Making informed economic choices about future funding of bed days in a Hospice specialist palliative care unit.

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Why this project?

- **Our Inpatient Unit is increasingly acute, with more complex and dependent patients.**
- **Our staffing levels are struggling to meet the needs of this patient group, sometimes unable to take admissions due to patient dependency**
- **Review of the IPU using Hurst and Roberts 'adapted acuity workforce planning tool' confirmed this acuity and pressure on staff.**
- **We need to undertake a refurbishment of the IPU and within this consider number of future beds.**

What needed to be considered?

- **Wider service needs- the IPU costs 50% of the total Patient Care budget.**
- **What our patients and families have told us they want- single rooms.**
- **What workload was achievable for the IPU team without investing in significant staff increases/costs.**
- **Recruitment to the IPU.**
- **Quality of care and staff welfare.**
- **Review of data e.g., occupancy, turnover, length of stay.**

What did the EA Course enable?

- An introduction and understanding of economic language.
- An understanding of economic principles, e.g. direct costs/indirect costs, set up costs vs running costs.
- An understanding of the different approaches available.
- The need to consider wider stakeholders
- An understanding that costs/benefits are both quantitive and qualitative and both are needed to 'tell the story', it is not just about direct monetary values.
- How to demonstrate benefits in a succinct way.

What were the outcomes of the project?

- By reducing the current beds from 6 shared and 6 single (18) to 15 single rooms, we could actually increase occupancy and reduce costs per bed day.
- A further spend of £271, 982 on staff and overheads would enable 15 single rooms to be adequately staffed at a higher occupancy rate than currently.
- This increased occupancy rate would mean that costs per bed day and therefore per admission would decrease.
- Single room status would enable admission regardless of gender or infection risk, which increases current available bed days.

What have been the benefits?

- **This work has directly fed into our strategic planning and we now plan to refurbish our IPU to 15 single rooms in 2017.**
- **Encouraged cross team working between clinical and financial teams and reinforced the benefits of this approach.**
- **I am able to look at other project set ups and critique them in a much more knowledgeable way.**
- **QIPP and Pathways to Outcomes models are very useful to demonstrate wider benefits to internal and external stakeholders.**

Making informed economic choices about future funding of bed days in a Hospice specialist palliative care unit. (Benson 2015)

Inputs

Investment
Increasing specific MDT staff groups to maximise bed days on an Inpatient Unit.

Resources required
› **Proposed staff increases:**

4 x Band 5 RN's

3 x Band 3 HCA's

1 x Band 2 HCA's

1 x Band 6 Social worker

5 hours increased Band 7 pharmacy input per week.

› **Supplies/equipment**

Clinical supplies and medication

› **Support services**

Proportional increase in costs related to Education, HR, Payroll, IT services.

Total operational costs
Increased costs of £271,982

The Service

Purpose of service
› Specialist palliative care inpatient beds- 79% charitably funded.

›Patients admitted from home or transferred from hospital.

Improvement opportunity
› To increase bed days by increasing the numbers of nurses who are currently unable to meet demands of patient acuity and dependency when the Inpatient Unit has high occupancy levels.

› To respond to increased demand for specialist palliative beds due to local bed closures.

› To make service as cost effective as possible.

›To maximise use of other MDT staff who have capacity to meet increased bed days.

Summary of Benefits

For service users
› Increased opportunity of bed availability.
› Increased opportunity of accessing specialist palliative care.
› More patients dying in preferred place of care.

For St Peter's Hospice
› Bed days increased by 679 per annum (↑12%).
› Potential for 54 more admissions per annum (↑14%).
›Anticipated admission costs reduced by £556 per stay.
› Decrease in cost per bed day (↓ £42.65).
› Service running at increased productivity- best use of charitable funds.
› Better use of MDT resources.

For other local services
› Reduced hospital admissions.
› Increased transfers from hospital.
› Releases intense primary care resources to be used for other patients with less complex needs.
› CCG's get increased patient care for their 21% investment.

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Thoughts for the future…

- **Development of an economic assessment module for senior clinical staff.**
- **General financial awareness training integrated into pre registration training.**
- **Easy read literature available to support learning.**
- **Organisational drive to ensure a collaborative approach between clinical and financial teams.**

The full case study of this economic assessment is available from:

https://www.rcn.org.uk/professional-development/research-and-innovation/innovation-in-nursing/building-nursing-capability-in-economic-assessment/chris-benson