National Institute for Health and Care Excellence

Final

Chapter 11 Social care extended access

Emergency and acute medical care in over 16s: service delivery and organisation

NICE guideline 94

March 2018

Developed by the National Guideline Centre, hosted by the Royal College of Physicians

1

ISBN: 978-1-4731-2741-8
Chapter 11 Social care extended access

Contents

1

11 Extended access to social care services

11.1 Introduction

At present access to social care differs throughout the country. Some areas have access to all community services where as others have very limited access. All areas do have access to an emergency social care system of sorts but in order for this to be effective we need to have 7-day access to all community social care services.

At weekends at present we do not have the necessary collaboration and multi-disciplinary planning between hospitals, community health services and therefore social care becomes increasingly difficult and does have an impact on hospital admission for social care reasons and readmission.

NHS England have stated that support services in hospitals, primary, community and mental health must be available 7 days a week. This will undoubtedly maintain patients in the community, facilitate timely discharge of dependant patients consequently, promoting flow of patients through the hospital.

Although this may have cost implications initially, NHS England is currently commissioning primary care services and, they are encouraging improvement of quality of primary care and more integrated out of hospital services.

11.2 Review question: Is urgent and/or routine extended access to social care services (for example, evenings or 7 day) more clinically and cost effective compared with standard access?

For full details see review protocol in Appendix A.

Table 1: PICO characteristics of review question

Population	Adults and young people (16 years and over) with a suspected or confirmed AME.
Interventions	Social care access. • Extended access to social care/social worker (early mornings, evenings, and 7-day). • Urgent/emergency access (duty social worker, same working day).
Comparison	Social care access. • Standard hours.
Outcomes	• Mortality (CRITICAL) • Avoidable adverse events (CRITICAL) • Quality of life (CRITICAL) • Patient and carer satisfaction or burden (CRITICAL) • Length of hospital stay (CRITICAL) • Admission avoidance (IMPORTANT) • Readmission up to 30 days (IMPORTANT)
Study design	Systematic reviews (SRs) of RCTs, RCTs, observational studies only to be included if no relevant SRs or RCTs are identified.

11.3 Clinical evidence

No clinically relevant studies comparing extended access social care with standard access social care were identified.

11.4 Economic evidence

Published literature

No relevant economic evaluations were identified.

The economic article selection protocol and flow chart for the whole guideline can found in the guideline's Appendix 41A and Appendix 41B.

11.5 Evidence statements

Clinical

No relevant clinical studies were identified.

Economic

No relevant economic evaluations were identified.

11.6 Recommendations and link to evidence

Recommendations	**-**
Research recommendation	**RR7. What is the clinical and cost effectiveness of providing extended access to social care services, for example during early mornings and evenings, and 7 days a week?**
Relative values of different outcomes	The guideline committee considered mortality, quality of life, patient and/or carer satisfaction, length of hospital stay and avoidable adverse events as the critical outcomes for decision making. Admission avoidance and readmission were considered to be important outcomes.
Trade-off between benefits and harms	No evidence evaluating the effectiveness of extended access to social care (early mornings, evenings and 7-days a week) compared with standard access was found. The committee were of the opinion that extended access to social care was an important component in maintaining patients in the community, facilitating timely discharge of dependent patients from hospital and consequently promoting flow of patients through the hospital system. These likely benefits would improve hospital performance and patient and/or carer satisfaction. Equity of provision across all days of the week might reduce the need for weekend admission to hospital, and facilitate discharge from hospital back to the community. However, given the lack of evidence for these outcomes, and the variety of methods for providing patient care in the community, the committee chose to make a research recommendation. The committee discussed existing guidance from NICE on social care and felt it was appropriate to cross reference the following guidelines: • Transition between inpatient hospital settings and community or care home settings for adults with social care needs (2015).[15] • Older people with social care needs and multiple long-term conditions (2015).[14] • Transition between inpatient mental health settings and community or care home settings (2016).[16] • Home care: delivering personal care and practical support to older people living in their own homes (2015).[13] • Intermediate care including reablement (2017).[17]–
Trade-off between net effects and costs	No economic evidence was identified for this question. The committee noted that enhancing access to social care would increase staffing costs but these might be offset by the hypothesised benefits of maximising independence, maintaining people in the community and reducing delayed discharges from hospital, thereby improving patient flow and releasing hospital beds. Increased investment in social care could therefore be cost-neutral, or even cost-saving. NHS England's Vanguard sites may provide some information on the cost-effectiveness of different methods of integrating social care with primary and secondary healthcare.[19] However, a recent report from the National Audit Office found that the initiatives focused on integrating care through the transfer of resources from secondary to social care (the Better Care Fund) has not (yet) resulted in improvements for patients or created usable savings.[12]

Recommendations	-
Research recommendation	**RR7. What is the clinical and cost effectiveness of providing extended access to social care services, for example during early mornings and evenings, and 7 days a week?**
	Although not specifically addressing weekend and extended hours, the National Audit Office *Discharging older patients from hospital* has estimated that £640 million could potentially be saved if 2.7 million bed days were averted in older patients who are clinically ready for discharge (up to £94 per day in the community compared with £303 in hospital).[11] However, there are many supply constraints on the provision of care home places and social care services that would need to be addressed. Given the lack of research evidence for the current review, it cannot be deduced whether these hypothesised effects would indeed allow funding currently allocated to secondary care to be diverted more effectively to social care provision. A scenario analysis was undertaken using an original health economic hospital simulation model – see Chapter 41. The analysis explored reducing length of stay for patients being newly discharged to care home. This analysis did not take into account any resource use and costs for an actual intervention, so cost effectiveness cannot be assessed. Two scenarios were tested, a 1 day reduction and a 5 day reduction in stay. With the 5 day reduction, the number of medical outliers was more than halved and there were considerable survival benefits and cost savings. Even the 1 day reduction saw a significant reduction in the incidence of medical outliers. The results of the scenario analyses found that targeting a reduction in the length of stay for patients being discharged new to care home can have a positive impact on hospital flow, reducing the number of medical outliers, ward occupancy and breeches of the A&E 4 hour waiting time target. The results also found that positively impacting on hospital flow can also lead to better patient focused outcomes for the entire hospital cohort, reduced length of stay across wards, reduced mortality and increased quality of life. The committee noted that an intervention targeting the end of the hospital pathway and moving patients into the community earlier could significantly improve hospital flow and be more effective than interventions targeting other areas of the pathway. However, they were unable to conclude if extended access to social care would be able to achieve this in a clinically and cost effective manner. They decided that more research was needed.
Quality of evidence	There was no evidence included in the review.
Other considerations	Access to social care is widely accepted as essential for maintaining independence and quality of life in the community for dependent people who might otherwise require hospital admission, and for promoting timely discharge of hospitalised but dependent patients back to the community. However, the administrative separation of health from social care combined with limited resources and rising demand from demographic change has created severe difficulties in maintaining social care provision while improving its quality. The current state of social care provision has been described as 'at breaking point' by the chairs of 3 parliamentary select committees in a letter to the Prime Minister on January 6th 2017[2] and 'in crisis' by

Recommendations	**-**
Research recommendation	**RR7. What is the clinical and cost effectiveness of providing extended access to social care services, for example during early mornings and evenings, and 7 days a week?**
	the Local Government Association[8] and by Age UK.[1] In 2014 the government set up the 'Better Care Fund'[18] as a collaboration between NHS England, the Department for Communities and Local Government, the Department of Health, and the Local Government Association. The programme aims to achieve improvements in social care provision by moving funds from secondary care to social care. However, an initial assessment by the National Audit Office found little evidence so far for improvements in services or efficiency savings.[12] It is likely that additional funding will be required to pump prime social care and at the same time maintain the secondary care services that will be required for the initial period. The committee discussed the limited social care provision out of hours and at weekends within the NHS and also the wide variations in practice between areas. At weekends it is usually difficult to access and coordinate multi-disciplinary planning between hospitals and community health services; the lack of access to social care results in potentially avoidable hospital admissions and readmissions. Some areas have access to a range of community care services, others very little. These local and regional variations may lend themselves to research evaluation provided the care processes and the populations being served can be adequately characterised. The gap between weekday and weekend provision requires particular attention, including the impact on hospital services and the 'weekend effect'.[9] Uniformity in the approach to delivering social care across England would also be helpful and would enable families and healthcare professions who may traverse between regions a greater ability to make informed decisions and so access the breadth of services possible. The committee were aware of other NICE social care guidelines that can be found on the NICE website (https://www.nice.org.uk/guidance/published?type=sc). The lack of evidence and current policy initiatives in this area prevented the committee making a strong recommendation. Research evaluation will need to take into account the diverse range of interventions which constitute 'social care', the processes and behaviours involved in delivering each intervention, and the interplay between interventions in terms of outcomes. Contextual factors include the current disposition of health services, seasonal effects and population affluence, health and dependency. Quantitative measures taken from existing NHS data sources will need to be supplemented by qualitative analysis of patients and staff experience.

References

1 Age UK. Briefing: Health and care of older people in England 2017, 2017. Available from: http://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Research/The_Health_and_Care_of_Older_People_in_England_2016.pdf?dtrk=true

2 Betts C, Hillier M, and Wollaston S. Letter to the Prime minister regarding health and social care, 2017. Available from: https://www.publications.parliament.uk/pa/cm201617/cmselect/cmcomloc/170106-Letter-to-Prime-Minister-on-social-care-and-NHS.pdf

3 Edmans J, Bradshaw L, Gladman J, Franklin M, Berdunov V, Elliott R et al. The Identification Of Seniors At Risk (ISAR) Score to predict clinical outcomes and health service costs in older people discharged from UK acute medical units. European Geriatric Medicine. 2013; 4:S77

4 Farber JI, Korc-Grodzicki B, Du Q, Leipzig RM, Siu AL. Operational and quality outcomes of a mobile acute care for the elderly service. Journal of Hospital Medicine. 2011; 6(6):358-363

5 Gitlin LN, Reever K, Dennis MP, Mathieu E, Hauck WW. Enhancing quality of life of families who use adult day services: short- and long-term effects of the adult day services plus program. Gerontologist. 2006; 46(5):630-639

6 Jordan JM, Elliott D, Singh-Patel S. Effect of a multi-disciplinary admitting team on quality and efficiency of inpatient care. Journal of General Internal Medicine. 2011; 26:S288

7 Kue R, Ramstrom E, Weisberg S, Restuccia M. Evaluation of an emergency medical services-based social services referral program for elderly patients. Prehospital Emergency Care. 2009; 13(3):273-279

8 Local Government Association. Adult social care funding: 2016 state of the nation report, 2016. Available from: http://www.local.gov.uk/publications/-/journal_content/56/10180/8022318/PUBLICATION

9 Meacock R, Anselmi L, Kristensen SR, Doran T, Sutton M. Higher mortality rates amongst emergency patients admitted to hospital at weekends reflect a lower probability of admission. Journal of Health Services Research and Policy. 2016; Epub

10 Moore M, Winkelman A, Kwong S, Segal SP, Manley GT, Shumway M. The emergency department social work intervention for mild traumatic brain injury (SWIFT-Acute): a pilot study. Brain Injury. 2014; 28(4):448-455

11 National Audit Office. Discharging older patients from hospital, 2016. Available from: https://www.nao.org.uk/wp-content/uploads/2015/12/Discharging-older-patients-from-hospital.pdf

12 National Audit Office. Health and social care integration, 2017. Available from: https://www.nao.org.uk/report/health-and-social-care-integration/

13 National Collaborating Centre for Social Care. Home care: delivering personal care and practical support to older people living in their own homes. NICE guideline 21. London. National Institute for Health and Care Excellence, 2015. Available from: https://www.nice.org.uk/guidance/ng21

14 National Institute for Health and Care Excellence. Older people with social care needs and multiple long-term conditions, 2015. Available from: https://www.nice.org.uk/guidance/ng22/resources/older-people-with-social-care-needs-and-multiple-longterm-conditions-1837328537797

15 National Institute for Health and Care Excellence. Transition between inpatient hospital settings and community or care home settings for adults with social care needs, 2015. Available from: https://www.nice.org.uk/guidance/ng27/resources/transition-between-inpatient-hospital-settings-and-community-or-care-home-settings-for-adults-with-social-care-needs-1837336935877

16 National Institute for Health and Care Excellence. Transition between inpatient mental health settings and community or care home settings, 2016. Available from: https://www.nice.org.uk/guidance/ng53/resources/transition-between-inpatient-mental-health-settings-and-community-or-care-home-settings-1837511615941

17 National Institute for Health and Care Excellence. Intermediate care including reablement. nice guideline 74. London: 2017. Available from: https://www.nice.org.uk/guidance/ng74

18 NHS England. Better Care Fund. 2016. Available from: https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/ [Last accessed: 22 February 2017]

19 NHS England. New care models. 2017. Available from: https://www.england.nhs.uk/ourwork/new-care-models/ [Last accessed: 14 March 2017]

20 Routhier D, Leduc N, Lesage A, Benigeri M. Service utilization by hospitalized suicide attempters with schizophrenia or depression in Montreal. Psychiatric Services. 2012; 63(4):364-369

21 Sadowski LS, Kee RA, VanderWeele TJ, Buchanan D. Effect of a housing and case management program on emergency department visits and hospitalizations among chronically ill homeless adults: a randomized trial. JAMA - Journal of the American Medical Association. 2009; 301(17):1771-1778

22 Shier G, Ginsburg M, Howell J, Volland P, Golden R. Strong social support services, such as transportation and help for caregivers, can lead to lower health care use and costs. Health Affairs. 2013; 32(3):544-551

23 Walker L, Jamrozik K. Effectiveness of screening for risk of medical emergencies in the elderly. Age and Ageing. 2005; 34(3):238-242

24 Walley AY, Xuan Z, Hackman HH, Quinn E, Doe-Simkins M, Sorensen-Alawad A et al. Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: interrupted time series analysis. BMJ. 2013; 346:f174

25 Weiss SJ, Ernst AA, Ong M, Jones R, Morrow D, Milch R et al. Effect of a social services intervention among 911 repeat users. American Journal of Emergency Medicine. 2005; 23(4):492-496

26 Wierdsma AI, Poodt HD, Mulder CL. Effects of community-care networks on psychiatric emergency contacts, hospitalisation and involuntary admission. Journal of Epidemiology and Community Health. 2007; 61(7):613-618

Appendices

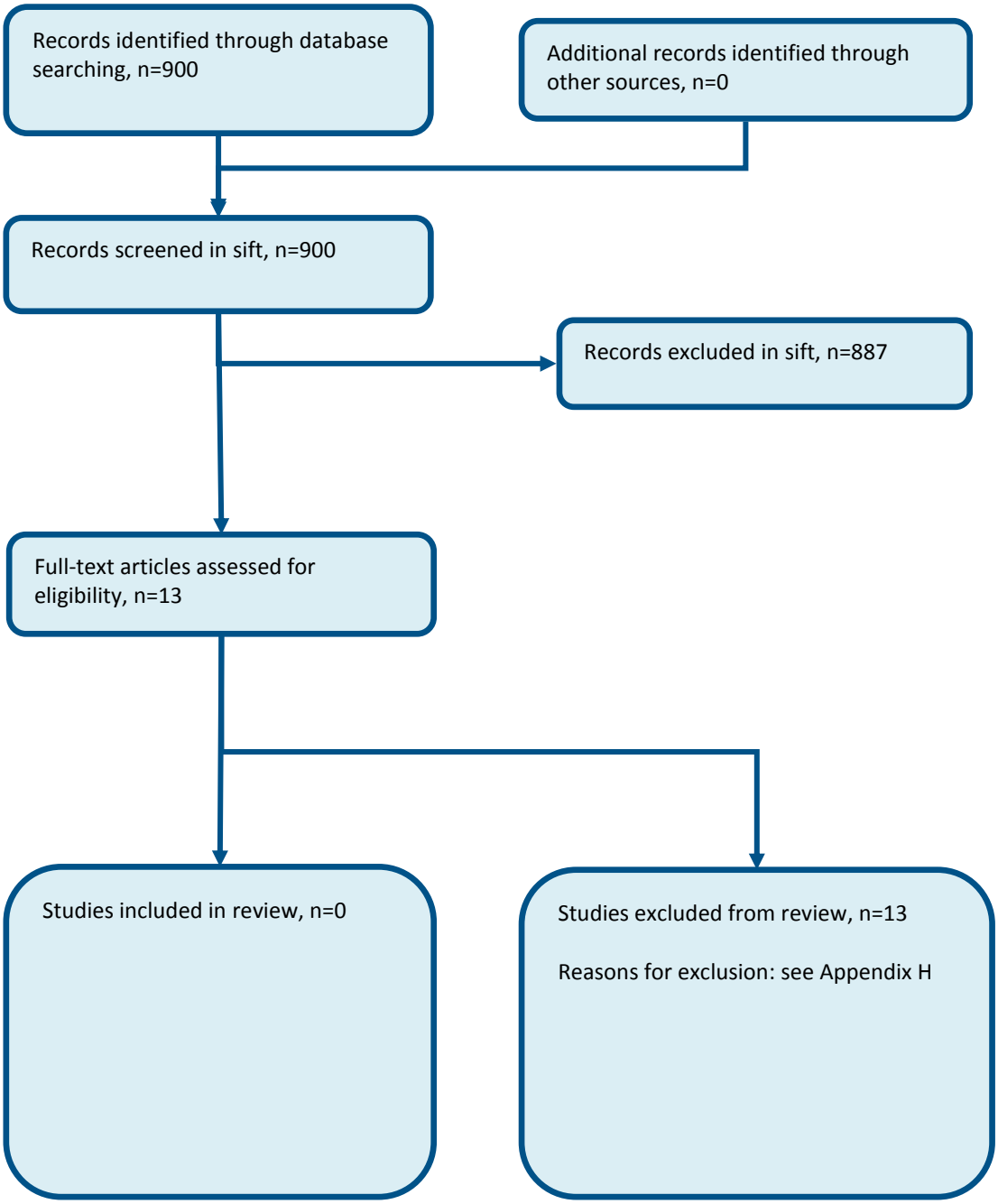
Appendix A: Review protocol

Table 2: Review protocol for: Is urgent and/or routine extended access to social care services (for example, evenings or 7 day) more clinically and cost effective compared with standard access?

Review questions: **Is urgent and/or routine extended access to social care services (for example, evenings or 7 day) more clinically and cost effective compared with standard access?**	
Objective	To determine if enhanced access to social care improves outcomes.
Rationale	-
Topic code	T3-1C
Population	Adults and young people (16 years and over) with a suspected or confirmed AME.
Intervention	Social care access. Extended access to social care/social worker (early mornings, evenings, and 7-day). Urgent/emergency access (duty social worker, same working day).
Comparison	Social care access. Standard hours.
Outcomes	Mortality (CRITICAL) Avoidable adverse events (CRITICAL) Quality of life (CRITICAL) Patient and/or carer satisfaction or burden (CRITICAL) Length of hospital stay (CRITICAL) Admission avoidance (IMPORTANT) Readmission up to 30 days (IMPORTANT)
Exclusion	Children and adolescents.
Search criteria	The databases to be searched are: Medline, Embase, the Cochrane Library, Social Policy & Practice. Date limits for search2005. Language: English.
The review strategy	Systematic reviews (SRs) of RCTs, RCTs, observational studies only to be included if no relevant SRs or RCTs are identified.
Analysis	Data synthesis of RCT data. Meta-analysis where appropriate will be conducted. Studies in the following subgroup populations will be included: • Frail elderly. • People with mental health problems and AME. In addition, if studies have pre-specified in their protocols that results for any of these subgroup populations will be analysed separately, then they will be included. The methodological quality of each study will be assessed using the Evibase checklist and GRADE.

Appendix B: Clinical article selection

Figure 1: Flow chart of clinical article selection for the review of social care extended access



Appendix C: Forest plots

No relevant clinical studies were identified.

Appendix D: Clinical evidence tables

No clinically relevant studies were identified.

Appendix E: Economic evidence tables

No relevant economic studies were identified.

Appendix F: GRADE tables

No clinically relevant studies were included.

Appendix G: Excluded clinical studies

Table 3: Studies excluded from the clinical review

Study	Exclusion reason
Edmans 2013[3]	Conference Abstract
Farber 2011[4]	Intervention and comparator are a mobile acute care for the elderly team versus a static, unit-based team, both operating on weekends as well as regular working hours, so probably not the correct comparison, that is, not looking at standard versus extended access.
Gitlin 2006[5]	Non-AME population. Intervention was a program for caregiver wellbeing.
Jordan 2011[6]	Conference Abstract
Kue 2009[7]	Non-comparative study. Descriptive study of experiences implementing EMS follow-up program for referral by paramedics of patients with poor access to social care.
Moore 2014[10]	Usual care versus SWIFT-Acute. SWIFT-Acute is an ED social work intervention delivered by a social worker.
Routhier 2012[20]	Incorrect intervention. Comparison of standard versus extended hours access to social care - comparison of pre- and post- suicide attempt service utilization.
Sadowski 2009[21]	Non-comparative study
Shier 2013[22]	Inappropriate comparison. Not a comparison of standard versus extended hours access to social care.
Walker 2005[23]	Incorrect intervention. KWAH intervention was a screening tool in the form of a questionnaire, delivered by a community nurse and project coordinator. No mention of social worker.
Walley 2013[24]	Non-AME population – social care service for opioid users.
Weiss 2005[25]	Non-AME population. Does not compare extended hours with none.
Wierdsma 2007[26]	Incorrect intervention. Compares neighbourhoods with and without a community-care network and their comparative use of emergency psychiatric services.

Appendix H: Excluded economic studies

No relevant economic studies were identified.