Economic Evaluation of community services:

A feasibility study: an economic evaluation of service delivery; providing a seven-day service from a community specialist palliative care team based at Ayrshire Hospice, covering all areas of Ayrshire and Arran

By Margaret Cassidy, Community and Day Services Manager, Ayrshire Hospice

Background

The Strategic Framework for Action states that by 2020 all people in Scotland who require palliative care will have access to it (identifying role of specialist palliative care).

A clinical services review was completed in June 2018 in order to identify whether the Ayrshire Hospice was meeting the needs of the local community. Gaps were identified in access to and provision of specialist palliative care out of hours, noted by patients and carers, stakeholders and staff although evidence was sporadic.

Further evidence is required in order to ascertain the level of unmet need; how and who it will be addressed by; identify the cost consequence and determine whether it will add value.

This paper aims to explore the impact of a seven-day service for patients and families as well as other professionals, alongside the competing demands of overall caseload management.

Method

A combination of quantitative and qualitative data will be examined in order to review the current provision of hospice services and advice available to patients and families within the community over the weekend.

In order to provide a benchmark for this study, comparison will be made with the seven-day clinical nurse specialist evaluation carried out at Edinburgh Marie curie and St Columba's Hospice, which was implemented April 2016 - March 2017.

Demonstrating Value

The overarching aim of this project is to demonstrate the value of community services provision from the Ayrshire Hospice and to carry out an economic assessment as set out in the HM Treasury Guidance. This assessment will determine the value of seven-day service provision, outlining the potential benefits to all concerned as well as monetising the costs.

In order to get started, creating the pathways to outcomes (Appendix 1) is a way of mapping out the service from a whole systems perspective. This then leads to identifying, quantifying and monetising the costs of set up and running the service, (Appendix 2). Further costings and potential benefits of the service will be discussed and demonstrated throughout this study.

Introduction

The Ayrshire hospice undertook a clinical services review throughout 2018; an independent research company was employed in order to adopt a non-biased approach. The research consisted of qualitative in-depth interviews with patients and carers, focus groups with staff, and an on-line survey of stakeholders followed up with qualitative in-depth telephone interviews. Stakeholders and staff made frequent reference to improvements in the referral process with the introduction of the triage service. There was reference to out of hours services in the community from stakeholders as well as patients and families, "development of community work required"; "faster response times for pain relief at weekends"; " advice line required 24/7"; "out of hours accessibility"; "more community based care, round the clock availability of care".

In response to this review, it is anticipated that a seven-day community specialist palliative care nurse service would go some way to addressing the perceived unmet need. A review of literature would appear to support this theory, Living and Dying well, (Scottish Government, 2008) highlights concerns around the availability of out of hours care for palliative care patients and their carers in Scotland. Melin-Johansson et al (2010), suggested that specialist palliative care in the community has been shown to improve quality of life for patients. District nurses tend to focus on practical issues, whereas clinical nurse specialists' discussions emphasise psychosocial factors for patients and families; overall inadequate out of hours support may contribute to unwanted hospital admissions, (O'Brien and Jack, 2009). Fergus et al (2010) recommend that, "certain patients with complex needs should be allowed to bypass NHS24 to access specialist services".

There is clearly evidence available to support the need to expand community services in order to improve delivery of care to patients and families at weekends, however, there will clearly be resource and cost consequences as a result; in the current financial climate, this requires careful consideration. This paper will endeavour to explore the potential for the hospice to deliver a seven-day service in the Ayrshire community, examining existing services and perceptions of staff and stakeholders. However, it must be emphasised that the proposal to provide this service is by redeploying the current SPCN establishment over seven days.

Current community service provision

Community services based at The Ayrshire Hospice comprises of nine specialist palliative care nurses (SPCNs) band 6 (x8 1.0, x1 0.8 WTE) and one staff nurse band 5 (0.8WTE), two triage nurses band 6 (1.0, 0.6 WTE) and a respite and response service (1.0 WTE co-ordinator band 5 and eight care assistants band (3 x3 1.0, x3 0.8, x2 0.6 WTE). SPCNs rotate into the triage service 2 days every week. All referrals are now managed through triage, which has centralised and streamlined the process to make it much more efficient. The triage nurse scrutinises all referrals, gathering relevant information before contacting the patient to carry out an initial telephone assessment. Patients may decline input or may not be progressed any further if they do not fit the referral criteria. Follow up will then be prioritised to the most appropriate part of the service; as a result, caseload numbers have reduced, releasing time to care for patients and families with the most complex needs.

Community specialist palliative care nurses (SPCNs) and triage nurses work Monday to Friday, the respite and response team work seven days per week, therefore there is inequity in service delivery. Currently, SPCNs will highlight patients whom they feel may require additional support at weekends to the respite and response team, mainly patients who are approaching end of life and their wish is to be cared for at home. However, the respite and response team also support patients who may be

on the waiting list for admission to the hospice in-patient unit (IPU) until a bed becomes available as well as patients discharged from hospital. The team are supported by the charge nurse in the IPU at weekends whom they will contact for advice if the patient has uncontrolled symptoms or there are additional complexities identified. The charge nurse may involve the medical team and may contact the GP/district nurse out of hours should medication require changing or prescribing.

Evidence to support gaps in current weekend service provision through unplanned responses

From January – November 2019 the Respite & Response team have captured information in the form of case studies for unplanned response visits at weekends to patients and families on the community caseload where input has been requested following calls to the hospice for additional advice or support. On review of twelve case studies, the following four examples illustrate where there was a potential need for input from SPCNs at weekends, whereby services could have been improved.

Case study 1

Initial call was from a carer to the charge nurse in IPU relating to an unexpected deterioration in his wife's condition, she was unable to transfer to the toilet and her husband was struggling with her care needs. The respite and response team were able to provide support and hands on care appropriately as needed. However, there were also issues with the patient's medications, which had not been fully addressed by the district nurse, the care assistant could not address these issues at the time but she passed this information on to the SPCN on Monday morning who carried out a home visit effectively that day. If the SPCN had been on duty Saturday/Sunday they could have worked together to meet the needs of this patient timeously and more efficiently, therefore, improving symptom management and reducing patient and carer distress.

Case study 2

A family called IPU for advice regarding their father whose condition had deteriorated overnight, he was very agitated and unsettled and was approaching end of life. A home visit was initiated by the hospice consultant (who had previous involvement in hospital), who assessed the patient and liaised with the out of hours GP and district nurses to set up a subcutaneous infusion with medication required to manage the patient's symptoms. The respite and response team also visited and provided care at end of life, supporting the family, staying with them until their father died peacefully at home as was his wish. The SPCN had been visiting regularly; if she had been on duty there would have been continuity of care, she could have given the advice and support required as opposed to a consultant having to leave a busy in-patient unit. This would also have been a more effective use of more appropriate resources.

Case study 3

IPU charge nurse received a call from a family following discharge from hospital, family upset and emotional, struggling to cope with the patient's condition. Respite and response team offered to visit to provide support. On arrival, the patient appeared anxious and breathless, he was also

complaining about pain; his wife was concerned about his medication and had many questions relating to this. The care assistants listened and reassured, they carried out personal care, offered practical advice, position change and non-pharmacological interventions to aid comfort. Both patient and his wife appeared to relax and became calmer because they felt listened to and supported. However, there were some issues with symptom management and the medication required to be reviewed. The respite and response team reported this to the SPCN on Monday morning and a home visit was arranged to carry out a holistic assessment and review of medication. If the SPCN had been on duty at the weekend, this assessment could have been carried out sooner and better symptom control could have been achieved.

Case study 4

Telephone call from patient's daughter to IPU at weekend, asking to speak to SPCN as mum appeared unwell. The staff nurse in the ward passed the patient on to the respite and response team who arranged to review the patient on a home visit. The patient did not want a GP to be called, as she was worried about being admitted to hospital. On arrival, the patient was very uncomfortable in her chair and required assistance to transfer to her bed. The patient was nauseated and had been vomiting; she complained of dizziness and felt hot to touch. The respite and response team advised that a GP review would be advisable and made the call on behalf of the family. They also provided personal care when the patient was incontinent and left the patient feeling more comfortable. A GP visited and prescribed anti-emetics, unfortunately her symptoms did not fully settle and a GP was called again the following day who changed the oral medication to a subcutaneous infusion. If an SPCN had been on duty, the patient could have been assessed and medication may have been prescribed more appropriately, therefore alleviating symptoms timeously. Two GP visits out of hours may also have been prevented if the SPCN had visited and liaised with out of hours GP.

In summary

At present the respite and response team, (band 3 care assistants) work over seven days. At weekends, they provide response visits only. These visits are usually planned on a Friday, and generated from internal referrals from the community SPCN, IPU staff if required on discharge home and potentially from the hospital palliative care team. This may include patients discharged from hospital usually requiring support at end of life, often compassionately in the last days of life; or to provide additional support or personal care in the short term (5 working days) until a social care package is in place. However, the respite and response team may also respond to requests for unplanned visits out of hours.

These case studies demonstrate examples of Response visits, which may have benefitted from SPCN input, had that service been available. In most cases, a combination of both services would have worked really well and would have addressed the immediate care and support needs for patients and families. In some instances, it may also have prevented another professional from becoming involved in the patient's care therefore managing resources within primary care. As these patients and families are already known to hospice services, there is more likely to be continuity of care and a consistent approach to assessment. Patient information is documented in the electronic system, which can be accessed by all clinical staff within the hospice.

Calls out of hours/weekends for advice

Nursing staff in the in-patient unit receive calls from health care professionals, (GPs and district nurses) as well as from patients and families looking for advice. These may be related to care needs, symptom management and medication issues or changes. The charge nurse on duty who may consult with medical staff if required manages the majority of these calls. Whilst the charge nurse is more than capable of giving advice, these calls can be quite time consuming, particularly when patients and families may require a lot of support and reassurance. This results in taking the charge nurse away from patient care when the in-patient unit may be extremely busy. Currently, follow up in the community cannot be offered from a specialist palliative care perspective as no SPCN on duty.

An audit of the calls to IPU at weekends was carried out over a period of 12 months in order to determine the number of calls received and by whom, time involved and the response required which could have been addressed by an SPCN on duty. From a cost perspective, it is important to recognise the use of current resources, monetising the time involved by the charge nurse in IPU and reducing the time to care for patients in the unit as well as supporting nursing staff in direct patient care.

Calls to IPU analysed over a 12-month period (1 Nov 2018 – 31 Oct 2019)

Calls received from	No	Reason	Action	Time & cost involved
Patients	39	Symptom control, advice & support, equipment	Advice given by CN, input from R & R	Band 6 at £23/hour Average call and follow up calls + documentation 1 hour £23 x 39 = £897
Carers	55	Advice & support, care needs	R & R input IPU admission	£23 x 55 = £1,265
GPs	10	Medication issues, S/C	Advice in setting up CSCI/changes	£23 x 10 = £230
District nurses	10	Symptom advice, additional care needs	Advice re medication R & R input	£23 x 10 = £230
ANPs	2	S/C medication	Medication advice	£23 x 2 = £46
Hospital medics	5	Mainly medication	Advice given by CN/ potentially supported by medics	£23 x 5 = £115
Total calls	121			£2,783

Discussion with charge nurses

IPU charge nurses feel that there would be significant benefits to patients and families who are seeking advice/support at weekends if there was an SPCN on duty as they would be dedicated to dealing with these calls and be more likely to respond timeously. Charge nurses may have difficulty in doing this, as may be dealing with a number of different issues, which take priority. They also feel that SPCNs have a better understanding of community-based services, systems and processes as well as contact details for primary care staff. SPCNs also have a better awareness of the community caseload, therefore providing a degree of continuity; they work closely with the respite and response team and would be able to support them in the community more readily.

There is currently a significant resource implication for IPU staff and the charge nurses in particular as they may be continually interrupted by calls which takes them away from carrying out their role. As the IPU is the only part of hospice services in operation at weekends, the charge nurse has full responsibility for managing all services including catering and housekeeping staff, maintenance and facilities staff, volunteers within the unit as well as those at reception. They often have to deal with unplanned requests from bereaved carers or prospective patients asking to be shown round the unit or perhaps dropping in to give a donation following admission. They have management responsibilities to deal with such as planning off duty, timesheets, PDRs, investigating incidents and managing staff absence. They may also be involved in managing direct care for complex patients as well as supporting junior staff to do so, this could be compromised if staff do not seek them out if busy dealing with calls. Ultimately, it would be a much better use of this resource if it could be redirected in this way.

Additional benefits highlighted were the opportunity for greater integration of the SPCN team with IPU staff, increasing awareness of one another's role, as well as team building. The charge nurses felt it would be helpful if the SPCN were based in the MDT room in IPU at the weekend, which is where the respite and response team base themselves currently. The SPCN would then buddy the respite and response staff, also relieving the charge nurse of the responsibility for lone working.

Discussion with medical staff

Benefits to patients/families: Medical staff felt the main benefits of having SPCNs on duty over the weekend for patients would be the ability to make more changes to medication where required on a Friday, rather than waiting until a Monday based on the fact that there is no current follow up arrangements in place (eg initiating a Fentanyl patch). Therefore, changes are made faster, potentially improving symptom control for patients more timeously. They are aware that there are often crises calls from patients, families and professionals, requiring a more detailed assessment. The respite and response team are recognised for their input in these circumstances but they are limited in the level of assessment which could be carried out by a specialist nurse. The medical team would clearly trust and value the SPCN assessment, although recognised that IPU admissions may be decreased or increased as a result. They felt it would be important to establish criteria, clarify the role and boundaries, before introducing to stakeholders.

Benefits to others: District nurses already work closely with SPCNs in the community, therefore medics felt they would call for advice more readily, knowing they have a community perspective. This may enable the DN to be more proactive in seeking advice and feel less daunted when speaking to peers as opposed to a consultant. They felt IPU charge nurses would be freed up to carry out their role and that there may be less demand on medics to give advice, although happy to maintain

support. They felt the respite and response team would benefit from additional support from their community colleagues. It was also considered that there may be less need for out of hours calls from GPs.

Impact on SPCNS: main thought was how caseload management would be affected having two days off during the week, although recognised that that with a team rota this would not be too frequent.

Any influence on practice: decision making on a Friday reiterated, felt the handover on Fridays and Mondays was really important, therefore days off then should be avoided. Concerns about raised anxiety if long periods in between weekend rota.

Feedback/consultation with district nurse team leaders

Attended Ayrshire area wide team leader meeting where there was representation from North, South and East Ayrshire. They clearly feel that they provide a high standard of palliative care to patients and families in and out of hours. The district nursing service operates over 24 hours with provision of services day, evening and overnight over seven days. Weekend services are rotational and input to palliative care patients will account for a significant number of home visits.

There was acknowledgement that district nursing teams had a good working relationship with the hospice and worked closely with the community SPCNs in particular. They also felt that advice provided by the hospice nursing and medical staff at weekends was beneficial and, in many ways, adequate, although had not considered that this had an impact on delivery of care in the IPU. They valued input from the respite and response team for patients and families at weekends and acknowledged that continuity provided by the community SPCN would be beneficial.

They were unsure about the potential impact of SPCN availability over a weekend on the prevention of avoidable hospital admissions, as they felt they already had this covered. However, they recognised that some GPs would be more likely to arrange admission, particularly when they did not know the patient/family. Overall, they appeared to be reasonably receptive to the suggestion that SPCN input at weekends may enhance patient care and were keen to maintain good communication and develop further partnership working.

Discussion with the Respite & Response team

The team currently seek advice and support from the charge nurse on duty in IPU, they would also not hesitate to contact a district nurse or GP if they felt this was required. However, they felt that an SPCN on duty at weekends could enhance care for patients and families, particularly from a specialist assessment and symptom management perspective. They also felt that SPCNs could provide continuity of care for patients and families as they have knowledge of the community caseload and a consistent approach to care in the community.

On occasions the respite and response care assistant has been asked to assess a patient's need for IPU admission at the weekend, the majority of the team felt out-with their comfort zone and anxious about making these decisions which would not normally be expected of their role, therefore the support of the SPCN would be most welcome in these situations.

Discussion with the SPCN team

In order to fully appreciate the thoughts of the community SPCN team in anticipation of piloting and potentially implementing a seven- day service, mainly one to one interviews were carried out using the following headings as a topic guide. Responses were then themed in order to capture the salient points.

1. Benefits to patients and families:
    - Continuity of care and a consistent approach
    - Specialist holistic assessment using knowledge and expertise
    - Follow up calls to patients where there are concerns
    - Reassurance from SPCN, trust and confidence in the role
    - Support Friday discharges and referrals triaged as urgent
    - May prevent need to call GP OOH
2. Benefits/impact on other teams
    - DN – access to SPCN support and advice over seven days. Consistent approach, familiarity and trust, therefore may contact more readily. Opportunity for joint visits
    - GP OOH – guidance in symptom management, may prevent GP visit, could also increase their workload
    - Charge nurses – free them up to carry out their role, releasing time to care. SPCN knows more of the community patients, systems and processes. SPCN available to review and visit, assess for admission/add to waiting list if required
    - R&R – Support particularly for patients with symptoms. Build on existing relationship, providing support and guidance as well as confidence building. Opportunity for joint working and free up team to see other patients
    - Medical staff – may be less interruptions, need to clarify role and boundaries
3. Implications for SPCN/team
    - Days off during the week may limit home visits offered to patients
    - Impact on caseload management, more pressure on colleagues
    - Attendance at GSF meetings, education and other meetings
    - Triage rota involves 2 days out of caseload already so need to take into consideration when planning weekend rota
    - Mixed feelings for and against planned visits to patients on caseload
    - Less peer support/opportunity to work with peers in other areas
    - Opportunity to catch up with other aspects of role
    - Days off during week seen as an opportunity for some
4. Influencing practice
    - Specialist review at weekend to patients where changes have been made
    - Changes made to medication on a Friday more readily, not all agreed with this
    - Ability to respond at weekend to patients and families who are struggling
    - Robust handover to SPCN colleagues on Fridays
    - Increased challenge at weekend geographically and to patients not known
    - Opportunity to develop assessment skills and learn from colleagues
    - Opportunity to link with OOH services, possibly be based alongside them
    - Contact details for all services including available palliative care pharmacies
    - Potential to undertake nurse prescribing role, systems and processes would require updating to enable clear communication and minimise risk

Costings of current Ayrshire Hospice community service/future potential 7-day service (Based on the same formula used at St Columba's/Marie curie hospices)

Top of band 6 total costs per SPCN	=	£44,658
Daily cost (£44,658/52/5)	=	£172
Daily cost Saturday (£172 + 30%)	=	£223
Daily cost Sunday + PH (£172 + 60%)	=	£275
Annual Saturday costs (£223 x 52)	=	£11,596
Annual Sunday + PH costs (£275 x 57)	=	£15,675

Total weekend salary costs +enhancements	=	£27,271
Additional mileage/travel costs	=	£7,552
Additional telephone costs estimated	=	£500
Total costs of weekend SPCN service	=	£35,323

Estimated potential cost avoidance on GP OOH call outs/consultant visits/charge nurse time, based on a review of the hospice caseload and quantifying the number of GP call outs and consultant visits documented within patients' notes. A sensitivity analysis has been applied to acknowledge that these figures represent estimates of the potential costs that may be avoided drawing on information recorded in the Hospice electronic patient documentation system. It is important to acknowledge the limitations of these data, particularly in relation to GP call outs as there may have been calls that have not been reported or recorded in this way and the estimate of potential GP call outs that could be avoided has not been validated by OOH services.

GP call outs ranging 3 –5 calls per weekend annually	£108.08 x 3 = £324.24 x 52 = £16,860.48 £108.08 x 5 = £540.40 x 52 = £28,100.08
Consultant home visits ranging 3-5 per year	£187.25 x 3 = £561.75/ £187.25 x 5 = £936.25
Charge nurse time over 12 months	£2,783
Estimate of total potential cost avoidance	£19,643.48 - £31,819.33

Curtis, L. & Burns, A. (2018) Unit Costs of Health and Social Care 2018, Personal Social Services Research Unit, University of Kent, Canterbury (OOH GP unit costs PSSRU 2012)

Further costs avoidance/savings

Additional costs, which may be avoided, are consultant telephone advice, as they may be reduced if SPCN on duty, effectively calls taken by the SPCN will be screened in the first instance and majority would probably be managed, however they may still require input to support the SPCN in decision making around symptom management and prescribing advice.

In addition, there may be potential to contribute to the prevention of avoidable hospital admissions, as it is recognised that the majority of patients and families would prefer to be cared for at home. The quality of benefits here are clear, however, there are assumptions that end of life care in the community "less costly". It is acknowledged, however that, "end of life care is complex and there is no clear evidence yet on the optimal care pathway" (Public Health England 2017).

With that caveat, costs below provide some indication of hospital admission costs, which a seven-day SPCN service may contribute to the avoidance of; however, this is purely an assumption at this stage until it could be quantified locally.

Inpatient specialist palliative care beds average cost per day: £404
Hospital specialist palliative care support average cost per day £201
Non-elective inpatient stays (long stays) £3026
Non-elective inpatient stays (short stays) £626

Curtis, L. & Burns, A. (2018) Unit Costs of Health and Social Care 2018, Personal Social Services Research Unit, University of Kent, Canterbury

In Comparison

Edinburgh Hospice and St Columba's Hospice evaluation 2016 – 2017

These two hospices agreed to work together to develop a seven-day service whereby a community CNS was based in each hospice to provide telephone support and home visits to patients and families on the community caseload.

Over a period of 12 months, 738 contacts were made with the CNS team at weekends. Across both hospice services, 95.8% of patients contacting the service were already known, 81% were unplanned urgent calls with some planned follow up calls/visits planned by the team prior to the weekend (19%). The most common reason for calling was for advice about symptoms, (29.8%), for support and information, 26.7% and calls relating to medication advice (22.9%). Calls were primarily received from patients or family members, (49%), district nurses, (36%) and the remainder others such as GPs

Financial summary of running costs and savings from report

The cost of running the service was based on additional staffing costs, calculation was based on Agenda for change Band 6 with 30% enhancement for Saturday and 60% enhancement for Sunday and public holiday working:

Top of Band 6 - £35,577 plus 20% on costs =		£42,692
Daily cost (£42,629/52/5)	=	£164.20
Daily cost Saturday (£164.20 + 30%)	=	£213.46
Daily cost Sunday & PH (£164.20+60%)	=	£262.72
Annual Saturday cost (£213.46 x52)	=	£11,099
Annual Sunday & PH cost (£262.72 x62)	=	£16,288

Estimated total cost to deliver the CNS service across both hospices –

(£11,099 + £16,288 x2) = £54,774

Potential savings: Research undertaken by Marie Curie 2013, examined costs of inpatient and community care, established the potential for a reduction of £280 per patient per day by caring for patients in the community and preventing hospital admission. Based on the assumption that a hospital admission was for a minimum of 3 days, a saving of £840 was estimated per patient. The pilot project at Edinburgh and St Columba's hospice demonstrated that 101 patients were supported to stay at home, therefore an annual saving of £84,840

Feedback from patients and families/clinical partners/CNS teams

> "Huge difference and peace of mind knowing support was there when I needed it"
>
> "My father was cared for at home by my mother. They could not have asked for any more. The care, sensitivity and support were beyond what could be expected"
>
> "Patients being discharged from hospital with unstable palliative care needs can have a weekend review"
>
> "Improved symptom control by allowing DN team to have access to specialist advice; because decision making is prompt and clear it allows patient care to be more streamlined"
>
> "Working in collaboration with district nurses to limit avoidable hospital admissions"

Summary

The CNS team took some time to be convinced that this service was needed, but now it has been embedded they are clear that patients and carers have improved access to specialist palliative care at the weekend, providing clinical decision making and emotional support to patients and families whose condition becomes unstable and where a crises admission is threatened. The service was received well with strong themes of partnership working, improved outcomes for patients and carers and teams see value in continued working patterns (Milton et al (2017)).

Conclusion

From a qualitative perspective, this study suggests that there is significant evidence available to support the introduction of a seven-day service in order to enhance and improve the level of care currently offered to patients and families in the Ayrshire community over weekends. There are also benefits anticipated for staff working within the hospice as well as stakeholders and other professionals working in the community setting. However, there are some concerns and a degree of apprehension around workload and what this service would look like, mainly from the community SPCN team but also from the medical team's perspective. This would co-relate with the findings from the comparative study in the Edinburgh hospices, bearing in mind that those services have now been established after being truly tried and tested. Caseload management is a priority for all teams, although input required to the triage service in Ayrshire is an added concern and should be taken into account when considering timings of rotas.

From a quantitative perspective, introducing this service would not be cost neutral; however, taking into account the potential cost avoidance figures, these are likely to offset some of the overall

expenditure. The overall additional cost of the weekend service is estimated at £35,323, and estimated potential costs that may be avoided range from £19,643.48 to £31,819.33 based solely on the avoidance of GP call outs, consultant time and charge nurse hours. However, further analysis is required in order to test this locally whilst implementing a pilot project over a twelve-month period. This could also release time to care for patients and families, particularly in the in-patient setting but could also affect shifting resources in the community. There is not enough evidence at present to demonstrate whether hospital admissions will be avoided or to quantify the associated cost, therefore further analysis is required with the collection of relevant data during a pilot period in order to determine this.

It is evident that specific criteria should be established at the outset and certainly before introducing any form of pilot. Further discussion around definition of roles and boundaries relating to the SPCN, charge nurse and medical staff is essential. Identifying the base for the weekend service is important as it will also help to shape and clarify responsibilities. There are many other factors to consider and will be taken into account in the following recommendations.

Recommendations

1. Engagement with out of hours services, doctors on call in particular should be involved at the earliest point of consultation

2. Further engagement with stakeholders including GPs, district nurses, social services and ambulance services

3. Consider introducing nurse prescribing in order to enhance the SPCN role, this must be supported by ensuring communication and documentation systems are established

4. Once the weekend service has been defined it should be marketed, information clearly explaining what is being offered and contact details should be provided

5. Introduce a pilot service which will be monitored throughout this phase, in order to ascertain what model of care is required to enhance services, reshape and re-model accordingly, ensuring resources are adequate, whilst evaluating over a twelve month period

This case study was completed by Margaret Cassidy, Community and Day Services Manager, Ayrshire Hospice in 2019. Margaret successfully completed an RCN leadership development programme commissioned by consortia of four hospices in Scotland. The programme was designed to empower professionals to understand the principles of economic assessment and apply them in their practice in order to demonstrate the value of, and continuously transform, their services. The programme is endorsed by the Institute of Leadership and Management.

Margaret can be contacted via margaret.wilkie@ayrshirehospice.org

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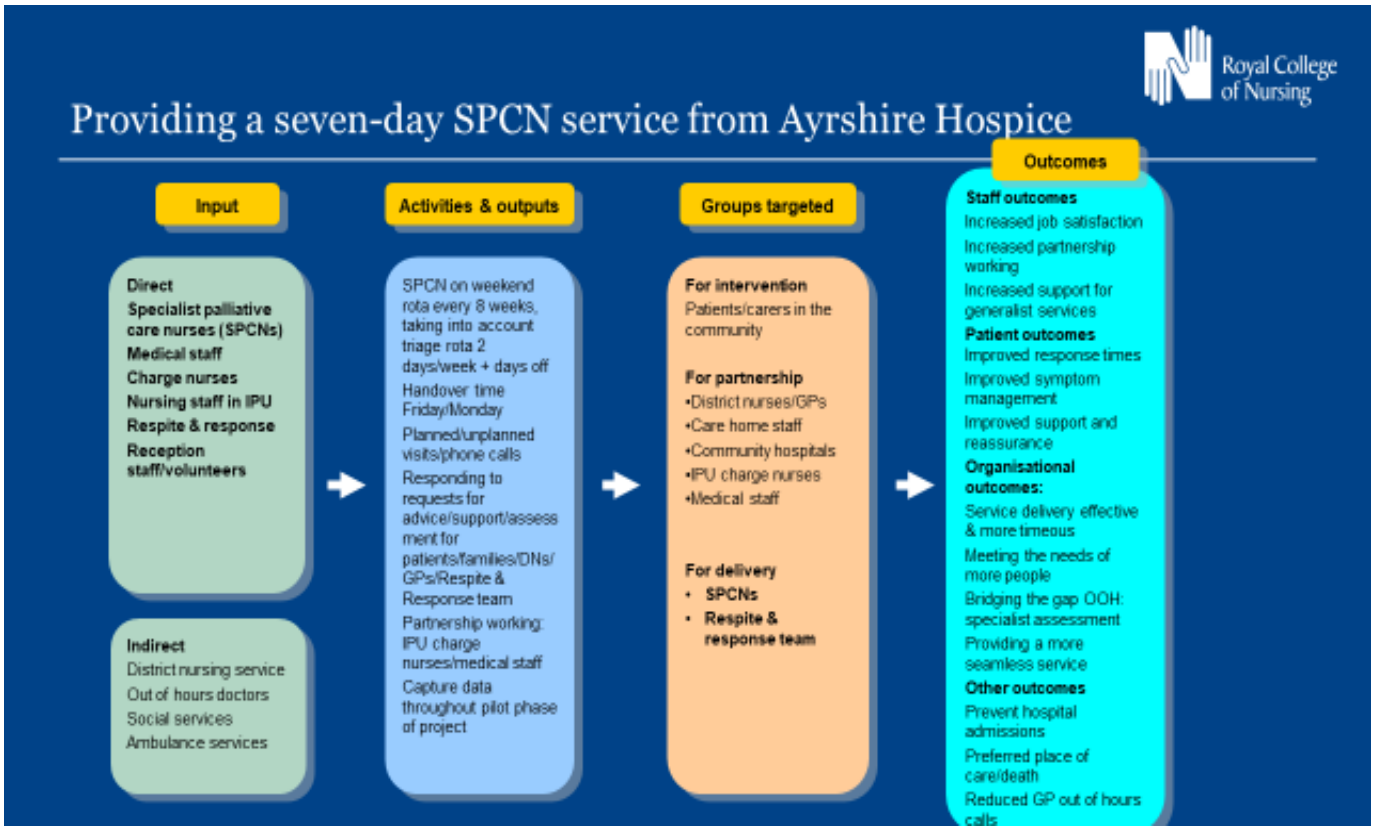
Appendix 1


Royal College of Nursing
Providing a seven-day SPCN service from Ayrshire Hospice
Input
Direct
Specialist palliative care nurses (SPCNs)
Medical staff
Charge nurses
Nursing staff in IPU
Respite & response
Reception staff/volunteers
Indirect
District nursing service
Out of hours doctors
Social services
Ambulance services
Activities & outputs
SPCN on weekend rota every 8 weeks, taking into account triage rota 2 days/week + days off
Handover time Friday/Monday
Planned/unplanned visits/phone calls
Responding to requests for advice/support/assessment for patients/families/DNs/GPs/Respite & Response team
Partnership working: IPU charge nurses/medical staff
Capture data throughout pilot phase of project
Groups targeted
For intervention
Patients/carers in the community
For partnership
•District nurses/GPs
•Care home staff
•Community hospitals
•IPU charge nurses
•Medical staff
For delivery
• SPCNs
• Respite & response team
Outcomes
Staff outcomes
Increased job satisfaction
Increased partnership working
Increased support for generalist services
Patient outcomes
Improved response times
Improved symptom management
Improved support and reassurance
Organisational outcomes:
Service delivery effective & more timeous
Meeting the needs of more people
Bridging the gap OOH: specialist assessment
Providing a more seamless service
Other outcomes
Prevent hospital admissions
Preferred place of care/death
Reduced GP out of hours calls

Appendix 2

Running costs (figures obtained from Ayrshire hospice finance department)

NAME: Margaret Cassidy

1. Be clear about what you mean by ongoing 'running'.

2. Do you need to present these on an annual basis (e.g. running cost for Year 1, running cost for Year 2, etc)? If so, you will need to indicate the relevant year clearly in your template and make sure you reflect 'real terms' costs accordingly.

Identify	**Additionality**	**Apportion**	**Full costs**	**Real terms**
Simply name the cost type/category	Is this 'over and above' for the purpose of your EA?	Should 100% of this cost type/category be included?	Do you need to adjust figure to reflect full costs (e.g. on-costs)?	Do you need to adjust figure to express it 'in today's money'?
Direct costs (2019 - 2020)				
SPCN Band 6 (9 posts – x8 (WTE) + x1 (0.8 WTE)	Current costs Mon - Fri		Total costs £44,658 x 9 = £401,922	
SPCN enhanced payments for weekends	Annual Saturday costs Annual Sunday + PH costs	£172 + 30% = £223 £172 + 60% = £275	Total £11,596 Total £15,675	Total additional weekend costs = £27,271
Telephone calls	Additional calls will be carried out at weekends		Additional £500	+£500
Travel costs	Mileage at 45p/mile for home visits over wider area		Additional £7552	+£7552 = £35,323
Indirect costs (indicate year)				