The Economics of Improving End-of-life Care in Care Homes with Dementia Patients

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Joint Authorship

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Structure of Presentation

• Overview of NHS North West Project
• Conclusions from Project
• Relationship with My Home Life
• Focus on Economic Appraisal of Project
  – Impact of NHS Payment by Results
  – Key Results
• Potential Way Forward (based on Liverpool PCT work)
• Conclusions
Overview of NHS North West Project

- £12m DoH funding to improve EoL care (2003)
- Implement GSF, LCP and PPC tools
- Gtr Mcr SHA set up education & training initiative for care staff, to improve quality of EoL care for older people with dementia (2004)

- Priorities:
  - Older people with dementia in care homes receive high quality EoL care and greater choice where they die
  - Reduce unscheduled hospital admissions for such patients
Overview of NHS North West Project

• 4 Care Homes and NHS MH Ward involved
• Adopted GSF and LCP as models of care
• SHA EoL Team developed, implemented, and delivered Education & Training sessions
• Organised external input to homes
• Members of the Primary Care Team, Palliative Care Team and the Relatives/carers of persons with dementia were also involved in the local implementation
Conclusions from Project

• The Evaluation established that Benefits of implementing the GSF and LCP in long-term care settings included:

  – Improved communication between nursing, care and medical staff;
  – Better symptom management; and
  – Better support for family members and carers.

• Full report available at:

Relationship with *My Home Life*

• The project and its findings were entirely consistent with several themes from *My Home Life*:
  – Improving health & healthcare
  – Supporting good end-of-life
  – Keeping workforce fit for purpose
Economic Appraisal

Data Collected

- Cost of SHA EoL Team relevant to initiative;
- Cost of homes releasing staff to attend training;
- External input of other parties to homes.

(All costs set at 2007/08 pay & prices)

- Average bed availability and occupancy
- Nos of deaths of homes’ patients in the home or hospital (& patients leaving for other reasons)
- Key details relating to the patients that had died


• Cost of homes releasing staff to attend training;
Impact of NHS Payment by Results

• Cause of admission is primarily medical (falls; broken hip or hip replacement; urinary infection; chest infection; stroke)
• “Dementia”, as such, excluded Acute PbR
• PbR tariff allocated according to: diagnosis, procedures, age & if complications
• Standard tariff irrespective of length of stay
Impact of NHS Payment by Results

• Local tariffs for where no National tariffs
• Terminally ill patient PbR tariff reflects condition presenting before death
• When in hospital – Care Home bed kept open for if/when they return: so charges still apply
Impact of NHS Payment by Results

• No savings for those who fund Care Home place even if hospital admission

• If patient dies in hospital, cost to PCT same even if LCP helped minimise LoS/ need for admission

• Reduced LoS helps reduce Hospital costs, but hospitals driven to continually reduce LoS through PbR approach
“Elephant In The Room” Question: Will PCTs save money?

- PCTs only save money from application of GSF & LCP if patient wishes to die in Care Home and does so, without admission to hospital

- One aim of GSF is to reduce hospital admissions

- Therefore, benefits are primarily Quality-based
Attributable Costs of SHA EoL Team

• 70% of Staff Costs = £73,829 pa
• 90% of Non-Staff Costs = £17,577 pa
• Total Costs = £91,406 pa

• Latter allows for accommodation hire, travel, information packs, registration fees with Central GSF Team (£380 per setting)
# Training Attendances and Costs

<table>
<thead>
<tr>
<th>Analysis of Training Sessions</th>
<th>Activity</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D &amp; E (Combined)</th>
<th>Total</th>
<th>Costs to Care Settings to Release Staff (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of Sessions*</td>
<td></td>
<td>7</td>
<td>9</td>
<td>8</td>
<td>10</td>
<td>34</td>
<td></td>
</tr>
<tr>
<td>Staff: Carers</td>
<td></td>
<td>27</td>
<td>54</td>
<td>53</td>
<td>107</td>
<td>241</td>
<td>£4,013</td>
</tr>
<tr>
<td>Staff: Trained</td>
<td></td>
<td>21</td>
<td>40</td>
<td>22</td>
<td>107</td>
<td>190</td>
<td>£6,413</td>
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<tr>
<td>Staff: Other**</td>
<td></td>
<td>1</td>
<td>10</td>
<td>11</td>
<td>4</td>
<td>26</td>
<td>£655</td>
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<tr>
<td>Total Attendances</td>
<td></td>
<td>49</td>
<td>104</td>
<td>86</td>
<td>218</td>
<td>457</td>
<td>£11,080</td>
</tr>
<tr>
<td>Attendances per Session</td>
<td></td>
<td>7.0</td>
<td>11.6</td>
<td>10.8</td>
<td>21.8</td>
<td>13.4</td>
<td>£326</td>
</tr>
</tbody>
</table>

*All sessions were scheduled for 3 hours; Cancelled sessions are excluded

**Assumed average of Trained and Untrained staff costs
External Input

- Totalled 20.3 hours per week – but varied in both volume and range of skills.
  - Care setting B had 0.4 hours per week – but all from Consultant in Palliative Medicine.
  - Other 4 settings ranged: 3.4 - 7.5 hours/week.
- Involved: District Nurse; Mental Health Assistant Practitioner; Palliative Care Educator/Registered General Nurse, and a Head of Education.
- Total Cost = £547 per week/£28,437 p.a.
Total Costs

- Attributable SHA EoL Team costs = £91,406
- Cost of homes releasing staff = £11,080
- External input = £28,437
- Total (Rounded) = £131,000

- Higher than would apply for PCT – economies of scale and pilot projects have costs ongoing projects would not have

- No allowance made for potential contribution of hospices. Local circumstances meant no patients likely to die in one. Also, not perceived role of hospices.
- PbR does not apply and funding is mix of charitable monies and PCT grants. No additional funds if Care Home patient uses one.
Impact on Activity

• Ave daily bed occupancy: 2005/06 = 129.5
  Oct06- Sept07 = 137.0

• Dementia patients dying in a Care Home:
  2005/06: 23 out of possible 48 – 48%
  Oct06- Sept07: 20 out of possible 32 – 63%
### Percentage of Patients that Died in Care Home/ Setting (Dementia Patients Only)

<table>
<thead>
<tr>
<th>% Died in Care Home/ Setting</th>
<th>Apr 2005 - March 2006</th>
<th>Oct 2006 - Sept 2007</th>
<th>Change in Percentage - Crude</th>
<th>Percentage Change in Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Homes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>75%</td>
<td>100%</td>
<td>25%</td>
<td>33%</td>
</tr>
<tr>
<td>B</td>
<td>45%</td>
<td>100%</td>
<td>55%</td>
<td>120%</td>
</tr>
<tr>
<td>C</td>
<td>83%</td>
<td>100%</td>
<td>17%</td>
<td>20%</td>
</tr>
<tr>
<td>D</td>
<td>30%</td>
<td>44%</td>
<td>14%</td>
<td>48%</td>
</tr>
<tr>
<td>E</td>
<td>33%</td>
<td>50%</td>
<td>17%</td>
<td>50%</td>
</tr>
<tr>
<td>Project Homes Total</td>
<td>48%</td>
<td>63%</td>
<td>15%</td>
<td>30%</td>
</tr>
</tbody>
</table>
Patients Dying in Preferred Place of Death

• Post training programme, i.e. Oct 06 – Sept 07
• Key details collected on patients that had died
• One Care Home did not provide data (2 pats)
• All patients stating “Home” died in their home (18 – 60%)
• All patients stating “Hospital” died in hospital (8 – 27%)
• Remaining 4 did not record an answer – all died in hospital
Potential Way Forward for Training
(based on Liverpool PCT work)

• Tailor & stratify training sessions so staff only attend those pertinent to their needs

• **Sessions accommodate maximum numbers of staff, without compromising the learning experience, i.e. 20 – 30?**

• Evaluate the opportunities and costs for delivery: trainers, accommodation, materials, refreshments, etc (May involve procurement)
Potential Way Forward for Training (based on Liverpool PCT work)

• Ensure regular and standard advisory input to care homes from existing staff who already engage with them (PCT staff or staff from organisations PCT contracts with)

• Local Care Homes demonstrate commitment to initiative(s) and contribute, for example, by releasing staff for training and providing facilities for training.
Potential Way Forward for Training
(based on Liverpool PCT work)

Illustration:

• 1,000 Care Home staff: 250 Trained; 500 Untrained care staff; 250 Non-care staff

• Sessional Requirements: Trained staff - 4; Untrained care staff – 3; Non-care staff – 1.

• Resultant: 2,750 attendances

• At ave 20 atts per session = 138 sessions

• At £250 per session = £34,500 (Exc Admin)
Potential Way Forward for Training
(based on Liverpool PCT work)

• Potential Inducements for Care Homes?
  – PCTs pay proportion of cost of staff cover
  – Pay for initial GSF registration

• Avoid danger of inducements reducing sense of ownership amongst Care Homes

• PCTs and Care Homes should agree qualifying criteria for participation and support:
  – Adopt GSF; Release staff; Integration of EoL tools
Conclusions

• Introducing EoL Education & Training programme for Care Staff will not save money for PCTs unless reduced hospital admissions

• Quality benefits of implementing GSF and LCP fully justify comparatively modest investment of such programmes

• PCTs and Care Homes working together can realise affordable, cost-effective ways forward

• **REFERENCE**: Rob Gandy, Bob McClelland, Susan Ashton, Brenda Roe, Deborah M Mazhindu, Stephanie Gomm, Elaine Horgan, Jane Hughes, Susan McAinsh, & Kim Wrigley (2010). An Economic Appraisal of an End-of-life Care Training Initiative for Care Homes with Dementia Patients. *Journal of Care Services Management* 4:4
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