



Benchmarking Network

# Older People's Care in Acute Settings National report

NHS Benchmarking Network  
March 2017

*Raising Standards through Sharing Excellence*

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# Older People's Care in Acute Settings

## Foreword

# Foreword

## **“It’s not how old we are, but how we are old”**

As National Clinical Director for Older People and Person Centred Integrated Care at NHS England, and a geriatrician in Manchester I am delighted to have been asked to write the foreword for this report. Frailty in older people is now very much everyone’s business and the data reported here are vital in helping us drive quality improvements across the country. Most of us are now fully familiar with popular narratives focused on the challenges of caring for, and supporting an ageing population. While not forgetting that this in part is testament to a remarkable success story for modern health care, we still have much to do to ensure that the experience of being old is a good one.

Population ageing is not a new phenomenon, but is nevertheless here to stay and on a scale never before experienced in society. The expansion of the older population in England is projected to continue accelerating over the next 20 years. Using 2010 as a baseline, the proportion of over 65’s will increase from 17% to 23% by 2035. To give an indication of what this will mean, in England in 2014, there were 9.5 million people aged 65 and over, and 471,000 people aged over 90. By 2035, it is projected that there will be 14.5 million people aged 65 and over, and 1.1 million people who will be aged over 90. Many of these people will be living with two or more long term conditions (multi-morbidity) and/or lost functional ability.

In the population aged 60 or older, one in seven people are living with frailty, a condition that increases in prevalence with age. Of those over 65, while half will remain physiologically fit, 50% will be living with frailty. 15% will be moderately or severely frail with significantly increased risks of requiring acute health care, care home support and death.

While 15 million people are living with a long-term condition, 58% of these will be over 60. In part combinations of multi-morbidity, frailty and lost functional ability will be contributing to the observed increase by two-thirds in Emergency Department attendances by people aged 60 and above between 2007 and 2014. Between 2010 and 2015 older people being admitted to hospital as an emergency has increased by 18% from 2010 to 2015.

These are big numbers and pose very real issues for both health and social care systems in understanding, planning for and meeting the health and care needs of this population. To ensure that we continue to deliver best value health care for all, we must do all we can to reduce demand through prevention where this is feasible, and to ensure that health and care systems remain effective through optimal and sustainable configuration.

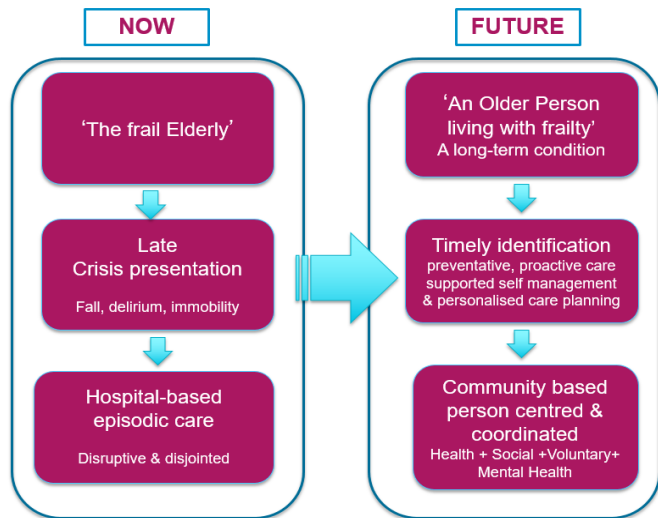


# Foreword

NHS England's "[Five Year Forward View](#)" clearly sets out how health services need to change to meet these objectives. To do this, and in particular to diminish unwarranted variation, all public services focused on the needs of older people must work collaboratively together using the best available data. The following are central to the delivery of best value care and support for the older population:

- **Preventing *modifiable* aspects of unhealthy ageing & *unnecessary* hospital admission**
- **Enabling people to have *greater control* of their care** through shared health & social care budgets
- **Supporting unpaid carers with partnerships** through the NHS, voluntary organisations, communities
- **Breaking down barriers** to support people with multi-morbidity including ***older people living with frailty***
- Supporting communities to **integrate out of hospital care, primary care & other community based services**
- **Improving support to older people in care homes**

We need to change the script from "*What's the matter with you?*" to "*What matters to you?*" to ensure that the NHS, and its partners, are working towards the objectives set out in the Five Year Forward View. Central to our approach for older people is the routine identification of frailty, which NHS England has now facilitated through changes to the GMS GP contract in 2017/18, where patients



aged 65 and over who are living with moderate and severe frailty will be identified using the Electronic Frailty Index (eFI). Primary care will deliver a clinical review and, where agreed with patients, share key information focused on improving outcomes.

Central to this is ensuring we accurately understand the scale, nature and impact of frailty in our ageing population. To do this we have characterised frailty as a long-term condition that requires routine identification nationally and which is amenable to effective management through targeted interventions. Our principle objectives are to reduce unwarranted variation and improve outcomes for people and those that matter to them. The diagram represents where we are now, and where we need to be. Diagrammatically it shows how the systems should move to working proactively with older people living with frailty, to prevent unwarranted outcomes through timely identification and community based and coordinated person centred approaches to care over time.



# Foreword

Whilst population stratification by anticipated future need is one part of the jigsaw in identifying frail older people, we know that from time to time, older people will require active intervention from acute care clinicians, whether they be geriatricians, nursing staff or therapy staff. The figures on rising Emergency Department attendances and emergency admissions certainly support this. Therefore, excellent acute care is a pre-requisite of the pathway, as is great care and support at home, after a stay in hospital.

The “Care of Older People in Acute Settings” benchmarking project sheds light on what is happening to older people whilst they are in the care of the acute pathway / in the acute phase of their illness. Whilst the vast majority of care for older people takes place outside of an acute setting, we must be mindful to ensure that older people receive the best possible care whilst in an acute hospital. Evidence suggests that older people require bespoke treatment plans, based on a Comprehensive Geriatric Assessment (CGA) and require as little time as possible in bed to achieve optimal outcomes. The benchmarking project reviews the acute pathway in four aspects: -

- Admission avoidance in A&E
- The assessment process
- The inpatient stay, and
- The supported discharge process.

The project also considers links with other sectors including primary care, mental health, community services and social care.

I commend this report to commissioners and providers of acute based care for older people as a way for them to assess their performance locally on key indicators against their peers, but also as an aid to understand what ‘good’ looks like by considering the specific configurations and service models of high performing services in the acute care of older people.

**Martin Vernon,**

**National Clinical Director - Older People and Person Centred Integrated Care**

**NHS England**

**March 2017**



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# Summary infographic

# NHSBN Older People's Care in Acute Settings 2016



**3%**

of Consultant workforce  
are Geriatricians

**52%**

of Trusts have a frailty unit

**89%**

of frailty units use CGA



senior medical cover to  
frailty units per day:

**12 hrs Mon-Fri**

**10 hrs Sat-Sun**



**45%**

of nursing staff on older people  
wards are unregistered



**14%**

of pay costs spent on bank &  
agency across the pathway



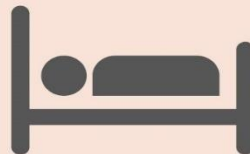
**83%**

of delayed transfers of care  
were attributable to people  
age 65 and over



**12 days**

average length of a delayed  
transfer of care



**56%**

of patients included in the service  
user audit have had a hospital admission  
in the last 12 months



**74%**

of organisations set estimated  
discharge dates within 24 hrs  
of admission





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# Project update

# Background to the project

- Care of older people in acute settings was identified by the Network membership as a priority topic and included, for the first time, in the 2014 work programme.
- A reference group met in February 2014 to scope out the project. The group comprised of members from Trusts / UHBs. The project scoping was assisted by Professor John Gladman, Professor of Older People's Medicine in Nottingham, who attended on behalf of the British Geriatrics Society.
- At this scoping event, it was agreed to concentrate on four aspects of the pathway included in this report:
  - Admission avoidance in A&E
  - Assessment of older people
  - Inpatient care
  - Supported discharge
- The reference group debated using "frailty" to define the project cohort, but due to a lack of a standardised definition, it was agreed to collect data based upon the 65+ age group.
- The data specification was agreed with the reference group and has been refreshed for each subsequent iteration of the project. Data collection for the first iteration of the project, collecting 2013/14 data, took place in 2014, and a second iteration, collecting 2014/15 data, took place in 2015.
- The Older People in Acute Settings project has proved popular with members, and the Network Steering Group agreed to include it in the 2016 work programme, collecting 2015/16 outturn data.
- Data collection for this third phase of the project ran from August 2016 to October 2016. Data underwent validation, where any outlying data points were queried, and an online benchmarking toolkit was produced. Members are able to view their position against other participating Trusts / UHBs on the members' area of the website at [www.members.nhsbenchmarking.nhs.uk](http://www.members.nhsbenchmarking.nhs.uk).
- The findings from the project were presented at a national conference in London on the 15th February 2017, along with good practice examples from members.



# Project participation

- Abertawe Bro Morgannwg University Health Board
- Aneurin Bevan University Health Board
- Ashford and St Peter's Hospitals NHS Foundation Trust
- Basildon and Thurrock University Hospital NHS Foundation Trust
- Belfast Health and Social Care Trust
- Betsi Cadwaladr University Health Board
- Bradford Teaching Hospitals NHS Foundation Trust
- Buckinghamshire Healthcare NHS Trust
- Calderdale and Huddersfield NHS Foundation Trust
- Cambridge University Hospitals NHS Foundation Trust
- Cardiff and Vale University Health Board
- Chesterfield Royal Hospital NHS Foundation Trust
- Colchester Hospital University NHS Foundation Trust
- Cwm Taf University Health Board
- Doncaster and Bassetlaw Hospitals NHS Foundation Trust
- East Kent Hospitals University NHS Foundation Trust
- Gateshead Health NHS Foundation Trust
- Heart of England NHS Foundation Trust
- Hywel Dda University Health Board
- Lewisham and Greenwich NHS Trust
- Milton Keynes Hospital NHS Foundation Trust
- North Bristol NHS Trust
- Northampton General Hospital NHS Trust
- Nottingham University Hospitals NHS Trust
- Peterborough and Stamford Hospitals NHS Foundation Trust
- Portsmouth Hospitals NHS Trust
- The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
- Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
- Royal Cornwall Hospitals NHS Trust
- Royal Devon and Exeter NHS Foundation Trust
- Royal Liverpool and Broadgreen University Hospitals NHS Trust
- Royal Stoke University Hospital, University Hospitals of North Midlands
- Royal United Hospitals Bath NHS Foundation Trust
- Sheffield Teaching Hospitals NHS Foundation Trust
- South Eastern Health and Social Care Trust
- South Tees Hospitals NHS Foundation Trust
- Southend University Hospitals NHS Foundation Trust
- Southern Health and Social Care Trust
- The Dudley Group NHS Foundation Trust
- The Hillingdon Hospitals NHS Foundation Trust
- The Ipswich Hospital NHS Trust
- The Newcastle upon Tyne NHS Foundation Trust
- United Lincolnshire Hospitals NHS Trust
- Walsall Healthcare NHS Trust
- Western Sussex Hospitals NHS Foundation Trust
- Wirral University Teaching Hospitals NHS Foundation Trust
- Wye Valley NHS Trust



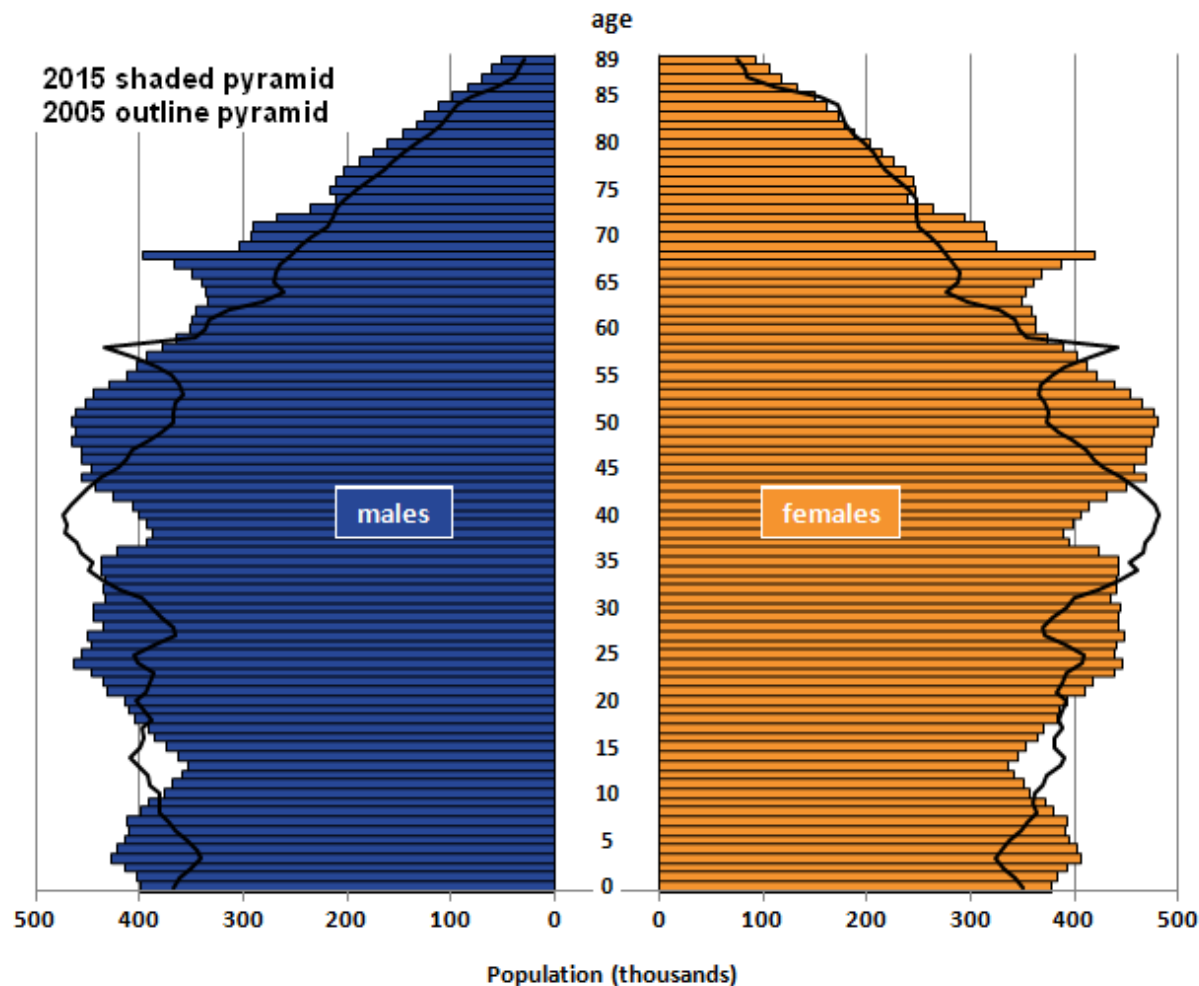


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# Overview metrics

# The ageing UK population

- Medical advances mean that people are living longer than ever before. When the NHS was created in 1948, life expectancy was 13 years lower than in 2016.
- Although medical advances and longer life expectancies are to be welcomed, the number of people living with multiple long term conditions has increased significantly.
- The chart on the right shows the increase in the projected number of people age 65 and over between 2005 and 2015. This trend is expected to continue as the baby boom generation reaches retirement.

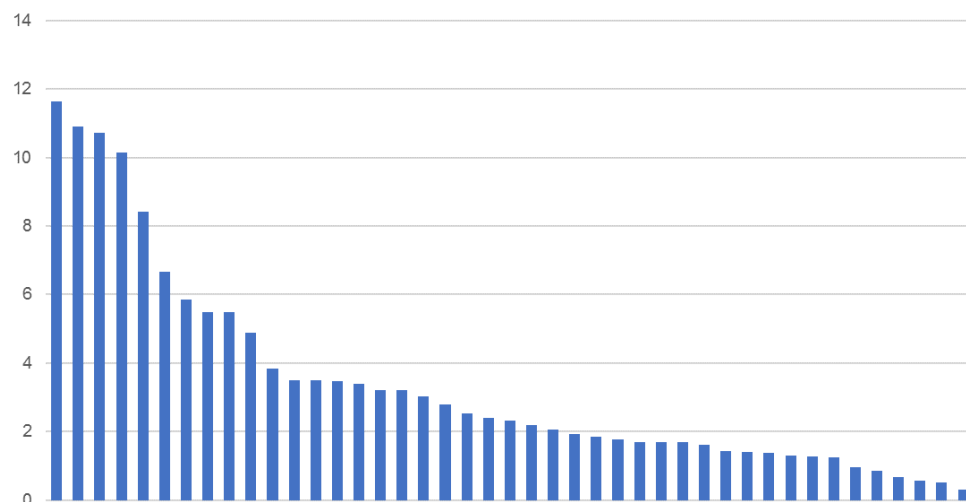


Source: Office for National Statistics, National Records of Scotland, Northern Ireland Statistics and Research Agency

# Participant overview

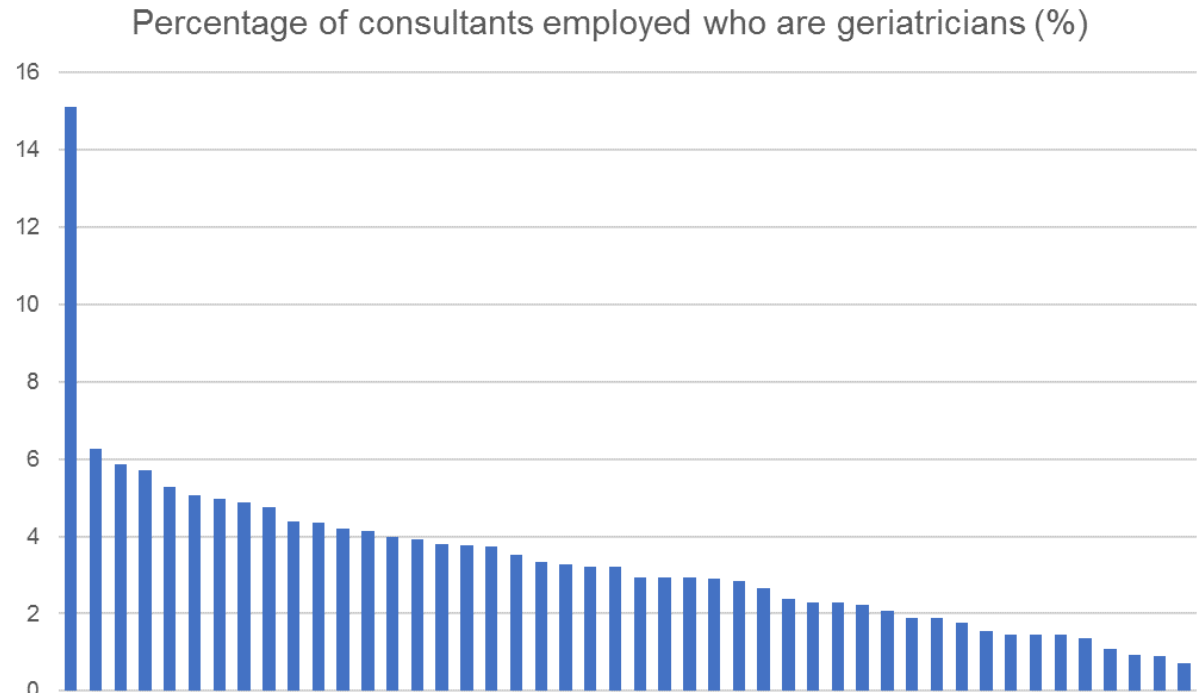
- Participating Trusts / UHBs ranged in size, from smaller district general hospitals to large teaching hospitals and Welsh UHBs. Organisations were able to submit more than one data submission, for example if they provided services for older people on three acute hospital sites.
- The turnover of participating organisations ranged from £104 million to £1,260 million. The mean Trust turnover was £512 million.
- The total number of staff employed by Trusts / UHBs ranged from 1,152 WTE to 17,607 WTE. The mean WTE employed by Trusts / UHBs was 6,187 WTE.
- Spend on the older people's services covered in this project, as a percentage of overall Trust / UHB turnover ranged from 0.5% to 11% and the average was 3.4%. It is important to note that this is just the four elements of the pathway benchmarked, and would not include, for example, surgical expenditure associated with older people.

Spend on older people's services as a percentage of overall / LHB turnover (%)



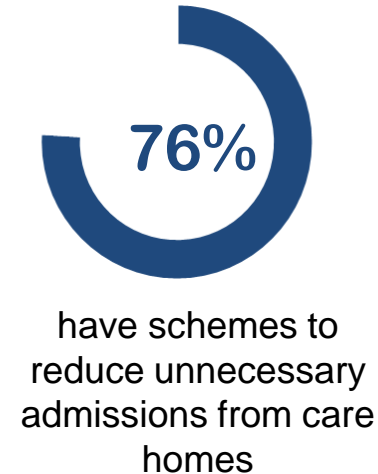
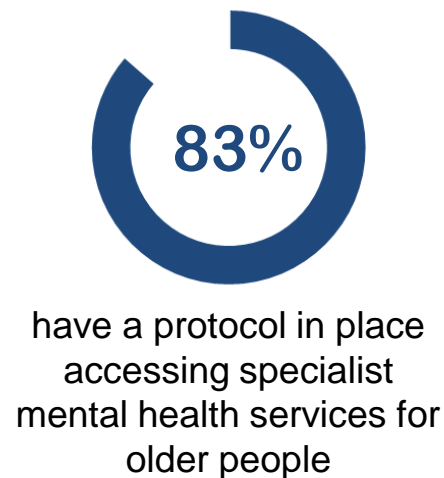
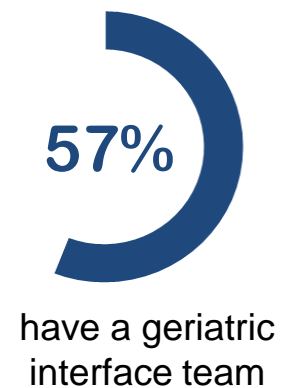
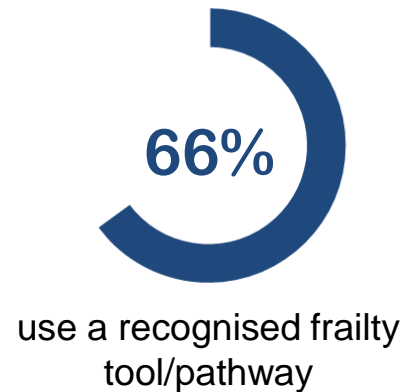
# Geriatrician workforce

- The average organisation that took part in the Older People in Acute Settings project has 8 WTE geriatricians.
- This figure ranges from 0.5 WTE in smaller district general hospitals, up to 31 WTE in the largest teaching hospitals and health boards.
- When the numbers of geriatricians are looked at in comparison with the total consultant workforce, geriatricians average 3.3% of the consultant workforce. This figure ranges from 0.7% to 15% in one large teaching hospital.



# Pathways and protocols in place

- Participating Trusts / UHBs were asked to identify pathways and protocols in place for the care of older people.
- 66% of organisations stated that they have a recognised frailty tool or pathway in use in the health and social care economy.
- 66% of Trusts stated they have a clearly defined strategy/operational policy for the delivery of acute medical care to older people.
- 63% reported that pathways exist which clearly state the roles and relationships between A&E, assessment units and inpatient wards.
- When asked if there was a local policy relating to the movement of older people once admitted to hospital, 43% answered yes.
- 57% of organisations reported that they have a geriatric interface team.
- Three quarters of participants have schemes in place to reduce unnecessary admissions from care homes.
- 83% of respondents reported having protocols in place to access specialist mental health services for older people.

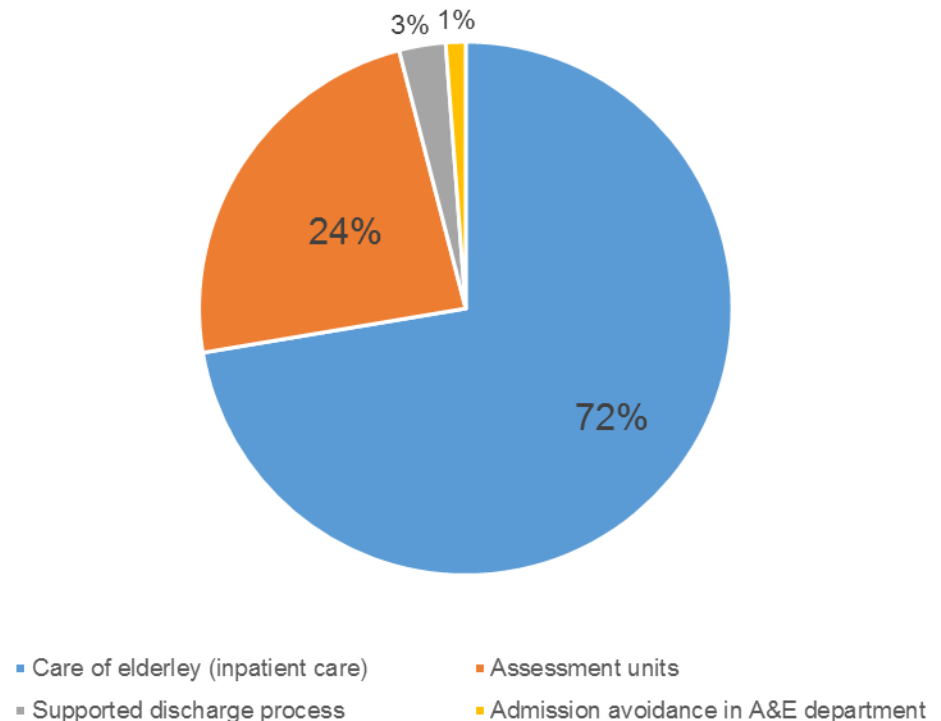




# Spend on older people's services

- When the cost of older people's services in acute care was split into the four different areas explored in this project, it was found that 72% of expenditure identified was for care of older people wards and inpatient care.
- 24% of total spend was on assessment units, 3% on the supported discharge process and 1% on admissions avoidance in A&E.
- The overall spend on bank, agency and overtime staff was collected. Participants with a very low bank/agency spend tended to show a high overtime spend. Bank and agency spend across all care of older people teams was 14.2% of pay costs in 2015/16.

Total Cost (£)





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# Admissions avoidance in A&E

# Teams available in A&E

- The availability of the appropriate teams in A&E is essential in avoiding unnecessary admissions. Participants were asked whether they had teams in place to assist with admissions avoidance. Where teams are available in A&E, participants were asked for the hours of availability on a weekday and at the weekend, over a 24 hour period. All teams showed reduced hours at weekends.

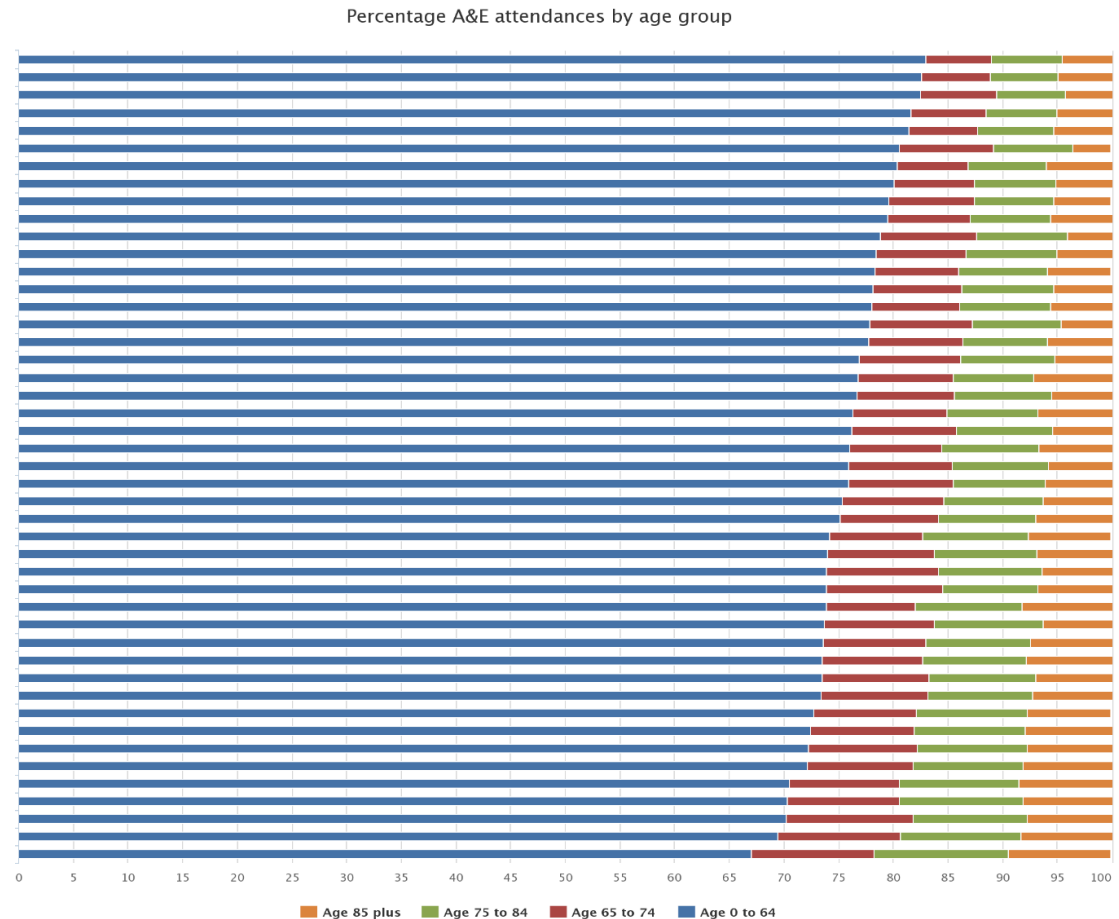
Team	Participants with a team available in A&E	Hours available Mon - Fri	Hours available Sat - Sun	% with no weekend hours
Dedicated geriatric team	40%	9.3	6.2	35%
Therapists	94%	9.4	6.9	25%
Rapid access to social workers	69%	9.7	6.6	29%
In-reach from hospital discharge team	33%	9.1	6.0	28%

- 40% of participants have a dedicated geriatric team located in A&E. Geriatric team availability fell by 3 hours per day at the weekend, with 35% reporting no availability at weekends. Five organisations reported having 12 hours of availability at weekends, showing wide variations in service models.
- 94% of participants have therapy teams available in A&E, with the mean hours of availability 9.4 hours during the week and 6.9 hours at weekends. 25% of those with therapy teams in A&E reported having no weekend provision.
- Two thirds of participants have rapid access to social workers in A&E to assist with admissions avoidance, however, over a quarter of these have no access to social workers at weekends.
- One third of participants have access to the hospital supported discharge team in A&E. Again the hours of availability are lower at weekends.



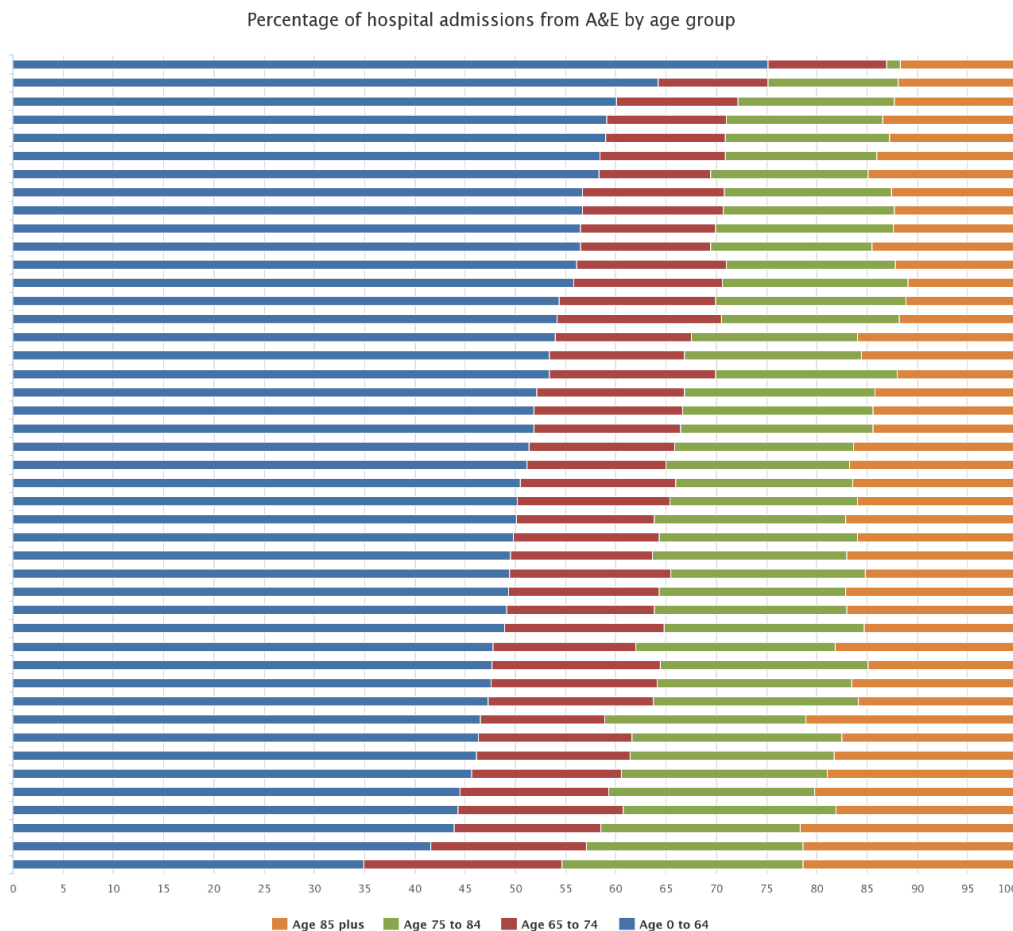
# A&E attendances

- To understand the scale of the numbers of older people accessing acute services, participants were asked for the age profile of service users at various points in the pathway. All data is for 2015/16.
- For A&E attendances, the age split was as follows:
  - 0 to 64 years old – 76%
  - 65 to 74 years old – 9%
  - 75 to 84 years old – 9%
  - 85 plus – 6%
- Over 65s are therefore the minority of attenders in A&E (24%), but become an increasing proportion of Trusts / UHB activity at each step in the pathway, shown later in this report.
- It is also important to note that there has been 3% growth in A&E attendances in last 12 months nationally.



# Admissions from A&E by age group

- As shown previously, attendances to A&E by those aged 65 and over accounts for 24% of all A&E attendances.
- Participants were then asked for the number of hospital admissions from A&E, again split by age categories. The results were:
  - 0 to 64 years old – 51%
  - 65 to 74 years old – 14%
  - 75 to 84 years old – 18%
  - 85 plus – 15%
- Conversion rates from A&E to admission average 25% across organisations. When this is looked at by age, 41% of 65-74 year olds convert to admission from A&E, 52% of 75-84 year olds convert, and 61% of those age 85+ are admitted to inpatient care after presenting at A&E.





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# Assessment units

# Assessment units

- The older people in acute settings project explores the following assessment units:-
  - Frailty units – an acute assessment unit focused on the care of the frail and older people
  - Short term assessment units - expected length of stay up to 12 hours
  - Other assessment units - expected length of stay 12 to 72 hours
- A modular approach was adopted and participants were asked to complete the data collection template only if they had the unit.
- Participants were asked to provide data for assessment units as a whole, as resources for older people work could not be split out by Trusts.
- Activity data has been collected by age groups to look at the proportion of older people accessing assessment units.





# Frailty units

- 52% of participating Trusts / UHBs have a frailty unit. The average frailty unit has 18 beds, and 100% of units are clinically led by a Geriatrician. Senior clinical staff review patients twice per day on 50% of frailty units, and once per day on 42% of units. The remaining 8% report less frequent senior clinical review. 81% report that senior clinical review is undertaken at weekends.
- 7% of frailty units have an expected maximum length of stay of 48 hours and 67% have an expected maximum length of stay of 72 hours. 19% reported a stay of greater than 72 hours was to be expected.
- The average hours that senior medical cover is available on frailty units over a 24 hour period during the week is 12 hours. At weekends, this reduces to 10 hours, with two organisations reporting no senior medical cover at weekends. Out of hours medical cover is provided by an on-call rota (generic) in 68% of frailty units, on-call specialist in 16% of Trusts / UHBs, and dedicated cover in 16%.
- 96% of frailty units have admission criteria, and 60% of frailty units use a recognised frailty tool on the unit. 89% state that they use Comprehensive Geriatric Assessment on the frailty unit.
- 20% of frailty units provide an outreach service working with primary and community care to case find individuals at risk of admission. Two thirds of participants with frailty units report that the hospital discharge team provide dedicated support to the frailty unit.

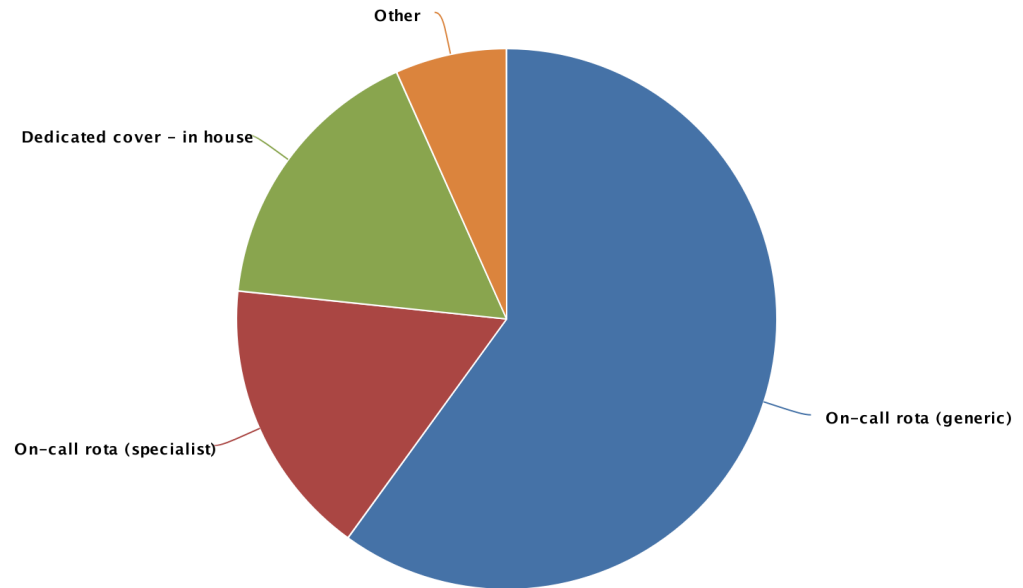




# Short term assessment units (up to 12 hours)

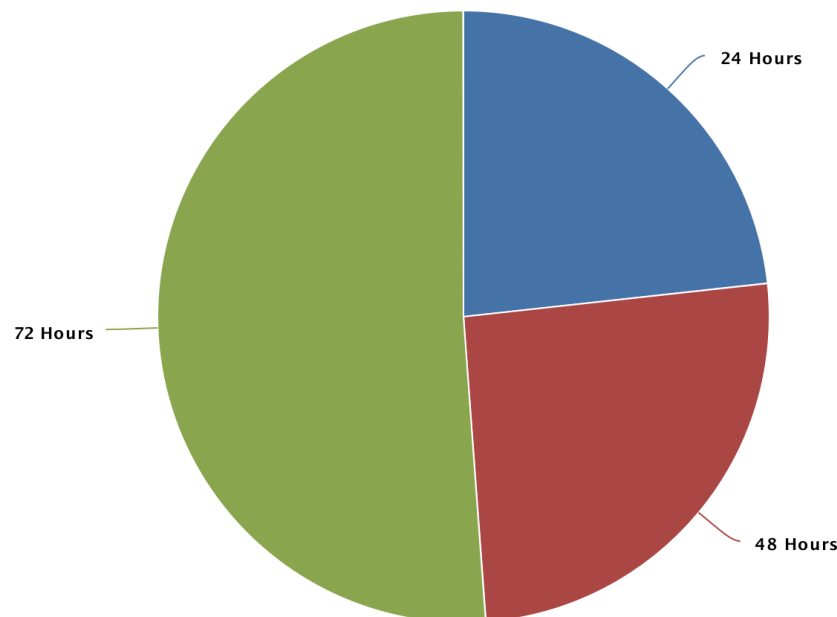
- 65% of participating Trusts / UHBs have a short term assessment unit. 32% reported that all admissions of older people go through the short term assessment unit.
- A recognised frailty tool is used in 38% of short term assessment units, and 40% state that they perform Comprehensive Geriatric Assessment. 23% have a dedicated geriatric team located in the short term assessment unit.
- 853% reported that other services provide in-reach to short term assessment units, pulling appropriate patients out and signposting to other services.
- The average short term assessment unit has 21 beds, however, this ranges from 3 beds to 60 beds.
- Clinical leadership is provided by a general physician in 66% of short term assessment units, and a geriatrician in 9% of cases. 25% reported an 'other' clinical lead.
- Senior medical cover is provided on average 15 hours per day during the week, with 26% of Trusts / UHBs reporting 24 hour cover. At weekends the average availability decreases to 12 hours, with four Trusts / UHBs reporting no senior cover. Many still have 24 hour cover at weekends.

Provision of medical cover OOHs to the short term assessment unit



# Other assessment units (12 to 72 hours)

Expected maximum length of stay on other assessment unit(s)

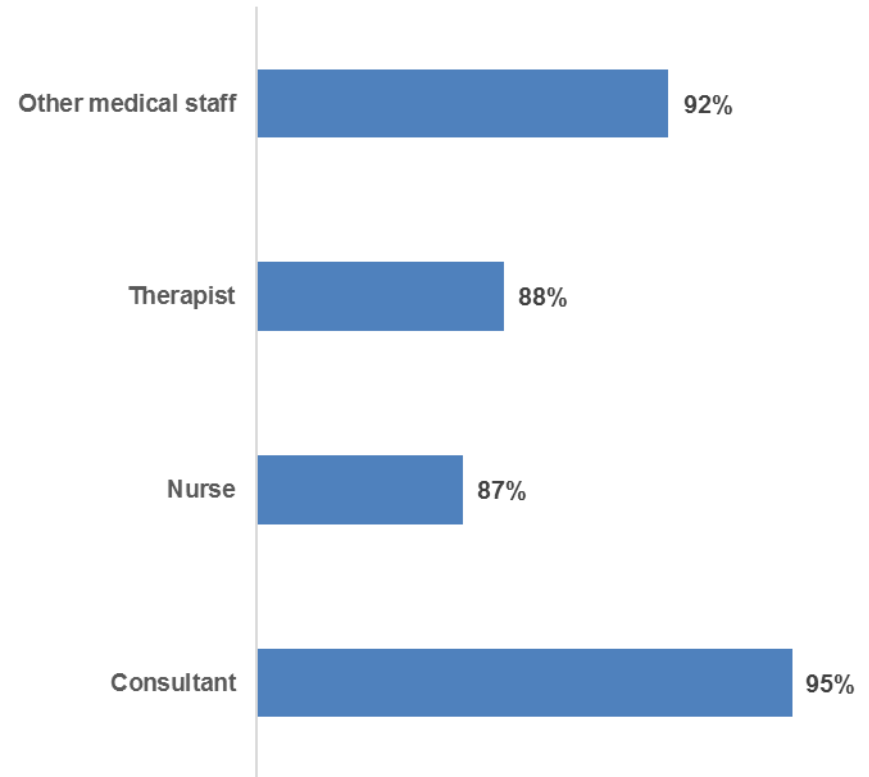


- 90% of Trusts /UHBs have other assessment units, with 40% reporting a recognised frailty tool being utilised within these assessment units.
- Comprehensive Geriatric Assessment takes place in 51% of other assessment units, and 35% have a dedicated geriatric team located in these other assessment units.
- The hospital discharge team provide dedicated support to 61% of other assessment units.
- The modal number of other assessment units within a Trust is one assessment unit, however, this ranges from 1 to 3. The average number of beds on these units is 39 beds.
- 23% of organisations reported an expected maximum length of stay on the other assessment units of 24 hours, and 26% reported 48 hours. 51% reported the expected maximum length of stay on these units was 72 hours.
- 73% of clinical leadership is provided by a General physician, 4% by a Geriatrician and 23% by an 'other' clinician.
- Senior medical cover is available, on average, 14 hours per day during the week and 12 hours on the weekend. Seven Trusts / UHBs report 24/7 senior medical cover on these units.

# Comprehensive Geriatric Assessment (CGA)

- This year participants were asked further questions on Comprehensive Geriatric Assessment (CGA).
- The definition of CGA used within the project was:
  - “CGA is a multi-dimensional, multi-disciplinary process which identifies medical, social and functional needs, and the development of an integrated/co-ordinated care plan to meet those needs.” (see **Appendix 1** for a fuller definition)
- 26% of participants reported that there is an MDT response that initiates CGA within the first hour of admission. 50% report that CGA is documented on a single, shared assessment document, accessible by all members of the MDT. 58% report that comprehensive geriatric assessments contain a care plan which has been discussed with the patients and/or their carers.
- 31% of organisations have an awareness programme for non-geriatricians about frailty and CGA.

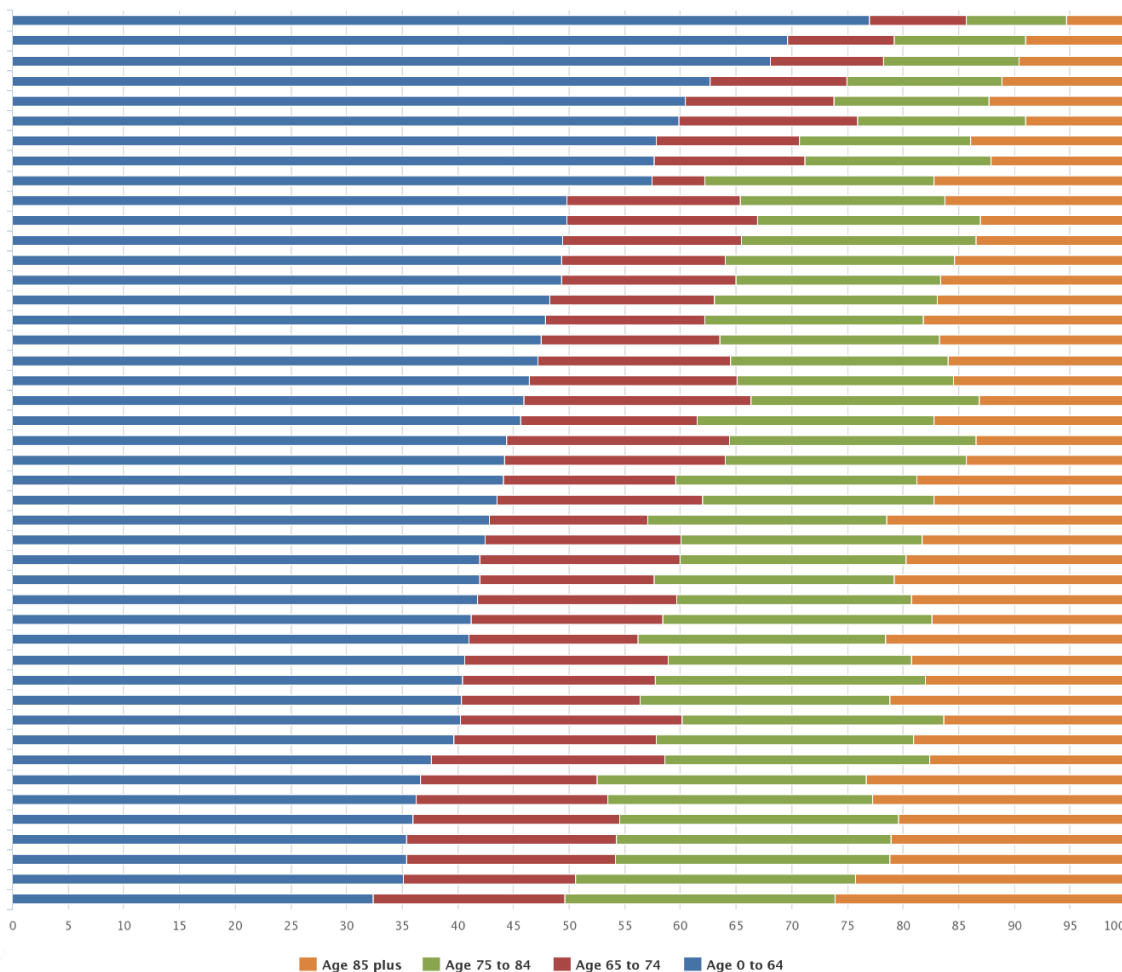
Who is involved in carrying out CGA on assessment units?



# Admissions to assessment units

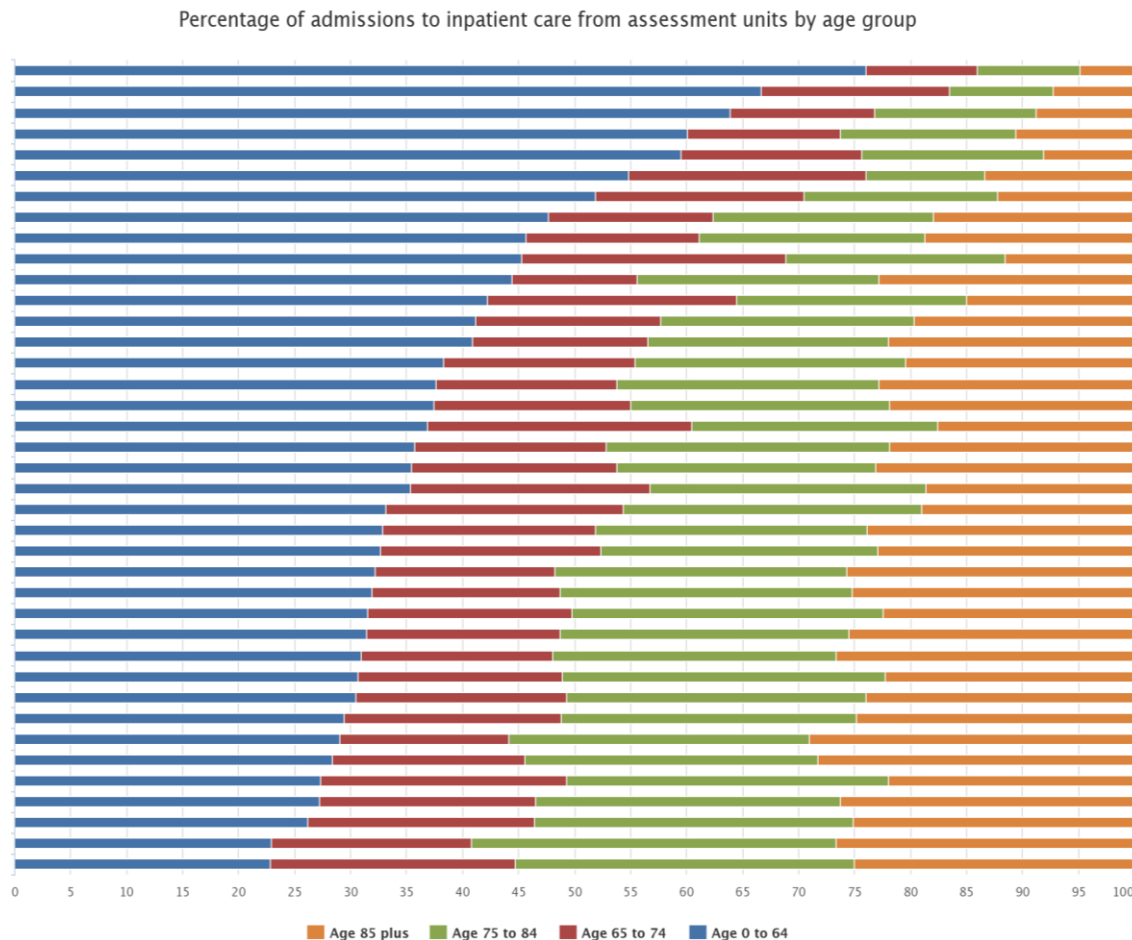
- Continuing the journey along the acute pathway, Trusts and UHBs were asked to provide the number of admissions to all assessment units, and then asked to give an age split.
- 47% of admissions to assessment units in 2014/15 were by those aged 64 and under.
- 53% of all admissions to assessment units are by those aged 65 and over. This can be further analysed:
  - Age 65 to 74 – 16% of admissions
  - Age 75 to 84 – 20% of admissions
  - Age 85 plus – 17% of admissions
- 69% of admissions come from A&E, 25% from GP, 7% from other sources.

Percentage of admissions to assessment units by age



# Admissions to inpatient care from assessment units

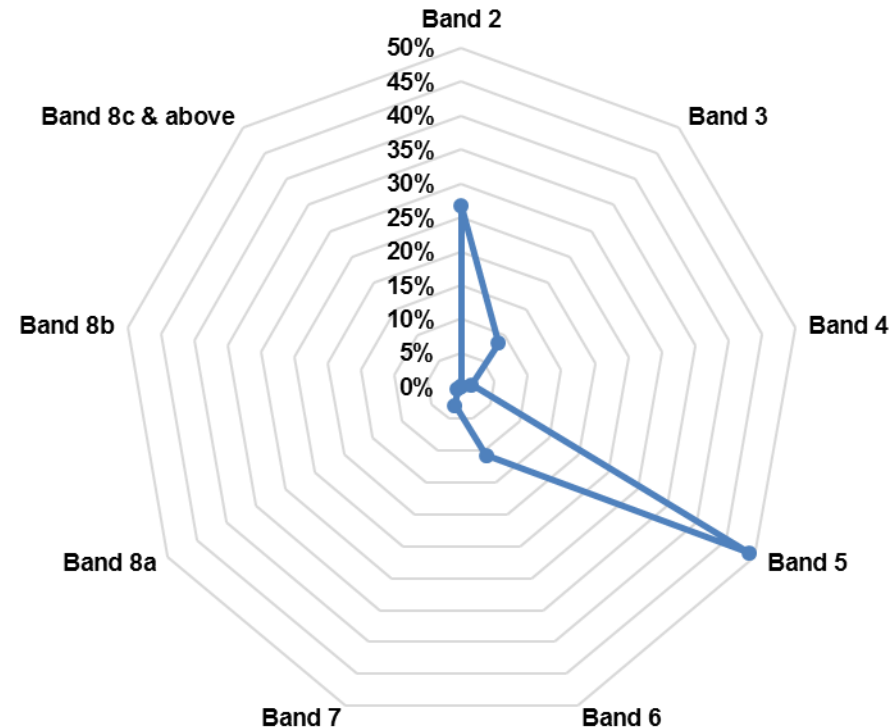
- As shown previously, 53% of admissions to assessment units are for people aged 65 and over.
- 61% of all admissions to inpatient care from assessment units are of those age 65 and over. This can be further split down into the following age categories:
  - Age 65 to 74 – 18%
  - Age 75 to 84 – 23%
  - Age 85 plus – 20%
- Older people are a minority of attenders at A&E (ages 65 and over account for 24% of all A&E attendances) but make up a higher proportion of the patient cohort at subsequent stages of the pathway. As this activity data shows, older people are more likely to enter an admission unit and more likely still to be admitted to inpatient care, than younger age groups.



# Assessment unit workforce

- Workforce data was collected across the pathway, and organisations are able to compare their workforce skill mix against other participants in the online toolkit.
- The nursing skill mix the assessment units was found to be:-
  - Band 2 – 27%
  - Band 3 – 7%
  - Band 4 – 1%
  - Band 5 – 49%
  - Band 6 – 11%
  - Band 7 – 4%
  - Band 8A + - <1%
- The nursing skill mix for assessment units is comprises 36% unregistered nurses, and 64% registered nurses. The compares to 42% unregistered nurses and 58% registered nurses in inpatient care of older people wards.

## Nursing skill mix (assessment units)



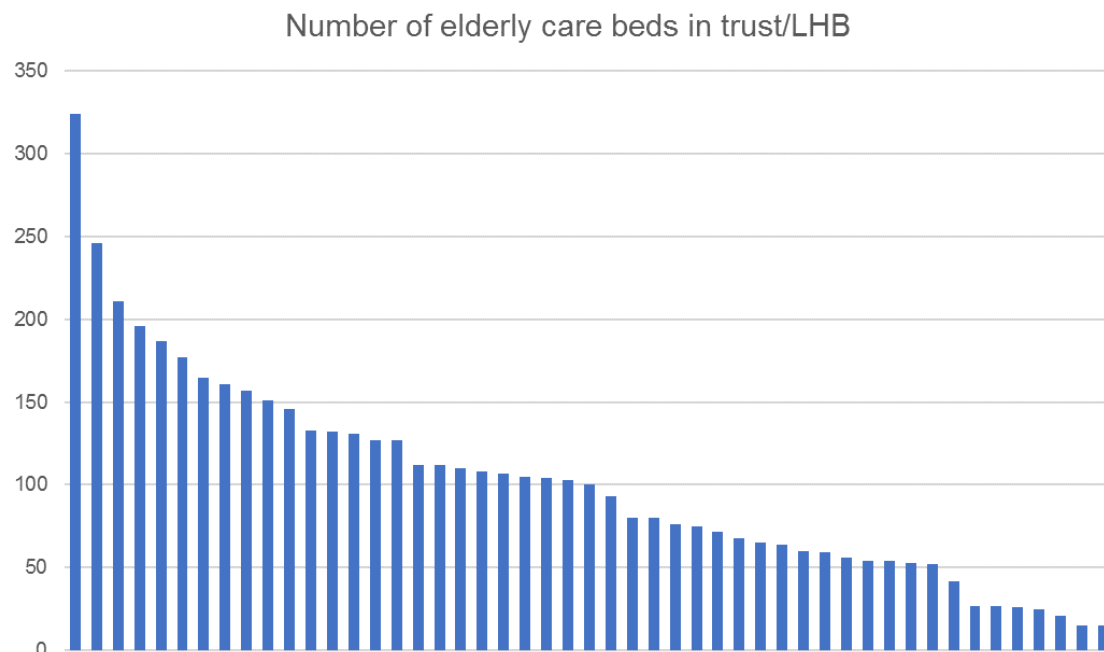


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# Inpatient care

# Care of older people beds

- The average number of care of older people beds in Trusts / UHBs is 102. There is wide variation of provision, from 15 to 324 beds.
- The number of designated medical beds ranged from 8 to 689 and the average number per trust / UHB was 229.
- 77% of Trusts / UHBs delivered CGA on care of older people wards. This decreased to 42% on other speciality wards.
- A nursing self-care model was delivered in 37% of organisations.
- Quality metrics later in the report are benchmarked per 100 care of older people beds, to allow for comparisons between hospitals.

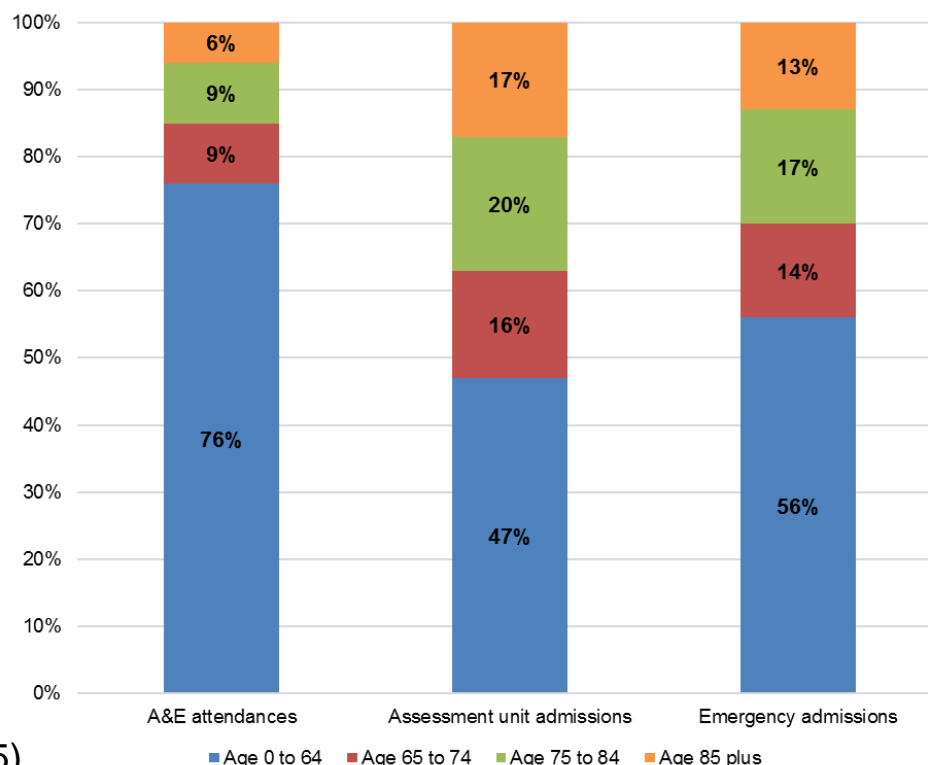




# Emergency admissions

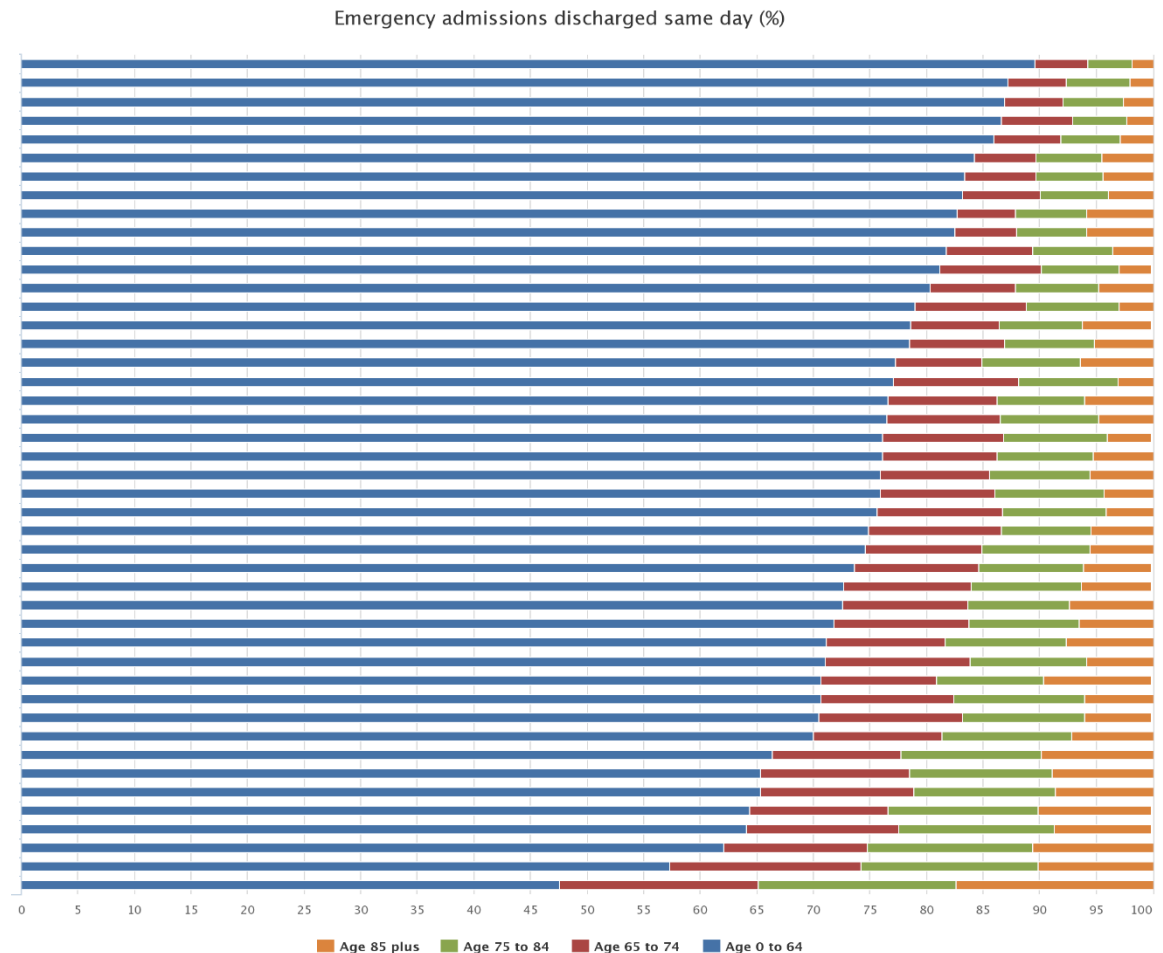
## Age profile across the acute pathway

- The age split of emergency admissions is:-
  - 0 to 64 – 56%
  - 65 to 74 – 14%
  - 75 to 84 – 17%
  - 85+ - 13%
- The age profile is very consistent with previous years.
- As can be seen from the chart, the highest proportion of older people are in assessment units (53%) whilst in A&E, older people account for 24% of attendances.
- The length of stay for emergency admissions by age group were as follows:-
  - All ages = 5.7 days
  - 65 – 74 = 7.2 days
  - 75 – 84 = 9.1 days
  - 85+ = 11.3 days (1 day increase since 2015)
- As expected, average length of stay increases with age.



# Emergency admissions discharged the same day

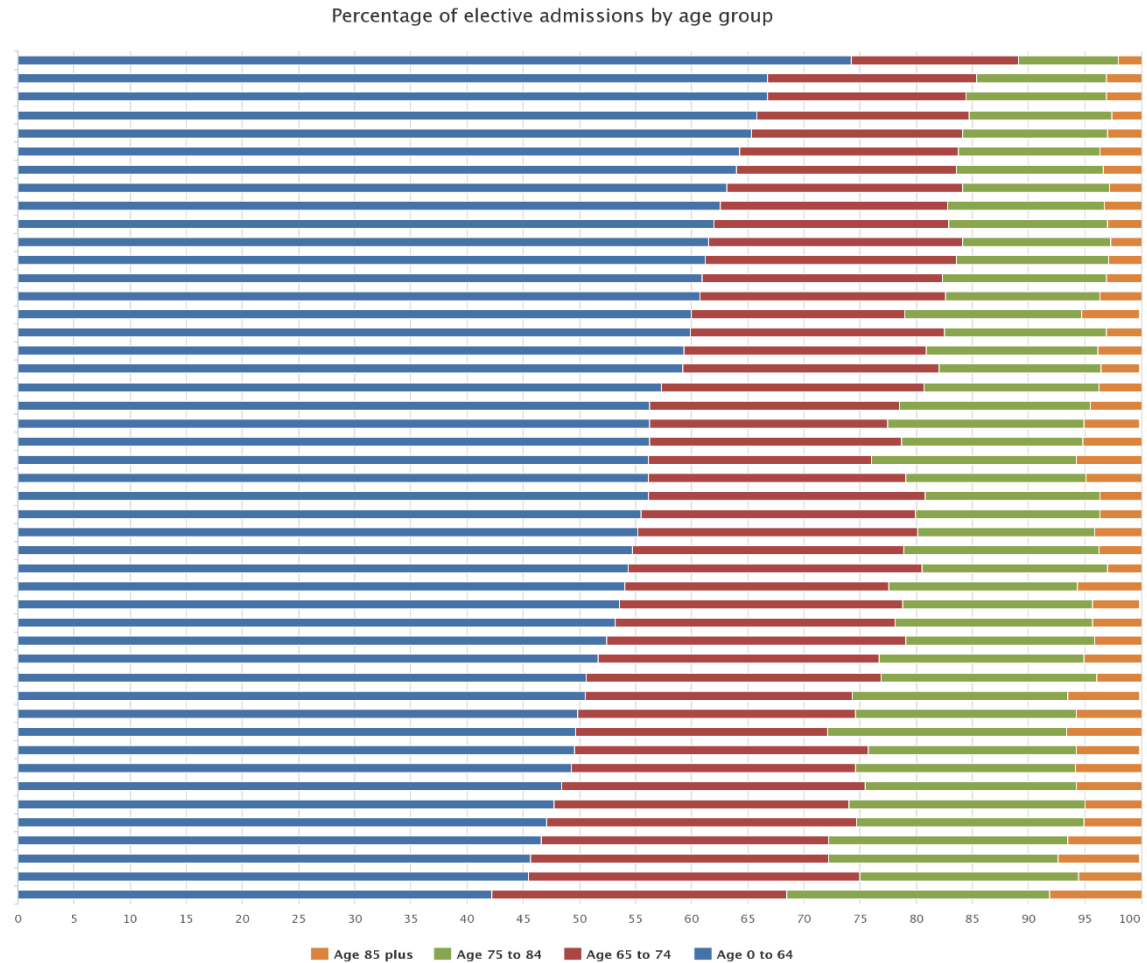
- The age split of emergency admissions discharged the same day was :-
  - 0 to 64 – 75%
  - 65 to 74 – 10%
  - 75 to 84 – 9%
  - 85+ – 6%
- For emergency admissions discharged the following day, the age split was:-
  - 0 to 64 – 70%
  - 65 to 74 – 11%
  - 75 to 84 – 11%
  - 85+ – 8%



# Elective admissions

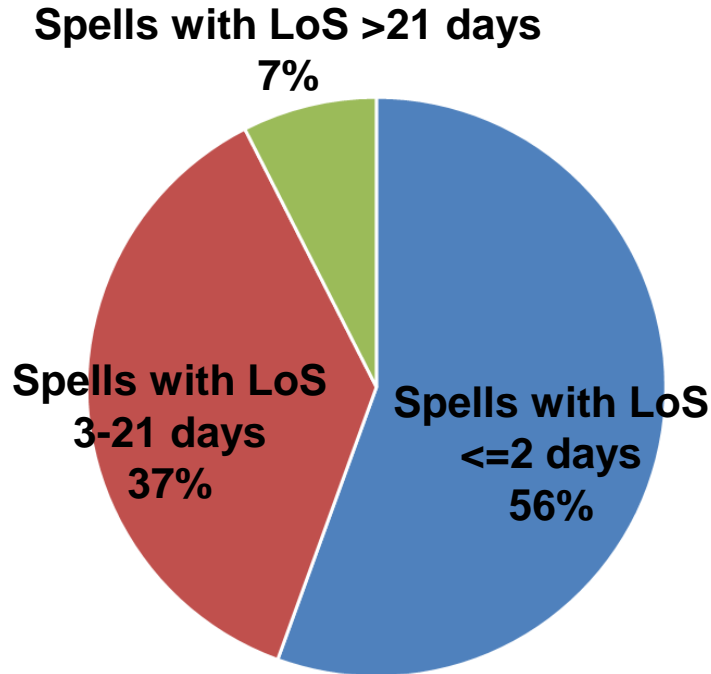
- The split of elective admissions by age range were reported as follows:-

- 0 to 64 – 56%
- 65 to 74 – 23%
- 75 to 84 – 16%
- 85+ – 4%

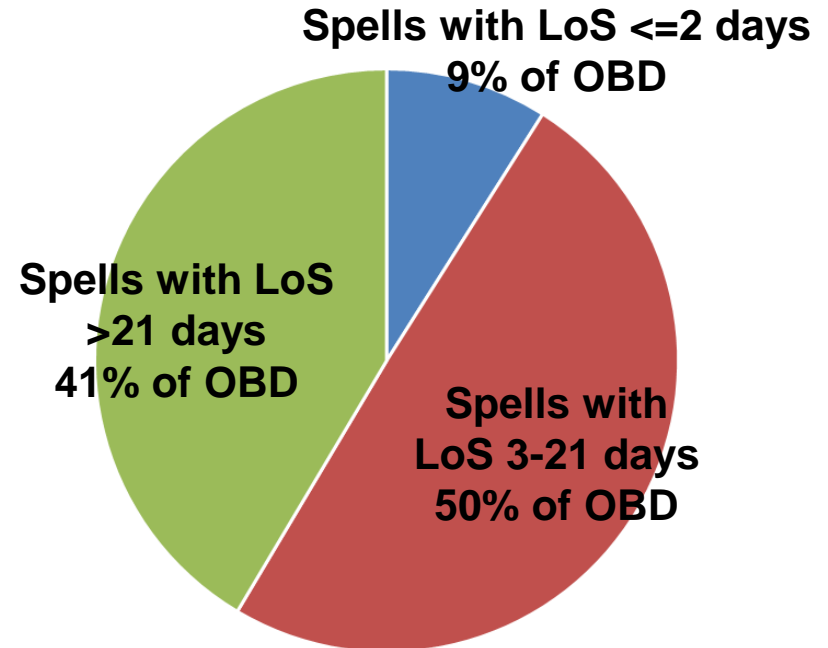


# Older people's care – the impact of long stays on OBDs

## Total number of spells



## Total number of OBDs



- The pie charts illustrate the impact of longer lengths of stay on secondary care utilisation.
- Spells with a length of stay of more than 21 days account for 7% of total spells, yet account for 41% of total occupied bed days, indicating the high proportion of capacity being utilised by a small number of people with long stays.

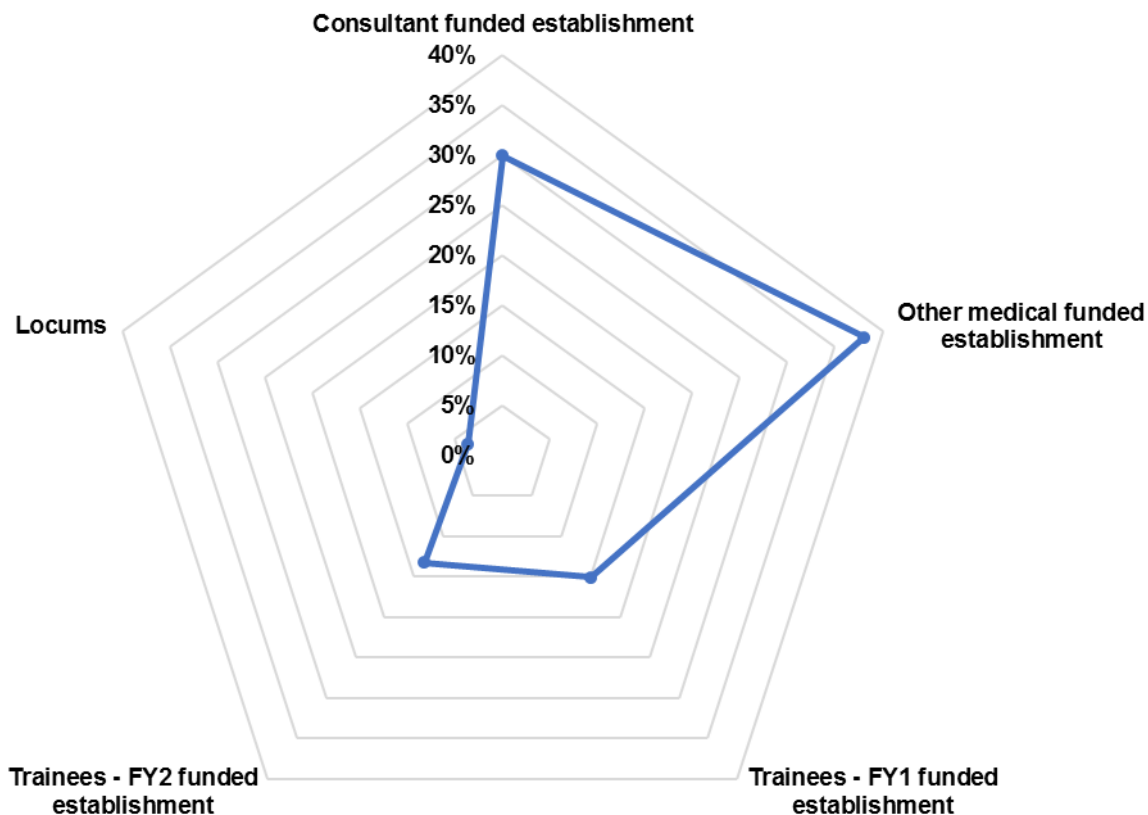


# Inpatient team workforce

## Medical team skill mix

- The average skill mix of the medical team on care of older people wards was:-
  - Consultant funded establishment - 30%
  - Other medical staff grades funded establishment – 38%
  - FY1 funded establishment – 15%
  - FY2 funded establishment – 13%
  - Locums – 4%
- Participants are able to view their own medical team skill mix and make comparisons against the national averages in the toolkit.

## Medical team staff mix (care of elderly team)

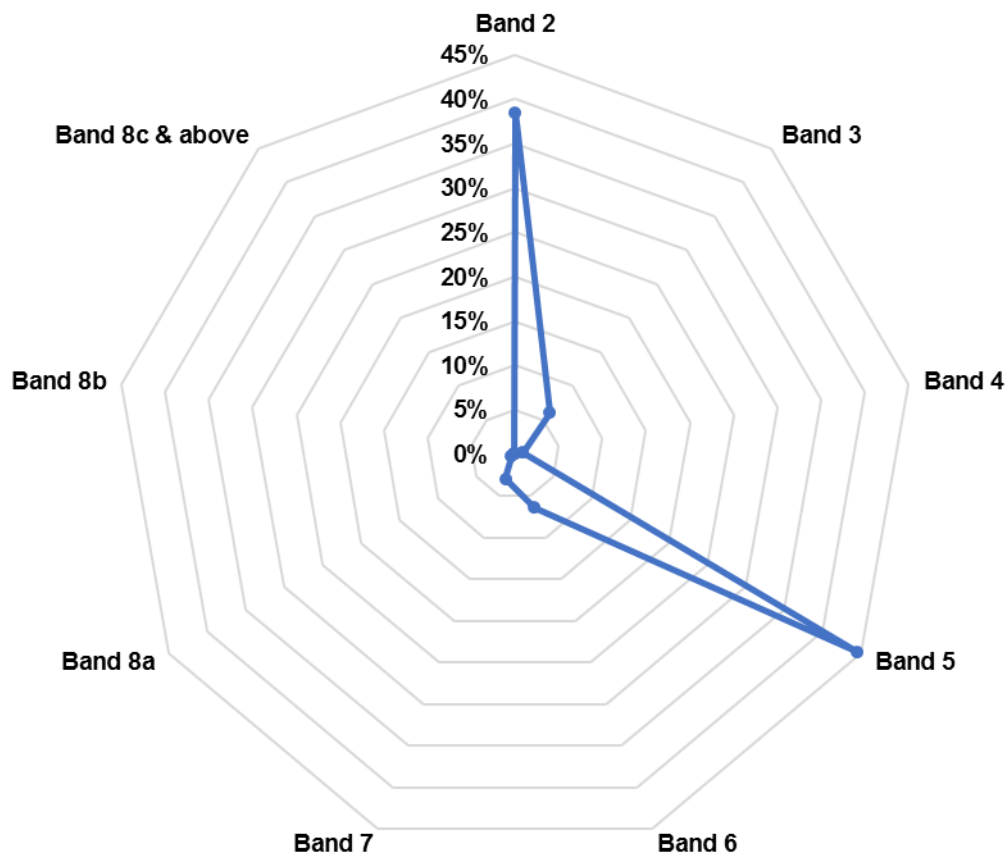


# Inpatient team workforce

## Nursing team skill mix

- The Nursing skill mix on the care of older people wards was found to be:-
  - Band 2 – 38%
  - Band 3 – 6%
  - Band 4 – 1%
  - Band 5 – 44%
  - Band 6 – 6%
  - Band 7 – 3%
  - Band 8A - <1%
- The ratio of registered to unregistered nurses on the care of older people wards was found to be 54:46. This is slightly higher than the RCN guidance of a ratio of 50:50 for basic, safe care.

## Skill mix (nursing only) – older people wards



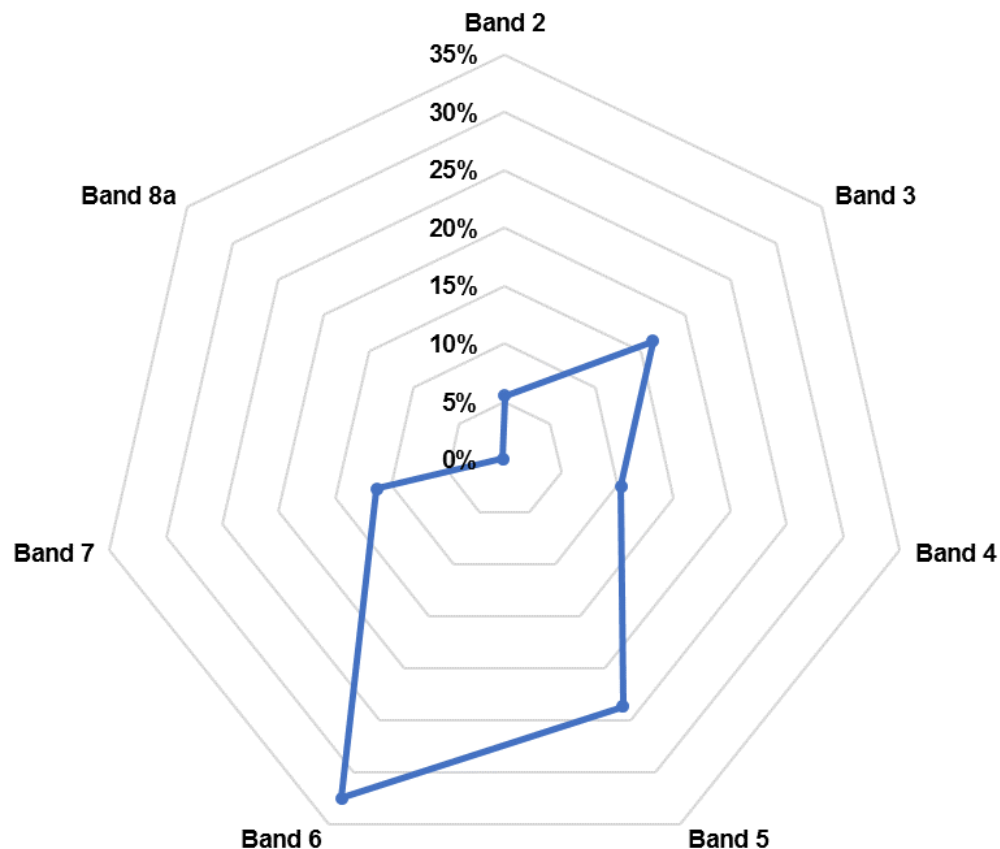
# Inpatient team workforce

## AHP team skill mix

- The AHP skill mix on the care of older people wards was:-

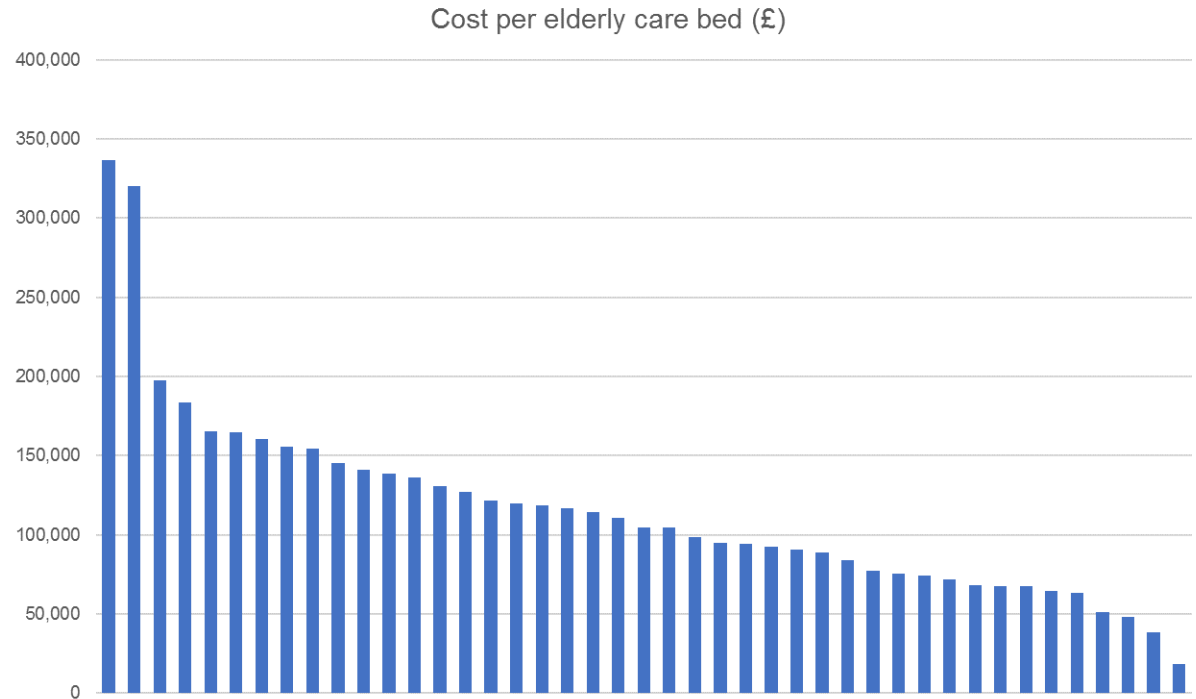
- Band 2 – 6%
- Band 3 – 16%
- Band 4 – 10%
- Band 5 – 24%
- Band 6 – 32%
- Band 7 – 11%
- Band 8A - <1%

## Skill mix (AHPs only) – older people wards



# Total cost per care of older people bed

- The average total cost per care of older people bed was £116,194.
- Total cost includes pay cost, non-pay and indirect cost/overhead allocations.
- Pay costs accounted for 74% of total costs.
- Older people wards, on average, reported a CIP of 3%; however this ranged from 0% to 6%.







Benchmarking Network

# Supported discharge process

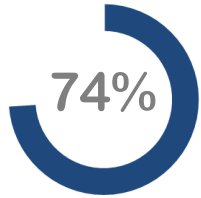
# Supported discharge process

- In the 2016, the benchmarking project collected more information on the supported discharge process in response the National Audit Office report “Discharging older people from hospital”, published in May 2016.
- The NAO report highlighted recommended good practice principles; that hospitals should identify patients’ needs as quickly as possible to determine if hospital is the best place to meet them, health and social care staff should work together to maintain momentum of treatment and discharge planning and staff should assess and rehabilitate patients in their home wherever possible. Compliance with these principles is considered on the following pages.



# NAO key principles

## Principle one: Early identification of needs



of Trusts reported setting an Expected Date of Discharge (EDD) within 24 hrs of admission. There is evidence from NHS Trusts and healthcare organisations abroad that setting an EDD can assist in reducing length of stay. The earlier the EDD is set the sooner planning can be put in place with relevant agencies.

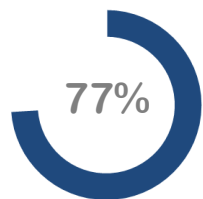
This report also highlights the importance of Comprehensive Geriatric Assessment in establishing a holistic view of service user needs. Results discussed above suggest increasing use of CGA across the pathway. In the service user audit (see results below), 33% of the sample received CGA in A&E or assessment unit and 46% on the wards.



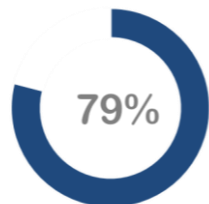
# NAO key principles

## Principle two: Maintaining momentum

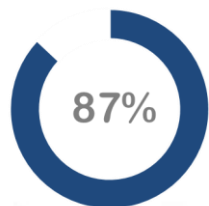
The process for ensuring the flow of information between all interested parties, both health and social care, is key to efficient supported discharge. The NAO identified difficulties with hospital staff maintaining knowledge of out of hospital services.



of trusts / UHBs reported that there was a documented supported discharge process consistently applied across all wards. Just over half of these (53%) reported that they had discharge information documented in a single “discharge passport” or equivalent.



hold daily progress chasing meetings.



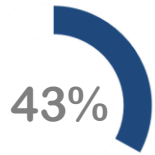
of older people wards maintain lists of older people no longer benefitting from acute care.



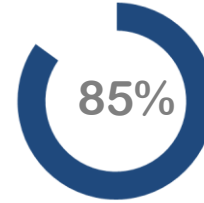
# NAO key principles

## Principle three: Assessment and rehabilitation at home

The NAO report recommends that assessment and rehabilitation should take place at home where possible. This project found the models and schemes being operated by participants following:



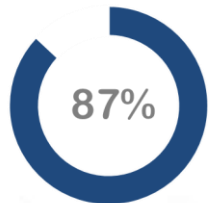
of Trusts operate a discharge to assess model.



operate early supported discharge schemes.



of trusts/ UHBs use "trusted assessors" to carry out holistic assessments.



have criteria outlining which patients might be suitable for intermediate care. Intermediate care assessments are carried out by the integrated discharge team (50%) or hospital discharge team (health only)(50%).



# Supported discharge service structure

- 77% of organisations have an integrated discharge team. 54% of these trusts / UHBs reported that discharges went through the integrated discharge team. Where supported discharges don't go through the integrated discharge team, 97% of trusts / UHBs reported that they are dealt with directly by the ward staff.

**70%**

have dedicated ward discharge co-ordinators.

**53%**

of organisations operate nurse led discharge and 38%, therapy led discharge.

**62%**

have access to social care at the weekends.

**75%**

have access to specialist transport schemes to expedite discharge.

**75%**

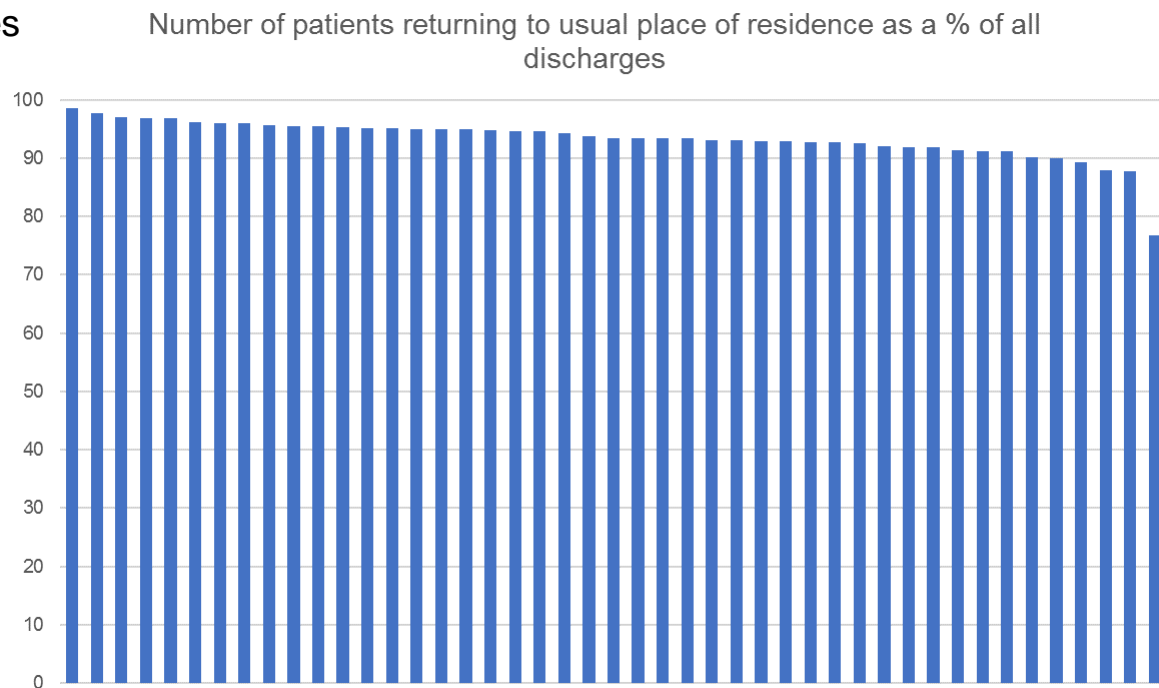
have access to dedicated pharmacy advice for supported discharges.



# Supported discharge process

## Number of patients returning to usual place of residence as a % of all discharges

- Although only a small number of Trusts were able to answer the question, responses received suggest round 4% of all discharges require some form of supported discharge.
- 93% of patients are discharged home to their usual place of residence.

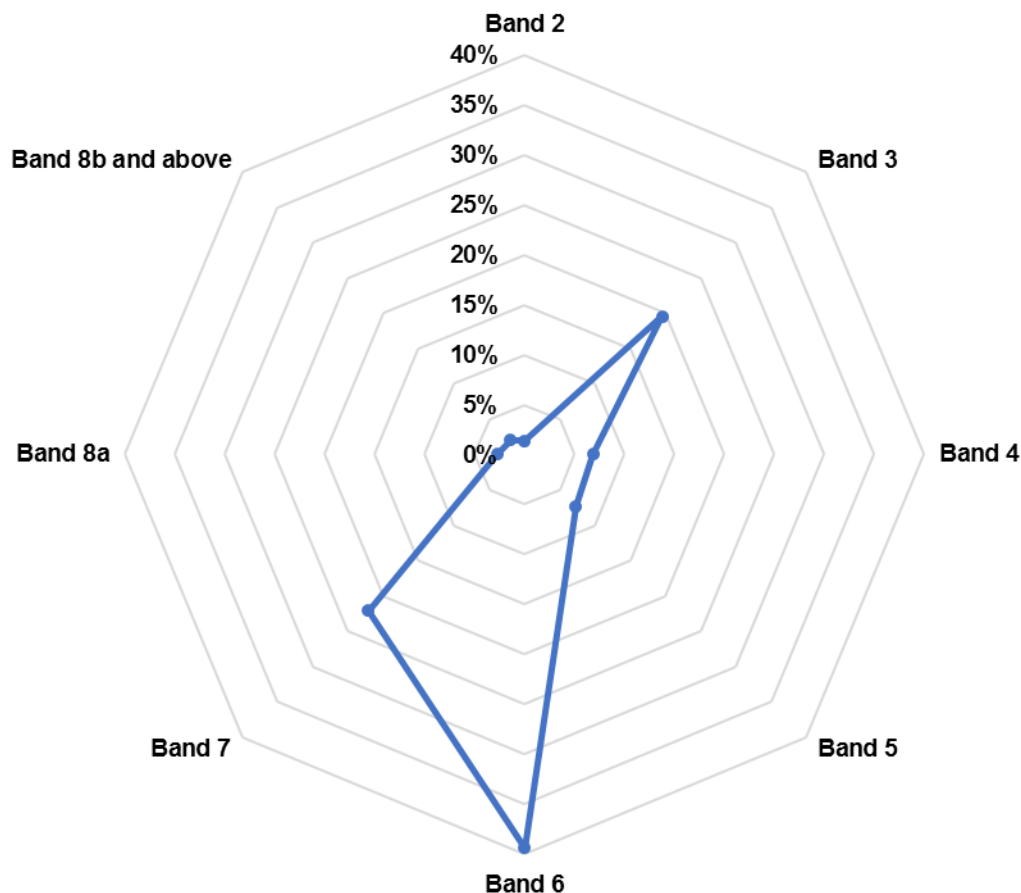


# Supported discharge team workforce

## Nursing team skill mix

- The nursing skill mix within the supported discharge team was reported as follows:-
  - Band 3 – 20%
  - Band 4 – 7%
  - Band 5 – 7%
  - Band 6 – 39%
  - Band 7 – 22%
  - Band 8A – 3%
  - Band 8B and above – 2%
- The average nursing skill mix in supported discharge teams has a richer skill mix than reported in other areas of the acute pathway.
- Together, Band 6 and Band 7 comprise almost two-thirds of the workforce.

## Skill mix (nursing only) – supported discharge team



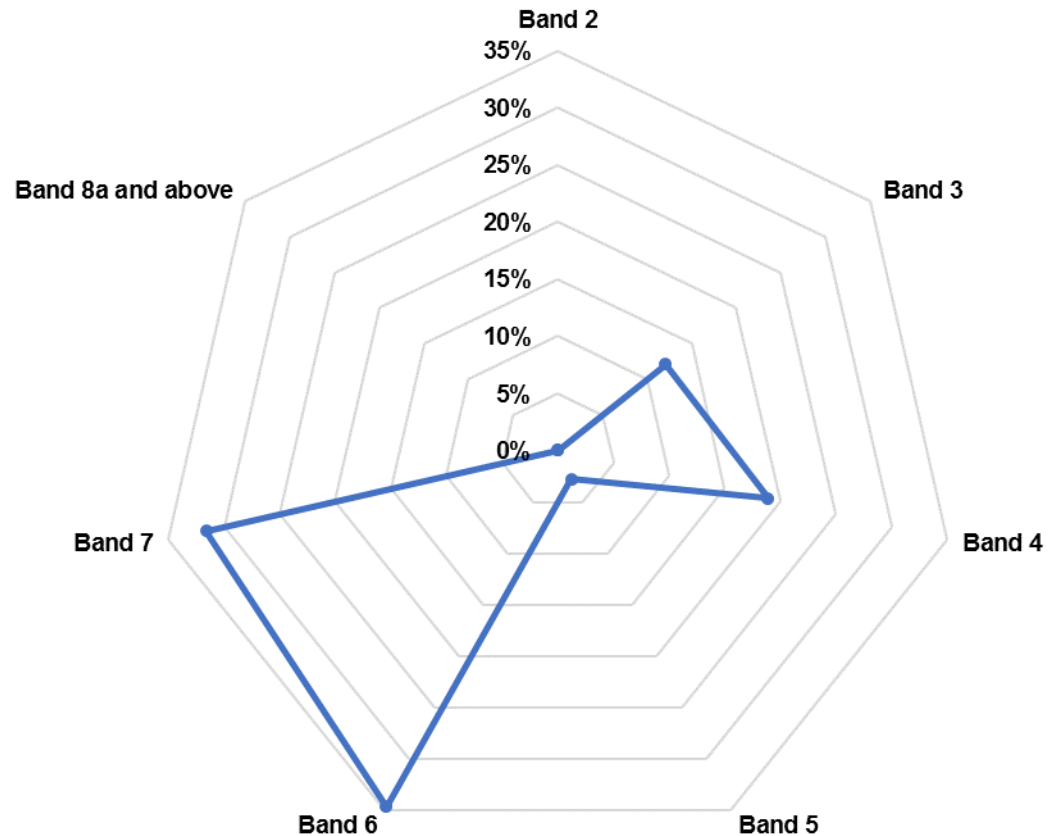


# Supported discharge team workforce

## AHP team skill mix

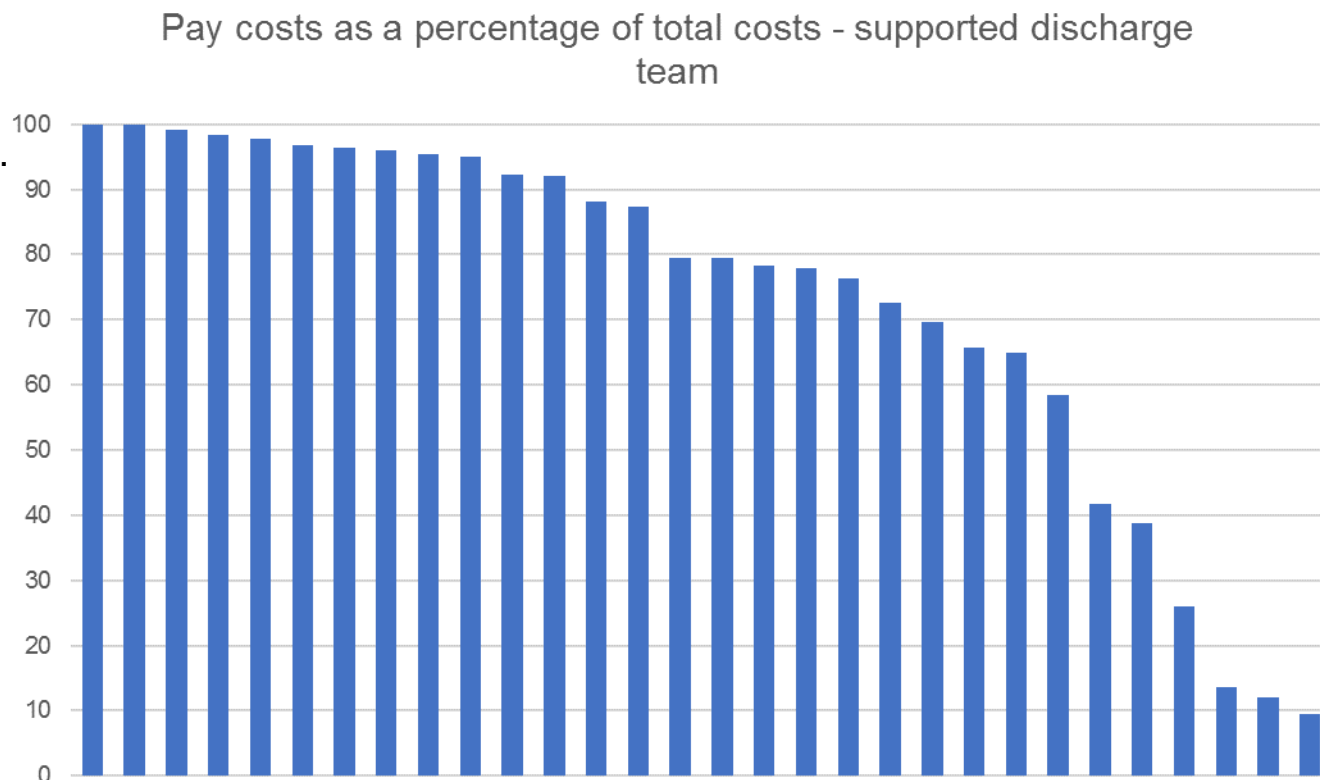
- The AHP skill mix within the supported discharge team was reported as follows:-
  - Band 3 – 12%
  - Band 4 – 19%
  - Band 5 – 3%
  - Band 6 – 35%
  - Band 7 – 31%
  - Band 8A and above – 0%
- Other workforce indicators across the supported discharge team:
  - Vacancy rate – 9%
  - Sickness rate – 4%
  - Turnover – 16%

## Skill mix (AHPs only) – supported discharge team



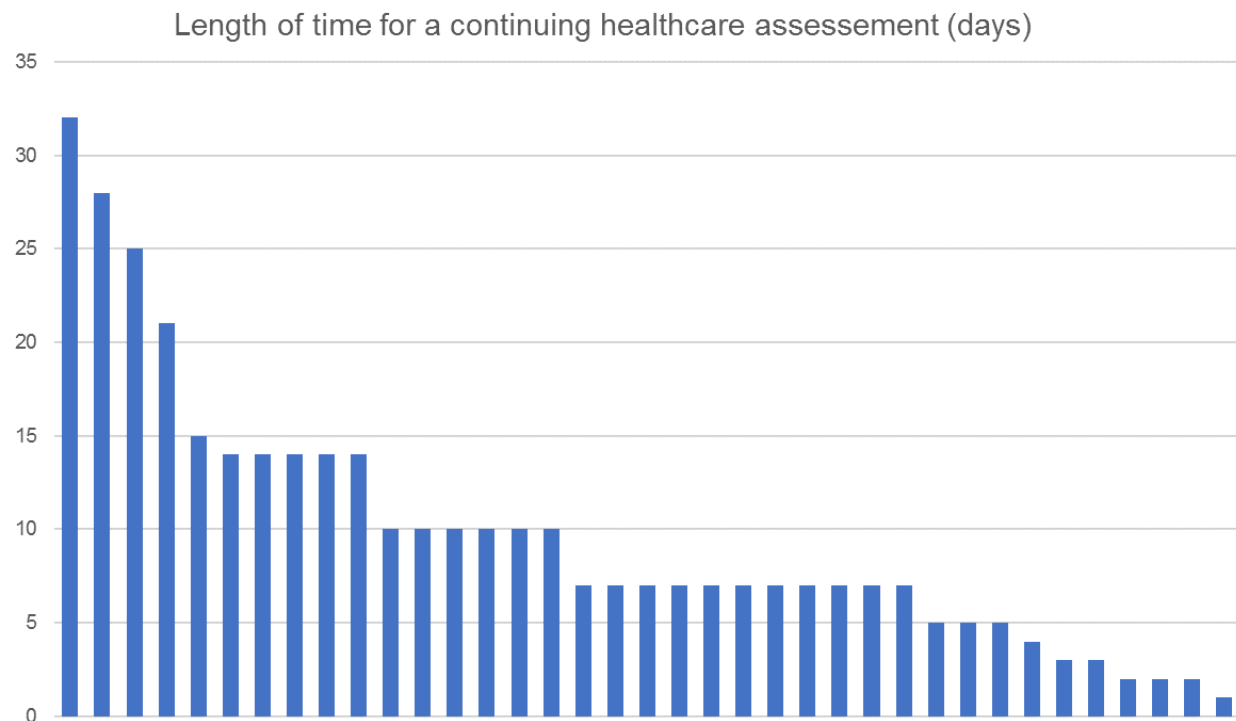
# Spend on supported discharge team

- On average, 73% of the total costs for the supported discharge team are on pay costs.
- The average CIP that a supported discharge team is assigned is 2%.



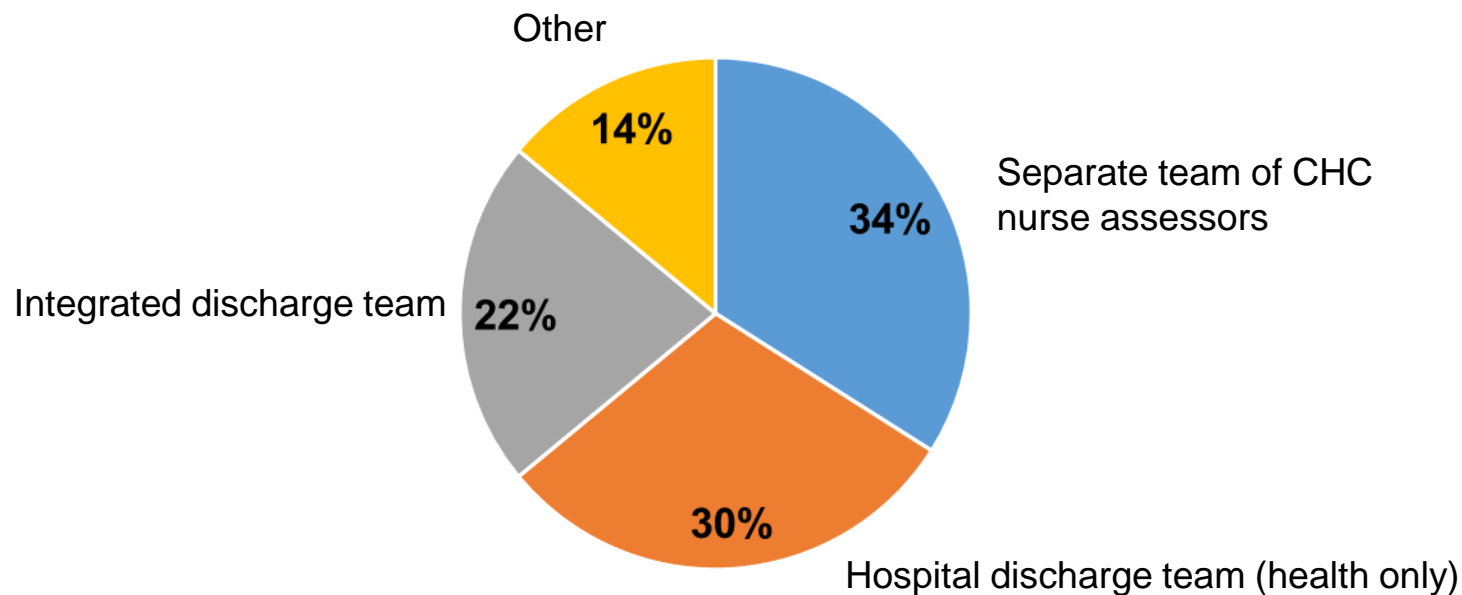
# Continuing healthcare assessment

- Continuing healthcare assessment was carried out within the following locations:-
  - Inpatient ward – 98%
  - Dedicated assessment ward – 38%
  - Intermediate care bed based unit – 56%
  - In “time to think” or transition beds – 50%
  - At place of care / own home – 61%
  - Other – 39%
- The average length of time for a CHC assessment to take place is 9 days (a 1 day improvement upon the reporting last year).



# Continuing healthcare assessments

## Who carries out CHC assessments?



- Although continuing healthcare assessments are most likely to be carried out by a separate team of CHC nurse assessors (34%), there are a number of different approaches taken across Trusts.



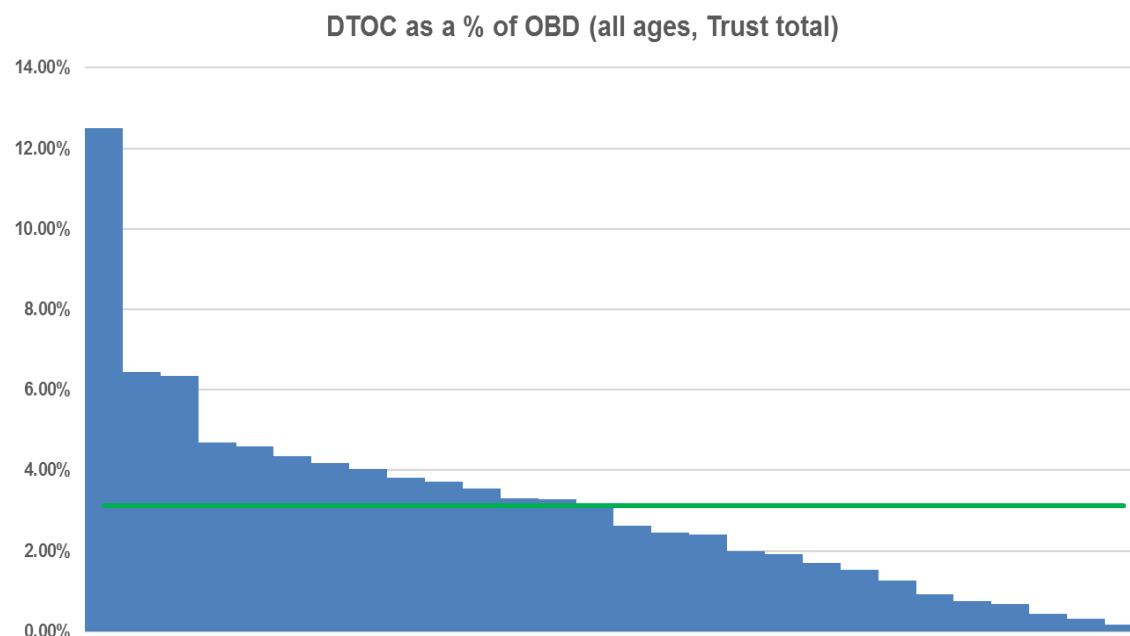


Benchmarking Network

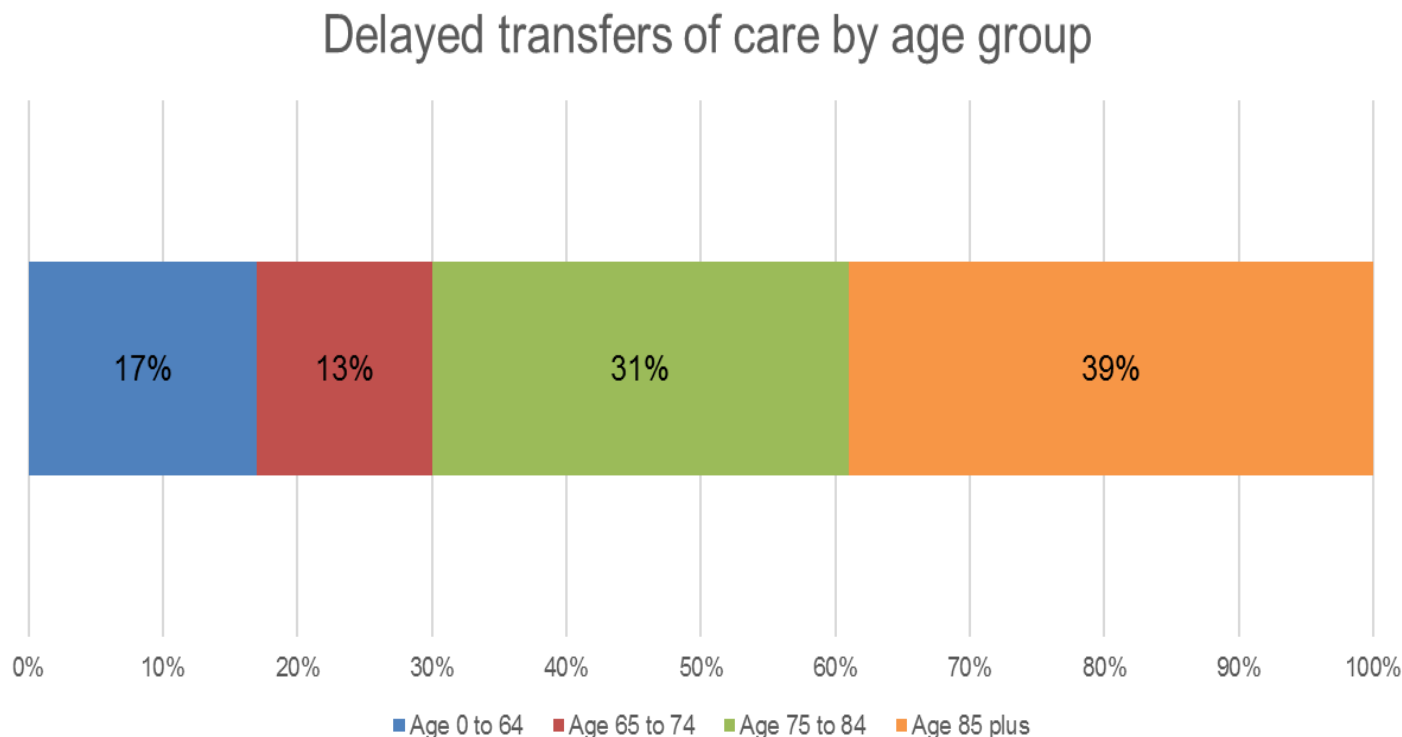
# Delayed Transfers of Care (DToC)

# Delayed transfers of care (DToC)

- DToCs average 3.1% of all occupied bed days in trusts / UHBs, consistent with the level of DToCs nationally suggested in the NAO Report “Discharging older patients from Hospital”.
- Two new questions which we asked this year with regard to DToCs and SITREP reports were “Do you agree your SITREP reports with your Local Authority partners before reporting” and “Did you impose a fine on and of your Local Authority partners in 2015/16”. The responses to these new questions were 71% and 15% respectively. This applies to England only.



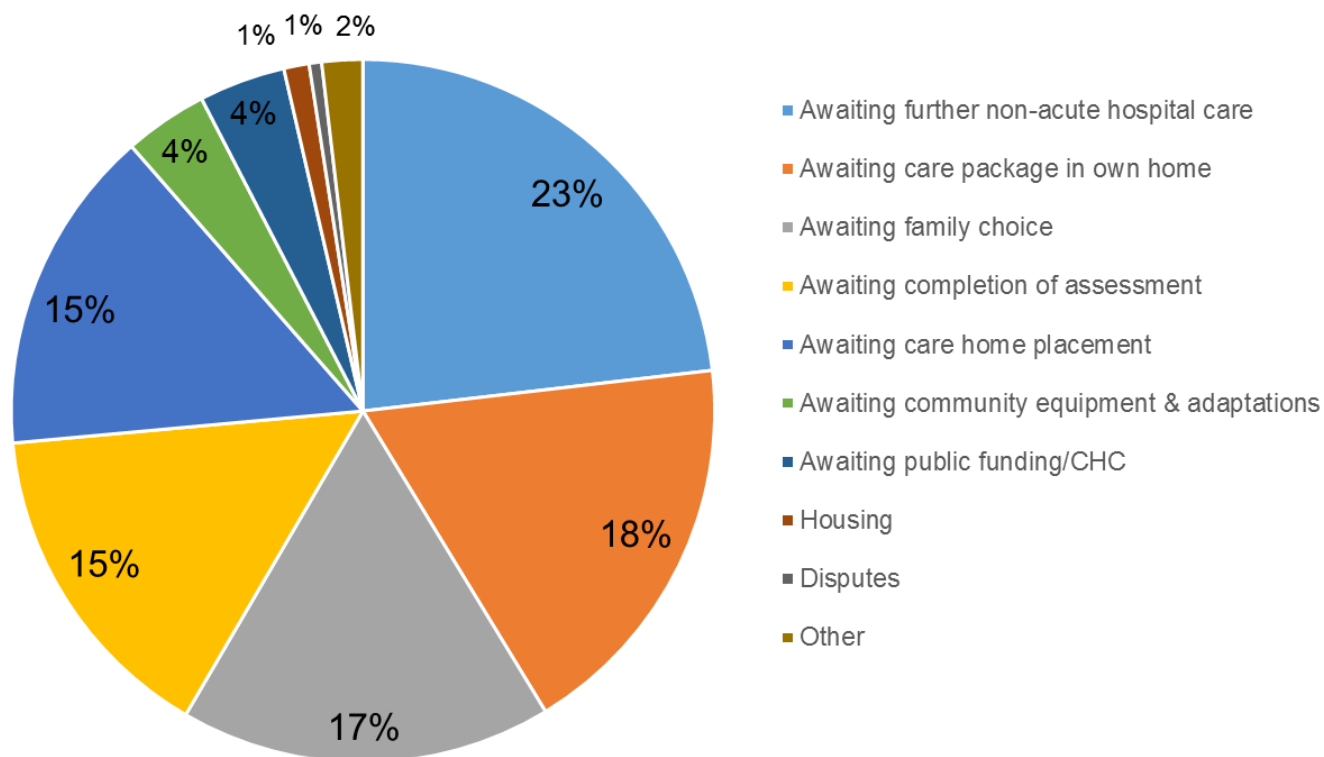
# Delayed transfers of care by age group



- 83% of DToCs in 2015/16 were attributable to people aged 65 plus (compared to 46% of emergency admissions aged 65 and over reported above)
- 39% of DToCs were in the 85 plus age group (compared to 13% of emergency admissions aged 85 and over).



# Reasons for DToC (trust total %)

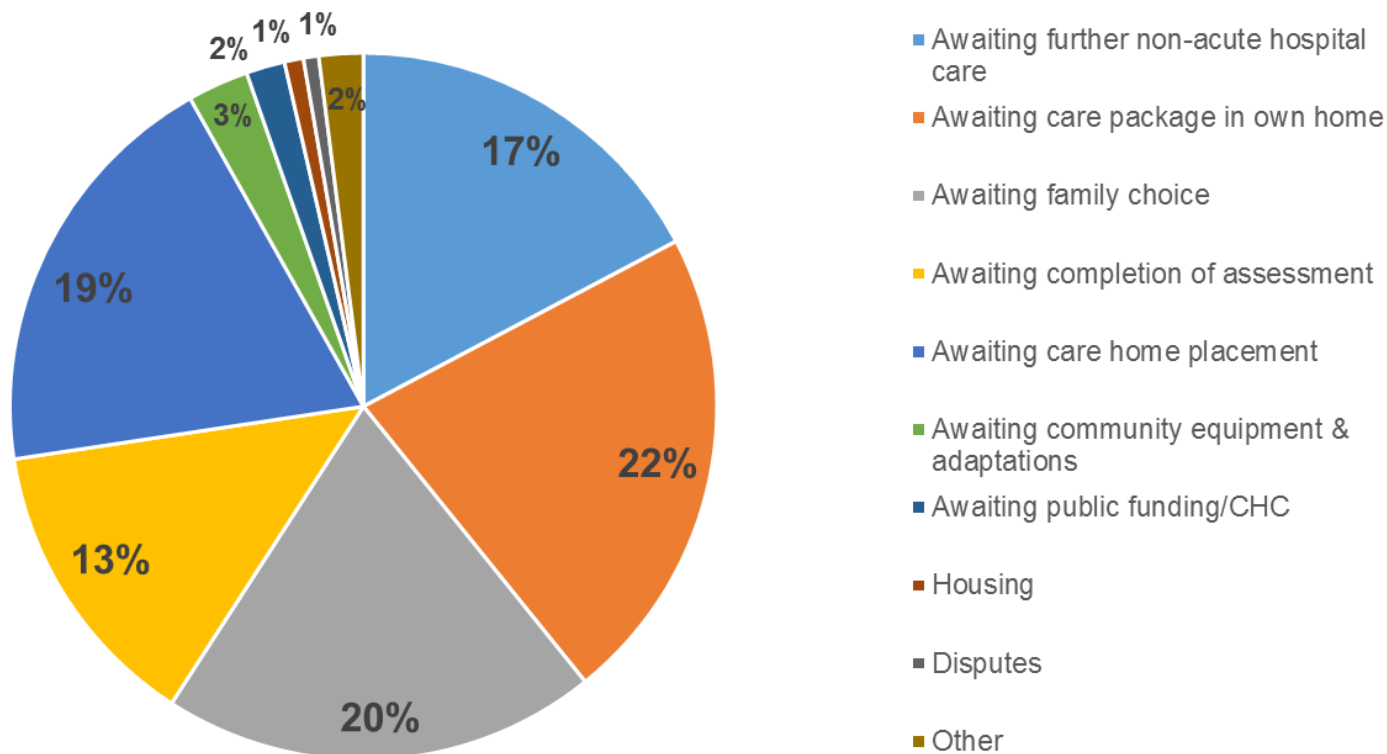


- The two most common reasons for DToCs (across all DToCs) reported were “awaiting further non-acute hospital care” at 23% and “awaiting a care package in own home” at 18%.





# Reasons for DToC (85+ age group %)



- In the 85+ age group, the most common reasons for DToCs reported were “awaiting a care package in own home” at 22% and “awaiting a care home placement” at 19%. “Awaiting family choice” as a reason for DToC becomes more apparent in this age group, reported at 20%.





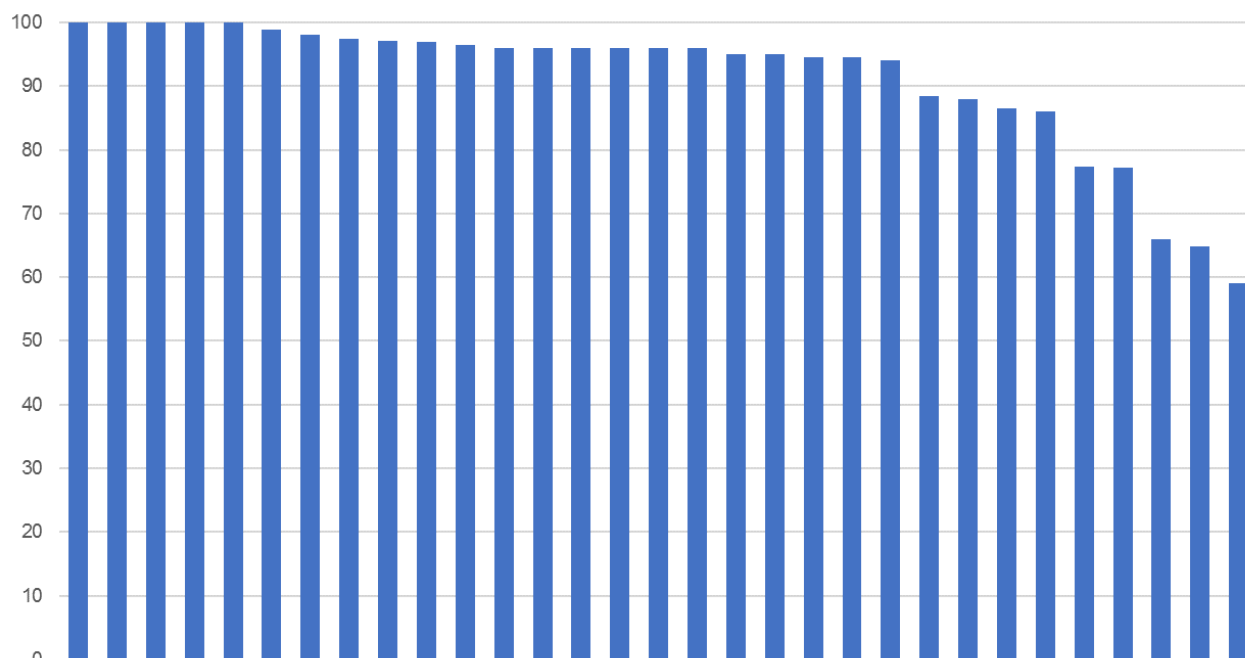
Benchmarking Network

# Quality and outcomes

# Patient satisfaction

- 86% of trusts / UHBs report that their care of older people wards routinely collect Patient Reported Experience Measures
- 77% of trusts / UHBs report they routinely carry out satisfaction surveys with service users and carers in the care of older people service.
- 51% of trusts / UHBs participate in local CQuIN schemes rated to the care of older people.
- Trusts report that 91% of patients would recommend their service to their friends and family.
- In terms of formal complaints, trusts /UHBs report on average 24 complaints per 100 care of older people beds.

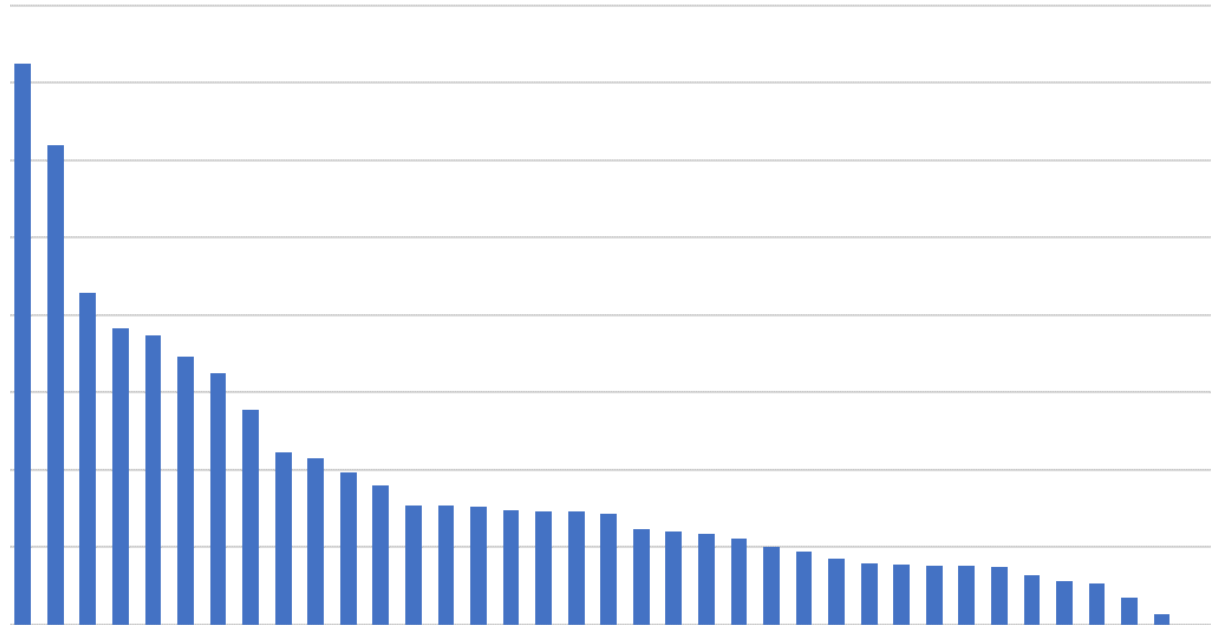
Friends & family test: Percentage of patients who would recommend the service (%)



# Serious incidents

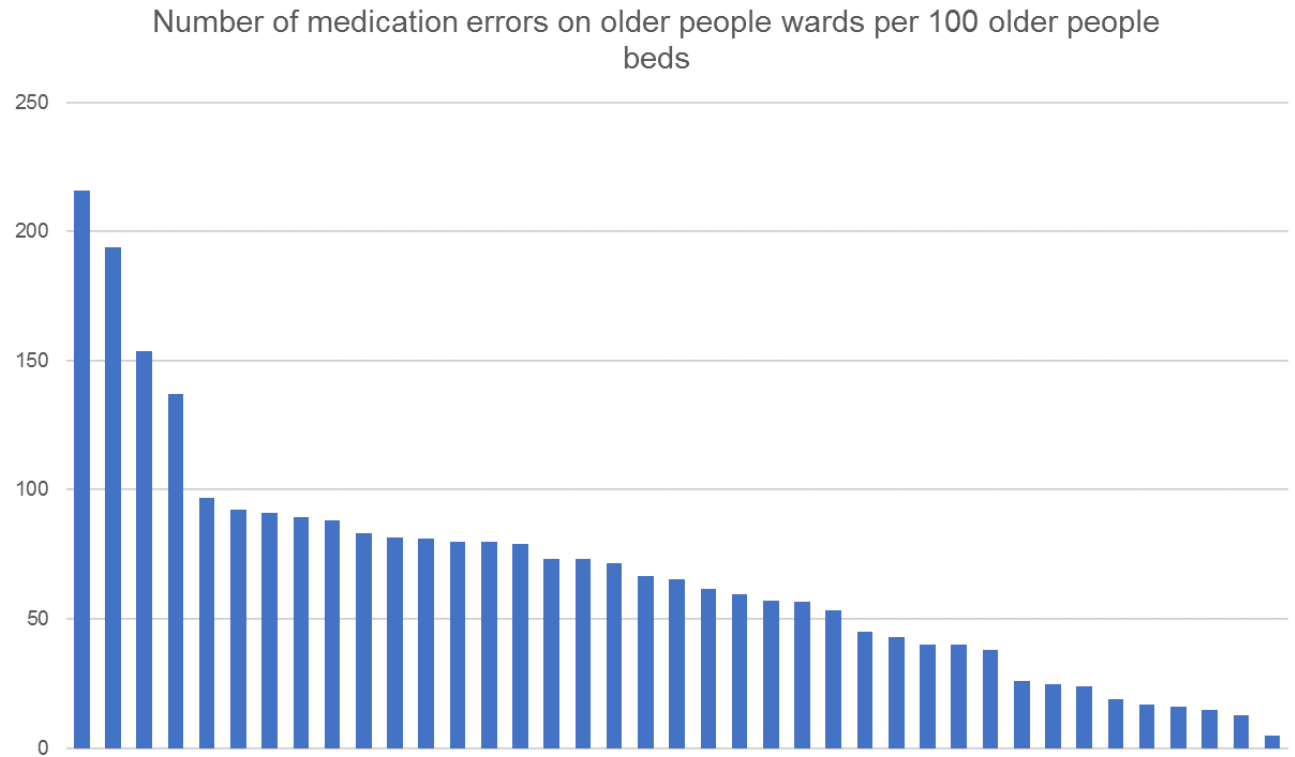
- Trusts / UHBs report on average 9 serious incidents per 100 care of older people beds.
- Of these, 62% of completed within 45 working days.
- Never events are a very rare occurrence in trusts / UHBs. Only 2 trusts reported a never event, keeping the incidence very low at less than 1 per 100 care of older people beds.
- Safeguarding incidents are reported at 21 per 100 care of older people wards.

Number of serious incidents (older people wards) per 100 older people beds



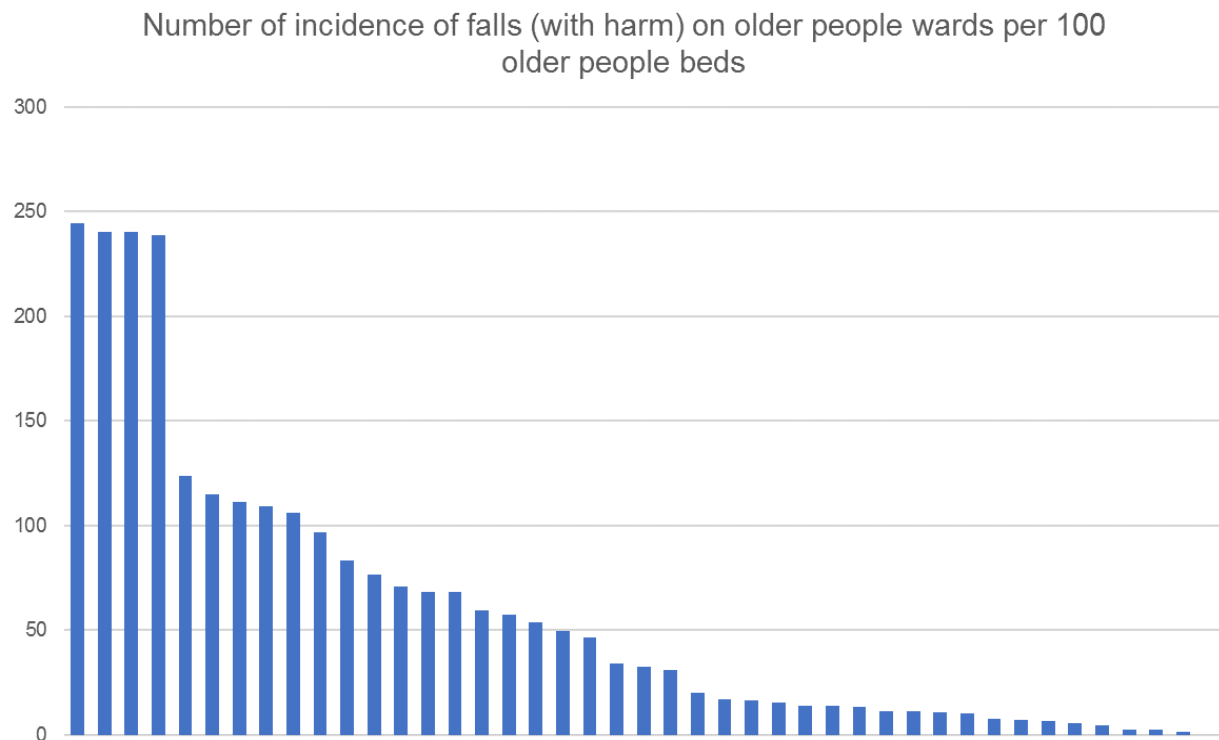
# Medication errors

- Medication errors on care of older people wards averaged 62 per care of older people beds in 2015/16.
- However, the results illustrate large variation in findings, possibly reflecting how trusts / UHBs record medication errors.



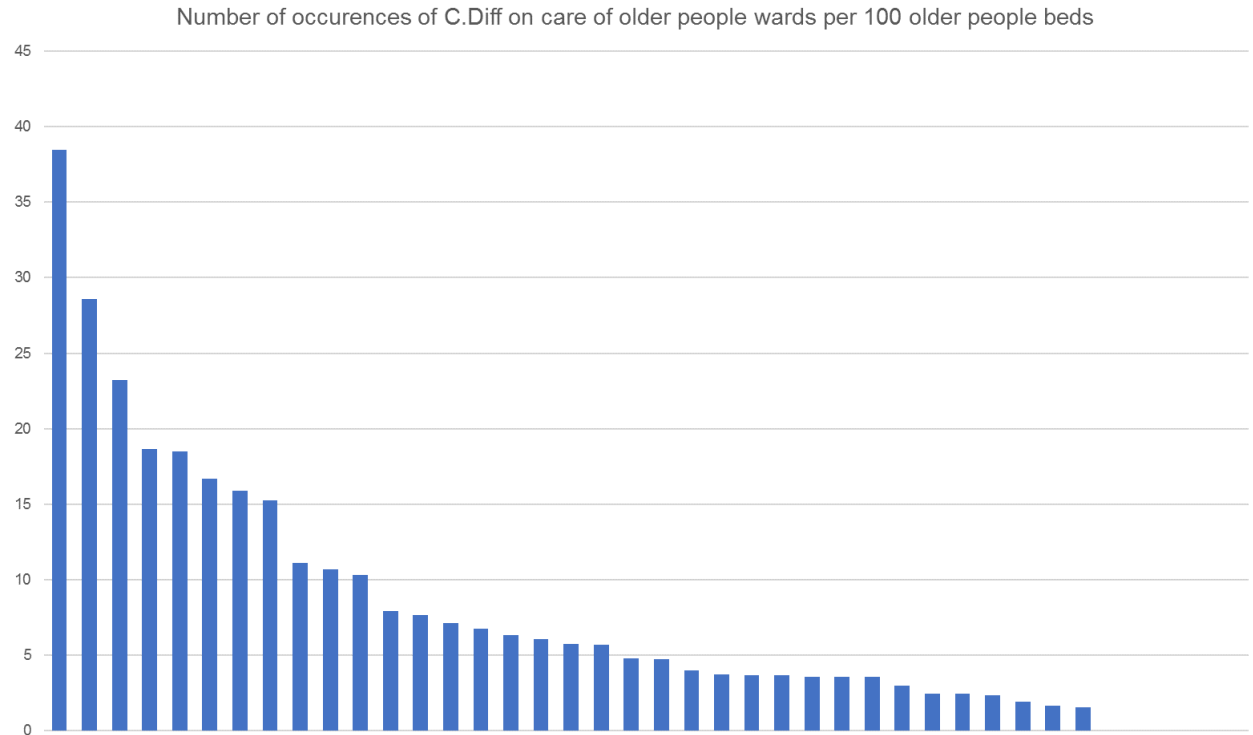
# Incidences of falls

- The mean number of incidences of falls (with harm) per 100 care of older people beds was 59 per year. Again, there is wide variation in reporting.
- Other metrics reported per 100 care of older people beds include:-
  - Incidences of pressure ulcers – 49
  - Occurrences of UTIs – 31
  - Patients catheterised – 163
  - Incidences of new VTEs – 6



# Occurrences of infection

- The number of occurrences of clostridium difficile on the care of older people wards was 8 per 100 care of older people beds.
- The number of occurrences of hospital acquired pneumonia on care of older people wards was 73.5 per 100 care of older people beds.
- Only a few trusts / UHBs reported having an occurrence of MRSA on the care of older people wards. The sample average was reported as 3 per 100 care of older people beds.





Benchmarking Network

# Overall workforce benchmarking



# Nursing workforce across the pathway

	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c & above
Admissions avoidance in A&E	4%	11%	0%	35%	28%	18%	4%	0%	0%
Assessment units	27%	7%	1%	49%	11%	4%	1%	0%	0%
Care of older people ward	38%	6%	1%	44%	6%	3%	1%	0%	0%
Supported discharge team	1%	20%	7%	7%	39%	22%	3%	0%	1%

- It can be noted from the above table that nursing staff have a richer skill mix across both the front-end and the back-end of the acute pathway.
- In particular, the proportion of band 5s and band 6s on inpatient wards is markedly different from the skill mix in assessment units. There is greater use of unregistered nursing staff on care of older people wards, than other areas of the pathway.



# Geriatric team availability across the front-end pathway

Hours of availability over a 24 hour period	Weekday	Weekend
Dedicated geriatric team in A & E	9.3	6.2
Senior medical cover – frailty unit	11.8	10.1
Senior medical cover – short term assessment unit	14.7	12.4
Senior medical cover – other assessment units	13.6	12.1

- There is less senior cover in A & E at both weekdays and weekends than the other parts of the acute pathway.
- All elements of the pathway show reduced senior medical cover at weekends.





Benchmarking Network

# Service user audit

# Service user audit

- The service user audit was run for the first time in 2015, with the aim of adding an extra level of analysis to Trust organisational level data submitted.
- 29 organisations submitted service user audit data – 1,450 individual service users were included in the audit.
- The audit process was as follows:
  - 1 older people ward to carry out the audit on 50 consecutive discharges during the data collection period
  - Data is collected by staff on the ward, no direct patient involvement
  - 11 questions

**NHS Benchmarking Network - CARE OF OLDER PEOPLE IN ACUTE SETTINGS**  
**SERVICE USER AUDIT 2016**

This sheet may be used to collect individual data on the designated care of older people ward.  
 This printable sheet is to assist local data collection only. Do not submit the individual sheets.  
 Please transfer data collected to the collation excel template for submission to us.  
 If you have any queries please contact Tom Davies on tom.davies@nhs.net or 0161 266 1335

No patient identifiable information should be noted on this sheet

Please complete for 50 consecutive patients discharged from one care of older people inpatient ward in the Trust/LHB

1 Age of the service user (years)

2 What was the primary ICD-10 code that the service user was admitted with? (If ICD-10 code not in the list please select 'other')

Code	Admitting reason	Tick one
N39	Disorder of urinary system, unspecified	
R64	Senility	
J22	Unspecified acute lower respiratory infection	
R65	Syncopal and collapse	
R69	Unknown and unspecified causes of morbidity	
R41	Other symptoms and signs involving cognitive function and awareness	
	Other	

3 Has the service user been diagnosed with dementia?

	Tick one
Mild dementia	
Moderate or mid-stage	
Severe or late stage	
Terminal	
No diagnosis	

4 What are the service user's normal living arrangements?

	Tick one
Own home	
Residential home	
Nursing home	
Sheltered Housing	
Unknown	
Other	

5 Has this service user had a hospital admission within the previous 12 months? (Circle one)  
Yes / No

6 Has this service user had an emergency hospital re-admission within the last 30 days? Yes / No  
 (If this current episode is a re-admission please select Yes)

7 At what point in the pathway was CGA delivered to this service user?

	Tick one
In the community/primary care	
A&E	
Assessment unit	
Inpatient ward	
CGA not delivered	

8 What was the length of stay in days for this service user?   
 Include length of stay on assessment units as well as IP ward if applicable

9 Was this patient a delayed transfer of care?

	Tick one
No	
Yes - attributable to NHS	
Yes - attributable to social care	
Yes - attributable to both	

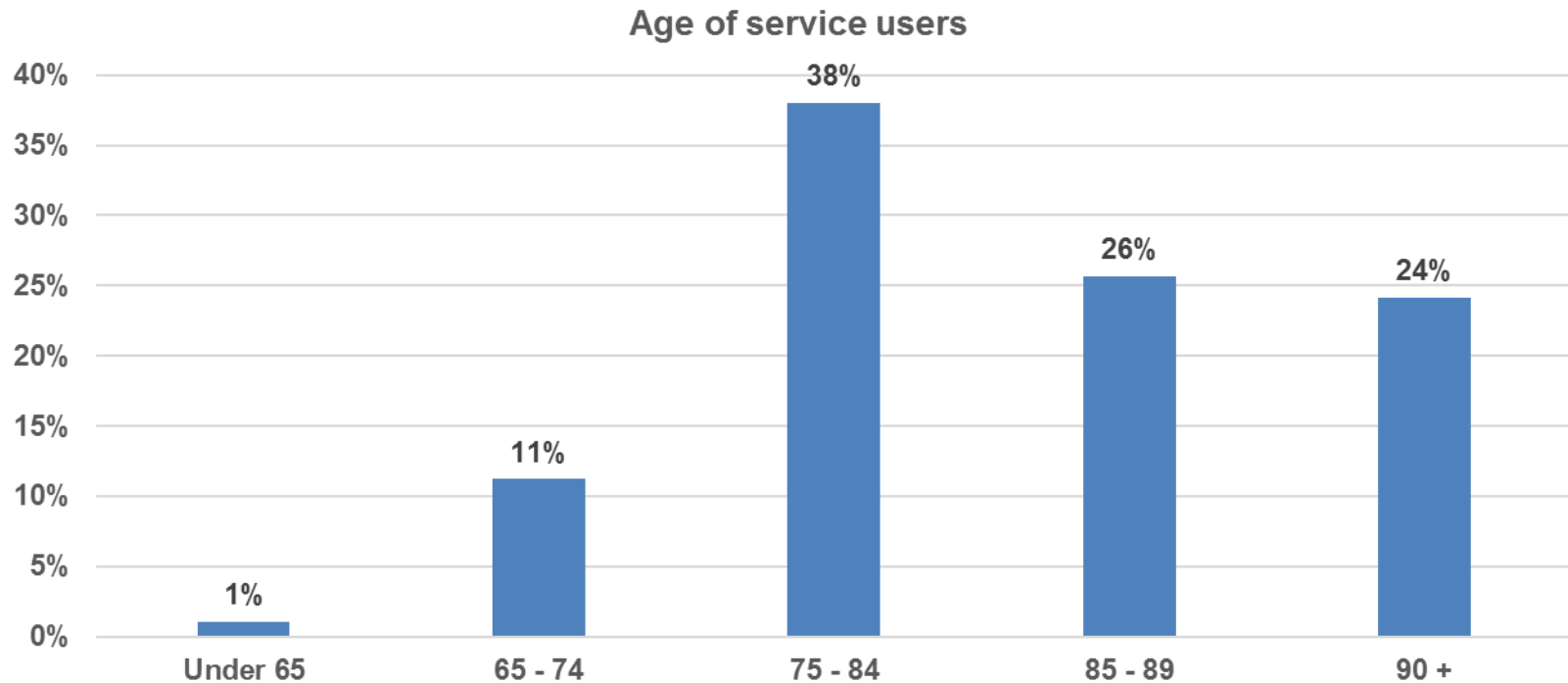
10 How many days was this patient delayed?

11 Where was this service user discharged to?

	Tick one
Own home	
Residential home	
Nursing home	
Sheltered Housing	
Transitional arrangements	
Hospice	
Died	
Other	



# Service user age profile

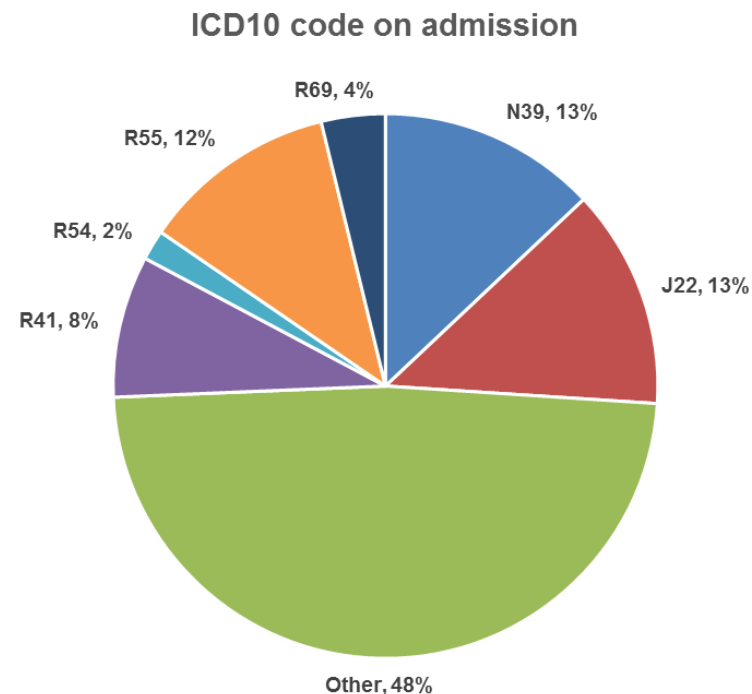


- 38% of patients on the older people wards were aged 75 – 84.
- 50% of the cohort were aged 85 and over.
- Participants are able to view the age split of their patients on the online toolkit, located on the NHS Benchmarking Network members' area.



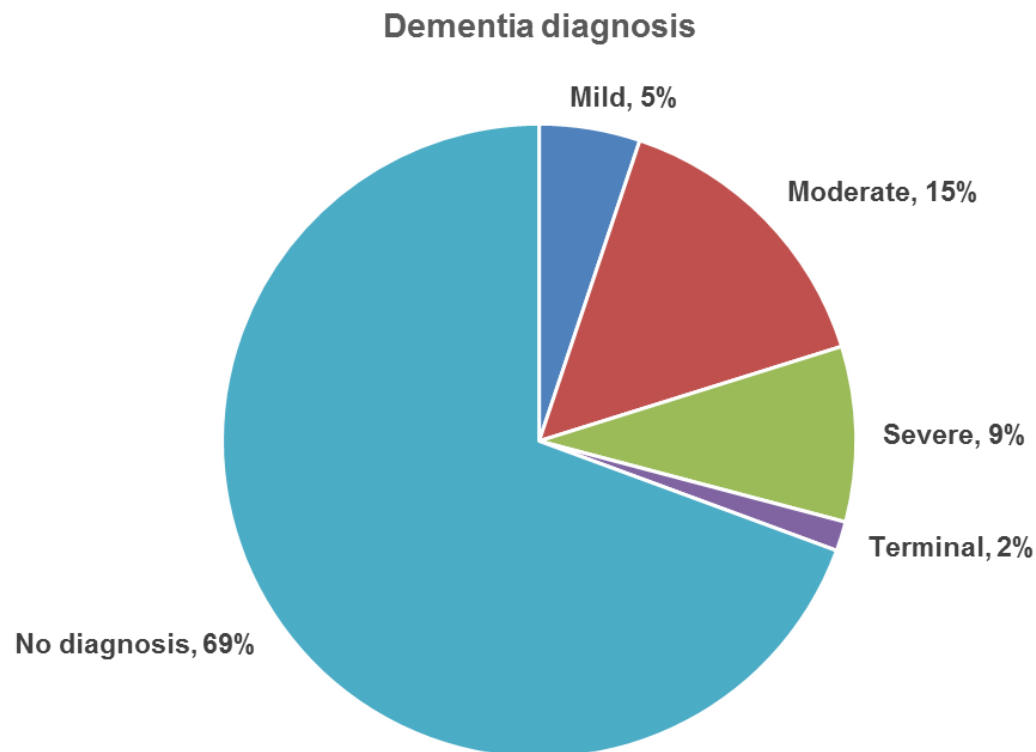
# ICD-10 code on admission

- The service user audit enabled the benchmarking of the numbers of patients admitted with frailty or frailty related conditions. As there's no ICD10 code for frailty as yet, the NHSBN worked with the British Geriatrics Society to select a number of ICD-10 codes which might be associated with frailty. These proxy frailty codes may give an indication of the number of people being admitted with symptoms or conditions associated with frailty.
- 6 ICD-10 codes were collected as 'proxy frailty codes'.
  - N39 - Disorder of the urinary system, unspecified
  - R54 - Senility
  - J22 - Unspecified acute lower respiratory infection
  - R55 - Syncope and collapse
  - R69 - Unknown and unspecified causes of morbidity
  - R41 - Other symptoms and signs involving cognitive function and awareness
  - Other
- 52% of patients admitted had a primary ICD10 code that could be a proxy measure for frailty.



# Dementia diagnosis

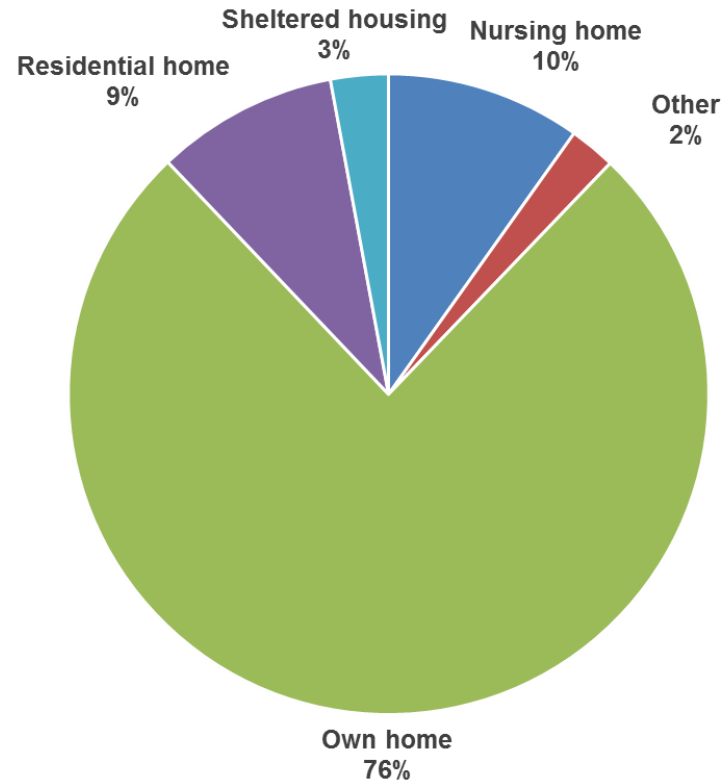
- A new question on dementia diagnosis was added into the service user audit this year.
- 31% of patients had a recorded dementia diagnosis
  - 5% 'mild'
  - 15% 'moderate'
  - 9% 'severe'
  - 2% terminal
- The results are consistent with research which suggests that 31% of older people in hospital will have dementia.
- 69% had no dementia diagnosis.



# Normal living arrangements

Normal living arrangements were found to be:-

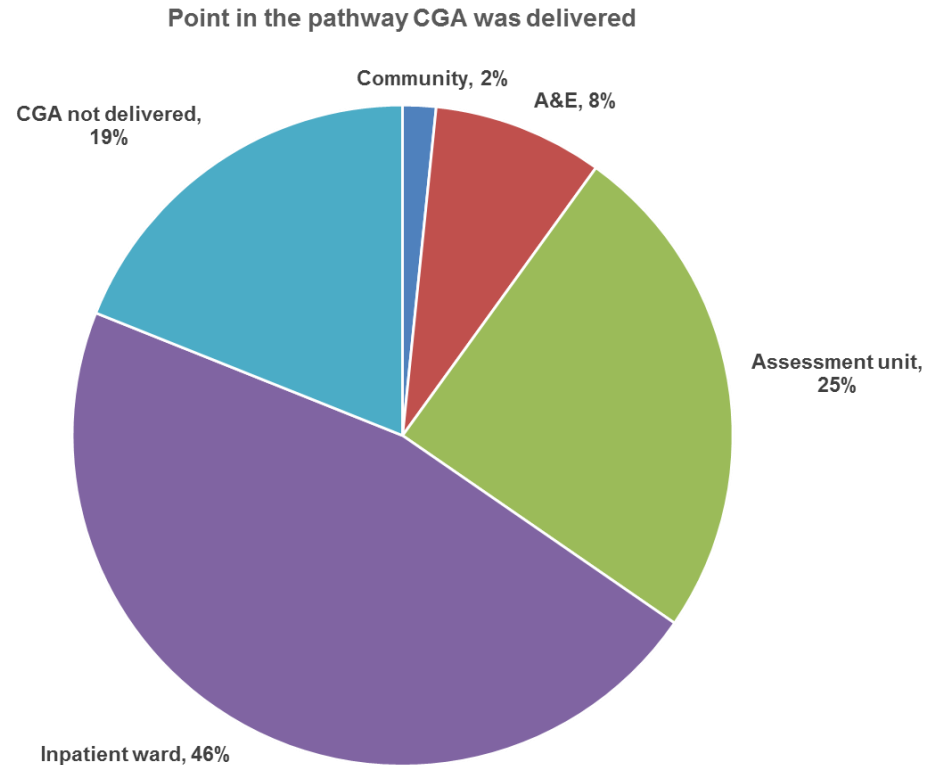
- Own home – 76%
- Residential home – 9%
- Nursing home – 10%
- Sheltered housing – 3%
- Other – 2%





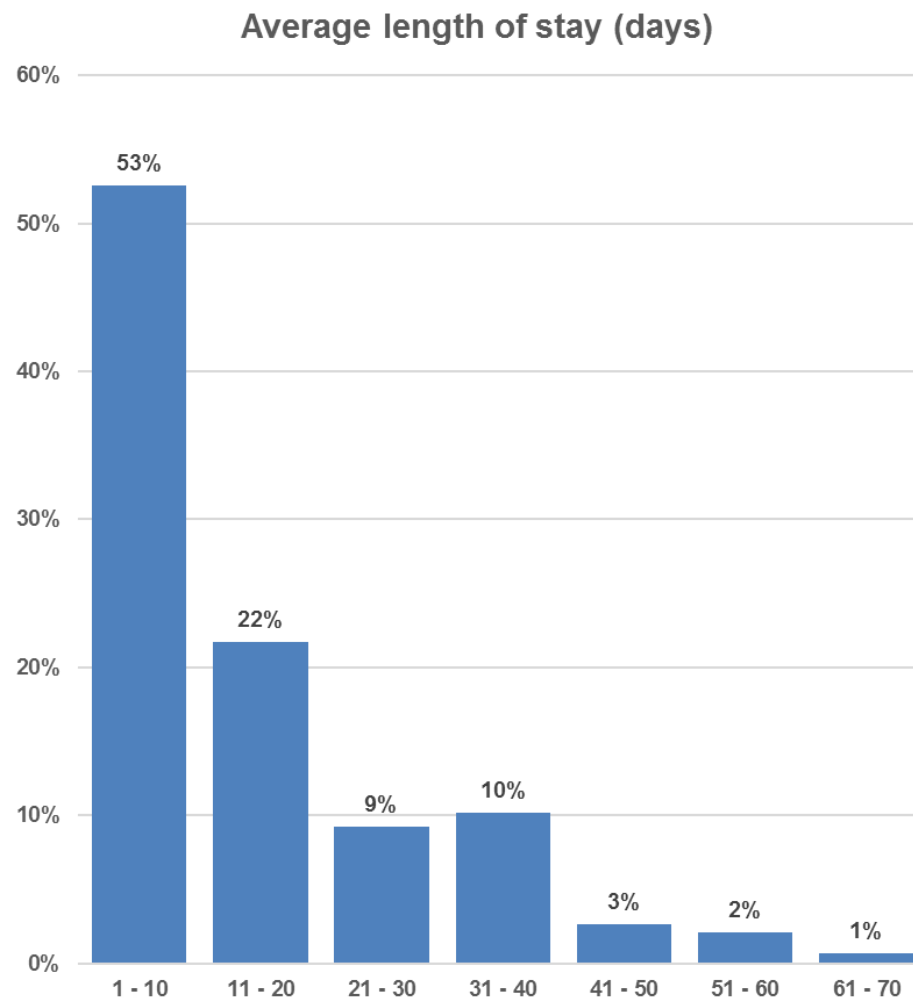
# Comprehensive Geriatric Assessment (CGA)

- 81% of service users received CGA which was fully documented
  - 8% received CGA in A&E
  - 25% on assessment unit
  - 46% on inpatient ward
  - 2% in community
- Appendix 1 has the full CGA definition

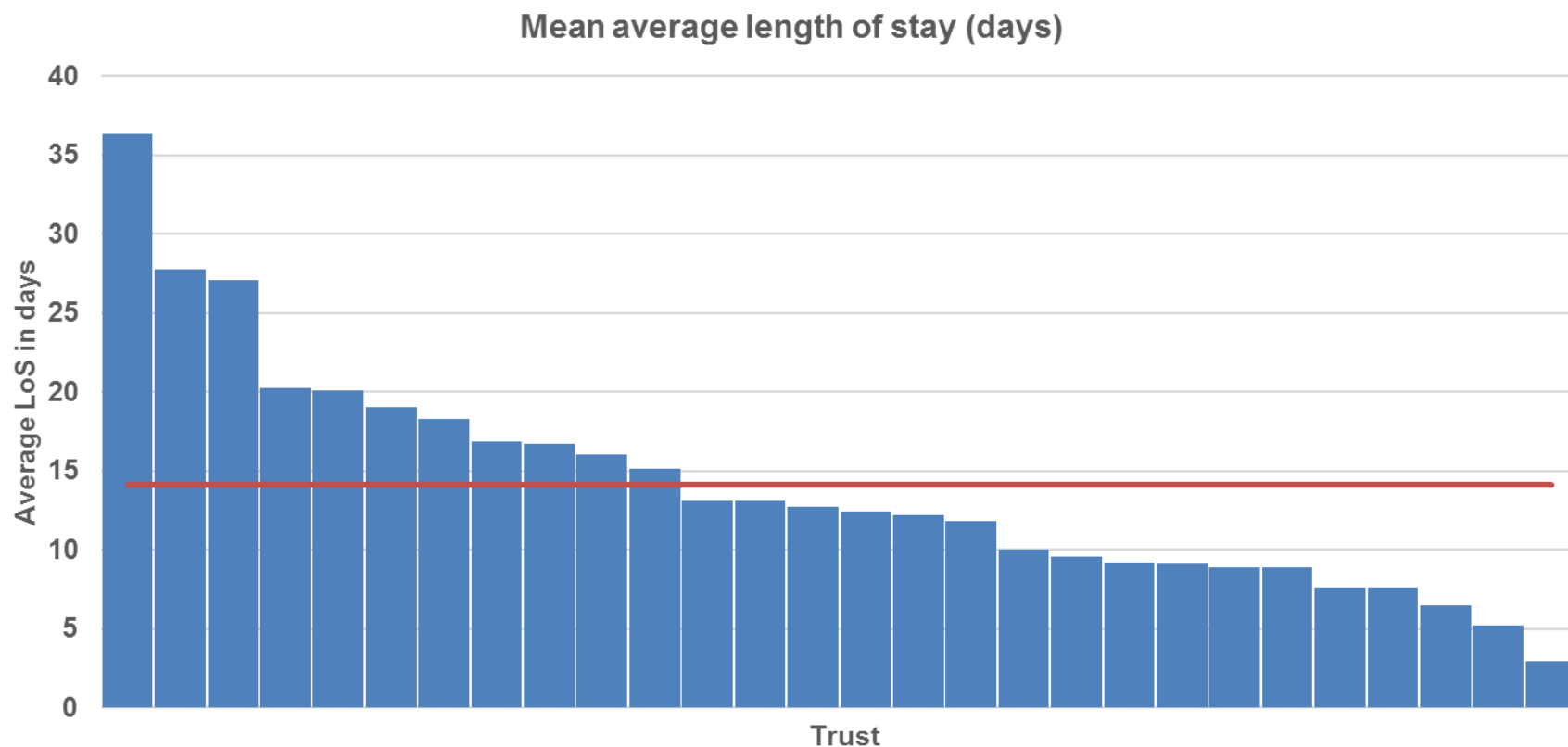


# Length of stay

- Average length of stay recorded in the service user audit was 14 days (from admission to hospital to discharge from older people ward) and the median value was 9 days.
- 53% of patients stayed for 10 days or less  
22% had a length of stay of 11 – 20 days  
25% had a length of stay greater than 21 days
- In terms of previous admissions:-
  - 56% of patients included in the service user audit had a hospital admission within the last 12 months
  - 26% of patients included in the service user audit were an emergency re-admission within 30 days of admission



# Mean average length of stay

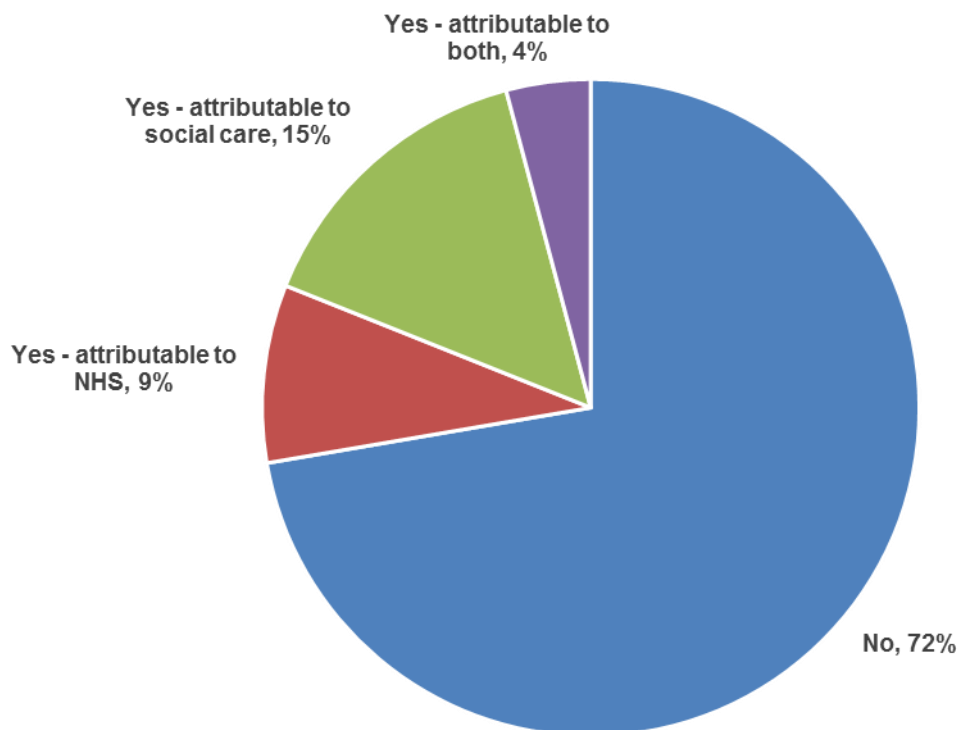


- The average length of stay for each participating organisation was calculated from the service user data received.
- The Trust / UHB average lengths of stay show wide variation from 36 days to 3 days range.

# Delayed transfers of care (DToC)

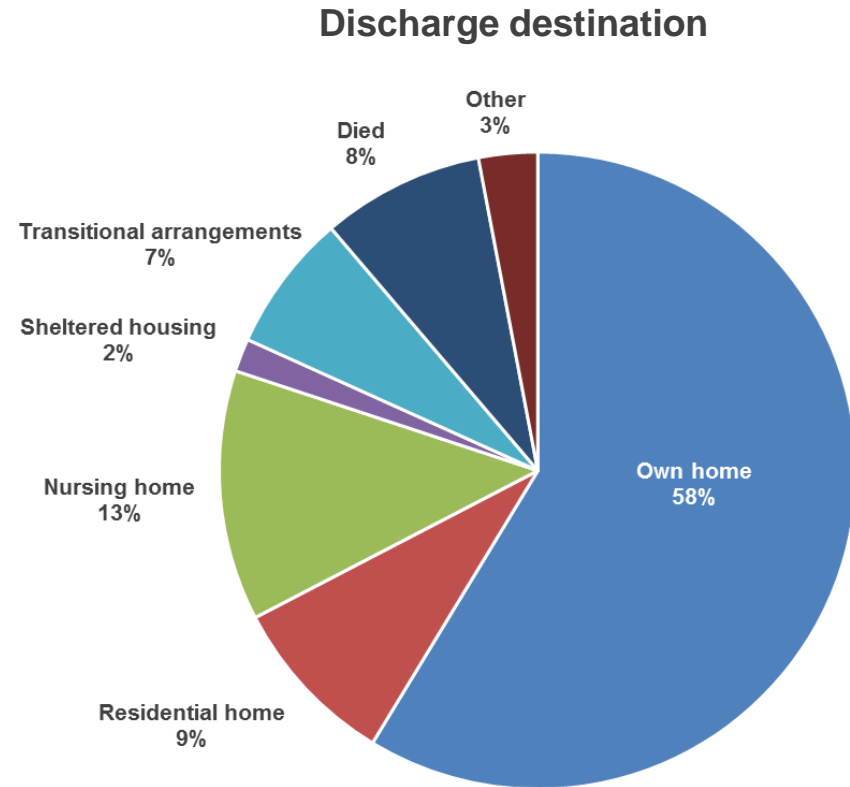
- 28% of patients in the service user audit were a delayed transfer of care.
- On average, the length of a DToC was 12 days (the median position reported was 7 days).
- In terms of the whole service user length of stay, it was calculated that 42% of this stay was attributable to days delayed.

## Was this patient a delayed transfer of care?



# Discharge destination

- 58% of service users were discharged to their own home. This compares to 76% of the cohort who were admitted from their own home.
- 9% of service users were discharged to a residential home and 13% were discharged to a nursing home.
- 7% of patients were discharged to transitional arrangements.
- 8% of the patient cohort died.



# Admissions from a nursing home

	Patients admitted from a nursing home	All patients
Average age	85 years	84 years
Percentage with a dementia diagnosis	73%	31%
Percentage admitted with a proxy frailty code	56%	52%
% who have had a hospital admission in last 12 months	58%	56%
% with emergency readmission in last 30 days	25%	26%
% receiving CGA	83%	81%
Average LoS	13 days	14 days
% who were a DToC	24%	28%

- From the service user audit, the cohort of patients who were admitted from a nursing home was extracted.
- The table above illustrates that the percentage of service users with a dementia diagnosis from a nursing home is more than double that of the whole sample.



# Dementia diagnosis

	Patients with a dementia diagnosis	All patients
% admitted with a proxy frailty code	64%	52%
Average LoS	15 days	14 days
Delayed transfer of care:		
No DTOC	65%	72%
NHS	8%	9%
Social care	23%	15%
Both	4%	4%
Usual place of residence:		
Own home	55%	76%
Nursing home	23%	10%
Residential home	18%	9%
Discharge destination:		
Own home	35%	58%
Nursing home	29%	13%
Residential home	16%	9%

- The cohort of patients with a dementia diagnosis was extracted from the whole sample for further analysis.
- Patients with a dementia diagnosis on average had a length of stay one day longer than the full sample.
- A lower percentage of patients were admitted to acute care from their own home (55% compared to 76%), and in terms of discharge back to their own home, 35% of patients with a dementia diagnosis went back home compared to 58% in the total patient sample.



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# Conclusion and next steps



# Conclusion and next steps

- This report presents the findings from the 2016 Older People's Care in Acute Settings project. All data presented in this report is 2015/16 outturn data. It is the third iteration of the project and has included data from 47 trusts / UHBs who between them made 56 submissions. The data the participating organisations have provided has enabled benchmarked comparisons to be made which are not available elsewhere in the NHS. The service user audit has provided further granularity on the service user's episode of care.
- Participating organisations have access to a comprehensive online benchmarking toolkit, allowing them to view their positions on hundreds of metrics covering service models, activity, workforce, finance and quality and outcomes across the acute pathway. The full findings from the service user audit have also been included. Participants have also been issued with bespoke dashboard reports, highlighting their position on key metrics against other participants. These have also been peer group profiled.
- The findings from this project were presented at a national conference in February 2017 and were well received by members. The Network Steering Group have agreed that the Older People's Care in Acute Settings project will not run as part of the 2017/18 work programme. Instead, there will be a project which collects data on Delayed Transfers of Care (DToCs) in a deeper dive. Data on DToCs will also be collected in other key projects, such as Mental Health, Community Services and the National Audit of Intermediate Care (NAIC).
- Members of the Network are able to access the online benchmarking toolkit to view their own benchmarked position on all metrics in this report at [www.nhsbenchmarking.nhs.uk](http://www.nhsbenchmarking.nhs.uk). To obtain a member login (or if your password has been forgotten), please contact Ashley Spencer on [ashley.spencer1@nhs.net](mailto:ashley.spencer1@nhs.net).
- The 2016/17 project is now complete. Any feedback should be e-mailed to Debbie Hibbert, Project Manager at [Debbie.Hibbert@nhs.net](mailto:Debbie.Hibbert@nhs.net).





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# Appendix 1

# Definition of Comprehensive Geriatric Assessment (CGA)

Comprehensive geriatric assessment (CGA) is a multidimensional and usually interdisciplinary diagnostic process designed to determine a frail older person's medical conditions, mental health, functional capacity and social circumstances. The purpose is to plan and carry out a holistic plan for treatment, rehabilitation, support and long term follow up. CGA is part of an integrated approach to assessment based on the following principles:

- The older person is central to the process
- Their capacity to participate voluntarily must be assessed, and if lacking, then there needs to be a system to address their needs in an ethical fashion.
- Links between social and health care should be good enough for older people who need comprehensive assessment to receive it in a timely and efficient manner, and proportionate to their degree of need.
- Assessments should be standardised and carried out to a reliable standard

Circumstances which warrant a comprehensive assessment include, among others -

- Acute illness associated with significant change in functional ability
- Transfers of care for rehabilitation/re-enablement or continuing care
- A frail patient prior to surgery or experiencing two or more "geriatric syndromes" of falls, delirium, incontinence or immobility.

For further information see British Geriatrics Society <http://www.bgs.org.uk/index.php/good-practice-guides/195-gpgcgassessment84>

