NICE National Institute for Health and Care Excellence

Putting NICE guidance into practice

Costing statement:

Implementing the NICE guideline on Transition between inpatient hospital settings and community or care home settings for adults with social care needs (NG27)

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Summary

The guideline considers how person-centred care and support should be planned and delivered during admission to and discharge from hospital. It addresses how services should work together and with the person, their family and carers, to ensure transitions are timely, appropriate and safe for adults with social care needs.

A guideline on the transition between inpatient hospital settings and community or care home settings is needed because of the negative effects on service users and their families when problems occur during the process. These problems can occur at both admission to, and discharge from, hospital.

Overall, it is expected that implementing the guideline will be cost saving. Implementing the guideline is likely to have resource implications (both costs and savings) for health and social care commissioners and for providers, and we advise them to assess these locally.

Potential areas for savings and benefits are:

- shorter hospital stays
- reduced hospital admissions (including a reduction in readmissions within 30 days)
- reduced care home admissions

Services, roles and responsibilities may need to be redesigned to generate these savings within existing resources. Potential areas of change for services, roles and responsibilities are:

- designated discharge coordinator posts and multidisciplinary working between community and hospital-based teams
- comprehensive assessments of older people with complex needs
- training and development
- investment in new electronic data systems and/or integration of existing data systems

In some instances this may incur additional costs at a local level.

The resource impact of implementing the guideline recommendations will depend on the extent to which organisations have already implemented legislation such as the Care Act 2014.

1 Introduction

1.1 This costing statement considers the resource implications of implementing the recommendations made in Transition between inpatient hospital settings and community or care home settings for adults with social care needs (NICE guideline 27).

1.2 We anticipate that the guideline will have resource implications (both costs and savings) for commissioners and providers of health and social care, but overall is likely to be cost saving. Organisations are encouraged to evaluate their own practices against the recommendations in the guideline and assess costs and savings locally.

1.3 A range of health, social care and other services are involved when adults with social care needs move into or out of hospital from their own homes or care homes. Families and carers also play an important part.

1.4 Services to support the transition between hospital and home for adults with social care needs are commissioned by clinical commissioning groups and local authorities. Acute hospital trusts, independent social care agencies, GPs and local authorities provide the services.

2 Background

Transition between hospital and the community or care home

2.1 A poor transition into or out of hospital can create significant anxiety, leaving people uncertain about their diagnosis and support (Vetter 2003[1]; Kydd 2008[2]; Ellins 2012[3]). This is particularly true

[1] Vetter N (2003) Inappropriately delayed discharge from hospital: what do we know? British Medical Journal 326: 927
[2] Kydd A (2008) The patient experience of being a delayed discharge. Journal of Nursing Management 16: 121–6

when someone's discharge from hospital is delayed (Ensuring the effective discharge of older patients from NHS acute hospitals National Audit Office).

2.2 Lack of integration between health and social care services is one of the factors that causes delays (Joining up health and social care: improving value for money across the interface Audit Commission). The Department of Health's Integrated care and support: our shared commitment sets out a framework for local integration using structures such as health and wellbeing boards.

2.3 Poor integration is not the only reason for delayed hospital discharges. Other reasons include, for example, people waiting for adaptations to their home and people waiting for a residential or nursing home place to become available. As a result, services should ensure that:

- transitions are discussed and planned carefully beforehand and are structured and phased
- the care plan supports effective collaboration between NHS and social care and other care providers during transitions

2.4 NHS England's Delayed transfers of care statistics for England show that in 2014/15, on a daily basis an average 3.7 adults per 100,000 population had their transfer of care delayed. This compared with 3.1 in 2013/14. For 2014/15 this is equivalent to over 1,500 delayed transfers each day throughout England (see figure 1).

[3] Ellins J, Glasby J, Tanner D, et al. (2012) Understanding and improving transitions of older people: a user and carer centred approach. London: National Institute for Health Services Research

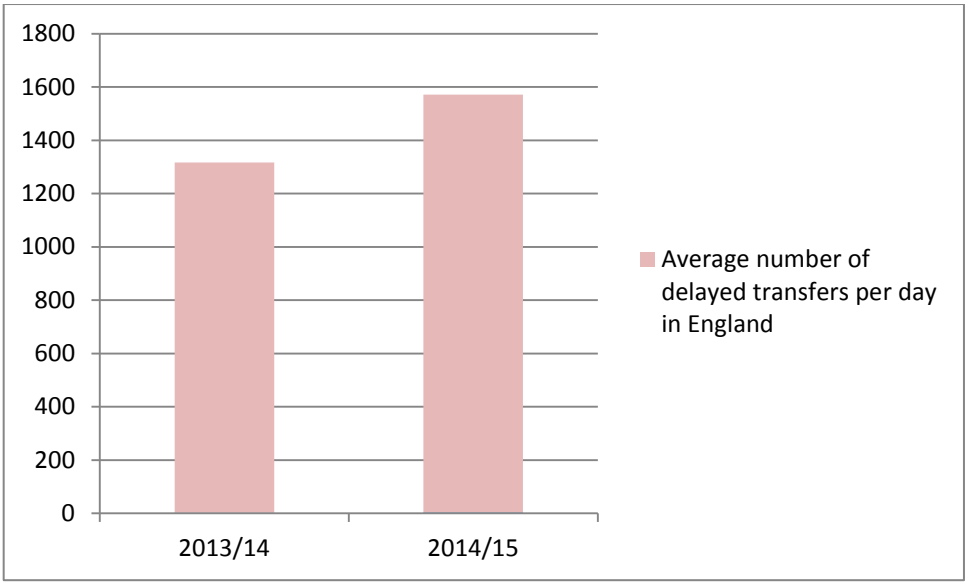

Figure 1 Average number of delayed transfers of care per day

2.5 Healthwatch England's Safely home: what happens when people leave hospital and care settings? report highlighted that poor hospital discharge practice leads to unnecessary patient suffering and millions in wasted resources.

2.6 A 2015 YouGov poll found that nearly a fifth of people who were discharged from hospital in the previous 3 years did not feel they received the social care support they needed afterwards. In addition, 1 in 8 felt they were unable to cope in their own home after being discharged. These issues are likely to lead to people being readmitted to hospital following discharge, or potentially admission to residential or nursing care.

2.7 In 2012-13 there were more than a million emergency readmissions within 30 days of discharge. This cost the economy more than £2.4 billion (Emergency admissions to hospital: managing the demand, National Audit Office).

2.8 In 2013/14 around 1.3 million people in England used social care funded by local authorities (Community care statistics, social services activity, England – 2013–14). Of these over 1 million

received community-based services, around 200,000 received residential care and 85,000 received nursing care.

Funding

2.9 The Better Care Fund was announced by the Government in June 2013 to improve integration of health and social care services. It is underpinned by the Care Act and creates a single pooled budget. The aim is to give the NHS and local government an incentive to work together more closely to improve or maintain people's wellbeing.

2.10 The Better Care Fund may be used to help implement the NICE guideline once the outcomes for the population and the pooled budget have been defined.

2.11 Reablement funding allocated to support people after discharge from hospital can help to shorten hospital stays, although not all reablement relates to hospital discharge. In 2015/16, the £3.8 billion Better Care Fund included £300 million for reablement funding. (NICE is producing a guideline on intermediate care including reablement which is expected to publish in 2017).

2.12 Measures from the Adult Social Care Outcomes Framework show that reablement services are helping more people to live at home after transfer from hospital (Measures from the Adult Social Care Outcomes Framework, England, 2013-14 Health and Social Care Information Centre).

3 Recommendations with potential resource impact

Recommendations that may have a local resource impact are discussed below.

Designated discharge coordinator posts and multidisciplinary working between community and hospital-based teams

Recommendations

3.1 If a community multidisciplinary team is involved in a person's care that team should give the hospital multidisciplinary team a contact name. Also give the named contact to the person and their family or carer (recommendation 1.2.2).

3.2 Make a single health or social care practitioner responsible for coordinating the person's discharge from hospital. Create either designated discharge coordinator posts or make members of the hospital- or community-based multidisciplinary team responsible. Select them according to the person's care and support needs. A named replacement should always cover their absence (recommendation 1.5.1).

3.3 Ensure that the discharge coordinator is a central point of contact for health and social care practitioners, the person and their family during discharge planning. The discharge coordinator should be involved in all decisions about discharge planning (recommendation 1.5.2).

Background

3.4 Sections 2.2 and 2.3 discuss the factors that may cause delays in discharge from hospital.

3.5 The guideline aims to reduce the lack of integration and planning that contribute to hospital discharge delays, hospital readmissions and avoidable admissions to residential or nursing care from hospital.

3.6 Local authorities should support people so that they can live in their own homes if at all possible, rather than hospitals or residential

care. This involves integrated and joint working with healthcare and other support services.

Savings and benefits

3.7 Implementing the recommendations to improve the integration between community and hospital multidisciplinary teams, as well as improving the coordination of a person's discharge from hospital is likely to lead to savings and benefits in several areas, although estimating these savings at a local and national level is challenging.

3.8 If hospital care is avoided (for example, due to reduced readmissions) or shortened, healthcare commissioners (clinical commissioning groups and NHS England) will make savings. These will come from reduced admission tariff payments and bed days avoided (beyond the length of stay for which the standard tariff applies). The non-elective tariff for a hospital admission depends on the diagnosis and Healthcare Resource Group (HRG) code used. Common reasons for non-elective admission for people over 65 include: pneumonia (£3050, HRG DZ11A) and cardiac conditions (£537, HRG EB01Z). The average cost per bed day is £222 (2015/16 Enhanced Tariff Option).

3.9 Hospital providers may make efficiency savings from reduced lengths of stay because more beds will be made available. In addition, where readmissions within 30 days are avoided, significant savings to hospital providers are possible due to the non-payment of tariff to providers for certain readmissions within 30 days.

3.10 Significant savings are also possible by reducing avoidable admissions to residential and nursing care. The weekly cost of social care in residential settings is taken from the Personal Social Services Research Unit's Unit costs of health and social care 2014. See table 1. It is worth noting that costs for self-funders of residential care may differ significantly to the figures quoted below,

and that around 80% of residential care is provided by the private sector (Residential elderly care, UK sector review, 2014).

Table 1 Average cost of residential care commissioned by local authorities in 2013/14

Service	Information	Cost
Weekly costs		
Residential care provided by private sector	Average fee to local authorities per resident per week	£553
Residential care provided by local authority	Average local authority expenditure per resident per week[a]	£839

[a] includes overheads (social services management and support services costs)

Costs

3.11 It is anticipated that the costs associated with implementing the recommendations will vary widely, depending on existing local arrangements. But we do not expect them to be significant. In most cases, existing community and hospital multidisciplinary team members are likely to be assigned the roles described. Associated costs will depend on the grading of the post.

3.12 Training costs associated with these roles are discussed in the 'Training and development' section.

3.13 NHS organisations and local authorities are encouraged to assess the resource impact based on their current circumstances and staffing levels, and the information provided above.

Comprehensive assessments of older people with complex needs

Recommendations

3.14 Start a comprehensive assessment of older people with complex needs at the point of admission and preferably in a specialist unit for older people (recommendation 1.3.10).

Background

3.15 NICE's economic analysis for the guideline concluded that comprehensive assessments of older people and care provided in hospital can reduce costs. This is because they can reduce admissions to care homes and, to a lesser extent, can reduce hospital costs, over the period of a year.

Costs

3.16 The unit cost of a comprehensive assessment of older people is estimated at around £242 (national tariff 2015/16, enhanced tariff option, outpatient attendance for geriatric medicine, first attendance multi professional). Costs will vary depending on local arrangements.

Savings and benefits

3.17 Based on assumptions in the economic analysis, implementing the recommendation would lead to an average reduction in expenditure of around £950 per person per year, for each older person given a comprehensive assessment. This is based on the reduced risk of admission to care homes as a result of the assessment and does not include any additional costs that may be incurred caring for the person in settings other than care homes.

3.18 Savings due to a reduced hospital stay are estimated at around £70. (This is derived from the average cost of an excess bed day from the national tariff 2015/16, enhanced tariff option [£222]).

Training and development

Recommendation

3.19 Ensure that all relevant staff are trained in the hospital discharge process. Training should take place as early as possible in the course of their employment, with regular updates (recommendation 1.7.1). See the guideline for details about what this training could include.

Background

3.20 Evidence in the full guideline showed that transitions training for hospital-based trainees improves their understanding of the patient's social context and also improves their skills in medicines management. Training both health and social care staff in the hospital discharge process is therefore expected to lead to several benefits.

Costs

3.21 The development of training programmes will lead to additional costs for hospital trusts and local authorities. There will also be ongoing costs linked to the additional staff time needed to introduce the training into routine practice. These costs will vary and should be assessed locally, according to the needs of the people using services and staff.

3.22 Skills for Care provides information on qualifications and training, including medication training, available to social care staff. It also offers free guidance and resources.

Savings and benefits

3.23 Care provided by hospital trusts and local authority staff trained in the hospital discharge process may help reduce: readmissions, the length of hospital stays, emergency attendances and the risk of care home admissions. See paragraphs 3.7–3.10 for more details.

3.24 The costing statement for NICE's guideline on 'Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes' concludes that a reduction in avoidable medicines-related admissions may save commissioners up to £530 million a year in England. For providers, it may allow for better use of nearly 2 million bed-days in England per year, or 4200 per hospital. The training recommended in NICE's guideline on transition between inpatient hospital settings and community or

care home settings for adults with social care needs supports the safe use of medicines and may contribute to these savings.

4 Other considerations

4.1 Additional costs may be incurred when implementing the following recommendations:

- Record multidisciplinary assessments, prescribed and non-prescribed medicines and individual preferences in an electronic data system. Make it accessible to both the hospital- and community-based multidisciplinary teams (recommendation 1.4.1).
- At each shift handover and ward round, members of the hospital-based multidisciplinary team should review and update the person's progress towards hospital discharge (recommendation 1.4.2).

4.2 The costs incurred will vary widely, depending on current data systems and staff protocol around shift handovers. If new electronic data systems are needed, or existing data systems need to be integrated, they could be significant. But any additional costs are likely to be offset by savings associated with improved practice, leading to, for example, reduced hospital stays. See paragraphs 3.7–3.10 for more details.

About this costing statement

This costing statement accompanies NICE's guideline Transition between inpatient hospital settings and community or care home settings for adults with social care needs (NICE guideline 27) and should be read in conjunction with it. See terms and conditions on the NICE website.

The cost and activity assessments in the statement are estimates based on a number of assumptions. They provide an indication of the potential impact of the principal recommendations and are not absolute figures.