Getting older patients home from hospital.

David Oliver

FMLM Conference
Manchester 17th October 2012

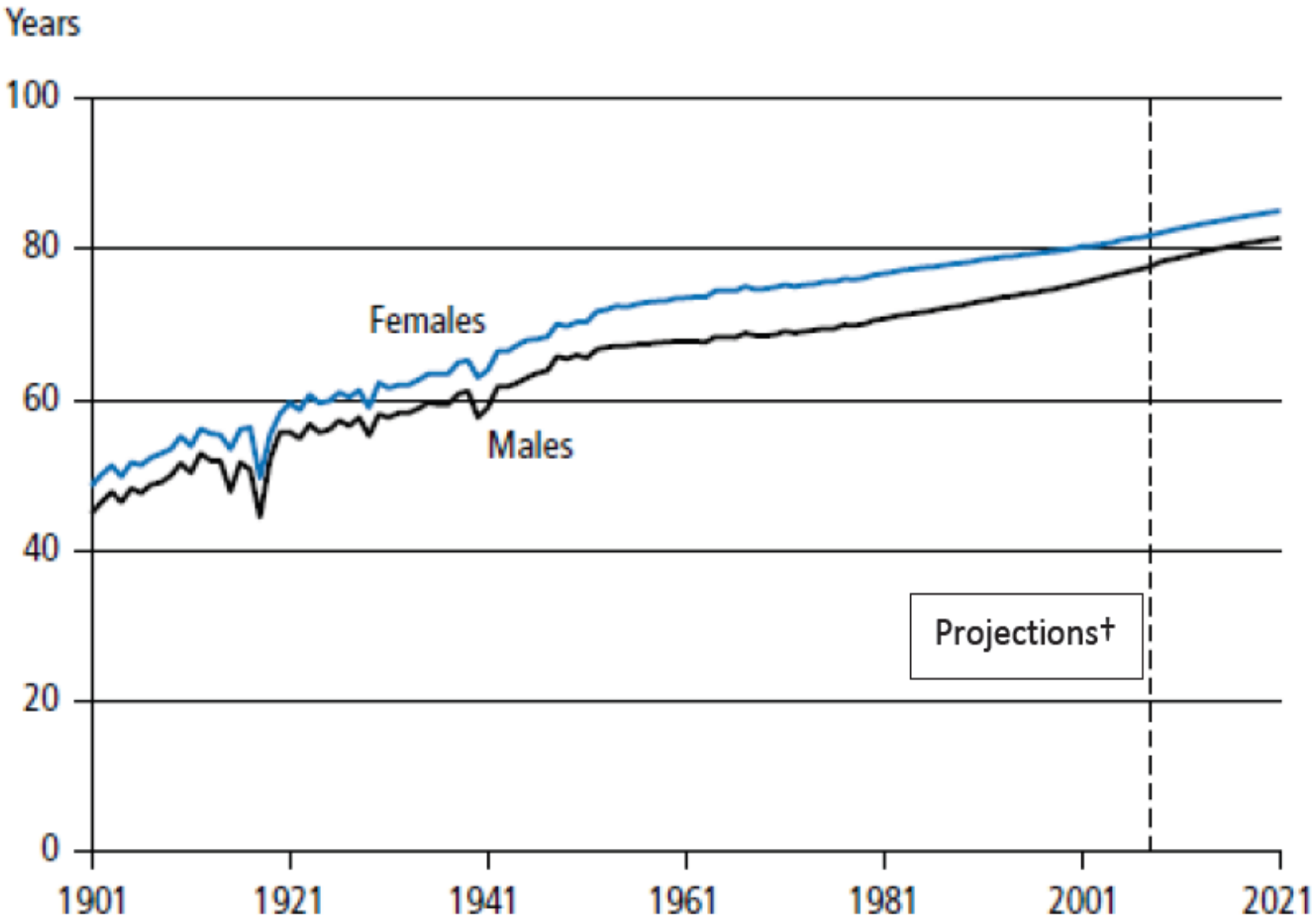
To Cover

- I: Why getting this right matters now?
- II: Who is actually in hospital beds?
    - Older people with complex needs
- III: What could hospital clinicians and clinical leaders do better *within* the acute pathway and *within* general hospitals?
- IV: The need to work across wider health and social care systems “end to end”
    - We don’t work in isolation. All parts of the pathway are interdependent
- V: The leadership challenges for us?

Just to save you writing...

- You can all have the slides
- I always answer emails after doing talks
- I will send copies of any of the slides and reports cited to people who do email me
- I will put email address up at the end
- Happy to be door-stepped afterwards

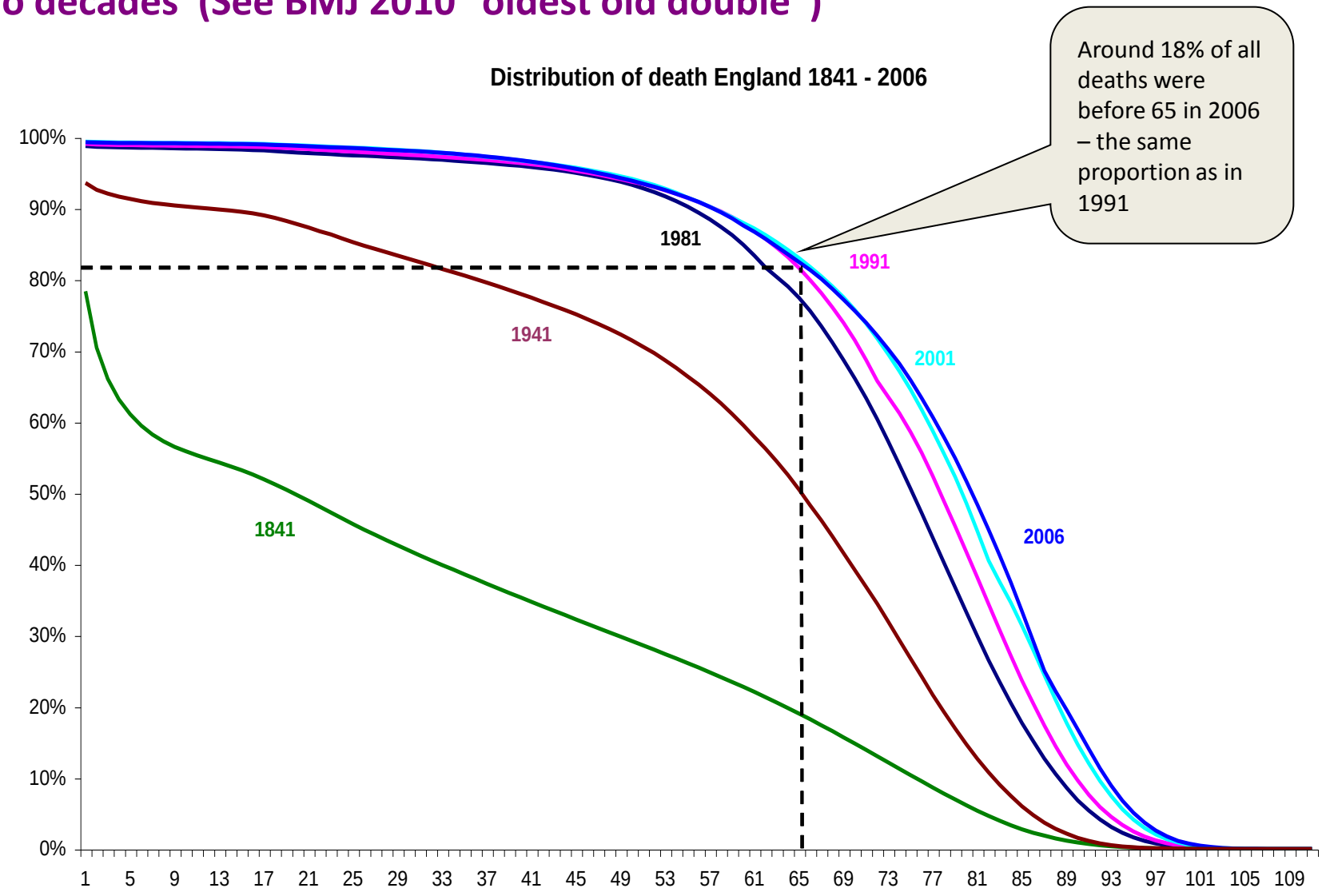
I: Why getting this right matters so much right now?



Source: Social Trends 40: 2010 edition, ONS

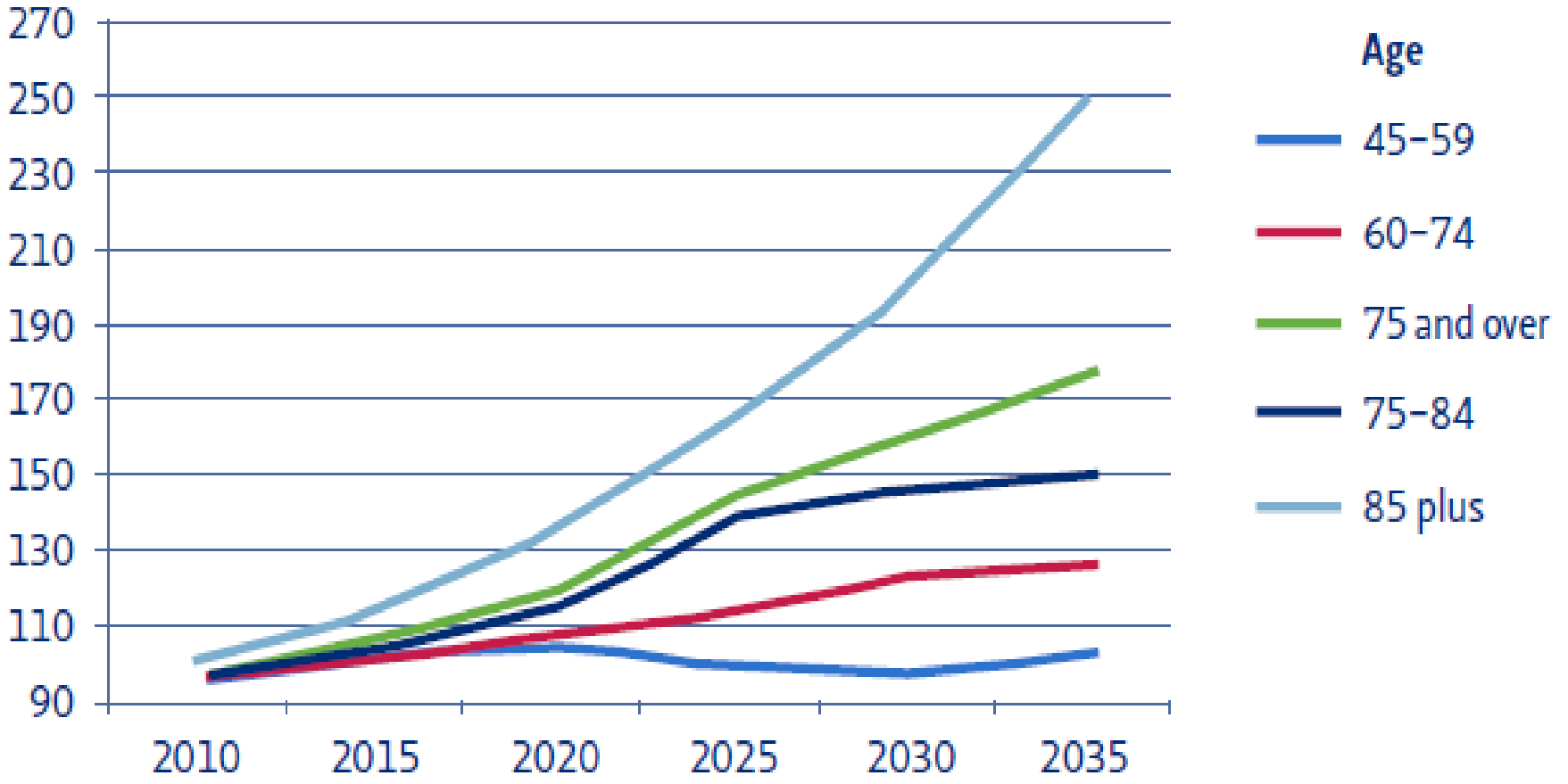
Figure 10: Life expectancy* at birth in men and women, 1901 to 2021, UK

Over the last 50 years, trend has moved from a **‘rectangularisation’** to an a **‘elongation’** (**from “old” to “older”**) **Number over 80 has doubled in past two decades (See BMJ 2010 “oldest old double”)**



Source: mortality.org, originally ONS

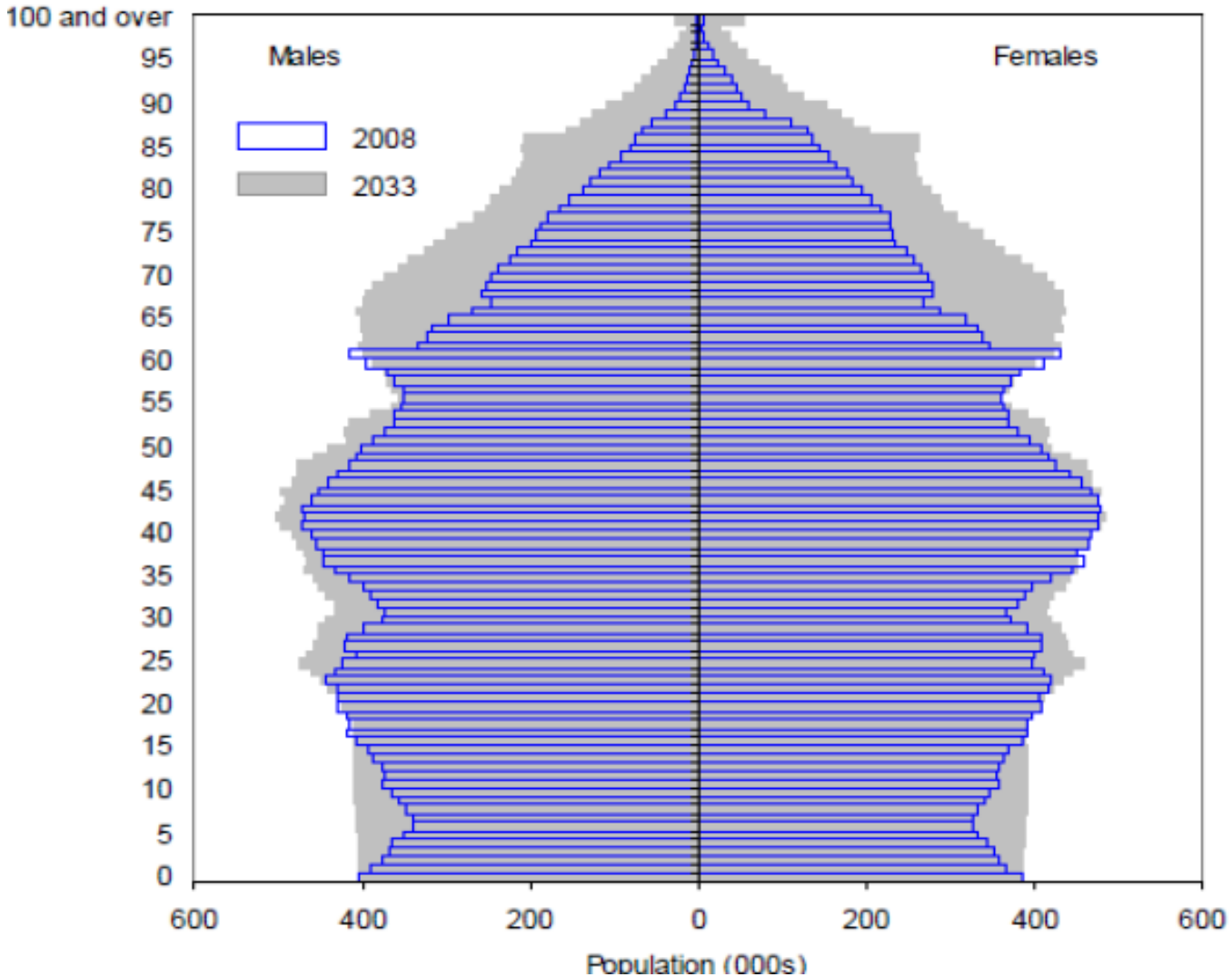
Figure 1. Projected population by age, United Kingdom, 2010–35 (2010 = 100)

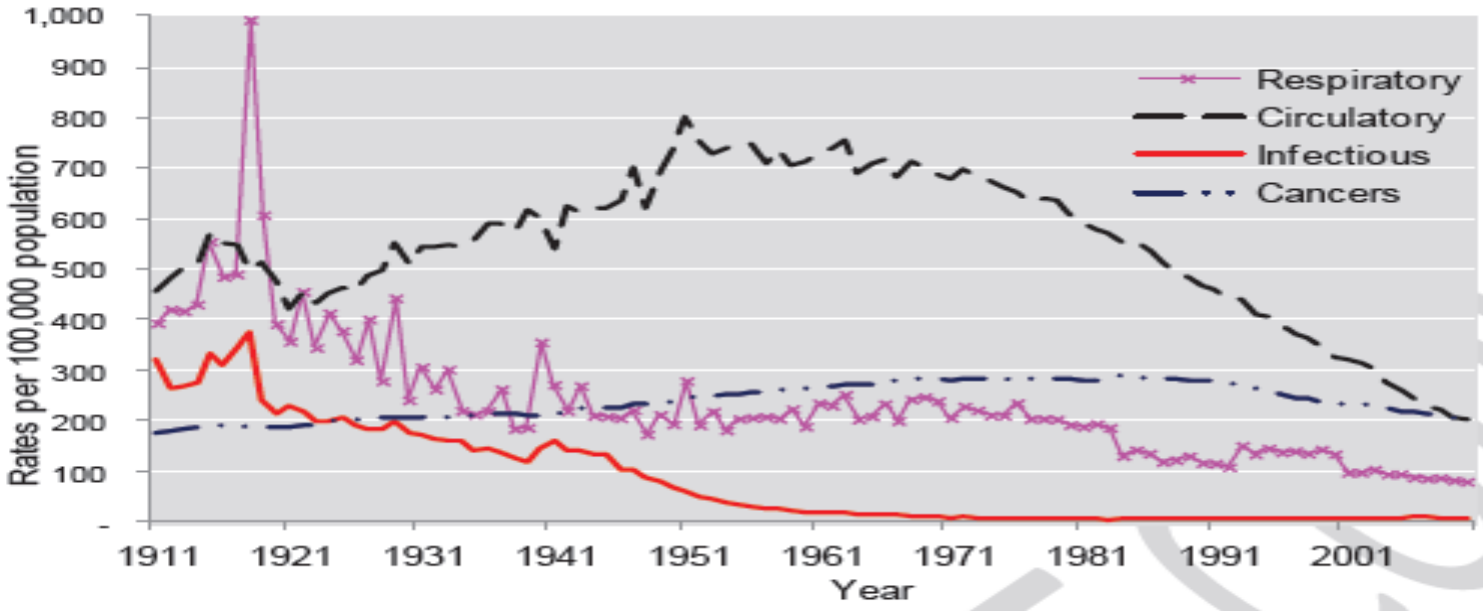


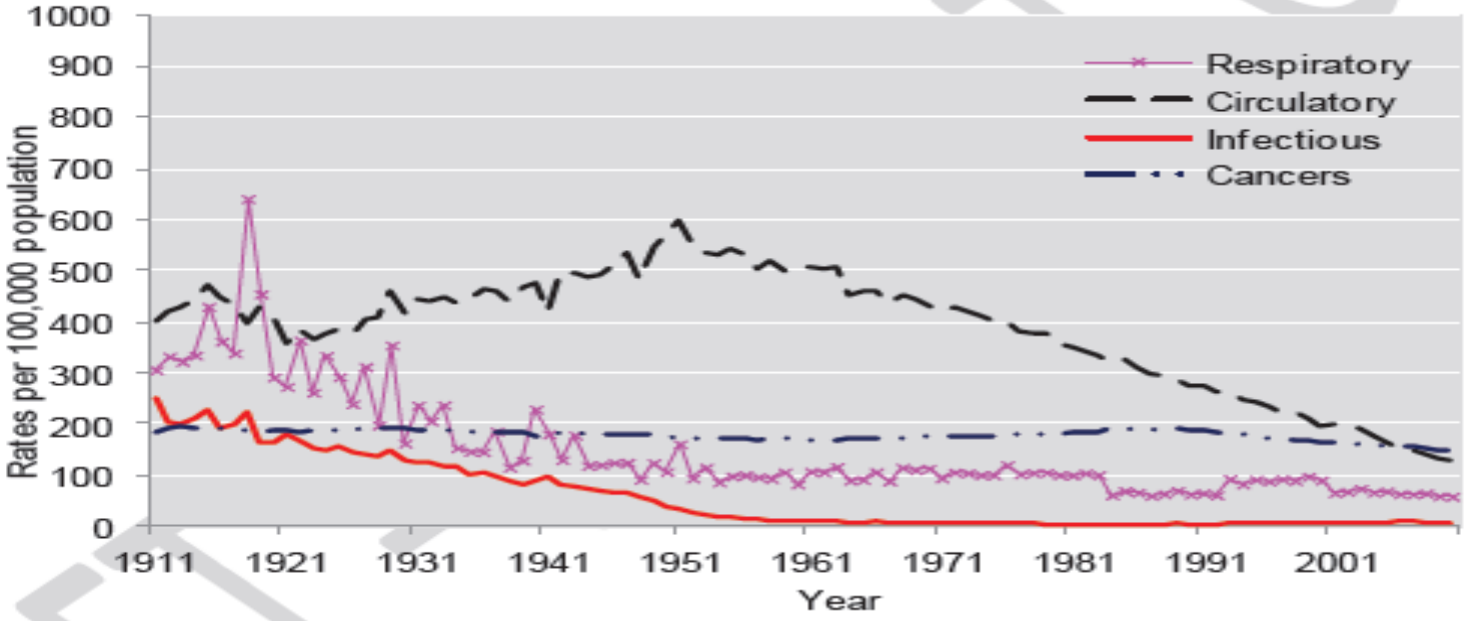
Source: Office for National Statistics (Oct 2011) National Population Projections 2010-based Statistical Bulletin.

ONS Projections

(146% increase in over 90s & 85% in over 80s in next 20 years)

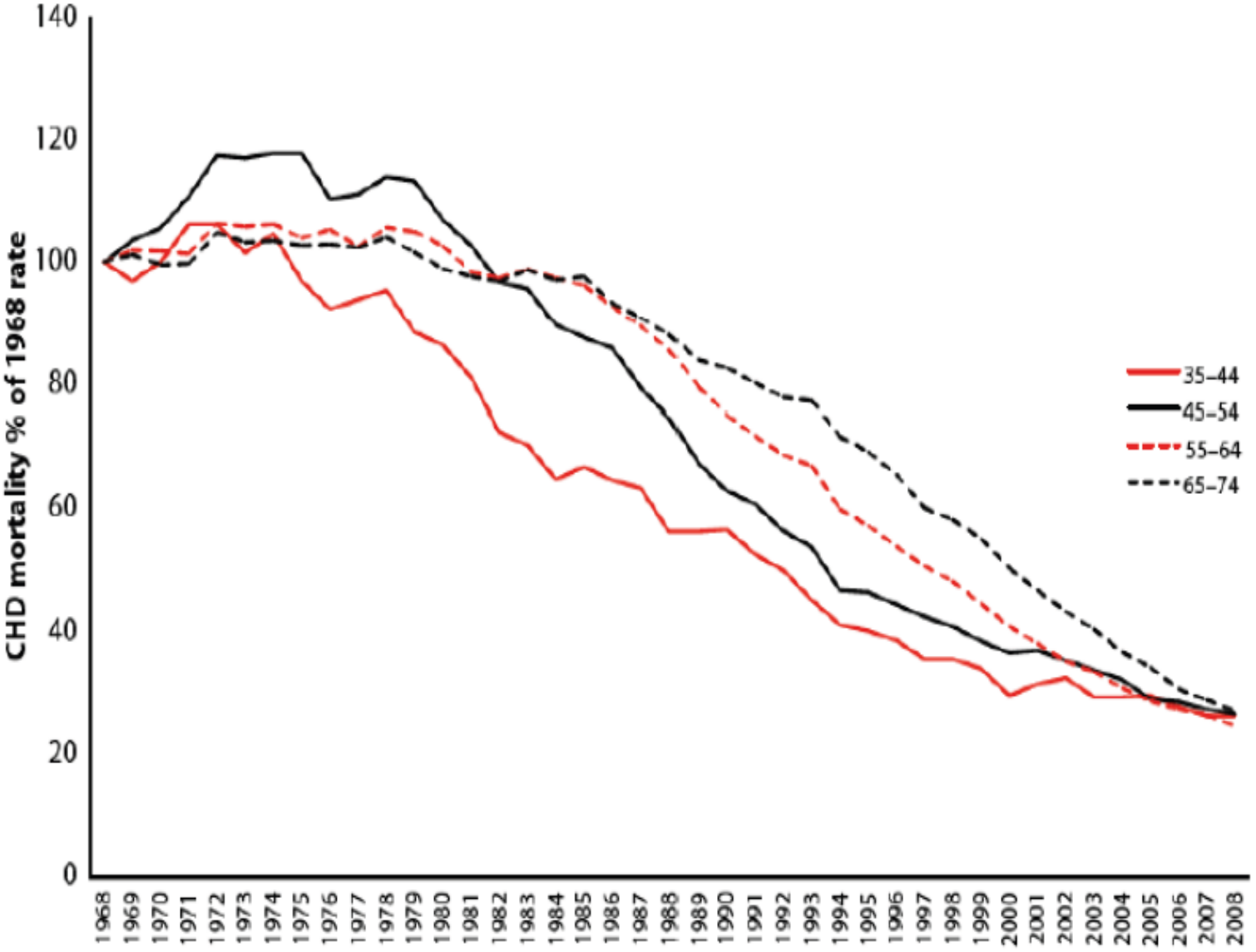






Source: ONS, 2011

lortality by major cause, in men and women (all ages), England and Wales, 1911-2010*



Source: BHF Coronary Heart Disease Statistics [40]

Figure 14: Age-specific death rates from coronary heart disease (CHD) in men aged 35+, 1968 to 2008, UK

People over 65 (England)...

- 60% adult social care spend (£9bn)
  - 1.25 M out of 1.7 m users
- 37% NHS Primary Care spend (£27bn)
- 46% acute care spend (£ 27bn)
- 12% NHS budget is on community health care (largely older people) (c £12bn)
- Often those interdependent on multiple services
  (e.g. 60% of home care service users have been in hospital in previous year. 80% of delayed transfers are over 70)
- Population ageing means this trend will continue

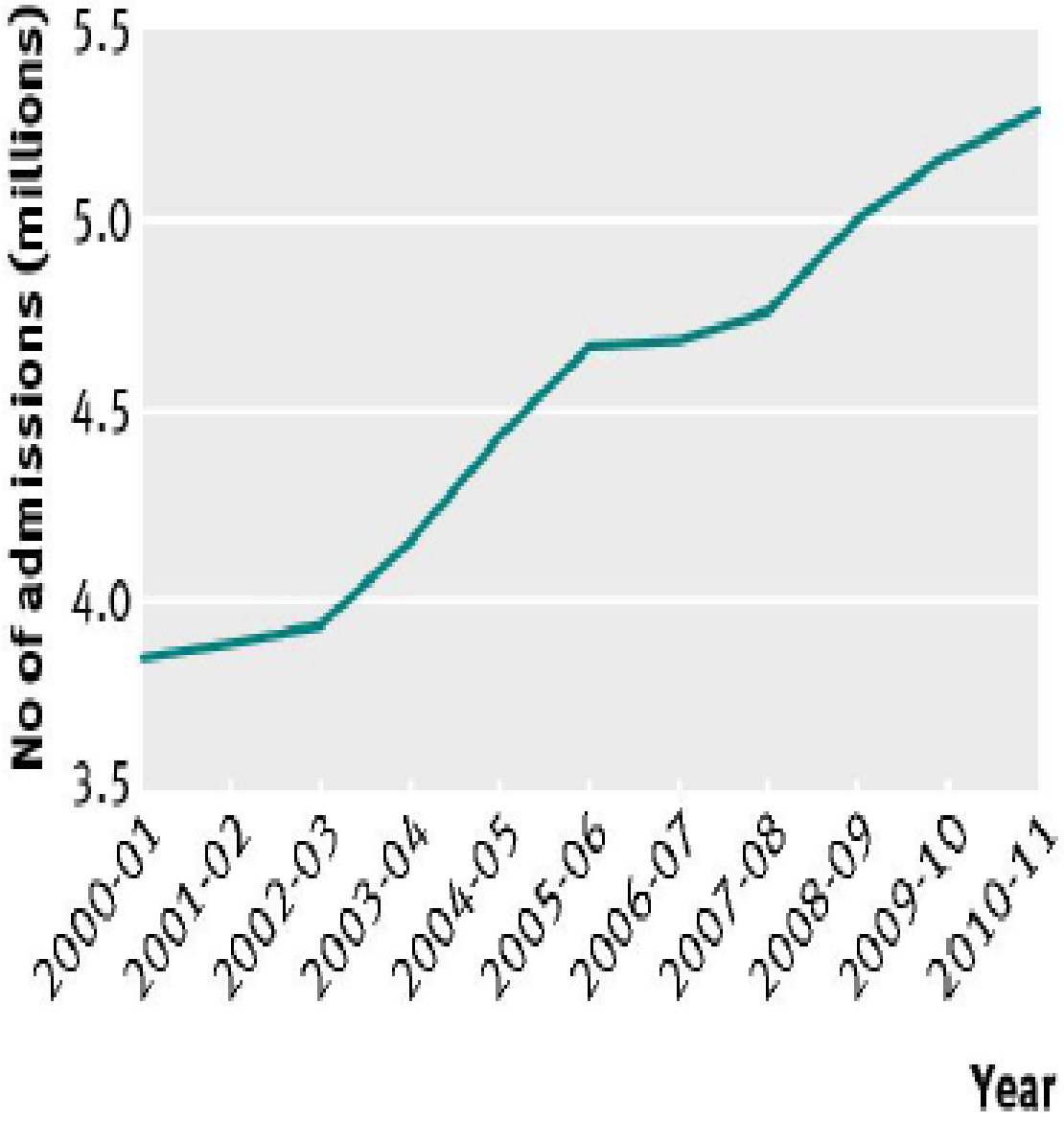
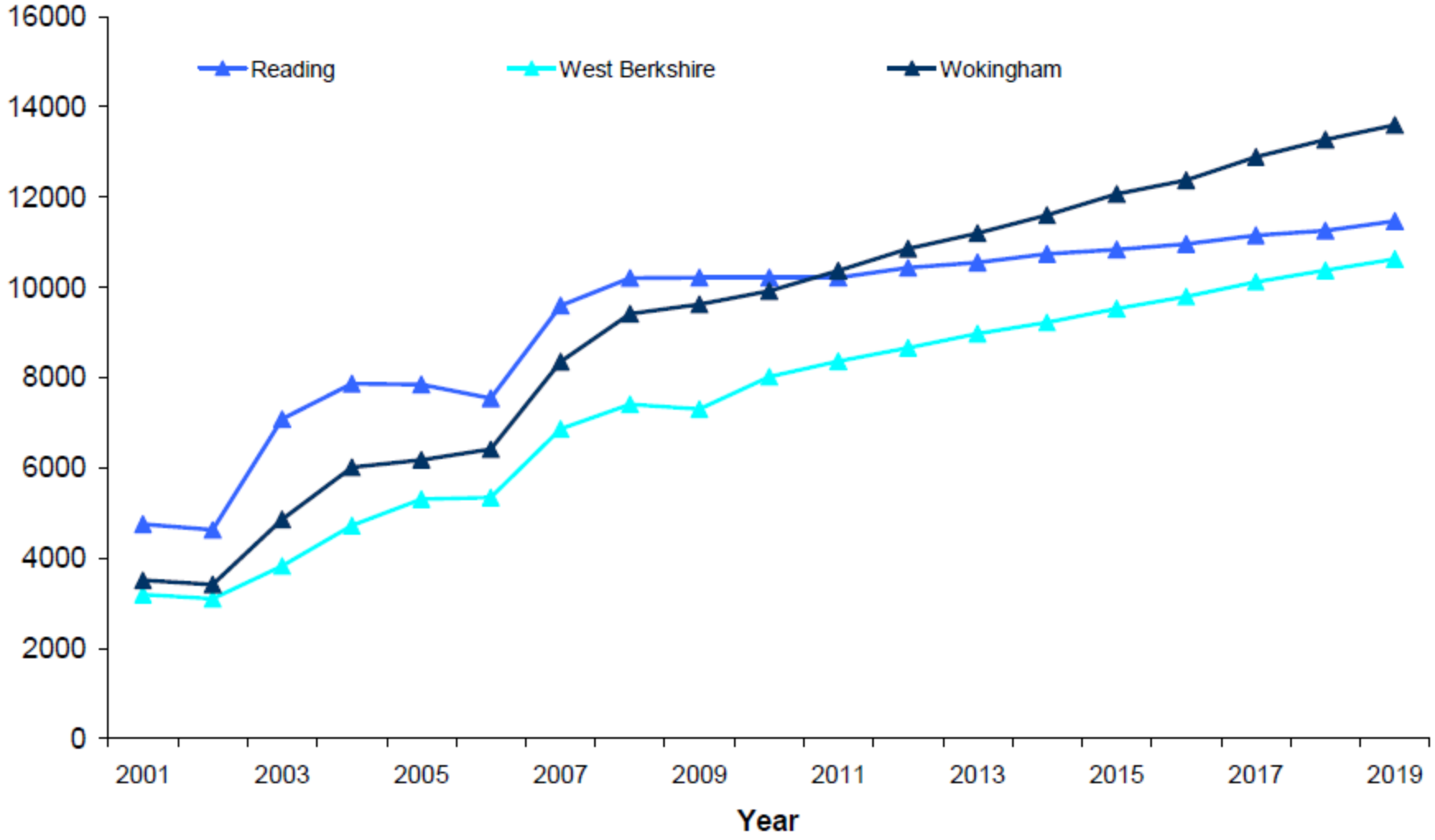


Fig 1 Emergency admissions to NHS hospitals in England, 2000-11[2]

Figure 1: The number of elderly care admissions to the Royal Berkshire Hospital from the three unitary authorities in the NHS Berkshire West area



EMERGENCY READMISSIONS: ENGLAND 1999-00 to 2009-10

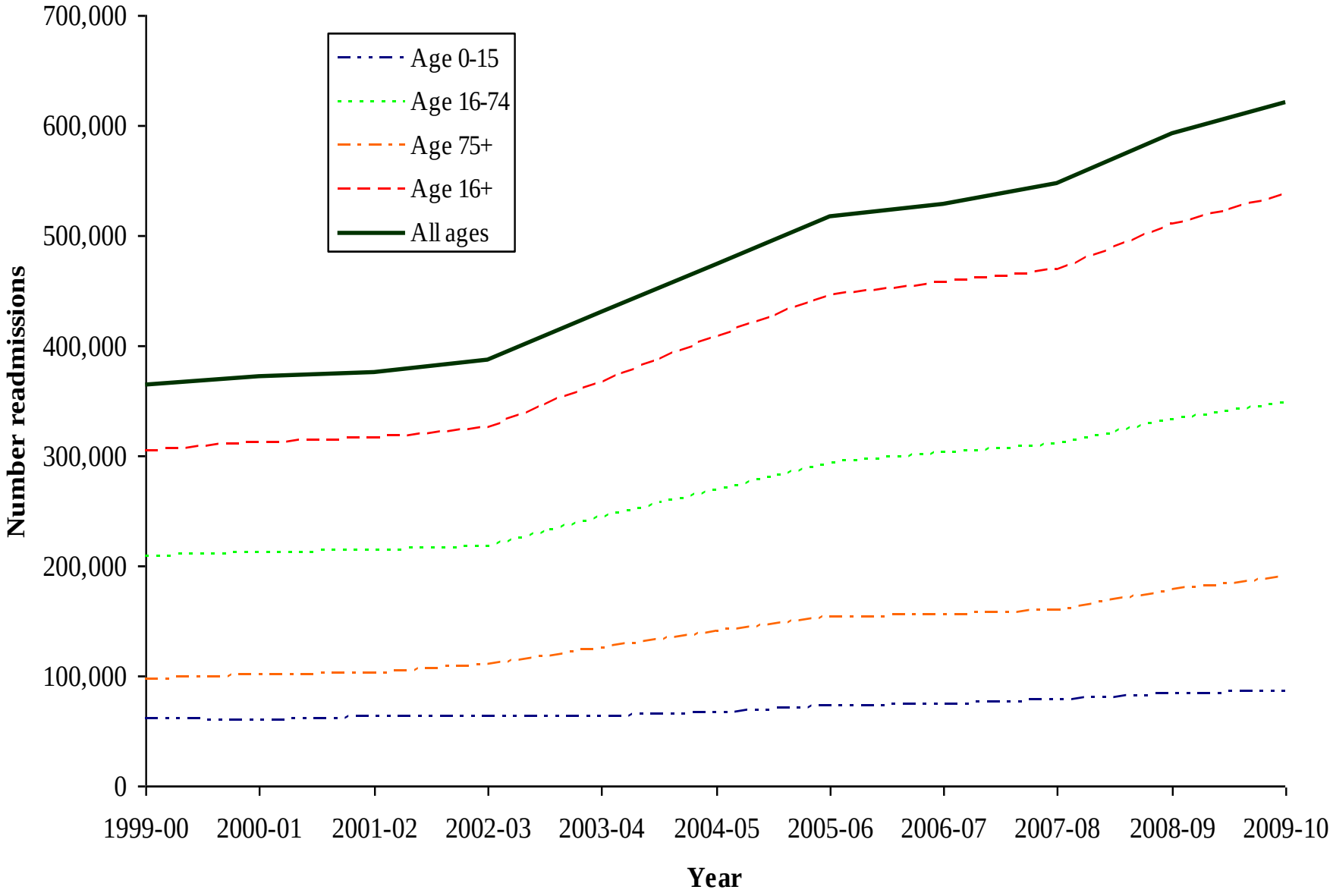
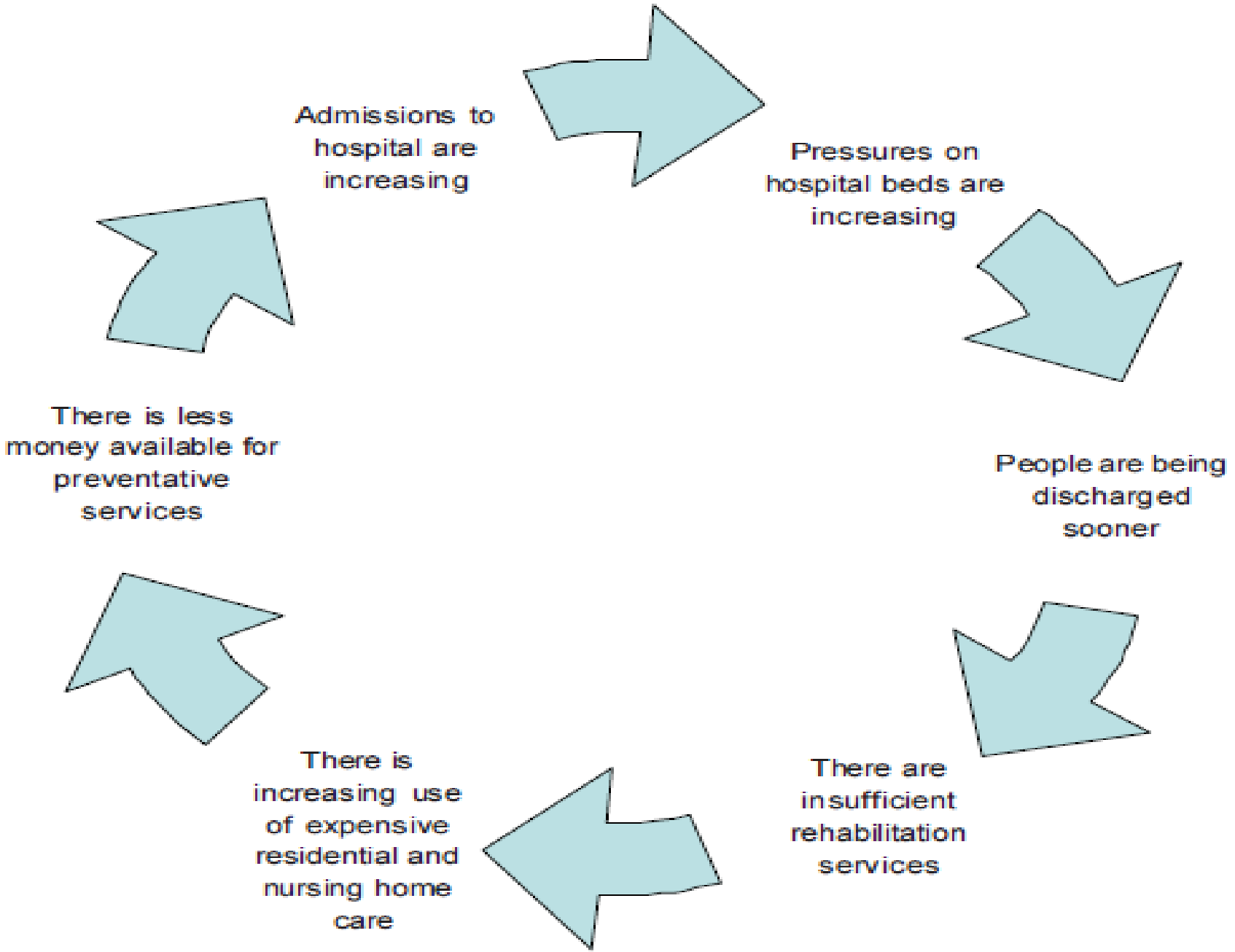


Figure 1: The vicious circle, Audit Commission (1997, 2000)



Delayed transfers of care from acute (England)

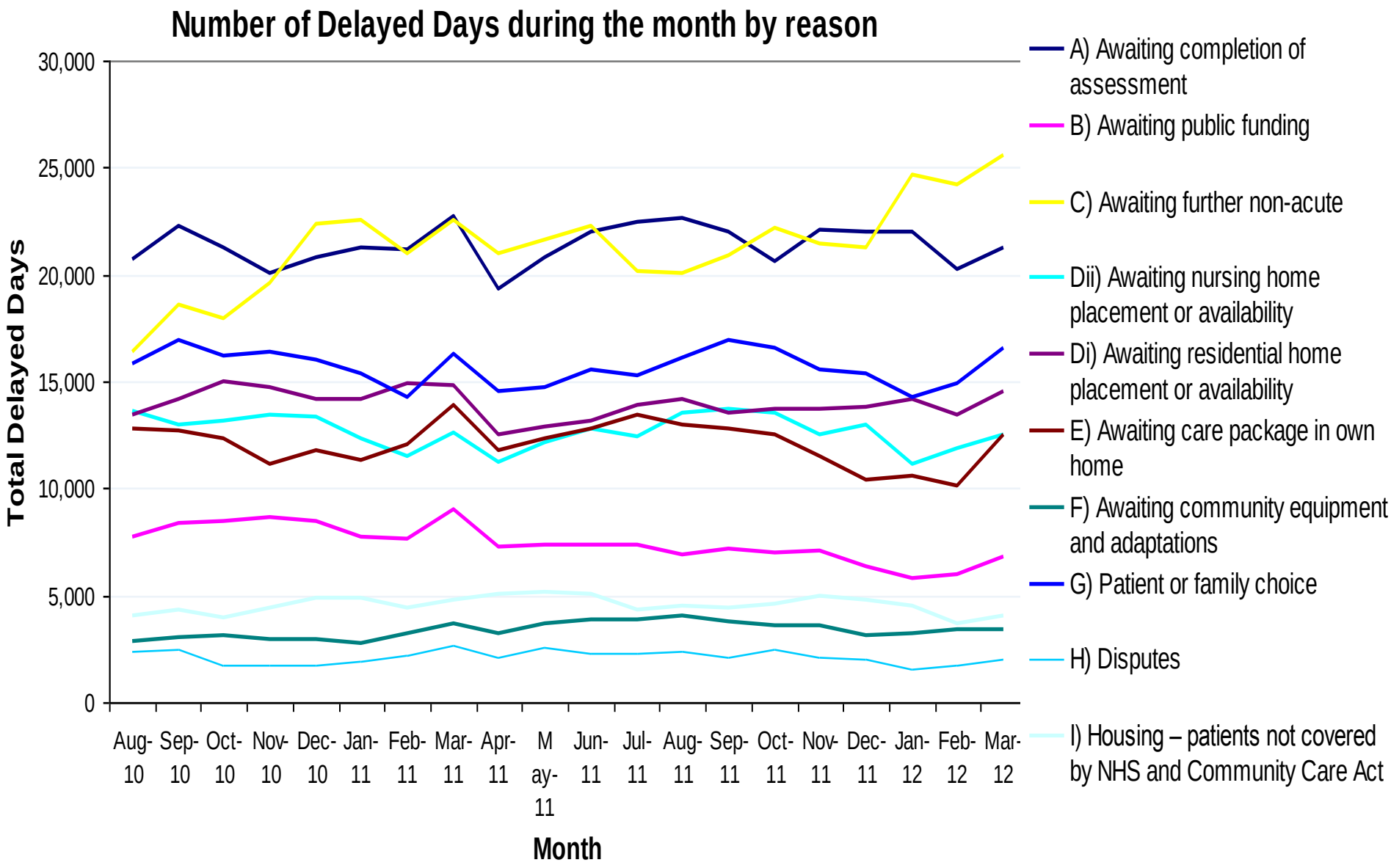
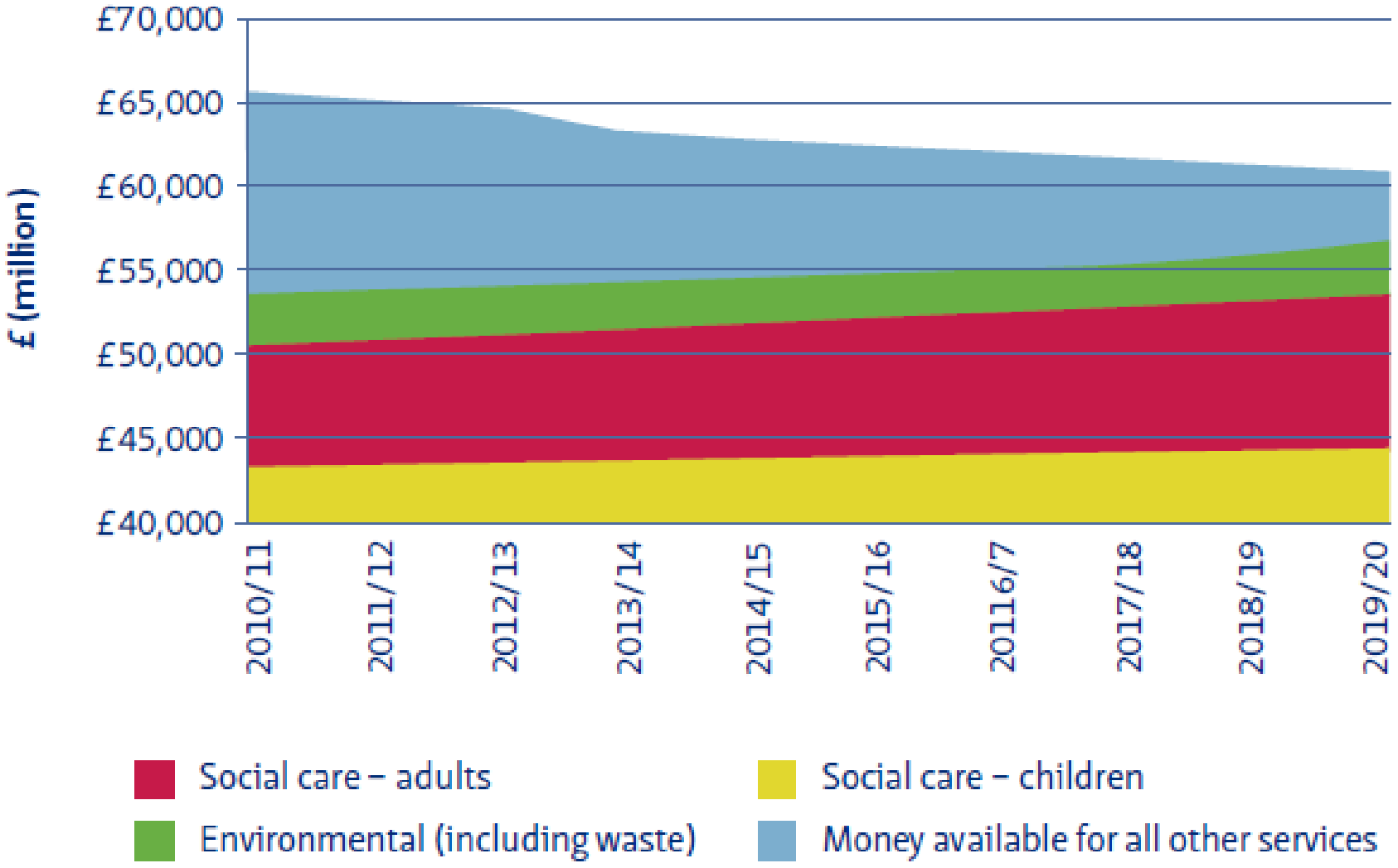


Figure 3. Social care and waste spending within the overall funding envelope



Source: Local Government Association

From NHS Confed “Papering over the Cracks” 2012

There are large numbers of people who are experiencing delays in being transferred to the right sort of care. This has both a **financial and a human cost**. Delayed transfers in care currently cost the NHS £545,000 per day (approximately £200 million per year). They are distressing for patients and, without action, the situation will get worse.

The patient and carer perspective

- Age UK “Older patients experience of hospital discharge”
- NHS Ombudsman – frequent issue is older people being discharged when not medically fit
- Patients’ Association Reports
- LINKS Reports
- Patient Survey
- Research e.g. Glasby “Care Transitions” work
- RCPsych Dementia Audit – only 25% of casenotes showed documentation of carers’ needs before discharge
- **Hospital discharge-planning, discharge, communication around this and post-discharge care is a frequent source of dissatisfaction**

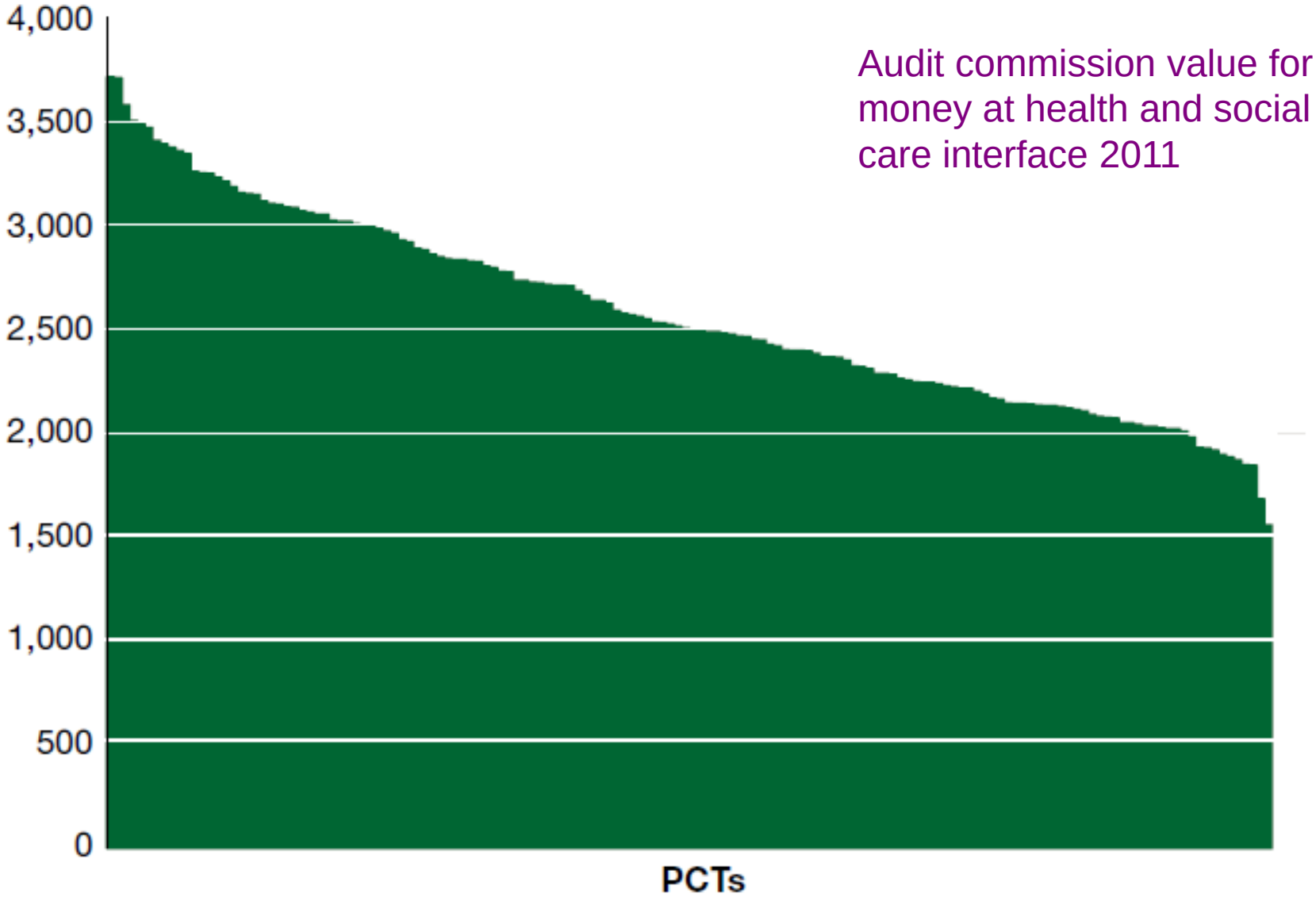
"Counting the Cost" Report. Alzheimer's Society
1,291 carers, 657 nurses, 479 ward managers

- 97% of nursing staff and nurse managers reported that they always or sometimes care for someone with dementia.
- 47% of carer respondents said that being in hospital had a significant negative effect on the general physical health of the person with dementia, which wasn't a direct result of the medical condition.
- 54% of carer respondents said that being in hospital had a significant negative effect on the symptoms of dementia, such as becoming more confused and less independent.
- Over a third of people with dementia who go into hospital from living in their own homes are discharged to a care home setting.
- 77% of nurse managers and nursing staff said that antipsychotic drugs were used always or sometimes to treat people with dementia in the

Counting the Cost Report Alzheimer's Society

- 1 in 4 adult beds is occupied by someone with dementia
- People with dementia stay and average 7 days longer
- The longer they stay in hospital the worse the effect on the symptoms of dementia and physical health, more likely to lose function, be discharged to a care home or be prescribed antipsychotics
- *"Much of the large sums of money spent on dementia care in general hospitals could be more effectively invested in workforce capacity and development and in community services outside hospitals to drive up the quality of care on the wards improve efficiency and ensure that people with dementia only access acute care when appropriate"*

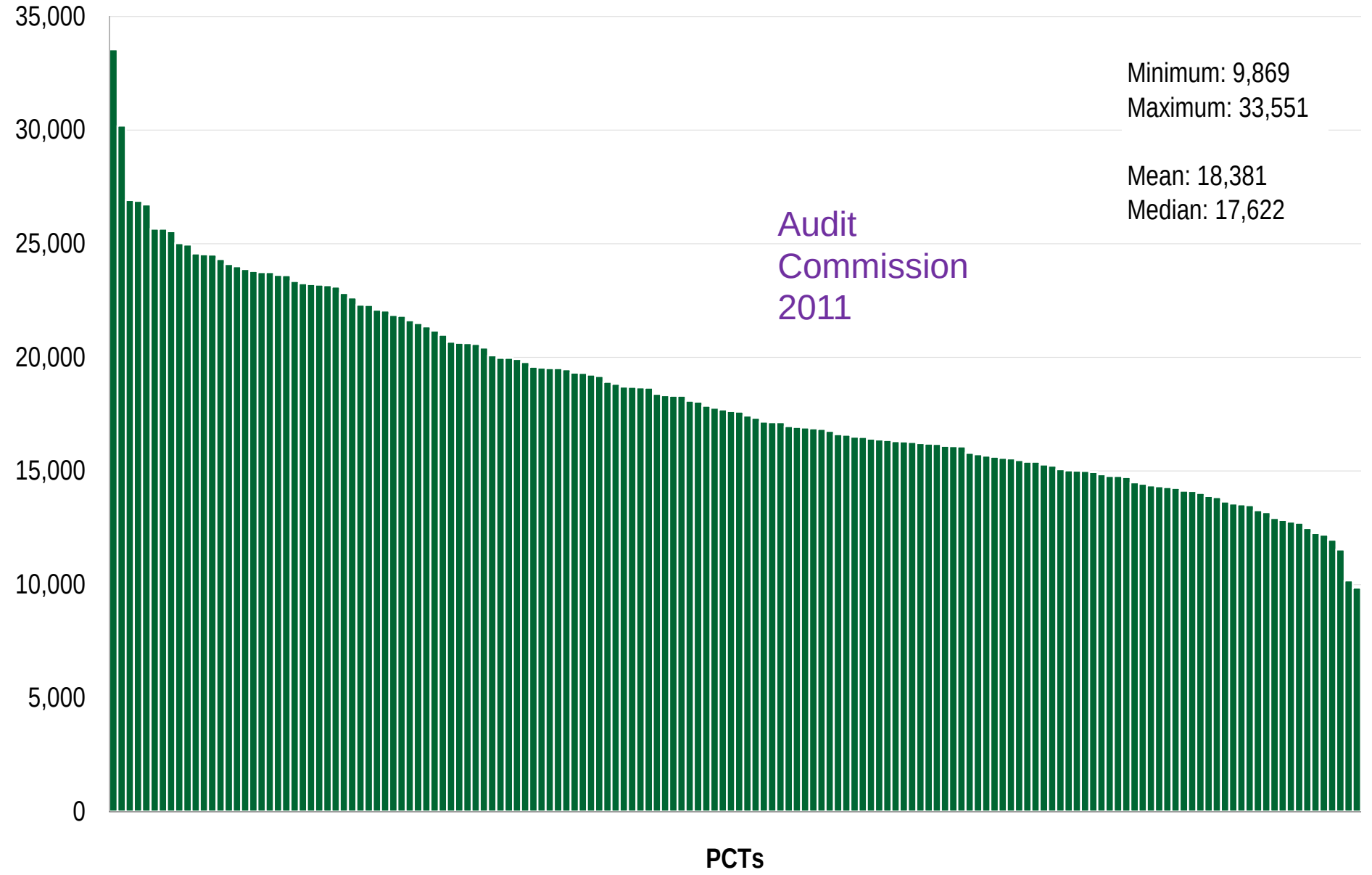
Figure 4: **Emergency admissions of people aged 65 and over in 2009/10 (per 10,000 population of people aged 65 and over)**



Audit commission value for money at health and social care interface 2011

Source: Hospital Episode Statistics 2009/10, analysed by the Audit Commission 2011

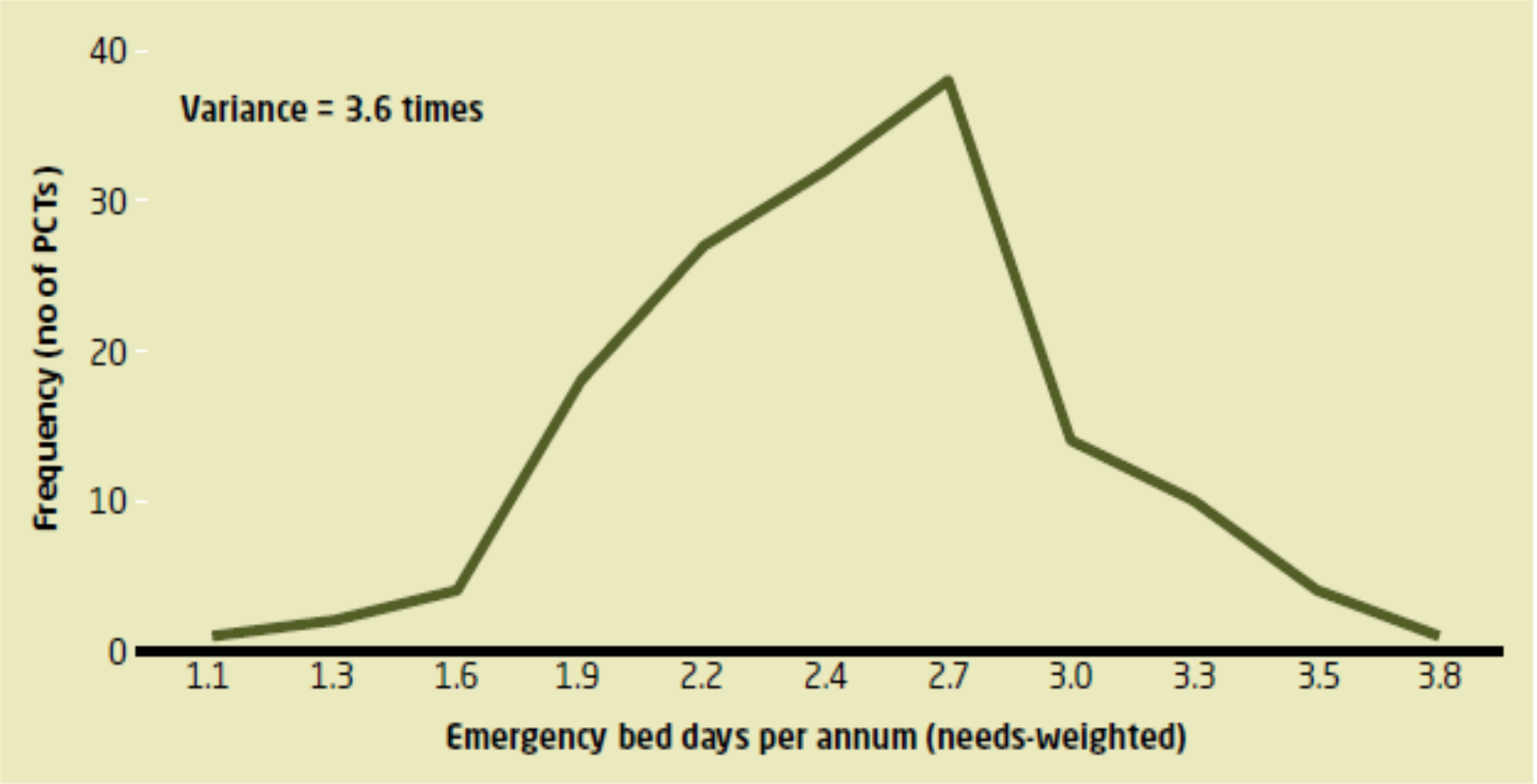
Variation in the number of emergency bed days for 65+ patients per 10,000 population, 2009/10 (England)



NB Excludes admissions where PCT is unknown; no data for one PCT; mid-2009 PCO population estimates used

From Kings Fund report 2012 on Emergency Bed use in Older People

Figure 2 Needs-weighted emergency bed days per person over 65, per annum, national distribution



From “An atlas of variations in social care”

Map 6: Age standardised emergency readmissions within 28 days of discharge for people aged over 75 in local authorities in England[96]

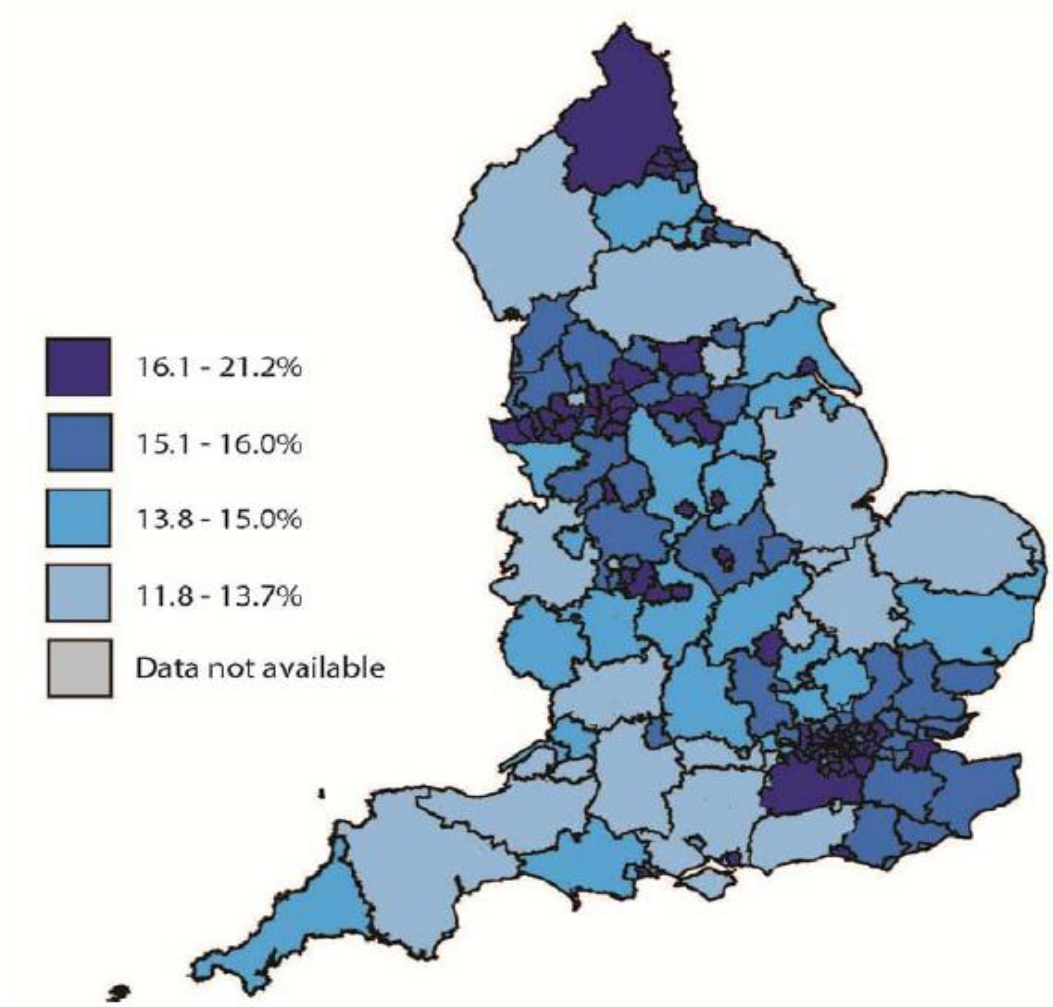
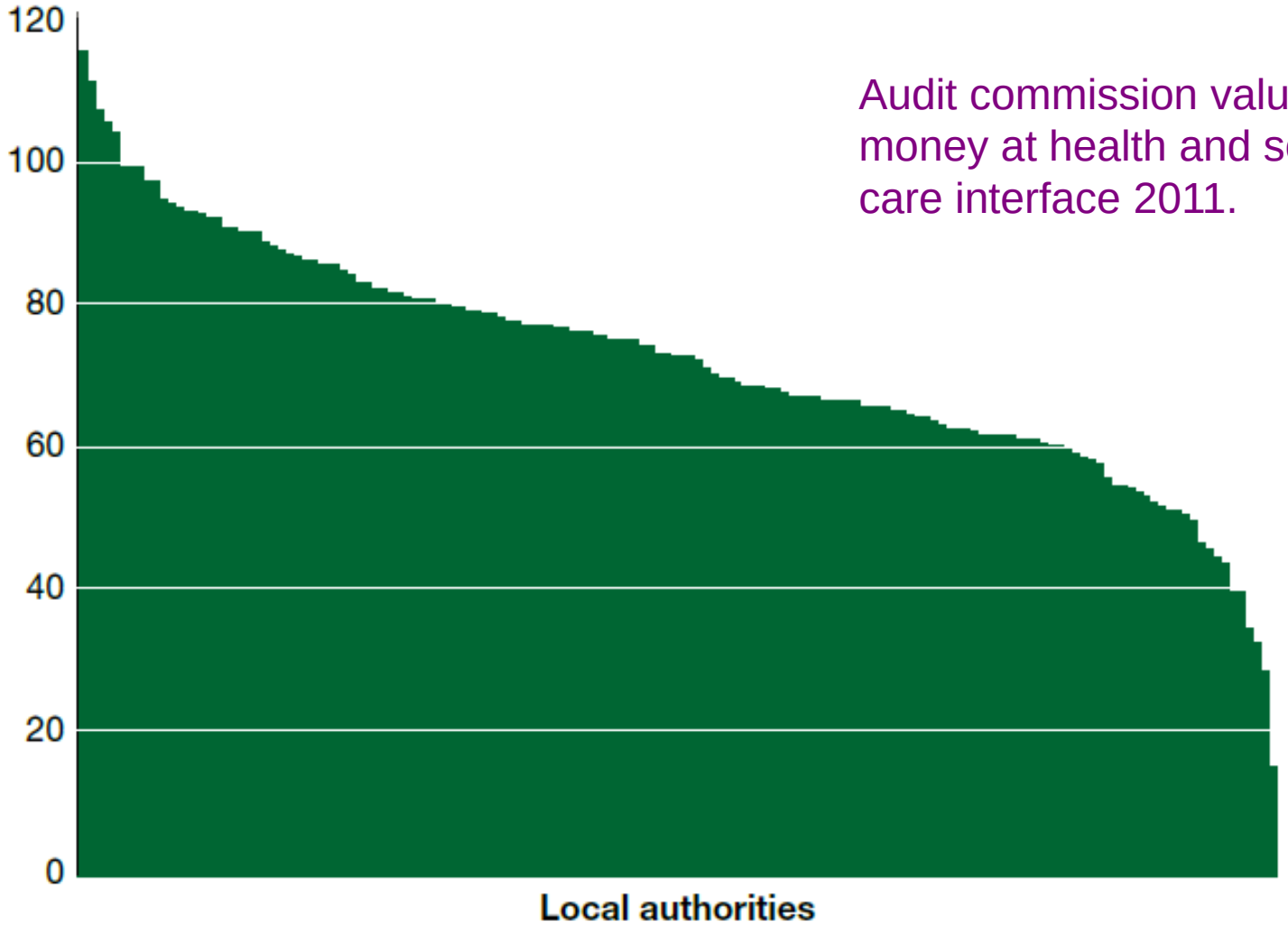


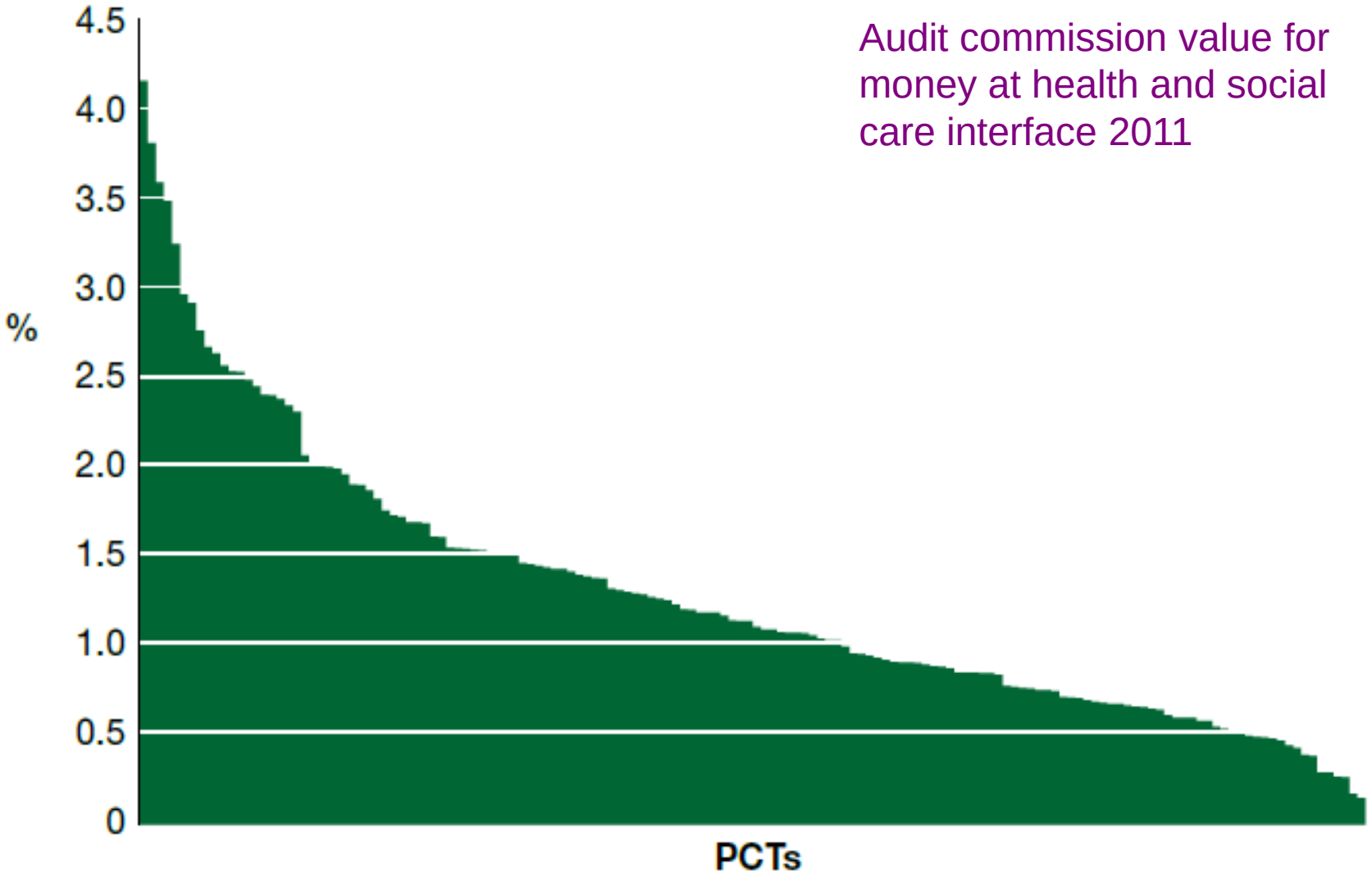
Figure 9: **Permanent admissions of people aged 65 and over to residential and nursing care in 2009/10 (per 10,000 population of people aged over 65)**



Audit commission value for money at health and social care interface 2011.

Source: Adult Social Care Combined Activity Return 2009/10, The Health and Social Care Information Centre

Figure 11: **The percentage of people aged 65 and over who are admitted to hospital from their own home and discharged to residential and nursing care in 2009/10**

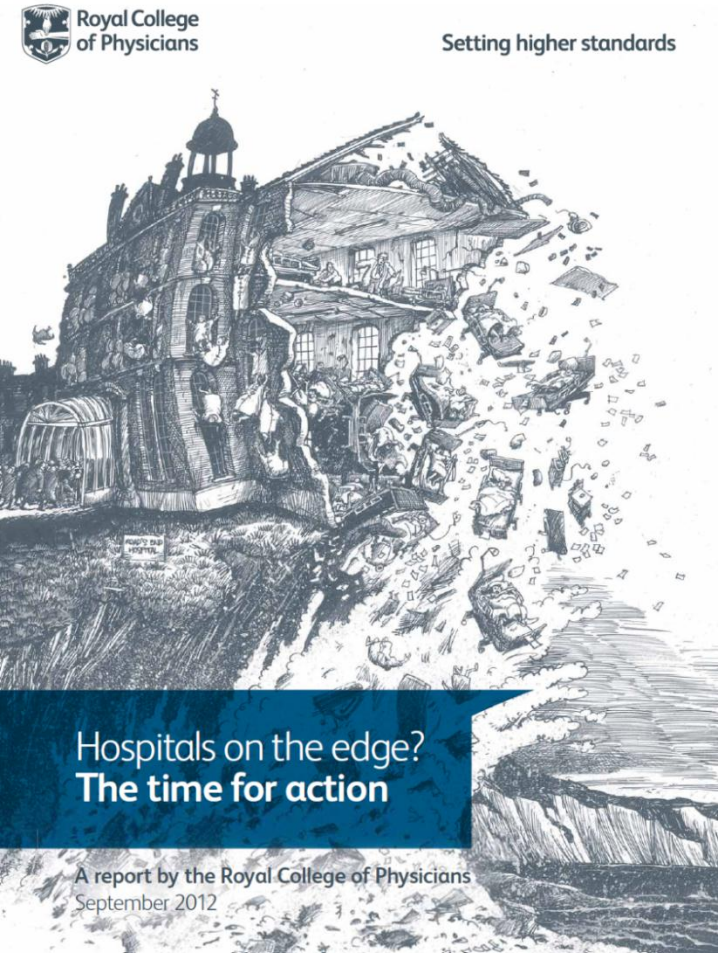


Audit commission value for money at health and social care interface 2011

Meeting the "Nicholson Challenge"

- 4% efficiency for *at least* 4 consecutive years
- £48 Bn of £106 Bn NHS Budget is spent on acute secondary care
- £12 Bn on community health services
- A key to unlocking the efficiencies must surely be to reduce unwarranted variation in activity "the best as good as the rest"
- Dissemination and implementation as important as innovation
- And reduce inefficiencies caused by delays, by problems at interfaces between services and by having people avoidably in the wrong bed or service for their needs

"our hospitals are struggling to cope with the challenges of an ageing population and rising hospital admissions" RCP 2012 (See also future hospitals work)



- "A fewer third general and acute hospital beds than 25 years ago but last decade has seen 37% increase in emergency admissions with biggest increase in over 75s"
- "Hospitals have coped by reducing length of stay but this fall has flattened and is now increasing for over 85s"
- "2/3 of patients admitted to hospital are over 65 and many have dementia, frailty or complex needs….buildings, services and staff are not equipped to deal with them"

II: Who is actually in hospital beds?

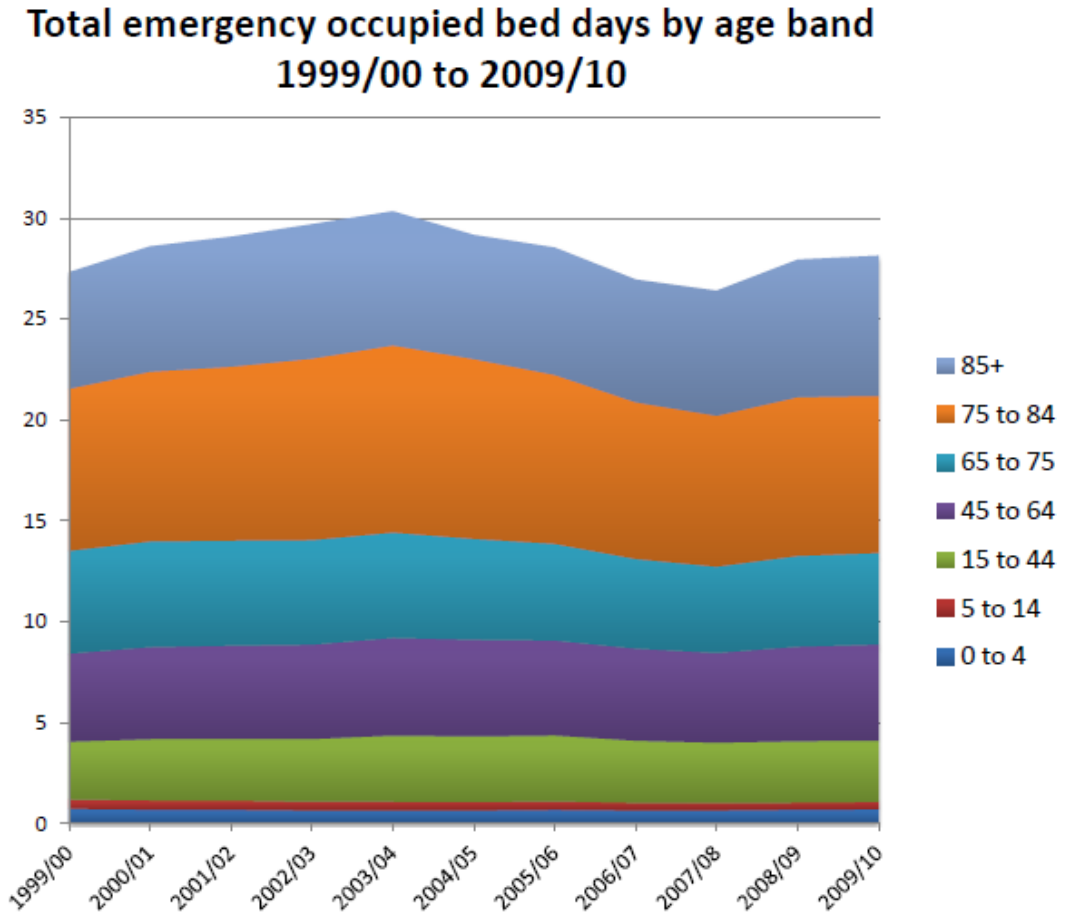
Older People R US

"Core Business" – not an afterthought

Everybody's business. Have our attitudes, values skills caught up with this reality

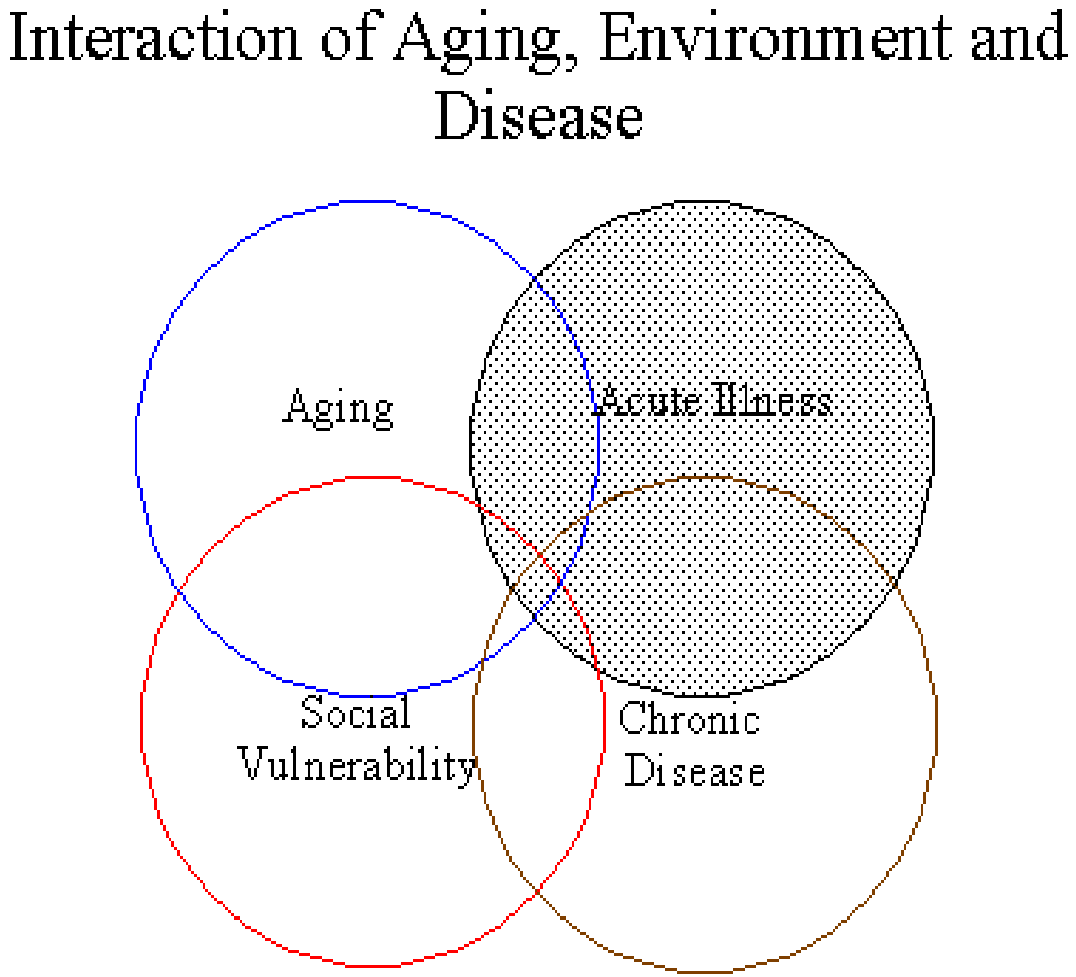
Over 65s in hospital (England)

(DH analysis of HES data)



- 60% admissions
- 70% bed days
- 85% delayed transfers
- 65% emergency readmissions
- 75% deaths in hospital
- 25% bed days are in over 85s

High intensity users of hospital services have overlap of physical and social vulnerabilities



Modern Hospital Casemix

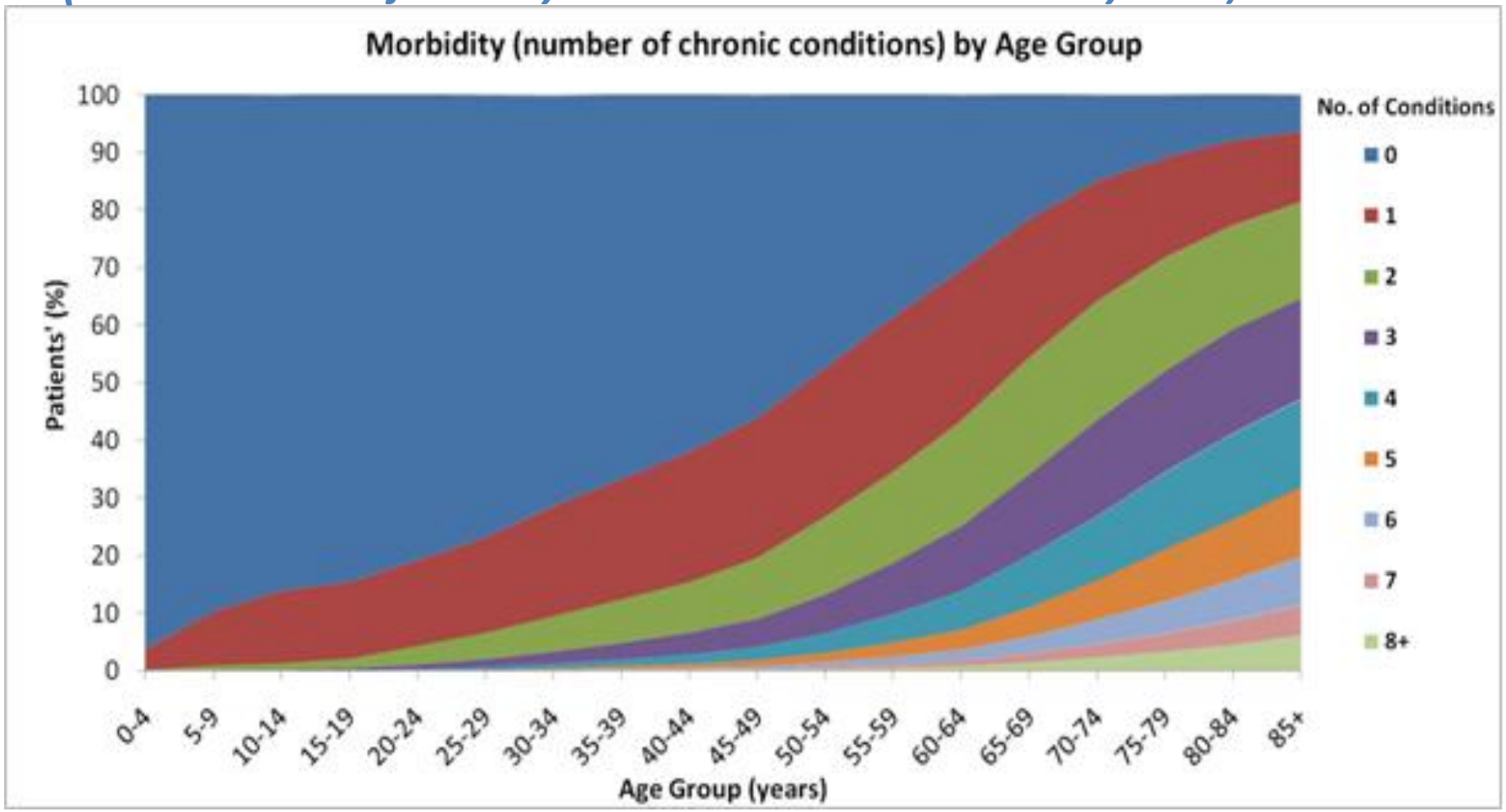
- 1 in 4 adult beds occupied by someone with dementia (stay an average 7 days longer)
- Delirium affects 1 in 4 patients over 65
- Urinary incontinence 1 in 4 over 65
- 1 in 4 over 65 have evidence of malnutrition
- Falls and falls injuries account for more bed days than MI and Stroke Combined
- Falls = 35% safety incidents (median age 82)
- Hip fracture is a good example
  - Median Age 84, 12 month mortality 20-30%, 1 in 3 have dementia, 1 in 3 suffer delirium, 1 in 3 never return to former residence, 1 in 4 from care homes

Older people in hospital

- Median Barthel Index for over 65s in hospital is 12 (so impairment in at least 3 ADLs)
- 70% have multidisciplinary team needs
- *Hubbard et al Age Ageing 2004*
- Majority of inpatients and bed days
- The older you are the longer your stay
- Emergency readmissions rising fastest >75
- Older people more likely to be moved repeatedly during hospitalisation
- *Kings Fund 2011 Continuity of care for older people in hospital*

Multimorbidity in Scotland

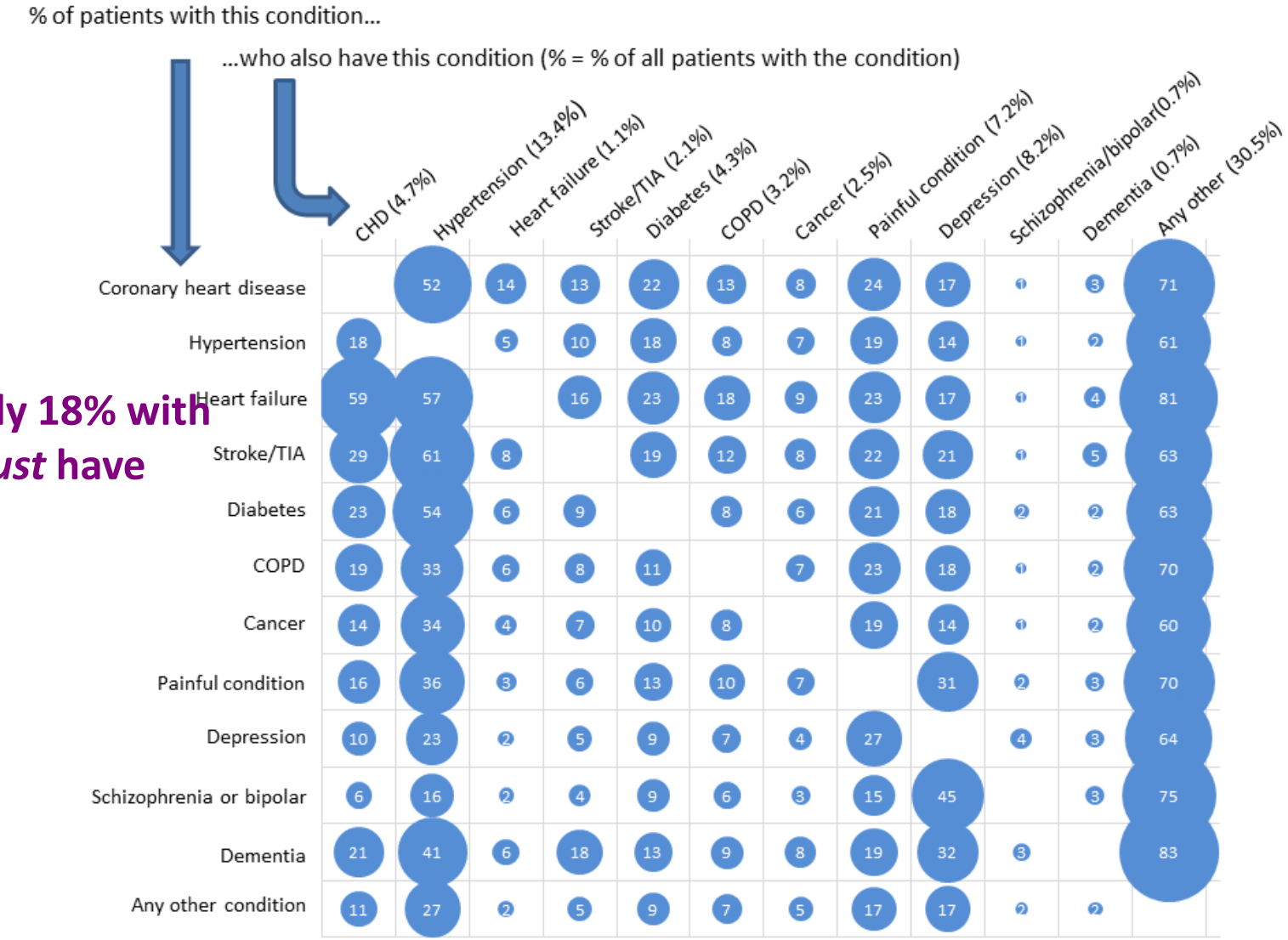
(Scottish School of Primary Care Barnett et al Lancet May 2012)



- The majority of over-65s have 2 or more conditions, and the majority of over-75s have 3 or more conditions
- More people have 2 or more conditions than only have 1

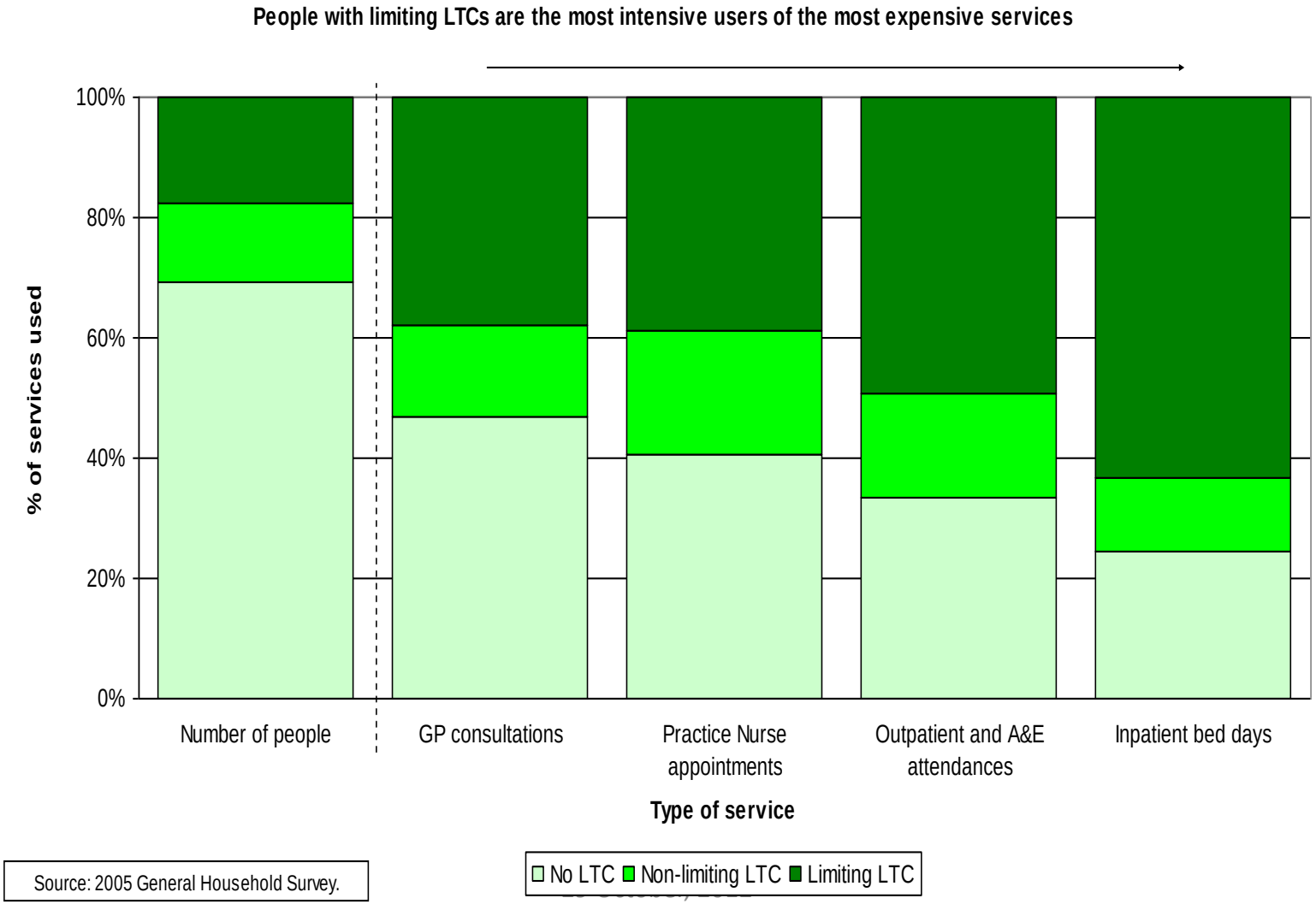
Most people with any long term condition have multiple conditions in Scotland

(Scottish School of Primary Care)

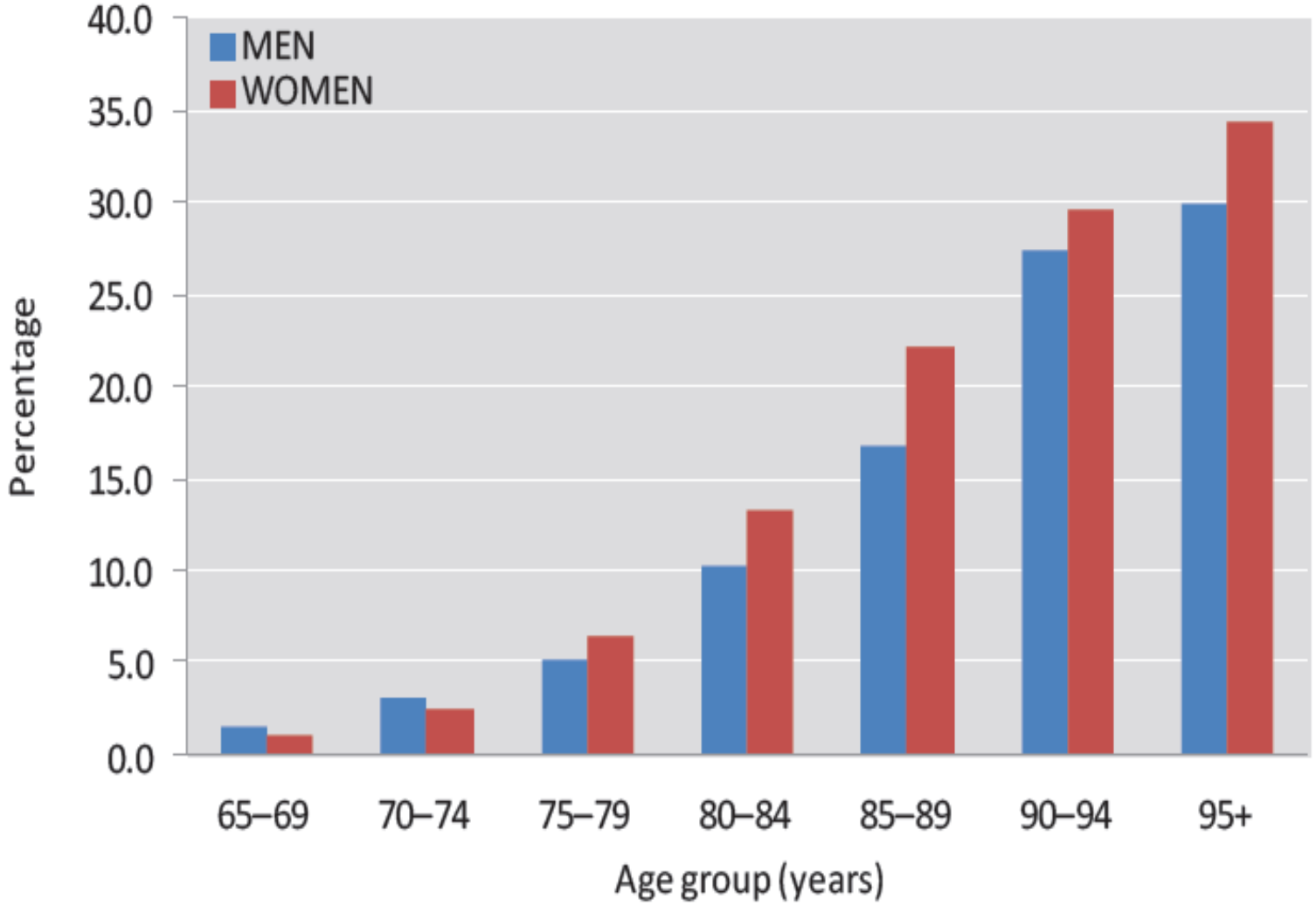


e.g. Only 18% with COPD *just* have COPD

People with **long-term conditions** have high health service use (55% of all GP appointments, 68% of outpatient and A&E appointments and 77% of inpatient bed days and therefore 69% total health spend.



Source: 2005 General Household Survey.



Source: Alzheimer's Society 2007 [22] Reproduced with permission from Alzheimer's Society. © Alzheimer's Society, 2007

Figure 4: The consensus* estimates of the population prevalence of late onset dementia in men and women aged 65 +, UK, 2007

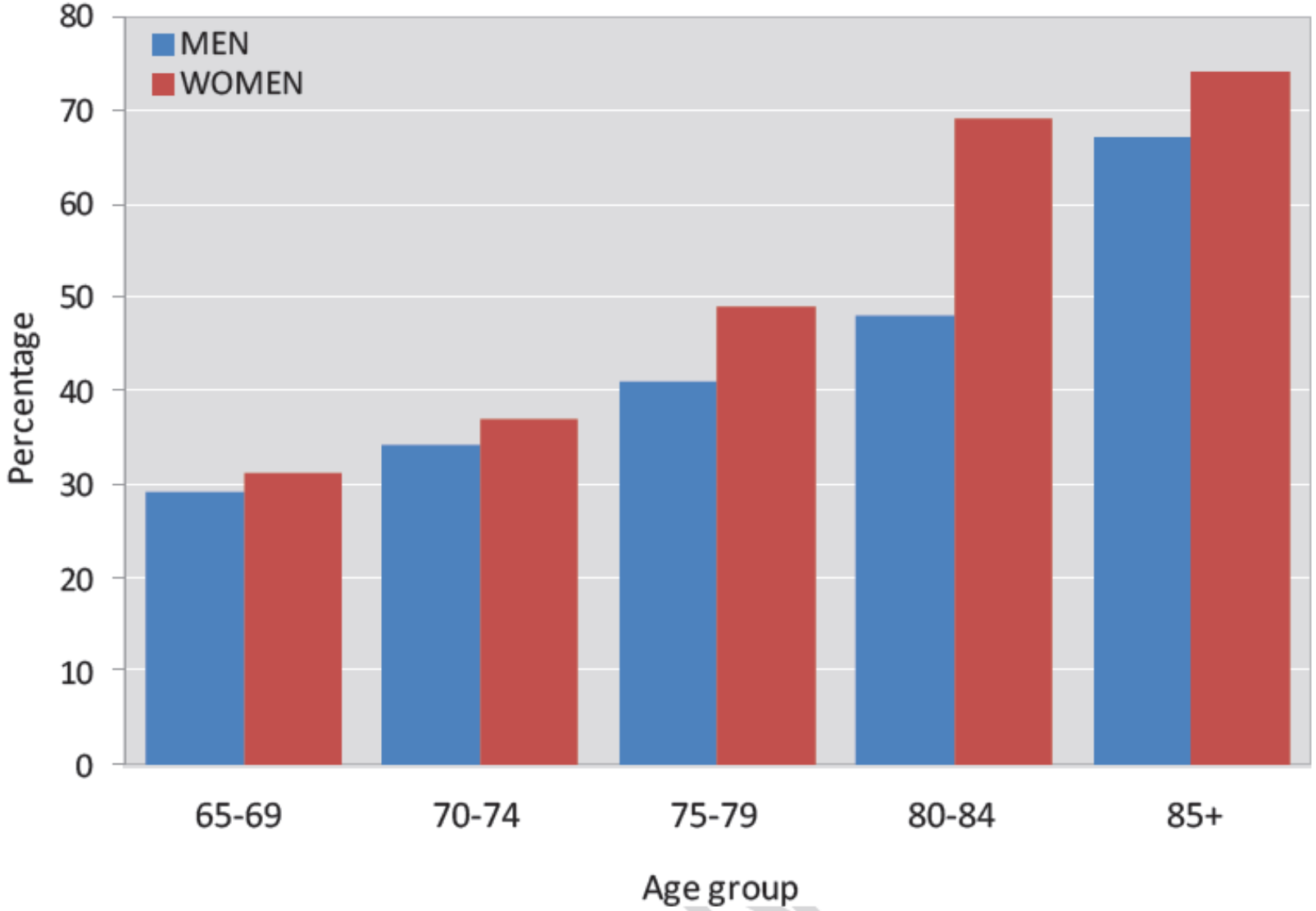
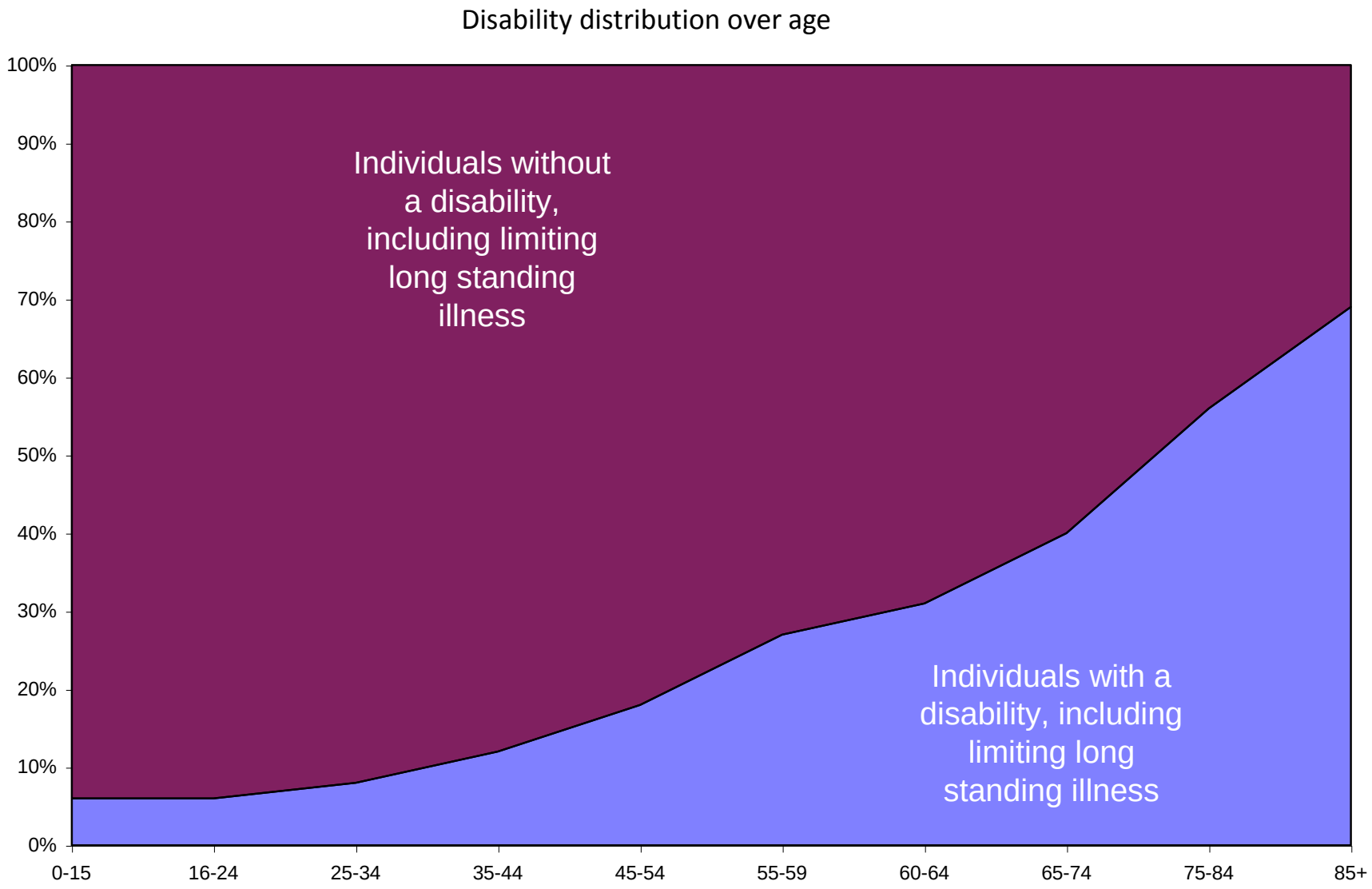


Figure 7: Prevalence of mobility problems[*] in men and women aged 65 +, England 2005

Reported prevalence of disability clearly rises with age. We also need to understand how the severity of disability varies with age.



Source: Family Resources Survey 2007

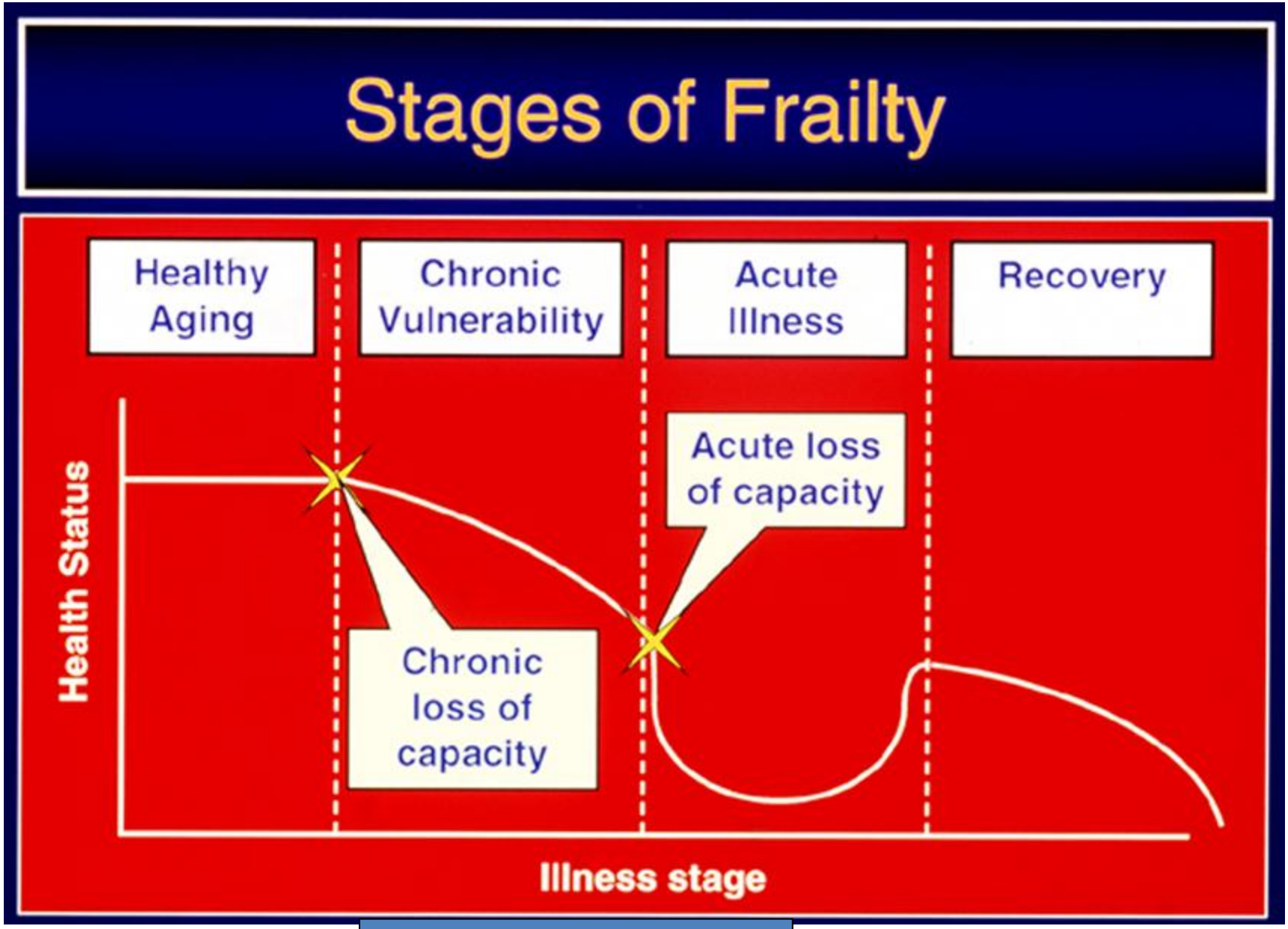
Frailty – *(only around 6% of over 65s but very high proportion of service use and predicts poor outcomes)*

[Weight loss, exhaustion, weakness, slow walking speed, diminished physical activity] (Fried Criteria)]

..*"Frailty is a failure to integrate responses in the face of stress. This is why diseases manifest themselves as the "geriatric giants"….functions …such as staying upright, maintaining balance and walking are more likely to fail, resulting in falls, immobility, incontinence, delirium or general failure to thrive . A small insult can result in catastrophic loss of function*"

Rockwood Age Ageing 2004

i.e. ***Poor Functional Reserve***


Stages of Frailty
Healthy Aging
Chronic Vulnerability
Acute Illness
Recovery
Acute loss of capacity
Chronic loss of capacity
Health Status
Illness stage

Fried 1999

lll: What could hospital clinicians and clinical leaders do better *within* the acute pathway and *within* general hospitals?

Many resources

The King's Fund

Ideas that change health care

BRITISH GERIATRICS SOCIETY

QUALITY CARE FOR OLDER PEOPLE WITH URGENT & EMERGENCY CARE NEEDS

Continuity of care for older hospital patients

A call for action

Authors
Jocelyn Cornwell
Ros Levenson
Lara Sonola
Emmi Poteliakhoff

March 2012

CLINICAL PRACTICE

Clinical Medicine 2012, Vol 12, No 3: 230–34

Transforming care for older people in hospital: physicians must embrace the challenge

D Oliver

The King's Fund

Ideas that change health care

The care of frail older people with complex needs: time for a revolution

The Sir Roger Bannister Health Summit, Leeds Castle

Author: Jocelyn Cornwell

March 2012

ESSAY

'Acopia' and 'social admission' are not diagnoses: why older people deserve better

David Oliver

Prof Ken Rockwood 2005

- *"If we design **services** for people with one thing wrong at once but people with many things wrong turn up, the fault lies not with the users but with the service, yet all too often these patients are labelled as inappropriate and presented as a problem"*

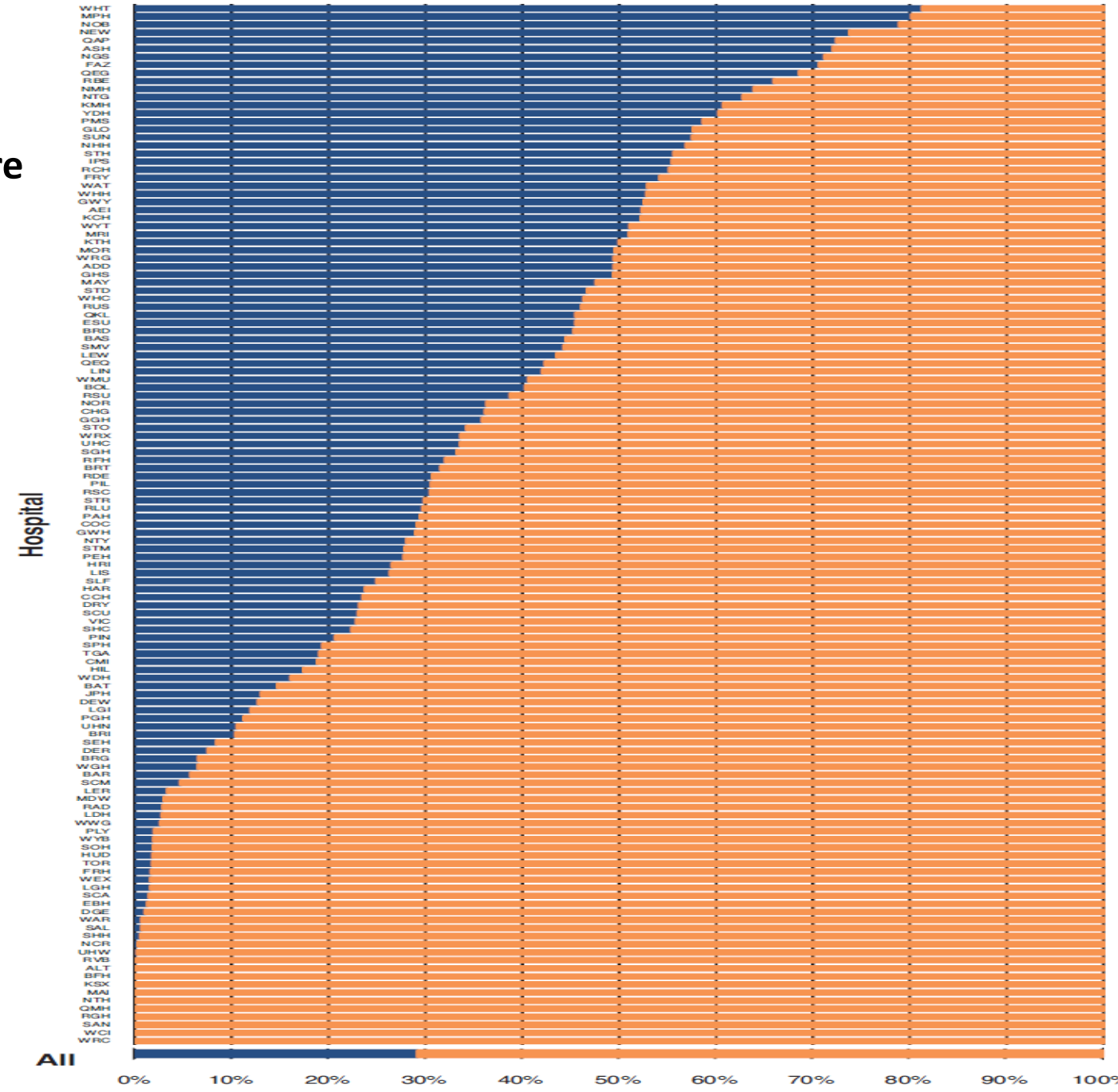
Poor quality for older people in hospital

- Outcomes (&application of best practice to deliver)
  - Audits on falls, fractures, hip fracture, continence, nutrition, dementia care, NCEPOD peri-operative care, mortality etc.)
- Experience (& delivery of dignified person-centred care)
  - Ombudsman “care and compassion”, Patients Association CARE Campaign, Alzheimer’s “Counting the Cost”, CQC DANI Inspections, All Parliamentary Enquiry, NHS Confed “Delivering Dignity” , National VOICES project on end of life care etc
- Safety
  - Falls, Drug Errors, Pressure Sores, Infection, Unsafe Discharge, Avoidable Death, Immobility, Delirium
- Efficiency
  - Variation in activity/outcomes etc
  - Inefficiencies at interfaces e.g. Delayed transfers

Surgery in 36 hrs, with falls and bone health assessments

Chart 21

National Hip Fracture Database



Unwarranted Variation

BMJ

BMJ 2011;343:d6553 doi: 10.1136/bmj.d6553

RESEARCH

Comprehensive geriatric assessment for older adults admitted to hospital: meta-analysis of randomised controlled trials

Graham Ellis *consultant geriatrician and honorary senior clinical lecturer*[1], Martin A Whitehead *consultant geriatrician*[2], David Robinson *consultant geriatrician*[3], Desmond O'Neill *associate professor of gerontology*[4], Peter Langhorne *professor of stroke care*[5]

Components of CGA *(Stuck A BMJ)*

- Medical: Problem List. Co-Morbid Conditions and Disease Severity. Nutrition. Pharmacy
- Functioning. Basic Activities of Daily Living. Instrumental Activities of Daily Living. Gait and Balance. Activity/Exercise Status
- Psychological: Cognitive Status. Mood
- Social Assessment: Informal Support Needs And Assets. Eligibility for care. Financial Assessment
- Environmental. Housing. Equipment. Transportation. TeleHealth.

Benefits of CGA (Ellis and Langhorne)

- 22 trials. 10,000 + participants, 6 countries
- Patients more likely to be **living at home** at end of scheduled follow up (OR 1.16)
- And at median follow up of 12 months (OR 1.25)
- Compared to general medical care
- Less likely to be **living in residential/nursing care** (OR 0.78)
- Less likely to **die or experience deterioration**(OR 0.76)
- More likely to experience **improved cognition** (Mean difference 0.08)
- **Specialist wards** had better outcomes than teams for

Profanities..

- “acopia”
- “social admission”
- “social work medicine”
- “medically discharged”
- “bed blocker”
- “inappropriate admission”
- “outlier”

Good practice..

- Good functional and social history (corroborated)
- What was the admission trigger?
- How long a deterioration?
- Apparently functional problems have reversible diagnoses: identify and treat
- If not possible then can rehab help?
- If not rehab then services/equipment?
- What are wishes of patient and concerns of carers? Realistic/Mental Capacity
- How safe is safe enough?
- Community step down services?

Apply the same principles *within* hospital

Age and Ageing 2007; **36:** 670–675
doi:10.1093/ageing/afm089
Published electronically 26 July 2007

The older persons' assessment and liaison team 'OPAL': evaluation of comprehensive geriatric assessment in acute medical inpatients

D. Harari[1,2], F. C. Martin[1,2], A. Buttery[1], S. O'Neill[1], A. Hopper[1]

[1] Department of Ageing and Health, Guys and St Thomas' NHS Foundation Trust, UK

Subjects acute medical inpatients aged 70+ years.

Intervention multidisciplinary CGA screening of all acute medical admissions aged 70+ years leading to (a) rapid transfer to geriatric wards or (b) case-management on general medical wards by Older Persons Assessment and Liaison team (OPAL).

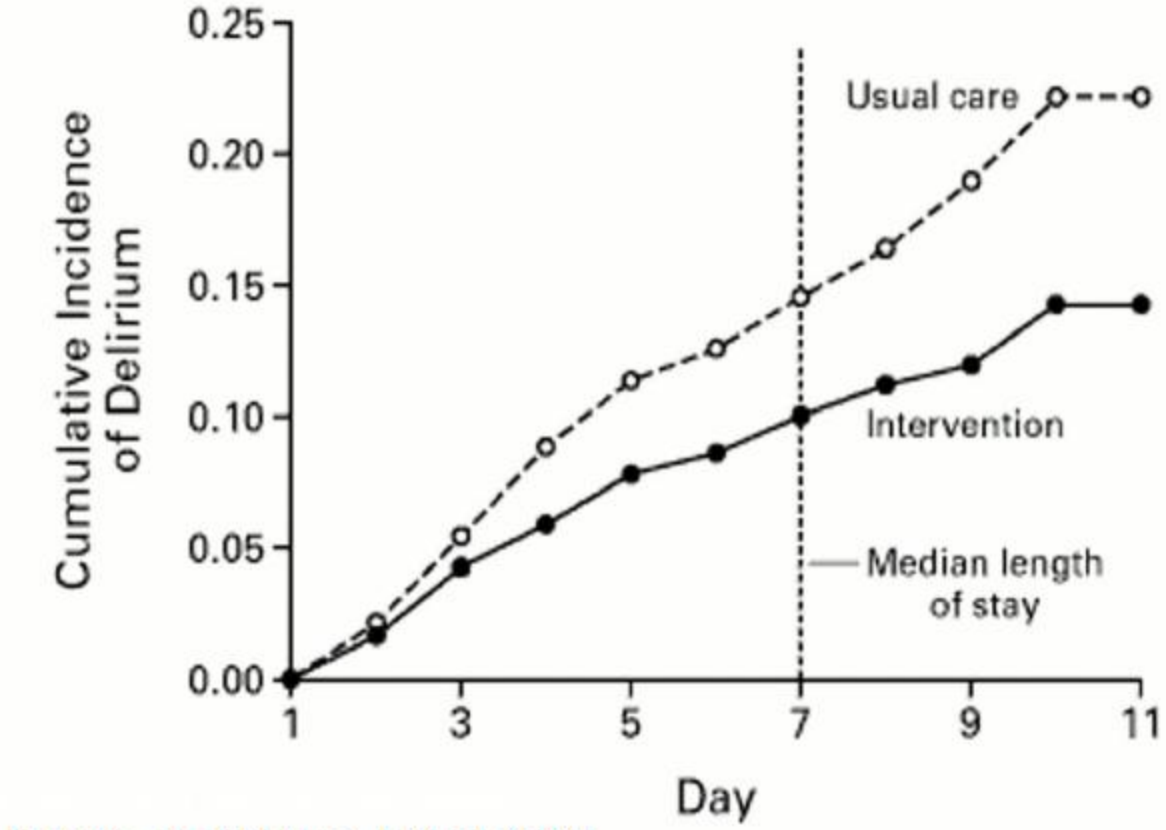
Methods prospective pre-post comparison with statistical adjustment for baseline factors, and use of national benchmarking LOS data. Pre-OPAL ($n = 46$) and post-OPAL ($n = 49$) cohorts were similarly identified as high-risk by the CGA screening tool, but only post-OPAL patients received the intervention.

Results pre-OPAL, 0% fallers versus 92% post-OPAL were specifically assessed and/or referred to a falls service post-discharge. Management of delirium, chronic pain, constipation, and urinary incontinence similarly improved. Over twice as many patients were transferred to geriatric wards, with mean days from admission to transfer falling from 10 to 3. Mean LOS fell by 4 days post-OPAL. Only the OPAL intervention was associated with LOS ($P = 0.023$) in multiple linear regression including case-mix variables (e.g. age, function, 'geriatric giants'). Benchmarking data showed the LOS reduction to be greater than comparable hospitals.

Conclusion CGA screening of acute medical inpatients leading to early geriatric intervention (ward-based case management, appropriate transfer to geriatric wards), improved clinical effectiveness and general hospital performance.

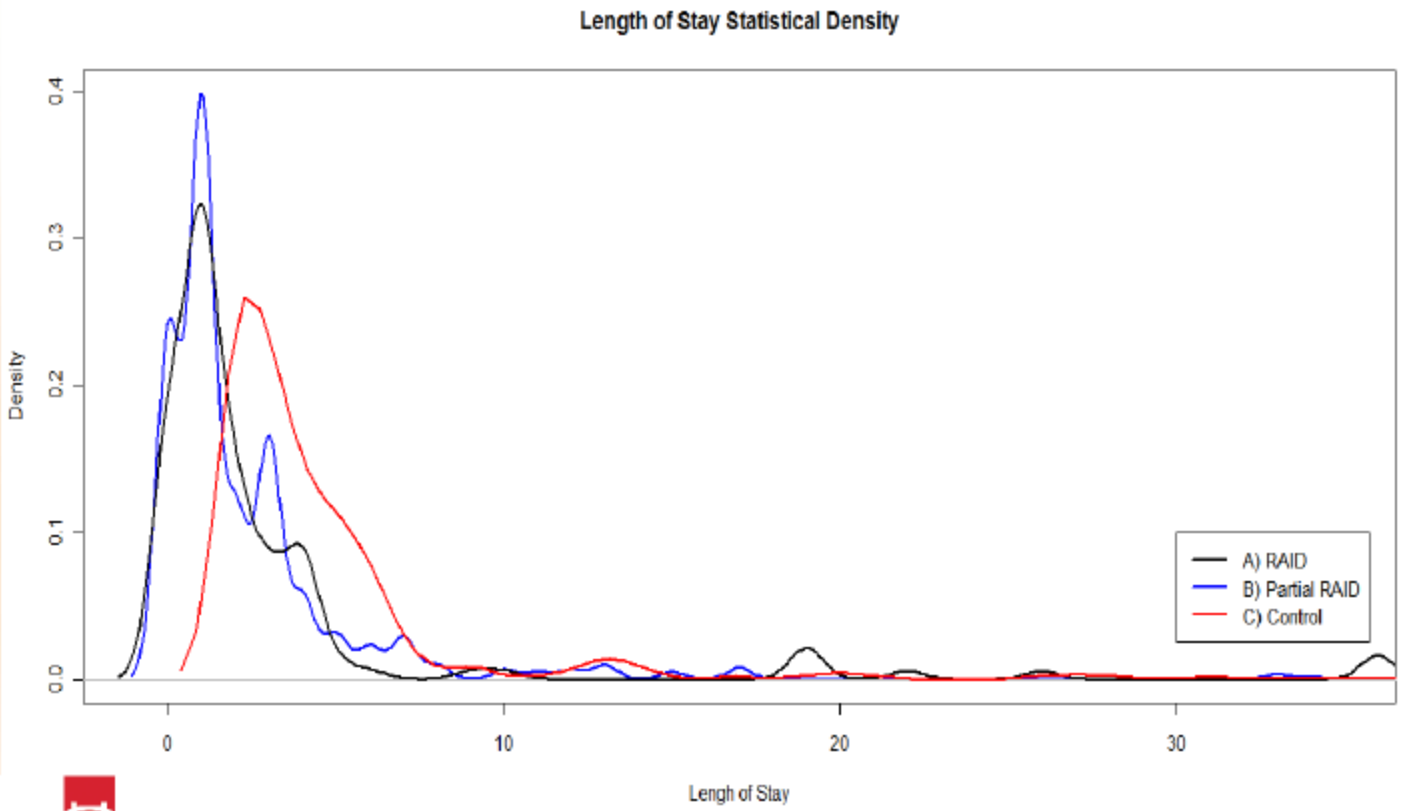
Preventing delirium

re-orientation, sleep, mobility, vision/hearing, hydration



Inouye et al N Eng J Med 1999

1. Length of stay: Retrospective Matched Control Study



Getting Better, Together.

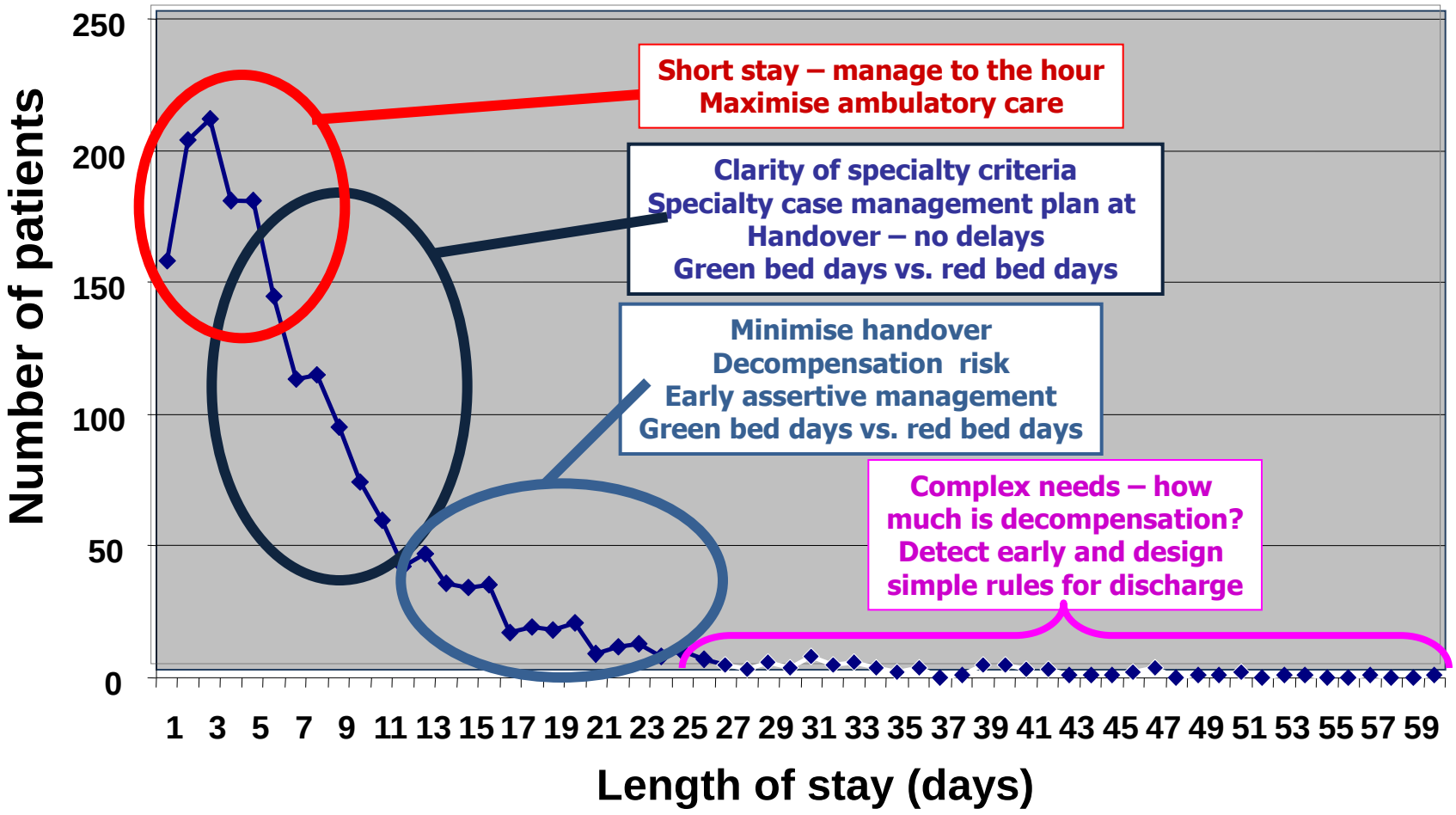
Sticking Plaster “quick fix” Solutions

- More beds (“any flat surface” “escalation”)
- Accelerate discharges when the ED full
- Divert ambulances
- Cancel elective admissions and reschedule elective surgery
- Hold admits in the emergency department until an inpatient bed is available
- Need to focus on reducing demand
- Right person in right service for needs at right time
- Patient flows
- Discharge planning
- Reducing internal delays

Managing the Streams

Identify the stream

- Short stay Sick specialty Sick general Complex
- Allocate early to teams skilled in that stream



Some Principles for organising care I

- Early expert assessment, diagnosis and decision making on "destination" - get it right the first time
- Consultant-led with access to allied professions and good, responsive links to social care, primary and community health
- "Destination" - get patient into right flow stream e.g.
  - Back Home (Zero day admission) – with additional support or review as identified inc . Ambulatory emergency care/home care rehab etc
  - Short-stay with aim to discharge quickly (up to 48 hours)
  - Home ward with appropriate staffing, environment and skillmix
  - So your bed configuration needs to be right
  - Match capacity to demand
- Try to set indicative/anticipated discharge dates and treatment goals/criteria required for safe discharge
- Minimise Internal Delays and end "hurry up and wait"

Some principles for organising care II

- Assertive case management/senior review – preferably 7 days a week.
- Continuity of care. Need one clinician “holding the ring”. Avoid repeated ward moves. Share information and avoid duplication and “death by assessment”
- Use of real time data on delays/departures from care pathway to problem solve re internal and external delays
- Adequate focus on rehabilitation as “core business” (7 days)..
- Everybody’s job – including doctors. It isn’t “social” and people aren’t “medically discharged”
- Staff working in every clinical area need to “own this” and have the right skills and knowledge. Not just elderly care/rehab wards
- MDT approach

Does daily senior review work?

Twice *weekly* consultant ward rounds *compared with* twice *daily* ward rounds

Impact:

- **Over study period, no change in length of stay on 'control' wards**
- **ALOS on study wards fell from 10.4 – 5.3**
- **The impact of twice-daily consultant ward rounds on the length of stay in two general medical wards**
- **No deterioration in other indicators (readmissions, mortality, bed occupancy)**

The impact of twice-daily consultant ward rounds on the length of
stay in two general medical wards
Aftab Ahmad, Tejpal S Purewal, Dushyant Sharma and Philip J Weston
Clinical Medicine 2011, Vol 11, No 6: 524–8

Focus on discharge

- ***Consistently*** **prioritising discharge activities can significantly reduce length of stay in elective or emergency clinical care pathways.**
- **Prioritising discharge activities only when beds are full may have little impact on patient throughput or average length of stay.**
- **Increasing beds may increase length of stay with no benefit to patient throughput.**

Simulation of patient flows in A&E and elective surgery Discharge Priority: reducing length of stay and bed occupancy
Michael Allen, Mathew Cooke & Steve Thornton, Clinical Systems Improvement 2010

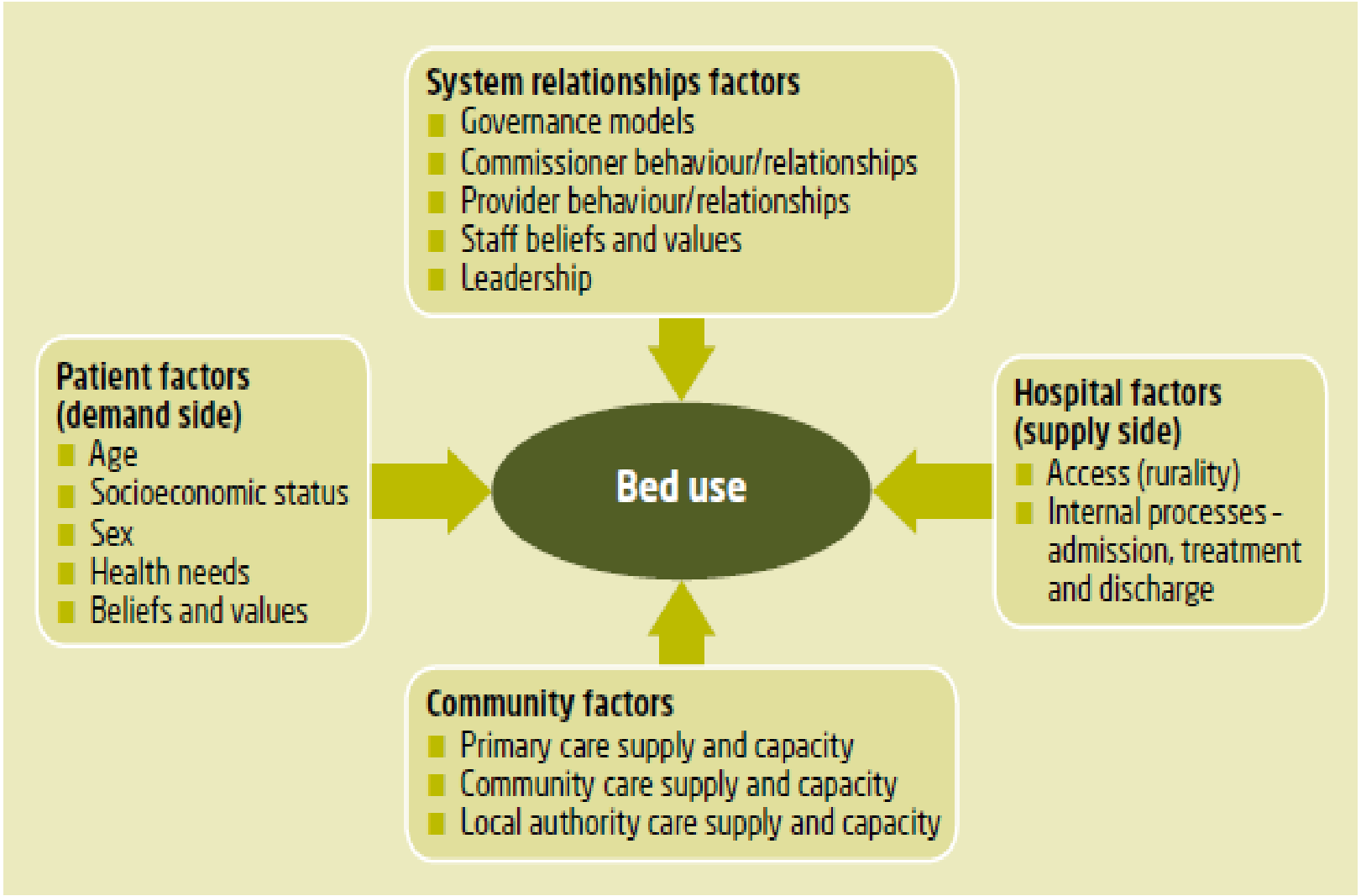
IV: The need to work across wider health and social care systems “end to end”

We don’t work in isolation. All parts of the pathway are interdependent

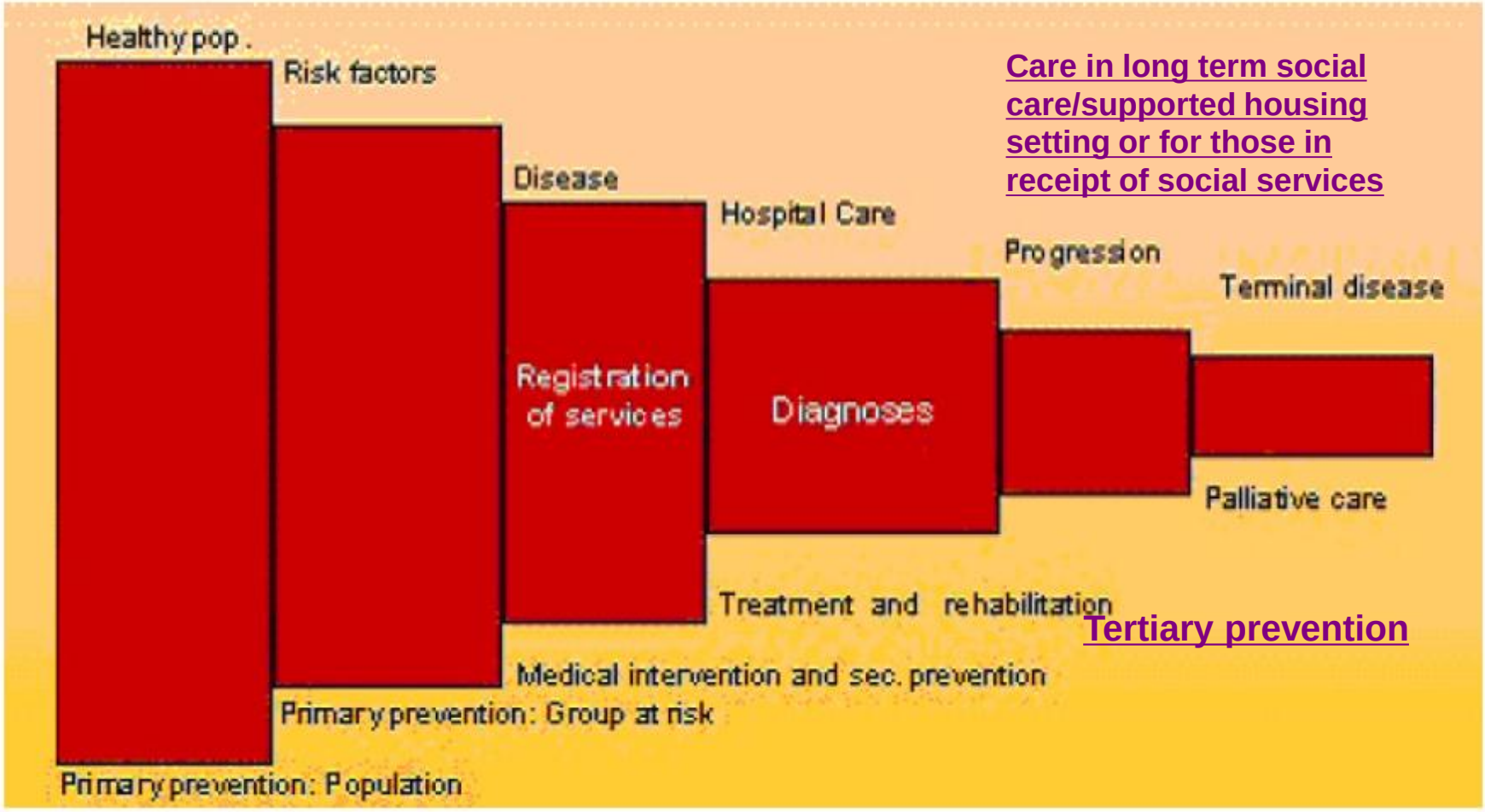
Rt Hon Stephen Dorrell MP 2011 (HSJ)

- *"**Systems** designed to treat occasional episodes of care for normally healthy people are being used to deliver care for people who have complex and long term conditions. The result is often that they are passed from silo to silo without the system having ability to co-ordinate different providers"*

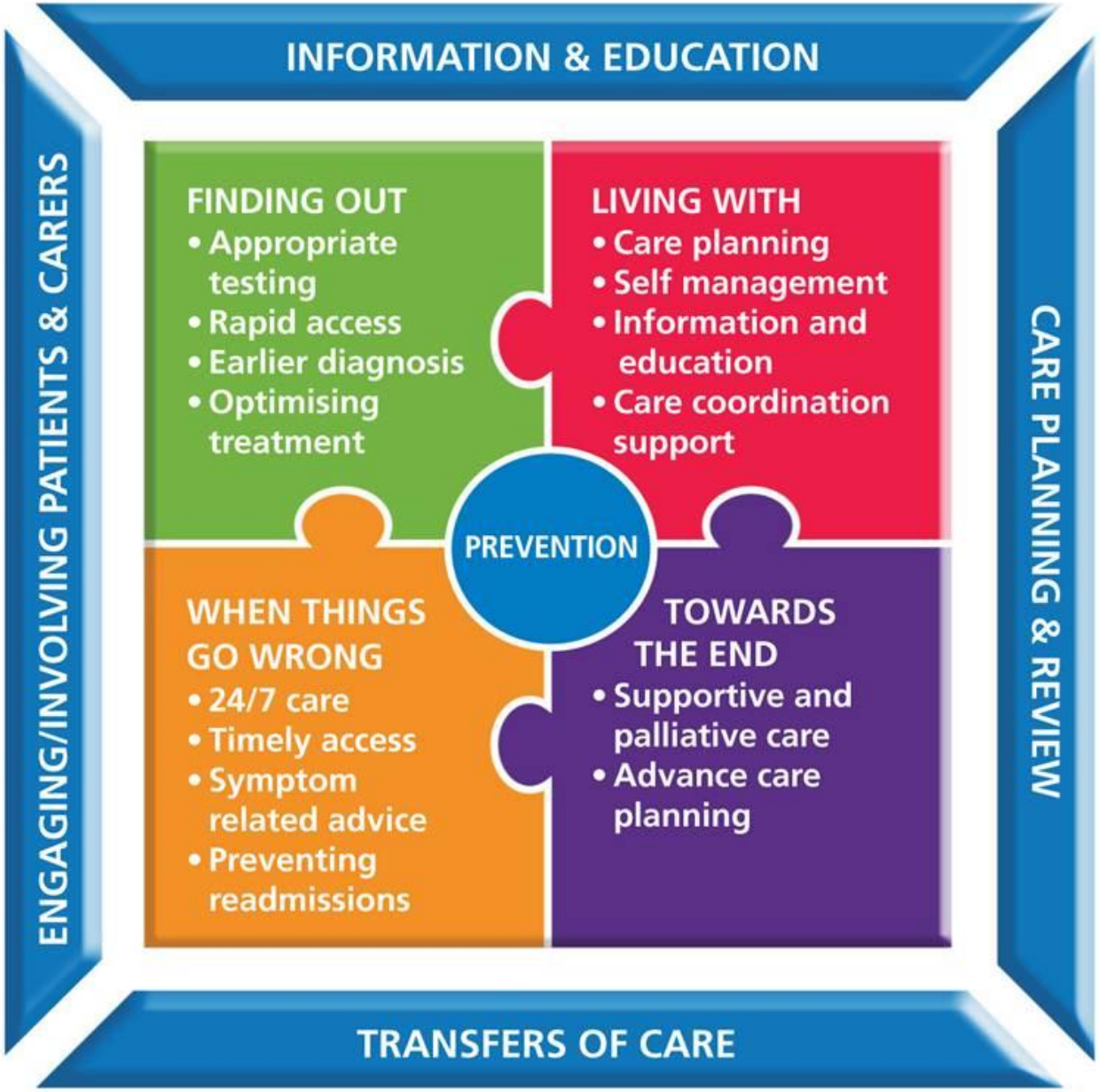
“Older People and Emergency Bed Use”
Kings Fund 2012



A different approach? Continuity of Care Model a better conception *(also requires right workforce, skills, capacity and resource in right part of system)*



71 Sunol R, Carbonell JM, Nualart L et al. Towards health care integration: The proposal of an evidence- and management system-based model. *Med Clin* 1999; 112 suppl 1:97-105.



From NHS Institute LTC in Older People. Gilmour Frew

Roland M BMJ 2012

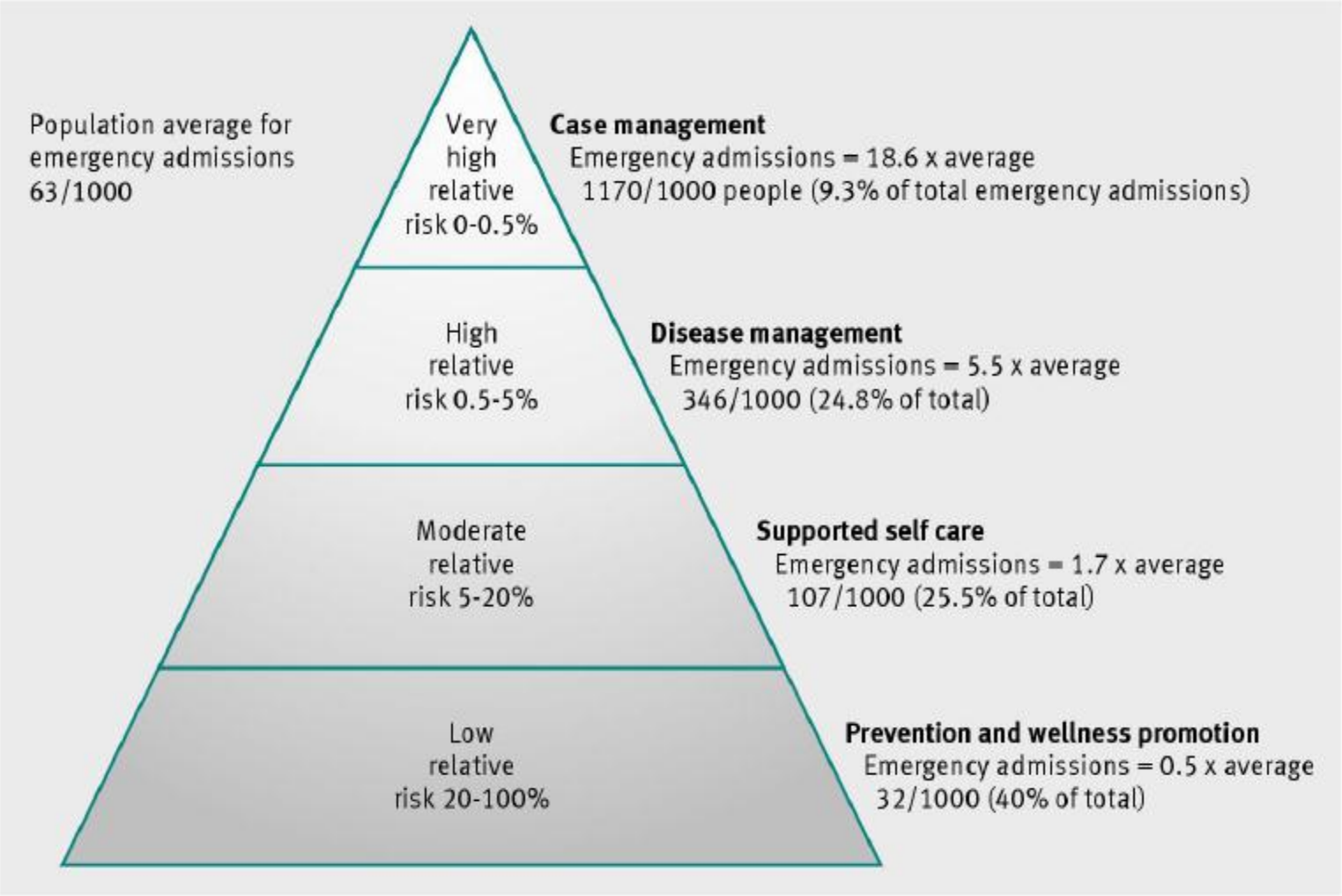
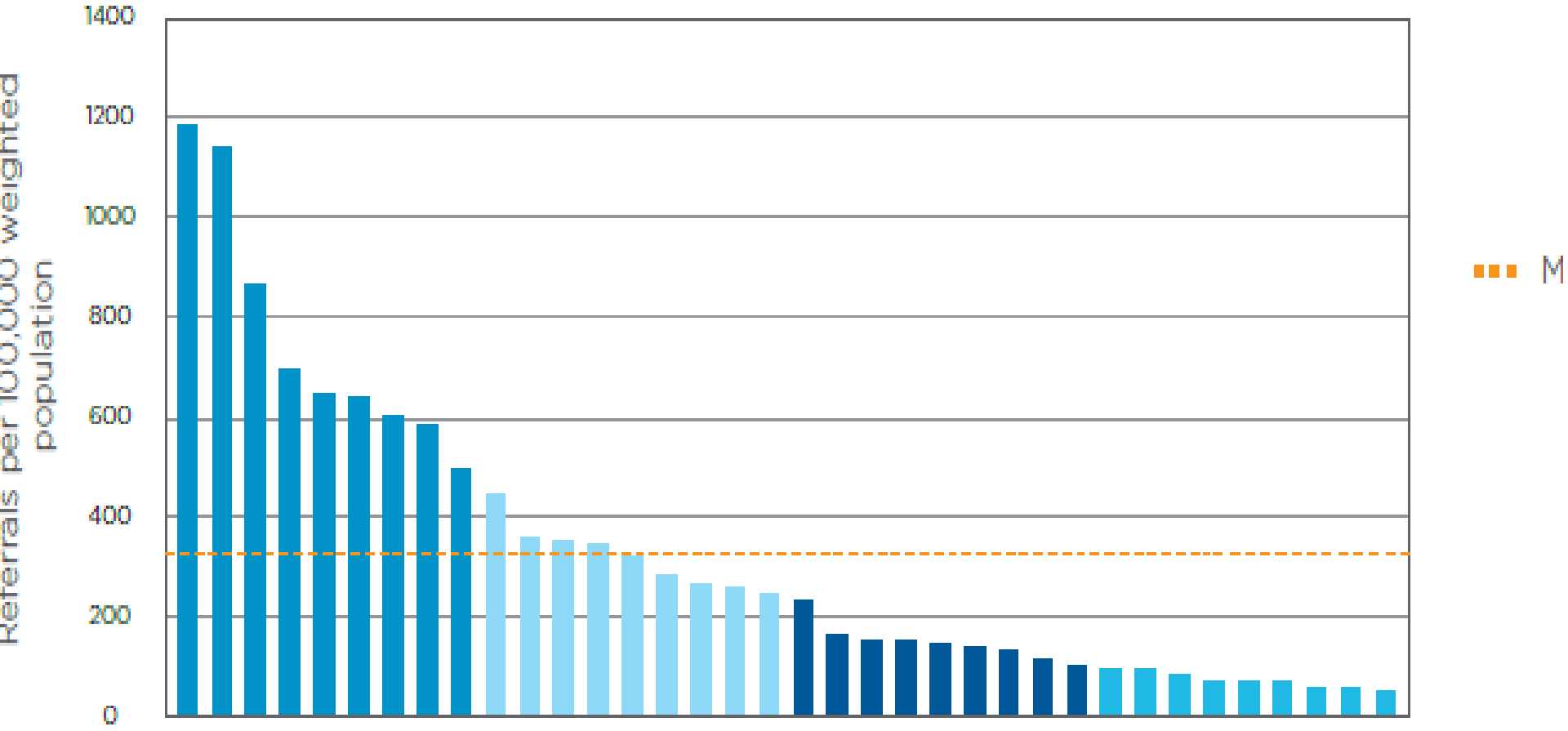


Fig 2 Rates of emergency hospital admission by different risk patients (based on Wennberg et al 1996).[9] Perc
emergency admissions is equal to the relative rate multiplied by the size of the population group

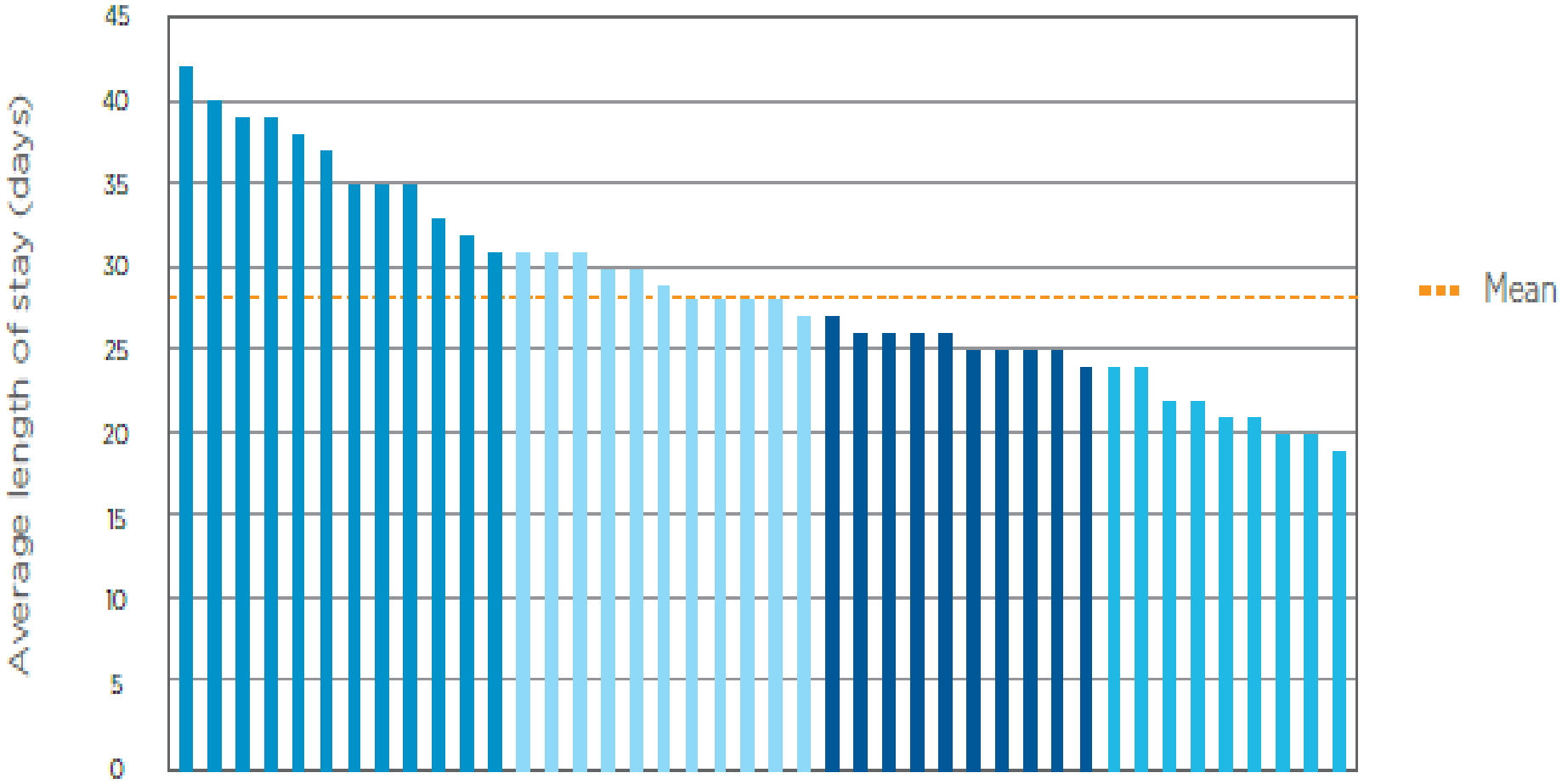
From national audit intermediate care 2012 (loads more graphs like this in report)

Figure 7.3.2: Referrals per 100,000 weighted population (bed based services) 2011/12



Intermediate Care Audit 2012

Figure 7.3.5: Commissioner view Average length of stay 2011/12



14. Where from:

Own home ☐ Residential care ☐ Comm hospital ☐ Respite care ☐
Intermediate care ☐ Tertiary specialist hospital ☐ Nursing home ☐ Clinic ☐

15. Reason for readmission – what happened? – tick any that apply

Same diagnosis ☐
New episode ☐
Deterioration of condition ☐
No change but carer concern ☐
Complications from original admission ☐
Surgical site infection ☐
Other infection ☐
Medication adverse reaction ☐
Other ☐
Unrelated illness/different diagnosis ☐
Poor discharge plan ☐
Failure of communication ☐
Relapse of long term condition ☐
End of life care ☐
Not a readmission (coding error) ☐
Non compliance with medication ☐
Risky discharge (hospital choice) ☐
Other – please specify

.....

If new unrelated illness/different diagnosis please specify

.....

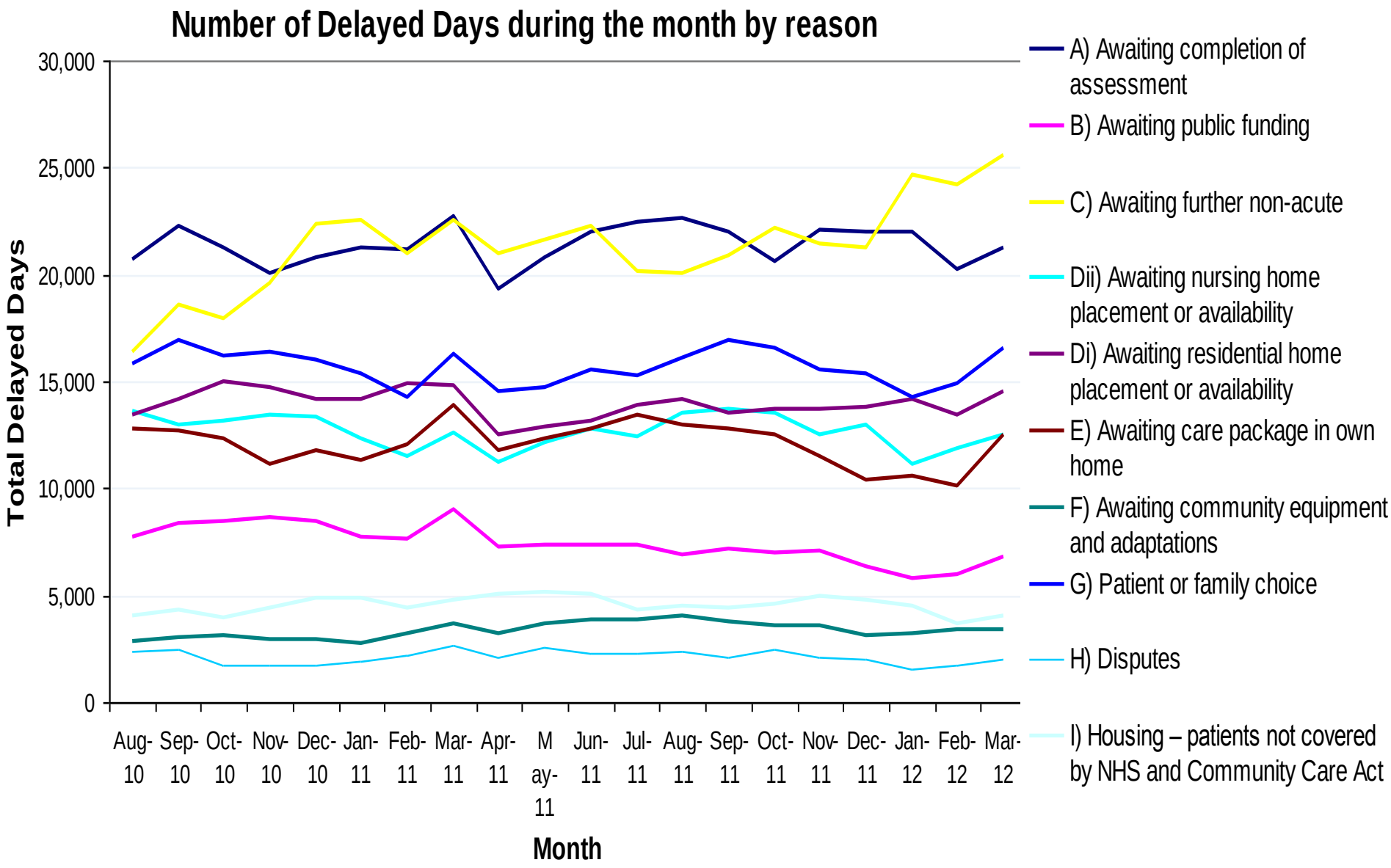
What do you know about readmissions locally? (14% average in over 65s NHS)

Foundation Trust Network

March 2012

BRIEFING ON THE READMISSION POLICY 2012/13 WITH ADDITIONAL INFORMATION ON THE REVIEWS

Delayed transfers of care from acute (England)



V: The Leadership Challenges for Us

Challenges for leaders?

(apart from not enough money and too much change?)

- Generalism versus specialism?
- Everyone with right skills or more specialist geriatricians
- Reconfiguration of beds/wards/teams
- Radical change in consultant working patterns/job plans
- Potentially threatening challenge to practice/clinical autonomy
- Enable effective MDT working
- Effective engagement with partners in primary care, community health, social care, mental health
- Making the right arguments to the right people in the right way at the right time
- Data – to examine service and to demonstrate improvement
- Adequate engagement of patients and carers

No room for defeatism. There is plenty we can do to improve care for our older patients.

- Thank You
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- David.Oliver@royalberkshire.nhs.uk