Older People’s Care in Acute Settings

Benchmarking Report

NHS Benchmarking Network

March 2016
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Foreword
Foreword

It is recognised that older people are a major service user cohort for both health and social care services, both in hospital (the acute setting) and in the community. It is well described that the population is ageing, as people are living longer, and as a result, there are more older people as a proportion of the overall population. Between 2005/06 and 2014/15 the number of people aged 65 or over in England increased by almost a fifth and the number aged 85 and over rose by approaching one third. The increase in the older population is projected to accelerate over the next twenty years. Whilst overall life expectancy is rising, there are also significant inequalities across the country in terms of life expectancy.

The RCP report “Hospitals on the Edge” recognises that hospitals are struggling to cope with the challenges of an ageing population and rising emergency admissions. The report notes that there are now a third fewer general and acute hospital beds than 25 years ago, however the last decade has seen a 37% rise in emergency admissions, with the largest proportion of this increase, from the over 75s. Many of these patients admitted to hospital have dementia, are frail and have complex needs, often presenting with multiple long-term conditions.

The King’s Fund estimates that NHS spending must increase by between 3% and 6% per year to keep pace with demand for health services and, that since 2010/11, the NHS has only received funding increases of 0.8% per year. NHS England are predicting large funding gaps, and although the government has pledged to increase NHS funding, significant savings will be required through increased productivity and efficiencies to close the gap. For social care, the funding picture is even more stark, as public funding for older people’s social care reduced by £0.66 billion between 2005/6 and 2014/15, and most of this decrease has been over the last five years. Government allocations to Local Authorities suggest that social care budgets are likely to be reduced further in this parliament.

As the recent Age UK briefing reports, the story is really a very simple one, as all the data essentially points in the same direction. The briefing notes: “The numbers of older people in England are steadily growing, and the proportion with long term conditions is growing faster still, but investment in health care overall is failing to keep pace with the impact of demographic change and other factors driving higher demand, and spending on social care has fallen quite spectacularly over the last five years”.

Benchmarking Network
Although the new models of care point towards more care being delivered out of hospital, there will always be occasions when an older person needs a period of acute hospital care. It is essential that we understand the older person’s pathway through hospital and identify factors that can facilitate quality of care and timely discharge. This project aims to explore variability of practice in this important area.

This benchmarking review of the acute pathway, concentrating on four elements – admission avoidance in A&E, assessment in the acute pathway, inpatient ward care, and supported discharge – provides a stocktake of service provision in the acute setting, and offers a further analysis of interventions considered best practice in the care of older people. For example, the delivery of Comprehensive Geriatric Assessment (CGA) is explored in the project, providing a picture of how CGA is being delivered in acute settings. A definition of CGA is provided at Appendix one.

The project also asks scoping questions about new models of acute hospitals working and looks at, for example, the extent of interface geriatrics, the emerging frailty units, linkages with intermediate care services (which bridge the gap between hospital and home), linkages with primary care, community care and specialist mental health services, and new models for discharge processes, for example, discharge to assess models.

The project is unique in bringing together key activity, financial, and workforce data with a number of quality and outcome measures, enabling a complete picture of service provision to be built.

We take this opportunity to thank the Clinical Quality Committee of the British Geriatrics Society for their support and advice, particularly in relation to the new service user audit element of the project.

We hope that Trusts / LHBs find the report and other outputs useful and would very much welcome your feedback.

References:
The Health & Care of Older People in England 2015, Jill Mortimer & Marcus Green, Age UK January 2016
Hospitals on the Edge: The Time for Action, Royal College of Physician, September 2015
Office for National Statistics Life expectancy at birth and age 65 by Local Areas in the UK statistics
The Spending Review – What does it mean for health and social care? The King’s Fund, the Nuffield Trust and the Health Foundation, December 2015

Claire Holditch
Project Director
NHS Benchmarking Network
Executive summary
Executive summary

- This report presents the findings from the second phase of a national benchmarking project looking at older people’s care 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 by the Network membership and the first iteration of the project ran in 2014, collecting 2013/14 data.

- The current iteration of the project, presented in this report, collects and analyses 2014/15 data.

- There are 49 participating services from Trusts and Local Health Boards (LHBs) in this version of the project.

- The project is available for participation for all members of the NHS Benchmarking Network who offer care for older people in the acute setting.

- This report, and the online toolkit, present the findings of the project across the four areas of the pathway; admissions 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.

- New for the 2015 project was the addition of a service user audit. This was developed in conjunction with the British Geriatrics Society, with the aim of complementing the existing organisational level data, and providing a further level of data to allow possible correlations to be explored and further analysis to be undertaken.

- Clearly, the older people’s pathway covers more than just the acute setting, however this project is targeted for completion by acute trusts and so necessarily focuses on areas on which they hold data. It is worth noting that the NHS Benchmarking Network runs a number of other benchmarking projects across the pathway, where data on the care of older people is collected and benchmarked. Most notable, the combined Mental Health Inpatients and Community project, the National Audit of Intermediate Care, and a comprehensive Community Services project. 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 when scoping the project due to the lack of a nationally agreed definition of ‘frailty,’ and the approach worked well in the first phase of 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. To access the online toolkit, go to the members’ area of the Network website at www.nhsbenchmarking.nhs.uk. If you would like a member login, or have forgotten your password for the members’ area, please contact ashley.spencer1@nhs.net.

Participating organisations have also been issued with a summary bespoke report, which indicates their own position on key charts in this report. Please contact NHS Benchmarking for your local report.

Key findings
Overview

- 59% of Trusts / LHBs state that they have a recognised frailty tool/pathway in use in the health and social care economy.
- 67% of Trusts / LHBs state that they have a clearly defined strategy/operational policy for the delivery of acute medical care to older people.
- 100% of Trusts / LHBs state that they have a designated Clinical Lead for Older People’s services in the Trust/LHB.
- 37% of organisations state that they have an outliers policy which specifically mentions the management of Older People in acute care, and 52% reported that they have a policy locally which related to the movement of older people once admitted to hospital.
- 89% of organisations state that they have specific dementia training for all staff.
- 57% of trusts / LHBs state that they have have a geriatric interface team in operation.
- The cost of each area of the pathway was explored, and it was found that 70% of expenditure on older people’s services was for the care of older people wards and inpatient care. 26% of total spend was on assessment units, 3% 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

- 34% of participating Trusts / LHBs have a dedicated geriatric team located in the A&E department. 93% report therapists are available in A&E to assist with admission avoidance of older people. 61% of organisations have rapid access to social workers in A&E, and 46% report that in-reach is provided by the Hospital Discharge Team.
Executive summary

- Hours of availability of teams in A&E typically decrease at weekends. Where there are dedicated geriatric teams in A&E, they are typically available for 9.4 hours per day during the week, reducing to 4.4 hours per day at weekends. Availability of other teams is explored later in the report.

### Activity
- On average, 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 relatively rich in this area, with staff generally being from higher bandings than compared to inpatient care.

### Assessment units

#### Service models
- 42% of Trusts/LHBs have a frailty unit, with 63% using a recognised frailty tool within the frailty unit. 86% of frailty units state that they use Comprehensive Geriatric Assessment (CGA), and 95% have a dedicated geriatric team located in the frailty unit.
- Clinical leadership on the frailty unit is generally by a Geriatrician. Senior medical presence is typically available for 13 hours per day during the week and 9 hours per day at weekends.
- 73% of Trusts/LHBs have a short-term assessment unit (up to 12 hours stay), with 27% using a recognised frailty tool within the short term assessment unit. Comprehensive Geriatric Assessment takes place in 53% of short term assessment units. 26% have a dedicated geriatric team located in the short term assessment unit. The average short term assessment unit has 19 beds, with clinical leadership typically being provided by a General Physician.
- 93% of Trusts/LHBs have other assessment units (between 12 and 72 hours expected maximum length of stay). 28% of these assessment units utilise a recognised frailty tool, and 60% state that they 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.

#### Activity
- Two-thirds of admissions to assessment units are from A&E, with 28% being admitted via their GP. 53% of admissions to assessment units are people aged 65 and over, and 63% of admissions to inpatient care from assessment units are of older people. The average length of stay on all assessment units is 25 hours.
Executive summary

- **Workforce**
  - The nursing skill mix in assessment units comprises 66% registered nurses and 36% unregistered nurses. The AHP skill mix is largely made up of band 6 staff (46%).

- **Finance**
  - The average cost per admission to an assessment unit was £291, although this figure showed wide variation.

**Inpatient care**

- **Service models**
  - The average number of care of older people beds per Trust / LHB is 103. Comprehensive Geriatric Assessment is delivered on 86% of care of older people wards, and 30% in other speciality wards. A social worker or supported discharge co-ordinator forms part of the MDT on care of older people wards in 93% of Trusts / LHBs.

- **Activity**
  - The average length of stay for emergency admissions for all ages is 5.2 days. This LOS increases to 6.5 days for emergency admissions for ages 65-74, 8.3 days for ages 75-84, and 10.1 days for people aged 85+.
  - The spells with an average length of stay of longer than 21 days account for 6% of spells in inpatient care, but 44% of all occupied bed days.

- **Workforce**
  - The nursing skill mix has the lowest ratio of registered to unregistered nursing staff of the elements considered in the acute pathway, 58% registered to 42% unregistered.
  - The average medical WTE per care of older people bed is 0.27.

**Discharge process**

- **Service models**
  - There is a documented supported discharge protocol consistently applied across all wards in 86% of Trusts / LHBs. 67% of organisations have an integrated discharge team (IDT) and, where supported discharges do not go through the IDT, they are dealt with directly by ward staff. 80% of organisations reported that inpatient wards have dedicated ward discharge co-ordinators.
Executive summary

Discharge process (continued)

Service models (continued)
- 95% of Trusts / LHBs operate Early Supported Discharge schemes, with 76% having access to dedicated Pharmacy advice for supported discharges.
- The average length of time for a continuing healthcare assessment to take place is 10 days.

Workforce
- The skill mix of the supported discharge team is relatively rich, with 77% of nurses being registered and 23% unregistered.

Quality
- Quality metrics are benchmarked per 100 care of older people 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 older people beds per annum is 28. Safeguarding incidents per 100 care of older people beds per annum average 12 incidents.
- Incidences of falls (with harm) on care of older people wards per 100 care of older people beds average 57 falls.

Service user audit
- 46% of service users on care of older people wards were admitted with ICD-10 codes that could be associated with frailty.
- 69% of patients admitted to the older people wards maintained their dependency on discharge as measured by their care setting (e.g. own home to own home). 16% increased dependency (e.g. own home to nursing home).
- 76% of service users included in the audit received CGA which was fully documented, with 49% receiving CGA in the Assessment Unit, and 49% receiving CGA on the inpatient ward. 2% received CGA in A&E.
Project update
Background to the project

- Care of older people in acute settings was identified by the Network membership as a priority topic. The project proposal was put to the Network Steering Group, who decided to include the project, for the first time, in the 2014/15 work programme (collecting 2013/14 data).

- A reference group met in February 2014 to scope out the project. The group comprised of members from Trusts / LHBs. 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.

- 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 first iteration of the project, collecting 2013/14 data, took place in 2014, and the results were published early in 2015.

- The Older People in Acute Settings project provided to be popular with members, and the Network Steering Group agreed to include it in the 2015/16 work programme, collecting 2014/15 outturn data.

- Data collection for the second phase of the project ran from August 2015 to October 2015. 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.nhs.uk.

- The findings from the project were presented at a national conference in London on the 24th February 2016, along with good practice examples from members.
Project participants

ABM University Local Health Board  
Ashford & St Peter's Hospitals NHS Foundation Trust  
Barnsley Hospital NHS Foundation Trust  
Basildon & Thurrock University Hospital NHS Foundation Trust  
Bradford Teaching Hospitals NHS Foundation Trust  
Buckinghamshire Healthcare NHS Trust  
Cardiff & Vale University Health Board  
Chesterfield Royal Hospital NHS Foundation Trust  
Derby Teaching Hospitals NHS Foundation Trust  
Doncaster & Bassetlaw Hospitals NHS Foundation Trust  
East Sussex Healthcare NHS Trust  
Guy’s and St Thomas’ NHS Foundation Trust  
Hywel Dda Local Health Board  
Imperial College NHS Healthcare Trust  
Leeds Teaching Hospitals NHS Trust  
Milton Keynes Hospital NHS Foundation Trust  
North Bristol NHS Trust  
North Cumbria University Hospitals NHS Trust  
North Tees and Hartlepool NHS Foundation Trust  
Northampton General Hospital  
Nottingham University Hospitals NHS Trust  
Poole Hospital NHS Foundation Trust

Portsmouth Hospital NHS Trust  
Queen Elizabeth Hospital, King’s Lynn NHS Foundation Trust  
Royal Cornwall Hospital Trust  
Royal Devon and Exeter NHS Foundation Trust  
Royal Liverpool and Broadgreen University Hospitals NHS Trust  
Royal Stoke University Hospital  
Royal United Hospital Bath NHS Foundation Trust  
Sheffield Teaching Hospitals NHS Foundation Trust  
Sherwood Forest Hospitals NHS Foundation Trust  
Southend University Hospitals NHS Foundation Trust  
St George’s Healthcare NHS Foundation Trust  
Taunton & Somerset NHS Foundation Trust  
The Dudley Group NHS Foundation Trust  
The Ipswich Hospital NHS Trust  
The Newcastle upon Tyne Hospitals NHS Foundation Trust  
United Lincolnshire Hospitals Trust  
University College London Hospitals NHS Foundation Trust  
University Hospitals Bristol NHS Foundation Trust  
University Hospitals Leicester NHS Trust  
University Hospitals of Morecambe Bay NHS Foundation Trust  
University Hospitals Southampton NHS Foundation Trust  
Whittington Health NHS Trust
Benchmarking comparisons

Overview
**Participant overview**

- Participating Trusts / LHBs ranged in size, from smaller district general hospitals to large teaching hospitals and Welsh LHBs. 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 £169 million to £1,290 million. The mean Trust turnover was £512 million.

- The total number of staff employed by Trusts / LHBs ranged from 2,572 WTE to 13,829 WTE. The mean WTE employed by Trusts / LHBs was 6,570 WTE.

- The mean number of consultants employed by Trusts was 319 WTE, and the mean number of geriatricians employed was 12 WTE. Geriatricians make up 3.6% (mean value) of the consultant workforce.

- Spend on the older people’s services covered in this project, as a percentage of overall Trust / LHB turnover ranged from 1% to 7% and the average was 3.6%. 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.
Pathways and protocols in place

- Participating Trusts / LHBs were asked to identify pathways and protocols in place for the care of older people.
- 59% of organisations stated that they have a recognised frailty tool or pathway in use in the health and social care economy.
- 67% of Trusts stated they have a clearly defined strategy/operational policy for the delivery of acute medical care to older people.
- 70% reported that pathways exist which clearly state the roles and relationships between A&E, assessment units and inpatient wards.
- 100% of participating organisations stated they have a designated clinical lead for older people’s services within the organisation.
- 37% stated they have an outliers policy which specifically mentions the management of older people in acute care.
- When asked if there was a local policy relating to the movement of older people once admitted to hospital, 52% answered yes.

- 67% … have a clearly defined strategy/operational policy for the delivery of acute medical care to Older People
- 70% …have pathways which clearly state the roles and relationships between A&E, assessment units and the wards
- 100% …have a designated Clinical Lead for Older People’s services in the Trust/LHB
- 59% …have a recognised frailty tool/pathway in use
91% of participating organisations stated they have a protocol with mental health services for accessing specialist mental health services for older people.

57% of Trusts have a geriatric interface team in operation. 68% of these geriatric interface teams have rights to admit patients.

88% of participants are using third sector schemes to enhance the care of older people. Examples of these schemes include:

- Using third sector organisations e.g. Age UK and British Red Cross for admissions avoidance and supported discharge ‘hospital to home’ schemes
- Third sector transport schemes
- Wellbeing services
- Royal Voluntary Service offering befriending services, and providing support with shopping, attending outpatient appointments, etc.
In this iteration of the project, participants were asked new questions about the Trust workforce for the care of older people.

- 44% of Trusts have Advanced Nurse Practitioners (ANPs) in Older People’s Care.
- For those who report having ANPs in Older People’s Care -
  - 22% report that every care of older people ward in the organisation has access to the ANPs
  - 29% provide advice and support wider than the care of older people wards
  - 32% link directly with community services
- 27% of Trusts participate in a consultant practitioner trainee programme.
- 89% have specific dementia training for all staff.
- 83% of the dedicated care of older people’s workforce have completed their local mandatory training requirements, and 78% have received an annual appraisal.
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 70% of expenditure identified was for care of older people wards and inpatient care.

26% 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 spend – average £735,184
- Agency spend – average £940,836
- Overtime spend – average £68,156
Older People 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. For example, if teams are available 9-5, the response would have been 8 hours.

34% of participants have a dedicated geriatric team located in the A&E department. Geriatric team availability fell by 5 hours per day at the weekend, with eight Trusts reporting no availability of a dedicated geriatric team at weekends. Three Trusts reported having 12 hours of availability at weekends, showing wide variations in service models.

93% of participants have therapy teams available in A&E, with the mean hours of availability 10 hours during the week and 7.6 hours at weekends. 18% of those with therapy teams in A&E reported having no weekend provision.

Almost two thirds of participants have rapid access to social workers in A&E to assist with admissions avoidance, however a quarter of these have no access to social workers at weekends. Two Trusts report having 24/7 rapid access to social workers to assist with admissions avoidance.

Almost half of participants have access to the hospital supported discharge team in A&E. Again the hours of availability are lower at weekends.

All teams showed reduced hours of availability at the weekend. Workforce numbers during the week and at weekends were not collected.

<table>
<thead>
<tr>
<th>% of Trusts with teams available in A&amp;E</th>
<th>Dedicated geriatric team</th>
<th>Therapy team</th>
<th>Social work</th>
<th>Supported discharge team</th>
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<tbody>
<tr>
<td>Weekday hours available</td>
<td>34</td>
<td>93</td>
<td>61</td>
<td>46</td>
</tr>
<tr>
<td>Weekend hours available</td>
<td>4.4</td>
<td>7.6</td>
<td>6.9</td>
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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 2014/15.

- 77% of attendances to A&E were by those aged 0 to 64 years old.
- 8% of attendees to A&E in 2014/15 were aged 65 to 74, and 9% were aged 75 to 84.
- People aged 85 and older accounted for 6% of all A&E attendances.
- In total, 23% 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 of Trusts / LHB activity at each step in the pathway, shown further on in this report.
As shown previously, attendances to A&E by those aged 65 and over accounts for 23% 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:
- 0 – 64 = 53%
- 65 – 74 = 14%
- 75 – 84 = 18%
- 85+ = 15%

Admissions to hospital from A&E for those aged 65 and over account for 47% of all admissions from A&E.
The average staff mix of the dedicated geriatric medical team in A&E (where a team was established) in 2014/15 was:

- Consultant funded establishment – 45%
- Other medical funded establishment – 14%
- FY1 funded establishment – 14%
- FY2 funded establishment – 28%
- Locums – 0%

Participants are able to view their own staff mix and make comparisons against the national averages on the online toolkit.
The nursing skill mix in admissions avoidance teams in A&E shows the team is made up of Band 5 nurses (28%), Band 6 nurses (27%) and Band 7 nurses (22%). Band 2 nurses also feature in the skill mix (12%).

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 79% of the nursing staff being registered and 21% unregistered.
The AHP skill mix of the admission avoidance team in A&E in 2014/15 was:

- Band 2 – 0%
- Band 3 – 6%
- Band 4 – 7%
- Band 5 – 19%
- Band 6 – 51%
- Band 7 – 16%
- Band 8 – 1%
Participants were asked for their pay, non-pay and indirect costs for each area of the pathway.

- The cost of admissions avoidance teams in A&E accounted for 1% of expenditure on older people’s services
- Pay costs accounted for 80% of the spend on admissions avoidance teams in A&E.
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.
42% of participating Trusts / LHBs have a frailty unit.

Of those Trusts / LHBs with a frailty unit:

- 63% use a recognised frailty tool; these include CSHA clinical frailty scale, ISAR, Bournemouth Criteria, Edmonton frailty tool, and Frail Safe.
- 11% of frailty units provide an outreach service working with primary and community care to case find individuals at risk of admission.
- 86% state that they use Comprehensive Geriatric Assessment on the frailty unit.
- 95% have a dedicated geriatric team located in the frailty unit.

The average frailty unit has 23 beds, however this figure ranges from 4 to 56 beds.

- 26% of frailty units have an expected maximum length of stay of 48 hours and 47% have an expected maximum length of stay of 72 hours. 11% reported a stay of greater than 72 hours was to be expected. No Trusts reported an expected maximum stay of 12 hours and 16%, 24 hours.
- Clinical leadership is provided by a Geriatrician on 95% of frailty units. 5% report clinical leadership is provided by a General Physician.
- The average hours that senior medical cover is available on frailty units over a 24 hour period during the week is 13 hours. At weekends this reduces to 9 hours, with 6 Trusts / LHBs reporting no cover at weekends.
- Out of hours medical cover is provided by an on-call rota (generic) in 67% of frailty units, on-call specialist in 22% of Trusts / LHBs, and dedicated cover in 11%.
Short term assessment units (up to 12 hours)

- 73% of participating Trusts / LHBs have a short term assessment unit. 21% reported that all admissions of older people go through the short term assessment unit.
- A recognised frailty tool is used in 27% of short term assessment units, and 53% state that they perform Comprehensive Geriatric Assessment. 26% have a dedicated geriatric team located in the short term assessment unit.
- 85% 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 19 beds, however this ranges from 4 beds to 56 beds.
- Clinical leadership is provided by a general physician in 61% of short term assessment units, and a geriatrician in 6% of cases. 30% reported an ‘other’ clinical lead, and 3% reported an Advanced Nurse Practitioner clinical lead.
- Senior medical cover is provided on average 16 hours per day during the week, with 31% of Trusts / LHBs reporting 24 hour cover. At weekends the average availability decreases to 15 hours, with no Trusts / LHBs reporting no senior cover. Many still have 24 hour cover at weekends.
**Other assessment units (12 to 72 hours)**

- 93% of Trusts / LHBs have other assessment units, with 17% reporting a recognised frailty tool being utilised within these assessment units.
- Comprehensive Geriatric Assessment takes place in 60% of other assessment units, and 44% have a dedicated geriatric team located in these other assessment units.
- The hospital discharge team provide dedicated support to 65% of other assessment units.
- The modal number of other assessment units within a Trust is 1 assessment unit, however this ranges from 1 to 4. The average number of beds on these units is 44 beds.
- 60% reported the expected maximum length of stay on these units was 72 hours.
- 85% of clinical leadership is provided by a General physician, 8% by a Geriatrician and 8% by an ‘other’ clinician.
- Senior medical cover is available, on average, 16.03 hours per day during the week and 15.16 hours on the weekend. 14 Trusts / LHBs report 24/7 senior medical cover on these units.

![Chart: Hours of availability of senior medical cover over a 24 hour period during the week]

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**NHS Benchmarking Network**

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Comprehensive Geriatric Assessment

- This year participants were asked further questions on Comprehensive Geriatric Assessment (CGA).
- Participants were asked a series of questions about the use of CGA within their organisation. 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)
- A quarter of participating organisations have an awareness programme for non geriatricians about frailty and CGA.
- CGA can be accessed in the community in 65% of organisations.
- Almost half of Trusts / LHBs document CGA on a single shared assessment document accessible by all MDT members.
- CGAs contain a care plan which has been discussed with the patient and/or their carers in 47% of organisations.
CGA is a multidisciplinary process. Organisations were asked whether different staff members were involved in carrying out CGA on assessment units.

- 89% reported that Consultants are involved in carrying out CGA
- Nurses and Therapists are involved in carrying out CGA in 82% of Trusts.
- Other medical staff are involved in carrying out CGA in 76% of organisations.
Routine assessments of older people

- 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 across the domains listed on the chart opposite.
- Participants were asked whether all older people accessing urgent care were routinely assessed for these issues.
- Only falls & mobility and activities of daily living were routinely assessed by 100% of participating organisations. 98% of organisations are routinely assessing for skin integrity, nutrition & hydration, and vital signs.
- Depression was assessed for in 62% of organisations.
Continuing the journey along the acute pathway, Trusts and LHBs 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
- 66% of admissions to assessment units come from A&E, and 28% came directly from a GP.
Admissions to inpatient care from assessment units (all types)

- As shown previously, 53% of admissions to assessment units are for people aged 65 and over.
- 63% 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 – 17%
  - Age 75 to 84 – 24%
  - Age 85 plus – 22%
- Older people are a minority of attenders at A&E (ages 65 and over account for 23% 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.
The average length of stay across assessment units is 25 hours. This ranges from 4 hours up to 53 hours.

The average time before a patient is assessed by a senior clinician was reported as 7 hours.
The average staff mix of the medical team on assessment units was:

- Consultant funded establishment – 28%
- Other medical funded establishment – 37%
- FY1 funded establishment – 19%
- FY2 funded establishment – 14%
- Locums – 2.5%

Participants are able to view their own staff mix and make comparisons against the national averages on the online toolkit.
The nursing skill mix the assessment units was found to be:

- Band 2 – 29%
- Band 3 – 6%
- Band 4 – 1%
- Band 5 – 46%
- Band 6 – 14%
- Band 7 – 3%
- 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.
The AHP skill mix of the admission avoidance team in A&E was:

- Band 2 – 2%
- Band 3 – 10%
- Band 4 – 5%
- Band 5 – 20%
- Band 6 – 46%
- Band 7 – 16%
- Band 8 – 1%
The average cost per admission to an assessment unit is £291.

Pay costs account for around three quarters of the expenditure on assessment units.

Assessment unit costs accounted for 26% of the total expenditure across the care of older people pathway in the acute hospital.
Inpatient care
Care of older people beds

- 86% of Trusts state that Comprehensive Geriatric Assessment is delivered on care of older people wards. This reduces to 30% on other specialty wards.
- A nursing self-care model is delivered by 30% of Trusts, on inpatient wards.
- A social worker or generic supported discharge co-ordinator forms part of the MDT supporting care of older people wards in 93% of organisations.
- The number of care of older people beds per Trust shows a wide variation, from 14 beds to 278 beds.
- The mean number of designated care of older people beds is 103 beds.
- Many of the quality metrics reported later in the report are benchmarked per 100 care of older people beds, to allow for comparisons.
Elective and emergency admissions

- People aged 65 and over account for 42% of elective admissions and 43% of emergency admissions.

- Emergency admissions are made up of the following age groups:
  - Age 65 to 74 – 13%
  - Age 75 to 84 – 17%
  - Age 85 plus – 13%
The mean values for average length of stay for emergency admissions are as follows:

- All admissions – 5.2 days
- Age 65 to 74 – 6.5 days
- Age 75 to 84 – 8.3 days
- Age 85 plus – 10.1 days

As would be expected, average length of stay increases with age. However, the average length of stay for each age group shows a surprising level of variation between Trusts / LHBs as illustrated in the chart opposite.
The previous slide shows that older adults have longer lengths of stay in hospital. The following charts show the impact of those long stays.

Spells with a length of stay of more than 21 days account for 6% of total spells, yet account for 44% of total occupied bed days, indicating the high proportion of capacity being utilised by a small number of people with long stays.

**Total number of spells**

- Spells with LOS > 21 days: 6%
- Spells with LOS between 3 and 21 days: 35%
- Spells with LOS <= 2 days: 59%

**Total number of occupied bed days**

- OBD for spells with LOS <= 2 days: 8%
- OBD for spells with LOS > 21 days: 45%
- OBD for spells with LOS between 3 and 21 days: 47%
The average staff mix of the care of older people wards was:
- Consultant funded establishment – 33%
- Other medical funded establishment – 31%
- FY1 funded establishment – 17%
- FY2 funded establishment – 15%
- Locums – 5%

Participants are able to view their own staff mix and make comparisons against the national averages on the online toolkit.
Nursing skill mix – inpatient care

The nursing skill mix on the care of older people wards was found to be:

- Band 2 – 37%
- Band 3 – 4%
- Band 4 – 1%
- Band 5 – 46%
- Band 6 – 7%
- Band 7 – 4%
- Band 8A + - <1%

The ratio of unregistered to registered nurses on the care of older people wards was found to be 42% to 58%.
The AHP skill mix on the care of older people wards was:

- Band 2 – 6%
- Band 3 – 14%
- Band 4 – 5%
- Band 5 – 31%
- Band 6 – 28%
- Band 7 – 15%
- Band 8 – 1%
The average cost per care of older people bed was £99,583.
Pay costs account for around 71% of the expenditure on the care of older people wards.
Inpatient care for older people costs accounted for 70% of the total expenditure across the older people pathway in the acute hospital.
Discharge process
86% of Trusts / LHBs reported that they have a documented supported discharge protocol that is consistently applied across all wards. Just over half reported that all discharge information is documented in a single discharge passport (or equivalent).

Two thirds of participants have an integrated discharge team, with 60% of these reporting that all supported discharges go through the IDT or equivalent. If there is no IDT, 81% report that supported discharges are dealt with directly by ward staff. 79% of inpatient wards have dedicated discharge co-ordinators.

40% of Trusts / LHBs operate therapy led discharge, and 69% operate nurse led discharge.

Three quarters of IDTs have access to dedicated pharmacy advice for supported discharges.

Just over half of participants have access to specialist transport schemes to expedite the discharge of patients from hospital.

Almost three quarters of participants have third sector schemes in place which have been commissioned to help with the discharge process from hospital.
95% of participating organisations operate Early Supported Discharge (ESD) schemes.

- 95% cover stroke within their ESD scheme.
- 38% cover neuro rehabilitation.
- 70% cover respiratory.
- 30% cover falls.
- 61% cover ‘other’ conditions, including orthopaedics, COPD, and heart failure.
93% of participants have criteria in place locally outlining which patients might be suitable for intermediate care.

Intermediate care assessments are carried out by a range of teams, as illustrated below.

**Who undertakes Intermediate Care assessments?**

- **Integrated discharge team**, 23%
- **Inpatient wards**, 18%
- **Assessment teams from IC providers**, 20%
- **Hospital discharge team (health only)**, 7%
- **Separate Intermediate care assessment team based in hospital**, 20%
- **Other**, 12%
Participants were asked where CHC assessments are carried out within the Trust.

98% reported that CHC assessments occur on inpatient wards.

43% are able to carry out assessments in transition beds, 29% on a dedicated assessment ward, 63% at home, and 24% in other locations.

CHC assessments are generally carried out by the hospital discharge team (39%) or a separate team of CHC nurse assessors (32%). The integrated discharge team carries out CHC assessments in 15% of organisations.

The average length of time for a CHC assessment to take place is 10 days. This figure ranges from 2 days up to 28 days.

The national framework for NHS CHC assessments states that decisions on eligibility should take no longer than 28 days.
Participants were asked to provide the number of delayed transfers of care for the Trust, and for the older people wards. It was then possible to calculate the percentage of delayed transfers of care in the Trust that took place on the care of older people wards.

38% of delayed transfers of care within participating organisations were on care of older people wards. This ranges from 8% to 68%.
Nursing skill mix – supported discharge team

- The average nursing skill mix in supported discharge teams has a higher skill mix than the other areas covered in this report.
- Band 6 and 7 staff make up 54% of the total supported discharge nursing team, with Band 5 staff contributing a further 19%.
- The supported discharge team has the highest registered to non registered nursing ratio with 77% being registered and 23% unregistered.
The skill mix of AHPs in the supported discharge team in 2014/15 was also found to have a rich skill mix:

- Band 2 – 0%
- Band 3 – 17%
- Band 4 – 17%
- Band 5 – 1%
- Band 6 – 44%
- Band 7 – 15%
- Band 8a – 3%
- Band 8b – 3%
The average skill mix of social care professionals in the supported discharge team is:

- 22 – 25: 0%
- 26 – 30: 60%
- 31 – 38: 40%
- 39 – 41: 0%
- 42 – 44: 0%

(social care bandings reported)
On average, 82% of the total costs for the supported discharge team are on pay costs.
Quality and outcomes
65% of Trusts state that their care of older people wards collect Patient Reported Experience Measures (PREMs).

70% of services state that they routinely carry out satisfaction surveys with service users / carers.

73% of Trusts are taking part in local CQUIN schemes related to the care of older people.

Formal complaints on the care of older people wards average 28 per 100 care of older people beds in 2014/15.

Serious incidents on care of older people wards average 12 per 100 care of older people beds.

Reassuringly, all participants reported zero never events recorded in 2014/15.
Medication errors on care of older people wards averaged 62 per 100 care of older people beds in 2014/15.

There is a large variation within this metric, possibly due to how Trusts record medication errors. The Network would like to work with participants to refine this definition further.
The mean number of incidences of falls (with harm) on care of older people wards was 57 per 100 older people beds per year.
The number of occurrences of clostridium difficile on care of older people wards was 10.5 per 100 care of older people beds.
Overall workforce benchmarking
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 services within the NHS and the data in this report shows there is still a significant reduction in availability of staff at weekends.

<table>
<thead>
<tr>
<th>Hours of availability over a 24 hour period:</th>
<th>Weekday</th>
<th>Weekend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dedicated geriatric team in A&amp;E</td>
<td>9.4</td>
<td>4.4</td>
</tr>
<tr>
<td>Senior medical cover – frailty unit</td>
<td>12.9</td>
<td>8.9</td>
</tr>
<tr>
<td>Senior medical cover – short term assessment unit</td>
<td>16.0</td>
<td>15.1</td>
</tr>
<tr>
<td>Senior medical cover – other assessment units</td>
<td>16.1</td>
<td>15.2</td>
</tr>
</tbody>
</table>
The medical team skill mix across the acute pathway highlights some interesting results. The highest concentration of consultants is in the dedicated geriatric team in A&E.

Trainees are also a presence across the acute pathway.
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 older people wards than in the admission avoidance teams and supported discharge teams.

<table>
<thead>
<tr>
<th>Area</th>
<th>Band 2</th>
<th>Band 3</th>
<th>Band 4</th>
<th>Band 5</th>
<th>Band 6</th>
<th>Band 7</th>
<th>Band 8a</th>
<th>Band 8b</th>
<th>Band 8c</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions avoidance in A&amp;E</td>
<td>12%</td>
<td>2%</td>
<td>2%</td>
<td>28%</td>
<td>28%</td>
<td>22%</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Assessment units</td>
<td>29%</td>
<td>6%</td>
<td>1%</td>
<td>46%</td>
<td>14%</td>
<td>3%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Care of older people wards</td>
<td>37%</td>
<td>4%</td>
<td>1%</td>
<td>46%</td>
<td>7%</td>
<td>4%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Supported discharge team</td>
<td>12%</td>
<td>11%</td>
<td>0%</td>
<td>19%</td>
<td>32%</td>
<td>22%</td>
<td>2%</td>
<td>1%</td>
<td>0%</td>
</tr>
</tbody>
</table>
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 older people wards.

<table>
<thead>
<tr>
<th></th>
<th>Band 2</th>
<th>Band 3</th>
<th>Band 4</th>
<th>Band 5</th>
<th>Band 6</th>
<th>Band 7</th>
<th>Band 8a</th>
<th>Band 8b</th>
<th>Band 8c</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions avoidance in A&amp;E</td>
<td>0%</td>
<td>6%</td>
<td>7%</td>
<td>19%</td>
<td>51%</td>
<td>16%</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Assessment units</td>
<td>2%</td>
<td>10%</td>
<td>6%</td>
<td>20%</td>
<td>46%</td>
<td>16%</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Care of older people wards</td>
<td>6%</td>
<td>14%</td>
<td>6%</td>
<td>31%</td>
<td>28%</td>
<td>15%</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Supported discharge team</td>
<td>0%</td>
<td>17%</td>
<td>17%</td>
<td>1%</td>
<td>44%</td>
<td>15%</td>
<td>3%</td>
<td>3%</td>
<td>0%</td>
</tr>
</tbody>
</table>
Service user audit
This year a service user audit was added to the Older People’s Care in Acute Settings project. Developed in conjunction with the British Geriatrics Society, the aim of adding in a further level of service user benchmarking data was to:

- Complement the organisational level data and to use this data to aid understanding of the key features of high performing services.
- Provide data to enable possible correlations to be explored and further analysis to be undertaken e.g. between length of stay and discharge destination.

Trusts were asked to select one care of older people ward to carry out the service user audit on.

50 consecutive discharges were selected for the service user audit, which ran simultaneously with the main data collection period (August – October 2015).

28 participating organisations submitted data for the service user audit, and the audit covers around 1,400 service users of older people wards between August and October 2015.
37% of service users on the care of older people wards were aged 75-84, 26% were aged 85-89, and 23% aged 90 plus. Participants are able to view the age split of their patients on the online toolkit, located on the NHS Benchmarking Network members’ area.
Participants were asked to choose the primary ICD-10 code that the service user was admitted with, either a code associated with frailty or to use a code for “other”.

The British Geriatrics Society selected a number of ICD-10 codes which might be associated with frailty. As there is no code for frailty, it was thought that these proxy frailty codes might give an indication of the number of people being admitted with symptoms or conditions associated with frailty.

46% of admissions were admitted with a “proxy frailty” ICD-10 code.

Note the full ICD-10 code descriptor can be found in Appendix 2.
Data was requested on the normal living arrangements and discharge destination of each service user included in the audit.

Normal living arrangements were found to be:
- Own home 75%
- Residential home 9%
- Nursing home 9%
- Sheltered housing 5%
- Other 2%

Discharge destinations were:
- Own home 54%
- Residential home 10%
- Nursing home 13%
- Sheltered housing 3%
- Transitional arrangements 7%
- Died 10%
- Other 3%
Previous admissions

- 55% of service users had had a hospital admission within the previous twelve months.
- 20% of service users included in the audit had had an emergency hospital re-admission within the last 30 days.

Comprehensive Geriatric Assessment

- 76% of service users had received CGA which was fully documented.
- Trusts were asked to state where in the pathway CGA was initiated:
  - 2% of patients received CGA in A&E
  - 48% received CGA on the assessment unit
  - 50% received CGA on the inpatient ward

Length of stay

- 51% of service users had a length of stay of less than 10 days
- 23% of service users had a length of stay of 11 – 20 days
- 26% of service users included in the audit had a length of stay of greater than 21 days. As shown previously in the report, lengths of stay greater than 21 days account for almost half of all occupied bed days in an average Trust.
Participants were asked to provide the Modified Rankin Scale of service users on discharge. This was chosen to measure the degree of disability or dependence in the daily activities of those service users leaving care of older people wards.

The scale runs from 0-6 and the following average positions were noted from the sample:

- 0 - No symptoms – 7%.
- 1 - No significant disability. Able to carry out all usual activities, despite some symptoms – 15%.
- 2 - Slight disability. Able to look after own affairs without assistance, but unable to carry out all previous activities – 11%.
- 3 - Moderate disability. Requires some help, but able to walk unassisted – 25%.
- 4 - Moderately severe disability. Unable to attend to own bodily needs without assistance, and unable to walk unassisted – 22%.
- 5 - Severe disability. Requires constant nursing care and attention, bedridden, incontinent – 10%.
- 6 – Dead – 10%.
Further analysis of the service user data allowed exploration of the change in dependency of care setting from admission to discharge, i.e. normal living arrangements compared to destination on discharge.

- 1% of service users reduced dependency of care setting from admission to discharge (e.g. residential home to living with family).
- 69% maintained dependency (e.g. own home to own home).
- 16% increased dependency (e.g. own home to nursing home).
- 10% died.
- 4% unknown.
Admissions from nursing homes

- A cut of the overall service user audit data was taken, looking at service users who were admitted from nursing homes specifically, to ascertain whether this patient cohort displayed different characteristics. The following shows the comparison with patients not admitted from a nursing home:
  - 69% have had a hospital admission in the last 12 months, compared to 55% average for the total sample.
  - 23% have had an emergency re-admission within the last 30 days (20% average for all service users).
  - 65% received CGA which has been fully documented (lower than the 76% for the total sample).
  - Average length of stay is 17 days (1 day longer than the sample average of 16 days).
  - ICD-10 codes on admission:
    - Proxy frailty code 49% (46% total average), other 51% (54% total average).
  - Discharge destinations:
    - Nursing home 83%, died 12%, residential home 3%, other 2%, hospice 1%.
Conclusion and next steps
Conclusion

- This report presents the findings of the 2015 Older People’s Care in Acute Settings project. All data shown in this report is 2014/15 data. 49 services from 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. Participants have also been issued with summary bespoke reports, highlighting their position against other participants on key metrics.

- The findings of the Older People’s Care in Acute Settings 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’s Care in Acute Settings should be included in the 2016/17 work programme looking at 2015/16 outturn data, allowing for year-on-year comparisons to be made.

- 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. If you would like a member login, or have forgotten your password for the members’ area, please contact ashley.spencer1@nhs.net.

- The 2015/16 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.
Appendix 1

Full definition of Comprehensive Geriatric Assessment (GCA)

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 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.

Appendix 2
Content of the Service User Audit

This form can be downloaded from the members’ area of the website at www.nhsbenchmarking.nhs.uk