

Putting NICE guidance into practice

Resource impact report: Intermediate care including reablement (NG74)

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Summary

This report focuses on the recommendations from NICE's guideline on [Intermediate care including reablement](#) that we think will have the greatest resource impact nationally (for England), and will need the most additional resources to implement or potentially generate the biggest savings. They are:

- offering reablement as a first option to people being considered for home care, if it has been assessed that reablement could improve their independence (**recommendation 1.4.2**)
- starting bed-based intermediate care within 2 days of receiving an appropriate referral (**recommendation 1.5.3**)

The cost of implementing recommendation 1.4.2 will vary depending on current practice. A worked example of the potential resource impact is included in section 3.1. The estimated annual cost of implementing recommendation 1.5.3 for the population of England is shown in table 1.

Table 1 Estimated annual cost of implementing recommendation 1.5.3

	2017/18	2018/19	2019/20	2020/21	2021/22
Additional capacity required in bed-based intermediate care (bed-days)	15,200	60,600	90,900	121,200	151,600
Resource impact each year for additional capacity in bed-based intermediate care (£000)	3,213	12,852	19,279	25,705	32,131

This report is supported by a [resource impact template](#) which may be used to calculate the resource impact of implementing the guidance by amending the variables.

Intermediate care including reablement services are commissioned by local authorities and clinical commissioning groups (CCGs). Services may be jointly commissioned as part of an integrated working approach. There are a number of providers including NHS hospital trusts, local authorities, community providers and not-for-profit social enterprises.

1 Introduction

- 1.1 The guideline offers best practice advice on Intermediate care including reablement¹.
- 1.2 This report discusses the resource impact of implementing our guideline on intermediate care in England. It aims to help organisations plan for the financial implications of implementing this NICE guideline.
- 1.3 Implementing the guideline may result in the following additional costs:
- costs of providing additional capacity in bed-based intermediate care
 - costs of providing additional capacity in reablement
- Implementing the guideline may also result in the following benefits and savings:
- reduced hospital admissions or re-admissions
 - quicker discharge from hospital
 - reduced requirement for, and cost of, home care
 - delayed or prevented admissions to care homes
- 1.4 A resource impact template accompanies this report to help with assessing the resource impact at a local level in England, Wales or Northern Ireland.
- 1.5 We have considered direct costs and savings to the NHS and local authorities and not those for the individual, the private sector or the not-for-profit sector. Any cost savings arising from a change in practice have been offset against the cost of implementing the change.

¹ Intermediate care including reablement will be referred to as 'intermediate care' throughout the rest of the report.

- 1.6 Intermediate care services are commissioned by local authorities and clinical commissioning groups (CCGs). Services may be jointly commissioned as part of an integrated working approach. There are a number of providers including NHS hospital trusts, local authorities, community providers and not-for-profit social enterprises.
- 1.7 Local areas are likely to configure their intermediate care service in different ways, to meet local circumstances and needs. People may be referred into the services either by health or social care practitioners.

2 Background

- 2.1 Admission to hospital and delays in hospital discharge can create significant anxiety, physical and psychological deterioration and increased dependence. Therefore, multi-disciplinary services, which help people recover, regain independence and return home, are vital. In facilitating timely transfer of care from hospital, intermediate care and reablement services aim to maximise people's independence and reduce unnecessary hospital admissions.

Intermediate care uses a range of service models to help people be as independent as possible. It can prevent hospital admissions, facilitate an earlier, smoother discharge, or be an alternative to residential care.

- 2.2 Intermediate care (IC) is defined in the [National Audit of Intermediate Care \(NAIC\), 2015](#) in 4 categories: crisis response, home-based intermediate care, bed-based intermediate care and reablement. These services span acute and long-term care and they respond to a range of health and social care needs. See [appendix B](#) for further details of these 4 categories of IC.

- 2.3 In the [2012 NAIC](#) it was suggested that IC capacity needed to increase significantly to meet potential demand. Given the aging population in England and the age profile of IC service users, it is likely that need for IC has grown since 2012.
- 2.4 The [2015 NAIC](#) reported continued wide variation in investment levels in IC across England. It also reported on the number of referrals to IC services by type of IC service, the investment in, and waiting times (from referral to assessment) for each type of IC. See table 2 for details.

Table 2 Referrals to, investment in, and waiting times for intermediate care services per 100,000 weighted population

Intermediate care service	Referrals per 100,000 population	Investment per 100,000 population (£ million)	Waiting times (mean, referral to assessment)
Crisis response	543	Included in home-based investment	3.7 hours
Home-based	808	0.7	6.3 days
Bed-based	266	1.3	1.3 days
Reablement	497	0.6	8.7 days

[NAIC, 2015](#)

- 2.5 Several recommendations in the guideline address issues identified in the 2015 NAIC. This report quantifies what it may mean to organisations to implement the guideline recommendations.

3 Significant resource impact recommendations

- 3.1 **Offer reablement as a first option to people being considered for home care, if it has been assessed that reablement could improve their independence (recommendation 1.4.2).**

Background

- 3.1.1 Offering reablement to people being considered for home care is associated with improved quality of life outcomes and long-term cost savings ([guideline appendix C3: economic report](#)).
- 3.1.2 Long-term savings are anticipated because of reduced use of home care and reduced admissions to hospital in the first 2 years following reablement. Costs are higher in the short-term because of the increased cost of reablement compared to standard home care.
- 3.1.3 Since no national data exist for the number of people being considered for home care, or for the proportion of these people currently being offered reablement, a worked example is provided below. This gives an indicative cost of providing reablement for an additional 1,000 people being considered for home care.

Assumptions made

- 3.1.4 The unit cost of reablement is £1,484 ([NAIC, 2015](#)) and reablement lasts for a period of up to 6 weeks.
- 3.1.5 Hospital admissions that may be avoided as a result of reablement are modelled in year 1 only. Further admissions may be avoided in year 2 ([guideline appendix C3: economic report](#)).
- 3.1.6 The unit cost per hospital admission that may be avoided as a result of reablement is £2,570 ([guideline appendix C3: economic report](#)).
- 3.1.7 Use of reablement (rather than home care alone) in this context does not affect the rate of death or admission to a care home ([guideline appendix C3: economic report](#)).
- 3.1.8 The unit cost of home care is £194.73 per week ([guideline appendix C3: economic report](#)). The cost of 6 weeks home care

prevented by a 6 week course of reablement is therefore £1,168 (£194.73 x 6).

3.1.9 These assumptions can be varied in the [resource impact template](#) which accompanies this report.

Costs

3.1.10 The net cost of providing reablement for an additional 1,000 people being considered for home care in line with recommendation 1.4.2 is summarised in table 3.

Table 3 Indicative cost of providing reablement for an additional 1,000 people being considered for home care

	Unit cost (£)	Units	Resource impact (£000)
Additional reablement	1,484	1,000	1,484
Reduced hospital admissions (year 1)	2,570	9	-23
Reduced home care	1,168	1,000	-1,168
Total resource impact			293

Benefits and savings

3.1.11 Savings from reduced hospital admissions in year 2 (following reablement) have not been included to simplify the indicative example but are likely to be at least equivalent to the savings in year 1.

3.1.12 Savings because of less people receiving home care in the medium/longer term have not been included due to the uncertainty in quantifying these savings. The cost of implementing this recommendation is therefore likely to be less than indicated above, and may be cost-saving in the medium/longer term. It is possible that providing reablement to people being considered for home care may prevent the requirement for any home care ([guideline](#)

[appendix C3: economic report](#)) and in these cases, savings could be very significant.

Other considerations

3.1.13 The local [resource impact template](#) can be used by organisations to model any local costs and savings associated with implementing this recommendation.

3.2 For bed-based intermediate care, start the service within 2 days of receiving an appropriate referral. Be aware that delays in starting intermediate care increase the risk of further deterioration and reduced independence (recommendation 1.5.3)

Background

3.2.1 When bed-based IC is provided, economic evidence ([guideline appendix C3: economic report](#)) suggests this is only likely to be cost-effective if provided within 2 days of referral.

3.2.2 The [2015 NAIC](#) data shows that while the average wait for bed-based IC from referral to assessment is 1.3 days, the average wait from referral to care is 3 days. Around 76% of care is provided within 2 days of referral.

3.2.3 To provide the approximately 24% of care not currently being received within 2 days of referral will require additional capacity in bed-based IC and will incur additional costs.

3.2.4 Savings from reduced bed-days in other areas, for example, reduced consultant-led bed-days may be achievable. However, they have not been included in the analysis below since any beds made available as a result of increased capacity in bed-based IC are likely to be occupied by other patients.

Assumptions made

- 3.2.5 The number of people receiving bed-based IC each year is around 146,000 ([NAIC, 2015](#)).
- 3.2.6 For the 24% of people not currently receiving care within 2 days of referral, the mean wait above 2 days for bed-based IC from referral to care is 4.33 days, equivalent to around 152,000 days of additional capacity required in bed-based IC. This will vary at a local level dependent on current local services.
- 3.2.7 The unit cost of 1 bed-day of bed-based IC is £212 ([NAIC, 2015](#)).
- 3.2.8 The additional capacity in bed-based IC is assumed to be built up over the next 5 years (rather than all costs being incurred in year 1). The pace of change will depend on resources available at a local level.

Costs

- 3.2.9 The net cost of providing additional capacity in bed-based IC to achieve recommendation 1.5.3 is summarised in table 4.

Table 4 Estimated annual cost of recommendation 1.5.3

	2017/18	2018/19	2019/20	2020/21	2021/22
Additional capacity required in bed-based intermediate care (bed-days)	15,200	60,600	90,900	121,200	151,600
Resource impact each year for additional capacity in bed-based intermediate care (£000)	3,213	12,852	19,279	25,705	32,131

3.2.10 These costs are the annual costs of building capacity in bed-based IC to achieve recommendation 1.5.3. The total cost of around £32.1 million will be recurrent from 2021/22 onwards.

Benefits and savings

3.2.11 Increasing capacity in bed-based IC is likely to create capacity in other areas such as consultant-led beds. This may lead to improved productivity for providers and may lead to additional income from an increased number of admissions and procedures reimbursed. Cash savings as a result of the increased capacity are unlikely.

3.2.12 Providing bed-based IC within 2 days of referral is also expected to improve outcomes for people receiving IC earlier than they would have done so previously. People are less likely to be re-admitted to hospital following discharge and are also less likely to be discharged into a care home ([guideline appendix C3: economic report](#)). Long-term savings are therefore likely as a result of implementing this recommendation.

3.3 *Recommendations with potential resource impact*

Background

3.3.1 Several other recommendations in the guideline have the potential to lead to increased costs and / or savings when implemented. The size of any potential costs or savings will depend on local current

arrangements and the extent to which organisations implement the recommendations.

3.3.2 Areas highlighted for potential resource impact are as follows:

- provision of information (recommendations 1.1.5, 1.7.1 and 1.7.3)
- integration (recommendations 1.2.1, 1.2.2 and 1.6.3)
- intermediate care teams (1.2.9)
- various areas related to referral into intermediate care (recommendations 1.4.1, 1.4.3, 1.4.4 and 1.4.5)
- crisis response (recommendation 1.5.4)
- specialist support (1.6.4)
- training and development (recommendations 1.8.1 – 1.8.4)

3.3.3 Investing in these areas may lead to increased benefits and savings including:

- reduced hospital admissions and re-admissions
- quicker discharge from hospital
- reduced need for home care
- delayed admissions to care homes

3.3.4 The local [resource impact template](#) can be used by organisations to model any additional investment in these areas and any associated savings.

4 Implications for commissioners

4.1 Intermediate care falls under programme budgeting category 23X (other: miscellaneous)

4.2 Intermediate care could be commissioned by either health or social care commissioners, or jointly as part of an integrated working approach.

5 Assumptions made

- 5.1 If a national tariff price or indicative price exists for an activity, this has been used as the unit cost. The resource impact template can be used to amend unit costs to account for any local market forces factor.
- 5.2 Using these prices ensures that the costs in the report are the cost to the local authority or CCG of commissioning predicted changes in activity at the tariff price, but may not represent the actual cost to individual organisations of delivering the activity.
- 5.3 For services for which there is no national average unit cost, various sources have been used to provide unit costs including the [NAIC, 2015](#) and the [guideline appendix C3: economic report](#).

6 Sensitivity analysis

- 6.1 There are some assumptions in the model for which no empirical evidence exists, so we cannot be as certain about them. Appropriate minimum and maximum values of variables were used in the sensitivity analysis to assess which variables have the biggest impact on the net cost or saving. This enables users to identify the significant cost drivers.

Appendix A is a table listing all variables modified. The key conclusions are discussed below.

- 6.2 The resource impact is sensitive to the cost of 1 bed-day for bed-based IC. Varying the baseline cost of £212 by 25% each way between £159 and £265 changes the baseline resource impact of £32.1 million to £24.1 million and £40.2 million respectively, a difference of around £16.1 million.
- 6.3 The resource impact is also sensitive to the mean wait for bed-based IC from referral to care above 2 days. Varying the baseline wait of 4.33 days between 3.33 days and 5.33 days changes the

baseline resource impact of £32.1 million to £24.7 million and £39.5 million respectively, a difference of around £14.8 million.

- 6.4 The resource impact is also sensitive to the number of people receiving bed-based IC. Varying the baseline proportion of 0.27% of the population between 0.24% and 0.3% changes the baseline resource impact of £32.1 million to £29 million and £36.2 million respectively, a difference of around £7.2 million.

Appendix A. Results of sensitivity analysis

<u>Individual variable sensitivity</u>	Individual variable sensitivity			Recurrent resource impact			Sensitivity ratio	
	Baseline value	Minimum value	Maximum value	Baseline resource impact (£000s)	Minimum resource impact (£000s)	Maximum resource impact (£000s)		Change (£000s)
Number of people receiving bed-based intermediate care	0.27%	0.24%	0.30%	32,131	28,990	36,238	7,248	1.00
Mean wait for bed-based intermediate care from referral to care (days) above 2 days	4.33	3.33	5.33	32,131	24,691	39,521	14,830	0.98
Cost of 1 bed day: bed-based intermediate care	£212	£159	£265	32,131	24,098	40,164	16,066	0.99

Appendix B. Terms used in the guideline

Bed-based intermediate care

Assessment and interventions provided in a bed-based setting, such as an acute hospital, community hospital, residential care home, nursing home, stand-alone intermediate care facility, independent sector facility, local authority facility or other bed-based setting. Bed-based intermediate care aims to prevent unnecessary admissions to acute hospitals and premature admissions to long-term care, and to support timely discharge from hospital. For most people, interventions last up to 6 weeks. Services are usually delivered by a multidisciplinary team but most commonly by healthcare professionals or care staff (in care homes).

Crisis response

Community-based services provided to people in their own home or a care home. These services aim to avoid hospital admissions. Crisis response usually involves an assessment, and may provide short-term interventions (usually up to 48 hours). Crisis response is delivered by a multidisciplinary team but most commonly by healthcare professionals.

Home-based intermediate care

Community-based services that provide assessment and interventions to people in their own home or a care home. These services aim to prevent hospital admissions, support faster recovery from illness, support timely discharge from hospital, and maximise independent living. For most people interventions last up to 6 weeks. Services are delivered by a multidisciplinary team but most commonly by healthcare professionals or care staff (in care homes).

Intermediate care

A range of integrated services that: promote faster recovery from illness; prevent unnecessary acute hospital admissions and premature admissions to long-term care; support timely discharge from hospital; and maximise independent living. Intermediate care services are usually delivered for no

longer than 6 weeks and often for as little as 1 to 2 weeks. Four service models of intermediate care are available: bed-based intermediate care, crisis response, home-based intermediate care, and reablement.

Reablement

Assessment and interventions provided to people in their home (or care home) aiming to help them recover skills and confidence and maximise their independence. For most people interventions last up to 6 weeks. Reablement is delivered by a multidisciplinary team but most commonly by social care practitioners.

For other social care terms see the Think Local, Act Personal [Care and Support Jargon Buster](#).

About this resource impact report

This resource impact report accompanies the NICE guideline on [Intermediate care including reablement](#) and should be read in conjunction with it. See [terms and conditions](#) on the NICE website.

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