

Older People in acute settings

Benchmarking report

April 2015



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Section 1:

Foreword



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Foreword



Professor John Gladman, British Geriatrics Society representative to the Older People project

There is much to be proud of about the care of older people in the UK. I reflect that, as a doctor who qualified in 1983, there were parts of the country at that time where older people were denied access to district general hospitals, or could do so only through a separate “on-take” system. Some were good, some were not. Specialist care for older people was often in sub-acute sites, some of which provided exceptional rehabilitation and palliation but not acute care. Over the decades, the notion of the “integrated take” became the default model for hospital admission for acutely unwell patients, whereby all such patients regardless of age had access to the same system. Over the same time, geriatric wards in acute hospitals were increasingly established, delivering that evidence based jewel - comprehensive geriatric assessment. All this was very welcome.

Over these same decades the numbers of patients rose and the number of beds fell. The model that emerged at the “front door” under such pressure was the medical assessment unit, short term (<72 hours) wards in which patients presenting as emergencies had access to acute diagnostics, therapeutics and triage – following which some patients could be discharged and others admitted to specialist wards for further care. This model is particularly necessary in the UK given the requirement for patients to stay in emergency departments for no longer than 4 hours. The model of care in medical assessment units is the classical medical model – designed to seek and treat single medical diagnoses quickly and effectively. At the same time, there has been an increase interest in community provision so as to prevent or shorten hospital admissions – hospital-at-home and intermediate care services.

There is increasingly recognition that older people are the major users of both hospital and community services, and yet that the system in place may be failing some of them – particularly those who are vulnerable through conditions such as dementia or the cumulative effects of multiple health and social problems. So now is an ideal time to take stock of what is happening across the entire acute care system. How much variability is there, and is this justifiable? To what extent are the specific needs of vulnerable older people being catered for, particularly in the urgent care parts of the pathway (emergency departments and medical assessment units)? What can be learned from the innovations and instances of excellence across the country?

This report provides a rich and up-to-date picture of the hospital care of older people in the UK that will be of immense value to support logical and informed improvements in the effectiveness and efficiency of acute care services for older people. I urge commissioners and providers to look closely at this report, to look critically at the services that they provide, to use this to drive forward improvements in the services they are responsible for, to participate in future iterations of this project, and to demonstrate continuing improvement.



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Section 1:

Executive summary



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Executive summary

Introduction

- This report presents the findings from the first phase of a national benchmarking project looking at older people in acute settings. The project has been led by the NHS Benchmarking Network (NHSBN), and developed in partnership with the British Geriatrics Society. The topic was identified as a priority area for the Network's work programme for 2014/15.
- The project was available for participation from all members of the NHS Benchmarking Network who offer care of older people in the acute setting. There were 47 participating Trusts and Local Health Boards (LHBs) in this first iteration of the project.
- The report and online toolkit present the findings of the project across the four areas of the pathway that are explored. The four elements of the acute pathway reviewed are admission avoidance in A&E, assessment units, inpatient care and supported discharge. Within each area of the pathway the service models, activity, workforce and finance data is explored. Key quality indicators are also presented, as well as an extensive good practice and innovation section.
- The NHS is faced with the demands of an ageing population and increasing numbers of people are living with multiple long term conditions. The *NHS Five Year Forward View* (NHS England, October 2014) acknowledges that the service is facing enormous challenges in continuing to provide support to frail, older people. Whilst data exists looking at the care of older people in specialist areas, for example stroke, there is little data looking at the pathway as a whole, as older people navigate through secondary care. This project provides a unique data set on the pathway of older people in secondary care, from what happens in A&E and assessment units, through inpatient care and finally ending with supported discharge processes.
- It is worth noting that the NHS Benchmarking Network runs a number of other benchmarking projects where data on the care of older people is collected and benchmarked. Most notably, the combined Mental Health Inpatients and Community project, the National Audit of Intermediate Care from 2012 to 2014, and the Integrated Care project, which is a commissioner based benchmarking project reviewing the commissioning of services for older people. It is worth examining the outputs from these projects to give a wider perspective on the care of older people in your locality.
- This benchmarking project reviews the activity of older people in secondary care by examining the proportion of activity that is related to those aged 65 and over. This approach was agreed at the scoping session for the project due to the difficulties with a finding a common technical definition for "frailty".
- The project also aims to explore links with other sectors, including primary care, community and mental health. The involvement of social care during admissions and discharges was of particular interest when designing the project.

Executive summary

- Findings presented within this report have been validated with participating Trusts / LHBs, and the report aims to give an overview of the findings of the project. An online tool is available to participating organisations, where they are able to view their own benchmarked position on key indicators, and drill down further to explore how their services compare with others nationally.
- Older people living with frailty, dementia and complex co-morbidities are now core business for both the statutory and the independent sector in all care settings. The recent *Commission on Hospital Care for Older People* (Health Service Journal / Serco, March 2015) recognised that people aged 65 in England can expect to live two more decades. By 2030, projected life expectancy at 65 will be 88 for men and 91 for women. One in four hospital inpatients has dementia, and 1 in 3 adults admitted acutely to hospital are in the last year of their life. The care of older people in acute settings continues to be a priority area, with most Trusts / LHBs facing pressures from increased A&E attendances at the front door of the hospital and delayed transfers of care at the back end.
- The NHS Benchmarking Network intends to run the project again in the 2015/16 work programme.

Key findings

- **Overview**
 - 35% of Trusts / LHBs have a recognised frailty tool/pathway in use in the health and social care economy.
 - 57% of Trusts / LHBs have a clearly defined strategy/operational policy for the delivery of acute medical care to older people.
 - 90% of Trusts / LHBs have a designated Clinical Lead for Older People's services in the Trust/LHB.
 - 37% of organisations have an outliers policy which specifically mentions the management of Older People in acute care, and 50% reported that they have a policy locally which related to the movement of older people once admitted to hospital.



Executive summary

- The cost of each area of the pathway was explored, and it was found that 65% of expenditure on older people's services was for care of elderly wards and inpatient care. 30% of total spend was on assessment units, 4% on the supported discharge process and 1% on admissions avoidance in A&E.
- Spend on bank, agency and overtime staff varies significantly between Trusts / LHBs. It is noted that where Trusts / LHBs spend more on overtime and bank staff, they typically spend less on agency staff.

Older people in A&E

- **Service models**
 - 24% of participating Trusts / LHBs have a dedicated geriatric team located in the A&E department. 85% report therapists are available in A&E to assist with admission avoidance of older people. 62% of organisations have rapid access to social workers in A&E, and 44% report that in-reach is provided by the Hospital Discharge Team.
 - Hours of availability of teams in A&E typically decrease at weekends. A dedicated geriatric team is typically available for 9 hours per day during the week, reducing to 6.5 hours per day at weekends. Availability of other teams is explored later in the report.
- **Activity**
 - 23% of A&E attendances are by those aged 65 and over, and 46% of admissions from A&E are aged 65 and over.
- **Workforce**
 - The skill mix of nursing staff, AHPs and social care professionals is typically rich in this area, with staff generally being from higher bandings than compared to inpatient care.
 - The presence of locums within the medical team is highest in the A&E department, with 7% of the dedicated geriatric team being locums.

Assessment units

- **Service models**
 - 30% of Trusts/LHBs have a frailty unit, with 42% using a recognised frailty tool within the frailty unit. 90% of frailty units use Comprehensive Geriatric Assessment, and 77% have a dedicated geriatric team located in the frailty unit.

Executive summary

- All Trusts / LHBs report clinical leadership on the frailty unit is by a Geriatrician. Senior medical presence is typically available for 13 hours per day during the week and 10 hours per day at weekends.
- 77% of Trusts / LHBs have a short-term assessment unit (up to 12 hours stay), with 18% using a recognised frailty tool within the short term assessment unit. Comprehensive Geriatric Assessment takes place in 42% of short term assessment units. 30% have a dedicated geriatric team located in the short term assessment unit. The average short term assessment unit has 33 beds, with clinical leadership typically being provided by a General Physician.
- 85% of Trusts / LHBs have other assessment units (between 12 and 72 hours expected maximum length of stay). 17% of these assessment units utilise a recognised frailty tool, and 28% use comprehensive Geriatric Assessment. The average number of beds on the other assessment units is 44. Clinical leadership on these units is typically provided by a General Physician.
- Vital signs are the only routine assessment carried out by 100% of Trusts / LHBs. Depression is routinely assessed for in just 44% of Trusts / LHBs.
- **Activity**
 - Over two thirds of admissions to assessment units are from A&E (68%), with 26% being admitted from their GP. 52% of admissions to assessment units are aged 65 and over, and 64% of admissions to inpatient care from assessment units are of older people. The average length of stay on all assessment units is 26 hours.
- **Workforce**
 - The nursing skill mix in assessment units is comprised of 65% registered nurses and 35% unregistered nurses. The AHP skill mix is largely made up of band 6 staff (52%).
- **Finance**
 - The average cost per admission to assessment unit was £311, although this figure showed wide variation from £60 to £594 per admission.

Executive summary

Inpatient care

Service models

- The average number of elderly care beds per Trust / LHB is 106 beds. Comprehensive Geriatric Assessment is delivered on 87% of elderly care wards, and 23% of other speciality wards. All inpatient wards have regular ward and board rounds. A social worker or supported discharge co-ordinator forms part of the MDT on elderly care wards in 86% of Trusts / LHBs.

Activity

- The average length of stay for emergency admissions for all ages is 5.6 days. This LOS increases to 7.5 days for emergency admissions for ages 65-74, 9.3 days for ages 75-84, and 10.9 days for ages 85+.
- The spells with an average length of stay of longer than 21 days account for 5% of spells in inpatient care, and 41% of all occupied bed days.

Workforce

- The nursing skill mix has the lowest ratio of registered to unregistered nursing staff, 44% registered to 56% unregistered.
- The average medical WTE per elderly care bed is 0.24 WTE.

Discharge process

Service models

- There is a documented supported discharge protocol consistently applied across all wards in 87% of Trusts / LHBs. 23% of organisations have an integrated discharge team and, where supported discharges do not go through the IDT, they are dealt with directly by ward staff. All organisations reported that inpatient wards have dedicated ward discharge co-ordinators.
- 85% of Trusts / LHBs operate Early Supported Discharge schemes, with 37% having access to dedicated Pharmacy advice for supported discharges.
- The average length of time for a continuing healthcare assessment to take place is 12 days.

Executive summary

- **Workforce**
 - The skill mix of the supported discharge team is rich, with 97% of nurses being registered and 13% unregistered. 91% of the AHP workforce is registered, and the social care skill mix has a higher banded workforce.
- **Quality**
 - Quality metrics are benchmarked per 100 care of the elderly beds to allow for comparisons between Trusts / LHBs of different sizes.
 - All quality metrics show variations in the numbers reported by Trusts / LHBs. It is acknowledged that Trusts / LHBs have differences in their definitions of certain metrics, and the NHS Benchmarking Network are keen to work with members to develop standardisation across quality metrics.
 - The mean number of formal complaints per 100 care of the elderly beds per annum is 22. Safeguarding incidents per 100 elderly care beds per annum average 16 incidents.
 - Incidences of falls (with harm) on elderly care wards per 100 elderly care beds average 36 falls.

Good practice

- Participating organisations were asked to provide any good practice in the services covered in this project. A large number of good practice examples have been provided by the participants in the project. These are detailed at the end of the report.



Section 2:

Background and process



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Background to the older people project

- At the end of the 2013/14 benchmarking year, the care of older people in acute settings was identified by the Network membership as a priority for the following year. The project proposal was put to the Network Steering Group, who decided to include the project in the 2014/15 work programme.
- A reference group met in February 2014 to scope out the project. The group comprised of members from acute Trusts / LHBs. The project scoping was also assisted by Professor John Gladman, 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
 - In patient care
 - Supported discharge
- The reference group debated using “frailty” to define the project cohort, but due to the word having many definitions, it was agreed to concentrate upon the 65+ age group activity data instead.
- After this reference group meeting, an initial data specification was designed by the NHS Benchmarking Network team, and shared with reference group for further refinement. A final version of the data specification was agreed with the reference group.
- Data collection for the project opened in July 2014 and closed in September 2014. 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 / LHBs on the members area of the website at www.members.nhsbenchmarking.co.uk
- The findings from the project were presented at a national conference in London on the 25th February 2015, along with good practice examples from members.



Background to the older people project

- The following objectives for the project were agreed by the Reference Group at the group's first meeting in February 2014:
 - To support service improvement through the provision of benchmarked comparisons on key metrics
 - To provide evidence for future planning, workforce design and discussions with commissioners
 - To support the development of outcome measures
 - To identify and share good practice
 - To support networking between Trusts / LHBs
 - To act as a national reference point for comparative data on the acute care of older people



Section 3: Benchmarking comparisons



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Overview



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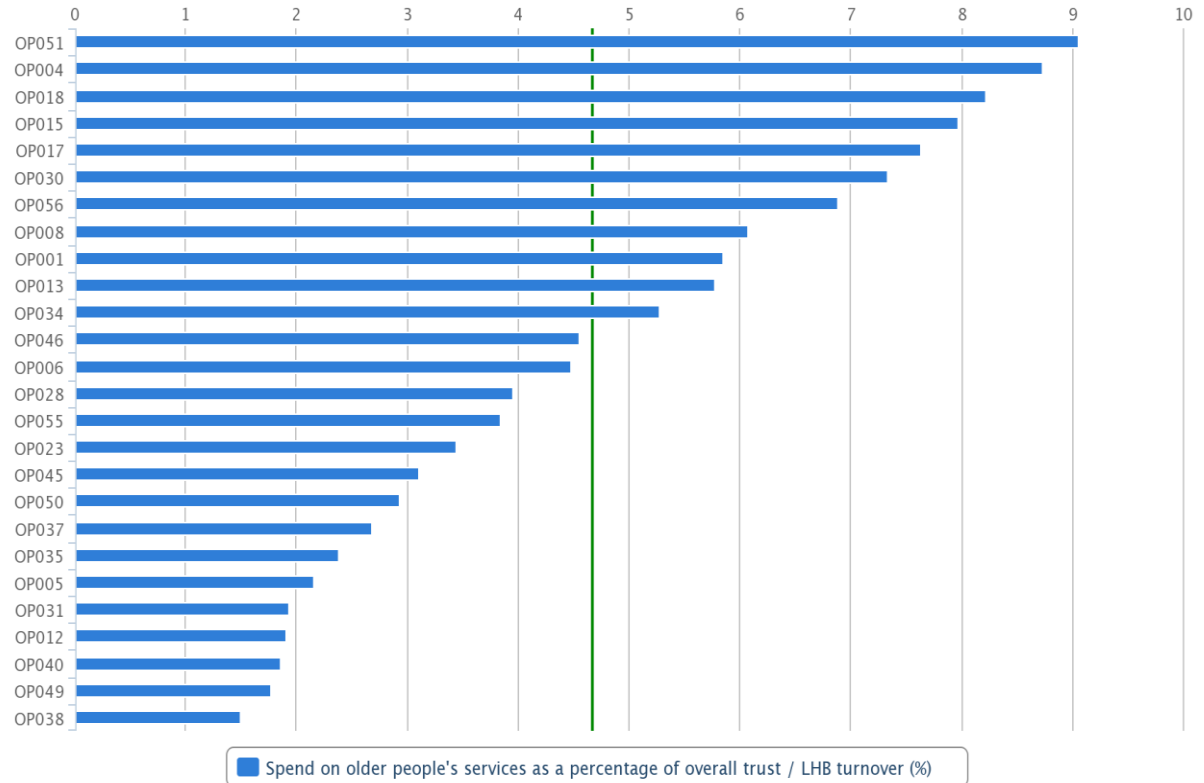
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Participant overview

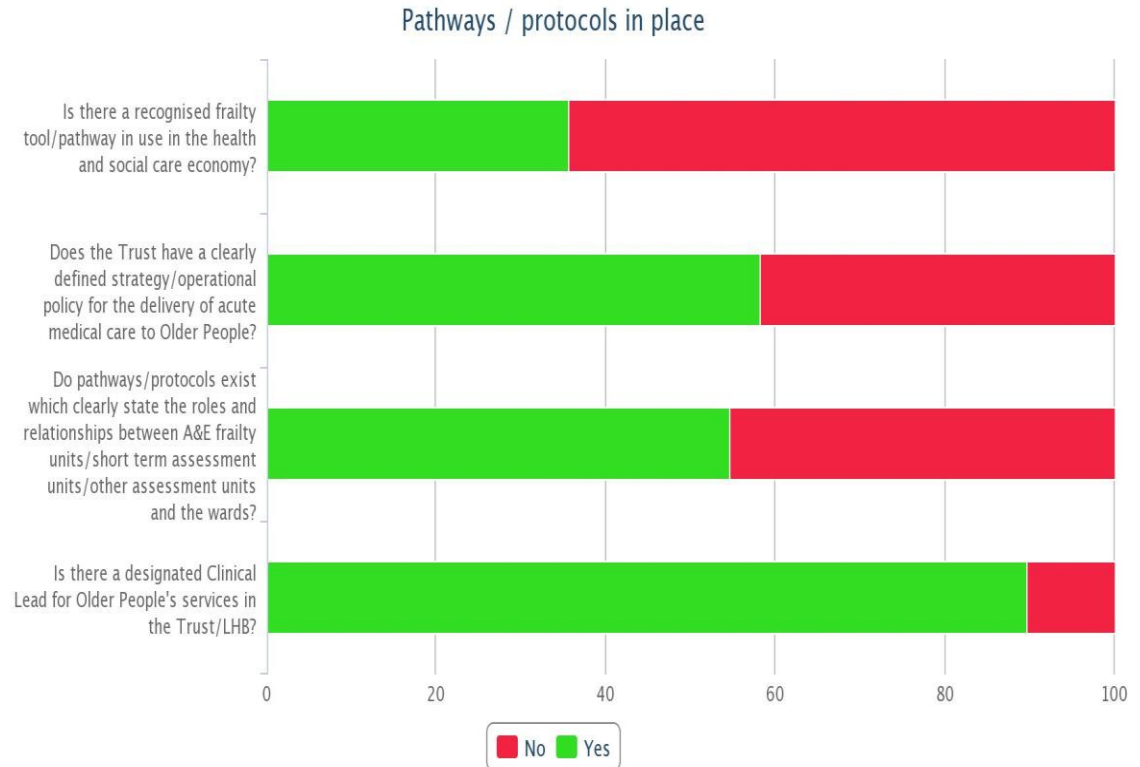
- Participating Trusts / LHBs ranged in size, from smaller district general hospitals to large teaching hospitals and Welsh LHBs. Trusts / LHBs were able to submit more than one data submission, for example if they provided services for older people on three acute hospital sites.
- The turnover of participating Trusts / LHBs ranged from £50 million to £930 million. The mean turnover was found to be £339m.
- The total number of staff employed by Trusts / LHBs ranged from 747 WTE to 14,447 WTE. The mean WTE employed by Trusts / LHBs was 5,864 WTE.
- Spend on older people's services as a percentage of overall Trust / LHB turnover ranged from 1.5% to 9% and the average was 4.7%. It is important to note that this is just the four elements of the pathway benchmarked.

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



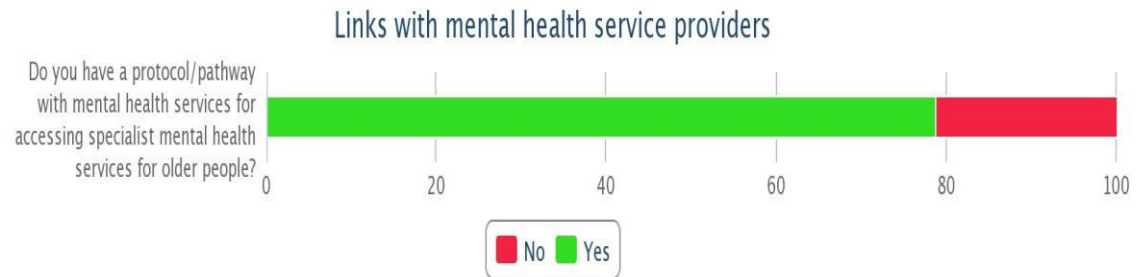
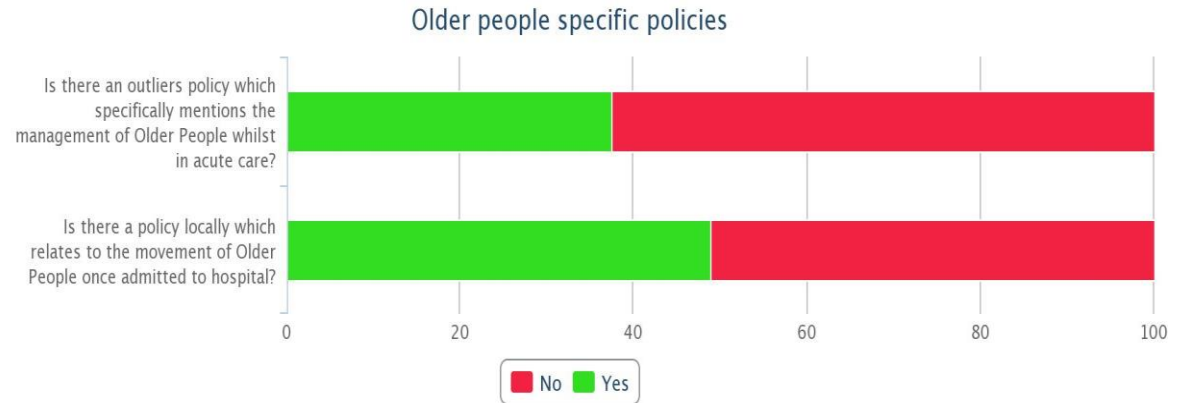
Pathways and protocols in place

- Participating Trusts / LHBs were asked to identify pathways and protocols in place for the care of elderly patients.
- 35% of providers used a recognised frailty tool or pathway within their health and social care economy.
- 57% of Trusts / LHBs have a clearly defined strategy or operational policy for the delivery of acute medical care to Older People
- In 56% of providers, pathways or protocols exist which clearly state the roles and relationship between A&E, frailty units and assessment units and the wards
- There is a designated clinical lead for Older People's services in 90% of Trusts/LHBs.



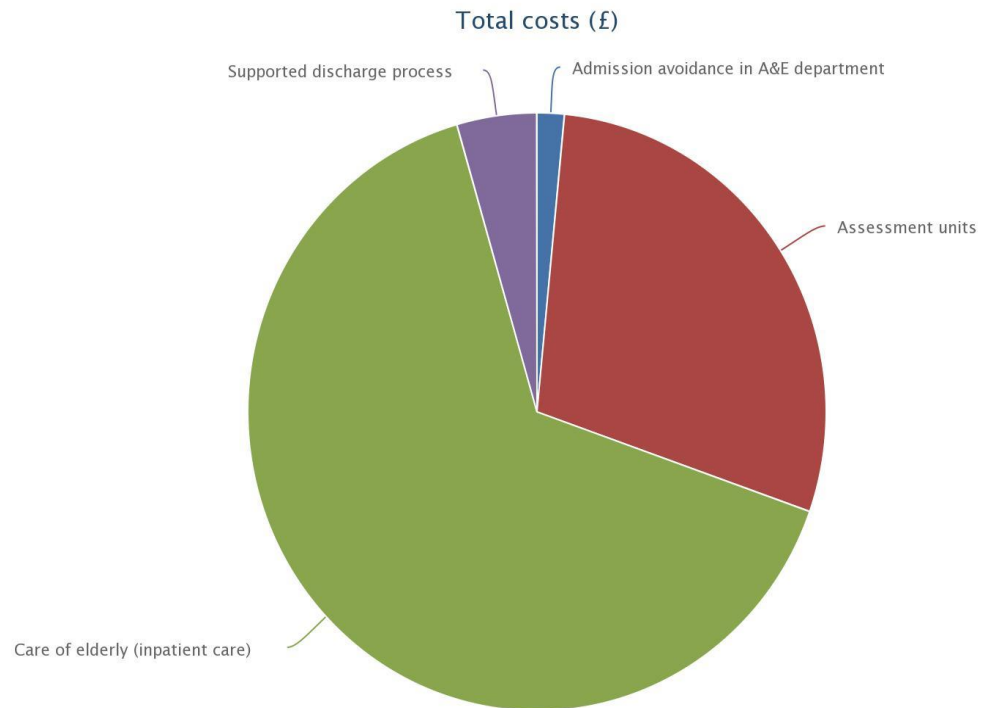
Older people specific policies

- Participants were asked questions about old people specific policies within their Trust / LHB.
- 38% of participants confirmed there is an outliers policy which specifically mentions the management of Older People whilst in acute care.
- 49% of participating Trusts / LHBs reported that they had a local policy relating to the movement of older people once admitted to hospital.
- Links with mental health services were also explored. 79% of participants confirmed that they had a pathway or protocol agreed for accessing specialist mental health services for older people.



Total costs of older people's service provision

- When the cost of older people's services in acute care was split in to the four different areas explored in this project, it was found that 65% of expenditure on older people's services was for care of elderly wards and inpatient care.
- 30% of total spend was on assessment units, 4% 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 spend – average £648,130
 - Agency spend – average £982,047
 - Overtime spend – average £59,641



Older people in A&E

Service models



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Teams available in A&E

The availability of the appropriate teams in A&E is essential in avoiding unnecessary admissions.

- 24% of participants have a geriatric team located in the A&E departments.
 - A range of models for geriatric teams in A&E were reported, ranging from a team available 4 hours/day Monday – Friday only, to 7 days a week 7am – 8pm.
- 85% of Trusts / LHBs have therapists available in A&E to assist with admissions avoidance.
- 62% of Trusts / LHBs have rapid access to social workers in A&E to assist with admissions avoidance.
- 56% of Trusts / LHBs hospital discharge teams do not provide in-reach to A&E.



Hours of availability of A&E teams

- 24% of Trusts confirmed that they have a dedicated geriatric team available in A&E, and these Trusts were asked for the hours that teams were available in A&E on a weekday and at the weekend over a 24 hour period.
- All teams showed reduced hours of availability at the weekend.
- Geriatric team availability fell by 2.5 hours per day at weekend, with three Trusts / LHBs reporting no geriatric team availability at weekends. One trust reported 12 hours of availability at weekends, the same trust was also the only participant who reported 12 hours availability during the week.
- Two Trusts / LHBs report 24 hour availability of a therapy team in A&E during the week and on a weekend. One Trust /LHB reported no cover from a therapy team in A&E at all, and 3 Trusts / LHBs have no availability at weekends.
- Social work teams showed the largest decrease in available hours at the weekends, on average teams provide just 6 hours of cover at weekends. Three Trusts /LHBs report no social work availability in A&E during the week, which increases to eight Trusts / LHBs reporting no cover on the weekends. Two Trusts /LHBs report 24 hour availability 7 days a week, showing 24/7 cover is possible in some areas.
- The hospital discharge team has the lowest hours of availability in A&E of all the teams reported on. Three Trusts / LHBs report no discharge team availability in A&E at all, and eight Trusts / LHBs have no cover at weekends.

| Mean hours available | Geriatric team | Therapy team | Social work | Supported discharge team |
|----------------------|----------------|--------------|-------------|--------------------------|
| Weekday | 9 | 10 | 9.5 | 8.4 |
| Weekend | 6.5 | 8.4 | 6.9 | 6 |

Older people in A&E

Activity



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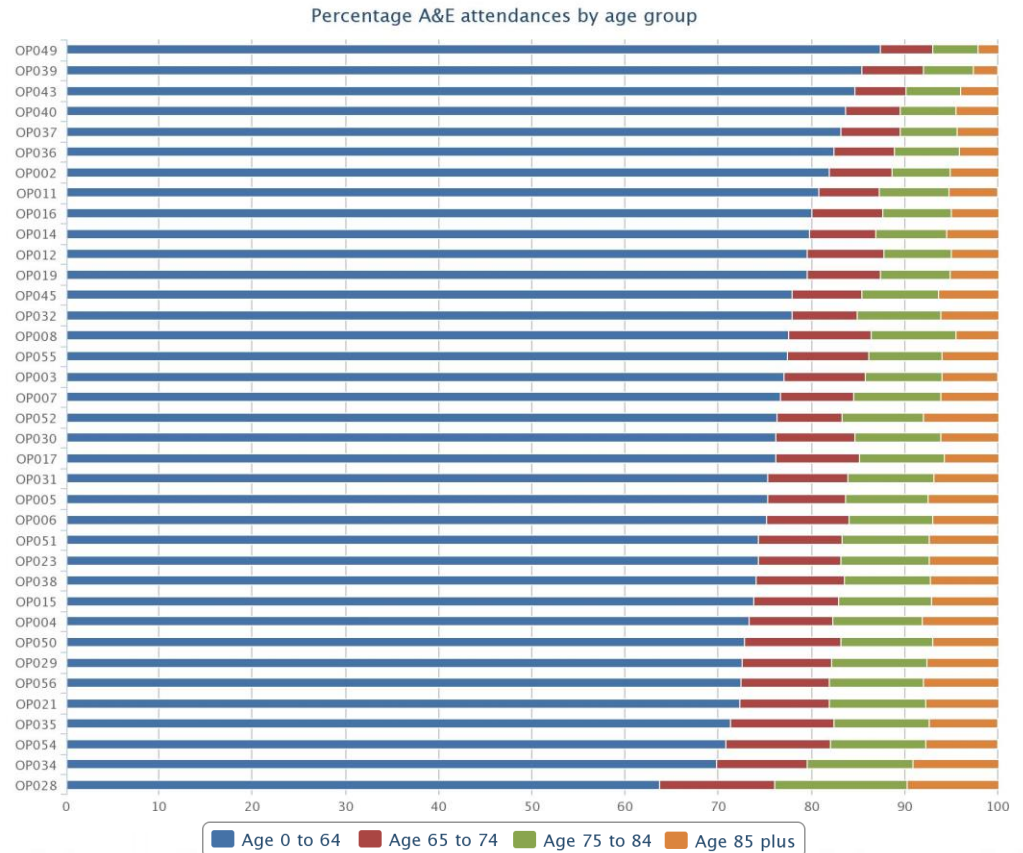


A&E attendances by age group

To understand the scale of the numbers of older people accessing A&E, participants were asked for the age profile of their A&E attendances.

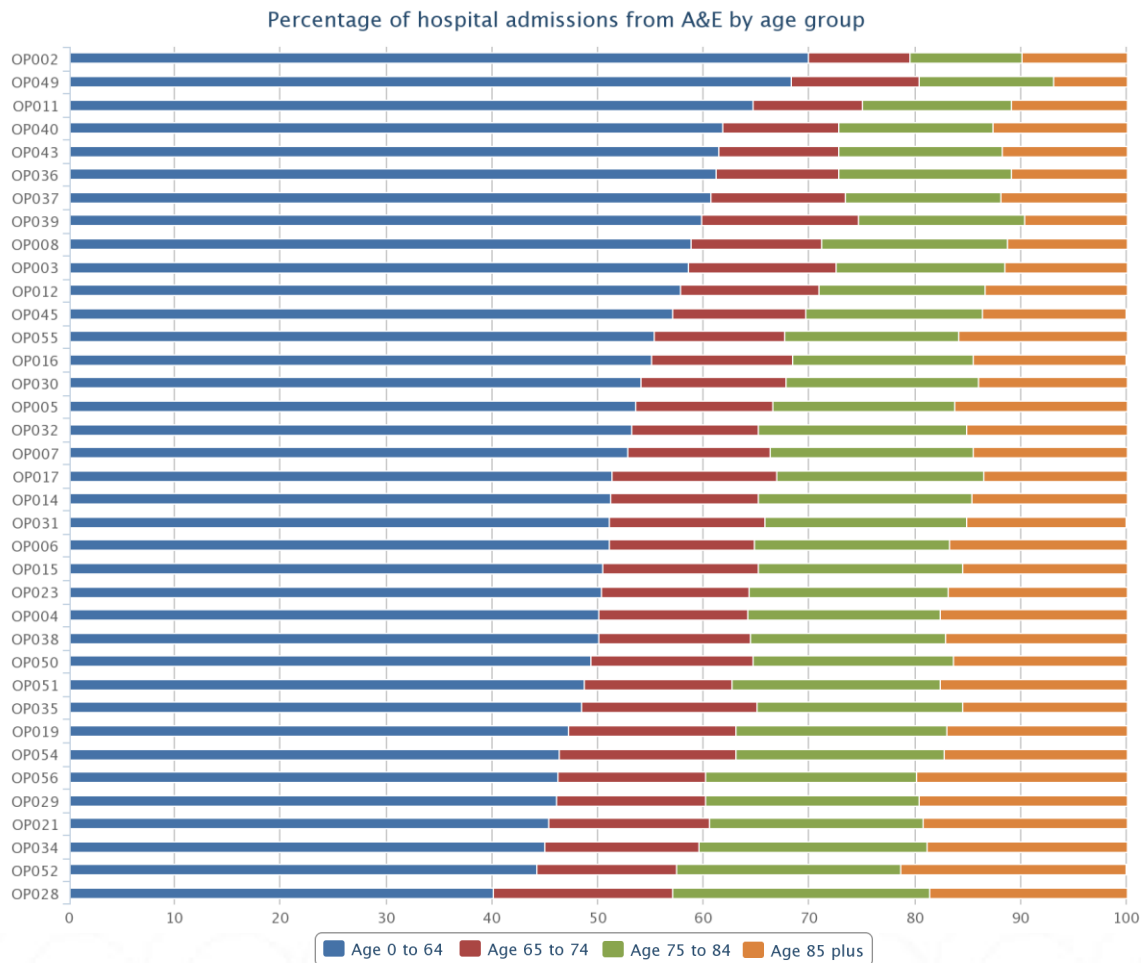
- 77% of attendances to A&E were by those aged 0 to 64 years old.
- The percentage of attendees aged 65 to 74 years was 8%, and those aged 75 to 84 account for 9% of A&E attendees.
- People aged 85 and older accounted for 6% of all A&E attendances.
- 22% of all A&E attendances are by those aged 65 and over.

Over 65s are therefore the minority of attenders in A&E (23%) but become an increasing proportion at each step in the pathway. 52% of admissions to assessment units are of older people (pg 57).



Hospital admissions from A&E by age group

- As shown previously, attendances to A&E by those aged 65 and over accounts for 22% 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 as follows -
 - Age 0 to 64 – 53%
 - Age 65 to 74 – 14%
 - Age 75 to 84 – 18%
 - Age 85 plus - 15%
- Admissions to hospital from A&E for those aged 65 and over account for 47% of all admissions from A&E.



Older people in A&E

Workforce



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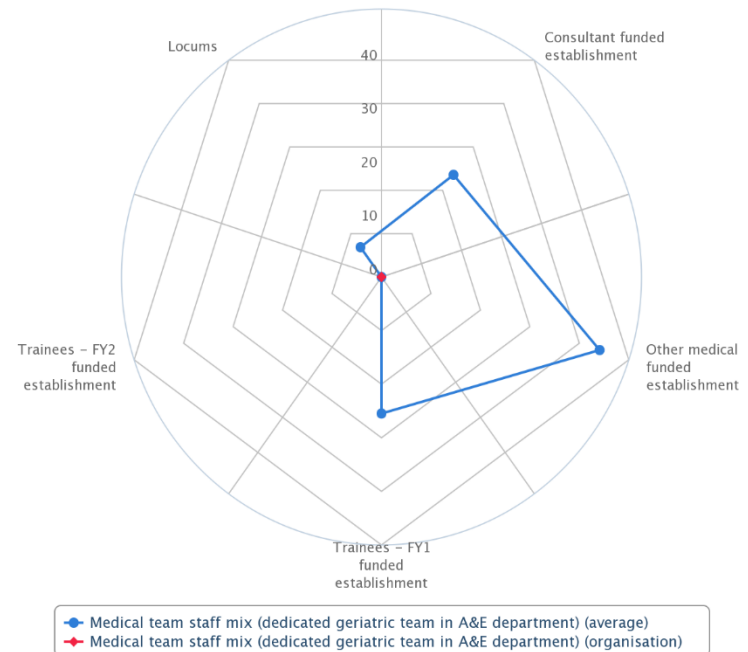
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Geriatric team staff mix in A&E department

- 24% of participants confirmed that they have a dedicated geriatric team available in A&E.
- The average staff mix of the dedicated geriatric medical team in A&E (where a team was established) was:-
 - Consultant funded establishment – 24%
 - Other medical funded establishment – 44%
 - FY1 funded establishment – 25%
 - FY2 funded establishment – 0%
 - Locums – 7%
- Participants are able to view their own staff mix and make comparisons against the national averages on the online toolkit.

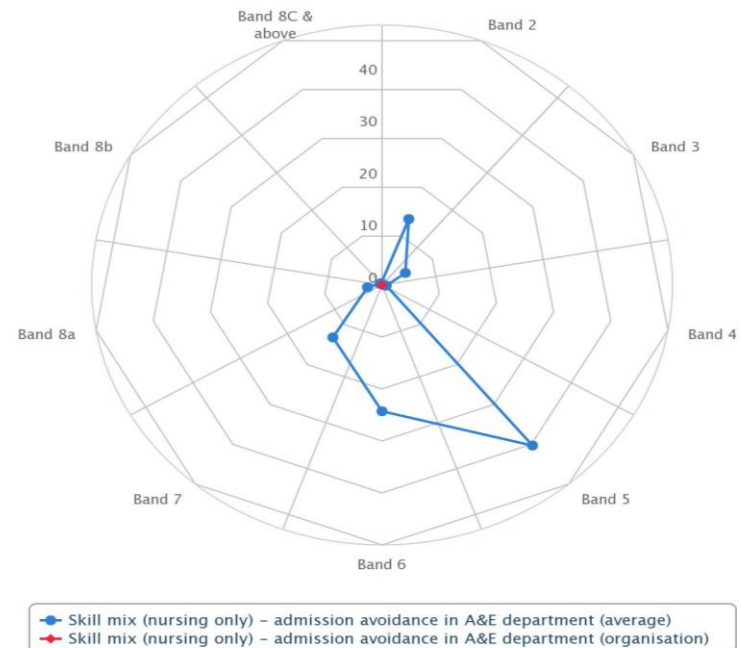
Medical team staff mix (dedicated geriatric team in A&E department)



Nursing skill mix in A&E department

- The nursing skill mix in admissions avoidance teams in A&E shows the team is made up of Band 5 nurses (40%), Band 6 nurses (24%) and Band 2 nurses (14%). Band 7 nurses also feature in the skill mix (13%).
- The nursing skill mix for admissions avoidance in A&E has a higher ratio of registered to registered nurses than the skill mix found in other areas of secondary care, with 81% of the nursing staff being registered and 19% unregistered.

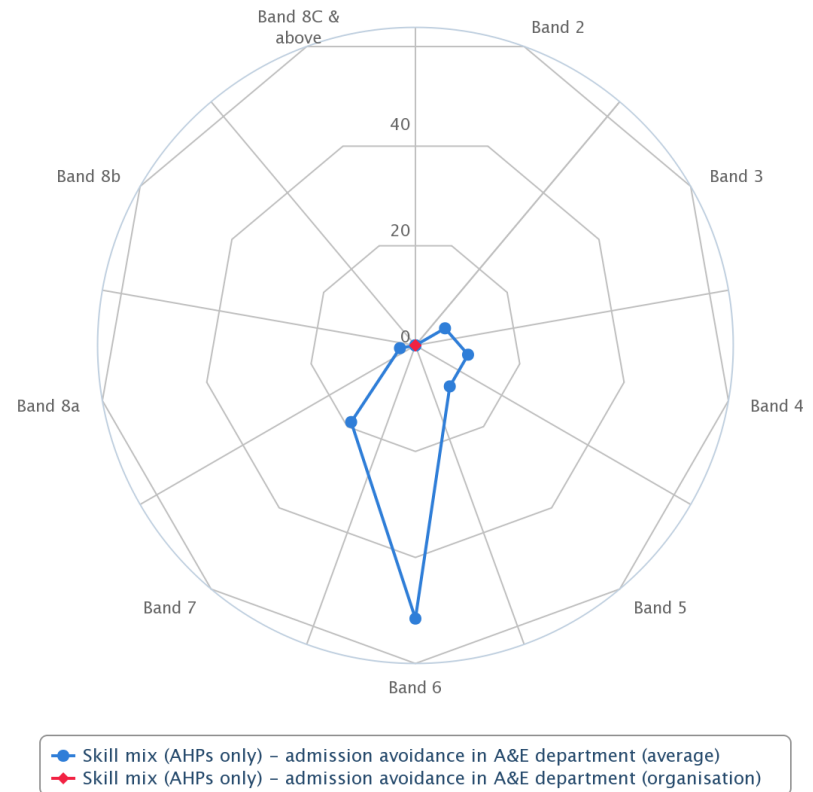
Skill mix (nursing only) – admission avoidance in A&E department



AHP skill mix in A&E department

- The AHP skill mix of the admission avoidance team in A&E was
 - Band 2 – 0%
 - Band 3 – 6%
 - Band 4 – 10%
 - Band 5 – 10%
 - Band 6 – 52%
 - Band 7 – 19%
 - Band 8 – 3%

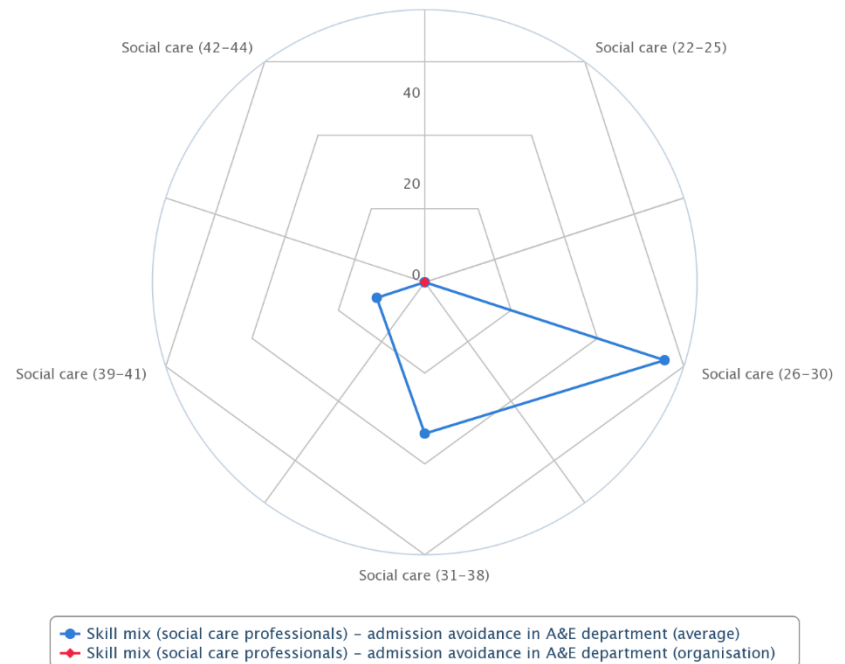
Skill mix (AHPs only) – admission avoidance in A&E department



Social care skill mix in A&E department

- Evidence suggests that integration with social care can result in lower emergency admissions for older people (What actions could be taken to reduce emergency admissions? NHS England, 2014).
- 62% of Trusts / LHBs have rapid access to social workers in A&E to assist with admission avoidance of older people.
- The average skill mix of social care staff in admissions avoidance in A&E departments was found to be
 - Bands 26 – 30 : 56%
 - Bands 31 – 38 : 33%
 - Bands 39 – 41: 11%

Skill mix (social care professionals) – admission avoidance in A&E department



Older people in A&E

Finance



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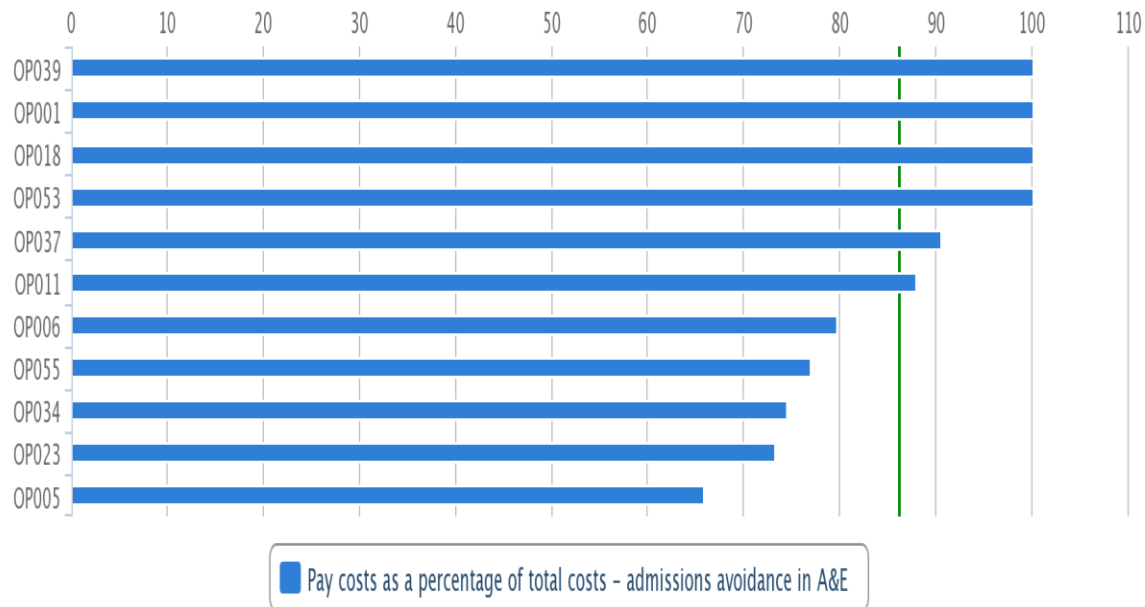
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Cost of admissions avoidance in A&E

- Participants were asked for their pay, non-pay and indirect costs for each area of the pathway.
- The cost of the admissions avoidance team in A&E accounted for just 1% of expenditure on older people's services.
- Pay costs accounted for 86% of the spend on admissions avoidance teams in A&E.

Pay costs as a percentage of total costs - admissions avoidance in A&E



Assessment units

Service models



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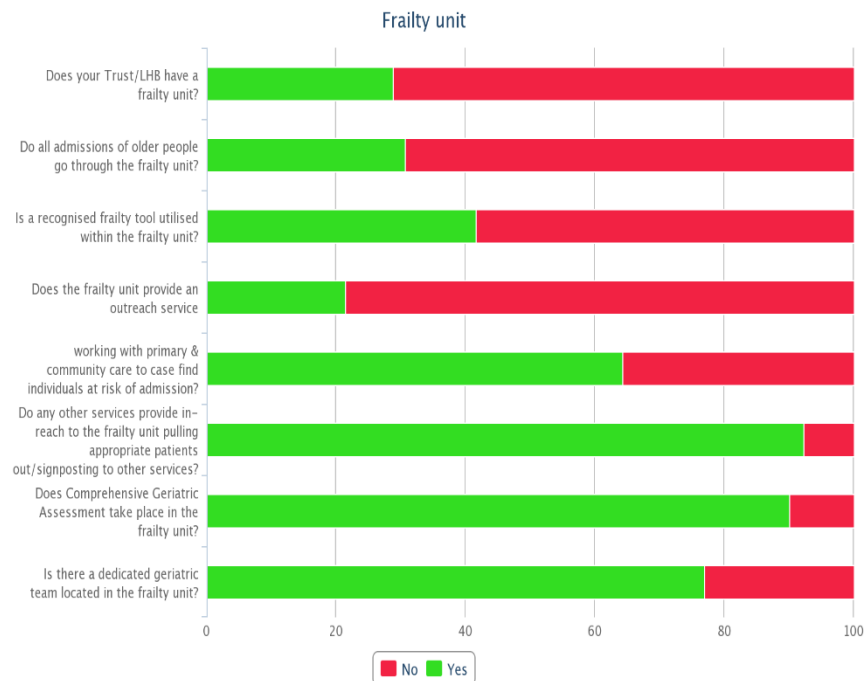
Assessment units

- 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 elderly
 - 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.



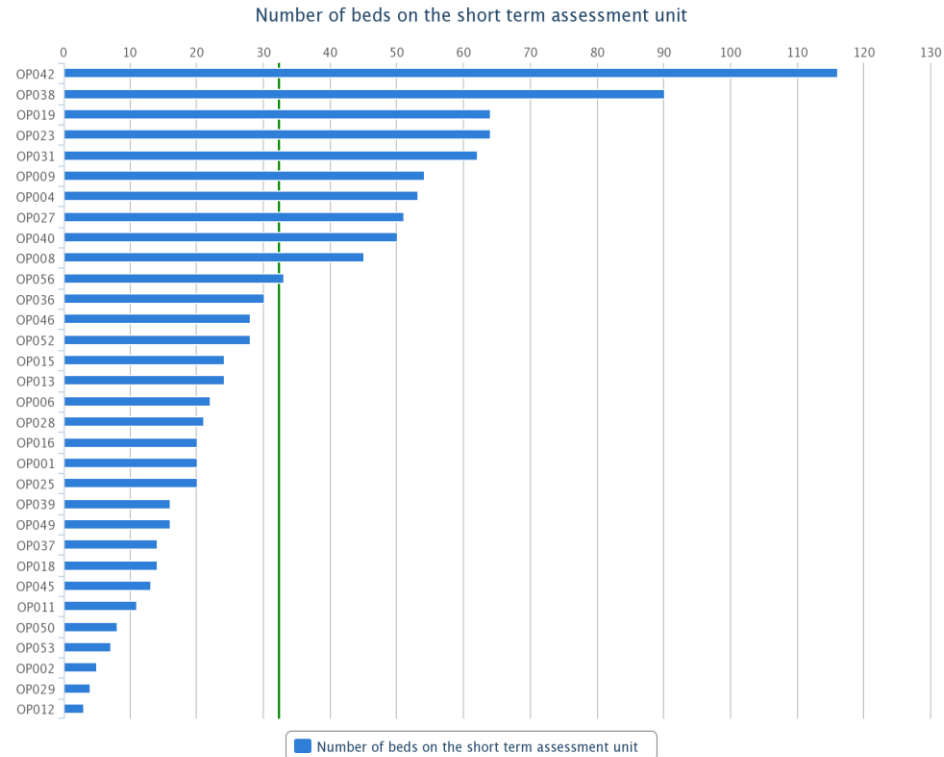
Frailty units

- 29% of participating Trusts / LHBs have a frailty unit.
- Of those Trusts / LHBs with a frailty unit -
 - All admissions of older people go through the frailty unit in 31% of Trusts / LHBs.
 - 42% use a recognised frailty tool; these include CGA, OPAL, UHNS Bournemouth Criteria tool and the Mayo Clinic Screening tool.
 - 21% provide an outreach service
 - 90% use Comprehensive Geriatric Assessment
 - 77% have a dedicated geriatric team located in the frailty unit
- The average frailty unit has 25 beds, however this figure ranges from 7 to 56 beds.
- 48-72 hours was the average expected maximum length of stay on the frailty unit. 23% reported a stay of greater than 72 hours was to be expected. 8% reported an expected maximum stay of 12 hours and 8%, 24 hours.
- Clinical leadership is provided by a Geriatrician in 100% of frailty units.
- The average hours of senior medical cover over a 24 hour period during the week is 13 hours. At weekends this reduces to 10 hours, with 3 Trusts / LHBs reporting no cover at weekends.
- Out of hours medical cover is provided by an on-call rota (generic) in 46% of frailty units, on-call specialist in 39% of Trusts / LHBs, and dedicated cover in 15%.



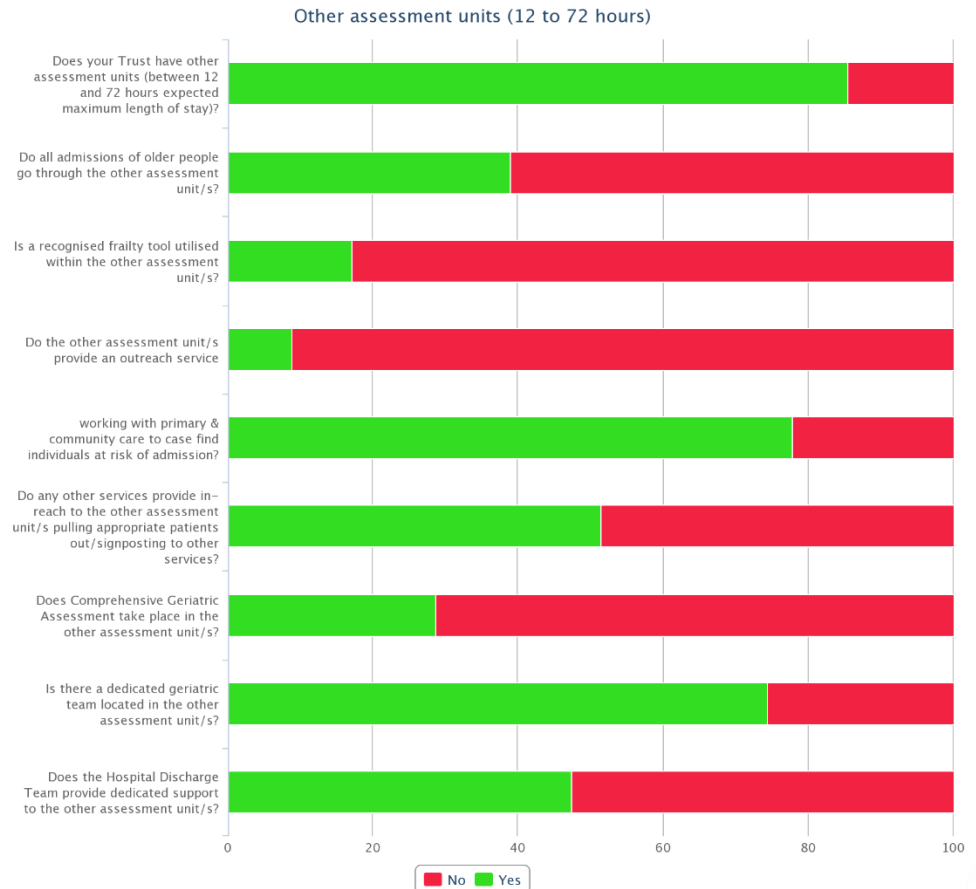
Short term assessment unit (up to 12 hours)

- 77% of participating Trusts / LHBs have a short term assessment unit. 33% reported that all admissions of older people go through the short term assessment unit.
- A recognised frailty tool is used in just 19% of short term assessment units, and 44% perform Comprehensive Geriatric Assessment. 31% have a dedicated geriatric team located in the short term assessment unit.
- 81% 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 32 beds, however this ranges from 3 beds to 116 beds.
- Clinical leadership is provided by a general physician in 79% of short term assessment units, and a geriatrician in 6% of cases. 15% reported an 'other' clinical lead.
- Senior medical cover is provided on average 17 hours per day during the week, with 43% of Trusts / LHBs reporting 24 hour cover. At weekends the average availability decreases to 16 hours, with 2 Trusts / LHBs reporting no senior cover, although many still have 24 hour cover at weekends.



Other assessment units (12 to 72 hours)

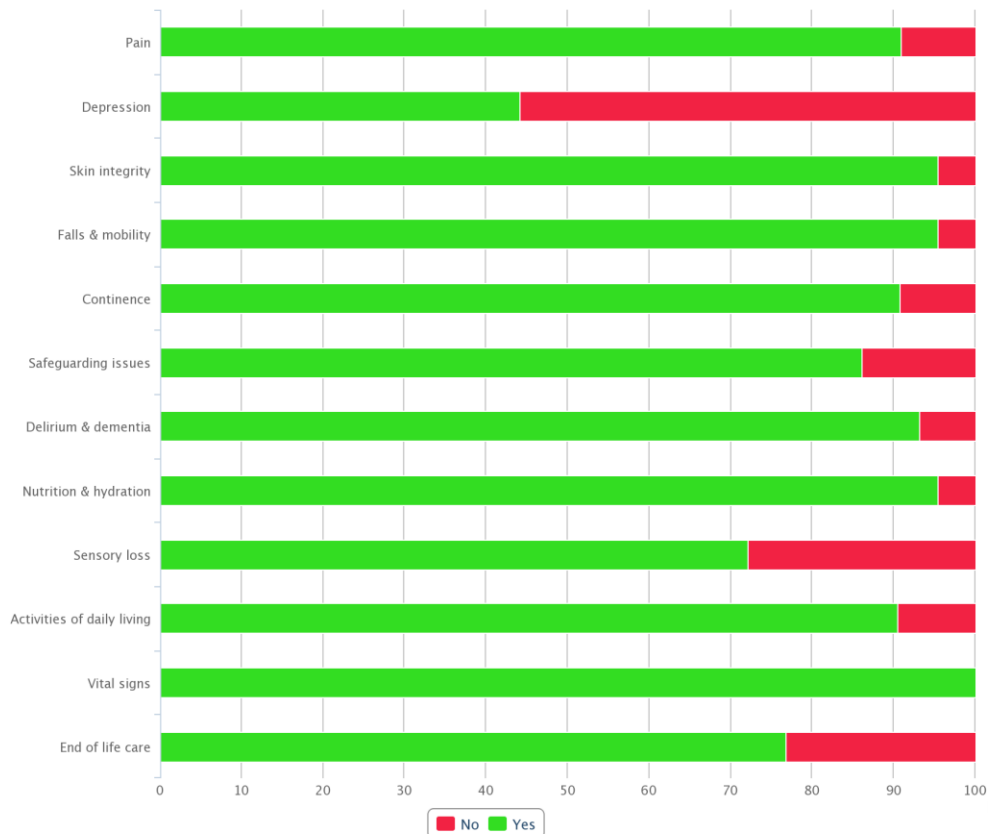
- 85% have other assessment units, with 17% reporting a recognised frailty tool is utilised within these assessment units.
- Comprehensive Geriatric Assessment takes place in 30% of other assessment units, and 74% have a dedicated geriatric team located in these other assessment units.
- The hospital discharge team provide dedicated support to 46% of other assessment units.
- The modal number of other assessment units within a Trust is 1 assessment unit, however this ranges from 0 to 7. The average number of beds on these units is 45 beds.
- 71% reported the average expected maximum length of stay on these units was 72 hours.
- 85% of clinical leadership is provided by a General physician, 6% by a Geriatrician and 9% by an 'other' clinician.
- Senior medical cover is available, on average, 15.4 hours per day during the week and 14.4 hours on the weekend. 10 Trusts / LHBs report 24/7 senior medical cover on these units.



Routine assessments of older people

- Participants were asked whether all older people accessing urgent care were routinely assessed for a number of issues.
- The publication 'Quality Care for Older people with Urgent & Emergency Care needs,' also known as the "Silver Book" states that all older people accessing urgent care should be routinely assessed for across these domains.
- Interestingly, only 'Vital signs' were assessed by 100% of participating Trusts / LHBs.
- 95% of Trusts / LHBs reported assessing routinely for skin integrity, falls & mobility, nutrition & hydration.
- Pain, continence and activities of daily living are assessed for in 90% of Trusts / LHBs.
- Depression was assessed for in just 44% of Trusts / LHBs.
- Clearly, most Trusts / LHBs are assessing for most issues listed, however work can be done in some areas to improve compliance with these guidelines.

Percentage of trusts / LHBs routinely assessing for the following conditions:



Assessment units

Activity



Benchmarking Network

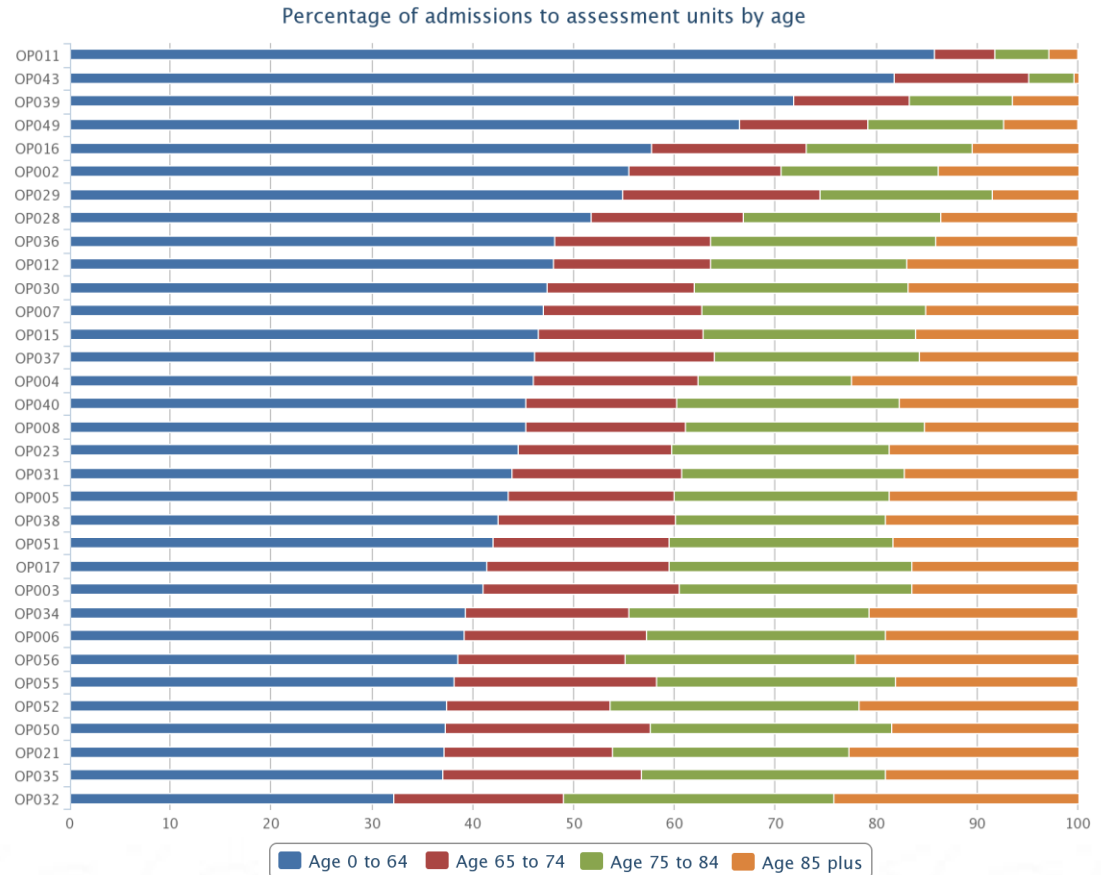
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Admissions to assessment units

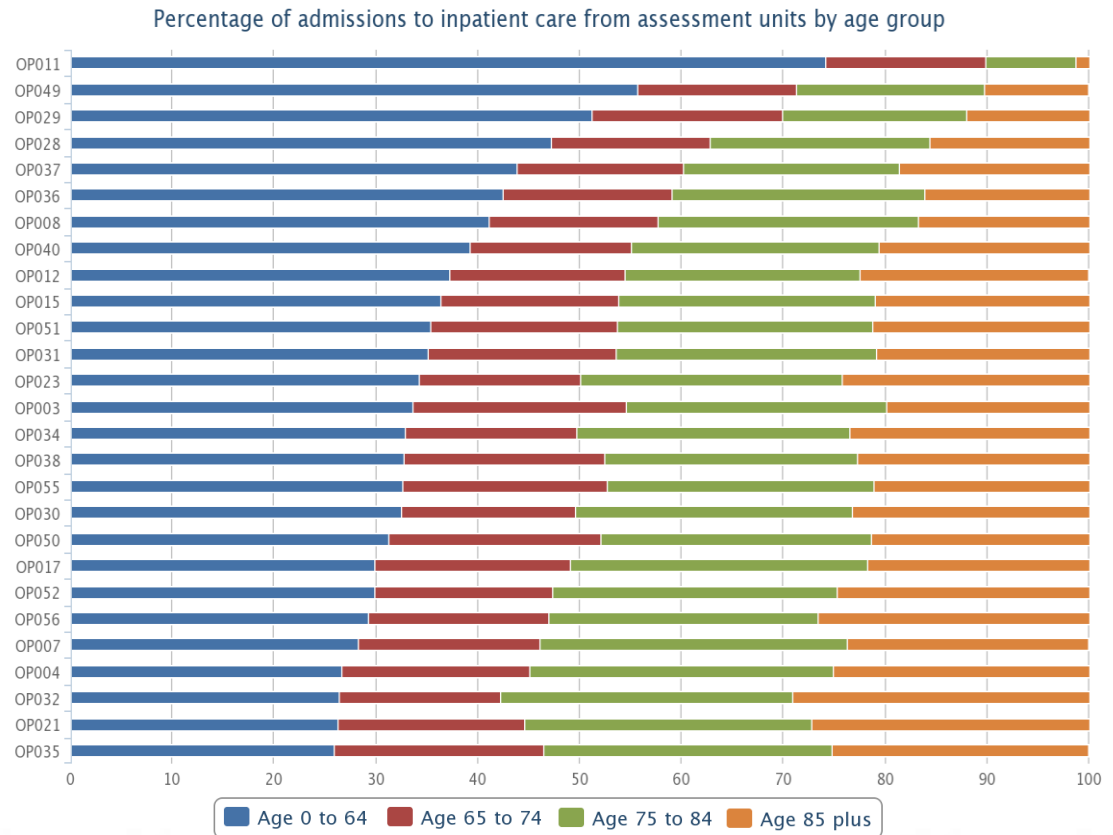
Trusts / LHBs were asked to provide the numbers of admissions to all assessment units.

- 48% of admissions to assessment units in 2013/14 were by those aged 64 and under.
- 52% 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 – 16% of admissions
- 68% of admissions to assessment units came through A&E departments, and 26% directly from a GP.



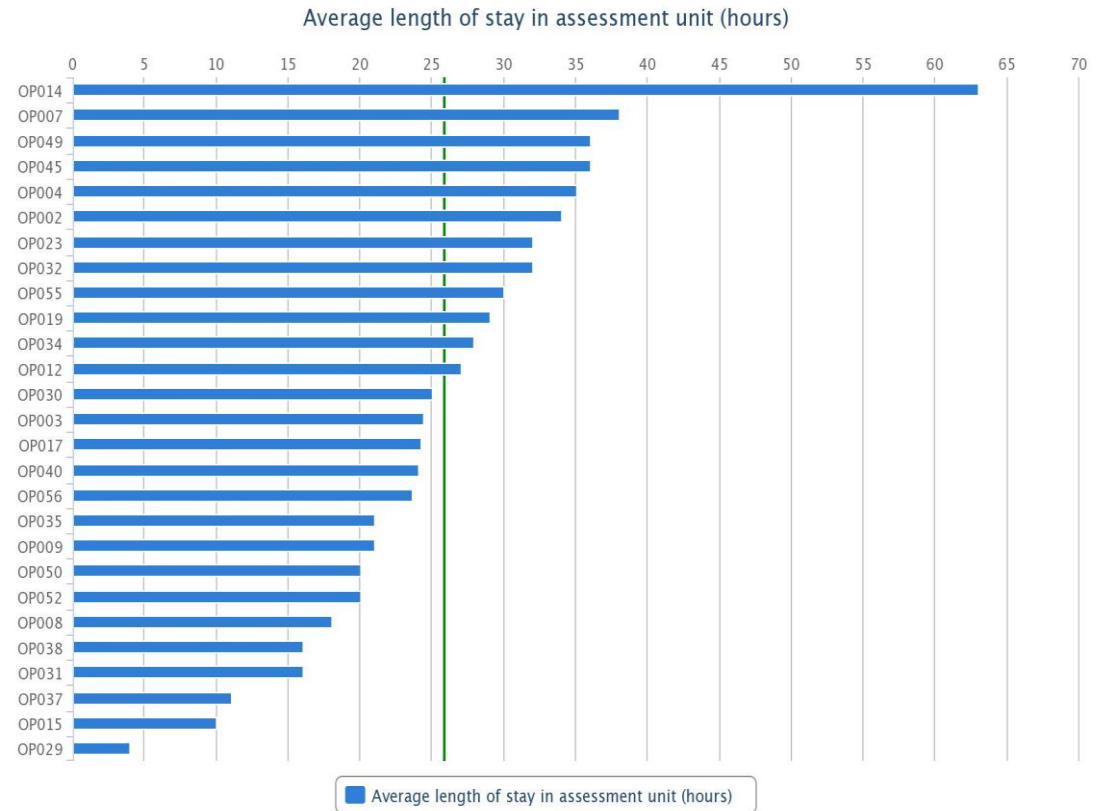
Admissions to inpatient care from assessment units

- As shown previously, 52% of admissions to assessment units are for people aged 65 and over.
- 64% of admissions to inpatient care from assessment units are of older people. This can be further split down in to the following age categories:
 - Age 65 to 74: 18%
 - Age 75 to 84: 25%
 - Age 85 plus: 21%
- Older people are a minority of attenders at A&E (ages 65 and over account for 23% of all A&E attendances) but step up in their proportion as one moves along 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.



Average length of stay on assessment units

- The average length of stay across all assessment units is 25.9 hours.



Assessment units

Workforce



Benchmarking Network

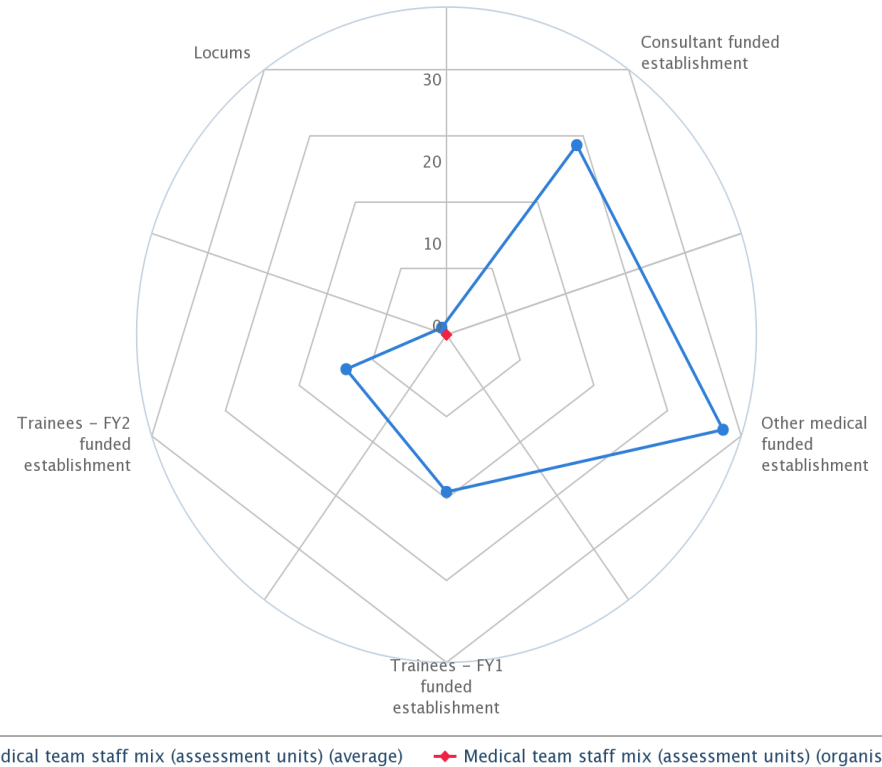
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Medical team staff mix – assessment units

- Participants are able to compare their own medical team skill mix against the national average on the online toolkit.
- The average staff mix of a medical team in assessment units is:
 - Consultant (funded establishment) – 29%
 - Other medical (funded establishment) – 37%
 - Trainees FY1 (funded establishment) – 19%
 - Trainees FY2 (funded establishment) – 14%
 - Locums – 1%

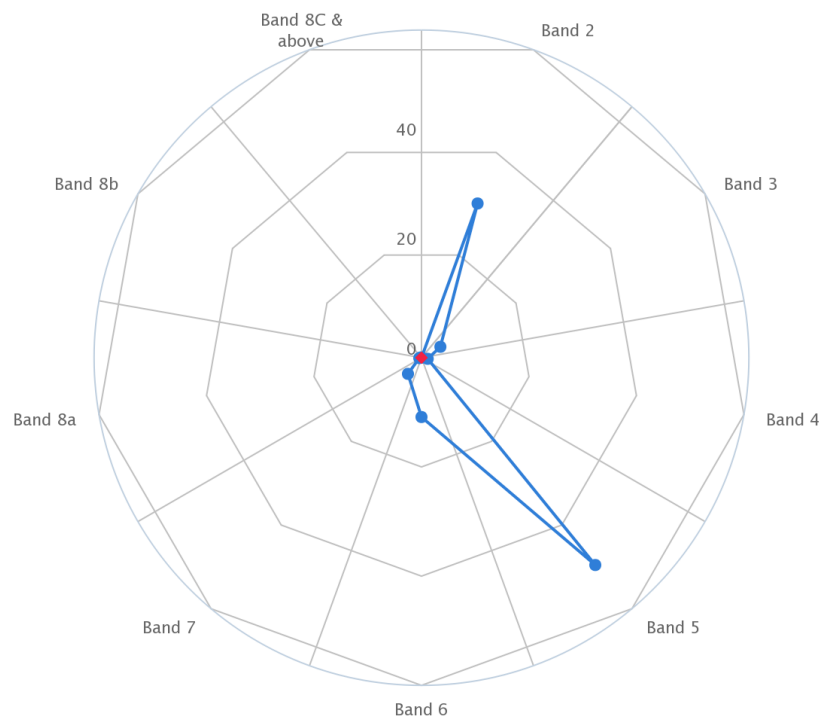
Medical team staff mix (assessment units)



Nursing skill mix – assessment units

- The skill mix of nurses on the assessment units was
 - Band 2 – 30%
 - Band 3 – 4%
 - Band 4 – 1%
 - Band 5 – 50%
 - Band 6 – 11%
 - Band 7 – 4%
- This skill mix gives a registered to non registered ratio of 65% to 35%.

Skill mix (nursing only) – assessment units

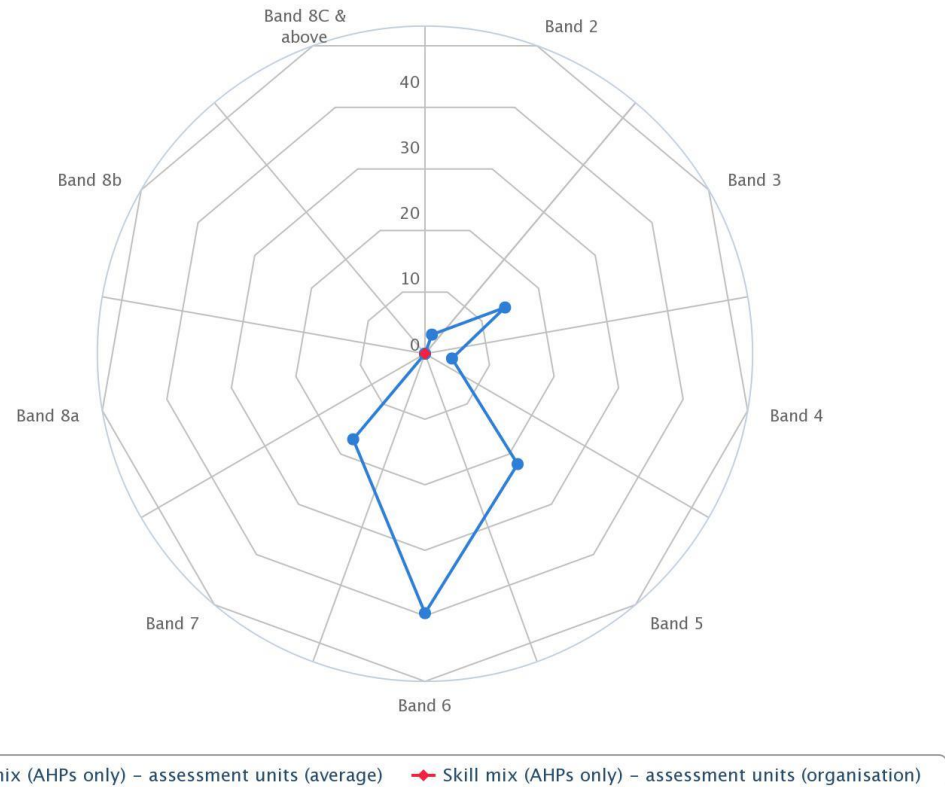


— Skill mix (nursing only) – assessment units (average) — Skill mix (nursing only) – assessment units (organisation)

AHP skill mix – assessment units

- The AHP skill mix on assessment units has a higher skill mix than other departments, with 77% of AHPs on assessment units being Band 5 and above.
 - Band 2 – 3%
 - Band 3 – 14%
 - Band 4 – 4%
 - Band 5 – 22%
 - Band 6 – 40%
 - Band 7 – 17%

Skill mix (AHPs only) – assessment units



Assessment units

Finance



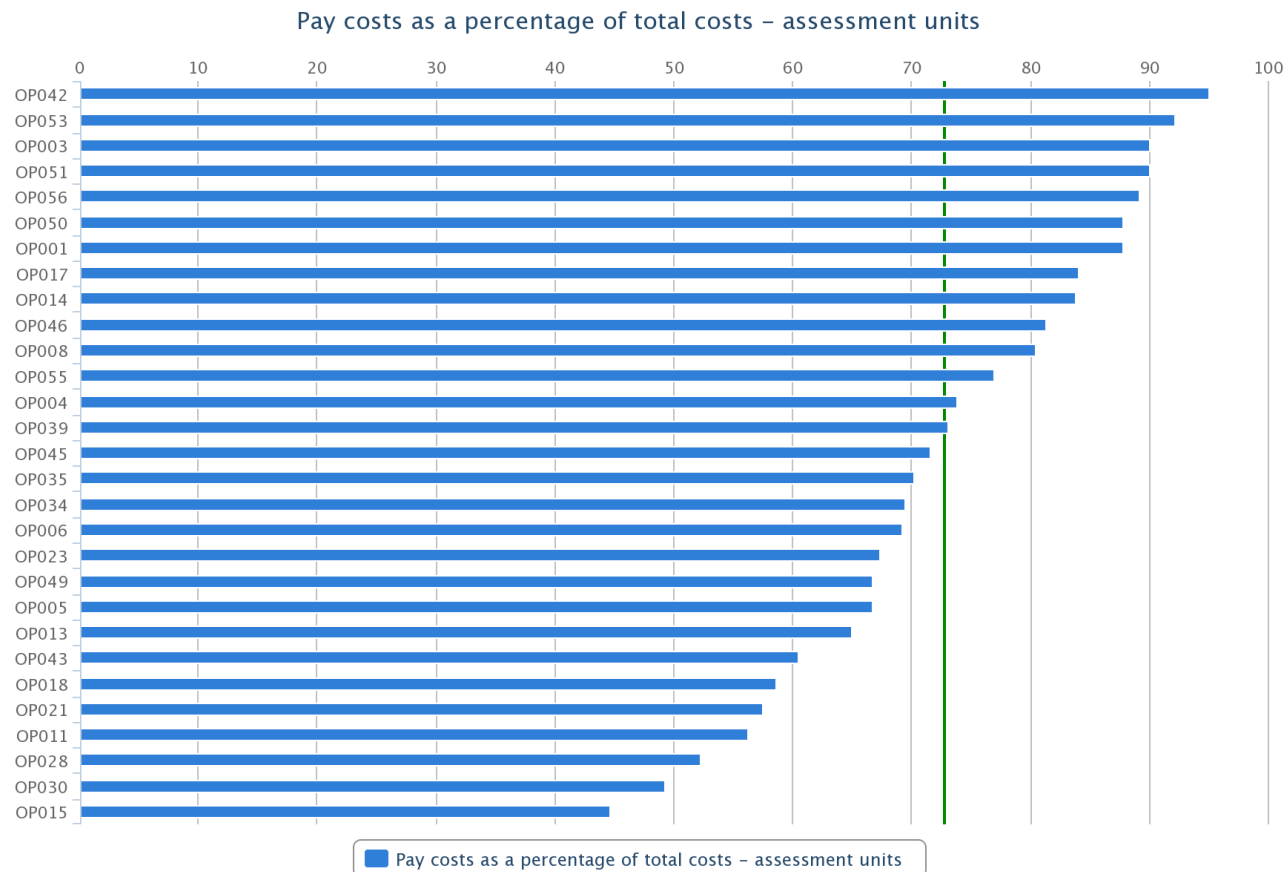
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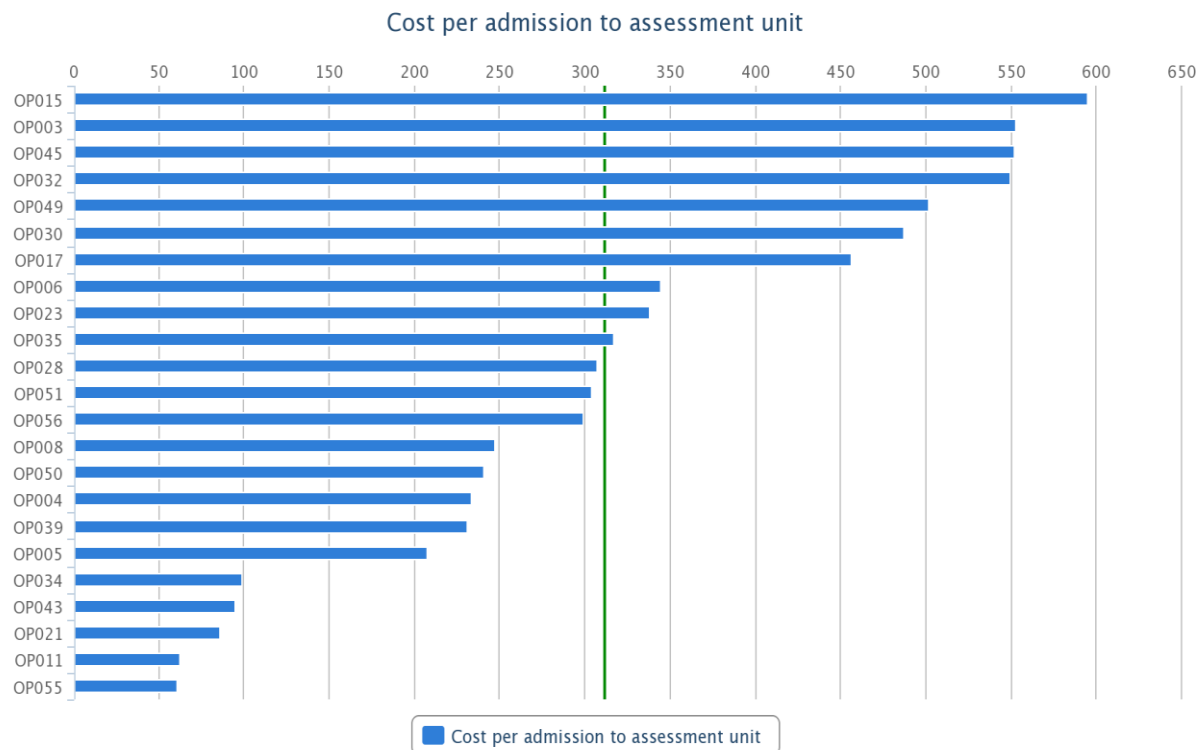
Spend on assessment units

- The cost of pay on assessment units accounts for an average of 73% of total costs.
- Mean assessment units CIP as a percentage of total budget is 3%. Many Trusts / LHBs reported a CIP of 0%, and one Trust reported a 10% cost improvement programme.



Cost per admission to assessment unit

- The average cost per admission to assessment unit is £311.
- There is wide variation within this, ranging from £60 per admission to £594 per admission.



Inpatient care

Service models



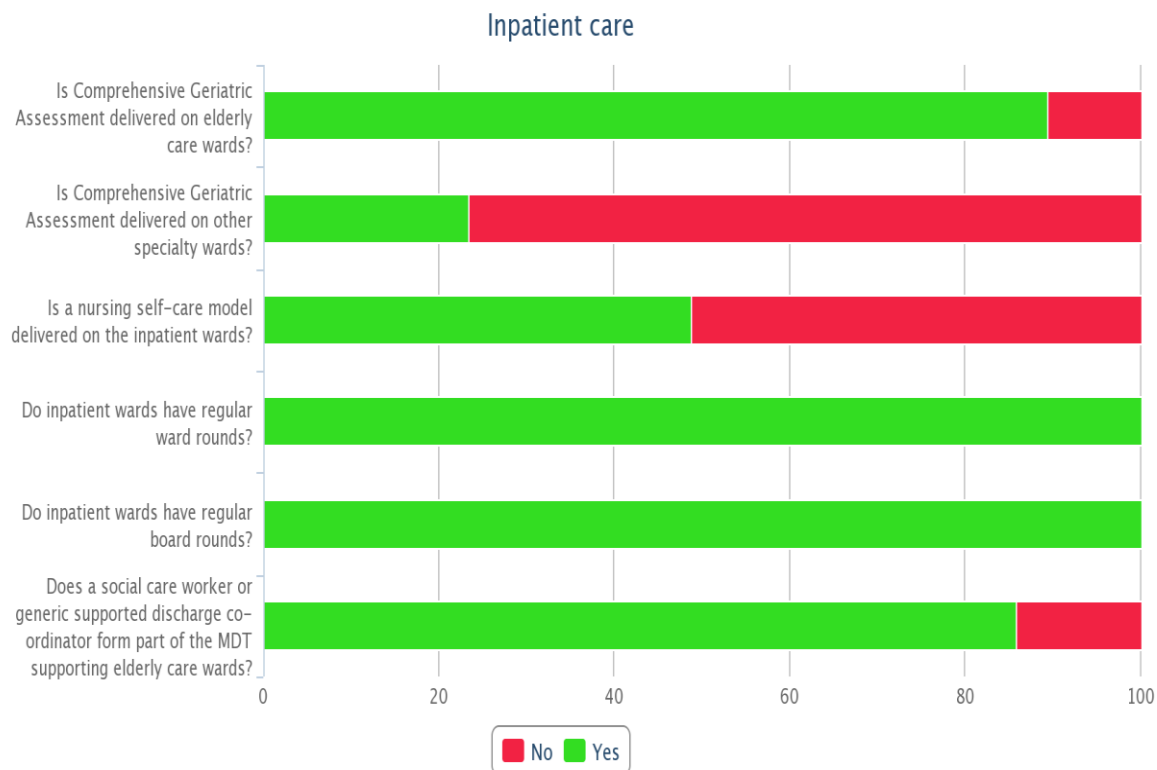
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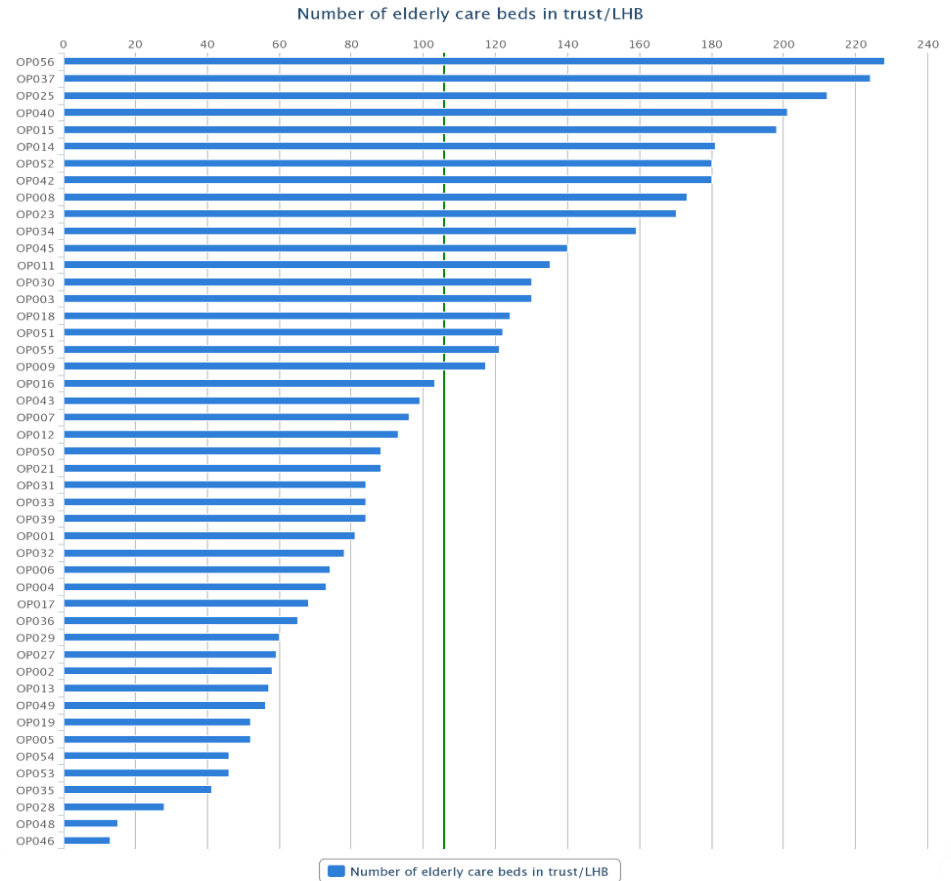
Inpatient care

- 87% of inpatient wards deliver Comprehensive Geriatric Assessment. This reduces to just 23% of speciality wards delivering CGA.
- 46% of inpatient wards deliver a nursing self-care model.
- 100% of inpatient wards carry out board rounds and ward rounds.
- 74% of ward rounds are carried out daily, 2% twice daily and 25% less than daily.
- 88% of board rounds are carries out daily on inpatient wards.
- A social care worker or generic supported discharge co-ordinator is part of the elderly care ward MDT in 86% of Trusts / LHBs.



Number of elderly care beds in trust

- The number of elderly care beds per Trust shows a wide variation, from 13 beds to 228 beds.
- The mean number of designated elderly care beds is 106 beds.
- Many of the quality metrics later on in the report are benchmarked per 100 care of the elderly beds, to allow for comparisons.



Inpatient care

Activity



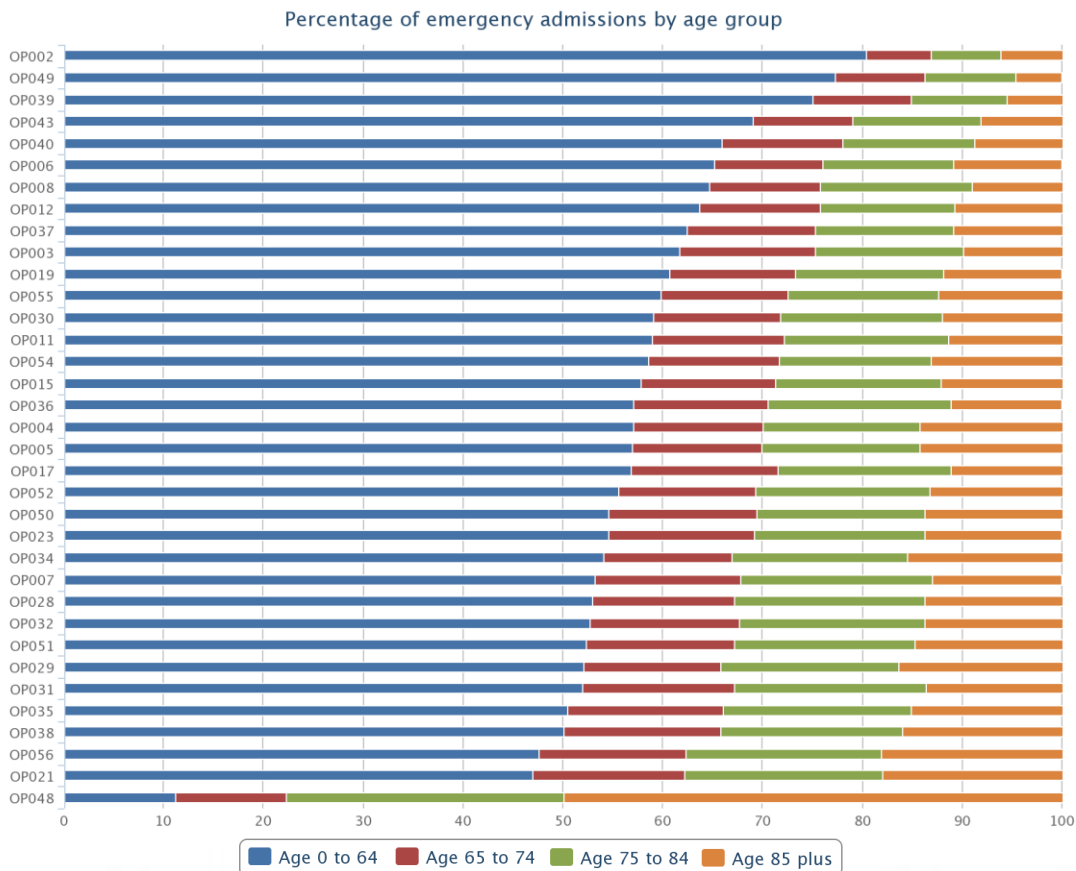
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Elective and emergency admissions

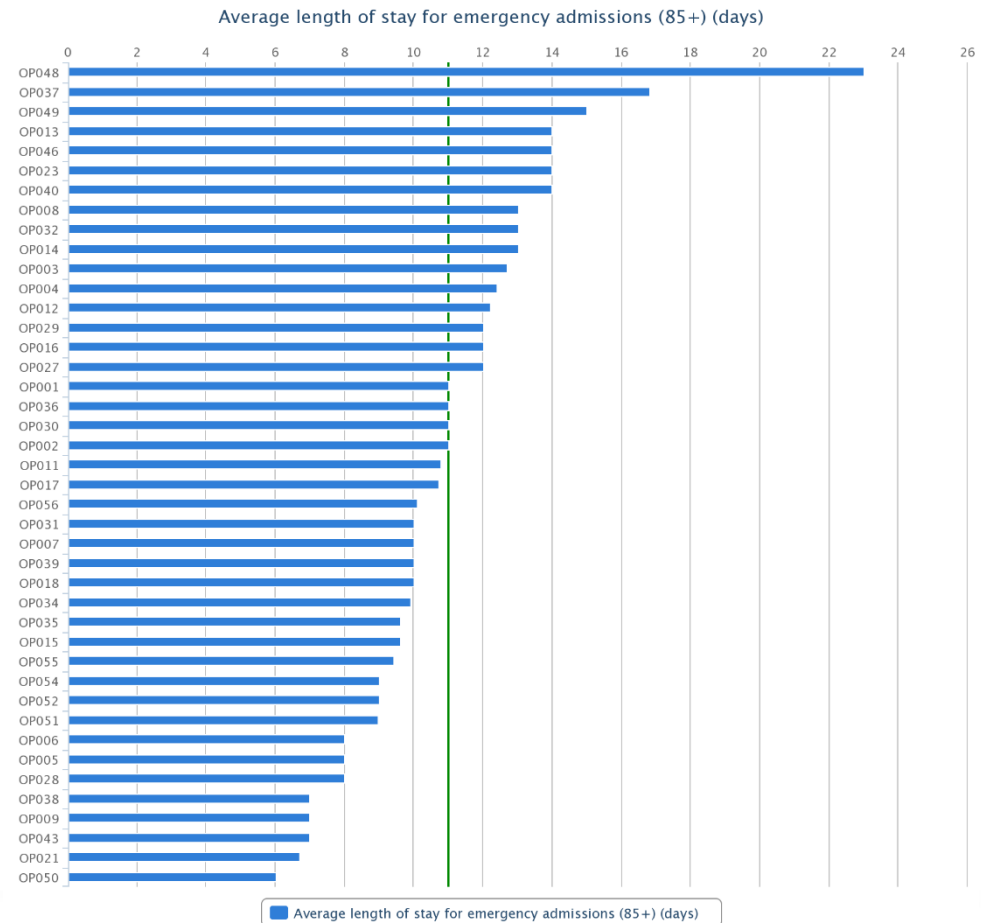
- Older people (age 65 and over), on average, account for 44% of elective admissions and 43% of emergency admissions.
- Emergency admissions are made up of the following age groups –
 - Age 65 to 74 – 13% of admissions
 - Age 75 to 84 – 16% of admissions
 - Age 85 plus – 13% of admissions



Average length of stay – emergency admissions

The mean values for average length of stay are as follows:

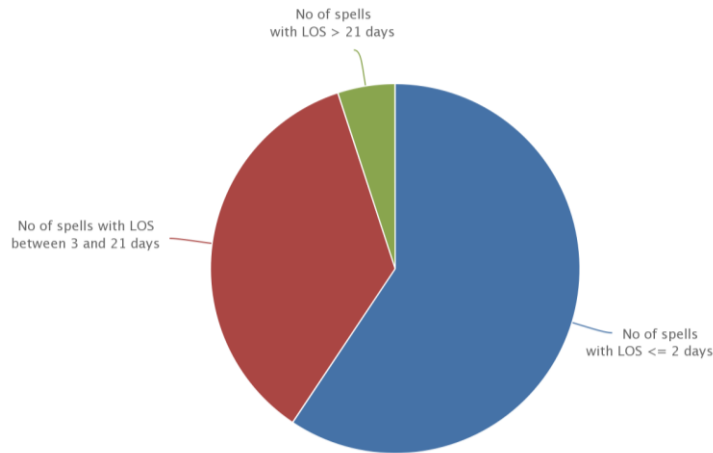
- All admissions – 5.6 days
- 65 to 74 – 7.5 days
- 75 to 84 – 9.3 days
- 85+ – 11 days



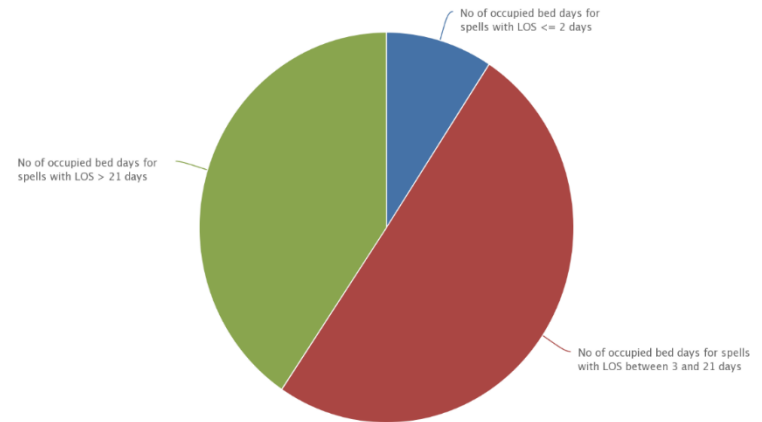
Impact of long stays

- Evidence points to older people typically having longer stays in hospital. The following charts show the impact of long stays in hospitals.
- Spells with a length of stay of more than 21 days account for 5% of total spells, yet account for 41% of total occupied bed days, indicating the resource being utilised by the “long-stayers”.

Total number of spells



Total number of occupied bed days



Inpatient care

Workforce



Benchmarking Network

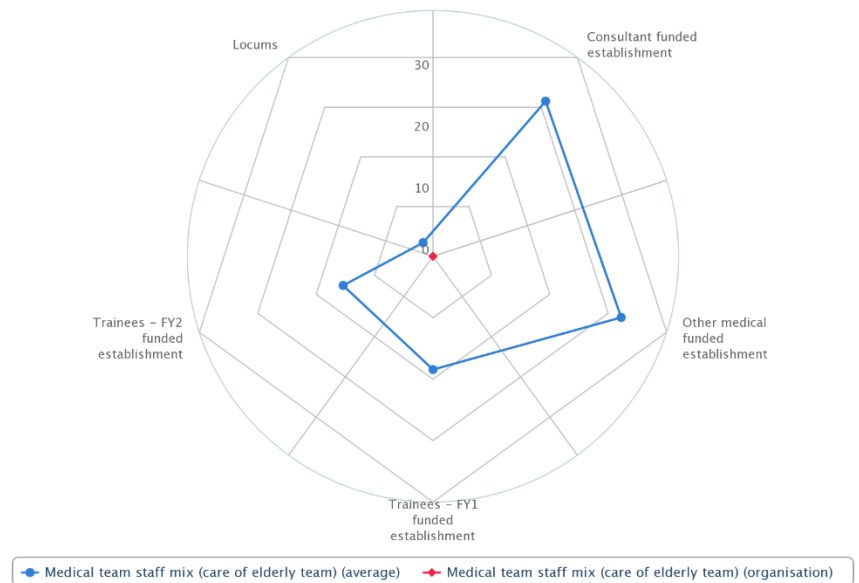
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Medical team staff mix – inpatient care

- Participants are able to compare their own medical team skill mix against the national average on the online toolkit.
- The average staff mix of the care of the elderly medical team for inpatient wards is:
 - Consultant (funded establishment) – 31%
 - Other medical (funded establishment) – 32%
 - Trainees FY1 (funded establishment) – 18%
 - Trainees FY2 (funded establishment) – 15%
 - Locums – 3%

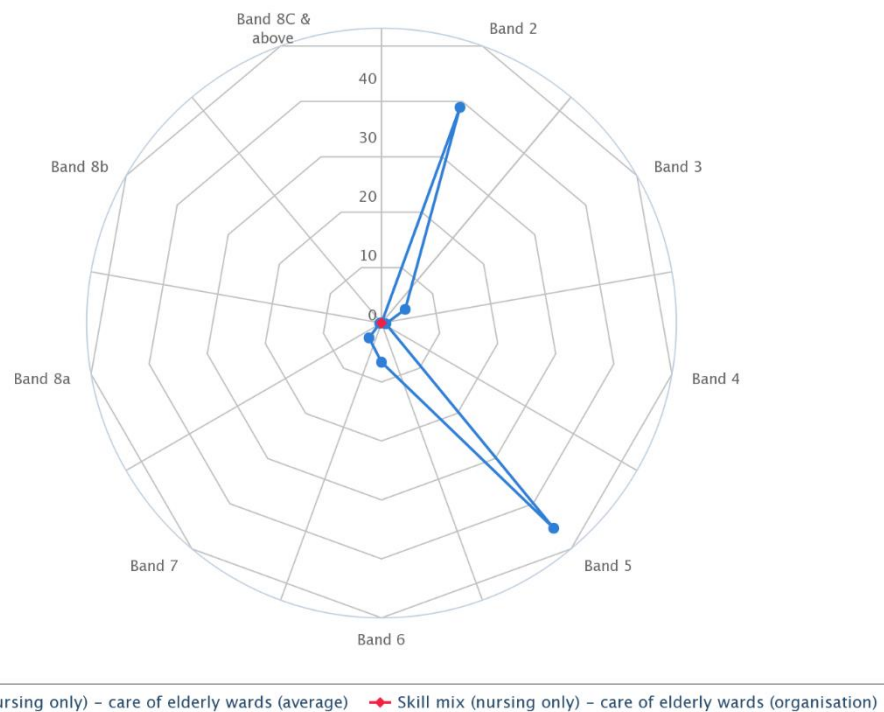
Medical team staff mix (care of elderly team)



Nursing skill mix – inpatient care

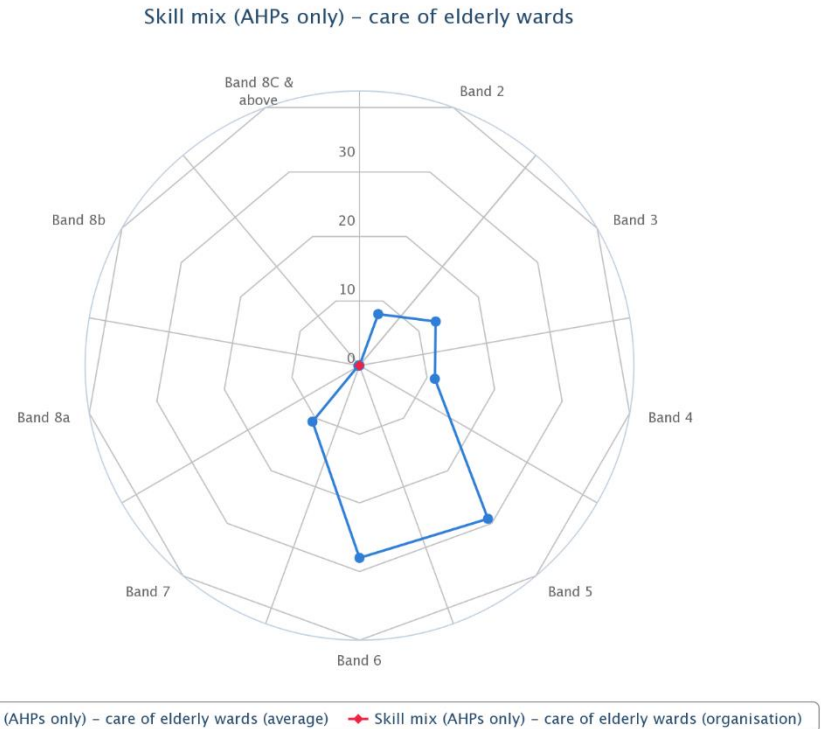
- The skill mix of nurses on the care of the elderly wards was found to be:
 - Band 2 – 39%
 - Band 3 – 5%
 - Band 4 – 1%
 - Band 5 – 45%
 - Band 6 – 7%
 - Band 7 – 3%
- This skill mix gives a registered to non registered ratio of 44% to 56%. Of the four areas of the acute pathway explored in this report, nursing skill mix on care of elderly wards has the lowest proportion of registered nurses compared to unregistered nurses.

Skill mix (nursing only) – care of elderly wards



AHP skill mix – inpatient care

- The average AHP team on the care of elderly wards was found to comprise:
 - Band 2 – 8%
 - Band 3 – 13%
 - Band 4 – 11%
 - Band 5 – 29%
 - Band 6 – 28%
 - Band 7 – 11%
- The skill mix of AHPs on the elderly care wards is lower than the team for admissions avoidance in A&E. The inpatient team is largely comprised of Band 6 and Band 5 therapists, whereas the majority (52%) of the A&E team is made up of Band 6 staff, with 27% of the A&E team being Band 5 and below.



Inpatient care

Finance



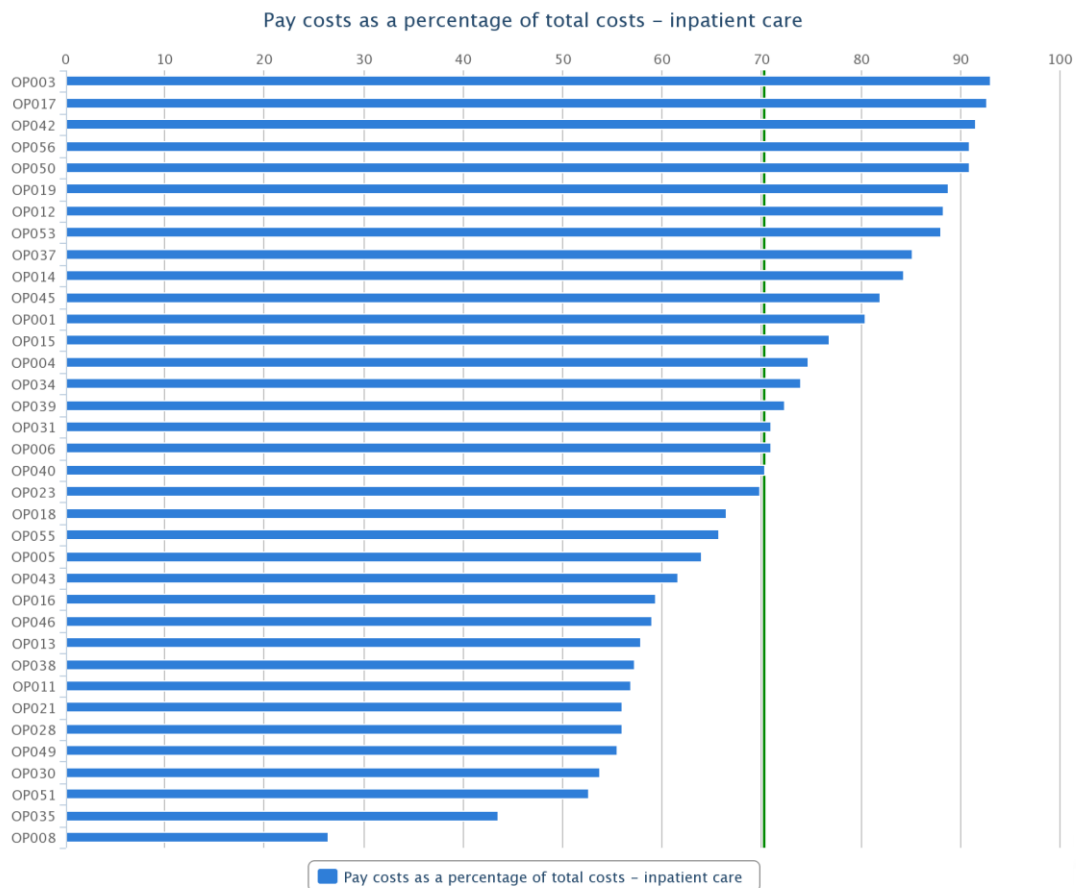
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Spend on inpatient care

- 70% of the total cost of the care of elderly wards is spent on pay costs.
- There is wide variation between Trusts / LHBs on the percentage spent on pay costs.
- The average cost per elderly care bed is £94,000. This shows variation, from £52,000 to £200,000



Discharge process

Service model



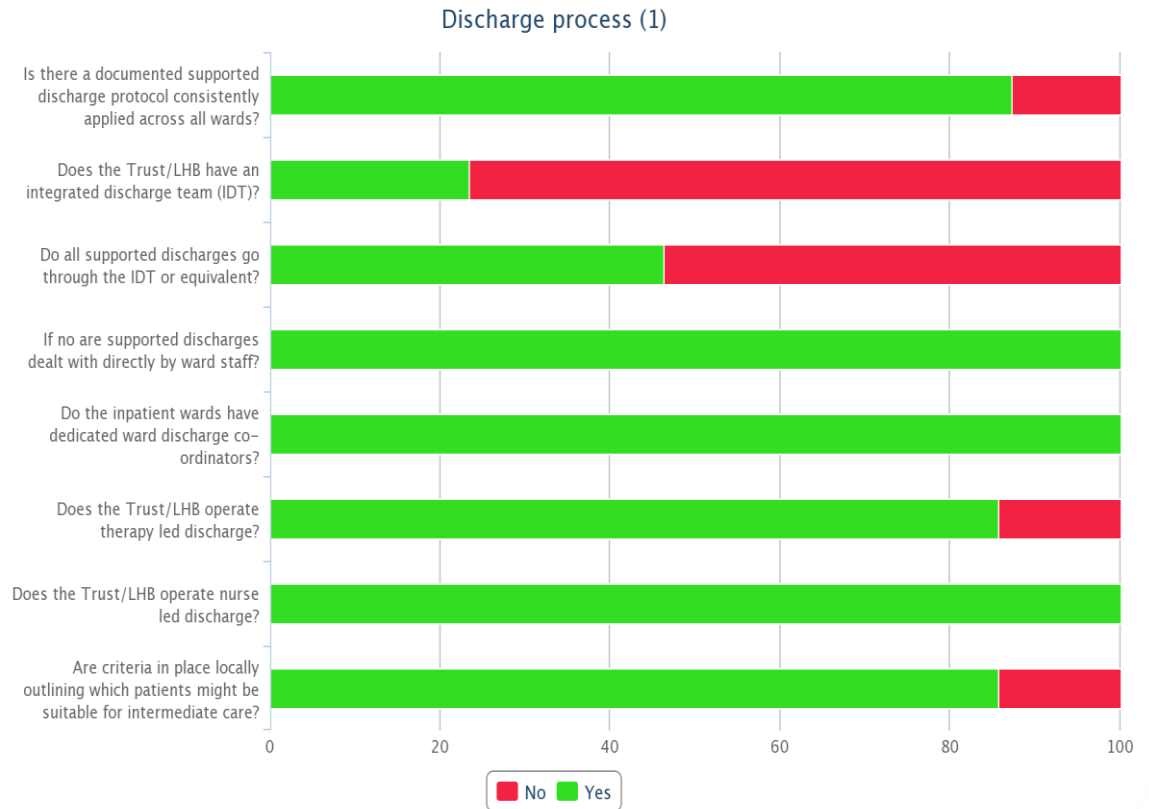
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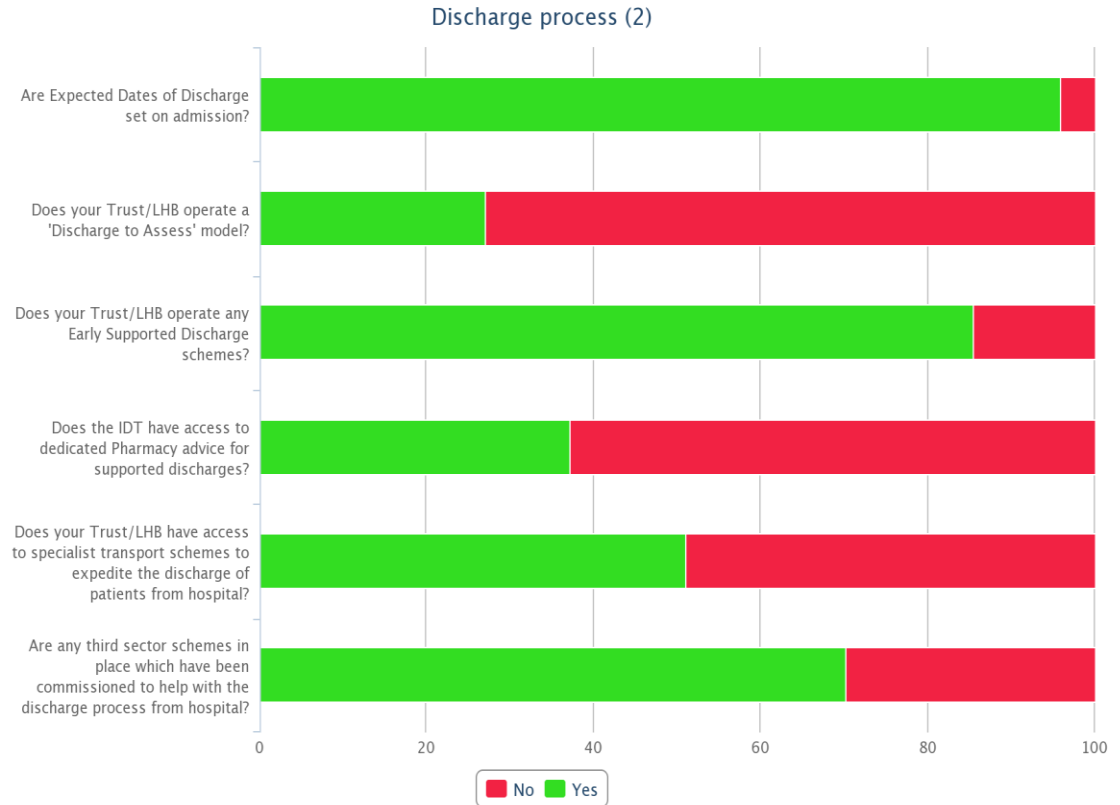
Supported discharge process

- 87% of Trusts / LHBs reported that they have a documented supported discharge protocol that is consistently applied across all wards.
- 23% of Trusts / LHBs have an integrated discharge team (IDT). 46% of Trusts / LHBs reported that all supported discharges go through the integrated discharge team (or equivalent).
- Where discharges are not supported by the IDT, they are dealt with directly by ward staff. All Trusts / LHBs reported that inpatient wards have dedicated ward discharge co-ordinators.
- 86% of Trusts / LHBs operate therapy led discharge.



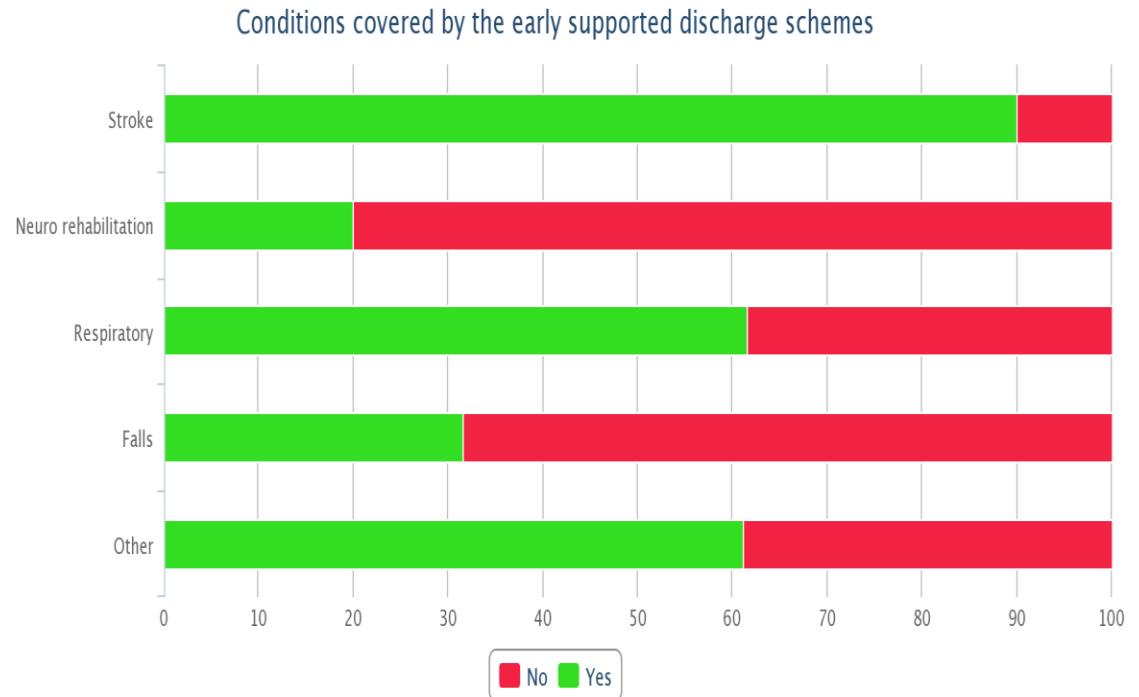
Supported discharge process

- 96% of organisations set an expected date of discharge on admission.
- 27% of Trusts / LHBs operate a 'Discharge to Assess' model
- Early supported discharge schemes operate in 85% of Trusts / LHBs.
- Hospital transport is an important service to ensure patients are not delayed in leaving hospital once discharged. 51% of Trusts / LHBs have access to specialist transport schemes to assist with the discharge of patients from hospital.
- 70% of participants reported having third sector schemes in place which have been commissioned to help with the discharge process.



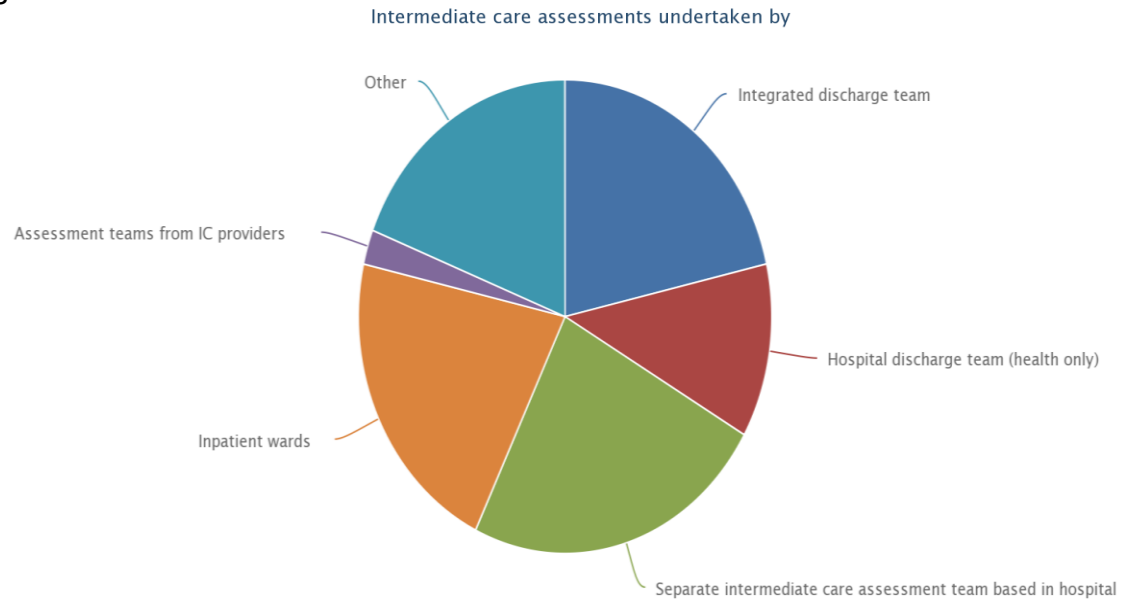
Early supported discharge schemes

- Early supported discharge schemes operate in 85% of Trusts / LHBs.
- Conditions covered by the early supported discharge scheme were reported to be
 - Stroke (90%)
 - Neuro rehabilitation (20%)
 - Respiratory (62%)
 - Falls (32%)
 - Other (61%)
- 'Other' conditions covered by the discharge team include
 - Orthopaedics
 - Frail older people
 - Cardiology



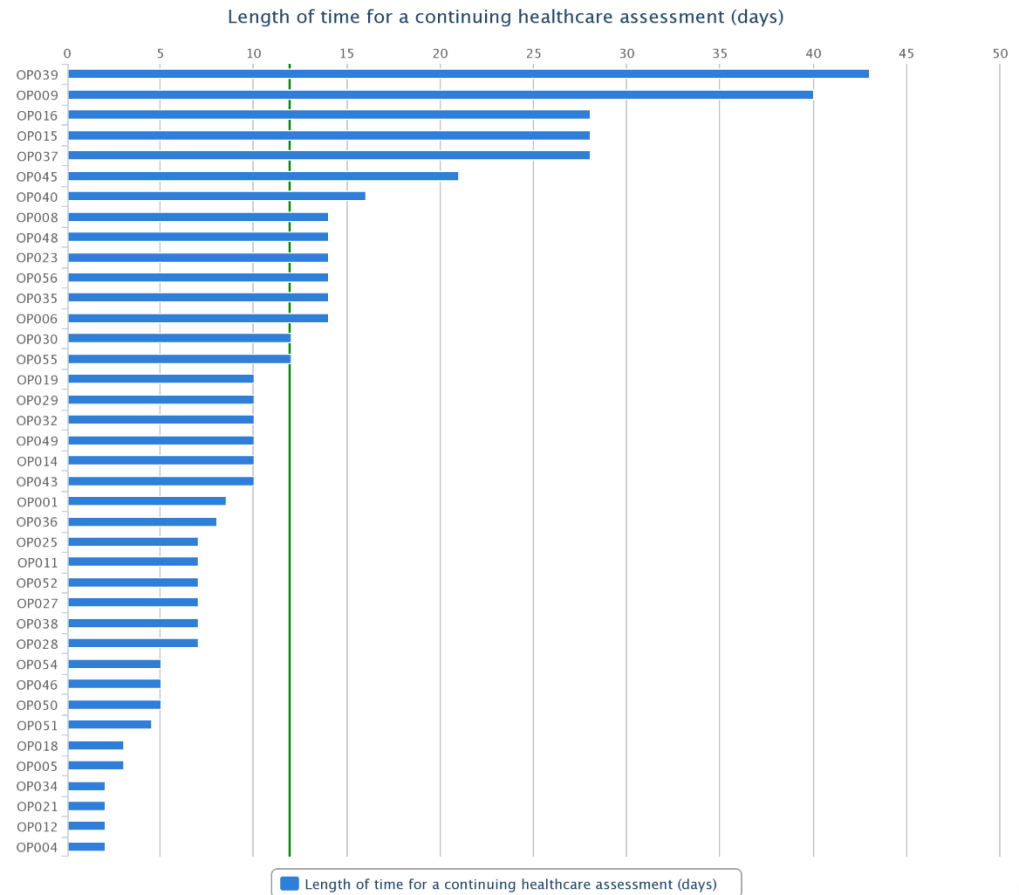
Intermediate care

- 86% of Trusts / LHBs have criteria in place locally outlining which patients might be suitable for intermediate care.
- Intermediate care assessments are reported to by undertaken by a variety of teams:
 - Integrated discharge team (21%)
 - Hospital discharge team (12%)
 - Separate intermediate care assessment team (24%)
 - Inpatient wards (21%)
 - Assessment teams from IC providers (2%)
 - Other (19%)



Continuing healthcare assessment

- In Trusts / LHBs where continuing healthcare (CHC) assessments occur, 100% report that they take place on inpatient wards.
- 60% are able to deliver CHC assessments in a patients own home, and 50% in intermediate care bed based units.
- CHC assessments are carried out by a separate team of CHC nurse assessors in 39% of Trusts / LHBs, integrated discharge teams in 34% of Trusts / LHBs and by hospital discharge teams in 18% of Trusts / LHBs.
- The average length of time for a CHC assessment is 11.9 days. The lowest reported time was 2 days, and the longest length of time for a CHC assessment to take place was 43 days.



Discharge process

Workforce



Benchmarking Network

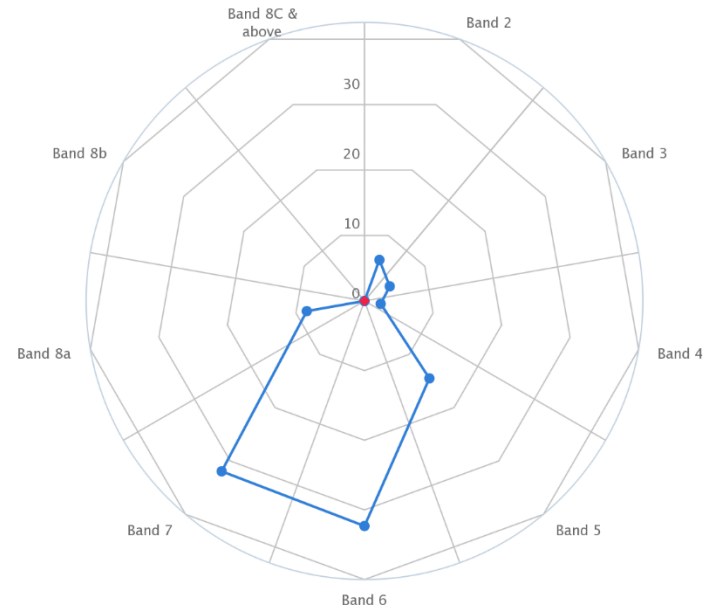
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Nursing skill mix – supported discharge team

- The average nursing skill mix in supported discharge teams has a higher skill mix than the other areas reported on in this report.
- Band 6 and 7 staff make up 64% of the total supported discharge nursing team, with Band 5 staff contributing a further 15%. Band 8a staff make up 8% of the work force.
- The supported discharge team has the highest registered to non registered nursing ratio with 87% being registered and 13% unregistered.

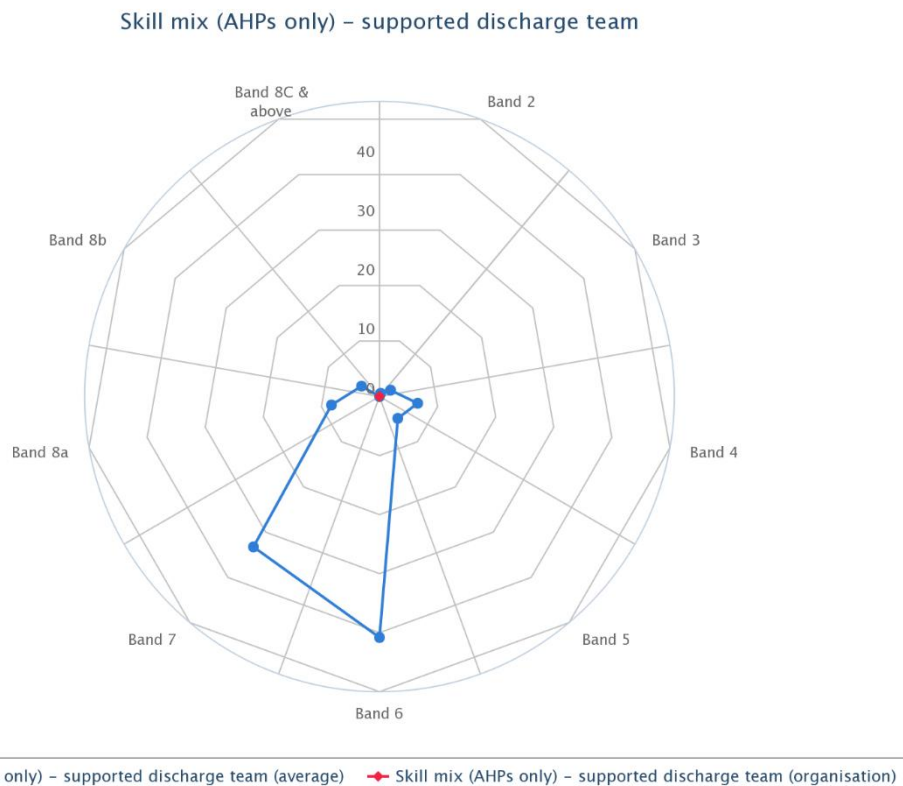
Skill mix (nursing only) – supported discharge team



— Skill mix (nursing only) – supported discharge team (average) — Skill mix (nursing only) – supported discharge team (organisation)

AHP skill mix – supported discharge team

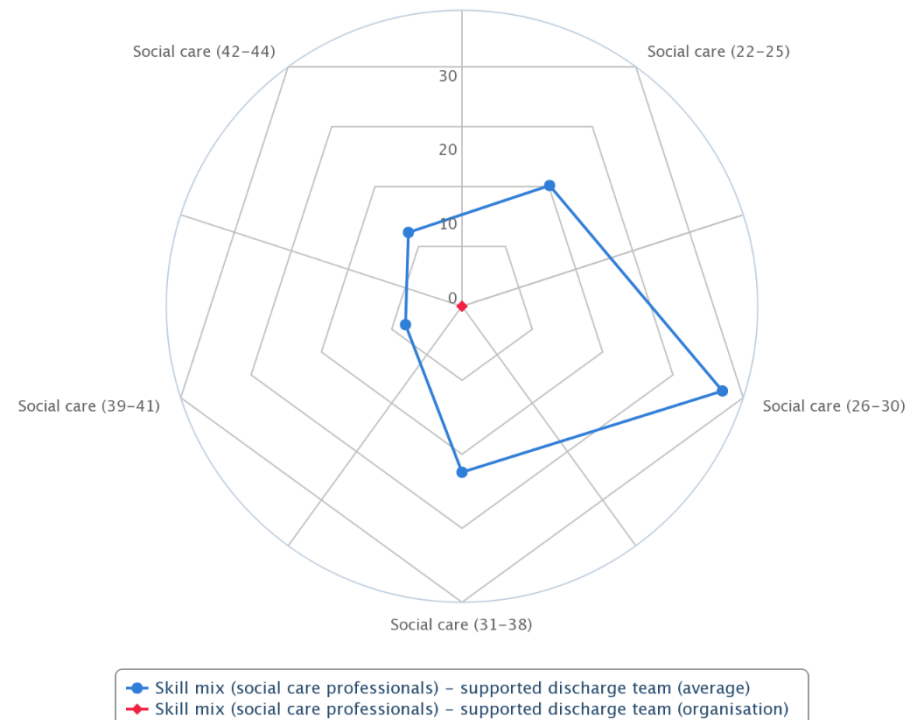
- The skill mix of AHPs in the supported discharge team was also found to be the area with the richest skill mix:
 - Band 2 – 1%
 - Band 3 – 2%
 - Band 4 – 7%
 - Band 5 – 5%
 - Band 6 – 41%
 - Band 7 – 33%
 - Band 8a – 8%
 - Band 8b – 3%
- 31% of AHPs on care of the elderly wards are unregistered, compared to 9% of the supported discharge team.



Social care skill mix – supported discharge team

- As with nursing staff and AHPs, the skill mix of the social care professionals within the supported discharge team is the richest identified in this project.
- The average skill mix of social care professionals in the supported discharge team is:
 - 22 – 25: 20%
 - 26 – 30: 37%
 - 31 – 38: 22%
 - 39 – 41: 8%
 - 42 – 44: 12%

Skill mix (social care professionals) – supported discharge team



Discharge process

Finance



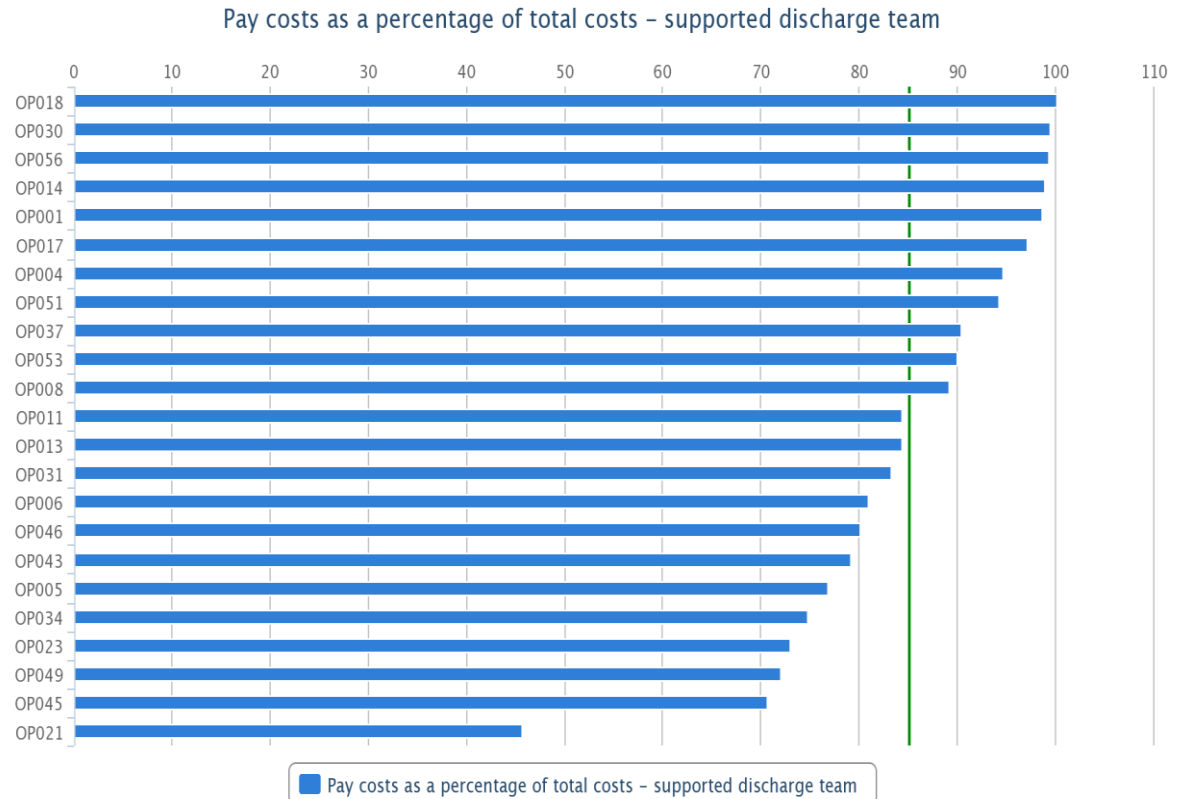
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Spend on supported discharge team

- On average, 85% of the total spend on the supported discharge team is for pay costs.
- The average supported discharge team CIP is 2.6% of the total budget. This ranges from 2 – 10% of total budget.



Quality & outcomes



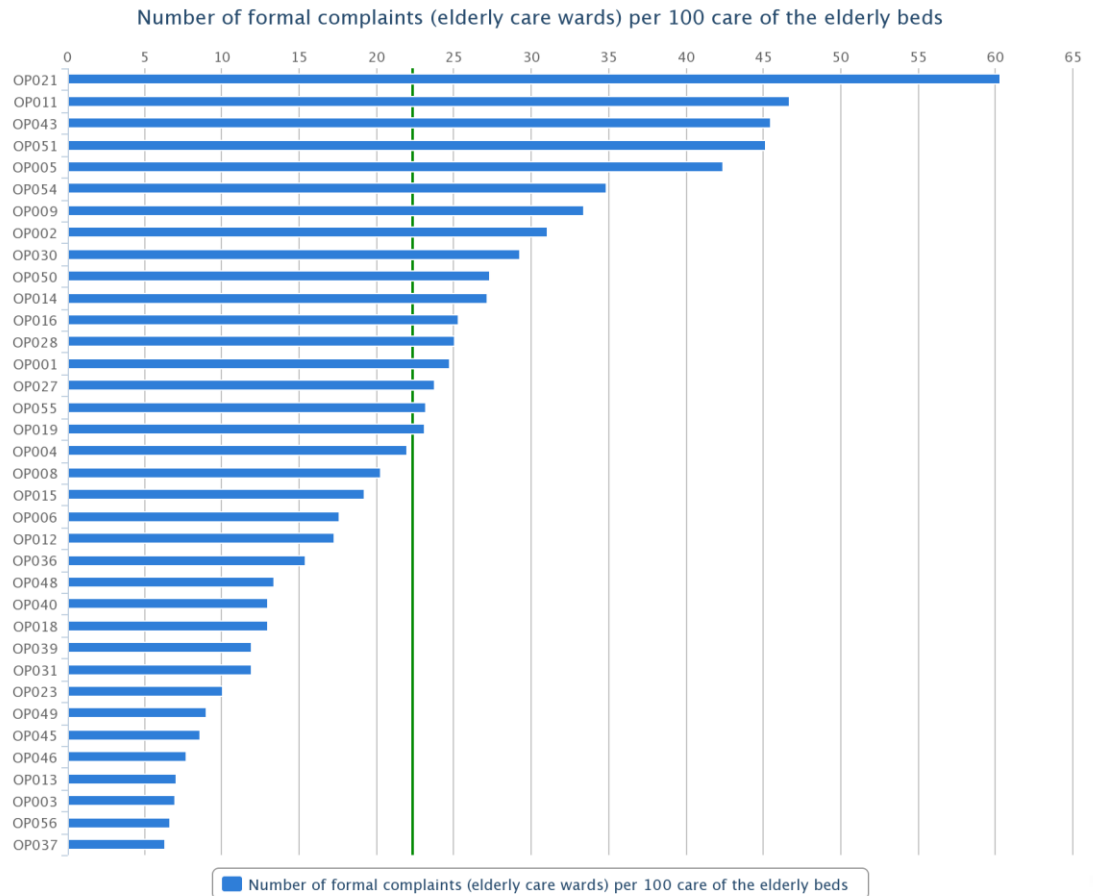
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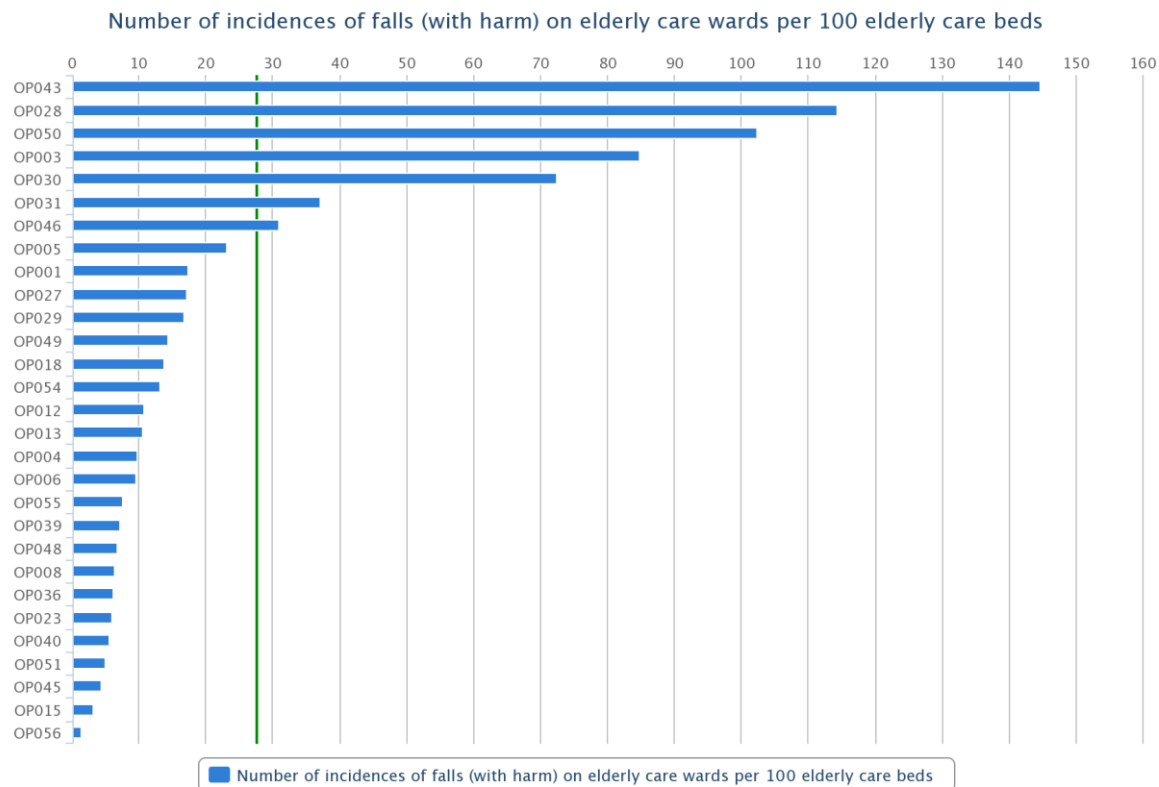
Formal complaints on elderly care wards

- Participants were asked to provide a range of quality metrics for their elderly care wards. The data shown is per 100 care of the elderly beds per year.
- The data provided has been benchmarked per 100 care of the elderly beds per year, to allow for comparisons between Trusts / LHBs.
- The average number of formal complaints on the care of elderly wards is 22 per 100 care of elderly beds per year. This figure ranges from 6 to 60 per 100 beds per year.



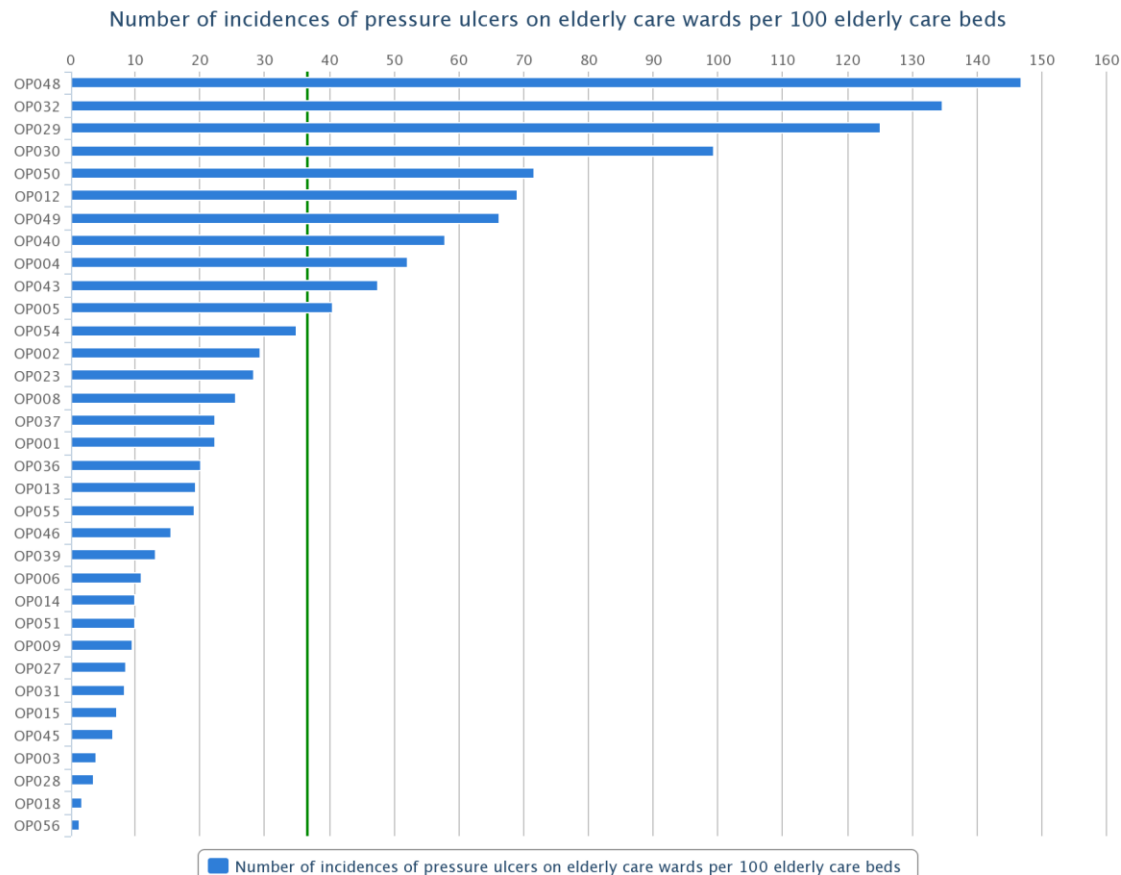
Incidences of falls

- The mean number of incidences of falls (with harm) on elderly care wards was 28 per 100 elderly care beds per year.



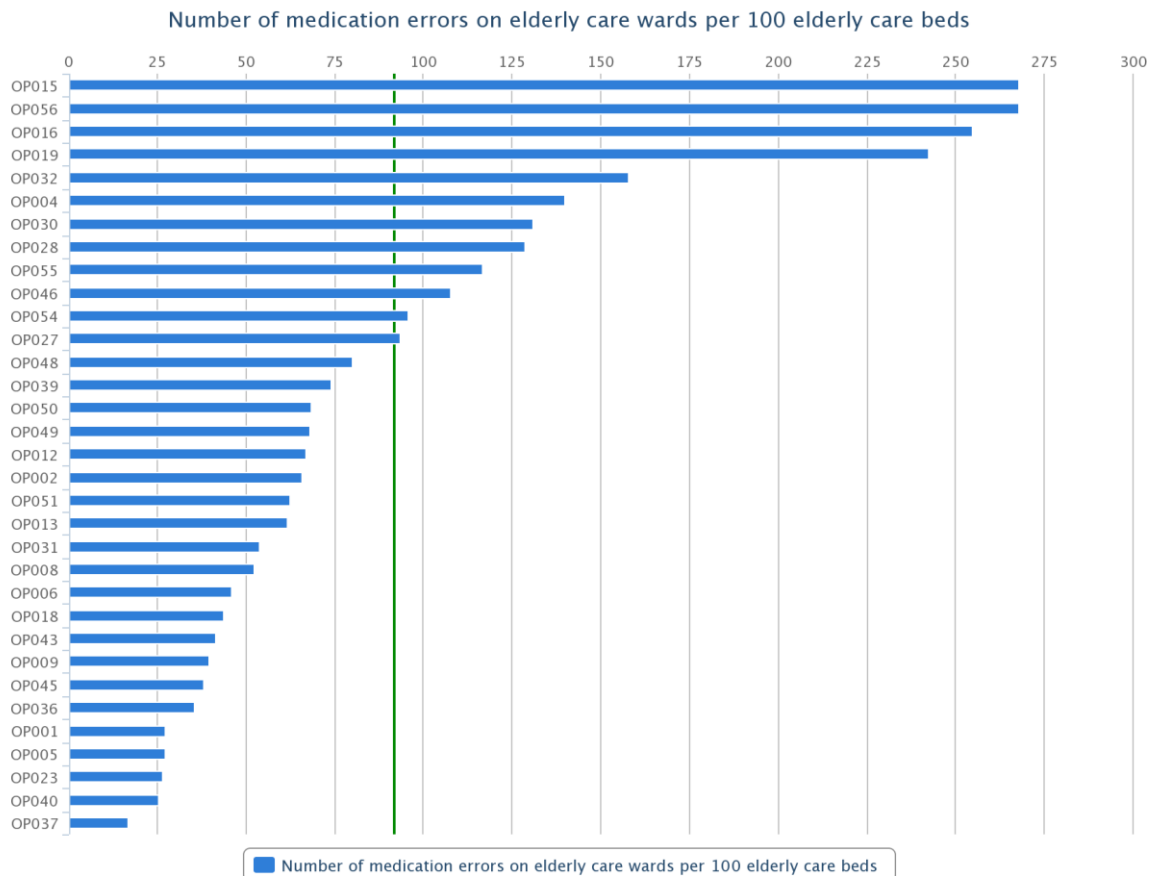
Incidences of pressure ulcers

- The mean number of incidences of pressure ulcers on elderly care wards is 36 per 100 elderly care beds per year.
- Again there is wide variation in the numbers reported, from 1 to 147 per elderly care bed per year.
- The variation in these quality metrics may be due to the variation in how Trusts / LHBs collect certain metrics, and the definitions used by each Trust / LHB.



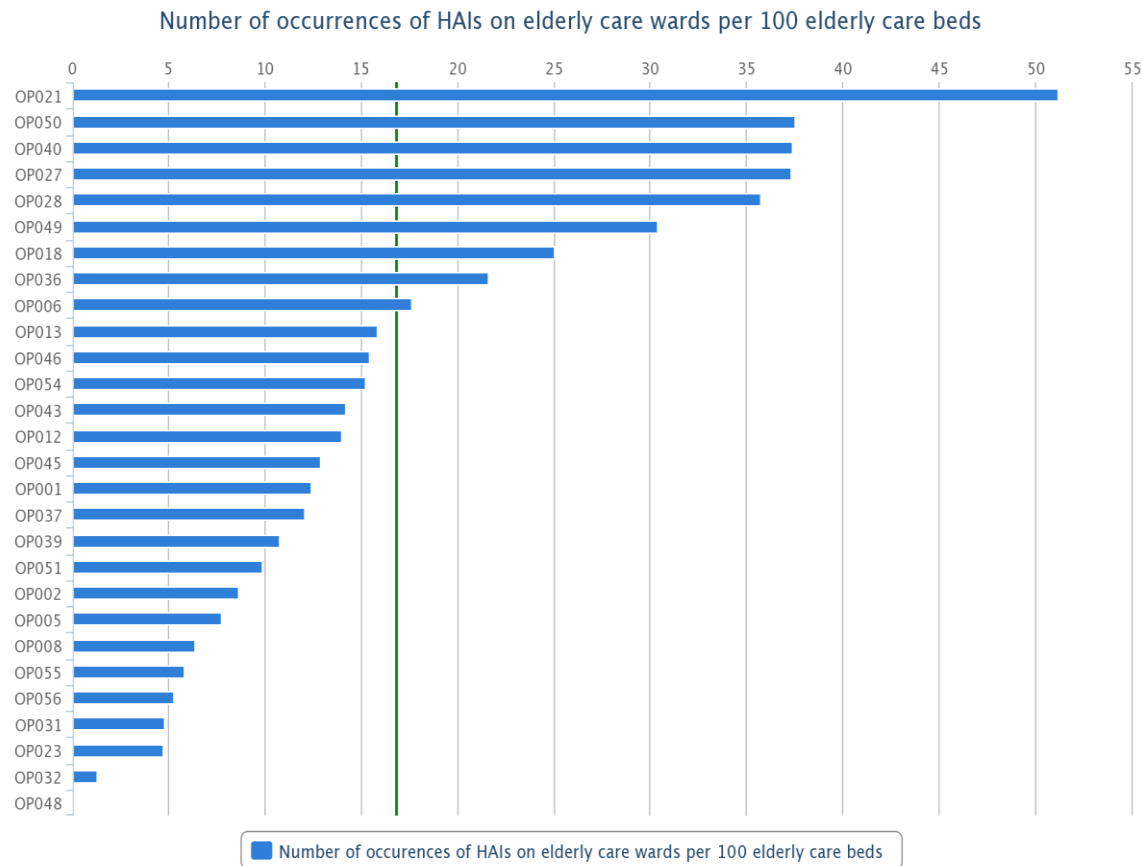
Medication errors

- The mean number of medication errors on elderly care wards is 36 per 100 elderly care beds per year.



Hospital acquired infections

- Participants were asked to provide as a minimum, MRSA, respiratory infection, diarrhoeal outbreaks, Clostridium difficile infection and transmissible spongiform encephalopathies.
- The mean number of occurrences of HAIs is 17 per 100 elderly care beds per year.



Section 4

Overall workforce benchmarking



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Geriatric team availability

- The project collected data on hours of availability of senior medical cover across the acute pathway (this was not collected for inpatient wards where medical cover is available 24/7).
- The results show that the cover from senior medical staff is less available on weekends.
- Patients access urgent care 24 hours per day, 7 days a week, and the availability of senior medical teams to assess and move patients on appropriately is essential to maintaining patient flows.
- There is a current drive towards 7 day working within the NHS and the data in this report shows there is still a significant reduction in availability of staff at weekends.

| Hours of availability over a 24 hour period: | Weekday | Weekend |
|---|---------|---------|
| Dedicated geriatric team in A&E | 9 | 6.5 |
| Senior medical cover – frailty unit | 12.9 | 9.9 |
| Senior medical cover – short term assessment unit | 17.4 | 16.1 |
| Senior medical cover – other assessment units | 15.6 | 14.7 |



Medical team skill mix – all pathway

- The medical team skill mix across the acute pathway highlights some interesting results. The highest concentration of consultants is on acute inpatient wards.
- Where there is a dedicated geriatric consultant presence in A&E, 24% of the medical team are consultant geriatricians.
- Trainees are also a presence across the acute pathway.

| | Consultant funded establishment | Other medical funded establishment | FY1 funded establishment | FY2 funded establishment | Locums |
|---------------------------------|---------------------------------|------------------------------------|--------------------------|--------------------------|--------|
| Dedicated geriatric team in A&E | 24% | 44% | 25% | 0% | 7% |
| Assessment units | 29% | 38% | 19% | 14% | 1% |
| Care of elderly medical team | 31% | 32% | 18% | 19% | 3% |



Nursing staff skill mix

- The table below shows the skill mix of nursing staff in the four areas of the acute pathway explored in this report.
- A richer nursing skill mix is found at the front and back end of the hospital, where there are more registered than unregistered nurses.
- The use of Band 2 nurses is significantly higher within assessment units and care of the elderly wards than in the admission avoidance teams and supported discharge teams.

| | Band 2 | Band 3 | Band 4 | Band 5 | Band 6 | Band 7 | Band 8a | Band 8b | Band 8c |
|-----------------------------|--------|--------|--------|--------|--------|--------|---------|---------|---------|
| Admissions avoidance in A&E | 14% | 5% | 1% | 40% | 24% | 13% | 3% | 0% | 0% |
| Assessment units | 30% | 4% | 1% | 50% | 11% | 4% | 0% | 0% | 0% |
| Care of elderly ward | 39% | 5% | 1% | 45% | 7% | 3% | 0% | 0% | 0% |
| Supported discharge team | 6% | 4% | 2% | 15% | 32% | 32% | 8% | 0% | 0% |



AHP skill mix

- The table below shows the skill mix of AHPs in the four areas of the acute pathway explored in this report.
- As with the nursing staff, a lower skill mix is found in the care of elderly wards.

| | Band 2 | Band 3 | Band 4 | Band 5 | Band 6 | Band 7 | Band 8a | Band 8b | Band 8c |
|-----------------------------|--------|--------|--------|--------|--------|--------|---------|---------|---------|
| Admissions avoidance in A&E | 0% | 6% | 10% | 10% | 52% | 19% | 3% | 0% | 0% |
| Assessment units | 3% | 14% | 4% | 22% | 40% | 17% | 0% | 0% | 0% |
| Care of elderly ward | 8% | 13% | 11% | 29% | 28% | 11% | 0% | 0% | 0% |
| Supported discharge team | 1% | 2% | 7% | 5% | 41% | 33% | 8% | 4% | 0% |



Social care skill mix

- The report also explored the availability of social care staff across the acute pathway by social care banding.
- The richest skill mix of social care staff is in the supported discharge team. Relatively lower banded staff are available at the front-end of the hospital, and the lowest banded social care staff are available in the assessment units and the inpatient wards.

| | 22 - 25 | 26 - 30 | 31 - 38 | 39 - 41 | 42 - 44 |
|-----------------------------|---------|---------|---------|---------|---------|
| Admissions avoidance in A&E | 0% | 56% | 33% | 11% | 0% |
| Assessment units | 67% | 0% | 33% | 0% | 0% |
| Care of elderly ward | 43% | 22% | 35% | 0% | 0% |
| Supported discharge team | 20% | 37% | 22% | 8% | 12% |



Section 5:

Conclusion and next steps



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Conclusion

- Requesting that Trusts/LHBs collect data on the 65+ age group has proved that it is possible to compare the four functions of the acute pathway across participants, and create a picture of the care of older people in the acute setting.
- A striking feature of the results is the very wide variation on many of the metrics reviewed in the project, suggesting there is room for greater compliance with evidence based practice and significant potential for service improvement.
- Of the four elements of the acute care pathway considered, the most investment in services is in the inpatient / elderly care ward. Very little relatively is invested in front-end admission avoidance schemes, with very little dedicated geriatric team input here. Given that this is an area on the pathway where significant impact could be made in terms of emergency admissions, Trusts / LHBs might consider shifting resources round to redress this imbalance. The evidence shows that time spent in A&E departments for older people is a predictor of inpatient length of stay and a stay in A&E of 4 – 8 hours increases inpatient length of stay by 1.3 days.
- *Safe, compassionate care for frail older people using an integrated care pathway* (NHS England, February 2014) recommends that expert decision makers should be available at the front door of the acute hospital from 8 am to 8 pm 7 days per week. It also recommends that specialist assessment should be made available within 12 hours of admission, 7 days per week. The benchmarking results have shown that only 24% of Trusts have dedicated geriatric teams available in A&E, with the hours of availability of these teams fewer than recommended. However, of the Trusts / LHBs who provided this data, on average patients were being assessed by a senior clinician within 6 hours of admission to assessment units.
- The benchmarking has shown that older people form a relatively small proportion of all patients attending A&E (23% of total admissions), but form a much higher proportion of patients in the assessment units (52% of assessment unit admissions) and a substantial proportion of overall hospital inpatients (44% of elective and 43% of emergency admissions). This highlights the need for accessible, alternative community services for older people to prevent unnecessary A&E attendances and emergency admissions.
- With the drive to forge forwards with 7 day working in the NHS, the benchmarking data provides some baseline positions for the care of older people in acute settings, particularly in admission avoidance in A&E and in assessment units. It would appear from the benchmarking data that these hours are much reduced at weekends from all staff groups benchmarked - medical staffing, therapy and social work.



Conclusion

- Assessment units are a point in the pathway where there remains the opportunity for staff to influence the onward journey of the patient through acute care, as many older people are admitted through an assessment unit, and potentially discharge from the assessment units. The service model delivered in assessment units has the potential to improve patient outcomes, reduce inappropriate hospitalisation, potentially reduce the need for long-term care, and hence keep costs down. It would appear from the benchmarking that A&E departments are utilising these units for a fuller assessment of older people with 68% of admissions coming from A&E departments.
- The use of Comprehensive Geriatric Assessment (CGA) *Comprehensive Assessment of the Frail Older Patient* (BGS, January 2010) has a strong evidence base for effectiveness and has been shown to increase the older patient's likelihood of being active and in their own home after a spell in hospital. The benchmarking results show that CGA would appear to be delivered fairly comprehensively on older people's wards (87%) but this reduces on other speciality wards to 23%. This may mean that older people who are outliers on other specialty wards are not receiving the gold standard assessment package. CGA was carried out in 44% of other assessment units and 30% of other assessment units. It is recognised that delivering holistic assessment in assessment units, with large throughput of patients is potentially difficult, and older people present particular challenges as they often present with non-specific conditions which make immediate diagnosis difficult. However, the benchmarked results show that there is the potential for growth in this area, and a baseline established against which to measure future trends. Trust / LHB outliers policies (available in 38% only) should make provision for the care of older people on other specialty wards, particularly in relation to the delivery of CGA.
- It is apparent that length of stay for emergency admissions increases as people are older (all ages = 5.6 days, 65 – 74 = 7.5 days, 75 – 84 = 9.3 days and 85+ = 11 days). There is the opportunity both in primary / community care settings and earlier in the acute pathway to reduce emergency admissions, to impact upon length of stay and costs. Those opportunities are particularly apparent in A&E and the assessment units.
- The results illustrate how quickly, even older people, now move through the stages of the acute pathway and hence the importance of services that support people post discharge.



Conclusion

- The skill mix benchmarked results show some interesting findings across the acute pathway and are explored further in **Section 6 Overall workforce benchmarking**. *Safe Staffing on Older People's Wards* (RCN, 2012) reports that more registered nurses means better care, increased patient safety and improved patient experience. Yet older people, who often have the most complex and intense needs of all, do not always fully benefit. Older people's wards tend to have a more dilute skill mix than other types of wards, especially when compared to adult acute / medical / surgical and children's wards. The benchmarking data has shown this to be this case. The recommended skill mix for basically safe care is 50:50 registered to unregistered nurses; for ideal good quality care this rises to a ratio of 65:35 registered to unregistered nurses. The average position reported for the benchmarking project was 56:44 which lies somewhere in between this ratio. Participants could use this benchmarking data as the opportunity to review nursing skill mix across their acute pathway, but particularly on inpatient wards.
- The benchmarked findings have shown that only 23% of Trusts / LHBs have an integrated discharge team, with a full complement of health and social care staff as part of the team. Nurse-led discharge is in place across all participants.
- There is still considerable variation on all quality and outcome metrics collected. Participants should view their benchmarked position via the online benchmarking toolkit across the range of metrics.



Next steps

Next steps

- This report represents the first iteration of the older people in acute settings project. 47 member organisations participated in the project to provide a wealth of data on the acute care of older people that is not available elsewhere in the NHS.
- Participating organisations have access to a comprehensive online tool allowing them to view their positions on hundreds of metrics covering service models, activity, workforce, finance and quality/outcomes across the acute pathway.
- The findings of the Older People project were presented at a national conference and were well received by members of the Network. The Network Steering Group have agreed that older people in acute settings should be included in the 2015/16 work programme looking at 2014/15 outturn data, allowing for year-on-year comparisons to be made.
- The NHS Benchmarking Network will work in partnership with the British Geriatrics Society to develop a set of quality indicators for the 2015/16 iteration of the project.
- Members of the Network are able to access the online toolkit to view their own benchmarked position on all metrics in this report and many others via the members' area of the network website www.nhsbenchmarking/nhs.uk.
- The 2014/15 project is now complete. Comments and suggestions for the project process, content and outputs can be sent to Debbie Hibbert, Project Manager at debbie.hibbert@nhs.net.

