of professional support is adequate.
- The ratio of nurses to beds varies between 1.34 at Countess Mountbatten to 1.91 at Earl Mountbatten. The average is around 1.6.
- The number of consultants appears high for the number of beds but St. Michael's Hospice has no consultant input and only 0.5 of other medical staff for 10 beds.

ACCESS TO SPECIALIST PALLIATIVE CARE BEDS

Providers of specialist palliative in-patient care were asked to supply an analysis of the PCT of residence of the new patients admitted to in-patient care. All providers managed to do that except The Rowans and Earl Mountbatten House (that was unable to distinguish between new and repeat admissions) and Countess of Brecknock House (that has not provided any usable data). Table 22 below contains that analysis.

Notes to Table 22

1. The numbers of different people gaining access to beds at Earl Mountbatten House and The Rowans have been estimated by assuming, in line with national averages that 70% of all admissions are new patient admissions.
2. The numbers of new patient admissions from outside the Network boundaries have been excluded from the calculations of the totals and percentages.
3. The numbers of new patient admissions where place of residence is unknown have also been excluded from the calculations of totals and percentages.

Table 22

PCT of residence of first admissions to specialist palliative care beds

	Countess Mountbatten	Oakhaven	St Michaels	St. Wilfrids	Macmillan Midhurst	Salisbury	Rowans	Earl Mountbatten	Christchurch	Countess of Brecknock	Total Patients for each PCT	PCT share of access to beds
Blackwater & Hart	2		15								17	0.9%
East Hampshire				16	32		137?				185?	9.4%
Eastleigh & Test Valley	110										110	5.6%
Fareham & Gosport	92						68?				160?	8.1%
Isle of Wight								330?			330?	16.7%
Mid Hampshire	67					1					68	3.4%
New Forest	23	153				23			29		228	11.5%
North Hampshire			125		17						142	7.2%
Portsmouth							115?				115?	5.8%
Southampton	163										163	8.2%
South Wiltshire						124					124	6.3%
Western Sussex				247	86						333	16.9%
Unknown				(2)			(1)				(3)	
Out of Network					(49?)	(8)					(57)	
TOTALS	457	153	140	263	135	148	320?	330?	29		1975	100%

General Comment

The percentage share of access will need to be compared with the ideal share of access as set out in the final column of Tables 16 above (see Part 4 of this report for that comparison).

SPECIALIST PALLIATIVE COMMUNITY CARE

There are nine specialist palliative care community teams.

- Countess Mountbatten Community Team
- Oakhaven Hospice Community Team
- Basingstoke Macmillan Service (combined with the hospital support team)
- St. Wilfrid's Hospice Community Team
- Macmillan Service, Midhurst
- Salisbury Community Palliative Care Team
- Portsmouth Specialist Palliative Care Team
- Macmillan Team, Earl Mountbatten House
- Countess of Brecknock House

There is also a Nursing Service at St. Michael's Hospice that provides 24 hour practical nursing care and cover/respite support for patients and carers in the community. It complements the Basingstoke Macmillan Service. Earl Mountbatten House also provides a 'Hospice at Home' service that complements the Macmillan Team service.

STAFFING

The NICE Guidance on Supportive and Palliative Care made recommendations about the professional composition of community based teams. The Table below shows how far the 9 teams comply with those recommendations. The Table also contains data about the numbers of nursing staff in each team.

Table 25

Staffing – Specialist palliative care community teams

	Countess Mountbatten	Oakhaven	Macmillan Service Basingstoke	St Wilfrid's Hospice	Macmillan Team Midhurst	Salisbury Hospice	Portsmouth SPC Team	Macmillan Team Isle of Wight	Countess of Brecknock	TOTALS
Consultant	1.7	0.72		0.7	0.2	0.5	1.0			4.82
Other medical	1.4			0.2		1.0				2.6
CNS	10	2.6		7	4.3	4.5	7	5		40.4
Other Nursing				0.6	1.4		0.5			2.5
Physiotherapists	Yes	Yes					Yes			
Occupational Therapists	Yes						Yes			
Dieticians										
Pharmacists										
Social Workers	Yes									
Chaplains										
Psychologists										
Admin support							Yes			

General Comment

- All the teams appear to have a long way to go before they can be described as multi-professional teams in compliance with the NICE recommended model.
- There is no consultant input into the service at Basingstoke or at Andover. There also appears to be no input into the Isle of Wight service but that may be an error on the data return.

PATIENT ACTIVITY DATA

Table 26

Patient Activity Data – Specialist Palliative Care Community Teams

	Countess Mountbatten	Oakhaven	Macmillan Service Basingstoke	St. Wilfrid's Hospice	Macmillan Team Midhurst	Salisbury Hospice	Portsmouth SPC Team	Macmillan Team Isle of Wight	Countess of Brecknock	TOTAL
New Patients	748	186		444	222	363	496	517		2976
Total Patients	1026	364		654	370	477	?	568		?
Deaths	677	153		397	231	260	306	301		2325
Age under 65	34%	26%		22%	31%	28%	28%	27%		
Age 65 & over	66%	74%		78%	69%	72%	72%	73%		
Cancer diagnosis	100%	98%		97%	91%	95%	96%	97%		
Other diagnosis	0%	2%		3%	9%	5%	4%	3%		

Notes:

1. Not all the teams have been able to provide data against all data items. A question mark indicates those items where no data is available.

General Comment

- The diagnosis of patients gaining access to most teams is around the national averages i.e. about 95% cancer and 5% other diagnoses. Countess Mountbatten however provides no access to people with diagnoses other than cancer but access to the Midhurst Team is around 9%.
- The 7 teams that have provided data are involved in the care of 43% of those whose deaths were due to cancer. The Isle of Wight Team is however involved in the care of around 70% of those who die from cancer each year
- The age of the patients seen is fairly consistent across all teams with about a quarter to a third of patients cared for being under 65 years.

TEAM AVAILABILITY

The NICE Guidance recommends that specialist teams are available to give telephone advice at all times and to undertake face-to-face assessments at home or in hospital, 9 to 5, seven days per week. The following table indicates the current availability of the nine teams.

Table 27

Team availability – Specialist palliative care community teams

	Direct Assessment 9 to 5 seven days per week	Telephone Advice
Countess Mountbatten	Mon-Fri only	Yes 24/7
Oakhaven	Yes	Yes 24/7
Macmillan Service Basingstoke	?	?
St Wilfrid's Hospice	Yes	Yes
Macmillan Team Midhurst	Yes	Yes 24/7
Salisbury Hospice	Yes (but emergency only 9-5 Sat & Sun)	Yes 24/7
Portsmouth SPC Team	Mon-Fri only	No
Macmillan Team IOW	Yes	No
Countess of Brecknock	?	?

General comment

- The pattern of team availability is variable across the Network with only 4 teams completely NICE compliant.

ACCESS TO SPECIALIST PALLIATIVE CARE COMMUNITY TEAMS

Each team was invited to provide an analysis of the PCT of residence of all patients gaining access to the team. That is given in Table 28 below.

Table 28

PCT of residence of patients in the care of specialist palliative community teams

	Countess Mountbatten	Oakhaven	Macmillan Team Basingstoke	St. Wilfrid's Hospice	Macmillan Service Midhurst	Salisbury Hospice	Portsmouth SPC Team	Macmillan Team Isle of Wight	Countess Brecknock	Total patients for each PCT	PCT share of access to teams
Blackwater & Hart	1		60?							61?	1.9%
East Hampshire				25	58		229			312	9.8%
Eastleigh & Test Valley	180									180	5.7%
Fareham & Gosport	184						61			245	7.7%
Isle of Wight								517		517	16.2%
Mid Hampshire	108					3			130	241?	7.6%
New Forest	43	186				52				281	8.8%
North Hampshire			70?		40					110?	3.5%
Portsmouth							206			206	6.5%
Southampton	227									227	7.1%
South Wiltshire						261				261	8.2%
Western Sussex				419	124					543	17.0%
Out of Network						(47)				(47)	
Unknown	(5)									(5)	
TOTAL	743	186	130?	444	222	316	496	517	130?	3184?	100%

Note to Table 28

1. No data has been received from the Macmillan Team at Basingstoke and the Countess of Brecknock House team.
2. The numbers in the Table for those two teams are estimates and therefore subject to verification as and when actual data is provided.

General comment

- The actual share of access is compared to ideal share of access in Part 4 of this Report.

SPECIALIST PALLIATIVE DAY CARE/THERAPY

There are eight providing organisations:

- Countess Mountbatten House, 36 places per week
- Oakhaven Hospice, 36 places per week
- St. Michael's Hospice, 30 places per week
- St. Wilfrid's Hospice, 45 places per week
- Salisbury Hospice, 24 places per week
- The Rowans, 48 places per week
- Earl Mountbatten Hospice, 75 places per week
- Countess of Brecknock House, ? places per week

There are therefore at least 294 places available per week across the whole Network.

STAFFING

The NICE Guidance on Supportive and Palliative Care did not make any specific recommendations with respect to the professional composition of the specialist day care team. However, Part 2 of this report does contain some guidance. The following table shows how far the existing services comply with that advice.

Table 29

Staffing – Specialist palliative day care/therapy

	Countess Mountbatten House	Oakhaven Hospice	St. Michaels' Hospice	St. Wilfrid's Hospice	Salisbury Hospice	The Rowans	Earl Mountbatten House	Countess of Brecknock House	TOTALS
Consultant	0.1	0.12		0.1	0.1				0.42
Other medical	0.2	0.28		0.1			0.2		0.78
CNS							1.0		1.0
Other nursing	1.7	1.4	0.72	1.2	1.08	3.05	1.86		11.01
Physiotherapists	Yes	Yes	Yes	Yes		Yes	Yes		
Occupational Therapists	Yes		Yes	Yes		Yes	Yes		
Social workers				Yes	Yes	Yes	Yes		
Dietician									
Chaplain	Yes		Yes						
Other staff e.g. complementary therapies	Activities Organiser Chiropracist Comp Therapist	Diversional Therapist	Diversional Therapist Comp Therapist						

General comment

- There appears to be no medical input into 2 of the day care services.
- There appears to be little input from clinical nurse specialists. This may indicate that some of the models of day care provision tend towards a social care model rather than a highly clinical interventionist model.
- Physiotherapy is available in 6 services, occupational therapy in 5 and social workers in 4.

PATIENT ACTIVITY DATA

Table 30

Patient Activity Data – Specialist palliative day care /therapy

	Countess Mountbatten	Oakhaven Hospice	St Michael's Hospice	St. Wilfrid's Hospice	Salisbury Hospice	The Rowans	Earl Mountbatten House	Countess of Brecknock House	TOTALS
Places per week	36	36	30	45	24	48	75		294
Places per year	1732	1800	1500	2250	1200	2496	?		10978
Attendances	1198	1285	1049	1715	990	1024	?		
% of places used	69%	71%	70%	76%	82%	41%	?		
Total number of patients	132	97	56	?	88	?	?		
Number of new patients	86	62	35	111	60	94	?		
Cancer diagnosis	100%	96%	80%	?	98%	?	?		
Other diagnosis	0%	4%	20%	?	1%	?	?		
Age under 65	26%	27%	31%	?	22%	?	?		
Age 65 & over	74%	73%	69%	?	78%	?	?		

Notes to Table 30

1. It will be seen that the day care services have not all been able to provide all of the data requested.
2. As a result the data is of limited value.

General comment

- Remarkably few new patients appear to benefit from the 5 day care services that have provided data – only around 350 per year. This is less than 7% of those who die from cancer each year.
- Take up of places at those 5 centres is uniformly quite high for this kind of service – 70 to 80%.

ACCESS TO SPECIALIST PALLIATIVE DAY CARE/THERAPY

Only 4 services have so far been able to provide any information about the place of residence of patients who access these services. Until the other 4 units are able to provide such information then it will not be possible to make any judgements about whether current access reflects the differential needs of the different PCT populations.

SPECIALIST PALLIATIVE HOSPITAL SUPPORT TEAMS

There are currently seven teams operating in the seven acute hospitals in the Network. Data about how they are staffed has been obtained from six of the teams and is set out in Table 31 below.

Table 31

Staffing – Specialist palliative hospital support teams

	Isle of Wight Healthcare Trust	Sothampton General Hospital	Portsmouth Hospitals	Royal Hampshire County Hospital	St Richard's Hospital	Salisbury District Hospital	North Hampshire Hospital	TOTALS
Consultant		1.1	1.0	0.5	0.4	0.5		3.5
Other medical		1.0						1.0
CNS	5.0	4.0	3.0	2.0	1.2	2.1		17.3
Other nursing			0.5		0.6			1.1
Physiotherapists			Yes					
Occupational therapists			Yes		Yes			
Dieticians								
Pharmacists								
Social workers								
Psychologists								
Chaplains								

General comment

- From the limited information provided only the Portsmouth Hospitals Team appears to have a core and extended team that approaches NICE Guidance recommendations.

PATIENT ACTIVITY DATA

Table 32

Patient Activity data – specialist palliative hospital support teams

	Isle of Wight Healthcare Trust	Southampton General Hospital	Portsmouth Hospitals	Royal Hampshire County Hospital	St Richard's Hospital	Salisbury District Hospital	North Hampshire Hospital	TOTALS
New patients seen	196	744	592	327	425	265		2549
Deaths	?	250	250	119	135	149		903?
Other discharge	?	488	328	285	290	293		1684?
Age under 65	17%	31%	27%	16%	20%	27%		25%
Over 65	83%	69%	73%	84%	80%	73%		75%
Cancer diagnosis	87%	92%	98%	95%	92%	94%		93%
Other diagnosis	13%	8%	2%	5%	8%	6%		7%

Notes:

1. The Isle of Wight has not been able to provide data about the outcomes of care.

General comment

- Nationally the proportion of patients seen who have a non cancer diagnosis is around 8%. The proportion across the Network at 7% is therefore in line with that although there is much variation around that average from 2% to 13%.
- The age of patients is fairly consistent across the 6 hospitals – around 75% across the Network. Those teams with a higher average of 80% or more e.g. St. Richard’s Hospital, are those that are serving older than average populations.

AVAILABILITY OF THE SERVICE

All six teams that have provided data have also given information about out of hours availability.

Table 33

Team availability – Specialist palliative care hospital support teams

	Direct Assessment 9 to 5 seven days per week	Telephone advice
Isle of Wight Healthcare Trust	Mon-Fri only	No
Southampton General Hospital	Mon-Fri only	Yes 24/7
Portsmouth Hospitals	Mon-Fri only	No
Royal Hampshire County Hospital	Mon-Fri only	Yes 24/7
St. Richard’s Hospital	Mon-Fri only	Yes 24/7
Salisbury District Hospital	Mon-Fri only	Yes 24/7
North Hampshire Hospital		

General comment

- None of the teams provide direct assessment and care at weekends.
- Two of the teams, at Portsmouth and the Isle of Wight, do not provide advice out of hours

GENERAL PALLIATIVE CARE SERVICES

There are three principal questions to which responses are required in the mapping process. They are as follows:

- To what extent has the Gold Standards Framework, or similar mechanisms, been introduced into primary care?

- To what extent has the Liverpool Care Pathway, or similar mechanisms, been introduced, particularly in the hospital setting?
- To what extent has the Preferred Place of Care been introduced?

Given that the implementation of the Department of Health's End of Life Care Initiative will have involved the Network in considering these questions, no separate collection of information has been undertaken.

PART 4 – COMPARISON OF SERVICES NEEDED WITH SERVICES AVAILABLE

SPECIALIST PALLIATIVE CARE BEDS

Number of beds

The needs assessment indicated that 93 beds would be needed for people with cancer and more tentatively 46 for people with other diagnoses. 116 beds are currently available.

At present it is estimated that 96% of current access to beds is by people with cancer (Table 22). That means that around 111 beds are currently available for cancer and 5 for non cancer. There are therefore 18 more beds available for people with cancer than are suggested by the needs assessment and a shortfall of around 40 beds for people with non-cancer when available beds are measured against the tentative assessment of 46.

CONCLUSIONS:

- **There is no case for increasing the number of beds available to the Network as a whole for people with cancer**
- **There appears to be a deficiency of up to 40 beds for people with other diagnoses**
- **Consideration should be given to making available more of the existing beds for people with non-cancer diagnoses.**

Access to beds by PCT of residence

Table 22 provides data about current access to beds by PCT of residence. This needs to be compared with the estimated ideal share of specialist palliative care resources contained in Table 16. The Table below provides that comparison. However a word of caution is required. As indicated in the introduction to Table 22 it is noted that 2 providers have not been able to provide the number of new patients gaining access to their beds and consequently notional numbers have been included in the Table. Furthermore Countess of Brecknock House has not so far been able to provide any usable data.

Table 34

Comparison of actual share of access to beds by ideal share by PCT of residence

	Actual share	Ideal share	Actual in relation to ideal share	Actual to ideal in % terms
Blackwater & Hart	0.9%	5.0%	-4.1%	-82%
East Hampshire	9.4%	8.6%	+1.2%	+14%
Eastleigh & Test Valley	5.6%	6.5%	-0.9%	-14%
Fareham & Gosport	8.1%	7.9%	+0.2%	+3%
Isle of Wight	16.7%	8.6%	+8.1%	+94%
Mid Hampshire	3.4%	6.5%	-3.1%	-48%
New Forest	11.5%	9.4%	+2.1%	+22%
North Hampshire	7.2%	7.2%	+0%	+0%
Portsmouth	5.8%	10.8%	-5.0%	-46%
Southampton	8.2%	10.8%	-2.6%	-24%
South Wiltshire	6.3%	5.8%	+0.5%	+9%
Western Sussex	16.9%	12.9%	+4.0%	+31%

The final column in this table shows the percentage variation (positive or negative) from the ideal share of access compared with actual access. The following should be noted:

- Blackwater Valley and Hart is provided with access to beds outside the Network. At present this has not been quantified but its current deficit of access is probably much less than is indicated by this Table.
- Actual share and ideal share is pretty much in balance for East Hampshire, Eastleigh & Test Valley, Fareham & Gosport, New Forest, North Hampshire and South Wiltshire.
- The disadvantaged PCT populations are Portsmouth and Southampton.
- Mid Hampshire appears disadvantaged. However, the in-patient data for Countess of Brecknock House has not yet been provided and as and when it is, it is anticipated that the deficit in current access will be much less than indicated.
- Isle of Wight, New Forest and Western Sussex appear to enjoy higher levels of access to beds than are indicated by their ideal share.

CONCLUSIONS:

- **For Portsmouth current share of access to specialist palliative care beds is around 45% less than needed and for Southampton 25% less than needed. For each Portsmouth that is the equivalent of a deficit of about 5 beds and for Southampton a deficit of about 3 beds.**

- **Current share of access to specialist palliative care beds for Isle of Wight is about twice more than is needed, for Western Sussex around 35% more and for New Forest about 20% more.**

Use of beds

There are some significant variations in the use of beds as evidenced by the patient activity data for each provider. These variations may be due to any one or several of the following factors: differences in admission and discharge criteria, differences in patient management, different casemix, exercise of patient choice, different levels of community support for patients at home. The variations that give rise to this conclusion are:

- Variations in the proportion of admissions ending in death as opposed to other discharge outcomes e.g. at St. Michael's Hospice the proportion is 64% but only 39% at Midhurst and 41% at Earl Mountbatten Hospice.
- Length of stay varies by over 60% as between Earl Mountbatten Hospice and St. Michael's Hospice – 8.2 days compared with 13.4 days.
- Bed occupancy is low at around 70% at The Rowans and at St. Michael's Hospice compared with 86/7% at three of the other units.

CONCLUSION:

There is a need for the Network to consider whether such variations are justifiable differences from what might be regarded as a common Network approach to e.g. admission criteria

Staffing

Medical staffing at consultant level appears to be more than adequate – on the basis of 114.5 beds within the Network and the recommendation in Part 2 of this Report 4.6 consultants are estimated to be needed compared with the 6.36 in post. That may be considered to be an even more generous allowance when taking into account that St. Michael's Hospice and Countess Brecknock House do not have any consultant input.

At more junior levels there is broad compliance with the recommendations in Part 2 of this Report – 12.97 medical staff are in post compared with 11.45 which would be recommended for the current number of beds. However, they are very unevenly spread and there are very few in hospitals at all.

With regard to nursing staff there is significant variation in the ratio of nursing staff to beds i.e. around 43% greater at Earl Mountbatten Hospice compared with Countess Mountbatten House. While some variation is to be expected, the extent of it is not and should be investigated.

The composition of the specialist teams complies to a large extent with the NICE recommendations. In the case of Oakhaven there is stated to be access to social workers, occupational therapy, chaplaincy and complementary therapies but the hospice does not employ these staff directly. There are deficiencies everywhere

(except Salisbury) for dieticians and there is no information available about the input of pharmacists.

CONCLUSIONS:

- **Medical staff provision for the Network as a whole at both consultant and other levels is more than adequate for the beds currently available but there is no consultant input at St. Michael's Hospice and at Countess of Brecknock House**
- **The variations in nursing staff ratios to beds are significant and consideration needs to be given as to whether they can be justified**

SPECIALIST PALLIATIVE COMMUNITY CARE

Staffing

Apart from the Macmillan Service at Basingstoke and the Countess of Brecknock House Team there is consultant input into all the teams. There is even some non-consultant input into three of the teams. The data from the Isle of Wight team indicates no consultant input but that may be attributed to a failure to apportion consultant time appropriately across core services.

Only the Countess Mountbatten House team approaches compliance with the NICE recommendations on the other professional composition of teams. It may be that in fact there is some access to other professions when needed. If so, it is suggested that that needs to be formalised so that the individuals who provide the service can be regarded as members of the community team. If there is no such access, then action will need to be taken to make good all the deficiencies highlighted in Table 25 above.

Numbers of Clinical Nurse Specialists

There are currently 40.4 nurses at Grade G and above that are employed in the 7 teams which have so far provided data. It is assumed that all these nurses are specialists in palliative care. The team at Basingstoke is a combined team serving both the community and the hospital and has problems in apportioning staff time between the two care settings. The team includes 3.9 nurses at Grade G and above. There appear to be a similar number of such nurses at Countess of Brecknock House but these need to be apportioned between in-patient and community services.

Taking all that into account it is estimated that there are around 44 nurses at Grade G or above who currently contribute to specialist palliative care community services. The need for such nurses as set out in Part 2 of this report is for 45 nurses (42.5 for cancer plus 2.5 to maintain current support of patients with non-malignant disease.)

PCT share of community team resources

In Table 16 above the ideal share of specialist palliative care beds for each PCT population is set out. The same percentage shares of resources can be used to indicate the ideal distribution of the assessed numbers of CNSs working in the community. Table 35 provides the detail of that distribution.

Table 28 provides data about current access by new patients to each of the teams by PCT of residence of those patients. The data is incomplete since there are two teams who have not yet been able to provide the relevant data. It is therefore not yet possible to indicate with certainty whether current access reflects differential need. However, until the relevant data becomes available, it is considered that some guide may be helpful. Accordingly, some assumptions have been made in Table 28 for those two providers about the numbers of patients seen and their PCTs of residence. Those numbers have been inserted into the fourth column of Table 35 and are identified by having a question mark attached to them.

Table 35

Share of community based clinical nurse specialists by PCT

	Ideal share of resources	Ideal share of CNS numbers	Numbers of new patients
Blackwater & Hart	5.0%	3	61(1.9%)?
East Hampshire	8.6%	4	312(9.8%)
Eastleigh & Test Valley	6.5%	3	180(5.7%)
Fareham & Gosport	7.9%	3.5	245(7.7%)
Isle of Wight	8.6%	4	517(16.2%)
Mid Hampshire	6.5%	3	241(7.6%)?
New Forest	9.4%	4	281(8.8%)
North Hampshire	7.2%	3.5	110(3.5%)?
Portsmouth	10.8%	5	206(6.5%)
Southampton	10.8%	5	227(7.1%)
South Wiltshire	5.8%	2	261(8.2%)
Western Sussex	12.9%	5	543(17.0%)
	100%	45	3184

If current access was reflective of the differential needs of each PCT population, then the percentages of ideal share in the first column would be expected to match the percentages in the final column.

There are 5 PCTs where there is rough equivalence – East Hampshire, Eastleigh & Test Valley, Fareham & Gosport, Mid Hampshire and New Forest.

There are 4 PCTs where there is considerably less access than would be anticipated – Blackwater & Hart, North Hampshire, Portsmouth and Southampton. In the case of the first two the data is subject to verification. As far as Portsmouth and Southampton are concerned there appears to be a genuine shortfall in anticipated access compared with actual access.

There are 3 PCTs where there is considerably more access than would be expected – Isle of Wight, South Wiltshire and Western Sussex. The numbers of patients expressed as a percentage of annual cancer deaths for these three PCTs are 122%, 94% and 78% respectively. The national average is around 40%. The Network average is around 60%.

Team availability

In Table 27 above the current availability of 7 of the teams out of normal hours is set out. This shows that Countess Mountbatten and Portsmouth need to extend their availability for direct assessment of patients to 9-5 at weekends. Portsmouth and the Isle of Wight Team need to extend availability to 24/7 for telephone advice.

CONCLUSIONS:

- **Consultant input is required into the teams at Basingstoke and Andover**
- **The numbers of clinical nurse specialists appear to be in balance with the recommended numbers**
- **Nearly all the teams have a long way to go in order to achieve compliance with NICE recommendations on professional team composition**
- **Access to community teams in Portsmouth and Southampton needs to be improved**
- **Out of hours availability for direct care and assessment and for telephone advice is patchy**

SPECIALIST PALLIATIVE DAY CARE/THERAPY

Number of places

There are currently at least 294 available day care places per week. One of the 8 providers has not provided any data as yet. The assessed need is for around 500 day care places per week. However, before considering whether the Network wishes to endorse such a recommendation it will be necessary for the Network to agree what the objectives of local service provision should be and what types of intervention should be offered. If access to day care/therapy across the Network is to be equitable then all providers would need to offer the same range of interventions.

Specialist team composition

There is some variation in current team composition at each provider. This may betoken equivalent variation in models of service. For example there is no medical input in 2 services, CNS availability in only one service, no social worker availability in 3 services. These variations reinforce the above advice for the Network to agree on what model (or models) of day care it wishes to see available across the Network.

Collection of data

As can be seen from Table 30 not all providers have yet been able to provide comprehensive data for all of the data items in the Table and therefore overall assessment of current facilities against what may be required is inevitably limited. However, the missing data could be picked up in the review recommended above.

Current access to day care

It has not been possible to ascertain whether current access to day care is reasonably equitable for each PCT population since only 4 providers have so far been able to supply data about place of residence of those who do gain access.

CONCLUSION:

- **It is recommended that the Network undertakes a review of day care with a view to deciding what model(s) of day care it wishes to see available to the Network population**

SPECIALIST PALLIATIVE CARE HOSPITAL SUPPORT

Team composition

Information has been provided by 6 of the 7 teams and is set out in Table 31. There appears to be no medical staff input at consultant level into the Isle of Wight team but that may be because there has been no apportionment of consultant time across the core services. The assessed numbers of consultants for the Network is 5.5 as compared with 3.5 available. The recommended number of other medical staff is 4.5 as compared with 1.0 available.

The numbers of CNSs total 17.3 from the 6 teams that provided information. It is therefore likely that the Network total will come close to matching the estimate of need at 19 CNSs.

As far as other membership of each team is concerned there appear to be major deficiencies as against the NICE recommendations. Only the Portsmouth team has a membership that approaches compliance with that advice. However, it may be that in fact there is access to specialists in the other professions but that the arrangements are not yet formalised sufficiently for the individuals concerned to be recognised as team members.

Availability out of hours

None of the teams provide direct assessment and care at weekends and two of the teams, Portsmouth and Isle of Wight are not available to provide telephone advice out of hours.

CONCLUSIONS:

- **Medical staff availability falls short of that recommended in the needs assessment**
- **The number of CNSs available is likely to come close to the recommended numbers**
- **There are major deficiencies in other professional team composition compared with NICE recommendations**

- **There are significant gaps in out of hours cover at weekends and in the provision of telephone advice**

MEDICAL STAFFING

Table 19 provided a summary of the Network medical staff requirements. The Table below provides a comparison between those requirements and the numbers of medical staff available. The numbers available are inserted in brackets.

Table 36

Network medical staff requirements compared with numbers available

Medical staff	In-patient	Community	Day therapy	Hospital support	Total
Consultant	3.7 (6.36)	3.75 (4.82)	1.0 (0.42)	5.5 (3.5)	13.95 (15.1)
Other medical	9.3 (12.97)	- (2.6)	2.5 (0.78)	4.5 (1.0)	16.30 (17.35)
TOTAL	13.0 (19.33)	3.75 (7.42)	3.5 (1.2)	10.0 (4.5)	30.25 (32.45)

It is clear from the above Table that the available numbers of both consultants and other medical staff are in excess of the recommended numbers. It should however be recognised that the actual number of beds available exceeds the recommended number for cancer by 23%. Consequently it might be expected that the actual numbers of medical staff apportioned to in-patient activity would be greater than the recommended number. In fact the numbers are 70% greater.

It is also noted that the apportionment of time of medical staff across the 4 core services is quite different from what is recommended.

CONCLUSIONS:

- **There appear to be adequate numbers of medical staff for the Network as a whole**
- **Given that there is no consultant availability in Basingstoke and Andover consideration should be given to making a distribution of available consultant manpower across the Network that may more nearly reflect the differential needs of the PCT populations.**

SUMMARY OF PRINCIPAL VARIATIONS BETWEEN CURRENT SERVICES AND ASSESSED NEED AND OTHER MATTERS REQUIRING CONSIDERATION

Specialist palliative care beds

1. A surplus of 18 beds for people with cancer and a deficit of up to 40 for people with other diagnoses.
2. Current access to beds does not reflect the differential needs of half of the PCT populations. Portsmouth and Southampton PCTs are particularly disadvantaged.
3. Variations in length of stay, bed occupancy and proportions of admissions ending in death require investigation.
4. Variation in ratios of nursing staff to beds requires investigation.
5. Deficiencies in team composition compared with NICE recommendations need to be remedied.
6. Consultant availability needs to be provided at Basingstoke and at Andover

Specialist palliative community care

7. Significant deficiencies in team composition as compared with NICE recommendations need to be remedied.
8. Consultant availability needs to be provided at Basingstoke and at Andover
9. The provision of around 44 clinical nurse specialists is comparable with assessed need for 45.
10. Access to community teams does not match assessed need in half of the Network PCTs. Portsmouth and Southampton PCTs are particularly disadvantaged.
11. Team availability outside normal hours does not yet comply completely with NICE recommendations.

Specialist palliative day care/therapy

12. A deficiency of around 200 places per week compared with the assessed need.
13. Variation in the models of service as between providers need to be reviewed and a Network view established about what models of day care it wishes to see available for the Network population as a whole.

Specialist palliative care hospital support

14. Significant deficiencies in team composition compared with NICE recommendations need to be remedied.
15. The numbers of CNSs appear to be at a level comparable to the assessed need for 20 nurses
16. Current medical staff input falls short of that recommended particularly at non-consultant level.
17. Significant gaps in out of hours cover at weekends and in the provision of telephone advice.

Medical staffing

18. A slight surplus of medical staff numbers compared with assessed need – 32.45 compared with 29.35
19. Distribution of medical staff numbers is concentrated in the south of the Network to the disadvantage of the population in the north.

Data Collection

20. The mapping survey has revealed that some providers have been unable to produce routine patient activity and other data in respect of the services they provide. The Network needs to consider what steps can be taken to ensure that in future all providers can provide such data.

August 2005