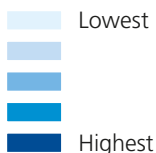


CARE OF OLDER PEOPLE

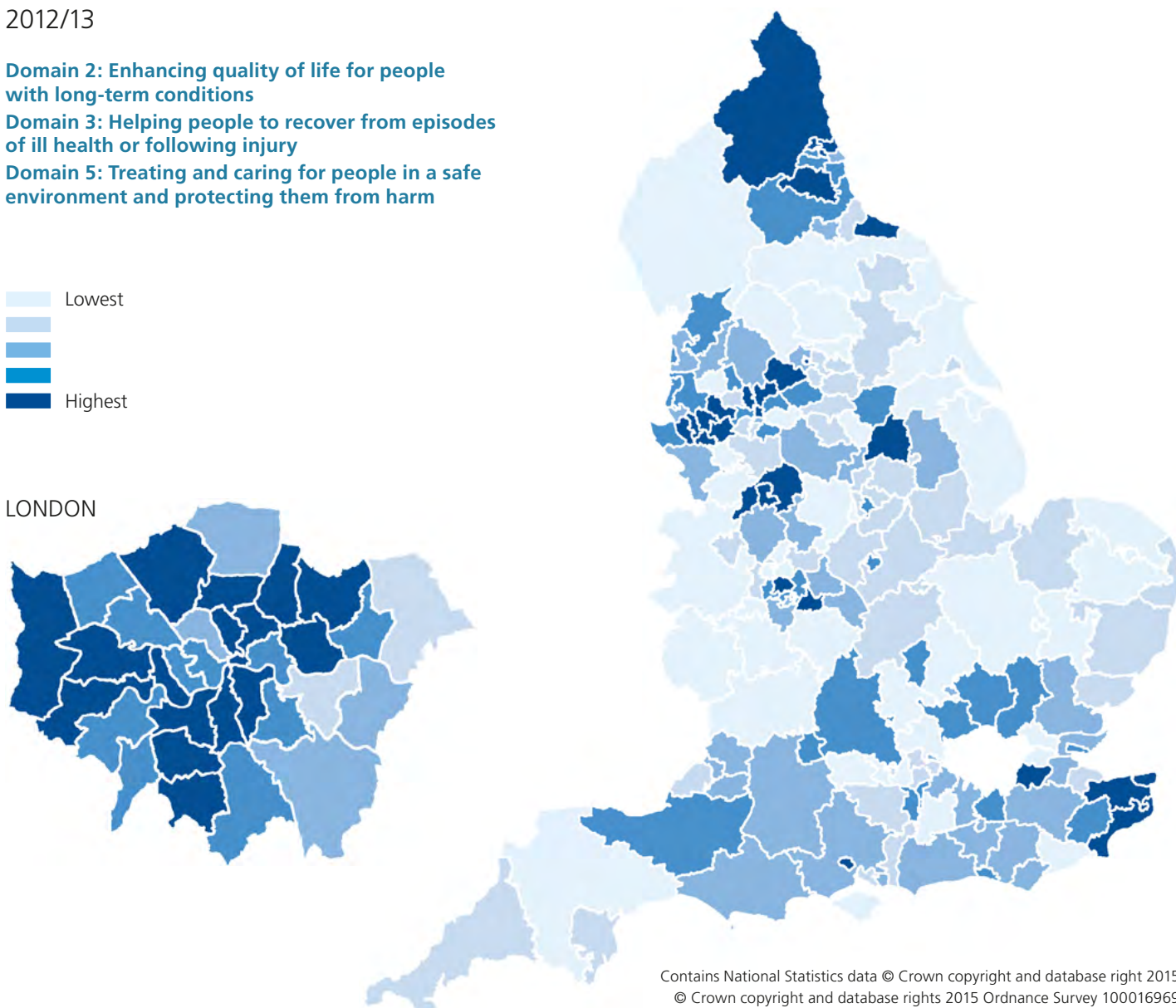
Map 61: Rate of emergency admission to hospital for people aged 75 years and over with a length of stay of less than 24 hours per population by CCG

2012/13

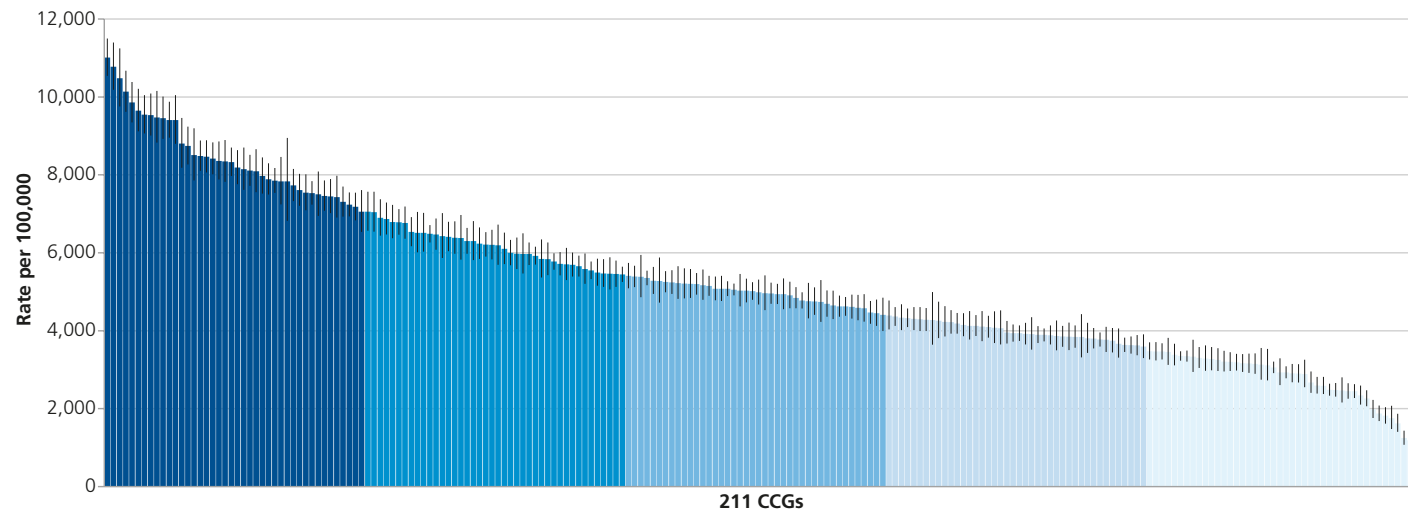
Domain 2: Enhancing quality of life for people with long-term conditions
 Domain 3: Helping people to recover from episodes of ill health or following injury
 Domain 5: Treating and caring for people in a safe environment and protecting them from harm



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Context

Older people aged 75 years and over admitted to hospital as an emergency but with a length of stay of less than 24 hours comprise a group of people most of whom do not need hospital care, and who could benefit from alternative care provision. For many older people who have multiple long-term conditions and frailty and are at a point of crisis in their health, medical assessment within two hours, followed by specific treatment, supportive care and rehabilitation, is associated with lower mortality, greater independence and reduced need for long-term care.

Intermediate care is an alternative to hospital care, and can prevent emergency admissions to hospital, including frailty-related hyper-acute presentations such as falls, delirium and sudden immobility, where older people need to be stabilised rapidly. There are several ways of providing a service to address avoidable admissions to hospital including the establishment of:

- › acute older care assessment units (“frailty units”) in accident and emergency (A&E) departments, rather than undertaking such assessments on a hospital ward once a person has been admitted;
- › multidisciplinary crisis response teams in the community.

In the National Audit of Intermediate Care 2014 (NAIC 2014; see “Resources”), four models of intermediate care were studied, including crisis response teams. The NAIC 2014 results showed that when crisis response teams are provided in a local area they reduce emergency admissions to hospital. Of the 60 crisis response teams that participated in NAIC 2014, only 10% of the 60,384 people discharged from their care required admission to hospital. In addition, the national median wait time from referral to assessment for the crisis response teams was only two hours.

Ultimately, it is important to identify older people with frailty before a health crisis occurs. Such people are likely to be known to local health professionals, and usually have weak muscles and, often, conditions like arthritis, poor eyesight, deafness and memory problems. They typically walk slowly, get exhausted easily and struggle to get out of a chair or climb stairs.

Magnitude of variation

For CCGs in England, the rate of emergency admission to hospital for people aged 75 years and over with a length of stay of less than 24 hours ranged from 1186 to 11,011 per 100,000 population (9.3-fold variation). When the seven CCGs with the highest rates and the seven CCGs with the lowest rates are excluded, the range is 2260–9536 per 100,000 population, and the variation is 4.2-fold.

Possible reasons for unwarranted variation include differences in:

- › the provision of alternative services to hospital care for older people, particularly crisis response teams;
- › the provision of acute older care assessment units in A&E departments;
- › ready access to primary and community care services out of hours and at weekends.

Options for action

To address avoidable admissions to hospital for older people with frailty and one or more co-morbidities, commissioners need to specify that service providers work together:

- › to develop a system whereby older people with frailty can be identified before a health crisis occurs and depending on the state of frailty provide an opportunity for self-management or case-management – data could be extracted from the primary care electronic health record, or simple tests could be devised such as assessing walking speed (taking more than five seconds to walk four metres is highly indicative of frailty);
- › to develop and implement integrated care pathways for older people with frailty across primary, secondary and social care (see “Resources” for NHS England practical guidance).

Commissioners need to use the NAIC 2014 report and the online benchmarking tool (see “Resources”) to consider the nature of provision and reconfiguration of intermediate care services in the locality, and in particular to consider commissioning community crisis response teams that provide extended hours services. When commissioning crisis response teams, commissioners need to specify that service providers develop team skills and broaden team membership to cover medical, nursing, support and therapy functions, with a GP, community geriatrician, community matron, specialist nurse, community nurses, therapists and social care representative on the multidisciplinary team.

In the context of existing provision, commissioners and service providers could also consider the need for establishing an acute older care assessment unit in the A&E department(s) in the locality.

RESOURCES

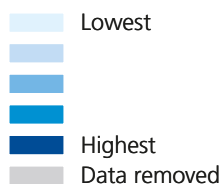
- › NHS Benchmarking Network. National Audit of Intermediate Care 2014 (NAIC 2014). <http://www.nhsbenchmarking.nhs.uk/partnership-projects/National-Audit-of-Intermediate-Care/year-three.php>
- › NHS Benchmarking Network. National Audit of Intermediate Care 2014 (NAIC 2014) The online benchmarking toolkit is available by logging in from the following webpage. <http://members.nhsbenchmarking.nhs.uk/login.aspx?ReturnUrl=%2fhome>
- › NHS England. Safe, compassionate care for frail older people using an integrated care pathway: Practical guidance for commissioners, providers and nursing, medical and allied health professional leaders. February 2014. <http://www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf>
- › Department of Health. Intermediate Care – Halfway Home. Updated Guidance for the NHS and Local Authorities. July 2009. http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@pg/documents/digitalasset/dh_103154.pdf

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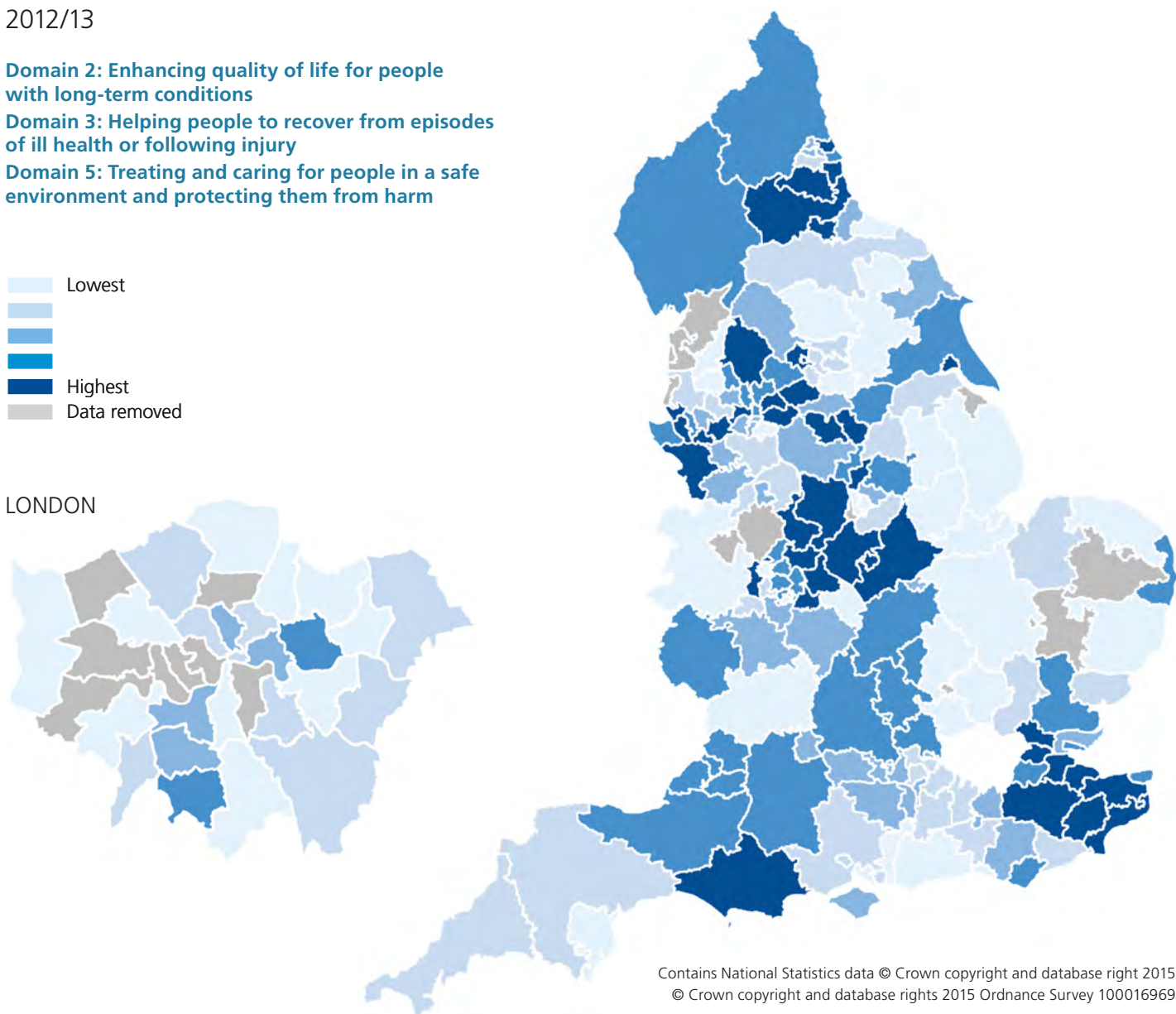
Map 62: Rate of admission to hospital for people aged 75 years and over from nursing home or residential care home settings per population by CCG

2012/13

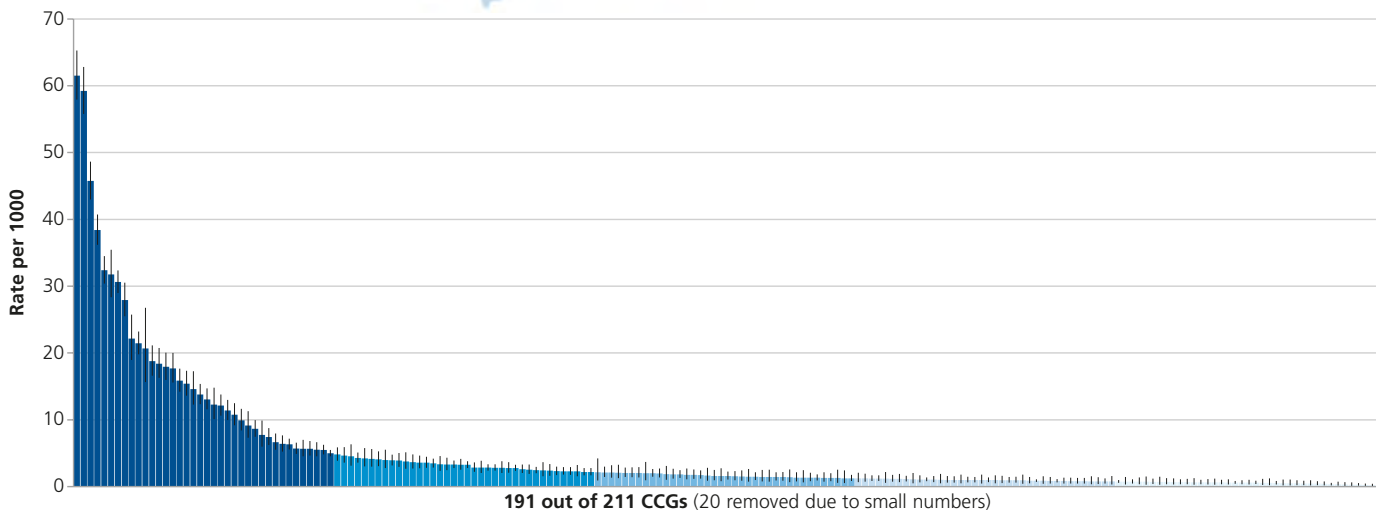
Domain 2: Enhancing quality of life for people with long-term conditions
 Domain 3: Helping people to recover from episodes of ill health or following injury
 Domain 5: Treating and caring for people in a safe environment and protecting them from harm



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Context

About 386,000 people live in care homes.¹ In England in 2013/14, there were 204,000 people aged 65 years and over in residential care homes and 85,000 people aged 65 years and over in nursing homes who were supported by councils with adult social services responsibilities (CASSRs).² People living in residential care or nursing homes typically have multiple long-term conditions (80% have dementia) and/or frailty, and are receiving multiple medications. Access to healthcare – GPs, pharmacists, and hospital specialists and therapies – is more variable for older people in some long-term care settings than for fitter, older people living in their own homes.

People in nursing or residential care homes can frequently be admitted to hospital for various reasons:

- end-of-life care, although with advanced care planning and support many older people could receive dignified end-of-life care in their long-term care setting;
- acute medical illness, particularly out of hours when the person's usual medical practitioner is not available;
- complications of medication use;
- falls – about 30% of all patients with hip fracture admitted to hospital are from the nursing or residential care home sector³.

Hospital admission can be distressing and disorientating for older people, leading to deterioration, healthcare-acquired infections, and falls. Pro-active and responsive healthcare planning can prevent hospital admission of older people from nursing or residential care homes.

Magnitude of variation

For CCGs in England, the rate of admission to hospital for people aged 75 years and over from nursing home or residential care home settings ranged from 0.1 to 61.5 per 1000 population (604-fold variation).⁴ When the six CCGs with the highest rates and the six CCGs with the lowest rates are excluded, the range is 0.3–30.6 per 1000 population, and the variation is 92.7-fold.⁵

The degree of variation observed may be due to differences in:

- the numbers of local authority-funded and private care homes in relation to the local population of older people;
- the use of care homes as temporary residential placements;
- accuracy of coding for the admission "source".

Possible reasons for unwarranted variation include differences in:

- access to health services for people in long-term care settings, particularly alternatives to the 999 ambulance service and acute hospital care when the condition of an older person changes out of hours;

1 National Institute for Health Research. Enabling Research In Care Homes (ENRICH). <http://www.enrich.nihr.ac.uk/research-community/understanding-care-homes.html#.VXGtIUbuSBR>

2 Health and Social Care Information Centre. Community Care Statistics, Social Services Activity, England – 2013-14, Final Release [NS]. 9 December 2014. <http://www.hscic.gov.uk/catalogue/PUB16133>

3 NICE. Hip fracture: The management of hip fracture in adults. NICE guidelines [CG124]. June 2011. <https://www.nice.org.uk/guidance/cg124>

4 Data from 20 CCGs have been removed due to small numbers.

5 For 2009/10 data by PCT, see Atlas 2.0, Map 65, pages 196-197.

- quality of pro-active management and care planning for vulnerable older people with multiple medical co-morbidities;
- capacity and skills of staff working in long-stay care, and the support available to these staff.

Options for action

Commissioners and service providers need to work together to assess the scale of the problem locally. To enable older people to remain in nursing or residential care homes, commissioners need to specify that service providers:

- use specific models of pro-active care, such as an enhanced primary care service;
- undertake advanced care planning, not only for foreseeable changes and deterioration in long-term conditions, but also for end-of-life care using the Gold Standards Framework (see "Resources"), with inclusion on primary care palliative care registers and information-sharing through the electronic palliative care co-ordinating system (EPaCCS);
- pro-actively review and adjust medication;
- set up programmes to reduce falls and fractures, e.g. preventative measures, case-management by nurse specialists, and dedicated GP input, especially for high-risk residents;
- set up hospital-at-home teams, especially for administration of intravenous fluids and antibiotics.

RESOURCES

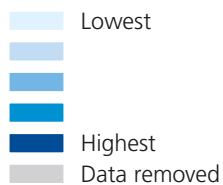
- NHS England. High quality care for all, now and for future generations: Transforming urgent and emergency care services in England – Urgent and Emergency Care Review End of Phase 1 Report. November 2013. <http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf>
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- Burtney L et al. Learning for care homes from alternative residential care settings. Joseph Rowntree Foundation. April 2014. <http://www.jrf.org.uk/publications/learning-for-care-homes>
- The Gold Standards Framework. Advanced Care Planning. <http://www.goldstandardsframework.org.uk/advance-care-planning>

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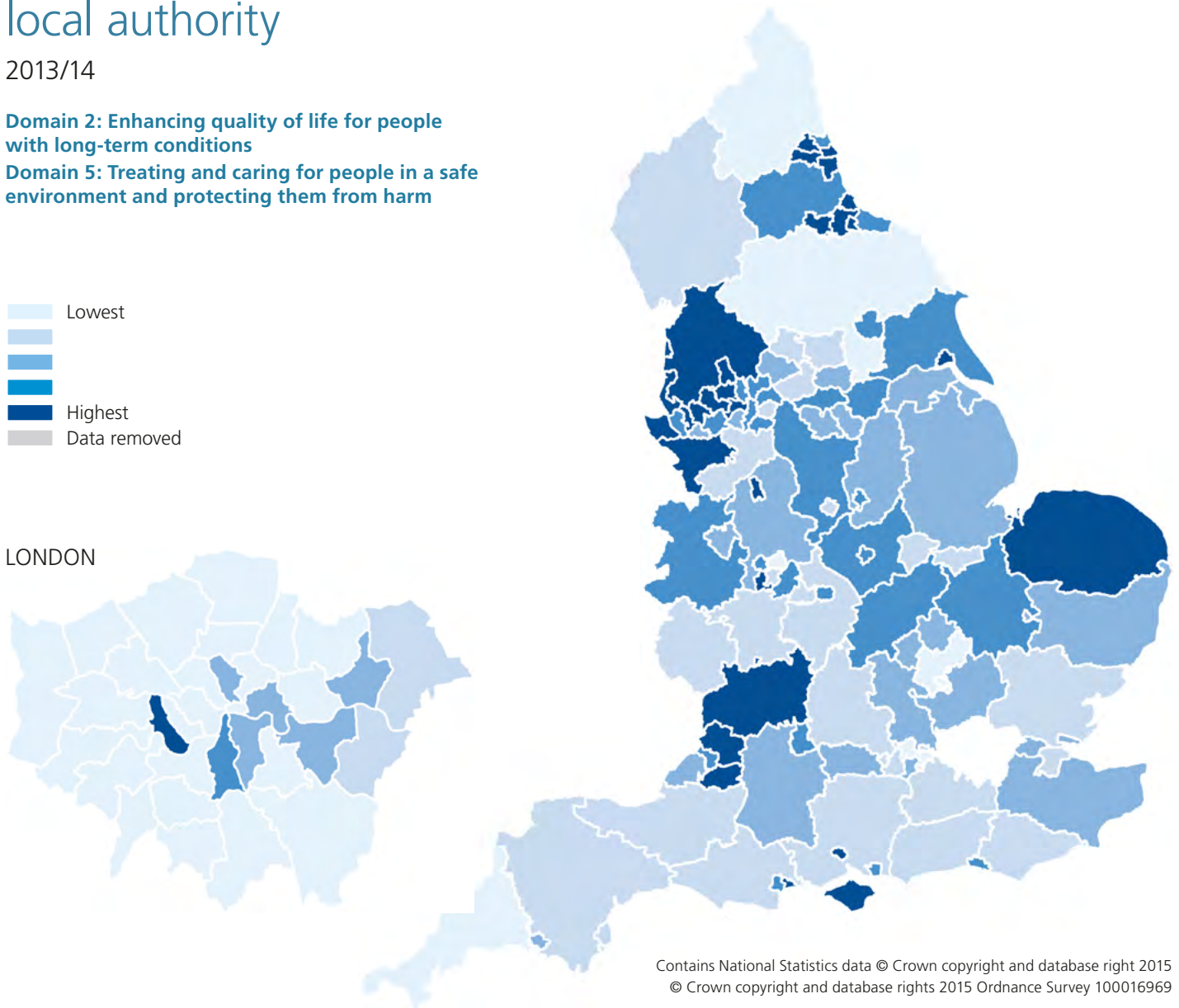
Map 63: Rate of council-supported permanent admissions of people aged 65 years and over to nursing home and residential care home settings per population by upper-tier local authority

2013/14

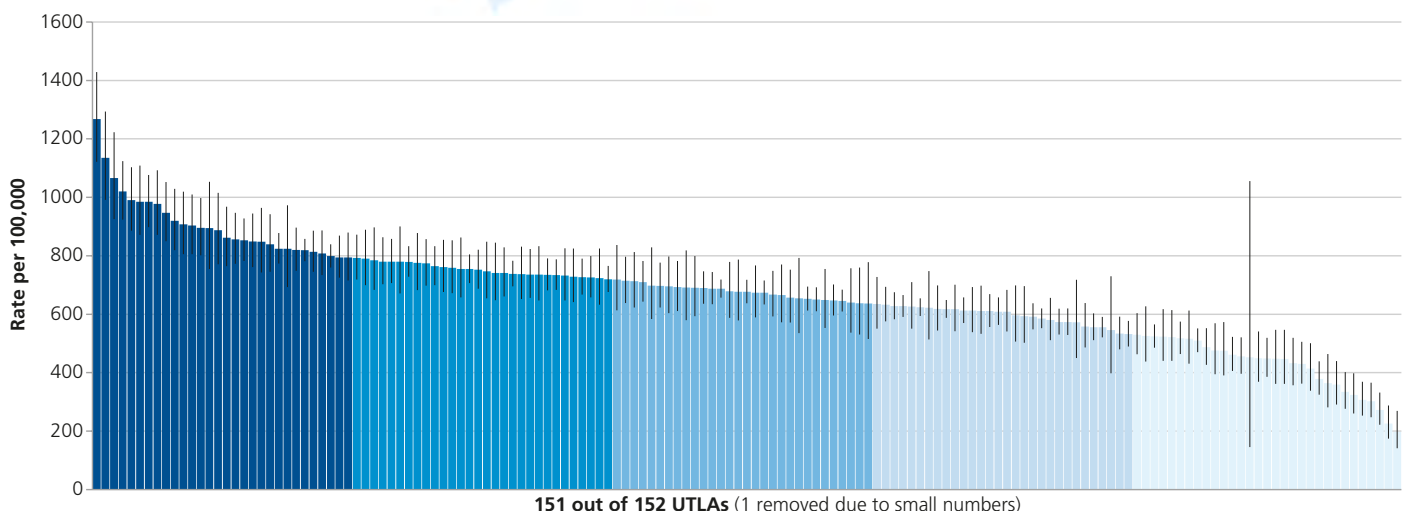
Domain 2: Enhancing quality of life for people with long-term conditions
 Domain 5: Treating and caring for people in a safe environment and protecting them from harm



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Context

The rate of permanent placements in residential and nursing care homes can be seen as an indication of the level and type of support older people receive in the local health and social care environment, reflecting not only access to but also the effectiveness of rehabilitation services that promote and maintain a person's independence.

Rehabilitation services become pivotal when an older person experiences acute health and social care crises. For instance, admission to hospital for an older person with frailty can cause a decline in mobility through a loss of muscle strength. For every seven days of inactivity, there will be a 10% loss of muscle strength, which represents a considerable loss in people with frailty and, in the absence of appropriate rehabilitation and re-ablement services to help a person regain independence, can be a precipitating factor in permanent admission to a nursing or residential care home. Research suggests that, where possible, people prefer to stay in their own home rather than move into residential care.

Comprehensive geriatric assessment (CGA; see "Resources") is a multidimensional and, usually, interdisciplinary diagnostic process designed to determine the medical conditions, mental health, functional capacity and social circumstances of an older person with frailty. The purpose is to develop and implement a holistic plan for treatment, rehabilitation, support and long-term follow-up. The British Geriatrics Society recommend CGA as one way of avoiding potentially challenging changes in an older person's life, such as permanent admission to a nursing or residential care home.

Magnitude of variation

For upper-tier local authorities in England, the rate of council-supported permanent admissions of people aged 65 years and over to nursing home or residential care home settings ranged from 198 to 1268 per 100,000 population (6.4-fold variation).¹ When the five UTLAs with the highest rates and the five UTLAs with the lowest rates are excluded, the range is 324–985 per 100,000 population, and the variation is 3.0-fold.

One reason for warranted variation is differences in the location of nursing and residential care homes, which tend to be clustered in urban areas that have mansion-type properties (which can be converted) or brownfield sites (where new larger homes can be built).

Reasons for unwarranted variation include differences in:

- access to rehabilitation services across the care pathway;
- timely contact with rehabilitation services;
- access to inpatient geriatric care;
- access to community-based care.

Options for action

Local health and social care services need to work together to reduce avoidable admissions to nursing or residential care homes. It is advisable that NHS and other commissioners and service providers undertake a joint strategic review of need for community and rehabilitation services in the local population of older people, including:

- the design and implementation of integrated or "pooled" service models, with an outcomes-based approach;
- assessing whether the investment in rehabilitation services is appropriate to the level of need.

In local authority areas where there is a high rate of placement in nursing and residential care homes, NHS and

other commissioners and service providers need as a priority to ascertain the reasons for this, and seek to address them.

To enable older people to remain in their own homes, commissioners need to specify that service providers:

- undertake CGA (see "Resources") on all older people with frailty at risk of acute health and/or social care crises, and involve them in the care-planning process;
- provide primary care with access to specialist support and diagnostic services to be able to support older people in the community;
- set up multidisciplinary teams to care for older people with frailty.

Local health and social care services also need to work with housing to make the residences of older people fit for purpose with respect to providing care at home for as long as possible.

CASE-STUDY RESOURCE

- Case-study 3: Oxleas NHS Foundation Trust and Royal Borough of Greenwich Adult Community Services. Rapid response service providing rehabilitation to older people. In NHS Improving Quality. Improving adult rehabilitation services in England. Sharing best practice in acute and community care. June 2014. http://www.nhs.uk/media/2487824/improving_adult_rehabilitation_services_in_england.pdf

RESOURCES

- NHS Benchmarking Network. National Audit of Intermediate Care 2014 (NAIC 2014). <http://www.nhsbenchmarking.nhs.uk/partnership-projects/National-Audit-of-Intermediate-Care/year-three.php>
- NHS Benchmarking Network. National Audit of Intermediate Care 2014 (NAIC 2014) The online benchmarking toolkit is available by logging in from the following webpage. <http://members.nhsbenchmarking.nhs.uk/login.aspx?ReturnUrl=%2fhome>
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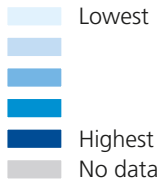
¹ Data from one CCG have been removed due to small numbers.

CARE OF OLDER PEOPLE

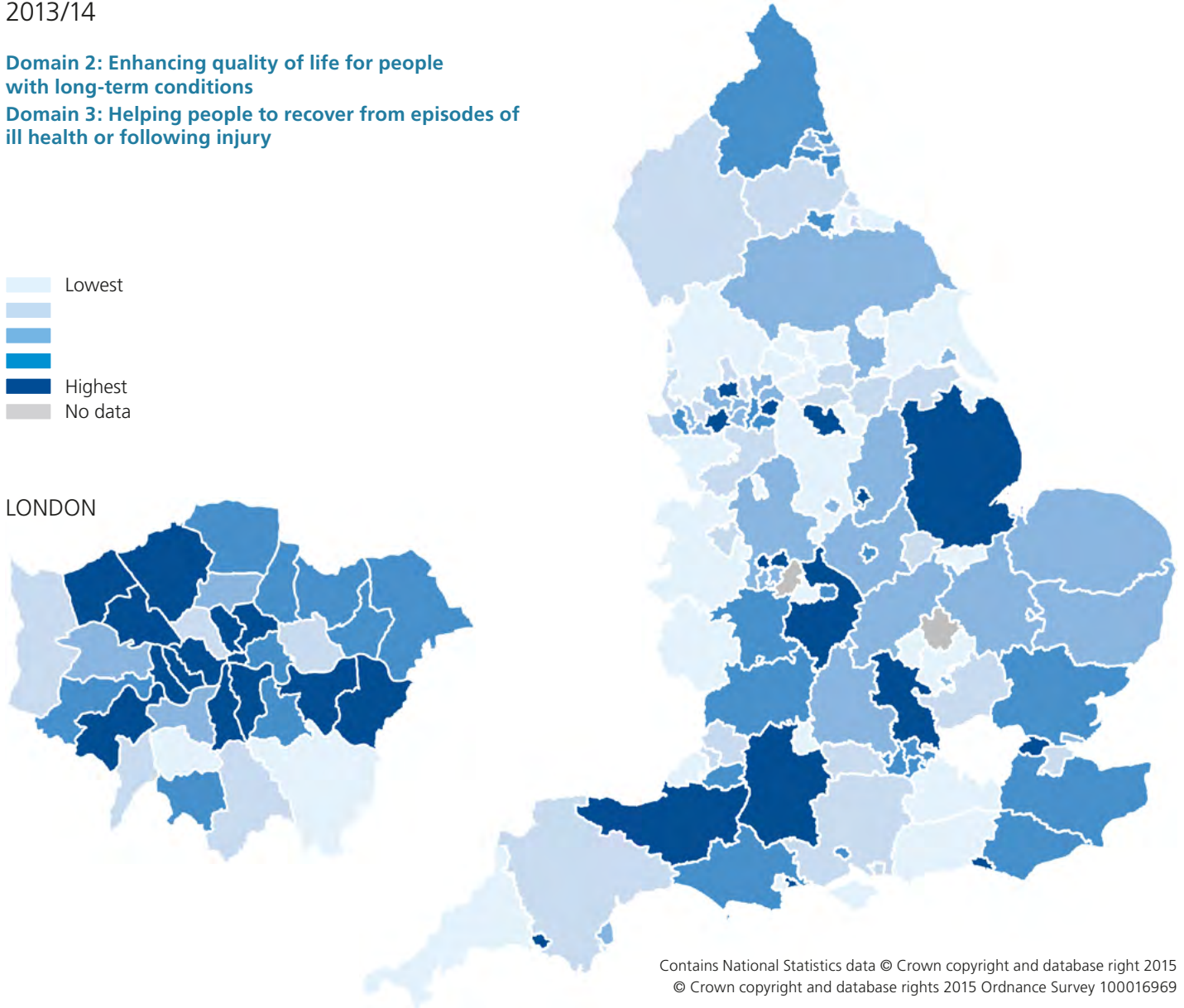
Map 64: Percentage of people aged 65 years and over who were discharged from hospital into re-ablement/rehabilitation services by upper-tier local authority

2013/14

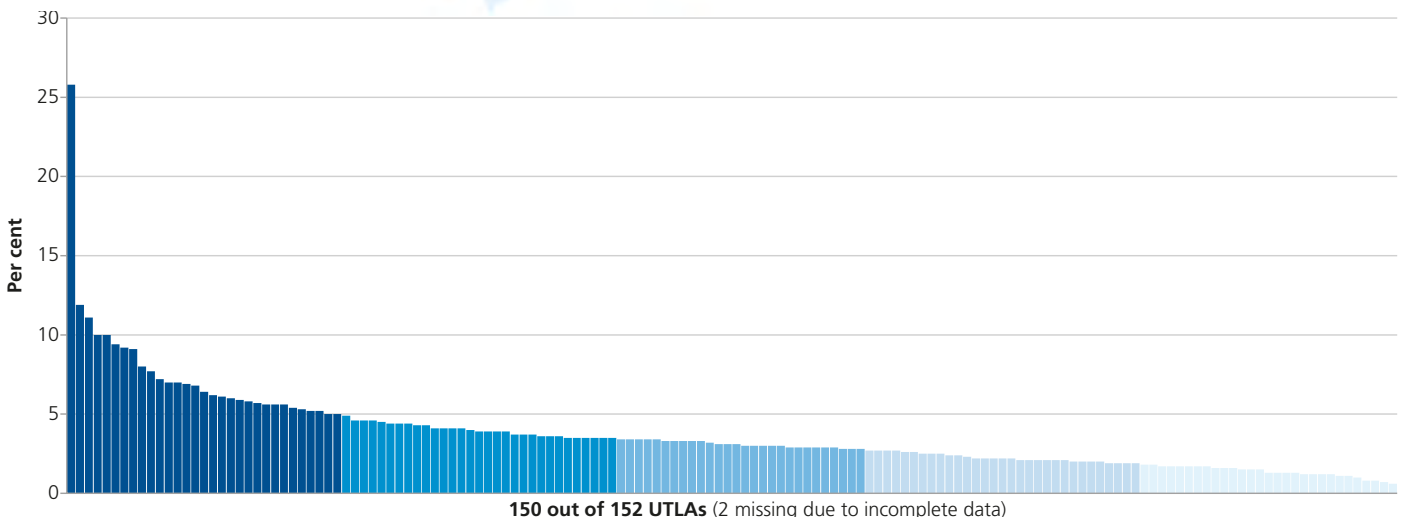
Domain 2: Enhancing quality of life for people with long-term conditions
 Domain 3: Helping people to recover from episodes of ill health or following injury



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Context

Intermediate care is a range of integrated services, including re-ablement and rehabilitation, designed to meet people's health and social care needs by:

- › promoting faster recovery from illness;
- › preventing unnecessary acute hospital admission;
- › preventing premature admission to long-term residential care;
- › supporting timely discharge from hospital;
- › maximising independent living.

Although no-one should be excluded from intermediate care, the key target groups are people who would otherwise face:

- › unnecessarily prolonged hospital stays;
- › inappropriate admission to acute inpatient care, long-term residential care or continuing NHS inpatient care.

As older people are particularly vulnerable at care transition points, services need to work together to meet older people's needs by providing access to appropriate care in the right place and at the right time. Intermediate care can increase the appropriateness and improve the quality of care for individuals, and help older people regain their health.

Comprehensive geriatric assessment (CGA; see "Resources") is a multidimensional and, usually, interdisciplinary diagnostic process designed to determine the medical conditions, mental health, functional capacity and social circumstances of an older person with frailty. The purpose is to develop and implement a holistic plan for treatment, rehabilitation, support and long-term follow-up. The British Geriatrics Society (BGS; see "Resources") recommends that older people should have a CGA in various circumstances, including when:

- › transfer of care is being planned for rehabilitation or re-ablement;
- › a person is receiving rehabilitation or re-ablement.

One of the key principles the BGS advocates is that older people are central to the process of CGA. In the National Audit of Intermediate Care 2014 (NAIC 2014; see "Resources"), although older people felt they were treated with dignity, they reported a lack of adequate involvement in the care planning process (patient reported experience measure, PREM).

Just as CGA is an interdisciplinary process, the teams undertaking re-ablement/rehabilitation need to be multidisciplinary, including the following functions: medical, nursing, physiotherapy and occupational and speech therapy, pharmacy, nutrition, and social care, with links to the voluntary sector. Mental health involvement in multidisciplinary teams is also important as many older people with frailty have dementia and/or depression. The effectiveness of care tends to increase as the range of disciplines involved expands.

In addition to the benefits for individual older people, the provision of intermediate care also has the potential to transform the local health and social care system by:

- › making more effective use of capacity;
- › establishing new ways of working.

The Better Care Fund (BCF; see "Resources"), announced by the government in the 2013 spending round, was established to support the transformation to integrated health and social care services. The BCF creates a local single pooled budget to incentivise the NHS and local government to work together to ensure people's well-being is the focus of health and care services. The BCF is part of the NHS two-year operational plans and the five-year strategic plans, as well as local government planning.

Magnitude of variation

Map 64: Discharge into re-ablement/rehabilitation services

For upper-tier local authorities (UTLAs) in England, the percentage of people aged 65 years and over who were discharged from hospital into re-ablement/rehabilitation services ranged from 0.6% to 25.8% (43-fold variation). When the five UTLAs with the highest percentages and the five UTLAs with the lowest percentages are excluded, the range is 1.1–9.4%, and the variation is 8-fold.

Map 65: At home 91 days after discharge into re-ablement/rehabilitation services

For UTLAs in England, the percentage of people aged 65 years and over who were still at home 91 days after discharge from hospital into re-ablement/rehabilitation services ranged from 58.9% to 100% (1.7-fold variation). When the five UTLAs with the highest percentages and the five UTLAs with the lowest percentages are excluded, the range is 64.9–95.6%, and the variation is 1.5-fold.

For both indicators, the main reason for warranted variation is differences in the proportion of people aged over 65 years in local populations. Possible reasons for unwarranted variation include differences in:

- › the level of investment in re-ablement/rehabilitation and community-based services;
- › strategic approaches to the provision of community-based services in local authority areas.

Although the reasons for variation cited above are similar, the degree of variation observed for these two indicators is noticeably different. Although there is variation in the percentage of people still at home 91 days after discharge into re-ablement/rehabilitation services, and therefore there is potential to improve the effectiveness of such services in some local authority areas, there is a much greater degree of variation in access to these services. Thus, when re-ablement/rehabilitation services are provided to older people they appear to be relatively effective, but provision is not uniform, raising questions about equity in the provision of these services. Moreover, after exclusions, it seems that provision is low for all local authority areas, with a maximum of only one in every ten older people discharged from hospital into re-ablement/rehabilitation services.

1 Data from two UTLAs are missing.

2 Data from one UTLA have been removed due to small numbers, and data from two UTLAs are missing.

Options of action

NHS and other commissioners and service providers in the local authority area need:

- › to undertake a strategic review of the provision of integrated care and community services for the local population of older people, including the level of investment in relation to need, and the current situation regarding patient flows;
- › to consider using finance from the Better Care Fund (BCF; see “Resources”) to help transform local services, with a view to expanding the provision of intermediate care, including re-ablement and rehabilitation services;
- › to take a whole pathway approach to the provision of health and social care for older people with frailty, rather than focussing on hospital care alone.

To improve the effectiveness of local re-ablement and rehabilitation services, NHS and other commissioners need to specify that service providers:

- › ensure that CGA (see “Resources”) is undertaken routinely on older people with frailty but including prior to discharge and care planning from hospital, and that older people are involved in the care-planning process;
- › establish multidisciplinary teams to provide care for older people with frailty.

In addition, when considering discharge and care planning, local health and social care services need to consider working closely with housing to ensure that the residences of older people are fit for purpose with respect to providing care at home.

CASE-STUDY RESOURCE

- › Case-study 3: Oxleas NHS Foundation Trust and Royal Borough of Greenwich Adult Community Services. Rapid response service providing rehabilitation to older people. In NHS Improving Quality. Improving adult rehabilitation services in England. Sharing best practice in acute and community care. June 2014. http://www.nhs.uk/media/2487824/improving_adult_rehabilitation_services_in_england.pdf

RESOURCES

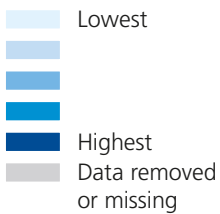
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- › NHS England. Safe, compassionate care for frail older people using an integrated care pathway: Practical guidance for commissioners, providers and nursing, medical and allied health professional leaders. February 2014. <http://www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf>
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- › NHS Networks. Improving Rehabilitation Services (IRS). <https://www.networks.nhs.uk/nhs-networks/clinical-commissioning-community/improving-adult-rehabilitation-services>
- › British Geriatrics Society. Comprehensive Assessment of the Frail Older Patient. January 2010. <http://www.bgs.org.uk/index.php/topresources/publicationfind/goodpractice/195-gpgcassessment>
- › Better Care Fund Taskforce. Better Care Fund. Policy Framework. December 2014. Department of Health and Department for Communities and Local Government. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/381848/BCF.pdf
- › NHS England. Better Care Fund Planning webpage. <http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/>

CARE OF OLDER PEOPLE

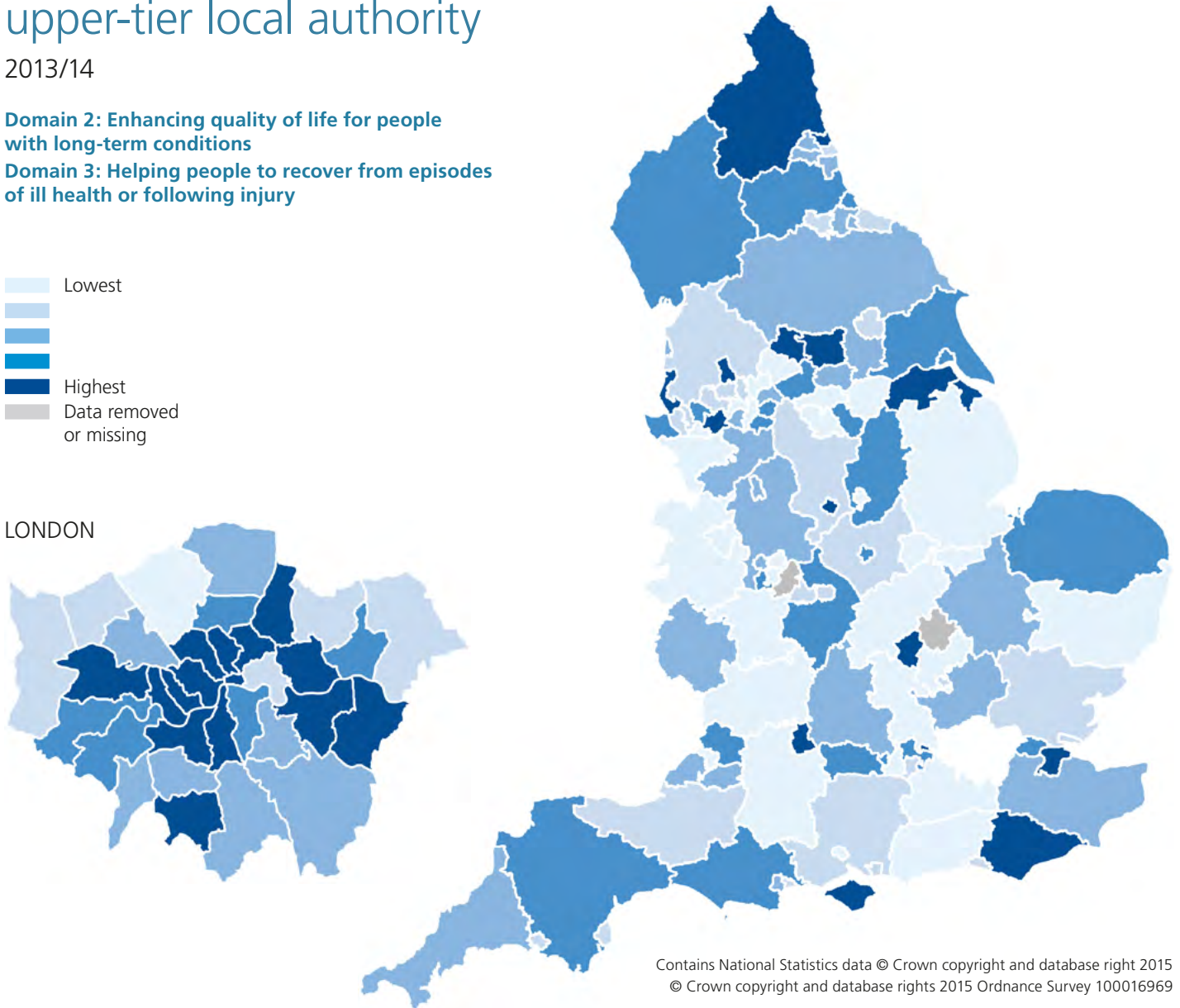
Map 65: Percentage of people aged 65 years and over who were still at home 91 days after discharge from hospital into re-ablement/rehabilitation services by upper-tier local authority

2013/14

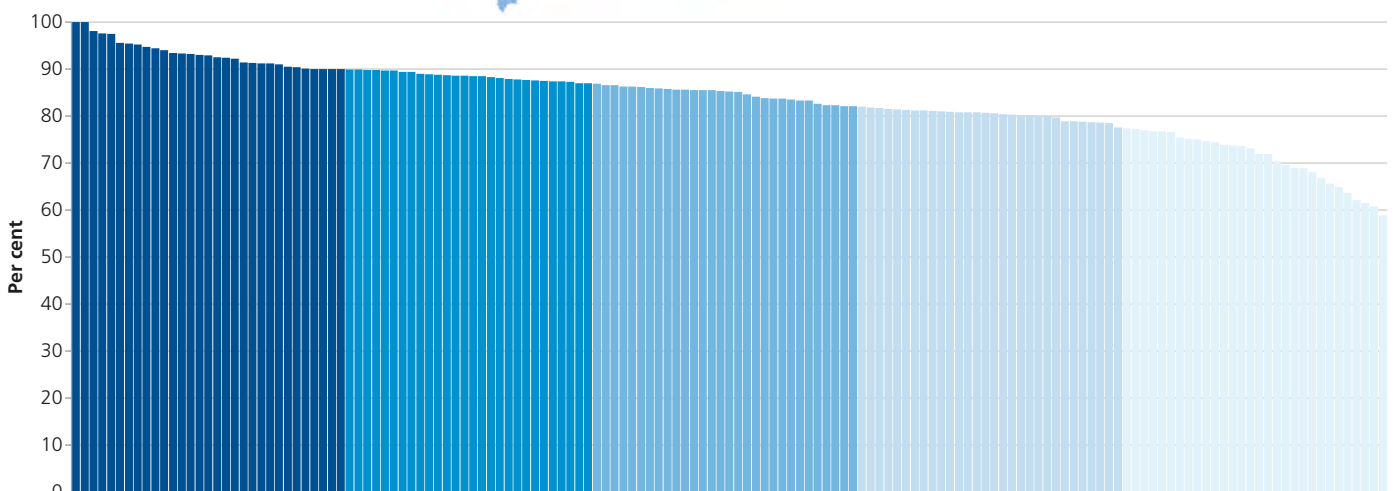
Domain 2: Enhancing quality of life for people with long-term conditions
Domain 3: Helping people to recover from episodes of ill health or following injury



LONDON



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149 out of 152 UTAs (1 removed due to small numbers, and 2 missing data)