NICE National Institute for Health and Care Excellence

Putting NICE guidance into practice

Resource impact report:
End of life care for adults: service delivery (NG142)

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Summary

This report focuses on the recommendations from NICE's guideline on End of life care for adults: service delivery that we think will have the greatest resource impact nationally (for England), and will need the most additional resources to implement or potentially generate the biggest savings. They are:

- Providing multipractitioner care **[recommendation 1.9]**
- Providing end of life care coordination **[recommendation 1.10]**
- Transferring people between care settings **[recommendation 1.11]**
- Providing out-of-hours care **[recommendation 1.12].**

The estimated total annual cost of providing end of life care (EOLC) services for a population of 500,000 is estimated at £2.3 million. Most areas will have a significant part of these services already in place. Clinical opinion suggests it is likely to be specialist areas that require the greatest increase in investment. There is high variability in services provided across different regions. For a health economy with 80% of services already in place, the resource impact of moving to 100% of services in place would be around £469,000.

Table 1 shows a range of investment of the likely resource impact for implementing the guideline (excluding ambulance services).

Table 1 Potential resource impact of providing end of life care for adults for a population of 500,000 using NICE recommendations.

Description				
Percentage of service already in place	70%	80%	90%	100%
Potential incremental resource impact (£000s)[1]	**704**	**469**	**235**	**0**

[1] Based on an estimated total annual cost of providing EOLC services of £2.3m

Investment in ambulance services should be considered locally as this may involve the commissioning of additional ambulances and may have set up costs including the cost of the vehicles and training of additional staff.

Services are commissioned by NHS England, clinical commissioning groups (CCGs), and Local Authorities. Providers of NHS commissioned services are hospital trusts, community providers, and the voluntary sector.

1 Introduction

1.1 The guideline offers best practice advice on end of life care for adults.

1.2 This report discusses the resource impact of implementing our guideline on end of life care for adults – service delivery in England. It aims to help organisations plan for the financial implications of implementing this NICE guideline.

1.3 The guideline provides the following definition of end of life: People are ‘approaching the end of life’ when they are likely to die within the next 12 months. The guideline recognises for some conditions EOLC may be provided for months or years.

1.4 The resource impact in table 1 estimates the cost of EOLC services outlined in recommendations 1.9, 1.10 and 1.12 for a population of 500,000. This includes core EOLC services that are already in place such as out-of-hours GPs, district nurses and paramedics. These are likely to vary between different regions. The percentage of services already in place can be assessed locally to arrive at the net resource impact of implementing the recommendations.

1.5 Services are commissioned by NHS England, clinical commissioning groups (CCGs), and Local Authorities. Providers are NHS hospital trusts, community providers, and the voluntary sector.

2 Background

2.1 EOLC may be delivered by disease-specific specialists and their associated teams; by generalists such as primary care teams or hospital-based generalists (for example, elderly care); or by

palliative care specialists in hospices, hospitals and community settings.

2.2 The aim of the guideline is to ensure that people have access to EOLC services in all care settings, according to their needs and wishes. It also includes advice on services for carers and other people important to adults who are approaching the end of their life.

2.3 For EOLC in adults, an estimate of the annual cost of a service for a population size of 500,000 people has been provided. Organisations can input estimates into the local resource impact template to reflect local practice and estimate the impact of implementing the guideline.

2.4 The economic model supporting the guideline assumes 0.8% of the population being identified as thought to be in the last year of life. This assumes a mortality rate of roughly 1% in the general population and approximately 20% of deaths being unpredictable.

The resulting 0.8% of the population whose deaths are not unpredictable should be identified as thought to be in the last year of life and therefore receive access to end-of-life care services. For a population of 500,000, it is assumed that 4,000 people are in their last year of life.

2.5 Recommendations for identifying adults who may be approaching the end of their life, their carers and other people important to them can be found in section 1.1 of the guideline.

3 Recommendations with potential resource impact

It is anticipated the following recommendations taken together are likely to have a significant cost:

3.1.1 **Providing multipractitioner care (recommendation 1.9)**

Provide access to the expertise of highly skilled health and social care practitioners, when needed, for adults approaching the end of their life, their carers and other people important to them with. They should have the skills to:

- meet complex care and support needs
- anticipate and prevent or minimise crises
- support people's preferences for where they would like to be cared for and die, if possible.

3.1.2 **Providing end of life care coordination (recommendation 1.10)**

Health and social care practitioners providing end of life care coordination should:

- offer information to the person approaching the end of their life, their carer's and others important to them, about who the multipractitioner team members are (including the lead healthcare professionals in each setting responsible for their care), the roles of the team members and how services are accessed
- ensure that holistic needs assessments are offered and the person's wishes and needs are discussed and acted on whenever possible
- ensure that care is coordinated across and between the multipractitioner teams and between care settings
- ensure that regular discussions and reviews of care, holistic needs and advance care plans are offered
- share information about the person's care between members of the multipractitioner teams.

3.1.3 Providing out-of-hours care (recommendation 1.12)

Adults approaching the end of their life, their carers and other people important to them should have access to:

- a healthcare professional available 24 hours a day, 7 days a week, who can access the person's records and advance care plan, and make informed decisions about changes to care
- an out-of-hours end of life care advice line
- an out-of-hours pharmacy service that has access to medicines for symptom management in adults approaching the end of their life.

Background

3.1.4 Discussions with experts from the committee indicate that one integrated service model is needed to deliver the recommendations outlined above. The resource impact template provides an example of resources needed to provide the services included in these recommendations (see appendix A).

Multipractitioner care

3.1.5 In addition to general medical services, for some people there is a need for access to specialist palliative care including physiotherapy, occupational therapy and counselling for people who require these services at the end of life. These could also be accessed from mainstream services where possible and appropriate.

Care coordination

3.1.6 Care coordination requires a team of healthcare professionals who approve, organise and coordinate packages of care including fast-track continuing care and specialist equipment. EOLC coordination

is an area identified by experts from the committee as having wide variations in practice.

Out-of-hours care

3.1.7 The availability of out-of-hours telephone services was comprehensive with the majority of services providing this every day of the week [RCP EOLC Audit 2015]. For out-of-hours care in acute settings, the most recent audit from the Royal College of Physcians (May 2015) identified that the availability of specialist palliative care staff around the clock varied widely, but only 11% (16) of hospital trusts offered a 24/7 face to face service. 37% (53/142) of sites had face to face access to palliative care services Monday to Sunday, 9 to 5pm.

3.1.8 Committee members identified that there are gaps in seven day working and gaps in specialist EOLC support for out-of-hours services during the last year of life (this is long before the final admission to hospital which the Royal College of Physicians (RCP) audit covered). The RCP audit also showed that very few patients who died had an advance care plan (ACP) in the hospital which the clinical teams could use for delivering care in the last days.

3.1.9 Committee members also identified that additional resources may be needed to develop information systems allowing appropriate clinicians to access a person's ACP and records over a much longer timeframe than the last admission to hospital.

Assumptions made

3.1.10 To assist with local calculations, the staffing configuration outlined in the health economics (Cost Analysis - Economic appendix) section of the guideline has been used to give an example staffing model in the 'assumptions input' sheet of the resource impact

template (see appendix A). This is based on information supplied by CCGs and guideline clinical expert opinion.

Pay bands have been updated to reflect 2019/20 NHS Agenda for Change pay estimates. Mid-point of each band used. Other than out-of -hours care, the salary costs of other staff assume they work standard hours. This can be amended in the resource impact template if appropriate.

3.1.11 The resource impact estimate is based on discussions with clinical experts from the guideline committee. This has been used to inform where additional resource may be needed over and above what are currently core services (out-of-hours GPs, district nurses, paramedics).

3.1.12 Many areas will have a significant part of these services already in place. Clinical opinion suggest it is likely to be specialist areas that require further investment. Table 2 shows a range of investment of the likely resource impact for implementing the guideline (excluding ambulance services).

Table 2 Potential resource impact of providing end of life care for adults for a population of 500,000 using NICE recommendations.

Description				
Percentage of service already in place	70%	80%	90%	100%
Potential incremental resource impact (£000s)[1]	**704**	**469**	**235**	**0**

[1] Based on an estimated total annual cost of providing EOLC services of £2.3m

3.1.13 From table 2 above it can be estimated that for every 10% of additional service needed, the potential incremental cost is £235,000 for a population of 500,000. This is based on a total baseline cost of service of £2.3 million, however within the services provided, there could be variations, for example care coordination

services may already be staffed at 100%, whilst other services such as out-of-hours care may be staffed at 70%.

3.1.14 The local template allows users to enter a percentage estimate for services already in place and identify where additional resources are needed**.**

Potential benefits

3.1.15 Based on assumptions from the economic information supporting the guideline, the following benefits are anticipated from implementing the above three recommendations:

- potential reduction in emergency hospital admissions.
- reduction in length of stay in hospital for adults reaching end of life.
- increase in the number of deaths in a person's preferred place of care.

Other considerations

3.1.16 Not all costs of providing a care coordination service could be estimated due to their variable nature. These include the cost of training, set up costs and any additional IT costs. The resource impact template allows users to enter any additional costs of this nature.

3.1.17 The recommendations included above are objectives within NHSE's National Programme for End of Life Care and the National Palliative and End of Life Care Partnership's national framework.

A further area where there may be a resource impact is as follows:

3.2 Transferring people between care settings (recommendation 1.11)

3.2.1 Develop systems to support the smooth and rapid transfer between care settings for adults approaching the end of their life. For example, organise services so that:

- ambulances or other transport services can move people between care settings without delay and in an efficient and compassionate way
- care packages and equipment are available to enable adults approaching the end of their life to move to the place where they would like to be cared for and die.

Background

3.2.2 This recommendation may require the provision of additional and timely ambulance support.

Assumptions made

3.2.3 Using the economic model supporting the guidance, it is assumed one additional ambulance service dedicated to palliative care may be required.

3.2.4 The commissioning of additional ambulances may have set up costs including the cost of the vehicles and training of additional staff. This would need to be agreed locally.

3.2.5 For a population of 500,000, based on the data in the economic model, it is estimated that there will be around 100 journeys per month or 1,200 journeys over a year. Most of these journeys will

currently take place, but the recommendation requires each journey is done a timely manner.

3.2.6 There may be an increase in the number of journeys as adults approaching the end of their life may move to their preferred place of care. This would need to be estimated locally.

3.2.7 The estimated cost per journey is £114 (National Schedule of Reference Costs 2017/18) - Ambulance transfer: £98 x average Market Forces Factor uplift 1.078 for 2018/19 and 2019/20 = £114]. This includes costs such as petrol, depreciation, consumables and ambulance staff. This gives an annual cost of around £136,000 for a population of 500,000. Therefore a 10% increase in journeys would have an estimated resource impact of £13,600 for a population of 500,000.

3.2.8 Other costs which could not be quantified due to their variable nature include cover for staff attending the transfer, staff training, and costs associated with transferring equipment. These can be entered in the template.

Benefits

3.2.9 Implementing this recommendation may enable adults to die in their preferred place of care.

3.2.10 There may be a reduction in hospital admissions or a reduction in the length of stay in hospital for adults reaching end of life. The template allows users to estimate the resources released from reduced admissions locally.

3.2.11 The cost of an admission to A&E (which is additional to the hospital admission) is assumed to be £106 (2019/20 Tariff VB09Z – Emergency medicine category 1). The cost of a non-elective admission to hospital for pain is £2,419. (2019/20 Tariff WH08A Unspecified pain with cc score1+). This code is used a proxy in the

template because it is a frequent reason for hospital admission in people who are approaching the end of life.

4 Implications for commissioners

4.1 The resource impact depends on how current services are configured and the extent to which EOLC services have been developed. The intent of guideline is to build on existing healthcare services where appropriate with palliative care specialists.

4.2 The programme budgeting code for inpatient specialist palliative care for people aged 19 and over is 02X. The incident classification code for ambulance services for Transfer / Interfacility / Palliative care is 23X.

5 Assumptions made

5.1 The resource impact template makes the following overall assumptions used to estimate costs and potential resources released (table 3).

Population

Table 3 Estimated number of adults who may use end of life services each year for a population of 500,000

Description	Percentage	Number of people
Average CCG population[1]		500,000
Percentage of population who are adults identified as thought to be in the last year of life[2]	0.8	4,000
People eligible for EOLC		4,000

1 Clinical commissioner opinion.

2 Per guideline health economics cost analysis. Estimate informed by guideline committee commissioners. The 0.8% figure was advised as an estimate commonly used by commissioners when commissioning end of life services (p15 Economic appendix - Cost analysis: Illustrative example costs of out-of-hours, end of life community services with a threshold analysis)

Appendix A. Rec. 1.9 Providing multipractitioner care, Rec 1.10 Providing EOLC coordination, Rec. 1.12 Providing out-of-hours care. Estimated population 500,000

Expenditure heading	Pay band	WTE	Future service (£)
Consultant	YC72 pt. 9-13	1.6	190,538
Associate specialist	MC41-11	0.5	51,634
Senior manager	08a	1	62,351
Counsellor	7	0.5	25,099
Physiotherapist	7	0.3	15,059
Occupational therapist	7	0.3	15,059
Clinical nurse specialist	7	4.7	235,931
District nurse	7	4	200,792
Staff nurse	6	4	167,444
Staff nurse	5	4	137,820
Administrators (multipractitioner care)	4	2	55,828
Healthcare assistant	3	8	194,704
Facilitator	7	2	100,396
Lead nurses	6	2	83,722
Administrators (care coordination)	3	2	48,676
24/7 Healthcare practitioners	Mid-point GP range	5.6	528,494
Nurse [out-of-hours]	6	3.6	197,194
Medication provision [contract management, pharmacy payments including stock audits]	7 pharmacies		36,162
Total estimated cost (£)		**45**	**2,346,903**

See resource impact template for further details of service cost calculations

About this resource impact report

This resource impact report accompanies the NICE guideline on End of life care for adults: service delivery and should be read in conjunction with it. See terms and conditions on the NICE website.