An Economic case for End of life care

Dr Barbara Barrie, Generalist lead
Dr Jane Bywater, Specialist lead
End of Life team TVSCN
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Facts

- 15m people living with long-term conditions and over 2 m with multiple long-term conditions: account for 55 % of GP appts and 77 % of inpatient bed days

- Growth in all areas of hospital activity: emergency admissions up 14 %; elective admissions up 22%, GP referrals and first OPA risen 26 %, in last 8yrs
- People in their last year of life experience an average of 2.28 hospital admissions and 30.1 bed days in hospital

- 10–12 % of total health costs is spent on care for people at EoL

- **CCGs allocated budgets for EOLC range from £51.83 to £2329.19 per patient per annum**

Predictions

From 2014 to 2024

- population of England expected to grow by 4.4 m (7%)
- no. of people > age 85 by 0.5 to 2 m (33%)

By 2025

- number of people living with dementia expected to grow to 1.3 million

(86% rise from 2014)

By 2030

- number deaths increase projected from 2.9 m to 3.4 m to 680,000 / yr

(17% rise)

- number people living with cancer expected to grow to 4 m

(60% rise from 2015)

- number older people needing help with activities daily living predicted 4.1 m

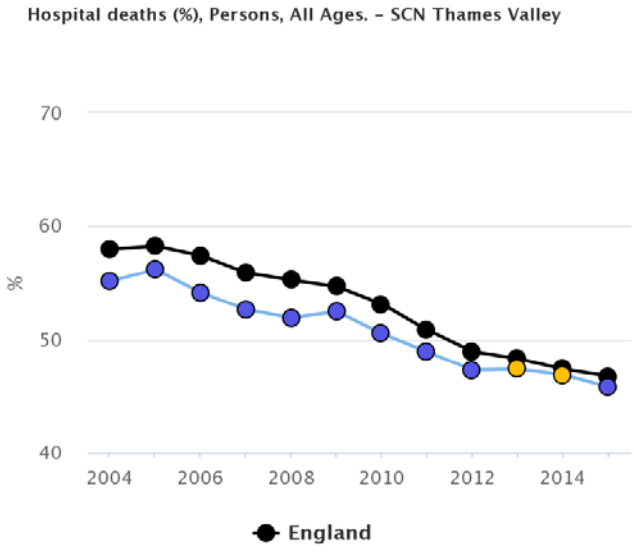
(61% rise from 2010)

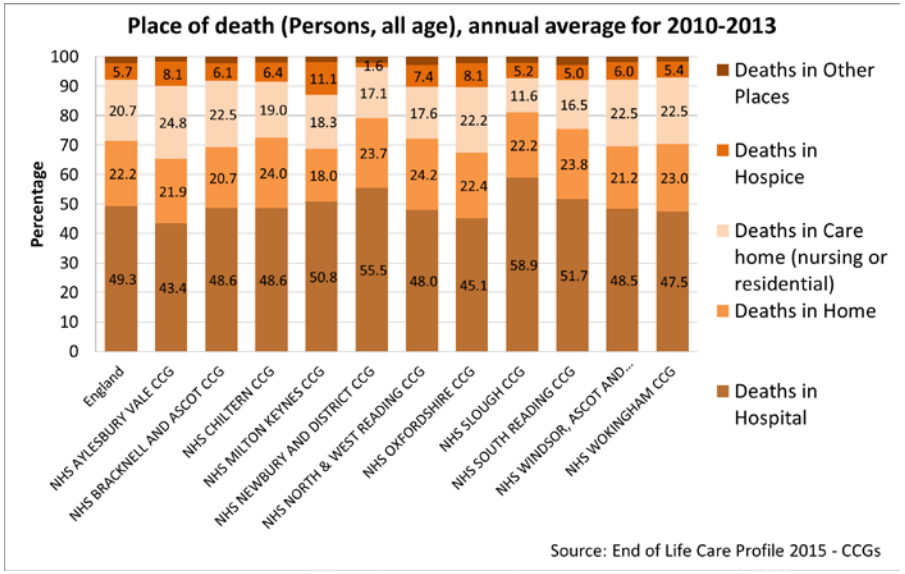
If admission rates continue to rise, growing and ageing population means NHS need approx. **17,000 additional beds by 2022**

Nuffield report 2017

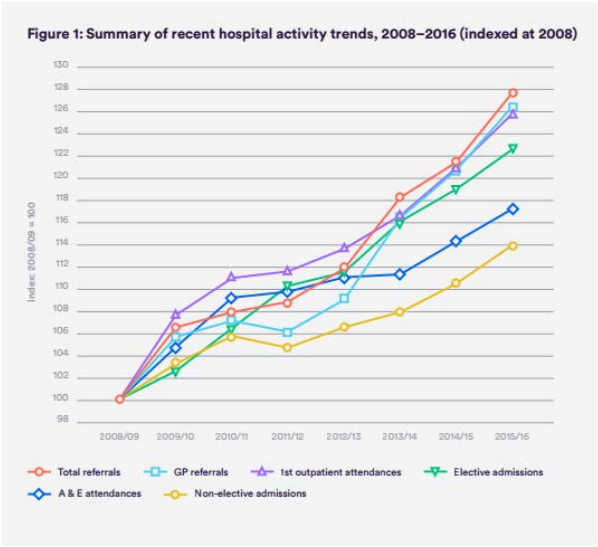
Making the CASE FOR CHANGE: A TVSCN project

- Consider impact of the changing demographics
- Understand actual patient need in Thames valley (NOT use activity as proxy)
- Describe what adds value
- Explore opportunities for us in Thames Valley





NHS England



Source: NHS England, 2017

Death in Usual Place Residence 2015

Area	Value	Lower CI	Upper CI
England	46.0	45.8	46.1
SCN Thames Valley	46.0	45.2	46.8
NHS Aylesbury Vale CCG	49.1	46.7	51.6
NHS Bracknell And Ascot...	42.9	39.6	46.2
NHS Chiltern CCG	46.4	44.4	48.3
NHS Newbury And Distric...	43.6	40.3	47.1
NHS North & West Readin...	45.3	41.7	48.9
NHS Oxfordshire CCG	49.1	47.7	50.5
NHS Slough CCG	33.4	30.2	36.8
NHS South Reading CCG	40.8	37.1	44.7
NHS Windsor, Ascot And...	42.6	39.7	45.6
NHS Wokingham CCG	46.0	43.1	48.8

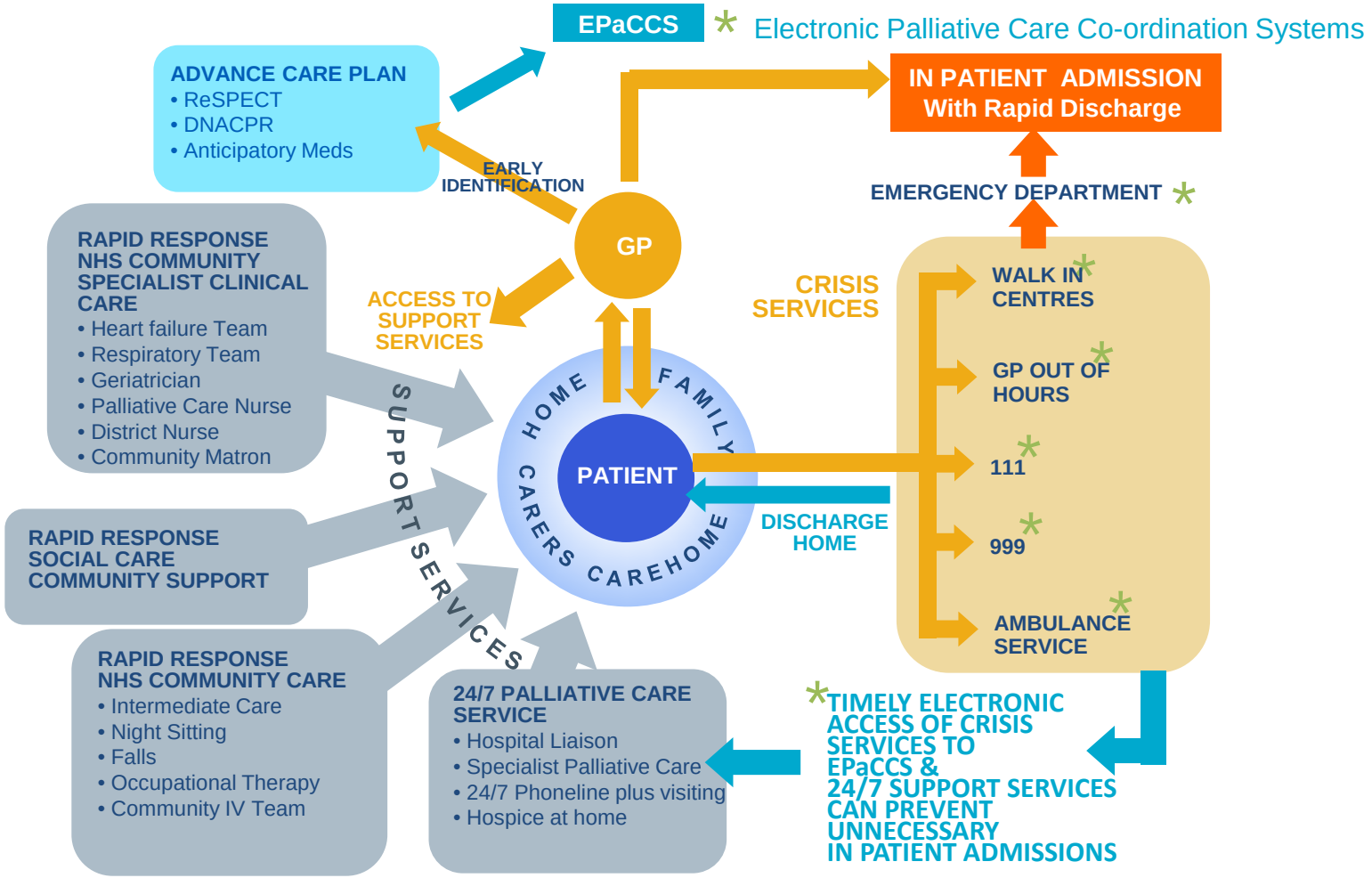
Source: Office for National Statistics

16% variation in place of death across CCGs in Thames Valley

www.england.nhs.uk

CASE FOR CHANGE:
Challenges of COMPLEXITY

NHS England



Evidence

What cost components are relevant for economic evaluations of palliative care, and what approaches are used to measure these costs? Palliat Med. 2017 Apr;31(4):323-337

- 2 x more likely to die in the preferred place if access to hospice Rapid Response Service. Cost neutral.
- Reduced length of hospital stay is the biggest driver of cost-saving from early SPC consultation
- Health care costs vary according to nature of illness

  eg COPD/ hospital costs vs dementia/ NH costs
- Informal care accounts for high proportion of costs during the last year of life
- 90% carers reported median 69 h 30 min care-giving/ week in last 3 mo life

The contributions to formal-care cost were

- hospital admissions accounted for >60%
- palliative care contributed 1%
- Including informal care costs led to increase total cost by 250%.

CASE FOR CHANGE- evidence

Coordinate my Care, LONDON 2010-2016

29,083 CMC urgent care plans created and 9,934 people died with place of death recorded:

- 78% of CMC patients died in their preferred place.
- 18% of CMC patients died in hospital v national average of 47%

A review of read CMC urgent care plans by Urgent care & OOH (111 and London Ambulance Service) reported that:

Knowing who to contact in an emergency helps to avoid unnecessary admissions to hospital

CASE FOR CHANGE- evidence

Marie Curie's Nursing Service

People who received the service were found to be significantly :

- more likely to die at home (78%) vs those receiving usual care (35%)
- were less likely to have an emergency admission at the end of life (12 % vs 29%)

Hospital care costs of those who received the service were
£1,140 per person less
than those who received usual care.

Case for change: evidence

- If access to community based EoLC improved **£104 million could be saved** from cancer patients alone from fewer emergency admissions & reduced length stay
- Where electronic systems are in place to share EoLC records, EPaCCS, recurrent savings after four years **c £270k for a population 200,000 people**
- Hospital costs are by far the largest cost elements of EoLC with care in the final three months of life **averaging over £4,500 per person** who died; bulk of cost due to emergency hospital admissions
- In a nursing home population, 56% admissions were deemed inappropriate

- Advance Care Planning improves EoLC, patient and family satisfaction, reduces care home admissions and stress, anxiety and depression in surviving relatives

Case for change:
Patient / Family experience

2 requirements in providing a sense of security at EoL:

Presence
24/7 availability and home visits

Competence
effective symptom control and skilful communication

http://spcare.bmj.com/content/early/2017/02/23/bmjspcare-2016-001141.long#T4

Case for change:
Shifting balance of care – a case study

- JS Female Age 72
- March 2017 –admitted to hospital following a fall –diagnosed metastatic renal carcinoma
- Delayed discharge home to die due to lack of available social care package –approx. 10 days
- Awarded CHC funding
- Died at home 54 days after hospital discharge
- Package of care –four visits pair day at least 2 carers
- District Nurse daily visit (syringe driver change and supportive care)
- Sue Ryder Community Nurse Specialist -3 visits
- GP – 5 telephone calls and eight home visits
- OOH GP Provider – two calls, one home visit
- Informal carers –husband (retired and well), sister(retired nurse) stayed for final 3 weeks

Nuffield report
Shifting the balance

- Requires **significant additional investment** in out of-hospital alternatives
- Requires **additional supporting facilities** in the community, appropriate workforce and strong analytical capacity
- **Workforce issues** for both health AND social care staff
- Underestimate the potential community based schemes may have for **revealing unmet need**
- Places additional responsibilities on **struggling primary care** and community care services
- **Change takes time** and does not give instant results
- Out-of-hospital care may be better for patients but **NOT cheaper** for NHS in short/ medium term

Unanswered Questions

- Which **interventions and settings** are more or less effective?
- What is appropriate for people with **different conditions** and combinations of conditions?
- What is the economics impact of the **family caregiver**?
- What might be effect of **policy changes** eg compassionate care benefits/ expanded homecare services?
- How **hospital specialist palliative care** improves patient experience?
- Is **discharge planning** as important as avoiding non-beneficial care?
- Can we have a standardised approach to **funding models** for EoLC?

Discussion

- Barbara.barrie@nhs.net
- Jane.bywater@suerydercare.org