Economic Impact Case Study: Northampton General Hospital Social Care Co-ordinator

How a dedicated, Macmillan funded, cancer social care co-ordinator has generated over £149,000 worth of efficiency savings for Northampton General Hospital; with every £1 spent by the Trust on the service in 2009/10 generating £38 worth of benefits; and has shown a positive contribution to improving health and wellbeing outcomes for people affected by cancer in Northampton.

Service summary

The Macmillan social care co-ordinator is a single post based at Northampton General Hospital in the Centre for Oncology, which forms part of the East Midlands Cancer Network. The Macmillan social care co-ordinator post was created in Northampton in February 2008. The post was implemented in response to the lack of a dedicated professional to address the social care needs of patients living with cancer and their families. The primary aims of the Macmillan social care co-ordinator are to enhance and improve the experience of people living with cancer across the health and social care journey by streamlining services, facilitating timely hospital discharge and preventing avoidable admissions to hospital. The Oncology Directorate wanted to shift from reactive to proactive care and to identifying and addressing the social care needs of patients and their families at the point of admission or in the out-patient setting.

Impact summary

In the year 2009-10, the social care co-ordinator reported:

- that 228 cancer patients and their families have accessed the service
- that she had facilitated 97 hospital discharges, influenced 10 avoidable admissions and facilitated 56 preferred place of care discussions
- that as a result of her intervention 466 excess bed days were saved, which equates to an efficiency saving of £149,586 in monetary terms

Taking into consideration the initial funding provided by Macmillan, every £1 spent on the service by Northampton General Hospital generates £38 of benefits for the Trust for the first 3 years.

If a Trust set the service up 'from scratch' and without Macmillan funding, every £1 spent on the service would generate £2.20 of benefits

In addition, wider evidence shows that the social care co-ordinator will have given cancer patients and their families:

- More choice and control
- Greater independence
- Reduced anxiety and stress
- Improved quality of life

1) Background to the economic evaluation

This case study is part of a wider programme of economic evaluation of Macmillan-funded services which will report in full in June 2011. An overarching report to be produced at a later date will set out, amongst other information, the aims and objectives of the evaluation; its methodology, key assumptions and caveats; and comparative analyses across services as well as with relevant findings reported in the wider evidence base. This present series of case studies reports quantifiable, direct financial costs and benefits that can be monetised. Where case studies include complementary analysis of wider in-direct benefits that are amenable to monetisation, these are introduced conservatively and with necessary caveats. Ongoing scoping of the literature will further refine these estimates as well as provide comparable cost effectiveness ratios.

2) The Service

Project aims and purpose

The Macmillan social care co-ordinator is a single post based at Northampton General Hospital in the Centre for Oncology, which forms part of the East Midlands Cancer Network. The Macmillan social care co-ordinator post was created in Northampton in February 2008. The post was implemented in response to the lack of a dedicated professional to address the social care needs of patients living with cancer and their families.

The primary aims of the Macmillan social care co-ordinator are to enhance and improve the experience of people living with cancer across the health and social care journey by streamlining services, facilitating effective and timely hospital discharge and preventing avoidable admissions to hospital. The Oncology Directorate wanted to shift from reactive to proactive care and to identifying and addressing the social care needs of patients and their families at the point of admission or in the out-patient setting.

Staffing

The social care co-ordinator is one full time, cancer specific post situated within the oncology and haematology multidisciplinary team and funded initially by Macmillan. The post holder also receives a small amount of IT support, accountants support and line management all of which are paid for by the Northampton General Hospital NHS Trust.

Services offered and intended outcomes

The social care co-ordinator provides the services (outputs and activities) illustrated in Figure 3 below to people living with cancer and their families. The outcomes the social care co-ordinator seeks to achieve are also outlined in Figure 3.

The social care co-ordinator also has an annual 'innovations budget' of £16,000 provided by Macmillan to spend on improving services to people living with cancer and their families. This money is not used to replace statutory services but to complement them where there are shortfalls in existing provision. The social care co-ordinator uses the budget to spot purchase care and support services in cases where statutory provision is not available or appropriate.

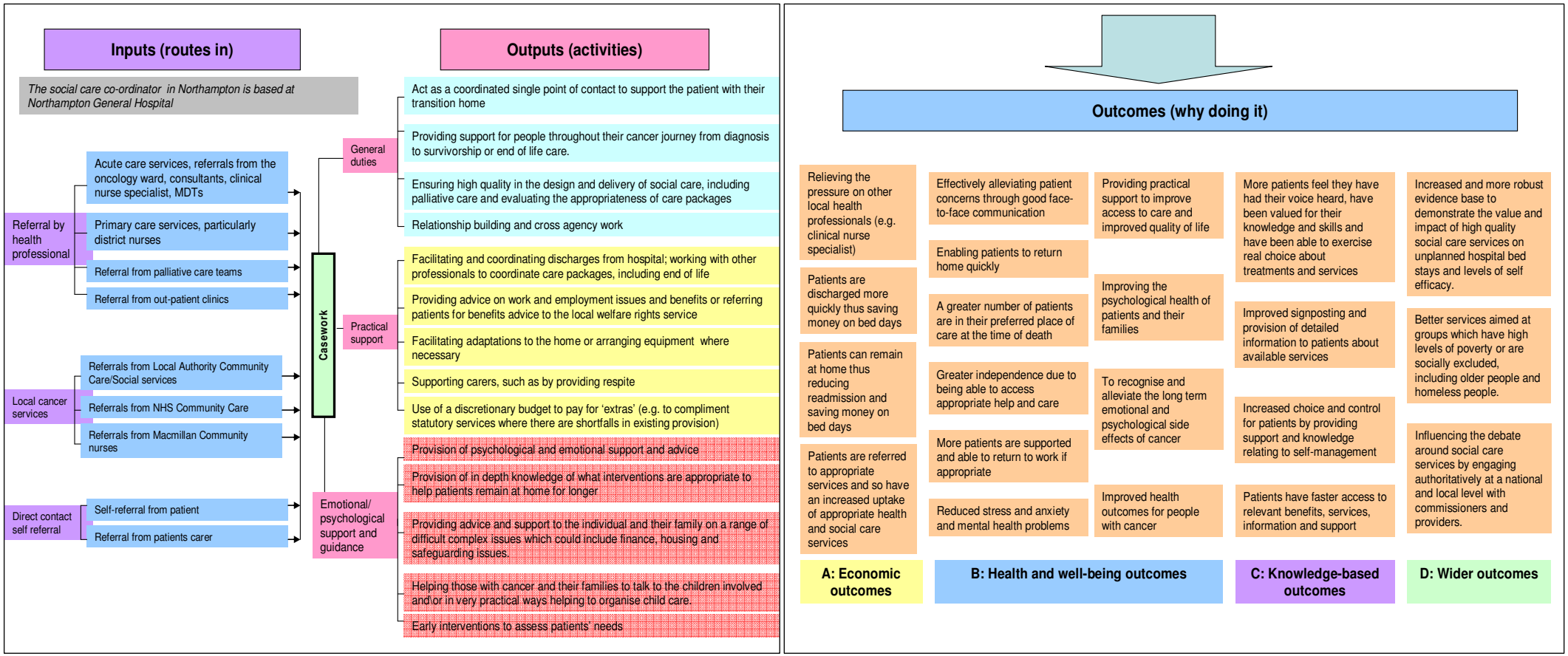
Delivery volume: referrals and patients/clients

In 2009-10, **228** patients were referred to the service. The social care co-ordinator sees all those who are referred. Table 1 below provides a breakdown of referral routes.

Table 1 : Referral routes 2009-10

Route	Proportion of referrals (2009-10)
Oncology Ward (Talbot Butler)	27%
Clinical Nurse Specialist	27%
Specialist Palliative Care Team	16%
Consultant	5%
Self-referral	7%
Carer	2%
Other (i.e. district nurses, social services)	9%

Figure 1: Pathway to outcomes for Northampton General Hospitals cancer specific, social care co-ordinator



Methods of delivery

The service is generally delivered to patients and carers at the patients' bedside whilst they are in hospital and awaiting discharge, although the post holder does on occasion visit patients in their own home after discharge to monitor their circumstances. Occasionally, the post holder also accepts referrals from out patient clinics. An essential element of the role is proactive engagement with professionals working within the oncology and haematology directorate, Clinical Nurse Specialists, the oncology ward and clinics to promote early identification of patients who may be in need of support services. This model is unique to the hospital and utilises a daily ward visit to check on admissions and potential referrals.

3) Impact Evidence

Locally gathered data indicates that the social care co-ordinator post is delivering a wide range of outcomes for both the local NHS acute trust and for patients living with cancer and their families. These can be grouped as per Fig 3b above.

Economic outcomes

Significant number of bed days saved:

- Patients are discharged more quickly than they would be if they had been referred to the Hospital Discharge Team thus saving money on bed days
- Patients feel adequately supported to remain at home thus reducing readmission and saving money on bed days

Table 2 provides a breakdown of key economic outcomes along with the number of cases that the social care co-ordinator has directly influenced.

Table 2: Economic outcomes of interventions 2009-10

	Feb – Apr 2009	May - Jul 2009	Aug – Oct 2009	Nov 09 – Jan 2010	Total
Admission Avoidance	1	4	3	2	10
Bed days saved by admission avoidance	14	56	42	28	140
Facilitate hospital discharge	28	25	27	17	97
Bed days saved by facilitating hospital discharge	95	76	91	64	326

It should be noted that the £16,000 'innovations budget' available to the post holder has played an important role in the number of bed days saved. Delayed discharges are often due to the fact that patients have to wait for an appropriate package of statutory health and social care support to be put in place before they can return home. Agreeing and implementing an appropriate package of statutory support can often be bureaucratic and take several days to implement. When putting the original bid together to create the social-care co-ordinator post the Cancer Lead Nurse calculated that patients requiring social care support after discharge spent an average of seven days more in hospital than necessary. The innovations budget has enabled the post holder to spot purchase services such as, care assistance to tide patients over until the agreed statutory package of support kicks in or to give patients a small amount of additional money to purchase take–away food until a 'meals on wheels' service is set up. The types of services purchased with the 'innovations budget' are often simple and not costly yet it can have a significant impact on reducing excess bed days.

Health and well-being outcomes

- **Greater independence**
- **Reduced anxiety and stress**
- **Improved quality of life**

A number of case studies illustrate the range of health and well-being outcomes being achieved by the service.(Appendix II)

Knowledge-based outcomes

- **Giving patients the ability to exercise real choice and wider access to advice and support** e.g. facilitating preferred place of care choices, including end of life

Wider outcomes that have been achieved by the service:

- **Freeing up the capacity of other health professionals** to undertake core functions e.g. clinical nurse specialists

4) Economic Evidence and Cost Calculation

Table 4, in appendix I, provides indicative figures for the currently available monetisable **costs and benefits to Northampton General Hospital Trust** of providing the service, based on 2009-10 data. This does not include the non-monetisable, categorical benefits summarised in the previous section 'Impact Evidence' and in Figure 3b.

Monetising costs and benefits at the highest-level shows that the:

- service costs **in total, £3,089 per annum,** on average (**with** Macmillan funding and excluding set-up costs)
- service costs **in total, £69,089 per annum,** on average (**with no** Macmillan funding, including the innovations budget and excluding set-up costs)
- service resulted in an efficiency saving from a reduction in excess bed days that equates to **£149, 586** in 2009-10

1. Effectiveness ratio

Analysing data at the activity level, we are able to make an approximated assessment of service cost effectiveness. The cost data included in Table 3 do not include set-up costs as the table provides a 'snapshot' of service costs and benefits in relation to the annual costs in 2009-10 and in two alternative scenarios: 1) with the Macmillan funding; 2) with no Macmillan project funding.

Table 3: Cancer social care co-ordinator cost effectiveness breakdown

Total cost of excess bed days saved	Total cost of service to the Trust	Cost-effectiveness ratio *= total cost of excess bed days saved/total cost of service*
£149,586	£3,089 (with Macmillan funding)	48.4
£149,586	£69,089 (with no Macmillan funding)	2.2

2. Possible return on investment

Applying a ROI calculation to the high-level data (total service costs, including set-up costs spread over 3 years) and total money saved by a reduction in excess bed days, we see that **every £1 spent by Northampton General Hospital in 2009-10 has generated £38.10 of efficiency benefits for the Trust**. This calculation excludes the social-care co-ordinator's salary, on-costs, overheads and the innovations budget which were funded by Macmillan for 3 years and which will then be covered by the Trust. It also does not include the indirect benefits. Alternatively and in order to provide a hypothetical or longer term scenario of possible returns from setting up a cancer social care co-ordinator post 'from scratch' (i.e. no Macmillan funding being included in the calculation) the ROI calculation shows that for **every £1 spent, £2.10 of efficiency benefits has been generated**. Again this does not include the indirect benefits.

Both calculations need to be interpreted against the context that the social care co-ordinator post was established in February 2008 which means that the set-up costs are set against three years of full operation. As the service operates over a longer period of time henceforth, the set-up costs will be spread out over a longer duration of time. The money spent would therefore generate greater amounts of benefits. This trend, however, is not indefinite as it would be limited by the time it takes for the service to reach saturation in terms of the number of cases the social care co-ordinator is able to handle given current set up.

3. Additional indirect benefits

There is also evidence to indicate that a specialist social care co-ordinator can free up the capacity of other staff to perform their core functions. This is an important wider benefit that warrants closer scrutiny. For example, a social care co-ordinator is able to provide a service to more patients in a given time period than a clinical nurse specialist (CNS) due to their expertise in developing appropriate care packages. They are often also able to offer a one-stop-shop whereas a CNS may need to refer on to multiple providers e.g. welfare rights, housing etc. If we apply a conservative estimate to these efficiency savings the return on investment increases further:

Applying a ROI calculation to the high-level data (total service costs, including set-up costs spread over 3 years) and total money saved by a reduction in excess bed days **and the freeing up of health professionals' capacity**, we see that **every £1 spent by Northampton General Hospital in 2009-10 has generated £39.40 of efficiency benefits for the Trust**. This calculation excludes the social-care co-ordinator's salary, on-costs, overheads and the innovations budget which were funded by Macmillan for 3 years.

Further to this in the hypothetical scenario of possible returns from setting up a cancer social care co-ordinator post 'from scratch' (i.e. no Macmillan funding being included in the calculation) the ROI calculation shows that for **every £1 spent, £2.20 of efficiency benefits has been generated**.

Evidently, by setting up complex packages of continuing health and social care support a number of costs are incurred by the local authority and the primary care trust. However these costs stand outside the scope of this case study but it is important to remember that patients and their families will be entitled to the statutory services levered in and care in the community costs are generally cheaper than staying in an acute hospital setting.

4. Potential costs incurred in the absence of the service

In the absence of a dedicated professional to assess the particular social care needs of patients living with cancer and their families, people would be referred to the hospital discharge team. However, it can take up to five working days for the discharge team to see someone once a referral has been received unlike the dedicated social worker who generally sees patients the same day as referral and if not the next day. Further to this, the majority of social care would be arranged through the local authority social service which takes time to organise resulting in an average of 7 days longer in hospital than is necessary. It could be argued therefore that the excess bed days saved as a result of the dedicated professional would not be realised. So

although the direct costs would be similar (with the exception of the innovations budget) the **saving in bed days of £149,586 would not have been achieved.**

Further to this it is also worth noting that:

- The discharge team are not specialists in cancer care, the dedicated worker is.
- Discharge team do not offer advice and information. They only see people who have clear social and health care needs.
- After discharge there is no continued support whereas the specialist co-ordinator offers continuing support and out-reach. Even after death families can ask for support.
- The discharge team have no discretionary 'innovation budget' to facilitate a speedy discharge.

5) Evidence to Support Quality and Productivity Effects

Published papers on social work and similar services indicate that the findings from this case study are in line with the wider literature: Such evidence includes:

- **Economic outcomes:** Evidence suggests that end of life care outside of hospital results in economic benefits; the National Audit Office calculates that £1.8 billion is spent annually on treating patients in the last year of their life. Providing opportunities for patient preferences in terms of choosing where to die would reduce hospital admissions by 10%, the average length of stay following admission by three days, and could free up to £104m to be redistributed[1]. Furthermore there could be potential savings due to a reduction in the number of complaints since approximately half of all complaints made to acute trusts relate to an aspect of end of life care.[2]
- **Improved psychological health:** Research shows that the emotional support provided by social workers improves levels of depression and other psychiatric symptoms for cancer patients[3].
- **Meeting patient needs:** Research on assessments indicates that setting up systems for the early identification of support needs can improve outcomes for patients both in terms of getting the help they need quicker, and improving psychological status[4]. This can result in economic outcomes through a reduction in the uptake of inappropriate services. The wider literature may be able to shed some light on potential cost savings as a result of a reduction in inappropriate use of services.
- **Increasing quality of life and wellbeing:** Studies have suggested that the provision of psychosocial support to cancer patients and their carers/families leads to increased wellbeing[5]. Specifically one study shows the benefit to family carers in terms of improving quality of life, and reducing the perceived burden of patients' symptoms and their care tasks[6].

6) Conclusions

The evidence outlined above demonstrates that the cancer social care co-ordinator is providing a clear return on investment for Northampton General Hospital Trust. This has to be interpreted against the context that the calculations have been based on existing quantified and monetised data on the most direct costs and benefits, and does not include the wider benefits that are currently not monetised. While the quantitative data is limited to the bed days saved as a result of a significant reduction in delayed discharge and admission avoidance and compared to what the general hospital discharge team would have achieved and freeing up other health professional time, this alone demonstrates that the service results in net efficiency savings. The evidence collated by the social care co-ordinator since coming in to post has persuaded Northampton General Hospital to continue to fund the post once the Macmillan funding comes to an end in February 2011.

The compelling case studies included in appendix II and the national evidence outlined above further highlight the wider outcomes of this service in respect of quality of life, health and well-being, knowledge, choice and empowerment.

As outlined by the National Audit Office, providing opportunities for patient preferences in terms of choosing where to die would, on a national scale, reduce hospital admissions by 10%, the average length of stay following admission by three days, and could free up to £104m to be redistributed[7]. This suggests that by providing opportunities for patient preferences of care beyond those at end of life, as is the case in Northampton, there are potentially huge amounts of resource nationally that could be effectively redistributed.

Appendix 1: Economic Evidence

Table 4: Available cost and benefit data for the social care co-ordinator post in Northampton.[8]

Cost/benefit type	Measure/s	Costs	Total
Direct costs – one off set-up costs			
1. Set-up costs incurred by the Trust – writing the business case to secure project funding from Macmillan	Staff time: wte x salary	• Cancer Lead Nurse (CLN) = 60 hrs x £42,736pa • Macmillan Development Manager (MDM) = cost neutral to Trust	• CLN =£1,313 • MDM = £0 **Total = £1,313**
2. Set-up and maintenance of computer	Value in £	• Cost, to Trust, of computer and set up= £1200	**Total = £1,200**
Direct costs - recurrent			
3. Staff costs including on-costs and overheads	Staff time: wte x salary (including on costs and overheads)	• Social Care Co-ordinator post (1wte x £31,454 pa) including on-costs and overheads (SCC) = £50,000 per year although currently cost neutral to the Trust. **(Macmillan funded these costs for 3 years, the Trust will continue to fund this post and associated costs from February 2011)** • Line management from Cancer Lead Nurse (CLN) = 5 hours per month x £42,736pa per year • IT support (IT) = 1 hour per month x £24,355pa per year • Support from finance to manage innovations budget (F) = 1 hour per month x £29,831pa per year	• SCC = £0 • CLN =£1,315 • IT = £150 • F = £184 **Total = £1,649 per annum**
4. Innovations budget	Value in £	• Discretionary budget not used to replace statutory services but to complement them where there are shortfalls in existing provision = £16,000 per annum. Currently cost neutral to the Trust. **(Macmillan provided this budget from February 2009 for 2 years it is not yet clear if the Trust will continue to provide this budget from February 2011)**	**Total = £0**
4. Home visit costs	Value in £	• Average mileage costs = £120 per month based on an average of 241 miles per month.	**Total = £1440**
5. Training	Value in £	• Mandatory training provided by the trust = Cost neutral as training is run as a matter of course and not provided specifically/exclusively for the social care co-ordinator • Macmillan training = Cost neutral as training is free and of no cost to the trust • Cancer Network training = Cost neutral as training is provided free to members • Cost neutral	**Total = £0**
6. Overhead costs	Value in £	• **Bulk of overhead costs included in staff time calculations above** • Business cards and cancer information leaflets = Cost neutral as provided free of charge by Macmillan	**Total = £0**
Direct benefits			
7.Bed days saved as a result of reducing delayed discharges	Number of days x average cost of bed day in the oncology ward	• 326 bed days saved x £321	**£104, 646 per annum**
8. Admission avoidance	Number of days x average cost of bed day in the oncology ward	• 10 admissions avoided (c14 days per admission saved): 140 bed days saved x £321	**£44,940 per annum**
Indirect benefits			
9. Freeing up the capacity of other health professionals	Number of hours x average hourly wage of health professional	• 228 patients referred in 2009-10 = 228 hours x £21.88 (this is based on a conservative estimate of the time nursing staff would have spent contacting appropriate services and filling out referral forms for these patients)	**£4,989 per annum**

Appendix II: Case studies outlining wider impact of the service

All names in the following case studies have been changed in order to respect the privacy of the patients involved.

Kim

Kim was a young woman who had carcinoma of the breast which had been treated with mastectomy, systemic chemotherapy and adjuvant radiotherapy. Kim was found to have lymphangitis and progression of disease to her lungs.

Kim was in cardiac failure and imminently dying, she wanted to be at home with her husband and young daughter but she lived in a new and very small house which did not have the room to accommodate a hospital bed.

Kim wanted to be at home to talk to her little girl about what was happening to her and to spend some time to prepare her for her loss. Kim felt very strongly that she needed to have these conversations in the family home not in a hospital ward. Kim wanted to be able to read her daughter a goodnight story whilst they were both tucked up in bed and Kim knew that she was running out of time.

The social care co-ordinator and the Macmillan OT conducted a home access visit that morning, they submitted a grant application for a rental stairlift so that Kim could access her bedroom and this was fitted the same day, the social care co-ordinator applied for urgent funding for carers and for Marie Curie night nurses and fortunately both were successful and able to start next day. They delivered the necessary equipment that day and in less than twenty four hours Kim arrived at home.

Kim remained at home for two days and then came back into hospital to die which was her preferred place of care. This story illustrates what can be achieved in a day when people work together and pull out the stops. In theory this discharge should not have worked, the time frames were too short and the logistics of fitting a stairlift and ordering equipment were thought to be impossible and a waste of money for such a short stay at home. However, it is impossible to quantify what this meant to Kim and her family.

Jane

Jane was a young woman admitted to the ward in January. Jane had been experiencing overwhelming fatigue and severe headaches for around four weeks, she was a busy professional and attributed her initial symptoms to her stressful working life. It was only when the severity of her headaches had caused her to collapse and be brought to hospital that a diagnosis of Non Hodgkins Lymphoma was made. Jane underwent an initial course of chemotherapy as an inpatient which she found to be gruelling both physically and psychologically, she was supported throughout her treatment by her parents who had been living abroad but had come over to stay for as long as they were needed.

Jane's personal life was complicated, she had been sharing a rented house with her sister. A couple of months into treatment, the tenancy had been relinquished and Jane's belongings put into storage. Jane felt adrift, she was homeless and had no part in packing up her lifelong possessions, she was anxious about where she would go when ready to leave hospital Jane felt that she needed to have something to focus on post treatment, she described how she wanted to make plans to start living again.

Jane felt that she had become reliant upon parents again, she felt powerless and lacking control, it became a priority for her to have a place of her own so the social care co-ordiantor had completed housing documents and submitted them as a matter of urgency.

Jane's illness had dealt a devastating blow; in the space of two months she had experienced the freefall from life as a busy professional woman very much in control of her future to

someone feeling frail and dependant. Jane was a very spiritual woman who valued nature and freedom highly, animals and the outdoors were a lifeline for her, she also liked to get out in her mum's car when she felt well enough and speed along the open roads with music at full blast.

Sadly, Jane's disease did not respond to treatment and continued to progress despite two courses of chemotherapy, she was aware that she had no further treatment options and desperately wanted to leave hospital. The housing department could not offer the prospect of accommodating Jane in an appropriate timescale and Jane's future looked bleak. Indeed, one Consultant had spoken to Jane about the prospect of not being able to leave hospital in time and Jane's response had been to state that she would prefer to take her own life in the nearest park rather than die on the ward.

This is when the idea of a holiday cottage was raised. The social care co-ordinator went away and searched through Google. The first two hits were for isolated country cottages and on the third occasion the co-ordinator came across a local country park which had privately owned lodges which the owners were happy to lease on a short term basis. Within two days and after frantic negotiations, Jane and her family had visited, accepted the lease and had moved in. The social care co-ordinator organised aids and equipment and with the invaluable assistance of a Palliative Care Consultant they had managed to sort medication and the delivery of Entonox. The social care co-ordinator had managed to expedite Marie Curie night nurses, the hospice at home service and Continuing care support for Jane and her family. Consequently Jane was able to spend her final few days in beautiful and peaceful surroundings with her friends and family around her.

Stuart

The social care-co-ordinator met Stuart on the ward; he had been diagnosed with malignant neoplasm of the nasopharnyx and had been treated with chemotherapy and radiotherapy. Stuart was a younger man who had a chaotic lifestyle, despite his diagnosis he had continued to drink and smoke heavily, he had missed various appointments and was largely non compliant with most aspects of his care. Stuart had been staying with a younger family member since being evicted from a flat he had shared with a partner six years ago, he had no tenancy agreement and the arrangement had been made without the permission of the council.

Stuart spent a prolonged admission on the ward as treatment was complicated by his co-morbidities. As Stuart's treatment progressed he stopped drinking and cut down on his cigarettes, he began to question his lifestyle choices and eventually announced that he did not want to return to his previous address. Stuart felt that the stay in hospital had given him the opportunity to stop drinking and break a lifelong addiction, he was anxious about returning to the flat as he was sure that he would be tempted back in to his old habits.

The social care co-ordinator completed housing forms with Stuart and discussed his case with the housing officer. Stuart was accepted on to the Council's waiting list as a matter of urgency but would still have to wait for a property to be allocated. As the co-ordinator regularly liaised with the housing department she was aware that this was likely to take another two to three weeks. At this point, Stuart was ready to be discharged from hospital and was keen to leave the ward. The co-ordinator was able to use her Innovations Budget to pay for an en-suite room in a Bed and Breakfast near to the hospital. The co-ordinator used her budget to pay for carers to support Stuart with laundry, shopping and meals.

Stuart moved into his new flat eighteen days later and for the first time in his life he had a place of his own. Stuart takes a real pride in his home, the social care co-ordinator helped him with benefits and a community care grant to furnish and decorate. The innovations budget meant that Stuart was able to leave hospital eighteen days earlier, saving £5,778 in bed days but affording Stuart immeasurable happiness.

[1] National Audit Office (2008) *End of Life Care* Available online at: http://www.nao.org.uk/publications/0708/end_of_life_care.aspx (accessed 30.09.10)
[2] Ibid.
[3] NICE, (2004) Improving Supportive and Palliative Care for Adults with Cancer: The Manual *NICE: Guidance on Cancer Services* Available online at: http://www.nice.org.uk/nicemedia/live/10893/28816/28816.pdf (accessed 29/09/10)
[4] NICE, (2004) Improving Supportive and Palliative Care for Adults with Cancer: The Manual *NICE: Guidance on Cancer Services* Available online at: http://www.nice.org.uk/nicemedia/live/10893/28816/28816.pdf (accessed 29/09/10)
[5] Hudson, Peter L; Remedios, Cheryl; Thomas, Kristina (2010) 'A systematic review of psychosocial interventions for family carers of palliative care patients' *BMC Palliative Care* 9 (17) Available online at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2924287/ (accessed 29/09/10)
[6] Milberg A, Rydstrand K, Helander L, Friedrichsen M. (2005) Participants' experiences of a support group intervention for family members during ongoing palliative home care. *Journal of Palliative Care.* 21**(**4):277–284
[7] National Audit Office (2008) *End of Life Care* Available online at: http://www.nao.org.uk/publications/0708/end_of_life_care.aspx (accessed 30.09.10)
[8] Cost figures have been rounded to the nearest £