

Summary: Intervention & Options

Department /Agency:
Department of Health

Title:
Impact Assessment of the End of Life Care Strategy

Stage: Final Proposal

Version: 4.4

Date: 30 June 2008

Related Publications: End of Life Care Strategy, End of Life Care Strategy Equality Impact Assessment, NHS Next Stage Review

Available to view or download at:

<http://www.dh.gov.uk/eolc>

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What is the problem under consideration? Why is government intervention necessary?

The end of life is an important area of care - everyone eventually dies, and many people are affected by, and need support during the illness and death of a loved one. Yet many people don't receive the best care. Also health professionals can be unwilling to accept that someone's condition is incurable, which can have a detrimental impact on the extent to which people's preferences for care are elicited and their needs planned for. Whilst some work has already been undertaken to improve care provision, the breadth of this area of care requires a national programme of work to be put in place.

What are the policy objectives and the intended effects?

The End of Life Care Strategy sets out the current status and challenges to the delivery of end of life care. It reflects the findings from the NHS Next Stage Review, setting out the national activities which will be undertaken to translate the SHAs' local visions for end of life care into action. It will support improved access to high quality end of life care, which will deliver co-ordinated services that meet people's needs and preferences for care. These services will address existing inequalities in end of life care provision, the principal focus of which is care for people with cancer.

What policy options have been considered? Please justify any preferred option.

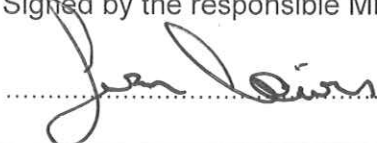
Four options have been considered. 1) take no action, leaving it to local agencies to improve end of life care in their area; 2) to focus on improving services in the community; 3) to improve community services and to put in place training on end of life care for health and social care staff; and 4) to take forward the work on community services and training, as well as to improve the provision of bereavement services. Option 4 is preferred as this will deliver the most significant improvements for patients, carers and relatives, and at the best value for money in terms of net benefits.

When will the policy be reviewed to establish the actual costs and benefits and the achievement of the desired effects? The policy direction set out in the End of Life Care Strategy, and its implementation, will be reviewed annually and a report published.

Ministerial Sign-off For final proposal/implementation stage Impact Assessments:

I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) the benefits justify the costs.

Signed by the responsible Minister:



Date: 15/7/2008

Summary: Analysis & Evidence

Policy Option: Two	Description: Improving community services
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COSTS	ANNUAL COSTS	Description and scale of key monetised costs by 'main affected groups' Comprehensive rapid response services, dedicated palliative care transport, strategic co-ordination and co-ordination centres, support for carers, the homeless and others affected by end of life care, information for care, limited training to deliver end of life care programmes	
	One-off (Transition) Yrs		
	£ £8m Capital		3
	Average Annual Cost (excluding one-off)		
	£ 160m	Total Cost (PV) £ 1,039m	
Other key non-monetised costs by 'main affected groups'			

BENEFITS	ANNUAL BENEFITS	Description and scale of key monetised benefits by 'main affected groups' Quality of life improvement for patients receiving responsive care according to their needs and wishes, for those enabled to die outside hospital if desired and for those receiving improved end of life care who still die in hospital	
	One-off Yrs		
	£		
	Average Annual Benefit (excluding one-off)		
	£ 444m	Total Benefit (PV) £ 3,518m	
Other key non-monetised benefits by 'main affected groups'			

Key Assumptions/Sensitivities/Risks QALYs valued at £50k. Net benefit assumes that at the margin the DH budget yields a QALY per £25k. Main assumptions/risks are on staff training numbers, staff recruited on average to middle of AfC pay scales. QoL average gain of 0.2 for patients over 6 weeks and lower to 12 months.

Price Base Year 78	Time Period Years 10	Net Benefit Range (NPV) £ 35m - 3,017m	NET BENEFIT (NPV Best estimate) £ 1,440m
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What is the geographic coverage of the policy/option?	England				
On what date will the policy be implemented?	16 July 2008				
Which organisation(s) will enforce the policy?	N/A				
What is the total annual cost of enforcement for these organisations?	£ 0				
Does enforcement comply with Hampton principles?	Yes				
Will implementation go beyond minimum EU requirements?	No				
What is the value of the proposed offsetting measure per year?	£ 0				
What is the value of changes in greenhouse gas emissions?	£ 0				
Will the proposal have a significant impact on competition?	No				
Annual cost (£-£) per organisation (excluding one-off)	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; text-align: center;">Micro 0</td> <td style="width: 25%; text-align: center;">Small 0</td> <td style="width: 25%; text-align: center;">Medium 0</td> <td style="width: 25%; text-align: center;">Large 0</td> </tr> </table>	Micro 0	Small 0	Medium 0	Large 0
Micro 0	Small 0	Medium 0	Large 0		
Are any of these organisations exempt?	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; text-align: center;">Yes</td> <td style="width: 25%; text-align: center;">Yes</td> <td style="width: 25%; text-align: center;">N/A</td> <td style="width: 25%; text-align: center;">N/A</td> </tr> </table>	Yes	Yes	N/A	N/A
Yes	Yes	N/A	N/A		

Impact on Admin Burdens Baseline (2005 Prices)		(Increase - Decrease)
Increase of £ 0	Decrease of £ 0	Net Impact £ 0

Key:	Annual costs and benefits: Constant Prices	(Net) Present Value
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Summary: Analysis & Evidence

Policy Option: Three

Description: Improving community services, education and training and improving environments for care

COSTS	ANNUAL COSTS		Description and scale of key monetised costs by 'main affected groups' Comprehensive rapid response services, dedicated palliative care transport, strategic co-ordination and co-ordination centres, support for carers, the homeless and others affected by end of life care, information for care, limited training to deliver end of life care programmes, improvements to hospital care environment
	One-off (Transition)	Yrs	
	£ 60m Capital	6	
	Average Annual Cost (excluding one-off)		
	£ 198m		Total Cost (PV) £ 1,338m
Other key non-monetised costs by 'main affected groups'			

BENEFITS	ANNUAL BENEFITS		Description and scale of key monetised benefits by 'main affected groups' Quality of life improvement for patients receiving responsive care according to their needs and wishes, for those enabled to die outside hospital if desired and for those receiving improved end of life care who still die in hospital. Quality of life improvements for immediate carers and limited improvements for relatives.
	One-off	Yrs	
	£		
	Average Annual Benefit (excluding one-off)		
	£ 574m		Total Benefit (PV) £ £4,548
Other key non-monetised benefits by 'main affected groups'			

Key Assumptions/Sensitivities/Risks QALYs valued at £50k. Net benefit assumes that at the margin the DH budget yields a QALY per £25k. Main assumptions/risks - staff training numbers, staff recruited on average to middle of AfC pay scales, QoL average gain of 0.2 for patients over 6 weeks, lower to 12 months and proportionally lower gains for carers/relatives

Price Base Year 78	Time Period Years 10	Net Benefit Range (NPV) £ 136m - 3,834m	NET BENEFIT (NPV Best estimate) £ 1,872m
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What is the geographic coverage of the policy/option?		England		
On what date will the policy be implemented?		16 July 2008		
Which organisation(s) will enforce the policy?		N/A		
What is the total annual cost of enforcement for these organisations?		£ 0		
Does enforcement comply with Hampton principles?		Yes		
Will implementation go beyond minimum EU requirements?		No		
What is the value of the proposed offsetting measure per year?		£ 0		
What is the value of changes in greenhouse gas emissions?		£ 0		
Will the proposal have a significant impact on competition?		No		
Annual cost (£-£) per organisation (excluding one-off)	Micro 0	Small 0	Medium 0	Large 0
Are any of these organisations exempt?	Yes	Yes	N/A	N/A

Impact on Admin Burdens Baseline (2005 Prices)		(Increase - Decrease)	
Increase of	£ 0	Decrease of	£ 0
		Net Impact	£ 0

Key:	Annual costs and benefits: Constant Prices	(Net) Present Value
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Summary: Analysis & Evidence

Policy Option: Four	Description: Improving community services, education and training, improving environments for care and care after death
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COSTS	ANNUAL COSTS		Description and scale of key monetised costs by 'main affected groups' Comprehensive rapid response, dedicated palliative care transport, strategic co-ordination/co-ordination centres, carer/homeless support, information supporting care, extensive training to deliver end of life care programmes, improvements to hospital care environment, comprehensive bereavement services
	One-off (Transition)	Yrs	
	£ 100m Capital	6	
	Average Annual Cost (excluding one-off)		
£ 226m			Total Cost (PV) £ 1,549m
Other key non-monetised costs by 'main affected groups'			

BENEFITS	ANNUAL BENEFITS		Description and scale of key monetised benefits by 'main affected groups' Quality of life improvement for patients receiving responsive care according to their needs and wishes, for those enabled to die outside hospital if desired and for those receiving improved end of life care who still die in hospital. Quality of life improvements for immediate carers and relatives.
	One-off	Yrs	
	£		
	Average Annual Benefit (excluding one-off)		
£ 790m			Total Benefit (PV) £ 6,269m
Other key non-monetised benefits by 'main affected groups'			

Key Assumptions/Sensitivities/Risks QALYs valued at £50k. Net benefit assumes that at the margin the DH budget yields a QALY per £25k. Main assumptions/risks - staff training numbers, staff recruited on average to middle of AfC pay scales, QoL average gain of 0.2 for patients over 6 weeks, lower to 12 months and proportionally lower gains for carers/relatives

Price Base Year 78	Time Period Years 10	Net Benefit Range (NPV) £ 682m - 6,018m	NET BENEFIT (NPV Best estimate) £ 3,171m
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What is the geographic coverage of the policy/option?		England		
On what date will the policy be implemented?		16 July 2008		
Which organisation(s) will enforce the policy?		N/A		
What is the total annual cost of enforcement for these organisations?		£ 0		
Does enforcement comply with Hampton principles?		Yes		
Will implementation go beyond minimum EU requirements?		No		
What is the value of the proposed offsetting measure per year?		£ 0		
What is the value of changes in greenhouse gas emissions?		£ 0		
Will the proposal have a significant impact on competition?		No		
Annual cost (£-£) per organisation (excluding one-off)	Micro 0	Small 0	Medium 0	Large 0
Are any of these organisations exempt?	Yes	Yes	N/A	N/A

Impact on Admin Burdens Baseline (2005 Prices)		(Increase - Decrease)		
Increase of £ 0	Decrease of £ 0	Net Impact		£ 0

Key: Annual costs and benefits: Constant Prices (Net) Present Value

Evidence Base (for summary sheets)

[Use this space (with a recommended maximum of 30 pages) to set out the evidence, analysis and detailed narrative from which you have generated your policy options or proposal. Ensure that the information is organised in such a way as to explain clearly the summary information on the preceding pages of this form.]

A. The Issue: End of Life Care

1. The end of life is an important area of care – everyone eventually dies (about 500,000 a year in England), and many people are affected by, and need support during the illness and death of a loved one.
2. However, as a society we are much less familiar with death and dying than we used to be. This has contributed to a general unwillingness to talk about wishes and preferences for care at the end of life, and to the low level of priority accorded to end of life care services within health and social care. It is also reflected in a frequent unwillingness by health professionals to accept that someone's condition is incurable, which can limit the extent to which people's preferences for care are elicited.
3. In recent surveys, a majority of people, ranging from 56%-74%, express a preference to be cared for and die at home. However, currently most deaths occur in institutions, with hospitals accounting for some 58% of deaths. Only about 18% of deaths occur at home, with a further 17% occurring in care homes (which for many people is their home).
4. Additionally, as a consequence of end of life care having developed out of the treatment and care of people with terminal cancer, good end of life care is generally more accessible to people with a cancer diagnosis. Typically, some 90% of the caseload of Hospices, which provide specialist care for people at the end of life, are cancer sufferers. Yet cancer accounts for only 25% of all deaths.
5. A number of initiatives have been put in place to improve services at the end of life, including:
 - National Institute for Clinical Excellence Guidance on Supportive and Palliative Care (2004);
 - District Nurses Training Programme in palliative care;
 - Additional £50m per annum for specialist palliative care; and
 - NHS End of Life Care Programme (2004-07).
6. However, more needs to be done to ensure consistent access to high quality care across the country.

B. Policy: End of Life Care Strategy

7. To bring about this national improvement in end of life care, the Government in 2006 announced the development of a national End of Life Care (EoLC) Strategy. This was published on 16 July 2008. This supports and complements the findings and proposals set out within the NHS Next Stage Review, published on 30 June 2008.
8. The EoLC Strategy sets out the challenges faced by service providers and commissioners in the delivery of effective, co-ordinated care for all people at the end of life. Complementing the Next Stage Review, which identifies local action to be taken forward by the Strategic Health Authorities (SHAs), the Strategy identifies the key issues that need to be addressed to improve the provision of care, and sets out the action that will be taken at a national level to support local organisations in the implementation of the Strategy.
9. This Impact Assessment presents an analysis of the estimated costs and benefits of the various options considered during the development of the EoLC Strategy.

C. Purpose and Intended Effect

10. The Strategy is intended to enable a step change in the provision of, and access to high quality end of life care. It will:
 - Increase public awareness and discussion of death and dying, making it easier for individuals to discuss their own preferences around end of life care;
 - Foster a more strategic approach to commissioning end of life care services across health and social care;
 - Ensure that health and social care staff have the necessary training to better identify when people are approaching the end of life, to help staff initiate discussions about their preferences for care, and to enable them to provide quality end of life care;
 - Ensure that people at the end of life, and their carers, have their needs properly assessed, and for these to be recorded on a care plan;
 - Ensure that care is well coordinated, and can be accessed rapidly 24/7;
 - Support the provision of high quality, integrated care across all settings;
 - Ensure that health and social care staff provide sensitive and culturally and spiritually responsive care during the last days of life and after death;
 - Establish the importance of involving family and carers in decisions about care, and of assessing their needs and ensuring that they are adequately supported;
 - Ensure health and social care organisations provide readily available information on all local services for those approaching the end of life;
 - Set out a programme of work for research into end of life care to support the evaluation and development of services and approaches to care provision; and
 - Establish mechanisms for the collection and analysis of data on end of life care services to support the commissioning and evaluation of services.

D. Consultation and Development

11. Over 300 clinicians, patients, charity representatives, managers from health and social care, academics and other experts were involved in the development of the EoLC Strategy. Input from these groups was sought in various ways, including through a consultation exercise and consultation event.
12. The six Working Groups and the Advisory Board, which oversaw and contributed to the development of the Strategy, also had significant stakeholder representation. The six Working Groups were:
 - Care Pathways and Service Models;
 - Analysis and Modelling;
 - Care Homes;
 - Levers for Change;
 - Measurement; and
 - Workforce.
13. Final recommendations were submitted by the Advisory Board to Ministers. These have, in tandem with the work of the SHAs to develop their local visions on end of life care for the NHS Next Stage Review, heavily informed the content of the final Strategy.

E. Policy Options

14. A number of policy options have been considered during the development of the Strategy. These options consisted of groupings of proposed activities which would deliver improvements in end of life care provision. The options reflected, in light of the finite resources of the NHS and other organisations, potential affordability constraints, and included:
 - Option one – No action: To take no central action, leaving it to local agencies to develop services according to their local priorities.
 - Option two - Improving community services: To improve the provision of services within the community so that more people are able to receive care which allows them to be cared and die in their own home. This includes: extending the current (2004/07) End of Life Care Programme, driving quality improvement through measurement of end of life provision, increasing public awareness of death and dying, developing co-ordination centres, implementing end of life registers and establishing rapid response and 24/7 community services.
 - Option three – Improving community services, education and training and improving environments for care: Incorporating and building on option two by ensuring that all staff who come into contact with people at the end of life have sufficient training to provide the best quality care, and that care environments are improved. This includes: as above, plus education and training for all staff groups involved in the delivery of end of life care, and improvements to care environments in hospitals for people at the end of life.

- Option four – Improving community services, education and training, improving environments for care and care after death: Incorporating and building on options two and three by improving the provision of bereavement services. This includes: as above, plus making bereavement services to be available to carers and staff, ensuring care is more responsive to cultural and spiritual needs, and providing comprehensive information on access to services.

15. Option four has been selected as it delivers the most significant improvements for people at the end of life, their carers and loved ones, and at the best value for money in terms of net benefits.

F. Financial treatment and areas of spend

16. Each of the three main options (excluding “option 1: no action”) is set out in the summary sheets, and within each area into a set of specific actions. We have given details of these actions in the following sections, preceded by a summary of the anticipated risks, assumptions and benefits arising from the strategy. The summary tables at the end of the section set out the estimated revenue and capital costs associated with the options outlined above.

17. This Impact Assessment sets out national estimates of the cost of implementing the strategy and an indicative profile year by year. The actual costs of implementation will depend on decisions taken by the NHS that will reflect local circumstances and affordability.

18. The activities and associated costs build up over the options and all activities for the preferred option, option 4, are described in the following paragraphs

19. All figures shown in the summary tables are inflated on 2007/08 prices at 3% for 2008/09 and 2.75% pa thereafter. The final column shows total costs at Present Value (PV). All PVs are the sum of future costs at present prices These have been inflated as outlined above and discounted at 6.2% per annum.

20. For each of the strategy activities described, a reference is provided to the estimated costs set out in the Option 4 table on page 17. This table sets out estimated costs over a 10-year period from 2009/10 to 2018/19. Annex A includes further details of how the costs are built up for each activity and over the main options (2 to 4) includes a range of cost to indicate possible variations to the cost estimates.

RISK AND ASSUMPTIONS OF THE END OF LIFE CARE STRATEGY

21. The main risks and assumptions for the strategy can be summarised as follows:

- (i) The number of additional staff identified as being necessary to carry out the strategy may be an underestimate – this is mitigated by taking advice from eg Marie Curie who have extensive experience of piloting the delivery of end of life care activities. We have also adapted the costs to be on an ‘organisation’ basis rather than

population basis (eg in calculating the Rapid Response costs) to more accurately reflect how services will actually be configured.

- (ii) It is assumed that new staff will on average be recruited at the middle of the relevant Agenda for Change paycales.
- (iii) The number of staff identified for training on aspects of delivering end of life care represents our best estimates but has some uncertainties over identifying exact numbers within specific staff groups. However, a large proportion of the requirements is clearly defined (eg GPs, consultants and senior medical staff, district and community nurses), while further work will be undertaken to refine numbers relating to eg social care and Allied Health Professionals
- (iv) The cost of training courses has been estimated as an average of the cost range for comparable training courses already delivered for cancer care – relating to Advanced Communications Skills Training and delivering care. This represents the best estimate of how much on average each training module would cost to train someone in the necessary skills to deliver high quality end of life care. It is also possible that in the long run these costs may represent an overestimate as initiatives such as e-learning may reduce overall costs of delivering training.
- (v) The capital cost estimates for improving hospital environments are reasonably reliable in terms of the range of possible costs at an individual trust eg the cost of establishing a two-bed palliative care suite is reasonably fixed. However, the evidence of the extent of improvements required across hospitals as a whole is largely anecdotal.

22. The costs shown represent the ‘best estimate’, but further details of identified risks are set out in Annex A.

BENEFITS OF THE END OF LIFE CARE STRATEGY

23. The End of Life Care Strategy highlights the deficiencies in the current delivery of end of life care – that many people are not able to die with dignity and peace of mind in the manner and location of their choosing. Furthermore, that care needs are not often properly assessed and taken account of when delivering care.

24. The benefits are thus identified, and quantified, on the basis of estimating improvements in quality of life, mainly for patients, but also for carers and relatives. A Quality-Adjusted Life Year (QALY) approach is taken, but modified to take a number of factors into account:

- That benefits are accrued in terms of improving quality rather than length of life given that the ultimate outcome is death.
- The number of people who could benefit from improved end of life care – 500,000 people die every year, of which 275,000 die in hospital. A substantial portion of these people would prefer to die outside hospital – a 50,000 reduction, for instance, would represent a 10 percentage point reduction in the proportion of people dying in hospital. However, those who die in hospital will also receive some benefit from more responsive and better co-ordinated end of life care.
- Carers and relatives will benefit in varying degrees from improvements in end of life care, for instance through care plans for carers, improved environments of care and improved bereavement services – all of which will provide increased peace of mind and by extension can be quantified in terms of ‘quality of life’ gains.

- The total benefits over the 10-year timescale set out for the costs indicate estimated benefits of around £6.3bn (PV) for the preferred option, option 4 (with net benefits around £3.2bn).
- Further details on the modelling of benefits arising from the strategy are set out in Annex B

25. The benefits will be delivered through the activities that are set out below:

COMMUNITY AND RAPID RESPONSE SERVICES [see also option 4 table, line 1]

26. Whilst a majority of people at the end of life express a wish to die at home, nearly 60% die in hospital. A significant reason for this is the lack of service provision in the community. With limited access to appropriately skilled care, many people at the end of life are admitted to hospital for relatively routine treatment. Frequently, there is then a lack of sufficient support in place in the community, as well as problems gaining prompt access to an emergency ambulance, to enable them to be discharged. Putting in place comprehensive 24/7 community medical and nursing cover, which can also provide a rapid response to emergencies, would enable the handling of many crisis episodes within the community setting, and would provide the necessary support to allow people to die at home.

AMBULANCE SERVICES [see also option 4 table, lines 2 – 3, 31]

27. Ambulance services, and patient transport providers, play a key role in enabling people at the end of life to access health care services at a time when they become increasingly debilitated and dependent. However, people at the end of life can experience substantial waits for an appropriately equipped and staffed vehicle, which could potentially be diverted to emergencies. This is a particular problem in relation to discharge from hospital, which can result in the failure of the patient to make it home, with the consequence that they die in hospital. There are also concerns that information on a person's preferences for care are not always disseminated to ambulance crews, leading to medical interventions that are not consistent with the person's wishes. Increasing the number of vehicles and staff would enable some of these issues to be addressed, as would ensuring that ambulance trusts have procedures in place to ensure that crews have access to details on the particular care needs and preferences of people who are at the end of life.

COORDINATION [see also option 4 table, lines 4 - 7]

28. Increasingly, GP practices have in place registers to support the identification of all people who are approaching the end of their lives. To ensure that everyone gets access to end of life care who requires it, these registers should be in place across the country. These registers should also be accessible to other service providers, to ensure that they are alerted to, and can cater for the specific needs of people at the end of their lives.

29. The use of registers helps to support the effective coordination of care across teams and agencies, which is particularly important for people at the end of life who often need responsive, integrated care from health, social care services and the voluntary sector. In line with the learning from Marie Curie Cancer Care's Delivering Choice Programme, establishing centres to provide a single route of access for coordination of care packages

would improve the overall ease of access to, and quality of care. Creating partnerships or networks of local agencies would help ensure that this co-ordination worked effectively, and was fully supported through local service planning and commissioning.

30. An important component of well-coordinated care is the development of care plans for both people at the end of life, and their carers, which accurately reflect their needs and preferences. Ensuring that care plans are put in place will enable agencies to prepare packages of care that effectively support care provision in the place of choice.

TRAINING AND EDUCATION [see also option 4 table, lines 8 - 16]

31. End of life care training is not explicit within pre and post registration training for registered staff, despite care at the end of life being such a substantial part of service provision. In addition, many support worker staff, and others who are unregistered, will have few, if any, of the competencies required to provide end of life care. Ensuring that competences are more defined, and assessed against, will help to establish it as a priority area of care, and will support overall improvements in the quality of care.
32. Having the initial discussions with people about the terminal nature of their condition, and talking through their preferences for care and undertaking assessments of, and care plans to meet, their needs is a very difficult area for health and social care staff. Many staff lack the confidence to broach the likelihood of death with the people they are caring for, and to engage in continuing discussions on an area which has such an emotional impact. They also often lack specific training on performing assessments for people at the end of life, whose needs can frequently differ to those with non-terminal conditions. Putting in place specific end of life communication and assessment training will improve staff confidence and ensure people's needs at the end of life are more fully elicited and addressed.

WORKFORCE EXPANSION [see also option 4 table, lines 17 - 19]

33. Whilst the training and education of the existing and future workforce is key to the delivery of improved end of life care, there is also a need for limited increases in workforce numbers. Specialist palliative care provision is currently focused on caring for people with cancer. To enable specialist teams to extend their support to people with other conditions, both in hospital and the community, will require some increase in the numbers of specialist staff.
34. In addition, elements of the Strategy place additional demands on staff, such as providing more comprehensive care assessments and in ensuring that the needs of isolated groups, such as the homeless, are met. This will require some additional numbers of general nursing staff.

IMPROVING THE ENVIRONMENT [see also option 4 table, lines 32 - 34]

35. The caring environment has a substantial impact on people's perceptions of the overall quality of care provided at the end of life, both for those who are dying and their relatives and carers. However, the caring environment in hospitals (where most people die) is often poorly designed, and does not effectively support care that accords the person at the end of life and their carers proper dignity and respect. Putting in place a programme of

improvements to hospital environments, such as the development of palliative care suites and areas for relatives and carers, will provide substantial improvements in the quality, and experience, of care.

36. Voluntary sector hospices play a vital role in the provision of care at the end of life for those with particularly complex symptoms. The hospice sector provides a lot of care out in the community, but they also provide in-patient care on behalf of the NHS. As with the improvements to hospital environments, providing a capital fund for the voluntary sector hospices will enable them to take forward improvements to the care environment to improve the overall quality of care provision.

BEREAVEMENT SERVICES [see also option 4 table, line 30]

37. The time up to, and after the death of a loved is a very difficult time, and can have long term effects on their health. Comprehensive support should therefore be available to carers and relatives to enable them to cope. This should reflect the varied needs of different carers and relatives, such as child carers or the relatives of someone who has died suddenly and unexpectedly. Ensuring that organisations dealing with people at the end of life have comprehensive information available on how to access bereavement support services will also improve the care that the bereaved receive.

EXTENDING THE END OF LIFE CARE PROGRAMME [see also option 4 table, line 20]

38. The aim of the NHS End of Life Care Programme was to provide training for generalist staff in end of life care, and to improve access to end of life care services. The principle focus for this was the dissemination of tools, the principal ones being the Liverpool Care Pathway (LCP), the Gold Standards Framework (GSF) and the Preferred Priorities for Care (PPC), which set out structured approaches to facilitate improvements in care provision. Continuing with this work will help to ensure long-term sustainability, and encourage broader service improvement across all end of life care services.

NATIONAL WORK PROGRAMME [see also option 4 table, lines 21 - 29]

39. Some development and piloting work will need to be undertaken to support the delivery of improvements to end of life care. Given its national applicability, it is necessary for this work to be led from the centre by the Department of Health. The work programme includes:
- The development of an Intelligence Network to undertake collation and analysis of data on end of life care to support the evaluation and development of end of life care services;
 - The development, piloting and roll-out of a national survey of bereaved relatives to measure the quality of care provision;
 - Supporting the audit of end of life care services through the development, piloting and roll-out of a tool for auditing primary care services, and through the provision of financial support for the National LCP Care of the Dying Audit;
 - Establishing pilots to explore the most effective methods for implementing locality-wide registers to record all those people who are approaching the end of life;
 - Providing support to the National Council for Palliative Care to establish a national coalition to take forward work on promoting awareness of end of life care issues;

- The development of a competency framework for end of life care to support workforce development initiatives;
- Establishing a group to provide advice and oversight on the implementation of the Strategy; and
- To consult on a set of quality standards for end of life care, and to take forward a programme of work on how these could be peer reviewed.

G. Areas Affected

40. The End of Life Care Strategy is likely to affect four particular groups, which can be described as follows:

- **NHS** – The End of Life Care Strategy sets out a number of activities to enable the NHS to improve End of Life Care services. The estimated costs and benefits of the strategy have been set out in the End of Life Care Strategy and this document. The most significant changes are improvements to community and acute services, including bereavement services, education and training for the workforce and improving the environments for patient care and mortuary services.
- **Voluntary Sector** – The voluntary sector already play a central role in end of life care provision. The End of Life Care Strategy will provide the sector with extensive opportunities to increase the range of their contribution. The activities which they may wish to contribute to are included in the costs set out in this document.
- **Private Sector** – The End of Life Care Strategy will have some impact on the private sector, specifically in relation to the training of staff in care homes. The provision of training by health services is incorporated in the costs for the Strategy set out within this document.
- **Local Government** – The End of Life Care Strategy will have an indirect impact on local government. The Strategy sets out the need for improved co-ordination of care, including social care, and more effective joint working between PCTs and Local Authorities. The Strategy identifies PCTs (and SHAs) as the lead agencies for fostering this engagement, and the costs to support this are set out in this document. The Strategy also has an impact on training for social care staff, which SHAs will oversee. The associated costs for this are also reflected in this document.

H. Links to other policy areas

41. The End of Life Care Strategy has been developed alongside, and is consistent with, a number of other strategy documents and policy areas. The key ones include:

- **NHS Next Stage Review** – the emerging findings from the work on the Strategy were shared with the SHA End of Life Care Pathway Chairs to help inform their work. Additionally, the chairs have had several opportunities to influence the development of the Strategy, and actively requested that a set of national quality standards be developed as part of the Strategy work;
- **Carers Strategy** – the important role played by carers, and a recognition of their needs, is strongly reflected in the Strategy. In particular, it identifies the importance of young carers and bereavement care, which is reflected in the Carers Strategy; and
- **Clinical policy areas** – the Strategy has been developed with input from a broad range of clinical specialists and a number of other clinical policy areas, so that the generic framework for end of life care which the Strategy sets out is applicable to the full range of

conditions, including: heart failure, neurological conditions, chronic obstructive pulmonary disease, renal disease etc.

42. Future developments in these, and other, policy areas will also be taken account of during the implementation of the Strategy.

I. Implementation

43. The End of Life Care Strategy will be implemented by the NHS, working in partnership with Local Authorities and with support from the Department of Health.
44. Implementation will be locally driven, with direction and support provided by the National Clinical Director with responsibility for end of life care, the Department of Health End of Life Care Team and the National End of Life Care Programme.

J. Additional impact tests

EQUALITY IMPACT ASSESSMENT

45. An Equality Impact Assessment has been undertaken to inform the development of the End of Life Care Strategy, and has been published on the Department of Health website. This should be consulted for issues surrounding race, disability, gender and human rights (see www.dh.gov.uk/eolc).

SUSTAINABLE DEVELOPMENT IMPACT TEST

46. We have considered the impact of the strategy on sustainable development, and no significant adverse impact was found. The strategy will be consistent with the five principles of sustainable development. In particular, it will support better care planning and deployment of transport and care services, providing a responsive service to patients and improving the quality of life of patients, carers and patients' relatives. It will also support stronger governance of end of life care service provision.

RURAL PROOFING IMPACT TEST

47. Rural issues have been considered as part of the development of the policy, but no significant adverse impact was found. Indeed, the move towards better co-ordinated care and increased coverage of community services is likely to impact positively on rural communities.

GREENHOUSE GAS EMISSIONS

48. The potential impact of the End of Life Care Strategy on greenhouse gas emissions has been considered. The main impact is on human resources, and so has little greenhouse gas

effects. One area of potential impact is the provision of more vehicles to support improved transport provision for people at the end of life. However, the number of additional journeys will be relatively small, and is likely to be at least partially offset by a reduction in the number of privately arranged journeys. Furthermore, better assessment, care planning, and support and information for carers should help reduce the number of unnecessary patient and nurse journeys related to medical care, which could be dealt by other means.

IMPACT ON COMPETITION

49. Implementation of the End of Life Care Strategy will have no negative impact, and may indeed have some positive impact as new providers, or existing voluntary sector providers, address the new models of care set out in the Strategy.

HEALTH IMPACT ASSESSMENT CHECK

50. Annex C summarises the Health Impact Assessment check.

SUMMARY OF END OF LIFE CARE STRATEGY COSTS [OPTION 1 – No action, entails no extra costs]

Option 2 – Improving community services

Revenue costs of the End of Life Care Strategy	£m											Total	Total (PV)
	09/10	10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19			
Costs identified:													
Rapid response/24h community services	24.9	29.6	34.9	42.2	43.3	44.5	45.7	47.0	48.3	49.6	410.0	265.7	
Palliative care transport - crew	7.1	12.9	18.9	19.4	19.9	20.5	21.0	21.6	22.2	22.8	186.3	120.0	
Ambulance trust - EOLC lead	0.1	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.3	0.3	2.5	1.6	
Co-ordination centres	2.7	5.6	7.7	9.9	10.2	10.5	10.8	11.1	11.4	11.7	91.7	58.4	
Rapid discharge facilitation	1.9	3.9	5.3	6.8	7.0	7.2	7.4	7.6	7.8	8.0	62.9	40.1	
Strategic co-ordination	1.8	3.8	7.7	9.9	10.2	10.5	10.8	11.1	11.4	11.7	88.9	56.0	
Assessment for carers	1.6	3.3	4.5	5.8	5.9	6.1	6.3	6.4	6.6	6.8	53.4	34.0	
Training - "care planning/assessment" - care home	2.2	6.5	10.1	16.4	16.8	17.3	17.7	1.8	1.9	1.9	92.6	63.1	
Training - "symptom management"	0.4	1.2	1.8	2.9	3.0	3.1	3.2	0.3	0.3	0.3	16.5	11.2	
Training - "care planning/assessment - staff	0.6	1.7	2.7	4.4	4.5	4.6	4.7	0.5	0.5	0.5	24.7	16.8	
Training - "starting the EOLC conversation"	0.4	1.2	1.8	2.9	3.0	3.1	3.2	0.3	0.3	0.3	16.5	11.2	
Training - social care staff	0.3	0.9	1.4	2.3	2.4	2.5	2.5	0.3	0.3	0.3	13.2	9.0	
Training - GP additional training	0.3	0.8	1.3	2.1	2.2	2.2	2.3	0.2	0.2	0.2	11.9	8.1	
Training - "nurse verification of death"	0.1	0.4	0.6	1.0	1.1	1.1	1.1	0.1	0.1	0.1	5.8	4.0	
Modifying existing communications skills training	1.1	1.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.4	2.0	
Training - backfill	0.1	0.4	0.6	1.0	1.1	1.1	1.1	0.1	0.1	0.1	5.8	4.0	
Specialist palliative care resources - hospitals	4.5	9.2	12.6	16.1	16.6	17.0	17.5	18.0	18.5	19.0	148.8	94.8	
Specialist palliative care nursing (supporting Rapid Response)	1.9	3.9	5.8	6.9	7.1	7.3	7.5	7.7	7.9	8.1	64.1	40.9	
Supporting homeless - nurse capacity	1.6	3.3	5.3	5.8	5.9	6.1	6.3	6.4	6.6	6.8	54.2	34.6	
EOLC 'programme'	5.5	11.3	15.5	19.9	20.5	21.0	21.6	22.2	22.8	23.5	184.0	117.2	
National 'observatory/intelligence' unit	1.1	2.4	2.5	2.5	2.6	2.7	2.7	2.8	2.9	3.0	25.1	16.3	
Extending the VOICES programme	0.5	1.1	1.1	1.1	1.2	1.2	1.2	1.3	1.3	1.4	11.5	7.5	
National public awareness tool	0.7	0.8	0.8	0.8	0.8	0.8	0.9	0.9	0.9	0.9	8.4	5.6	
Extending the National Care of the Dying Audit	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	3.0	2.0	
ADA	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3	2.3	1.5	
Piloting EOLC registers	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.3	0.2	
Competency framework development	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	
EOLC standing committee	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	
Total revenue costs identified	62.2	106.2	143.5	181.1	186.0	191.2	196.4	168.7	173.3	178.1	1,586.8	1,025.8	
Capital costs of the End of Life Care Strategy	£m												
	09/10	10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19	Total	Total (PV)	
Costs identified:													
Palliative care transport - vehicle	2.9	3.0	3.1	0.0	0.0	0.0	0.0	3.6	3.7	3.8	20.1	13.3	
Total capital costs identified	2.9	3.0	3.1	0.0	0.0	0.0	0.0	3.6	3.7	3.8	20.1	13.3	
TOTAL costs of the End of Life Care Strategy	65.2	109.2	146.7	181.1	186.0	191.2	196.4	172.3	177.0	181.9	1,606.8	1,039.1	

Option 3 – Improving community services, education and training and improving environments for care

Revenue costs of the End of Life Care Strategy	£m											
	09/10	10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19	Total	Total (PV)
Costs identified:												
Rapid response/24h community services	24.9	29.6	34.9	42.2	43.3	44.5	45.7	47.0	48.3	49.6	410.0	265.7
Palliative care transport - crew	7.1	12.9	18.9	19.4	19.9	20.5	21.0	21.6	22.2	22.8	186.3	120.0
Ambulance trust - EOLC lead	0.1	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.3	0.3	2.5	1.6
Co-ordination centres	2.7	5.6	7.7	9.9	10.2	10.5	10.8	11.1	11.4	11.7	91.7	58.4
Rapid discharge facilitation	1.9	3.9	5.3	6.8	7.0	7.2	7.4	7.6	7.8	8.0	62.9	40.1
Strategic co-ordination	1.8	3.8	7.7	9.9	10.2	10.5	10.8	11.1	11.4	11.7	88.9	56.0
Assessment for carers	1.6	3.3	4.5	5.8	5.9	6.1	6.3	6.4	6.6	6.8	53.4	34.0
Training - "care planning/assessment" - care home	6.7	19.6	30.2	49.1	50.4	51.8	53.2	5.5	5.6	5.8	277.8	189.3
Training - "symptom management"	1.2	3.5	5.4	8.7	9.0	9.2	9.5	1.0	1.0	1.0	49.4	33.6
Training - "care planning/assessment - staff"	1.8	5.2	8.0	13.1	13.4	13.8	14.2	1.5	1.5	1.5	74.1	50.5
Training - "starting the EOLC conversation"	1.2	3.5	5.4	8.7	9.0	9.2	9.5	1.0	1.0	1.0	49.4	33.6
Training - social care staff	0.9	2.8	4.3	7.0	7.2	7.4	7.6	0.8	0.8	0.8	39.5	26.9
Training - GP additional training	0.9	2.5	3.9	6.3	6.5	6.6	6.8	0.7	0.7	0.7	35.6	24.2
Training - "nurse verification of death"	0.1	0.4	0.6	1.0	1.1	1.1	1.1	0.1	0.1	0.1	5.8	4.0
Modifying existing communications skills training	1.1	1.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.4	2.0
Training - backfill	0.4	1.2	1.9	3.1	3.2	3.3	3.3	0.3	0.4	0.4	17.4	11.9
Specialist palliative care resources - hospitals	4.5	9.2	12.6	16.1	16.6	17.0	17.5	18.0	18.5	19.0	148.8	94.8
Specialist palliative care nursing (supporting Rapid Response)	1.9	3.9	5.8	6.9	7.1	7.3	7.5	7.7	7.9	8.1	64.1	40.9
Supporting homeless - nurse capacity	1.6	3.3	5.3	5.8	5.9	6.1	6.3	6.4	6.6	6.8	54.2	34.6
EOLC 'programme'	5.5	11.3	15.5	19.9	20.5	21.0	21.6	22.2	22.8	23.5	184.0	117.2
National 'observatory/intelligence' unit	1.1	2.4	2.5	2.5	2.6	2.7	2.7	2.8	2.9	3.0	25.1	16.3
Extending the VOICES programme	0.5	1.1	1.1	1.1	1.2	1.2	1.2	1.3	1.3	1.4	11.5	7.5
National public awareness tool	0.7	0.8	0.8	0.8	0.8	0.8	0.9	0.9	0.9	0.9	8.4	5.6
Extending the National Care of the Dying Audit	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	3.0	2.0
ADA	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3	2.3	1.5
Piloting EOLC registers	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.3	0.2
Competency framework development	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
EOLC standing committee	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
Quality standards/EOLC peer review	0.4	0.9	1.3	1.4	1.4	1.5	1.5	1.5	1.6	1.6	13.1	8.4
Total revenue costs identified	71.4	132.6	184.2	246.4	253.2	260.2	267.3	177.4	182.2	187.2	1,962.0	1,280.9
Capital costs of the End of Life Care Strategy	£m											
	09/10	10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19	Total	Total (PV)
Costs identified:												
Palliative care transport - vehicle	2.9	3.0	3.1	0.0	0.0	0.0	0.0	3.6	3.7	3.8	20.1	13.3
Improving the environment - patient care area	3.1	3.2	6.5	6.7	6.9	7.0	0.0	0.0	0.0	0.0	33.3	24.3
Improving the environment - mortuary viewing room	2.4	2.5	5.1	5.2	5.4	5.5	0.0	0.0	0.0	0.0	26.1	19.1
Total capital costs identified	8.4	8.7	14.7	11.9	12.2	12.6	0.0	3.6	3.7	3.8	79.5	56.7
TOTAL costs of the End of Life Care Strategy	79.8	141.2	198.9	258.3	265.4	272.7	267.3	180.9	185.9	191.0	2,041.5	1,337.7

Option 4 – Improving community services, education and training, improving environments for care and care after death

Revenue costs of the End of Life Care Strategy		£m										
	09/10	10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19	Total	Total (PV)
Costs identified:												
1 Rapid response/24h community services	24.9	29.6	34.9	42.2	43.3	44.5	45.7	47.0	48.3	49.6	410.0	265.7
2 Palliative care transport - crew	7.1	12.9	18.9	19.4	19.9	20.5	21.0	21.6	22.2	22.8	186.3	120.0
3 Ambulance trust - EOLC lead	0.1	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.3	0.3	2.5	1.6
4 Co-ordination centres	2.7	5.6	7.7	9.9	10.2	10.5	10.8	11.1	11.4	11.7	91.7	58.4
5 Rapid discharge facilitation	1.9	3.9	5.3	6.8	7.0	7.2	7.4	7.6	7.8	8.0	62.9	40.1
6 Strategic co-ordination	1.8	3.8	7.7	9.9	10.2	10.5	10.8	11.1	11.4	11.7	88.9	56.0
7 Assessment for carers	1.6	3.3	4.5	5.8	5.9	6.1	6.3	6.4	6.6	6.8	53.4	34.0
8 Training - "care planning/assessment" - care home	6.7	19.6	30.2	49.1	50.4	51.8	53.2	5.5	5.6	5.8	277.8	189.3
9 Training - "symptom management"	1.2	3.5	5.4	8.7	9.0	9.2	9.5	1.0	1.0	1.0	49.4	33.6
10 Training - "care planning/assessment" - staff	1.8	5.2	8.0	13.1	13.4	13.8	14.2	1.5	1.5	1.5	74.1	50.5
11 Training - "starting the EOLC conversation"	1.2	3.5	5.4	8.7	9.0	9.2	9.5	1.0	1.0	1.0	49.4	33.6
12 Training - social care staff	0.9	2.8	4.3	7.0	7.2	7.4	7.6	0.8	0.8	0.8	39.5	26.9
13 Training - GP additional training	0.9	2.5	3.9	6.3	6.5	6.6	6.8	0.7	0.7	0.7	35.6	24.2
14 Training - "nurse verification of death"	0.1	0.4	0.6	1.0	1.1	1.1	1.1	0.1	0.1	0.1	5.8	4.0
15 Modifying existing communications skills training	1.1	1.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.4	2.0
16 Training - backfill	0.4	1.2	1.9	3.1	3.2	3.3	3.3	0.3	0.4	0.4	17.4	11.9
17 Specialist palliative care resources - hospitals	4.5	9.2	12.6	16.1	16.6	17.0	17.5	18.0	18.5	19.0	148.8	94.8
18 Specialist palliative care nursing (supporting Rapid Response)	1.9	3.9	5.8	6.9	7.1	7.3	7.5	7.7	7.9	8.1	64.1	40.9
19 Supporting homeless - nurse capacity	1.6	3.3	5.3	5.8	5.9	6.1	6.3	6.4	6.6	6.8	54.2	34.6
20 EOLC 'programme'	5.5	11.3	15.5	19.9	20.5	21.0	21.6	22.2	22.8	23.5	184.0	117.2
21 National 'observatory/intelligence' unit	1.1	2.4	2.5	2.5	2.6	2.7	2.7	2.8	2.9	3.0	25.1	16.3
22 Extending the VOICES programme	0.5	1.1	1.1	1.1	1.2	1.2	1.2	1.3	1.3	1.4	11.5	7.5
23 National public awareness tool	0.7	0.8	0.8	0.8	0.8	0.8	0.9	0.9	0.9	0.9	8.4	5.6
24 Extending the National Care of the Dying Audit	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	3.0	2.0
25 ADA	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3	2.3	1.5
26 Piloting EOLC registers	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.3	0.2
27 Competency framework development	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
28 EOLC standing committee	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
29 Quality standards/EOLC peer review	0.4	0.9	1.3	1.4	1.4	1.5	1.5	1.5	1.6	1.6	13.1	8.4
30 Bereavement service in acute trusts	8.4	17.2	23.6	30.3	31.1	32.0	32.9	33.8	34.7	35.7	279.7	178.2
Total revenue costs identified	79.7	149.8	207.8	276.7	284.3	292.2	300.2	211.1	216.9	222.9	2,241.7	1,459.1
Capital costs of the End of Life Care Strategy												
	£m											
	09/10	10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19	Total	Total (PV)
Costs identified:												
31 Palliative care transport - vehicle	2.9	3.0	3.1	0.0	0.0	0.0	0.0	3.6	3.7	3.8	20.1	13.3
32 Improving the environment - patient care area	3.1	3.2	6.5	6.7	6.9	7.0	0.0	0.0	0.0	0.0	33.3	24.3
33 Improving the environment - mortuary viewing room	2.4	2.5	5.1	5.2	5.4	5.5	0.0	0.0	0.0	0.0	26.1	19.1
34 Additional capital support to hospices	0.0	40.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	40.0	33.0
Total capital costs identified	8.4	48.7	14.7	11.9	12.2	12.6	0.0	3.6	3.7	3.8	119.5	89.7
TOTAL costs of the End of Life Care Strategy	88.2	198.4	222.5	288.6	296.6	304.7	300.2	214.7	220.6	226.7	2,361.2	1,548.9

Specific Impact Tests: Checklist

Use the table below to demonstrate how broadly you have considered the potential impacts of your policy options.

Ensure that the results of any tests that impact on the cost-benefit analysis are contained within the main evidence base; other results may be annexed.

Type of testing undertaken	<i>Results in Evidence Base?</i>	<i>Results annexed?</i>
Competition Assessment	Yes	No
Small Firms Impact Test	No	No
Legal Aid	No	No
Sustainable Development	Yes	No
Carbon Assessment	Yes	No
Other Environment	No	No
Health Impact Assessment	No	Yes
Race Equality	Yes	No
Disability Equality	Yes	No
Gender Equality	Yes	No
Human Rights	Yes	No
Rural Proofing	Yes	No

Annexes

ANNEX A – Activity cost description, risk assessment and estimated cost range

OPTION 1 – COST DESCRIPTION

Rapid Response/24hr community services

Description	Cost basis	Risks/assumptions	Cost range - Yrs 1-2
Patients need a range of services to ensure their care needs are met. As clinical circumstances can change rapidly, such services need to be available on a 24-hour, 7-days-a-week basis.	There are two key sources of estimated costs for this activity. The most comprehensive assessment is a SCHARR study of economic costs for palliative care. The most robust estimate from 4 pilot areas is of £1,725 per 1000 population for a full rapid response service. However, some service already exists. An Audit Commission audit of 24hr services was used to estimate the shortfall in services. A second estimate from Marie Curie evaluated pilot work is a cost of £528K per 700,000 population for a full rapid response service.	The main risk in costs is the robustness basing costs on 1 PCT (Calderdale PCT provided the source for the £1,725 figure). However, this is mitigated by the fact that this area was studied in detail, and results from other pilot areas are similar – mostly lower. The MC costs are slightly higher, but assumes little in the way of existing services. Therefore the MC costs are very likely to be an overestimate of the costs required. The SCHARR estimate for Calderdale is likely to be the most realistic estimate. Assume roll out to maximum capacity by year 4.	£46.4 - £59.5m
Extra specialist palliative care nursing capacity to support workload from improved rapid response services	We have estimated that by improving rapid response services, that may in turn generate extra workload to deal with assessed care needs arising from those services. We have estimated that this could be handled by: 1 @ band 7 (SPC nurse)	No specific model for how these additional staff would be deployed – best estimate of additional support required. May be some variation in actual pay of staff employed – assumption made on mid-point of AfC pay range but estimates made for extreme ends (or potentially different grade)	£5.0 - £6.6m

Palliative Care transport [Vehicles – CAPITAL]

Description	Cost basis	Risks/assumptions	Cost range - Yrs 1-2
Transport vehicles/ambulance	MC estimate a cost of £55K per vehicle per 350,000 population.	PSSRU describes costs for “Patient Transport Services”. PTS ambulances are slightly different to Emergency Ambulances and costs are quoted at around £32K (06/07 prices). MC cost is likely to be more robust estimate as these are dedicated vehicles however, some risk that £55K is therefore an overestimate or it may be that PTS does not cover palliative care services.	£5.4 - £6.6m
Crew	MC estimate costs for a crew of 4 at around £112K per ambulance. Using PSSRU and AfC	It is assumed that the crew complement includes one member as driver of the vehicle. Possible variation in costs could	£17.4 – £22.4m

	costs, this is likely to equate to: 1 fully qualified paramedic 1 technician 2 care assistants equivalent to 1 @ band 7 1 @ band 6 2 @ band 3	occur depending on grade/level of staff available/actually employed and position on pay range – mid-point of AfC pay scales assumed.	
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EOLC Programme

Description	Cost basis	Risks/assumptions	Cost range - Yrs 1-2
Costs of supporting acute trusts to deliver EOLC according to the Liverpool Care Pathway	This is based on: 1 band-7 type post per acute trust to provide facilitation to encourage roll-out of the tools + events/workshops, training materials (eg e-learning), administration support, travel and equipment for the facilitator. £55-60K per acute trust	May be some variation in actual pay of staff employed – assumption made on mid-point of AfC pay range but estimates made for extreme ends (or potentially different grade)	£14.1 - £18.9m
Costs of supporting all GPs in PCTs to deliver EOLC according the Gold Standards Framework	This is based on 1 band-7 type post per PCT to provide facilitation to GPs to encourage roll-out of the tools + events/workshops, training materials (eg e-learning), administration support, travel and equipment for the facilitator. £55-60K per PCT.	May be some variation in actual pay of staff employed – assumption made on mid-point of AfC pay range but estimates made for extreme ends (or potentially different grade)	

Co-ordination centres

Description	Cost basis	Risks/assumptions	Cost range - Yrs 1-2
Effective mechanisms need to be put in place to facilitate the co-ordination of care both within individual organisations and across organisational boundaries.	This has been costed on the basis of a team of 5 per 2 PCTs consisting of a project manager and 4 admin staff as follows: 1 @ band 8 4 @ band 2	As basis for costs would cover 2 PCTs, there may be some economies of scale for larger aggregations of PCTs. This variation has not been costed as yet but would probably reduce costs. May be some variation in actual pay of staff employed – assumption made on mid-point of AfC pay range but estimates made for extreme ends (or potentially different grade)	£7.6 - £9.3m

Strategic co-ordination

Description	Cost basis	Risks/assumptions	Cost range - Yrs 1-2
Service delivery modelled on Marie Curie <i>Delivering Choice</i> programme ¹	MC estimate costs for a project team to facilitate the <i>Delivering Choice</i>	Exact make up of teams may vary in different locations – however, it is likely to require approximately	£4.9m - £6.0m

¹ Details of the Marie Curie *Delivering Choice* programme can be found at <http://deliveringchoice.mariecurie.org.uk>

	model of service delivery on the basis of £120K per 700,000 population (2 PCTs) to £170K per 1,400,000 population (4 PCTs).	1 @ band 8 (senior manager) 4-7 @ band 2 (admin) May be some variation in actual pay of staff employed – assumption made on mid-point of AfC pay range but estimates made for extreme ends (or potentially different grade)	
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Specialist Palliative Care resources – hospital

Description	Cost basis	Risks/assumptions	Cost range - Yrs 1-2
Boards of PCTs and NHS Trusts will need to ensure that adequate specialist palliative care resources are in place in acute trusts to improve the quality of care provided.	Likely to require around ½ consultant + ½ nurse per acute trust: ½ @ consultant ½ @ band 7	May be some variation in actual pay of staff employed – assumption made on mid-point of AfC pay range but estimates made for extreme ends (or potentially different grade)	£12.1 - £15.1m

Assessment for carers

Description	Cost basis	Risks/assumptions	Cost range - Yrs 1-2
Carers should be offered an assessment of their needs and a formal 'carers care plan'	Costs relate to additional nurse capacity to offer carers an assessment of their needs and provide them with a formal 'carers care plan'. Estimated at 1 nurse per PCT: 1 @ band 6	May be some variation in actual pay of staff employed – assumption made on mid-point of AfC pay range but estimates made for extreme ends (or potentially different grade)	£4.1 - £5.6m

Supporting the homeless – nurse capacity

Description	Cost basis	Risks/assumptions	Cost range - Yrs 1-2
Additional nurse capacity to ensure comprehensive assessment of needs for homeless people are communicated to relevant organisations providing health and social care	We estimate that approximately ½ to 1 nurse per PCT would be sufficient to ensure that the needs of homeless people can be properly communicated between all the relevant agencies: ½ to 1 @ band 6	May be some variation in actual pay of staff employed – assumption made on mid-point of AfC pay range but estimates made for extreme ends (or potentially different grade)	£4.2 - £5.6m

National observatory/intelligence unit [CENTRAL]

Description	Cost basis	Risks/assumptions	Cost range - Yrs 1-2
Establish and run an intelligence unit/observatory to enable analysis of register and other data to support improved EOLC	Costs estimated on similar lines to that for the National Cancer Intelligence Network – costs based on set-up costs, commissioning and carrying out research and analysis of collated data on EOLC	No specific risks have been costed – estimating variation at around +/- 10%	£3.1 - £3.8m

Extending the VOICES programme [CENTRAL]

Description	Cost basis	Risks/assumptions	Cost range - Yrs 1-2
Further development and implementation of surveys of bereaved relatives based on the VOICES questionnaire	Costs estimates are typical annual survey costs to collect detailed data on a range of care issues, in this case using the views of bereaved relatives to improve EOLC. Costs are expected to be around £1m per year.	Some variation in costs may occur due to sample size and survey coverage. Currently estimating at +/- 10%	£1.5 - £1.8m

National Public Awareness tool [CENTRAL]

Description	Cost basis	Risks/assumptions	Cost range - Yrs 1-2
A tool to raise awareness of EOLC issues, to improve understanding of services and needs.	Costs are based on public awareness tools used in other areas such as cancer and are typically around £700K per year	Some variation in costs may occur due to sample size and survey coverage. Currently estimating at +/- 10%	£1.4 - £1.7m

Ambulance Trust – EOLC lead

Description	Cost basis	Risks/assumptions	Cost range - Yrs 1-2
Appointing an EOLC lead in ambulance trusts to enable effective liaison with other services and raise profile of EOLC	Costs are estimated on the basis of ¼ to ½ senior manager per ambulance trust: ¼ to ½ @ band 8	Some of these managers are likely to be in ambulance trusts already, but may require some adjustments to job roles. In general assuming +/- 10% to allow for variations in job role, staff and salary.	£0.2 – £0.3m

Extending the National Care of the Dying Audit [CENTRAL]

Description	Cost basis	Risks/assumptions	Cost range - Yrs 1-2
Extension of the existing National Care of the Dying Audit	Costs for extending the NCOD are based on a cost of around £80K per 100 hospitals and assuming this will be implemented in 350 hospitals	No specific risks identified. Currently estimating +/- 10% variation in costs	£0.5 - £0.7m

After Death Analyses (ADA) [CENTRAL]

Description	Cost basis	Risks/assumptions	Cost range - Yrs 1-2
Implement After Death Analyses (ADA) of care given to dying patients	Costs for implementing ADA are currently under review and based on pilots in Walsall.	Costs based on 1 pilot area may not be representative, however it is felt that £190K is likely to be an overestimate; in many cases the cost may be much lower.	£0.45 - £0.55m

Piloting EOLC registers [CENTRAL]

Description	Cost basis	Risks/assumptions	Cost range - Yrs 1-2
Piloting the development of registers for collecting data about patients receiving EOLC	Costs for piloting EOLC registers are based on 1 analyst @ 1 day per week for 6-12 months, resulting in a per site cost of £40K and covering 3 sites.	No specific risks identified. Currently estimating +/- 10% variation.	£0.2 - £0.3m

Competency framework development [CENTRAL]

Description	Cost basis	Risks/assumptions	Cost range - Yrs 1-2
Agree EOLC competencies with <i>Skills for Health</i> and <i>Skills for Care</i>	Estimated costs of £40K and £75K respectively to develop competencies within the respective programmes	No specific risks identified. Currently estimating +/- 10% variation.	£0.10 - £0.15m

EOLC Standing Committee [CENTRAL]

Description	Cost basis	Risks/assumptions	Cost range - Yrs 1-2
A committee bringing together a range of individuals and organisations committed to fostering greater discussion of EOLC issues in the national media and local communities	Costs based on around 20-30 members forming the committee with estimated expenses at around £200-400 per person per annum	Small risk of higher annual expenses. May need small additional secretariat costs.	£4000 - £12,000

Training the workforce in EOLC

Description	Cost basis	Risks/assumptions	Cost range - Yrs 1-2
Training on care planning and assessment – enabling appropriate care to be given according to choice in the appropriate setting.	Based on similar communications skills courses run in care homes of around £15K per care home. Assume training for total of 5,000 care homes trained over 6 years	Assume that training costs could vary by +/- 10%	£7.9 - £9.6m
Training on symptom management to enable delivery of care according to set guidelines and protocols	Based on similar courses relating to cancer – training 1,000 wards at £15K per ward and 13,000 ‘Community’ and District Nurses at average of £800 per head. Training programme completed over 7 years	Costs of training course, based on similar cancer communications skills courses cost around £400 to £1,200 per head per course depending on length/ level of detail. Average is considered most likely since majority of staff not likely to need the most advanced training. Also assume that costs drop considerably to around 10% once the main cohort is trained as competency development will ensure adequately trained staff come naturally through staff training system. Assume that economies of scale are already factored in as costs are based on similar existing courses.	£1.0 - £1.9m

Training on care planning and assessment for nurses	Cost basis as above but for 13,000 'community and district nurses', 8,000 AHP and social workers – completed over 7 years	As above	£1.5 – £2.9m
Training on “Starting the EOLC conversation” to enable GPs and other ‘first/early’ contact staff to initiate difficult conversations about EOLC	Cost basis as above (£800 per head, per course) but for 10,000 GPs and 7-10,000 consultants and senior medical staff	As above	£1.0 – £1.9m
Training social care staff to deal with EOLC	Cost basis as above (£800 per head, per course) but for 10,000 GPs and 13,000 social care staff	As above	£0.8 - £1.6m
Training GPs to deal with EOLC issues beyond starting the EOLC conversation eg support OOH and rapid response	Cost basis as above (£800 per head, per course) but for 10,000 GPs.	As above	£0.7 - £1.4m
Training – nurse verification of death to enable this to be done in a timely manner	Cost based on 2 days training per PCT per year at £1000 per day	Based on information from training courses carried out in Hull, annual training requirements are around 2 days per year. Likely to be in the range 1-3 days per PCT per year.	£0.3 - £0.7m
Modifying existing communications skills training	Cost based on modifying comparable existing cancer training courses and skilling up trainers to deliver the training.	No specific risks identified. Currently estimating +/- 10% variation.	£2.1 – £2.6m
Training backfill	Cost of covering for staff engaged in training activities	Workforce have suggested that main pressure will be in primary care – data suggests GP locum costs of between £1000 - £1800 per week per GP. Assuming 2 days training on average per GP to cover communications and dealing with EOLC issues, costs between £285 - £500 per GP. Further advice suggests that team or on-site training for groups of staff unlikely to attract backfill costs, however, on a very crude basis, may add 50% extra backfill costs to the estimates– likely to be a maximum estimate	£0.4 - £0.6m

OPTION 2 – COST DESCRIPTION

AS OPTION 1 with extended training programme and improvements to hospital environments

Training the workforce in EOLC

Description	Cost basis	Risks/assumptions	Cost range - Yrs 1-2
Training on care planning and assessment – enabling appropriate care to be given according to choice in the appropriate setting.	Based on similar communications skills courses run in care homes of around £15K per care home. Assume training for total of 15,000 care homes trained over 6 years	Assume that training costs could vary by +/- 10%	£23.7 - £28.8m
Training on symptom management to enable delivery of care according	Based on similar courses relating to cancer – training 3,000 wards at £15K per	Costs of training course, based on similar cancer communications skills courses	£3.0 - £5.7m

to set guidelines and protocols	ward and 40,000 'Community' and District Nurses at average of £800 per head. Training programme completed over 7 years	cost around £400 to £1,200 per head per course depending on length/ level of detail. Average is considered most likely since some majority of staff not likely to need the most advanced training. Also assume that costs drop considerably to around 10% once the main cohort is trained as competency development will ensure adequately trained staff come naturally through staff training system. Assume that economies of scale are already factored in as costs are based on similar existing courses.	
Training on care planning and assessment for nurses	Cost basis as above but for 40,000 'community and district nurses', 25,000 AHP and social workers – completed over 7 years	As above	£4.5 - £8.7m
Training on "Starting the EOLC conversation" to enable GPs and other 'first/early' contact staff to initiate difficult conversations about EOLC	Cost basis as above (£800 per head, per course) but for 30,000 GPs and 20-30,000 consultants and senior medical staff	As above	£3.0 - £5.7m
Training social care staff to deal with EOLC	Cost basis as above (£800 per head, per course) but for 30,000 GPs and 40,000 social care staff	As above	£2.4 - £4.8m
Training GPs to deal with EOLC issues beyond starting the EOLC conversation eg support OOH and rapid response	Cost basis as above (£800 per head, per course) but for 30,000 GPs.	As above	£2.1 - £4.2m
Training – nurse verification of death to enable this to be done in a timely manner	Cost based on 2 days training per PCT per year at £1000 per day	Based on information from training courses carried out in Hull, annual training requirements are around 2 days per year. Likely to be in the range 1-3 days per PCT per year.	£1.2 - £1.8m
Modifying existing communications skills training	Cost based on modifying comparable existing cancer training courses and skilling up trainers to deliver the training.	No specific risks identified. Currently estimating +/- 10% variation.	£2.1 - £2.6m
Training backfill	Cost of covering for staff engaged in training activities	Workforce have suggested that main pressure will be in primary care – data suggests GP locum costs of between £1000 - £1800 per week per GP. Assuming 2 days training on average per GP to cover communications and dealing with EOLC issues, costs between £285 - £500 per GP. Further advice suggests that team or on-site training for groups of staff unlikely to attract backfill costs, however, on a very crude basis, may add 50% extra backfill costs to the estimates – likely to be a maximum estimate	£1.2 - £1.8m

Description	Cost basis	Risks/assumptions	Cost range - Yrs 1-2
Patient care areas – redesign of existing premises in acute settings to improve the environment	Costs based on improvements in 70 hospitals per year ie assumes that all hospitals will need redesign work at some point in the next 5 years but varying depending on the extent of work required from £21K for basic redesign to £145K for a 2-bed palliative care suite. Costs shown in main tables are based on average £83K per hospital	Risks are that all hospitals are in need of substantial work. Assume that this will average out.	£3.2 - £21.8m
Mortuary viewing rooms – redesign of existing premises in acute care settings to improve the environment	Costs based on improvements in 70 hospitals per year ie assumes that all hospitals will need redesign work at some point in the next 5 years but varying depending on the extent of work required from £38K for basic renovation to £91K for extensive re-design and renovation. Costs shown are based on average £65K per hospital	Risks are that all hospitals are in need of substantial work. Assume that this will average out.	£5.7 - £13.7m

OPTION 3 – COST DESCRIPTION

AS OPTION 2 plus the following

Bereavement services

Description	Cost basis	Risks/assumptions	Cost range - Yrs 1-2
To enable organisations to ensure that processes are in place so that care after death is sensitive and responsive to cultural and spiritual needs	Costs are on the basis of the following per acute trust: 1 @ band 8a (senior manager) 2-3 @ band 4 3-5 @ band 2 (admin) 22K funeral costs, £3K for information/leaflets and one-off set-up costs of £10K	Costs may vary according to the precise make up of the team in terms of grades/salary May be some variation in actual pay of staff employed – assumption made on mid-point of AfC pay range but estimates made for extreme ends (or potentially different grade)	£18.8 - £22.8m

Additional support to hospices [CENTRAL]

Description	Cost basis	Risks/assumptions	Cost range - Yrs 1-2
Additional funding to support capital development in hospices	Central	No specific risks/assumptions	£40m in 2009/10

Note on Agenda for Change salaries used in the costings

See page 8 for a description of financial treatment of costs in this Impact Assessment. The Agenda for Change pay rates used as the basis for costing activities that involve staff recruitment can be found at <http://www.nhsemployers.org/pay-conditions/pay-conditions-217.cfm> (see rates for 1 November 2007), with on-costs of around 20% included.

Annex B – estimating benefits of the End of Life Care strategy

This section sets out quantification of the benefits of the strategy based on existing methodologies for quantifying economic benefits of policies and evidence related to improving quality of life.

It sets out the variables that have been built into a model to describe how benefits may accrue as a result of different options for delivering the strategy set out in this Impact Assessment. The variables are summarised below and then set out in more details along with the assumptions behind them.

Table 1: EOLC benefit model – variables, range and representative case

EOLC benefits model - variables	Variable range	Representative case
1. Quality of life improvement <ul style="list-style-type: none"> • For patients • For carers/relatives 	0.00-1.00 ²	0.22 (0.25*0.22) to (0.75*0.22) ³
2. Length of time to death (length of time receiving EOLC)	0 – 52 weeks	6 weeks
3. Number of patients affected <ul style="list-style-type: none"> • Those dying in hospital • Those dying outside hospital 	500,000	225,000 275,000
4. % of people dying outside hospital	0-100%	55%
5. Number of carers/relatives <ul style="list-style-type: none"> • Option 1 • Option 2 • Option 3 	0- <i>n</i>	1 2 3

Quality of Life improvement

1. **A QALY (Quality Adjusted Life Year)** is a measure of the value of one year of life composed of two main components: improvements in longevity and improvements in the quality of life. This is quantified in terms of a value between 0 and 1 where 1 represents a year of life in 'perfect' health. This however is a theoretical construct that is not directly observable and by definition will have subjective elements in all quantifying efforts (Lou Lan et al, 2005). Bearing this in mind, we consider some assumptions.
2. For improvements in quality of life (or health state), we look at studies on patients with Major Depressive Disorder (MDD). The condition is associated with impaired functioning, well-being, and reductions in health related quality of life, which are important features in EOLC. Since the policy is aimed at improving patients' suffering and state of mind (anxiety/depression, comfort etc) these values are used as proxies for improvements in states of health in the model. The studies show that

² Refers to health state which can vary from 0 to a year of life in 'perfect' health, which is assigned a value of 1

³ Under the 3 options of the strategy it is envisaged that there would be increasing benefits for relatives/carers from 0.25 of the benefit to patients under option 1 to 0.75 of the benefit to patients under option 3.

quality of health scores differed on average by about 0.3 between patients who were moderately ill and those that were markedly ill, and by about 0.14 between those who were markedly ill and seriously ill (Sapin, C. et al. 2004). Using this as a guide, we set bounds for the improvement in health at between 0.10 and 0.30, and take the mid point 0.20 as the representative case.

3. The policy also aims at improving the experience of carers and family of patients. It is conceivable that carers may become considerably stressed to the point of being physically unwell if not properly supported through the end of life care process. Evidence⁴ suggests that such anxiety and stress can be alleviated by providing practical help, respite and comfort. Since carers are not themselves patients we assume that benefits to them will be a fraction of the improvement experienced by patients. Thus, the fractions 0.25, 0.5, and 0.75 are assumed for options 2, 3, & 4 respectively, and a reduced modified qaly value that depends on the level of policy changes, is computed for carers. This however captures only the immediate benefits to carers; long term benefits to carers have not been counted.

Length of (treated) time to death

4. Following evidence in existing literature and HES data, we assume that the main period of treated time to death will be on average 6 weeks in the representative case, and that this is the period that yields the maximum benefit in a given 12 month period. For patients with protracted illnesses, the length of treated time to death may vary significantly and may be up to 12 months (or longer). Furthermore, having a strategy in place means identifying patients earlier in the end of life path and this may result in extending treated time to death for many patients. The benefits to patients of these longer periods of treatment have been included in the calculation of benefits but we assume proportionally lower levels of benefits in the earlier period before death. This is in line with evidence that over half of the (hospital) activity associated with end of life care occurs in the last 1-3 months of life, particularly in the last month, and that virtually all people who die in a given year spend some of that time in hospital.

Number of patients affected

5. Current data shows that of the total number of patients ($N = 500,000$) that die in a year, 55% die in hospital. The strategy aspires to reduce this. For modelling purposes, we set a benchmark reduction to 45% i.e. a reduction by ten-percentage points (at 2.5% per year for the first 5 years). Thereafter we assume that deaths in hospital will continue to fall, at a slower rate as we approach the steady state, assumed to be 35% following evidence from the Netherlands, where we expect a levelling off. This implies that in year 1, the number of patients that will be enabled to die outside hospital will be $N_1 = 12,500$. We know that $N_3 = 225,000$ patients currently die outside hospital, therefore the remaining $N_2 = 262,500$ patients will still die in hospital in the first year. Realistically not all these remaining patients will be reached in each year, so we assume that the proportion that will receive benefits in any one year will be half.

⁴Paper commissioned by Marie Curie, "Valuing Choice – Dying at Home: A case for the more equitable provision of high quality support for people who wish to die at home".

6. Although these latter groups are unlikely to experience the full benefits, having a strategy in place that delivers improvements in patients' care as they approach the end of their lives, as well as the choice of where to die, will conceivably deliver some improvements to all patients even if their wish to die outside hospital is not met. For patients who still die in hospital, there will now be the benefit of earlier assessment, care planning etc which may be substantial. For those who already die outside hospital there should be an overall improvement in the care experience even though their choice on where they die is already being met. For the group that still die in hospital, because the policy only delivers half of its objective, i.e. alleviation of discomfort, care planning etc without the choice of dying at home, we assume that they receive only 0.4 of total benefits. For those that already die outside hospital, the benefits will be even smaller so we assume the fraction to be 0.2.

Numbers of carers/relatives

7. For each patient we assume that there will be at least one carer, which may be a trained nurse or family member. In most cases, and where the policy is more broadly defined (as in options 3 and 4), the patient may be in close contact with up to 3 people in this crucial stage, and these people would benefit from the strategy. Thus, we assume that the number of carers to be 1, 2, and 3 for options 2, 3, and 4 respectively.

8. The benefit function therefore computes total benefits to the three categories of patients and their carers as a value that depends on the time to-death, improvements in health states, the number of patients and the fraction of benefits assumed to accrue to them. QALYs are valued at £50k (see para 10 for explanation). The net benefit figures is calculated using opportunity costs, which are estimated to be twice the displayed Total Cost, assuming that at the margin the DH budget yields a QALY per £25k. Main assumptions/risks are on staff training numbers, staff recruited on average to middle of AfC pay scales.

9. The results for the representative case (at outlined in table 1) are as follows:

	Benefits over 10 years (NPV - £)
Option 2	£3,518m
Option 3	£4,548m
Option 4	£6,269m

10. The £50,000 figure for the value of the QALY is a rough estimate derived from (i) DEFRA estimate of a willingness to pay for an additional life year of £29,000

(<http://www.defra.gov.uk/environment/airquality/publications/stratview-analysis/annexes-icgb.pdf>

see the description of 'Chronic Mortality' in Table A2.5). This sum would be for a one year extension to life expectancy. But this extension is most likely at post-retirement ages. At these ages QoL is typically about 0.78 or 0.73 (source: <http://www.york.ac.uk/inst/che/pdf/DP172.pdf>) – ie £29,000 is for about ¾ of a QALY. Hence the implication is that a full QALY should be worth about £38,400 – at

2004 prices. This needs to be raised to 2008 prices (uprated by nominal GDP per capita growth, like DfT's VPF). UK GDP growth over the past four years has been about 23%, but the population has grown by about 2.7%, so GDP per capita growth would have been 20%. Hence £38,400 would be £46,000 at today's values (ii) An upward rounding to take account of alternative methodologies that suggest that the figure might be a substantial under-estimate.

A. Jones-Lee et al

(http://pcpoh.bham.ac.uk/publichealth/nccm/PDFs_and_documents/Publications/RM03_JH13_Final_Report.pdf) took DfT's estimate of the value of a prevented fatality and divided by the PV of discounted quality-adjusted life expectancy for road accident victims. The number of discounted QALYs they used was about 20. The DfT VPF in 2005 prices was £1,427,340 (excluding medical and ambulance costs). Since then money GDP has grown by 17.9% but population has grown by about 2.1% so the uplift for GDP per capita growth would be about 15.5%, making the current VPF (without medical/ambulance costs) about £1,649m – and if this is for discounted QALYs, then a QALY should be worth about £82,000.

B. Henderson - estimates the value of a QALY of around £60,000 using the Murphy and Topel method (see Journal of Political Economy, 2006, vol.114, no.5, The Value of Health and Longevity, Kevin M. Murphy and Robert H. Topel).

11. It is estimated that marginal extra spending from the DH budget can achieve benefits at around a QALY for every £25,000. This assessment of the opportunity cost of DH spending foregone is consistent with NICE practice: "If NICE decides **not to** recommend use of an intervention with a cost per QALY gained within or below the range £20,000 to £30,000 per QALY gained, or decides **it will** recommend use of an intervention within or above this range, it must explain the reasons why." See <http://www.nice.org.uk/media/998/50/SVJ2ForPublicConsultation.pdf>.

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ANNEX C – Health Impact Assessment checks

Are the potential positive and/or negative health and wellbeing impacts likely to affect specific subgroups disproportionately compared with the whole population ?

Anecdotal evidence suggests that people from less affluent backgrounds are less likely to be able to die outside hospital should they choose to do so, because the necessary support mechanisms are less likely to be in place eg relatives able to provide care and support to people near the end of their lives, or lack of access to properly planned care in the community.

There may also be specific cultural aspects to end of life care, which would be addressed by having proper assessment of patients' needs and care planning, and so may be of particular relevance to certain ethnic groups.

A key aim of the End of Life Care strategy is to enable these assessments to happen and for care to be carried out in a co-ordinated and responsive way. It also stresses the importance of care being spiritually and culturally appropriate. Therefore, the impact of the strategy is likely to be positive in terms of addressing these inequalities.

However, it will also have benefits for all patients nearing the end of their life and will not disproportionately disadvantage any sub-group of the population.

Implementation of the policy should not have any adverse impact on housing, as the strategy deals with better integration of care services, rather than new facilities, per se, and should for instance in the case of choice of where to die, enable someone to die at home rather than in hospital.

It will also not impact adversely on employment, as the intention is to better co-ordinate existing services rather than implement new employment policies, as well as to support training and education for staff across health and social care. Several of the main activities do require recruitment of new staff, although the number required would be phased in over a number of years and would largely be for local determination. Staff moves would not be necessary but will result in a modest increase in the availability of local jobs.

Are the potential positive and/or negative health and well-being effects likely to cause changes in contacts with health and/or care services, quality of life, disability or death rates ?

The strategy should have a positive impact on contacts with health and social care services, making the delivery of end of life care more efficient. This would be achieved by the implementation of key activities around assessing patients' needs, care planning, and co-ordination centres that would enable services in different sectors to be better co-ordinated. A key benefit of delivering the strategy is to improve the quality of life of people being cared for near the end of life. This will be brought about by, for instance, increased mental wellbeing through peace of mind, dignity and choice in relation to the manner and location of death. It will also bring benefits in terms of quality of life improvements by providing support to carers, and for relatives to enable them to deal with the death of a loved one with increased peace of mind in the knowledge that care has been delivered with sensitivity and to a high standard.

Are there likely to be public or community concerns about potential health impacts of this policy change ?

No. There are unlikely to be public or community concerns about potential health impacts of the End of Life Care Strategy as the strategy is broadly about improving the quality of care, better co-ordination of care, providing a responsive service to patients and support for carers and relatives. It has been developed with support from a broad range of health and social care professionals, and charitable and voluntary organisations.