An Economic Assessment of Community Services at St. Vincent's Hospice

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EXECUTIVE SUMMARY

Purpose:	most recent strategy document, Our Future Plans 2014-19, defined the direction of service development at the Hospice during the last 4 years. In preparation for the next strategy, in acknowledgement of changes within the wider health and social care landscape, and against a background of increasing operational costs and decreased statutory funding, the Hospice Board of Trustees commissioned a review of the community services currently provided by the hospice. There was a recognition that future developments would need to be aligned to Scottish Government and Renfrewshire HSCP priorities. The first step in this process was the Community Review Project (CRP), the recommendations of which, in conjunction with the recommendations of a business review, were presented to the Board of Trustees in February 2019. Following this, Brona McGee (Director of Care) and Mairi-Clare McGowan (Consultant in Palliative Medicine), were instructed to carry out an economic evaluation of the community services, with the purpose of demonstrating how of its local community into the future in a sustainable manner. The Board of Trustees and Chief Executive Officer (CEO), Kate Lennon, supported an opportunity to participate in the RCN Demonstrating Value (Applying the principles of economic assessment in practice) programme. This report is the outcome of that process.

Structure:

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provide them, what the activity and outputs of these services were, who was being targeted (groups targeted) by these services, and finally, what were the outcomes/benefits.

In keeping with the findings of the CRP, it was agreed that the current structure would not fulfil the needs of the service going forward. After further discussion and refining of the scope of the project, two strands emerged:

Economic evaluation, using a cost-effectiveness approach of a Bereavement/Trauma Support Group compared with the current model of Bereavement/Counselling Support (CRP Recommendation 3).

Business case incorporating economic evaluation principles for a seven day CNS/Respite-Response(RR) Community Service (CRP Recommendations 1 and 4).

Summary:

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2. BACKGROUND

2.1. All of these issues mentioned above, come during a time when the demographics of Scotland show an ageing population. There are far more people living into their eighties, nineties and beyond than ever before. Along with this, there are many more people living with multiple co-morbidities, including dementia and frailty. In addition, at a time when resources are stretched, when government and the NHS tell us that hospitals are not the answer and that more care needs to be delivered in the community, the statistics still show that almost 50% of people are dying in hospital.

2.2. Against this background, ospice serves the population of Renfrewshire. In 2018, this was 177,790 people, with 2,015 deaths during that time[6] .At a conservative estimate, it could be expected that up to 80% of these deaths were unavoidable (NRScotland) and therefore there could potentially have been palliative care needs. This would give an approximate number of patients who could benefit from palliative care input at 1,612

2.3. During this same time period, accepted 165 referrals for our community nurse specialist team and looked after 114 patients in our inpatient unit (with a significant overlap between these two groups). Even accounting for the fact that there is a second hospice in Renfrewshire who will have been referred a different group of patients, it is clear that there are a large number of patients in Renfrewshire who died during 2018 and who were never referred to specialist palliative care services.

2.4. -19[7], defined the direction of service development at the Hospice during the last 4 years. In preparation for the next strategy, in acknowledgement of the issues de((w)13(it3(n)%ETBT1 51

Box 1 – Recommendations from the Community Review Project (CRP)

The following recommendations are proposed:

1. There is a clear sense from the survey results that there is a need for increased support at home in order to support patients and their families. This is supported by a previous project undertaken by the CNS team which highlighted that patients and families would benefit from a 7-day community service, but the support required need not be provided by a Specialist Nurse. It is recommended that a feasibility study is carried out, looking at the provision of a respite and response social model of palliative care.

2. It is recommended that there is further research carried out into methods of support the hospice could provide to carers. Again there was a clear sense that informal group

   group has not been high although the sessions have evaluated positively and research into potential barriers to this service is required.

3. It is recommended that a review of the provision of counselling and bereavement support is undertaken to understand the ways in which the development of these services

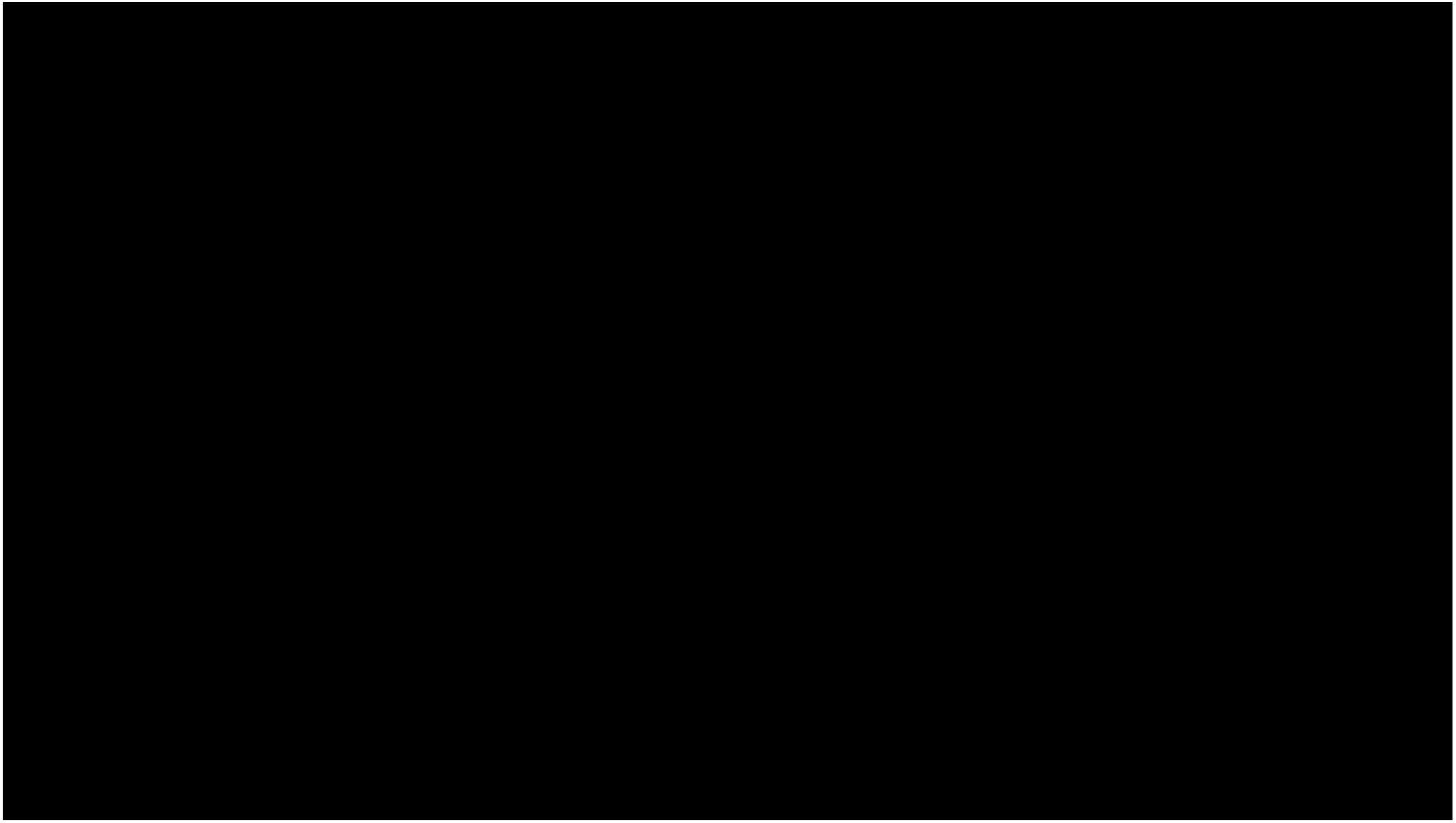
3. DEVELOPMENT OF THE ECONOMIC EVALUATION PROJECT

3.1.

d to provide them, what the activity and outputs of these services were, who was being targeted (groups targeted) by these services, and finally, what were the outcomes/benefits.

3.2. This process covered all of the services and staff provided by the hospice which primarily focussed on patients (and their families) still living at home. This included the

Figure 2



4.2. Pilot Study

4.2.1. This economic evaluation will take a cost effectiveness analysis approach to running a Living with Loss and Grief Group compared with one-to-one bereavement counselling. The assumption being made is that the benefit/outcome of seeing clients in a group setting will be equivalent to the one-to-one approach, but that access will be widened and more people will be able to benefit from the service. This new approach to bereavement support will also be in line with the SVH 2014-2019 Strategy and the recommendations of the Community Review.

4.2.2. The Living with Loss and Grief Group will run for an initial 8-week pilot. The Pathway to Outcome which maps this approach is shown in Figure 3. The sessions will offer exercises to be used at times when the participants are feeling drained, anxious and low. The tools are drawn both from ancient cultures and current research and include: Tai Chi exercises; Energy hold and finger holds to manage emotions; Emotional Freedom Technique; Head, neck and shoulder release; Acupuncture (without the needles) for pain and traumatic stress; and Visualisation.

4.2.3. The group will have 8-10 participants and will be led by the Hospice Counsellor. Support will be given by the Hospice Social Worker and 1 volunteer who has previously worked within the PFST. The impact of the sessions will be measured each week by participants scoring themselves against 15 symptoms of trauma, and by collecting comments both written and verbal. The Counsellor will continue to see additional clients on a one to one basis in the morning prior to the group session, and on their second working day. A comparison of the numbers of clients expected to be seen in the groups (plus the additional individual sessions) versus the figures for the most recent year of individual counselling, is shown in Box 2.

Box 2 – Capacity and Costs of Counselling Services

All salary costs are inclusive of Pension/NI as applicable based on SVH salary scales. Since 2018 there has been no pay rise within the organisation. NI is unchanged but there has been a 2% increase in pension costs

2018:	60 clients in total seen by 2 counsellors
Assume that:	Counsellor 1 sees 4 client sessions per day (lasting 1 hour each)
	Counsellor 2 sees 5 client sessions per day (lasting 1 hour each)
	Counsellors each see clients 2 days/week
	Counsellors run sessions over 40 weeks of the year
Therefore:	There are 720 client sessions/year For 60 clients they attend for an average of 12 sessions each
Cost of Counsellors:	Counsellor 1 - £16.79 per hr
	Counsellor 2 - £20.29 per hr
	Counsellor 1 sees 40% of clients and Counsellor 2 sees 60%
	Counsellor 1 had 288 sessions x £16.79 = £4835.52
	Counsellor 2 had 432 sessions x £20.29 = £8765.28

Total cost for 60 cliee1lssion

Pilot project:	8-10 clients to be seen in group setting over 8 weeks
Set-up costs:	Preparation 10 hrs (counsellor) = 10 x £17.14=£171.40
	Training 2hr (counsellor + social worker) = 2x£17.14+ 2x£21.57 = £77.42
Total set up costs = £248.42	
Assume:	8 clients per group
	Roll out to 5 groups run per year

death of a loved one, but may still be in a caring situation or indeed themselves have a

5. COMMUNITY SERVICES REDESIGN

5.1. Drivers

5.1.1. As discussed above, the demographi

5.3. Service Redesign

5.3.1. In redesigning the service, the authors were aware of the need to maintain the specialist elements of assessment, symptom control, advanced care planning and complex emotional support for patients in order to maintain the benefits described in section 5.2. However, we also need to increase our reach to the many people in Renfrewshire not currently accessing specialist palliative care (see section 2), widen the demographic of patients accessing the service (currently >90% are cancer patients), and further develop the range of support available to include hands-on practical support and carer respite (see CRP Box 1)

Figure 4


Activities & outputs
Groups targeted
Outcomes
Direct
CNS (Band 7) 1 WTE
CNS (Band 6) 3 WTE
Specialist Community Services:
CNS Home Visits
For intervention
Patients with life-limiting conditions who need specialist:
Staff outcomes
Are competent and skilled to deliver specialist service
Have high level of job

5.4. Benefit Comparison of Community Services

5.4.1. In order to determine wheth

d. Provision of practical/social support and carer respite increases the percentage of

referral to the hospice. For example, a patient may require a RR service to support them at home while a social services care package is being arranged, but may not have any symptoms or psychological needs which would traditionally have been the trigger for the GP or hospital team to refer to the hospice CNSs.

5.4.6. As a conservative estimate, we have assumed an increase in 30% of referrals to the CNS service and a similar increase in activity. Outcome measurements would include all of those detailed above, and in addition, would have the OACC measures embedded from the start, enabling them to more clearly identify specific outcomes for patients including the effectiveness of measures to control pain and other symptoms.

5.4.7. The comparison of the current and projected data for the community services is summarised in Table 1 below:

Table 1: Comparison of Data for Community CNS Services

Type of Data	Current Service (actual data 2018/19)	Redesigned Service (projected figures)

5.4.8. Please note, as stated above, that the figure quoted in Table 1 of 91% of patients dying at home or in homely setting, is based on a small sample size over 6 months only and cannot be assumed to be replicable. There are many factors which contribute to a lity of social care packages, complexity of symptoms etc., and for some patients, even with the best supportive care available, admission to hospital is the only viable (and perhaps even preferable) option. For all these reasons, and given that the current annual rate of deaths at home/homely setting in Scotland is approximately 52%, the authors have estimated that an 80% rate is an achievable target for our service.

5.4.9. It should also be noted that the data above assumes that there will be a 30% increase in referrals accepted to the service and that the pattern of support remains constant for all those patients (that is, the proportion of home visits/telephone consultations etc.).

5.4.10. The HCA-provided Respite/Response (RR) Service will run alongside the CNS service. Both will be managed by the Band 8a Community Services Manager (CSM). It is envisaged that patients will initially be holistically assessed by a CNS, with specific attention to symptom-control, psychological needs and advanced care planning (ACP). Patients thought to be requiring and appropriate for the RR service would then be added to the HCA caseload, which will be managed by the CSM.

5.4.11. To try to provide an estimate of the potential numbers of patients who might be referred and the benefits they might receive, we took the example of the Strathcarron Hospice @ Home Service. It is not directly comparable as that service concentrated mainly on referrals for patients in the last two weeks of life, but their five-year evaluation recommended broadening this remit which would bring it closer to the RR model we are considering. In the first year of their service they were referred 243 patients (and the number increased year on year throughout the five years of the project). These patients were in addition to referrals to their CNS Team. If we consider that this service covered a population approximately twice the size of Renfrewshire, we could assume that our service could potentially receive referrals for up to 120 additional patients per year.

5.4.12. In the Strathcarron model, patients were seen by HCAs (80% by 2 staff members at a time) for an average of one hour per visit (range 0.5-2.5 hrs). They provided support to patients including personal care, psychological support and non-medical symptom management as well as general discussions/relaxation techniques etc, and they also provided psychological support, discussion around family issues as well as allowing time out for family/carers.

5.4.13. The results of the Strathcarron model showed that patients using H@H who were at home 15 days prior to their death had a much-reduced rate of acute hospital attendance during that time compared to those with no H@H input (11 vs 46%) with no significant differences in case mix between the two groups. They were also less likely to have NHS24 activity (0.25 vs 0.4 contacts). In addition, patients with H@H were also more likely to have District Nurse (DN) involvement (100% vs 63.4%) suggesting that H@H patients were better linked into this additional support.

5.4.14. Although as stated above, the two models are not exactly comparable, the benefits that our patients could achieve through the new RR service are potentially significant. Gathering the evidence of the outcomes (as shown in the Strathcarron report) would need to be an integral feature of the service from conception onwards.

5.5. Cost Comparison of Community Services

5.5.1. The current running costs of the CNS Service are detailed in Box 3. Please note that the salary costs for the Band 7 Team Lead are included although this post is being held vacant at present.

Box 3 – Running Costs of Current Community CNS Team Service

5.5.2. The projected running costs for the Community CNS/Respite-Response Service are shown in Box 4.

Box 4 – Project Running Costs of Community CNS/Respite-Response Service

All salary costs are based on the mid-point of the appropriate NHS Agenda for Change (AfC) scales (2019/20) to give the most direct comparison with the current service costs. Please note it is recognised that this team is not currently active during this fiscal year, and further costs would be required in salary increases for 2020/21.

All salary costs included assumed 25% on-costs for pension/NI etc. and a 7% supplement for hours worked at weekends. Dedicated administration costs have also been built in to the service as this would help free up nursing time from administrative duties such as contact recording, would facilitate written communication with GPs and would provide support to the oad etc.

5.5.3. It can be seen from the data in Boxes 3 and 4, that there would be a projected shortfall in funding between the current service and the redesigned service. This would be in the region of **£236,787** and in all likelihood would be greater since the earliest such a service could feasibly start would be into the 2020/21 fiscal year. Costs for the current and future models would both increase, but since SVH salary scales do not match the NHS AfC scales, this would mean a bigger diversion in the costs, with a bigger projected shortfall next year.

5.5.4. However, it is important to see these additional costs against the benefits of the service (see section 5.4) including increased referral rates, increased numbers of patients accessing the combined CNS/RR Service, reduced hospital use in the last few weeks of life and increased likelihood of achieving a preferred place of death at home or in a homely setting. These benefits would also likely include a cost-saving in acute hospital usage although this should be considered against potential increased costs in the community (e.g. social carers, DN and GP involvement) as noted in the Strathcarron H@H report.

5.5.5.

6. DISCUSSION

6.1. The authors have attempted to evaluate two separate aspects of community services at -based economic principles.

6.2. The first was an evaluation of a pilot project being developed to provide group-based psychological support, with a view to scaling it up to a rolling programme throughout the year. Evidence informed an assumption that the benefits to clients of the group therapy would, in most cases, not be less than those receiving one-to-one counselling (with the proviso that group clients could be referred on to individual counselling if clinically indicated).

6.3. On this basis, a cost effectiveness analysis comparing group therapy, run alongside individual therapy by a single counsellor, versus individual therapy alone run by two counsellors, demonstrates that the combined group/individual service is a more cost-effective way to deliver this service, with the assumption that the quality of the service will not be affected.

6.4. The second aspect to this project was to compare the current Community CNS Service at the hospice with a re-

importantly, there would be an ability to look at how the service could be run across a wider area serving more potential patients.

6.8. Although on the surface there may not be any cost savings here, in reality, it might be possible to run the service 7 days a week across a wider area with less than double the number of staff (remembering that our model was based on the minimum number required to cover all the shifts rather than the optimum number to provide the service to

7. RECOMMENDATIONS

7.1. The authors put forward the following recommendations for consideration:

a. The Group Therapy pilot should be supported, and if positively evaluated, should be fully rolled out.

b. The Group Therapy model should be extended to support the development of other Group-
Carers Support, Wellbeing/Symptom Control, and Therapeutic Groups such as Music or Art Therapy, and could potentially be developed in partnership with other local organisations (e.g. Renfrewshire Carers Centre). An economic assessment of each of these proposals would be recommended before proceeding.

c. The development of the Community CNS/RR Service will be the preferred model moving forward. As it currently stands, it does not appear to be financially viable within current resources. However, given the scope of the benefits described within this report, the authors believe it is imperative that the hospice exhausts all efforts to find a sustainable funding solution.

d. Following recommendation C consideration should be given to the following options:

Option 1

tutory/trust funders with a proposal for the new service, looking to access sufficient funds to bridge the current gap and building increasing costs into the application for a minimum of three years.

Option 2

anisation (e.g. a neighbouring hospice) with a view to developing a joint model, taking into account all of the potential benefits to patients and carers in our Community as previously detailed.

I and benefits would be reassessed based on the combined resources of the organisation and the needs of the wider population encompassed by the services.

This case study was completed by Brona McGee, Director of Care and Mairi-Clare McGowan, Consultant in Palliative Medicine, St Vincent's Hospice, Howwood in 2019. Brona and Mairi-

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