

# **Delivering a responsive and effective specialist community palliative care service in an environment of change.**

An economic assessment of innovations made within the community nurse specialist team at St Richard's Hospice.

By Vanessa Gibson

## **Abstract**

### **Background**

Specialist palliative care services face many challenges not least projected demographic changes, an increasing demand to widen their services to any patient with a life limiting diagnosis and on-going restructuring of statutory services.

This paper aims to explore the impact of a range of innovations introduced within a community specialist palliative care team in response to escalating demands upon the service.

### **Method**

The impact of three key innovations was explored. Direct comparisons pre and post innovations where undertaken where possible and wider literature explored to enhance understanding of the wider implications of changes made to practice.

### **Findings**

Innovations introduced incurred limited set up and running costs, however they released a significant amount of clinical nurse specialist time which could then be redeployed to support patients with the most complex needs.

### **Conclusion**

Practical benefits for the clinical nurse specialist service, patients, general practitioners and the local acute hospital are clear, however further work is required to enhance team resilience and reduce the risk of burnout. This is of particular importance as team efforts are now much more focused upon patients with the most complex needs.

## **Background**

This paper aims to explore the economic impact of a range of interventions introduced by the community nurse specialist team. The paper has been written to demonstrate to the community nurse specialist team and senior management team the value of these interventions in terms of both cost avoidance and more effective use of current resources.

Specialist palliative care services are facing many challenges not least a drive to broaden access to their services for people with wide ranging diagnoses.

Traditionally a cancer based service, specialist palliative care providers are also facing an increasingly aged population, with chronic illnesses and multiple health problems who wish to be cared for and die within their own home (Calanzani et al, 2013).

Staff employed within specialist palliative care have traditionally been viewed as willing to 'go the extra mile' for patients, however this staff group also face issues common within health care settings including high stress levels and low levels of engagement with their employing organisation (Point of Care, 2015). Within a resilience framework produced by Point of Care (2015) there is an emphasis on organisations recognising situations which cause stress and taking action to reduce stress levels to reduce the risk of burnout and improve job satisfaction.

St Richard's Hospice provides a specialist palliative care service to a total population of 296,603 within South Worcestershire Clinical Commissioning Group. Total running costs for the hospice for 2015-2016 is £7.6 million. The majority of this 7.6 million funding is provided by charitable donations through numerous hospice charity shops and proactive fundraising activities. Of the 7.6 million required 26% statutory funding is received. The hospice offers a range of services including day hospice, in patient unit, counselling, bereavement support, chaplaincy care and a large community nursing team. This report specifically relates to the community nurse specialist (CNS) team and their responses to some of the challenges outlined above.

## **Introduction**

The CNS team provide a community specialist palliative care service for patients referred with a life limiting illness whose needs cannot be met by other care providers i.e. GPs and District Nurses. The team is well established and respected with referrals received from all South Worcestershire GP practices (31 practices in total), District Nursing services, social services, voluntary sector and local acute hospital staff members. In addition patients and their families are able to self-refer.

During 2013 it became increasingly apparent that the CNS service was facing multiple challenges including:

- Increasing referral numbers from all referral sources (including acute, primary health care and self-referral) - average referral numbers increased from 84.3 per month in 2013 to 91.5 in 2014
- Increased pressure within the acute sector resulting in patients being discharged home much more rapidly and with more complex needs
- Widening access to hospice services saw increasing numbers of patients and families with non-malignant disease accessing hospice support. Often these patients have multiple co-morbidities and therefore more complex needs
- Local primary health care services, most notably district nursing services, were restructured. During this restructuring several of the senior and most experienced District Nurses retired resulting a District Nurse workforce which appeared reduced and less experienced
- Increased pressure within GP practices resulted in GPs being less able to undertake home visits in what the CNS team perceived to be a timely manner

- There was increasing pressure from colleagues within primary health care for the hospice to 'pick up' aspects of their roles which they were no longer able to undertake

Within the CNS team there was a perception of increasing stress levels, the team were consistently working additional hours to manage caseload numbers which were escalating to a point where full time CNS's had approximately 60 patients on their caseload. There is no nationally agreed caseload number for palliative CNS's, historically the team had seen a year on year increase which saw caseload numbers for a full time CNS raise from 45 to 60 over a 4 year period. As identified by Point of Care (2015) and Calanzani et al (2013) innovation was required to address the identified challenges whilst maintaining a high quality service which was responsive and sensitive to the needs of both patients and families and worked within current financial constraints.

## Assessing the impact of a service redesign

To address the problems outlined above a whole service review was undertaken and a range of innovations introduced.

The aim of the service review was to achieve the following:

- Reduction in CNS stress levels
- Reduction in additional hours worked by the CNS team
- Reduction in CNS sickness levels
- Improved patient satisfaction

The specific changes include:

Table 1: Innovations and implications

Key innovation	Implications
Telephone Triage role development	<ul style="list-style-type: none"> <li>• Standardised first assessment of all new referrals- including level of urgency</li> <li>• Phone caseload for less complex patients</li> <li>• Enhanced helpline function</li> <li>• Released CNS capacity for the most complex patients</li> <li>• Increased support to CNS team</li> <li>• Prevention of unnecessary home visits</li> <li>• Step down contact prior to discharge</li> </ul>
Changes to on call process	<ul style="list-style-type: none"> <li>• Single point of contact for patients 24/7</li> <li>• Up-skilled and empowered inpatient unit staff</li> <li>• Reduction in out of hours contact for CNS team</li> <li>• Reduction in stress levels for CNS team</li> </ul>

Proactive caseload management	<ul style="list-style-type: none"> <li>• Capped caseloads (7 patients per day worked)</li> <li>• Introduction of a waiting list</li> <li>• Introduction of dependency monitoring</li> <li>• Development of geographical teams</li> <li>• Improved data collection</li> </ul>
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## Assessing the impact

To assess the impact of the innovations an economic assessment was carried out. This economic assessment focused upon:

- Set up and on-going running costs  
This included direct costs i.e. additional equipment and indirect costs i.e. additional input from supporting departments including the admin team
- Cost and time avoidance for specific innovations
- Implications outside the organisation for example costs avoided by potential admission avoidance

The economic assessment focused on the impacts across a range of stakeholders:

### For those using the service

The service aims to offer a co-ordinated and responsive service which supports patient choices regarding their preferred place of care and death. Choice is therefore a central tenet of the service and an increased range of types of contact have enabled patients to exercise increased choice (no contact, service initiated phone contact, patient initiated phone contact or face to face visit). This choice has been enhanced further by the provision of a helpline and changes to on call processes, each of which give immediate access to specialist palliative care advice promoting self-management and potentially preventing unnecessary GP reviews and admissions.

Although the impact of these changes for patients and families is difficult to measure for many patients a priority is to avoid unnecessary admissions. Data collected suggests that between 1<sup>st</sup> January 2015 and 31<sup>st</sup> March 2015 a total of 39 interventions were undertaken without which it is perceived the patient may have been admitted to an alternative care environment. Unfortunately this data was not collected previously therefore comparison is not possible.

## To St Richard's Hospice

### Impact on time available for care

For the wider organisation the increased role of triage has seen 30 new referrals discharged at the time of referral between 1<sup>st</sup> January and 31<sup>st</sup> April 2015. This may be because the patient declines the teams support, does not meet the services referral criteria or has needs which may be better met by another service or department. This decision is reached following an initial telephone discussion with

the patient by a member of the triage team and as a result a total of 30 first assessment visits have been prevented.

The economic benefits of the prevention of unnecessary first visits are summarised in box 1: Costs are based solely on CNS salary costs.

Box 1: First contact innovation

	Minutes spent on home visit	Minutes spent on triage phone contact
Travel time	60	0
Consultation time	90	20
Documentation time	120	30
Total time	270	50
Cost per first contact	£108.58	£20.11
Cost of 30 first contacts	£3,257.55	£603.25
<b>Total cost saving of £2,654.30 for 4 months Per year this would equate to £7,962.90</b>		

Average CNS salary used with NHS on costs gives an hourly rate of £24.13

However rather than simply being a cost saving this change in practice has resulted in more effective resource allocation. Time saved by the CNS team in not undertaking unnecessary first visits provides totals 135 hours over a 4 month period. Over a year this equates to 405 hours released from unnecessary first assessment visits providing additional hours to focus on those patients with the greatest needs. Over a year hours released equates to a total of 90 appropriate first visits.

In addition the triage team now hold a telephone caseload which consists of patients with less complex needs and those being supported towards discharge from service. Before the introduction of this caseload each of these patients would have been supported in their home by a CNS. It can therefore be realistically argued that the telephone triage caseload is in addition preventing routine review visits. To attribute an approximate figure to how many contacts are made to patients who are on the triage caseload an average month (May 2015) was reviewed. During this time there were a total of 47 contacts. Costings for review visits differ from those of an initial assessment as less time is required. Cost and time savings are summarised in box 2 and are based solely on CNS salary costs.

Box 2: Review contact innovation

	Minutes spent on home visit	Minutes spent on triage phone contact
Travel time	60	0
Consultation time	45	10
Documentation time	30	5
<b>Total time</b>	<b>135</b>	<b>15</b>
Cost per review contact	£54.29	£6.03
Total cost of 47 review contacts	£2,551.75	£283.53
<b>Total cost saving over the month of May of £2,268.22</b>		
<b>Per year this would equate to a saving of: £27,218.64</b>		

Average CNS salary used with NHS on costs gives an hourly rate of £24.13

Again it should be emphasised that although it is possible to demonstrate a cost saving a more important outcome of this change in practice is effective use of resources. Total hours saved over 1 month equates to 105.75 hours which could be used to undertake 47 appropriate review appointments or 23.5 first visits per month. Over 1 year this equates to 1,269 hours released for more appropriate home visits, enabling a total of 564 review visits to be undertaken or 282 first assessment visits.

This redistribution of work to maximise the use of the triage service has released a significant amount of CNS time which can now be used to respond to increasing demands upon the service, allowing the service to target those patients with the greatest needs and enhance responsiveness.

Total yearly impact of triage innovations are summarised in box 3.

Box: Summary of innovations

	Cost savings	Hours released
First contact innovation	£7,962.90	405
Review contact innovation	£27,218.64	1,269
<b>Total yearly saving</b>	<b>£35,181.54</b>	<b>1,674 hours or 44.64 weeks</b>

A patient scenario demonstrating the impact of triage innovations is given in appendix 1.

## Impact on staff wellbeing

It was hoped that the innovations introduced would also result in a reduction in additional hours worked and overall sickness levels for the CNS team as this can enhance staff resilience. Table 4 however demonstrates that this has not occurred.

Table 4: Days lost to sickness and additional hours worked

	1.4.13 - 31.3.14	1.4.14 – 31.3.15	Difference in hours
Hours lost to sickness	116	148	+ 32
Total additional hours worked	1,713.2	1754.5	+ 41.3

Table 4 also demonstrates that despite a release in capacity as outlined above, the CNS team continue to work an approximate additional 46 weeks per year in total. This equates to a yearly average per CNS of 101.47 hours or 2.7 weeks.

As the innovations were introduced over several months in 2014 a direct comparison of hours lost to sickness and additional hours worked for the first 4 months of 2014 and 2015 has been undertaken to further explore these issues. This again demonstrates an on-going increase in additional hours worked and sickness levels. See table 5:

Table 5: Hours lost to sickness and additional hours worked

	Jan- Apr 2014	Jan – Apr 2015	Difference in hours
Hours lost to sickness	13	90	+77
Total additional hours worked	595.25	624.5	+ 29.25

The additional introduction of dependency monitoring shows that core activity now centres around those patients identified as being in an unstable or deteriorating condition. These are the groups of patients who present more complex needs in comparison to those patients who are stable or expected to die imminently. Numbers of interventions logged for stable patients from 1<sup>st</sup> January- 31<sup>st</sup> April 2015 is 302, this compares to 1,672 logged for unstable patients.

The release of CNS capacity through effective use of time has clearly enabled the service to focus upon those patients with the greatest needs. Whilst this is a success for the team and has seen caseloads maintained within lower capped levels it has also resulted in the CNS's spending the majority of their clinical time within high pressure situations, therefore there remains a continued risk of burnout and on-going work is required to address this.

Appendix 2 gives an example of the level of dependencies seen by a selection of CNS's over a one week period.

## Changes to the on-call process

Changes to the on call process have also been made. This see's calls initially directed to staff within the inpatient unit. Skilled nursing staff within the inpatient unit are able to filter calls, providing an immediate response to some calls or escalating the call to the on call CNS where appropriate. From introduction of this innovation in March 2014 until end of February 2015 a total of 154 calls were managed by the inpatient unit staff. The economic impact of this change is summarised in box 4. Costs are based solely upon CNS and Staff Nurse salaries. It should be noted that whilst this has demonstrated a cost saving for the CNS team additional costs have been incurred by the inpatient unit as their staff are now spending time triaging on call contacts.

Box 4: on-call innovation

	Staff nurse	CNS
Minutes per call	5	20 (Additional time is as a result of time taken to log onto the patient data base remotely)
Total minutes taken for 154 calls	770	3080
Equates to total hours	12.83	51.33
Total cost	£179.26	£1238.59
<b>Total year cost saving of : £1,059.33</b>		

Average CNS salary used with NHS on costs gives an hourly rate of £24.13

Average Staff Nurse salary used with NHS on costs gives an hourly rate of £14.48

## To wider health care organisations

As previously discussed the release of additional capacity and increased ability to support complex patients twenty four hours a day, seven days a week could be expected to be preventing not only admissions to the acute sector but also a reduction in the need for GP review.

It could for example be argued that without a CNS practising as a non-medical prescriber and issuing a prescription to a patient, that patient would have required a GP review. Improved data collection introduced as part of this raft of innovations now



enables us to begin to demonstrate the value of this activity could be having for our wider health care colleagues- in particular GPs. Data collected shows that from 1<sup>st</sup> January 2015- 31<sup>st</sup> April 2015 a total of 40 prescriptions were issued, potentially preventing the need for 40 GP contacts. Using costings provided by Kernick and Nettle (2002) potential savings for GPs are listed below:

- Phone contact: costs £4.61 per contact. Total possible cost of 40 phone contacts therefore is £184.40
- Contact in the surgery per patient consultation is £9.21. Total possible cost of 40 surgery based consultations therefore is £368.40
- Contact in a clinic costs £18.44 per clinic appointment. Total possible cost of 40 clinic based appointments is therefore £737.60
- Contact in the patients home: £29.06 per home visit. Total possible cost of 40 GP home visits is therefore £1,162.40

Perhaps more importantly for time pressured GP's the ability of non-medical prescribers to issue prescriptions and prevent some GP practice based reviews has potentially released GP capacity. Looking simply at GP appointments prevented if appointments are a minimum of 10 minutes as suggested by Health and Social Care Information Centre (2013) this equates to 400 minutes saved over a four month period, over a year this equals 1200 minutes or 20 hours saved.

When looking at prevention of acute admissions it is difficult to identify what interventions prevent admission. It is recognised that data collection in relation to this is subjective however the CNS team have identified that between 1<sup>st</sup> January 2015 and 31<sup>st</sup> April 2015 there were 39 instances where they believe that their intervention has potentially prevented an acute admission. It is well documented that as end of life approaches patients can spend increasing amounts of time within the acute sector (Public Health England, 2013, National Audit Office, 2008). The Kings Fund (2011) state that acute care costs £200 per day with 10% of all emergency admissions requiring an inpatient stay of two weeks or more. If it is assumed that 10% of the 39 acute admissions identified as being avoided had taken place and had required a total acute stay of two weeks duration each a potential cost of £10,920 has therefore been avoided over a four month period, over a year this equates to £32,760. More importantly the team would suggest that data now being collected demonstrates that they have potentially prevented 156 acute admissions over a one year period, enabling those patients to remain within their home environment.

## Key costs of the innovations

To assess the overall economic impact of the raft of innovations introduced it is also necessary to take into account the overarching costs incurred. Costs listed are based on:

- The teams experiences of introducing the changes to practice i.e. planning time, monitoring time, re-print costs
- Salary costs which were:
  - Staff nurse hourly rate (with NHS on costs) £14.48
  - CNS hourly rate (with NHS on costs) £24.13

Costs can be broken down per activity as detailed below:

Planning time (start-up costs- not recurring):

Activity	Detail	Cost
CNS Meeting time 80 minutes approximately across several CNS meetings.	80 minutes approximately across several CNS meetings with an average of 10 CNSs in attendance	£321.73
Refining data collection templates	15 minutes of one CNSs time and 15 minutes of database managers time	£9.35
Updating CNS team leaflet	15 minutes of CNS team leader time	£6.03
Updating discharge postcard	15 minutes of CNS time	£5.69
Developing new data collection tool	60 minutes of CNS team leader time and 60 minutes of care quality managers time	£45.98
Senior managers time	90 minutes of CNS team leader, Care Director and Unit Manager time	£67.26

Equipment and resources:

Item	Detail	Cost
Team leaflet	Reprint once updated	£450
Pager purchase	Required 13 additional pagers	£100.36
Pager monthly rental	Additional 13 monthly rental costs	£282.75
Discharge postcard	Reprint once updated	£450

On-going monitoring:

Activity	Detail	Cost
Monitoring on call activity	15 minutes CNS time each day	£6.03

Indirect costs:

Activity	Detail	Cost
Increased admin support	7.5 hours per week	£68.37
Increased postal costs	Additional letters to patients at time of referral and discharge	Unable to quantify

Redeployment of staff resources (ongoing cost)

Activity	Detail	Cost
Geographical team meetings	Each GP attached CNS attends 1 meeting per month for 1 hour over a 1 year period	£3,474,72
Inpatient unit staff	Redeployed to answer out of hours calls	£159.88

**A full summary of costs incurred and cost saving are provided in appendix 3.**

## Conclusion

The range of interventions introduced aimed to address increasing demands upon a team of specialist nurses working within a community setting by enabling them to focus their interventions on those patients with the most complex needs. This report demonstrates that this has been achieved through a comprehensive service redesign. Changes to practice have released 1,674 hours of CNS time over a one year period, this equates to an additional 44.64 weeks per year. This time can now be redirected to those patients and families with greatest need, helping to prevent admission, maintain patients within their preferred place of care, increase patient and carer satisfaction and reduce the demands on wider health care services. For example improved data collection allows the team to now demonstrate the ability of nurse independent prescribers to potentially save GPs a minimum of 20 hours surgery consultation time per year by issuing prescriptions direct to patients within their own home environment. Whilst data highlighting admission prevention interventions could suggest that the team have been able to potentially produce a yearly NHS saving of £32,760. For patients and families this data also demonstrates a service which is able to respond to their needs in a timely manner- a benefit to them which has been enhanced by released capacity.

For the CNS team the innovations introduced have reduced the impact of managing competing demands upon their time- time is focused upon the patients with the most complex need. There is however an on-going piece of work required in relation to supporting a team of CNSs whose time is now predominantly being spent in highly pressurised situations. It is noticeable from this piece of work that additional demands upon the CNS team have not decreased, a significant amount of additional hours worked still occurs (average of 2.7 weeks per year per CNS). Levels of

sickness have also increased during the time period examined (an additional 32 hours being lost to sickness). As part of this work stream was aimed at improving team resilience and preventing burnout there is clearly more work to be done.

It is envisaged that the team will continue to refine and build upon the changes to practice introduced. For the wider organisation the results of this report will be used to inform on-going strategy development work and it is envisaged at this time that the role of triage is likely to be extended across the organisation so that the benefits experienced by the CNS team can be replicated within other departments.

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## **Appendix 1:**

### **Case study scenario demonstrating the impact of triage assessment and changes to the on call process**

#### **Prior to the innovations**

Mrs N was referred to the community service. Diagnosed with advanced breast cancer she was about to commence chemotherapy but was referred for pain control. The allocated CNS undertook a first assessment and agreed a management plan with Mrs N and her husband. This involved the titration of analgesics. Mrs N was visited weekly by her CNS who supported her as her analgesics were gradually increased from paracetamol to a opioid. As chemotherapy commenced Mrs N was still in pain. This reached crisis point, Mrs N became very distressed and called an out of hours Doctor and an injection of strong opiates was given. Further follow up visits were required by the CNS to increase the opiate dose to a point where pain was fully controlled.

A strong therapeutic relationship was established and Mrs N was reluctant to be discharged. As a result the CNS agreed to visit Mrs N once a month until her chemotherapy had completed.

In total Mrs N received 10 visits at home from her CNS prior to completion of chemotherapy and discharge back to the primary health care team. Total cost of CNS interventions in this situation would have been approximately £597.19

#### **Post innovations**

Mrs N was referred to the community service. Diagnosed with advanced breast cancer she was about to commence chemotherapy but was referred for pain control.

Triage undertook an initial telephone assessment and gave Mrs N some basic advice regarding pain management, mainly to take paracetamol regularly and maintain a pain diary until the CNS visited her at home.

At first home assessment the allocated CNS had a clear record of Mrs N pain issues and was able to suggest the introduction of opiates and continued use of a pain diary. At the next review visit it was clear that Mrs N required a significant increase in her opiate dose. This was actioned via a call to the GP and a follow up visit by the CNS arranged. At this point Mrs N was pain free but anxious about discharge- Mrs N made a call to the on call service and received immediate and sensitive support. T the next CNS visit a plan of action was agreed which saw Mrs N transferred to the triage step down caseload. Mrs N received 3 calls from the team at monthly intervals before she felt confident enough to be discharged. Supporting information was sent to Mrs N informing her how and when she could be re-referred. In total Mrs N had 4 triage contacts and 3 CNS home visits which is a significant reduction in contacts

and costs incurred. The total cost of CNS interventions in this situation would have been approximately £255.36

By changing the way in which Mrs N was supported approximately £341.83 cost saving was achieved. In relation to time which was released for use with other patients a total of 850 minutes were released, this equates to 14.2 hours.

## Appendix 2: Levels of complexity for a sample of CNS's over a one week period

CNS 1:

<b>Patient Status</b>	<b>Number logged</b>
Stable	1
Unstable	8
Deteriorating	4
Dying	0

CNS 2:

<b>Patient Status</b>	<b>Number logged</b>
Stable	2
Unstable	22
Deteriorating	2
Dying	0

CNS 3:

<b>Patient Status</b>	<b>Number logged</b>
Stable	0
Unstable	14
Deteriorating	7
Dying	0

CNS 4:

<b>Patient Status</b>	<b>Number logged</b>
Stable	0
Unstable	17
Deteriorating	5
Dying	0

CNS 5:

<b>Patient Status</b>	<b>Number logged</b>
Stable	4
Unstable	23
Deteriorating	14
Dying	4



Data listed shows consistent targeting of activity within the patients with most complex needs whose condition is unstable or deteriorating. This was one of the aims of the service redesign- to enable the CNS team to spend more time with those patients with greatest need.

## St Richard's Hospice Community CNS Service

### INPUTS

#### Investment

**Set up costs: £1456.40**

**On-going yearly costs:  
£14,240.11**

Costs consist of:

1. Planning time
2. Resources (for patients and staff)
3. Increased administration support
4. Realignment of staff into geographical teams
5. Refocus of services i.e. on call is filtered through the inpatient unit

### THE SERVICE

#### The history

- Specialist community CNS service in South Worcestershire
- Well established- consistent referrals from all areas

#### Pressure points

- Referral numbers increasing
- Complexity increasing
- High caseload numbers
- Consistent additional hours worked
- Ineffective use of existing resources
- Unnecessary visits where being undertaken
- Need for increased peer support as high levels of stress
- Time limited for complex patients

#### Action

3 key innovations including:

Expansion of triage, proactive caseload management and changes to on call process

### SUMMARY OF BENEFITS

#### For those using the service

- Enhanced access 24/7- via changes to on-call provision and released capacity
- Increased choice. 30 patients over a 4 month period where able to choose not to see a CNS at home
- An average of 10 patients per month had a prescription written within their home by a CNS reducing the need for GP review.

#### For St Richard's Hospice

- 1,674 hours of CNS time released
- £35,181.54 costs saved which can be redeployed to increase cost effectiveness

#### Wider health care services

- Potential reduction in unnecessary admissions saving approximately £32,760 and preventing 156 admissions over a 1 year period.
- Reduction in number of GP reviews (saving a minimum of 20 hours GP time over a 1 year period)

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