

FTN BENCHMARKING DRIVING IMPROVEMENT IN ELDERLY CARE SERVICES

Elderly care services remain a strategic focus for trusts that must provide high quality care for an increasingly ageing population. Despite a wealth of best practice guidance and audits of care for older patients, there has been no comprehensive comparison of how care pathways for older patients are delivered and managed in different trusts. In the Foundation Trust Network's (FTN) first benchmarking project in this area 16 acute trusts explored how the quality and efficiency of their elderly care services could be improved by delivering more holistic and integrated care.

KEY FINDINGS

- Trusts that provide early specialist geriatric assessment of older patients in A&E and short-stay medical units achieve significantly fewer admissions and lower lengths of stay in hospital.
- Trusts with integrated and collaborative working practices with non-acute services (community care, social care and nursing homes) also achieve lower lengths of stay for older patients. Effective systems to support the early discharge of older patients from hospital significantly reduce the risk of these patients becoming dependent on ongoing bed-based care.
- Trusts have launched significant initiatives to improve the care environment, patient experience and clinical outcomes of older patients with dementia. However, the availability of electronic information on quality measures such as malnutrition scores and in-patient falls for elderly care wards is an area that could be improved.
- Ensuring that the expert geriatric workforce is available at times of peak demand from older patients will improve operational efficiency. Improving the trust-wide coding of activity and costs to elderly care services will also be key to better understanding the demands on the service.

OLDER PATIENTS PRESENTING AT HOSPITAL

Older patients account for a disproportionate amount of hospital activity and often present with complex social and medical needs. Providers of acute services are facing greater pressure to meet the needs of this patient group as budgets for social services and out-of-hospital care are reduced despite the demands posed by an increasingly ageing population. Within this context the early identification of frailty and acute health needs in older patients, and more effective partnership working to provide integrated case management and continuity of care across traditional primary and secondary care settings will be increasingly important.

Across the 16 trusts participating in the benchmarking study, older patients (aged 65 and over) account for over 25% of all A&E attendances, 45% of hospital admissions, and 82% of hospital stays that last over 20 days.

FIGURE 1: RELATIONSHIP BETWEEN A&E ATTENDANCES FOR OLDER PATIENTS AND PRIMARY CARE SPEND



Over 45% of older patients admitted to hospital have a prior long-term condition and 53% of A&E attendances for older patients end in a non-elective admission to hospital, compared to only 20% for patients aged under 65.

Figure 1 shows that trusts serving communities with lower primary care investment report higher A&E attendance rates. The provision of accessible and high quality primary and community care is a key factor in determining the number and acuity of older patients presenting to hospital with health problems. It is critical that commissioners, providers and local authorities work together across health and social care economies to reduce these emergency admissions by focusing on prevention and early intervention for chronic conditions, particularly in primary and community setting.

BENEFITS OF EARLY SPECIALIST INVOLVEMENT

MAIN FINDINGS

Whether or not an older patient is admitted to hospital depends on the experience and specialist knowledge of the doctors, nurses and therapists who are involved in the early assessment of these patients. Trusts that use early geriatric specialist screening and assessment of older patients in A&E or short-stay Medical Assessment Units (MAU) have 33% fewer non-elective admissions.

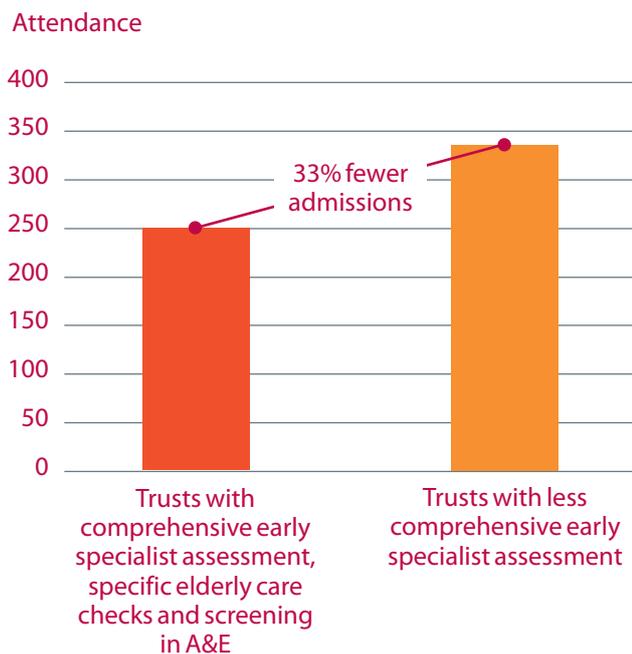
Trusts operating early specialist assessment for older patients with medical falls (i.e. falls that did not require surgery) also demonstrate faster streaming of patients to dedicated elderly care wards (average 1.4 days compared with 4.4 days) and a lower overall length of stay from admission to discharge (12.4 days compared with 17.8 days).

Trusts operate different models to facilitate early specialist assessment, including:

Ward-based models Following admission older patients are streamed to units with dedicated short-stay (<48hrs) beds run by specialist geriatric teams. Patients receive rapid assessment for potential discharge from hospital or transfer to acute geriatric wards for continuing specialist care.

Peripatetic specialist team models All frail older patients are screened and assessed by a dedicated specialist geriatric team regardless of the ward location or speciality the patient is initially admitted to. The team also offers proactive in-reach services to A&E and short stay medical assessment units.

FIGURE 2: NON-ELECTIVE ADMISSIONS FOR PATIENTS OVER 65, PER WEIGHTED HEAD OF POPULATION



Referral models Patient flow is not actively influenced by geriatric specialist teams. Consultant-to-consultant referrals are used to arrange assessment from specialist teams for older patients on non-geriatric wards

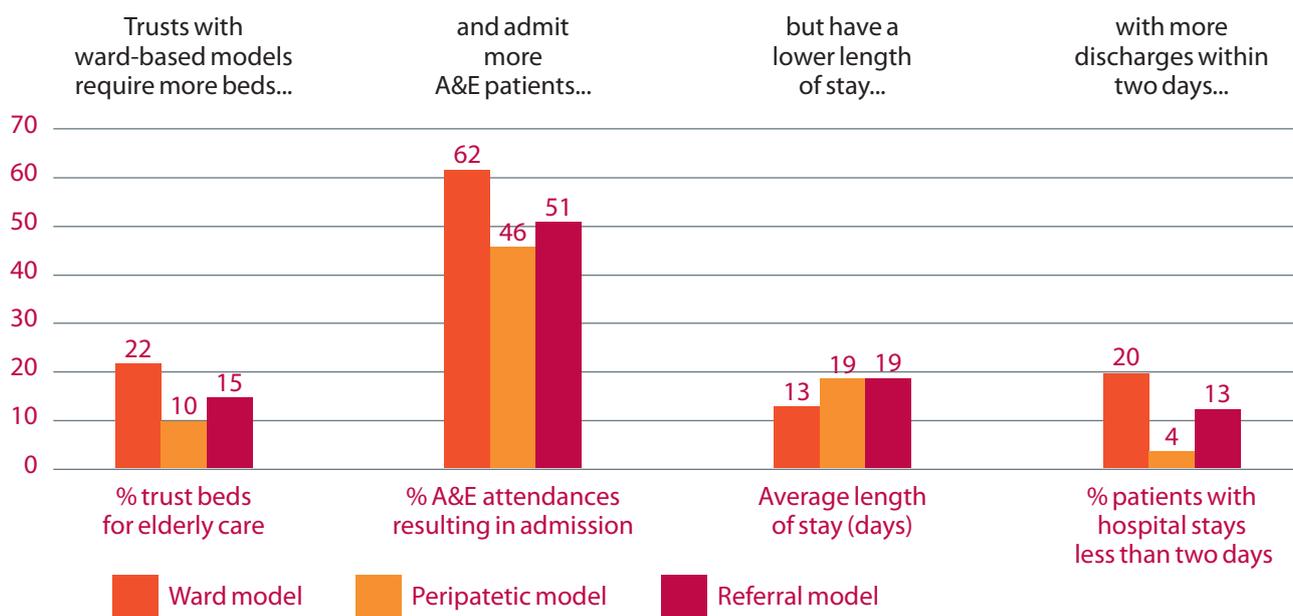
For example, by developing a dedicated specialist elderly care short-stay assessment ward one acute foundation trust in the South improved the

percentage of older patients discharged from short-stay wards within 48 hours of arrival from under 20% in 2010 to over 42% by September 2011. The trust also successfully reduced the average length of stay of older patients in specialist geriatric wards from 15 days in April 2010 to eight days in September 2011. These reductions help avoid patients becoming dependent on bedded care during long hospital stays, and help support older patients in living independently at home.

A different foundation trust in the South East operates a multidisciplinary team of consultants, nurses and therapists with specialist expertise in elderly care. This team proactively seeks out and screens all patients aged over 75 within one working day of admission. The impact of their work has led to a reduced average length of stay for older patients on geriatric specialist wards (from 37 days in 2006 to 24 days in 2011) and general medicine wards (11 days to 6 days) with no associated increase in re-admission rates. These efficiency gains have allowed for the removal of geriatric and general medicine beds to support service redesign initiatives in the trust.

When comparing the different models for delivering early specialist assessment, trusts note that the peripatetic team model is not as restricted by bed capacity as ward-based models, and allows specialist assessment to benefit patients who are not treated on

FIGURE 3: FEATURES OF DIFFERENT ELDERLY CARE SERVICE MODELS



dedicated elderly care wards. However, challenges with the peripatetic model include increasing and upskilling staff roles for confident specialist assessment, and building collaborative approaches with general medicine wards to ensure the specialist assessment team is not viewed solely as a 'take away' service.

Figure 3 shows that as might be expected, ward-based models require more dedicated beds for elderly patients. Trusts with ward-based models also admit a higher proportion of older patients presenting at A&E, though these patients have a lower length of stay compared to trusts operating peripatetic or referral models. Both the ward-based and peripatetic models offer the benefits of delivering early expert specialist assessment to support admission avoidance and appropriate patient streaming.

ISSUES TO CONSIDER FOR SPECIALIST ASSESSMENT OF OLDER PATIENTS

Specialists in geriatric care, including doctors, nurses, and therapists, can deliver definitive treatment and advice to older patients to set them on the right care pathway avoiding longer stays and unnecessary admissions to hospital. It is crucial that specialist input occurs early in the patient pathway (A&E or MAU) and that a multidisciplinary approach is used to meet the full needs of the patient.

The time pressures on geriatric specialists mean that efficient triage at hospital entry points such as A&E is crucial so that geriatric consultants are not called to assess all older patients presenting at A&E regardless of clinical needs. Some trusts are exploring using Emergency Nurse Practitioners with geriatric expertise to improve triage processes at A&E. Other trusts are increasing their use of standardised assessment tools such as the Abbreviated Mental Test and the Get Up and Go Test to aid the early comprehensive assessment of older patients' needs in A&E.

USE OF GERIATRIC WARDS

Across the 16 trusts 9% to 32% of total bed capacity is dedicated to elderly care (mean 18%); and 8% to 55% of non-elective bed-days for all older patients were coded against geriatric specialties (i.e. the patient was under the care of a geriatrician consultant).

There was no significant correlation between dedicated capacity and admission volumes or length of stay for older patients. This reflects that trusts are using their dedicated elderly care beds in different ways: for example some trusts without access to intermediate care beds keep patients for longer in the acute setting to ensure all their care needs are met, while other trusts with more community beds have shorter acute lengths of stay as acute beds are used to stabilise and prepare patients for continuing care and earlier discharge to step-down hospitals.

Providers are successfully adapting their care delivery based on the availability of local out-of-hospital services; however, there is still a need for more integrated and joined-up system-wide care across the whole health economy to allow patients to have seamless transitions of care across hospital and primary/community settings.

On elderly care wards, activity is predominantly non-elective. Admission criteria for elderly care wards varied widely across trusts. The average age of patients on these wards was between 75–83 years, with the greatest variation seen in the proportion of patients aged over 85 on these wards (ranging from 15% to 57%).

The average non-elective length of stay for older patients on dedicated elderly care wards was 16 days. This is significantly longer than the average length of stay for older patients on other wards such as general medicine (7.1 days) or surgical wards (6.7 days), reflecting the more complex care needs of patients on dedicated elderly care wards.

Overall there is a system-wide push for reductions in the average length of stay for patients, and a focus on treating the presenting acute condition and providing care until the patient is ready to be discharged to a less acute setting. However, retaining patients under specialist acute geriatric services until they are ready to be discharged can improve quality and patient experience, and reduce re-admission rates.

Participating trusts believe that a renewed emphasis should be placed on meeting the health needs of older patients who are not placed in dedicated elderly care wards. In this respect the peripatetic model is of

considerable value in delivering specialist geriatric care for patients on outlying wards while maintaining dedicated elderly care ward for the most complex and frail older patients.

Trust data indicate that there are opportunities to improve the accuracy of data coding and the attribution of hospital activity to geriatric specialties. These improvements will provide a more comprehensive evidence-base to support the increasing need for accurate service-line information in order to manage demand and develop the service.

DISCHARGE PLANNING AND SUPPORT

MAIN FINDINGS

Trusts with lower lengths of stay and delayed discharges (where the patient has not been discharged despite being medically fit for discharge) also demonstrate effective discharge planning and proactive management of the interface between acute and community care.

There is significant variation in the level of delayed discharges for older patients who have had medical falls that did not require surgery; the time between patients being judged medically fit for discharge and actual discharge occurring varies from 0.3 to 10.8 days.

Trusts with average delayed discharges of two days or more take twice as long to refer patients to social services. These trusts also agree social care packages only two days after patients are judged medically fit. In comparison, trusts that agree packages prior to the patient being judged medically fit for discharge have delayed discharges of less than two day on average [see Figure 4].

Figure 5 shows that patients admitted from their own homes who are then discharged to care homes following their hospital stay have significantly longer lengths of stay, compared to patients who return to their original place of residence. This further emphasises the need for collaborative working with social services and care homes to put arrangements and care plans in place to minimise the delay in discharging medically fit older patients from hospital.

At the benchmarking workshop trusts shared successful initiatives to expedite discharge. One trust in the Midlands has been developing a “five patients discharged a day” initiative, where discharge co-coordinators help older frail patients navigate the acute system with the aim of reablement and independent living at *home* rather than in bedded facilities. This initiative is an example of how care co-ordination across traditional hospital and

FIGURE 4: IMPACT OF SOCIAL CARE REFERRALS ON THE TIMELY DISCHARGE OF OLDER PATIENTS

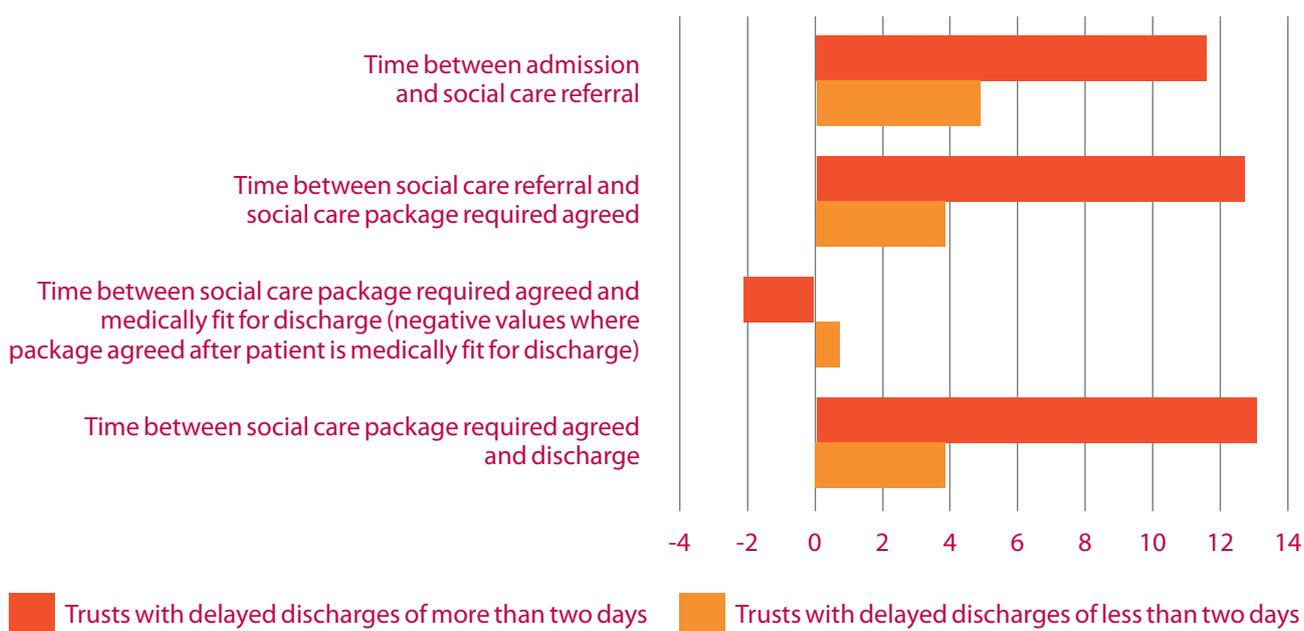
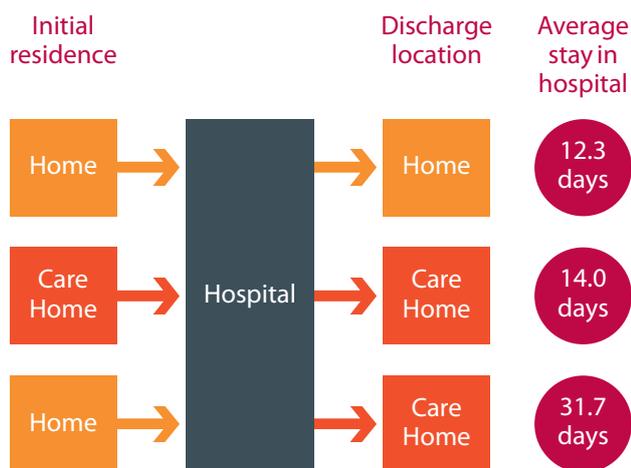


FIGURE 5: RELATIONSHIP BETWEEN CHANGES OF RESIDENCE AND LENGTH OF STAY IN HOSPITAL



primary/community care settings successfully delivers seamless, integrated and high-quality care for patients. The service runs seven days a week and supports patients for their first three days following early discharge from an acute hospital bed and mobilises ongoing care. Over five hundred patients have been supported by the service to date and although these patients have high levels of medical, nursing, rehabilitation and care needs, only two (0.4%) have been readmitted within 28 days of discharge.

Another trust in the South identifies nurse discharge co-coordinators on each ward, sets a target of three discharges per ward every day, and monitors progress in daily planning and review meetings. By empowering nurses with discharge co-ordinating roles and clear goal-setting this trust is successfully reducing the length of stay of its older patients. The development of staff roles to improve patient experience was a priority for trusts and this should be supported by the new provider-led workforce framework.

In addition to effective discharge planning, several trusts are adopting innovative approaches to post-discharge and out-of-hospital support for older patients. One trust is successfully developing partnership working arrangements with local GPs and nursing homes to increase the benefits of geriatric evaluation and pathway management in primary care settings.

This collaborative initiative includes geriatrician consultant ward rounds at nursing homes, geriatrician telephone contact and accessibility for GPs and care home managers, and geriatrician involvement in end of life care discussions and medical advisory meetings. An alert system has also been established in the acute trust to flag when a nursing home resident is admitted. This facilitates early assessment and review by geriatric specialists who can liaise with both the GP and nursing home to support discharge. This regular structured contact between hospital geriatric consultants, GPs and nursing home managers has led to a 60% reduction in the rate of hospital admissions for local nursing home residents, reductions in acute length of stay and cost savings to the wider health system through the review and modification of medication and fluid management. It is important that initiatives such as this, which focus on partnership working across the primary and secondary care interface, are adopted more widely to improve health outcomes and the experience of older patients.

At another trust the acute geriatric specialist team is successfully reducing re-admission rates by making post-discharge follow-up calls to older patients judged as vulnerable and living at home alone with minimal carer support. This contact with patients helps meet the psychological needs of older patients who often expect longer hospital stays. The calls are used to reassure patients, support their compliance with medicines plans and ensure that ongoing care is being delivered.

QUALITY OF CARE

Delivering the highest quality care and patient experience, particularly for the most frail older patients and patients with delirium and dementia, is a focus for all the participating trusts.

On average, 9% of non-elective admissions for patients aged over 65 had a diagnosis of dementia in the 16 participating trusts. Trusts in the benchmarking project have invested significant time and effort in improving work practices and ward environments to support the safety and dignity of these older patients.

One trust has launched a two-day multi-professional training and awareness course on dementia and delirium to help hospital staff recognise the signs and causes of patient confusion. These courses are attended by staff from all disciplines and grades (including hospital porters, nurses, doctors and managers) as well as a patient with dementia and his wife, who shares his experiences of hospital care directly with staff. These workshops are a powerful vehicle for challenging attitudes and reshaping working practices based on patients' views.

Trusts are also investing in initiatives where a booklet containing information on individual patients' likes and dislikes travels with the patient and provides guidance to all hospital staff on how to deliver personalised care based on their patients' needs and preferences.

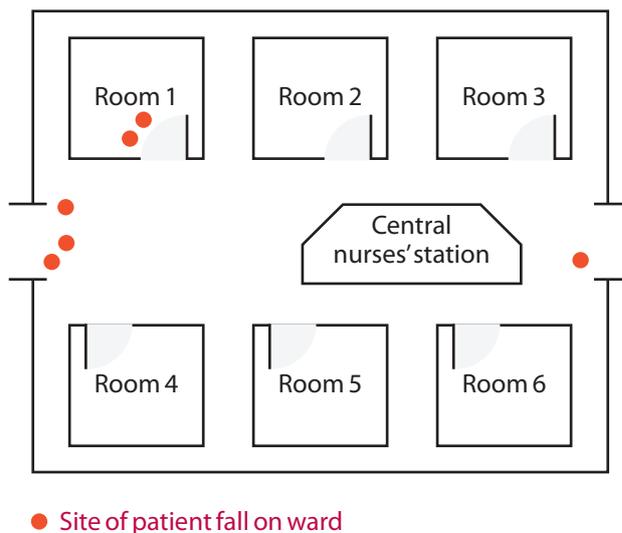
Several trusts are also embarking on programmes to provide a more positive therapeutic ward environment for patients with dementia. This includes changing floor coverings and introducing new pictorial signage to improve way-finding; and using colour contrast and privacy screens in toilet design. These initiatives have helped support patient dignity and independence, and reduce patient confusion and incontinence.

A fall while in hospital was recorded in 12.6% of inpatient admissions for older patients, and patient frailty is a key element of care that acute geriatric staff are addressing. Trust strategies to minimise the risk of patients falling included auditing and visually displaying falls hotspots on wards (See Figure 6), completing falls risk assessments for all vulnerable patients, and engaging trust staff in training and taking ownership for safety improvements.

Quality and patient satisfaction metrics measured in this study were not significantly associated with workforce levels and staff mix (e.g. there was no association observed between bed-days per nurse and rates of pressure ulcers). This partly reflects the lack of comprehensive electronic data on quality metrics such as pressure ulcer rates and malnutrition.

Ahead of the January 2012 announcements on regular nursing rounds, several trusts have already

FIGURE 6: HOT SPOT ANALYSIS OF PATIENT FALLS



implemented such ward rounds on elderly care and dementia wards, where elderly care nurses and therapists ensure contact with vulnerable older patients occurs at regular intervals. Trusts have seen patient experience and safety improve as a result – “it’s about being proactive not reactive; anticipating patient needs and preventing agitation and confusion”. Trusts are also developing hospital-wide staff education campaigns to support the health and well being of patients and ensure that all staff, regardless of occupation, help patients in need.

ISSUES TO CONSIDER FOR MANAGING QUALITY OF CARE INFORMATION

Many trusts are only able to routinely provide quality metrics that are required for mandatory central submissions, such as infection rates. Other quality information such as malnutrition scores is generally collected manually within patient notes with audits conducted to assess performance. The availability of this quality information in an electronic format should be reviewed, especially given the continued focus on comprehensive assessments of quality outcomes.

The collection and presentation of quality data specifically for elderly care wards rather than the whole hospital should also be an area of improvement. New quality metrics such as medication timeliness and catheterisation rates were also suggested by trusts as useful additional measures of clinical quality.

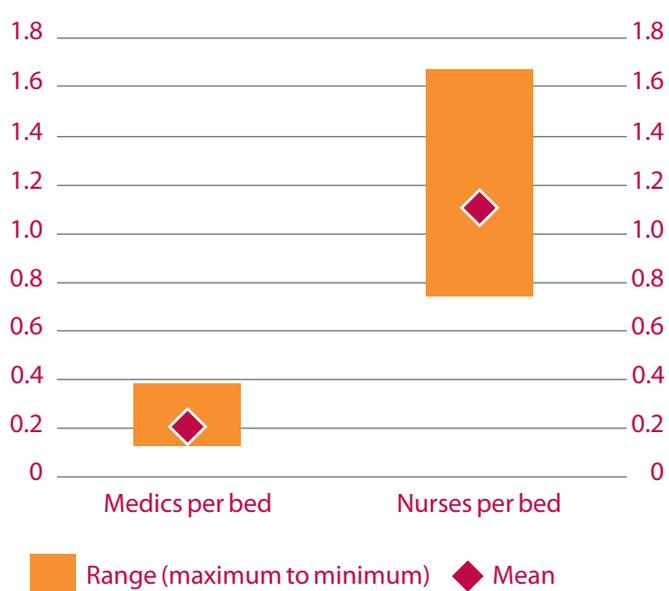
WORKFORCE AND COSTS

There is significant variation in both the number and mix of staff on dedicated elderly care wards. Some trusts have over twice as many nurses per bed compared to other trusts; the ratio of elderly care nurse whole-time equivalents (WTE) to each dedicated elderly care bed ranges from 0.7 to 1.7 (mean of 1.1). The number of elderly care bed-days per nurse WTE also varies significantly from 114 to 703 bed-days per WTE, though it should be noted in this workforce section that some trusts have difficulty in definitively assigning bed-day activity and workforce numbers specifically to elderly care specialties.

In dedicated elderly care wards the proportion of nursing staff that are senior nurses (band 6 and above) varies from 7% to 14% across trusts (mean of 11%). The rest of the elderly care ward nursing staff is divided equally into band 5 nurses (average 45% of all nurses across participants) and band 1–3 nurses (43% of all nurses). On average trusts reported having 2.6 WTEs elderly care specialist nurses in place.

The ratio of nurses to medical staff working on elderly care wards shows considerable variation (between 3:1 and 7:1 nurse to medical WTEs, mean of 5:1). Figure 7 below shows that for elderly care wards there is more variation in the number of nurses per bed than medics per bed.

FIGURE 7: RATIO OF MEDICAL AND NURSING STAFF PER ELDERLY CARE WARD BED



There is also considerable variation in the seniority of the medical team; the ratio of geriatric consultants to other geriatric medical staff varies from 1:4 to 1:1 amongst participating trusts (mean of 1:3)

The variations observed in workforce staffing levels, seniority and mix did not correlate with other metrics such as the average length of stay or quality metrics such as infection rates, pressure ulcers, patient falls, or patient satisfaction. Trusts felt the use of the geriatric specialist workforce was most important in determining patient outcomes and productivity, rather than staffing establishment levels and seniority per se. For example, trusts operating models of early specialist geriatric assessment did not necessarily need higher doctor to nurse ratios, as therapists and physiotherapists with expertise in geriatric care formed part of the assessment teams to provide holistic multidisciplinary care.

Five of the 16 trusts report medical and nursing pay costs per spell that exceed the average Payment by Results income per spell of £2,700 for elderly care ward admissions. In addition to reinforcing the need for accurate service-line reporting for elderly care services, this finding reflects the high costs associated with caring for complex older patients in acute settings.

ISSUES TO CONSIDER FOR THE SPECIALISED GERIATRIC WORKFORCE

Matching supply and demand is an area where operational efficiency can be improved. Several trusts note that out-of-hours periods, especially in the early evening (6–8pm) and on weekends, show peaks in activity for older patients presenting at A&E; this may reflect referral patterns from GP out-of-hours services and locums. However, several models of early specialist geriatric assessment in A&E operated a Monday-Friday 9–5 service, with relatively few trusts having a geriatrician available at weekends and during extended hours.

Although 24/7 specialist geriatric cover is not necessarily desirable or feasible, more flexibility in staff deployment is required to better match supply and demand: “we need our expert workforce to be available at times of peak demand, especially out of hours”. In one trust a model using a community team

operating in A&E for 18hrs a day, 7 days a week has shown promising results. However, trusts note that having a geriatric medical staff available out of hours may be of limited use if associated multidisciplinary healthcare professionals, other agencies such as social services, and relatives and carers are not similarly contactable during this out-of-hours period.

A key future workforce challenge facing trusts is the demand from an increasing aging population. To cope with this demand trusts will have to review

models where geriatric speciality teams are expanded to provide early specialist assessment for increasing numbers of older patients, or implement initiatives to up-skill other clinical specialties to ensure that older patients receive tailored care regardless of which hospital ward they are placed in. More flexible working across traditional community and acute settings, which has already been championed by trusts in this benchmarking study, will also be needed to support the delivery of more integrated and effective care to older patients in the future.

THE FTN BENCHMARKING PROCESS

This is the FTNs first Elderly Care benchmarking project, which was delivered in partnership with McKinsey & Company. Each participant trust established a project team with a clinical, data and operational manager lead, and a board-level sponsor to oversee the project. Following an initial scoping phase, trusts attended a workshop where the data collection and definitions were discussed in detail and agreed. During the data collection and validation periods support was provided by the FTN Benchmarking team, with regular contact to ensure trusts were collecting comparable and robust data.

Participants collected information about the type of elderly care services that were available to patients within the acute trust and in community settings. Performance across trusts was assessed by collecting information on acute activity, clinical quality, patient safety, staffing levels and workforce costs for the period April 2010 to March 2011. Detailed patient-level pathway information was also collected for patients discharged from elderly care wards following admission for medical falls (i.e. falls that did not require surgery).

A findings workshop provided an opportunity for trusts to discuss the main findings as a group, share best practice, identify improvement opportunities and develop action plans.

THE FOUNDATION TRUST NETWORK

The Foundation Trust Network (FTN) provides a distinct voice for NHS foundation trusts. We aim to improve the system for the public, patients and staff by raising the issues facing existing and aspirant FTs and strengthening the influence of FTN members.

Over the last six years the FTN Benchmarking programme, run in partnership with McKinsey & Co, has facilitated significant cost savings, quality improvements and efficiency gains for over 100 member trusts. For more information visit www.foundationtrustnetwork.org/members/benchmarking/ or contact Sivakumar.Anandaciva@foundationtrustnetwork.org or Isabel.Lobo@foundationtrustnetwork.org