Regional Frailty Community of Practice

Intelligence for the North East & North Cumbria area

Version 1.0 FINAL DRAFT

September 2018

Programme overview

The Care Closer to Home Network for Cumbria, the North East and Hambleton, Richmondshire and Whitby has prioritised frailty as an area of focus. A regional frailty toolkit, *'Frailty I-Care'*, has been developed in order to create a common understanding of frailty, establish a supportive way for learning and sharing best practice and to achieve optimum outcomes for the population of each local health economy. The I-CARE approach reflects the components of effective care: Involve, Consider, Respond and Evaluate.

Metrics

The frailty toolkit is underpinned by a set of key outcome metrics which have been agreed by local and national experts, and these are considered to be the best reflection of the broad recommendations of the toolkit (when accounting for data availability, relevance and quality). It is anticipated that the set of metrics may be refined and evolve over time to more specifically reflect the local projects and new interventions taking place within each area.

This report has been developed for the CNE Care Closer to Home Programme by NEQOS and NECS with support and guidance from the Regional Frailty Community of Practice. It contains an overview of quantitative and qualitative measures which relate to frail or older people (65+ years), in order to present the current state and variation across the North East and North Cumbria area and compared to England as a whole.

The report should be read in conjunction with the 'Supporting Information' document which provides supplementary details relating to each metric.

The role of metrics is key to support the Community of Practice members in identifying areas of good practice and priority areas for development, and in demonstrating improvements over time, and also in order that members can contribute to the development of the metrics so they continue to reflect the local work taking place across the area.

The metrics have been grouped into four categories, which reflect the three gaps highlighted within the Five Year Forward View and Next Steps, and the transformation needed to address these gaps:

Health and wellbeing - Population health outcomes and lifestyle factors

Care quality and experience - Positive patient experience, safe and effective care

Sustainability - Financial and clinical sustainability of services

Transformation drivers - Measures to help drive long term improvements

Analysis notes

It has been necessary to abbreviate the names of some CCGs to shortened versions for formatting and presentation purposes. The North East and North Cumbria area is referred to as CNE.
The latest information available is presented for each organisation. Timescales vary throughout the report, with data presented for each indicator as far back as is available to best inform the reader of trends over time.
It is not always possible to present the data using each of the chart types due to the format of the data available.
Unless otherwise stated, the CNE average includes all organisations in the region.

What does the rating colour scheme mean ?

Statistical significance has been calculated to indicate whether the measure is statistically above or below / better or worse than the comparator average based on the methodology described by Public Health England (*http://fingertips.phe.org.uk/profile/guidance*).

Values highlighted in GREEN and RED indicate when an area is statistically significantly better or worse than the England value for that particular indicator. AMBER indicates where an area's value is not significantly different to the England value.

For some indicators, a different colour scheme is used – PALE BLUE and DARK BLUE to indicate values that are statistically significantly higher or lower than the England value. Some indicators are presented in this way because it is not straightforward to determine whether a high value is good or bad, or due to concerns with data quality.

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23	Mortality	Proportion of deaths in usual place of residence

Summary

Demographic information — Clinical Commissioning Group (CCG)

Demographic information	Period	North Cumbria / Cumbria	Northumberland	Newcastle Gateshead	North Tyneside	South Tyneside	Sunderland	North Durham	Durham Dales, Easington & Sedgefield	Darlington	Hartlepool & Stockton-On-Tees	South Tees	Hambleton, Richmondshire & Whitby	England rate	CNE rate
The proportion of patients aged 65 years and over	2017	22.2	23.4	15.5	19.4	19.1	18.7	19	20.2	19.3	17.7	18	25.1	17.3	19.1
The GP practice deprivation score estimate (IMD 2015)	2015	21.2	20.5	27.3	21.3	30.6	29.7	20.7	30.2	23.6	27.4	34.5	14.5	21.8	
The proportion of patients who live in a nursing home	2014/15	0.7	0.7	0.6	0.6	0.5	0.5	0.7	0.8	0.9	0.8	0.8	0.5	0.5	0.7

Clinical Commissioning Group (CCG)

Number	Part of system	Metric	Period	Cumbria	Northumberland	Newcastle Gateshead	North Tyneside	South Tyneside	Sunderland	North Durham	Durham Dales, Easington & Sedgefield	Darlington	Hartlepool & Stockton-On-Tees	South Tees	Hambleton, Richmondshire & Whitby	England rate	CNE rate
1	Primary Care	Proportion of patients (65+) who have had a frailty assessment	2017/18	81.2%	11.1%	18.3%	22.3%	25.5%	18.3%	9.8%	17.5%	16.9%	10.8%	28.6%	25.4%	25.6%	25.3%
2	Primary Care	Proportion of patients (65+) who have moderate or severe frailty recorded	2017/18	10.7%	7.2%	8.1%	8.3%	9.5%	7.0%	3.5%	14.2%	9.9%	7.8%	14.9%	11.9%	9.5%	9.4%
3	Primary Care	Proportion of patients (65+ years) with moderate or severe frailty who have had a fall	2017/18	13.7%	10.5%	15.7%	13.4%	14.9%	8.7%	16.2%	16.5%	17.1%	6.5%	15.4%	12.8%	10.6%	13.8%
4	Primary Care	Proportion of people (65+) with severe frailty who have received a medication review	2017/18	66.2%	62.2%	62.7%	69.1%	47.5%	45.5%	72.2%	79.5%	71.9%	60.7%	72.3%	58.2%	65.8%	65.8%
5	Primary Care	Proportion of patients (65+) prescribed 10 or more unique medications	2017/18	7.7%	7.6%	11.2%	9.1%	10.7%	11.0%	10.0%	10.8%	7.9%	10.0%	10.5%	6.1%	8.2%	9.5%
6	Primary care	Proportion of patients (65+) who have received the flu vaccination	Jan '18	76.7%	74.3%	75.4%	74.9%	74.6%	73.1%	72.7%	72.3%	72.4%	73.3%	74.6%	73.7%	72.6%	74.4%
7	Mental Health	Proportion of patients aged 65+ with a recorded diagnosis of dementia compared to those estimated to have dementia	Jun '18	64.1%	69.1%	76.9%	71.3%	73.4%	69.2%	68.1%	81.4%	76.5%	86.6%	75.0%	60.0%	67.6%	72.6%
14	Emergency care	A&E attendance rate (per 1,000 population) for patients aged 65+ years	2017/18	417.7	445.7	415.8	468.4	598.1	562.5	414.8	369.5	476.9	528.9	361.3	294.8	419.8	439.4
15	Emergency care	Emergency admission rate (per 1,000 population) for patients aged 65+ years	2017/18	225.6	269.6	305.7	314.7	328.4	289.2	262.5	255.1	242.0	299.5	274.6	211.0	255.1	273.4
16	Emergency care	Emergency readmission rate (per 1,000 population) within 30 days of discharge from hospital, for patients aged 65+	2017/18	174.5	189.2	187.6	208.4	227.5	210.0	188.5	185.1	157.5	189.7	175.9	144.6	193.2	188.4
18	Emergency / secondary care	Conversion rate (%) from A&E attendance to hospital admission (65+ years)	2017/18	43.2%	38.3%	38.1%	39.1%	44.1%	19.0%	32.4%	35.5%	32.0%	28.3%	41.4%	38.0%	41.3%	35.2%
19	Emergency care	Hospital activity in the last year of life (patients aged 65+ years)	2017/18	6.58%	7.81%	8.22%	9.45%	9.32%	7.67%	6.03%	6.85%	6.58%	6.58%	6.85%	6.30%		7.35%
23	Mortality	Percentage of deaths in usual place of residence	2017/18	50.0%	49.4%	47.3%	53.7%	43.1%	43.1%	51.5%	52.5%	52.4%	43.3%	50.6%	53.6%	46.7%	48.8%

Local Authority (LA)

Number	Part of system	Metric	Period	Cumbria	Northumberland	Newcastle upon Tyne	Gateshead	North Tyneside	South Tyneside	Sunderland	Durham	Darlington	Hartlepool	Stockton-On-Tees	Middlesbrough	Redcar and Cleveland	North Yorkshire	England
9	Care in the community	The proportion of people (aged 65+ years) who use services who have control over their daily life	2016/17	79.0%	80.0%	73.0%	74.2%	74.7%	75.3%	77.2%	74.8%	78.7%	83.1%	76.5%	81.8%	75.3%	75.8%	74.7%
10	Care in the community	The proportion of people (aged 65+ years) who use services who reported that they had as much social contact as they would like	2016/17	50.2%	46.5%	49.8%	49.8%	45.6%	49.1%	46.5%	47.3%	45.6%	50.9%	45.7%	48.6%	53.3%	44.4%	43.2%
11	Care in the community	Carer reported quality of life (score out of 12)	2016/17	8.5	8.9	8.2	8.5	8.5	8.3	8.2	8.7	7.5	9.0	8.2	8.7	8.5	8.3	8.0
21	Social care - discharge	The proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	2016/17	85.0%	91.5%	83.3%	80.8%	92.3%	86.2%	79.7%	88.1%	77.3%	76.2%	75.3%	90.9%	83.1%	83.6%	82.5%
22	Social care - discharge	Long-term support needs of older adults (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	2016/17	668.9	777.0	879.8	846.2	808.3	843.4	909.0	762.7	795.9	921.5	894.7	904.9	959.3	489.4	610.7

Foundation Trusts (FT)

Number	Part of system	Metric	Period	North Cumbria	Northumbria	Newcastle	Gateshead	South Tyneside	Sunderland	CDD	North Tees & Hartlepool	South Tees
17a	In hospital delays	Stranded patient: LOS 7+ days (% occupied beds per day)	2017/18	37.7%	44.6%	0.0%	18.6%	33.5%	39.4%	41.7%	39.6%	35.7%
17b	In hospital delays	Stranded patient: LOS 21+ days (% occupied beds per day)	2017/18	4.2%	5.5%	0.0%	6.8%	2.9%	5.4%	4.5%	5.5%	4.1%
20	Secondary care	Hospital Trust indicator set: % of Falls with harm	Jul '18	0.43%	0.87%	0.15%	0.54%	0.31%	0.17%	0.74%	0.34%	0.41%
		% of Patients with pressure ulcers (all)	Jul '18	3.68%	5.27%	3.79%	2.28%	9.15%	4.99%	2.06%	0.22%	5.85%
		Patient experience of hospital care (score/100)	to Jan '18	81.5	83.1	83.5	81.9	80.6	81.6	79.7	79.3	81.9
		Type 1 A&E waiting times (% < 4 hours)	2017/18	88.4%	87.1%	90.6%	92.9%	93.6%	85.9%	86.1%	90.9%	94.9%

Legend:
- Significantly Better
- Similar
- Significantly Worse
- Significantly Higher
- Similar
- Significantly Lower

Demographic information

Rationale

In order to understand the context of organisational achievement for each metric, key information relating to the populations has been presented below.

The proportion of patients aged 65 years and over is taken from the attribution dataset for GP and CCG (registered population), based on April 2017.

The GP practice deprivation score estimate (2015) is based on the registered population of each GP practice (using Lower Super Output Areas). A lower score equates to less deprived areas.

The proportion of patients who live in a nursing home is based on the NHAIS/Exeter GP payment system (aggregated from all known lower geography values) and based on 2014/15 data.

The proportion of patients aged 65 years and over (2017)
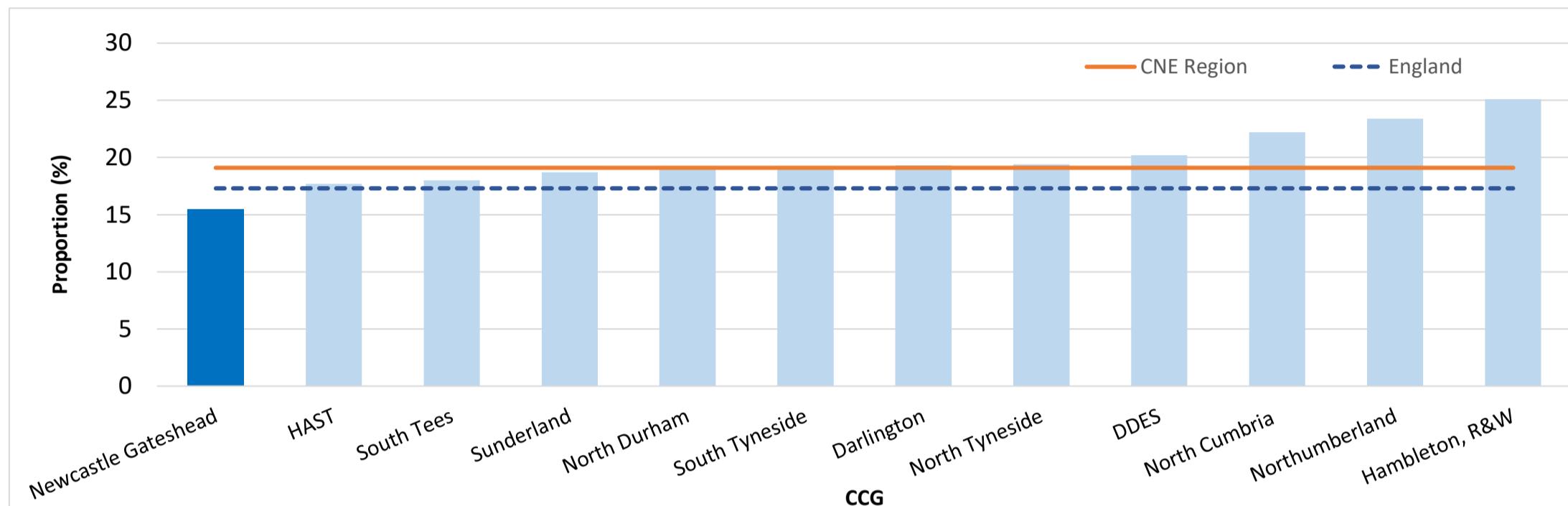
The GP practice deprivation score estimate (2015)
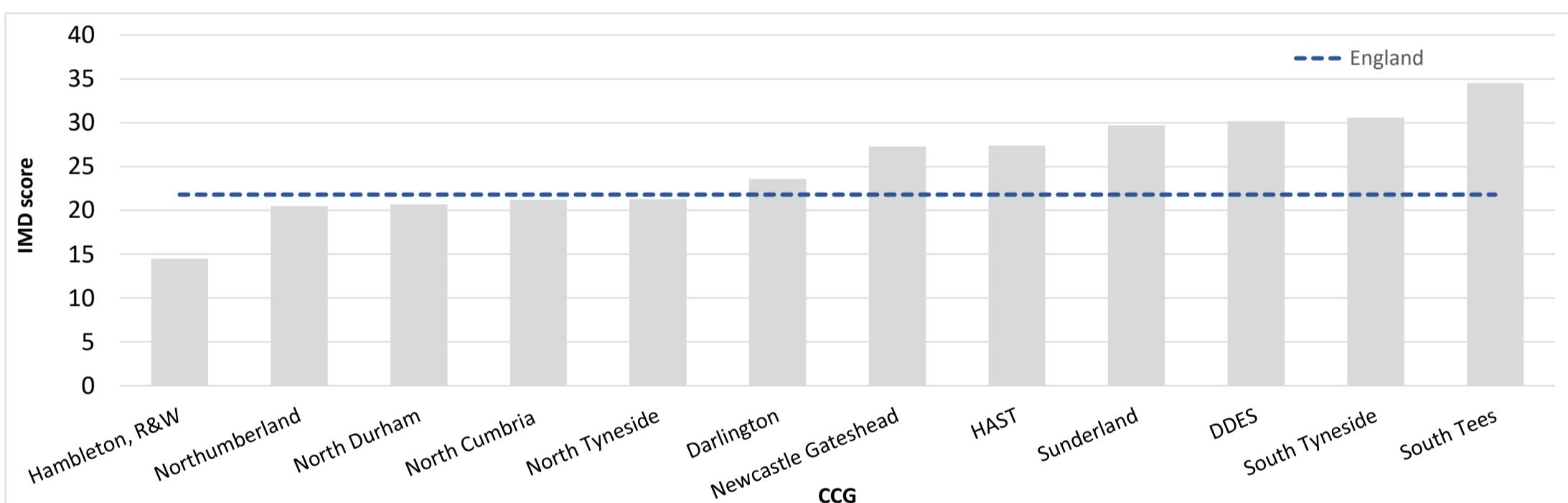
The proportion of patients who live in a nursing home
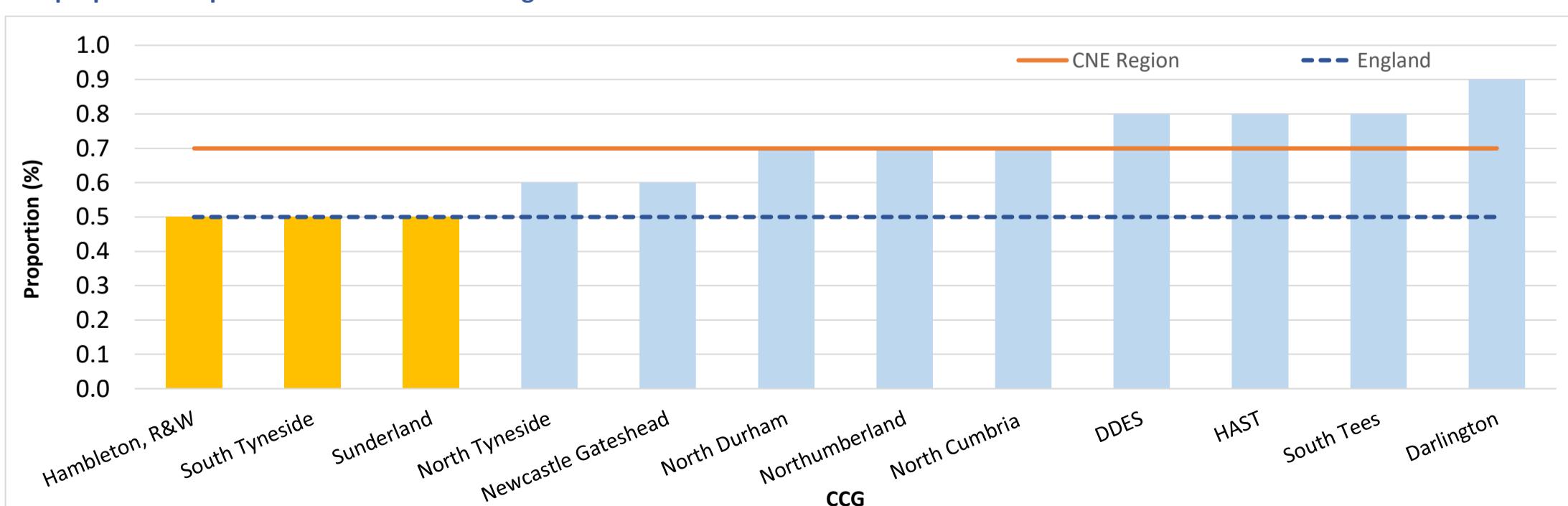
1. Patients aged 65 years or over who have had a frailty assessment

The proportion of patients aged 65 and over who have had a frailty assessment using an appropriate tool, recorded in GP practices

Data source: NHS Digital (GMS PMS Core Contract Data Collection), *Time period:* July 2017 - March 2018

Rationale

Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. Around 10% of people aged over 65 years have frailty, rising to between a quarter and a half of those aged over 85 years[1]. It is important to identify patients who may be living with frailty by stratifying populations of older people by risk of future health and care utilisation, to ensure health interventions are appropriately targeted.

What is the data telling us?

The proportion of patients aged 65 years and over who have had a frailty assessment recorded varies substantially by CCG. The CNE CCGs are highlighted in dark grey on the chart; three of these (North Durham, HAST and Northumberland) have relatively low achievement and one CNE CCG (North Cumbria CCG) has almost the highest achievement in England. The England and CNE averages are very similar, at 25.6% and 25.3%, respectively.

NOTE: This data may not yet be robust enough to obtain a true understanding of the number of patients with a frailty assessment done as preliminary analysis both locally and by NHS England suggests that data could include patients who have been 'batch-coded' for frailty based on a clinical system tool (such as the electronic Frailty Index, eFI), and for whom a clinical assessment or verification of their condition has not yet taken place.

What does success or improvement look like?

- An increase over time in the proportion of patients aged 65 years and over who have had a frailty assessment done in order to improve proactive case finding and the subsequent care planning and case management of those identified as living with frailty.

1. British Geriatric Society https://www.bgs.org.uk/resources/resource-series/fit-for-frailty

Proportion of patients aged 65+ years who have had a frailty assessment using the appropriate tool up to the end of Q4 2017/18
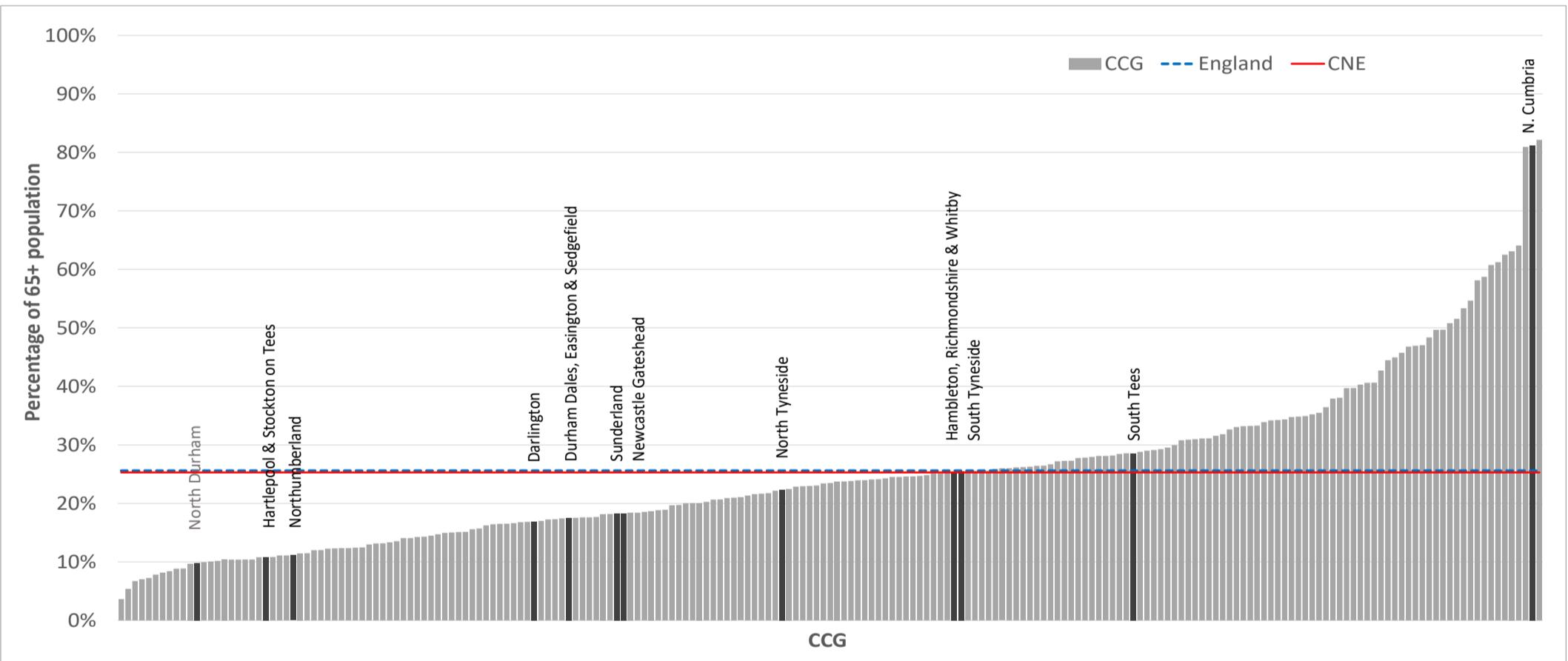
For additional information on this metric please refer to the supplementary appendix document.

2. Patients aged 65 years or over who are identified as living with frailty, and the severity of their condition

Patients aged 65 and over who have a diagnosis of moderate or severe frailty, identified using an appropriate tool and combined with clinical review

Data source: NHS Digital (GMS PMS Core Contract Data Collection), *Time period:* July 2017 - March 2018

Rationale

Early identification of frailty in older people aids targeted support to help them stay well for as long as possible. A number of validated tools are suggested by NHS England to establish the presence of frailty for all patients aged 65 years and over[2]. Depending on the level of frailty identified, various approaches to care are recommended, based on key principles and processes, and with a focus on the needs of the individual.

What is the data telling us?

The chart shows the recorded frailty status for patients aged 65+ years for each CCG within CNE, in addition to the regional and England average figures, ranked by the proportion of patients in the age group who have a frailty assessment recorded. For this period, the proportion of patients 65+ years with moderate or severe frailty ranges from 3.5% in North Durham to 14.9% in South Tees. The CNE rate is 9.4% and the England average is 9.5%. Further variation at GP practice level is expected. The pale blue section of the bar represents those patients who have had an assessment but where the frailty severity is not reported as moderate or severe. These patients may either have mild frailty or be fit.

The table indicates the frailty status (number of patients aged 65+ years) and includes figures for those recorded as moderate or severely frail. It must be noted that this data is based on the 2017/18 final extraction and is not possible to use data from this source to map those that move from one frailty category to another. There were **58,030** patients aged 65+ years across CNE who were recorded as having **moderate or severe frailty** at the end of Q4 2017/18. Data is <u>not</u> available from all GP practices in CNE.

NOTE: As reported in the previous metric, this data may not be robust due to batch coding.

What does success or improvement look like?

- An increase over time in the proportion of patients 65+ who have had a frailty assessment done in order to provide an up to date indication of the frailty severity profile across CNE and the number of patients this relates to.

2. https://www.england.nhs.uk/ourwork/ltc-op-eolc/older-people/frailty/

Recorded frailty status of patients aged 65 years and over, by CCG, up to the end of Q4 201718
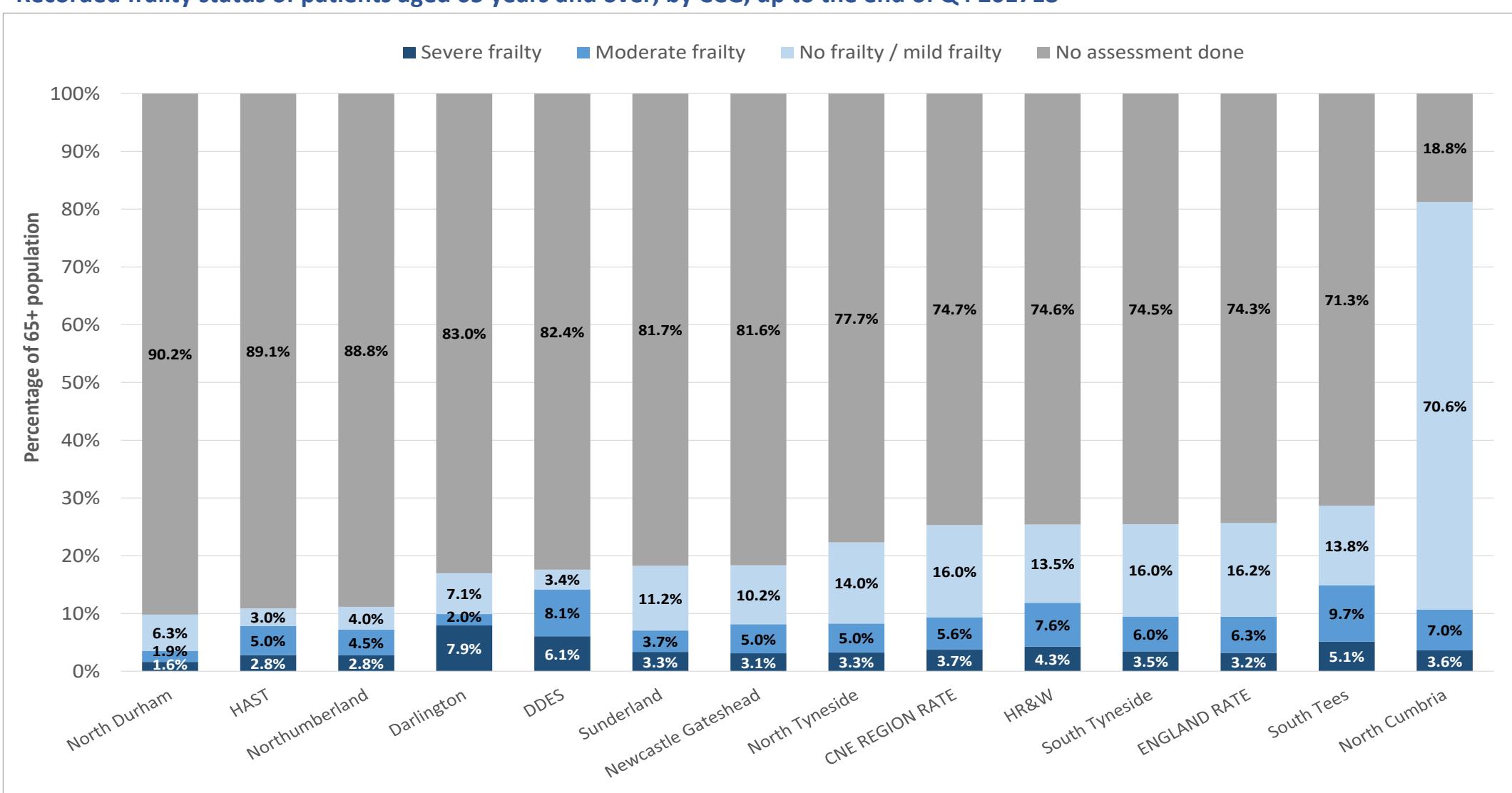
	Patients aged 65 years and over	Patients aged 65+ years with **NO** frailty assessment recorded	Patients aged 65+ years with frailty assessment recorded	Patients aged 65+ years with moderate frailty recorded	Patients aged 65+ years with severe frailty recorded	Total patients aged 65+ years with moderate or severe frailty recorded
North Durham	49,410	44,584	4,826	927	803	1,730
HAST	53,083	47,330	5,753	2,672	1,494	4,166
Northumberland	77,426	68,807	8,619	3,456	2,133	5,589
Darlington	21,044	17,492	3,552	419	1,671	2,090
DDES	59,716	49,261	10,455	4,848	3,626	8,474
Sunderland	53,647	43,855	9,792	1,985	1,797	3,782
Newcastle Gateshead	69,851	57,048	12,803	3,513	2,178	5,691
North Tyneside	42,684	33,160	9,524	2,129	1,405	3,534
HR&W	36,676	27,374	9,302	2,773	1,575	4,348
South Tyneside	30,225	22,524	7,701	1,821	1,047	2,868
South Tees	53,792	38,399	15,393	5,235	2,768	8,003
North Cumbria	72,761	13,658	59,103	5,127	2,628	7,755
CNE REGION RATE	**620,315**	**463,492**	**156,823**	**34,905**	**23,125**	**58,030**
ENGLAND RATE	**10,042,351**	**7,468,288**	**2,574,063**	**630,921**	**320,262**	**951,183**

For additional information on this metric please refer to the supplementary appendix document.

3. Patients aged 65 years and over with moderate or severe frailty who are recorded as having had a fall in the preceding 12 months

Patients aged 65 years or over, who have a diagnosis of either moderate or severe frailty diagnosed using the appropriate tool, who have had a fall.

Data source: NHS Digital (GMS PMS Core Contract Data Collection), *Time period:* July 2017 - March 2018

Rationale

Information on frailty can help predict who is likely to have a fall and the routine identification of those most vulnerable of falling allows general practice to target interventions at individuals most likely to benefit. Tools and guidance are available from NHS England for support[3]. Where clinically appropriate, a discussion will take place with the patient / carer regarding whether the patient has fallen in the last 12 months. A falls risk assessment should follow the guidance set out in NICE Clinical Guideline 161.

What is the data telling us?

Across England, the proportion of patients aged 65+ years with moderate or severe frailty who have had a fall recorded in primary care ranges from 1.25% to 24.3%, as shown in the quintile chart below. The CNE average is 13.6%, compared to the England rate of only 10.8%. The bars highlighted in yellow indicate the CNE CCGs, and 7 CCGs are in the highest quintile for this measure. Three CCGs have rates lower than the England average. The second set of charts shows the position of each CCG when compared to the 'similar' 10 CCGs (based on demographic profile, methodology used by RightCare[4]), indicating that there is substantial variation across the CNE CCGs and their peers.

NOTE: As reported in the previous metric, this data may not be robust due to batch coding.

### What does success or improvement look like?

- An increase over time in the proportion of patients 65+ years old who have had a frailty assessment done and an improvement in data quality in order to provide an up to date indication of the frailty severity profile across CNE and to allow appropriate targeting of appropriate interventions such as a falls risk assessment.

3. https://www.england.nhs.uk/publication/supporting-routine-frailty-identification-and-frailty-through-the-gp-contract-20172018/
4. https://www.england.nhs.uk/rightcare/products/nhs-rightcare-intelligence-tools-and-support/

Proportion of patients aged 65+ years with moderate or severe frailty, who have had a fall, by CCG, to the end of Q4 2017/18
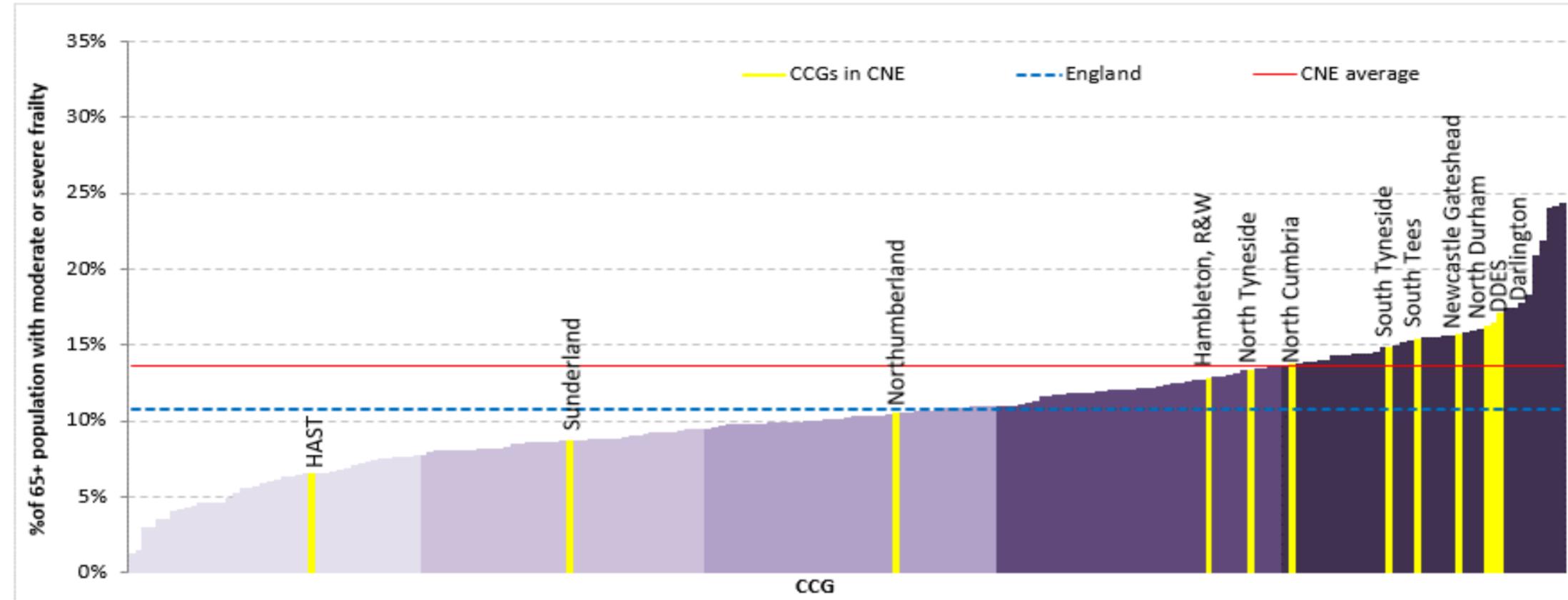
Proportion of patients aged 65+ years with moderate or severe frailty who have had a fall, by CCG, to the end of Q4 2017/18, compared
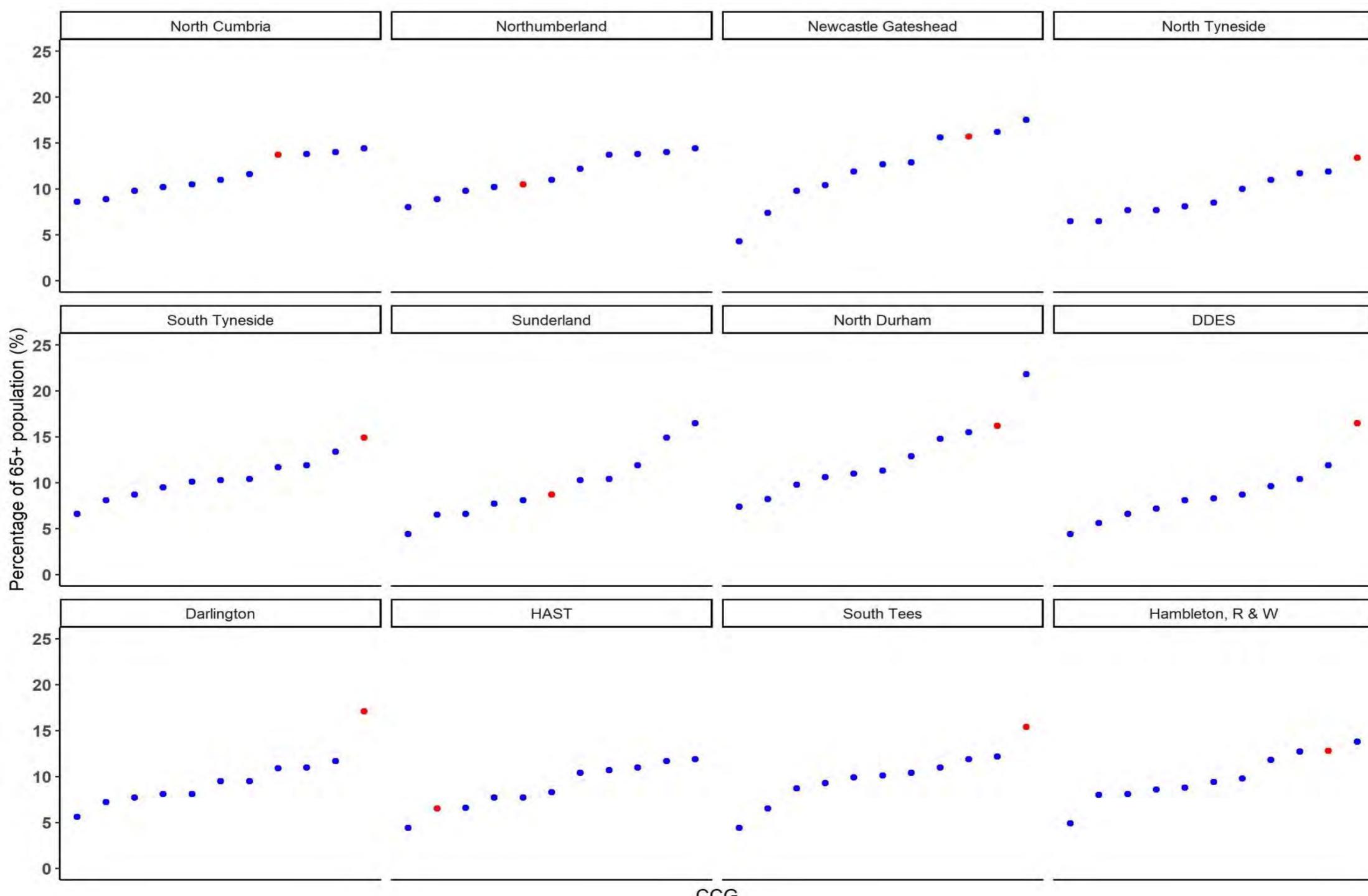
For additional information on this metric please refer to the supplementary appendix document.

4. Patients aged 65 years and over with severe frailty who have received an annual medication review

Patients aged 65 years or over, who have a diagnosis of severe frailty diagnosed using the appropriate tool, who have received an annual medication review on or after their severe frailty diagnosis.

Data source: NHS Digital (GMS PMS Core Contract Data Collection), *Time period:* July 2017 - March 2018

Rationale

Comprehensive medicines management for people with frailty is vital, especially for those individuals who are at risk of polypharmacy. Using a validated tool such as the STOPP START tool[5] (referred to in NICE Clinical Guideline 5 - Medicines Optimisation) to carry out a comprehensive review of medications in those with frailty is highly recommended. Such individuals almost always take four or more regular medications and are therefore at increased risk of the adverse effects of polypharmacy.

What is the data telling us?

Across England, the proportion of patients aged 65+ years with severe frailty who have received a medication review ranges from 34.4% to 88.9%, as shown in the quintile chart below. The CNE average is 65.77%, which is very similar to the England rate of 65.79%. The bars highlighted in yellow indicate the CNE CCGs, and DDES CCG is the only CCG in the highest quintile for this measure. Seven CCGs have rates lower than the England average.

The second set of charts shows the position of each CCG when compared to the 'similar' 10 CCGs (based on demographic profile, methodology used by RightCare[4]), indicating that there is substantial variation across the CNE CCGs and their peers.

NOTE: As reported in the previous metric, this data may not be robust due to batch coding.

What does success or improvement look like?

- An increase over time in the proportion of patients 65+ years old who have had a frailty assessment done and an improvement in data quality in order to provide an up to date indication of the frailty severity profile across CNE and to allow appropriate targeting of appropriate interventions such as medication reviews.

4. https://www.england.nhs.uk/rightcare/products/nhs-rightcare-intelligence-tools-and-support/
5. https://www.networks.nhs.uk/nhs-networks/nhs-cumbria-ccg/medicines-management/guidelines-and-other-publications/Stop%20start%20pdf%20final%20Feb%202013%20version.pdf/view

Proportion of patients aged 65+ years with severe frailty, who have received an annual medication review, by CCG, to the end of Q4 2017/18
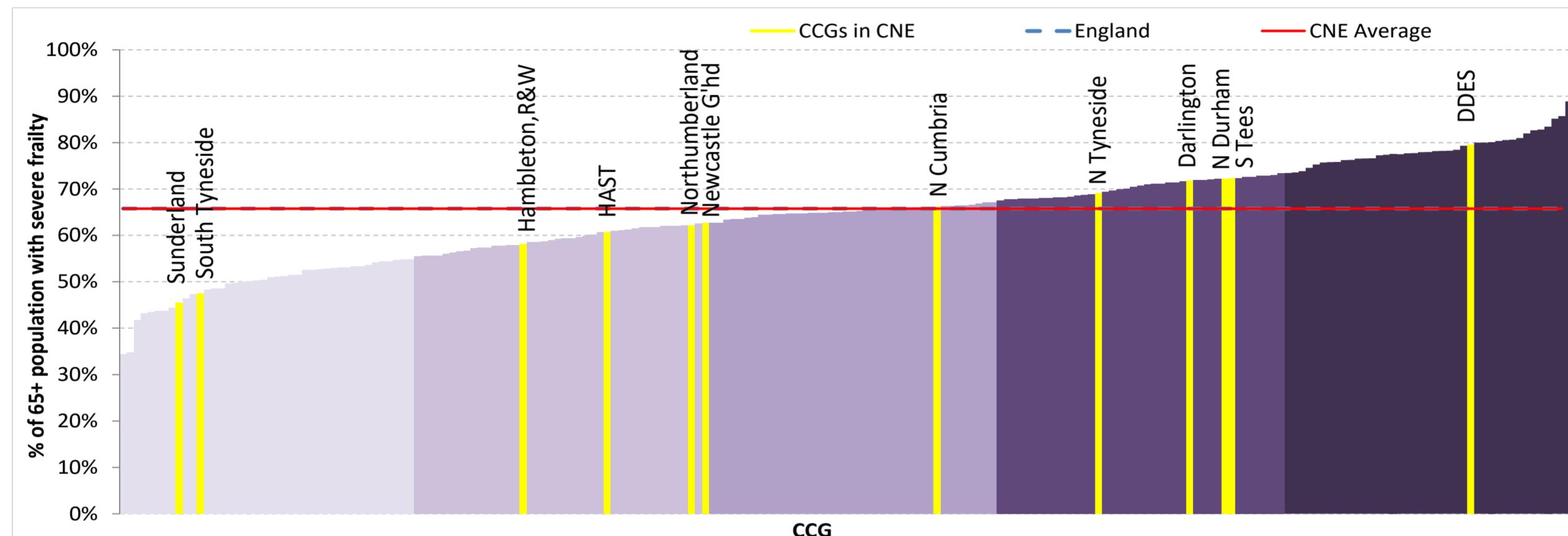
Proportion of patients aged 65+ years with severe frailty who have received an annual medication review, by CCG, to the end of Q4 2017/18, compared to the
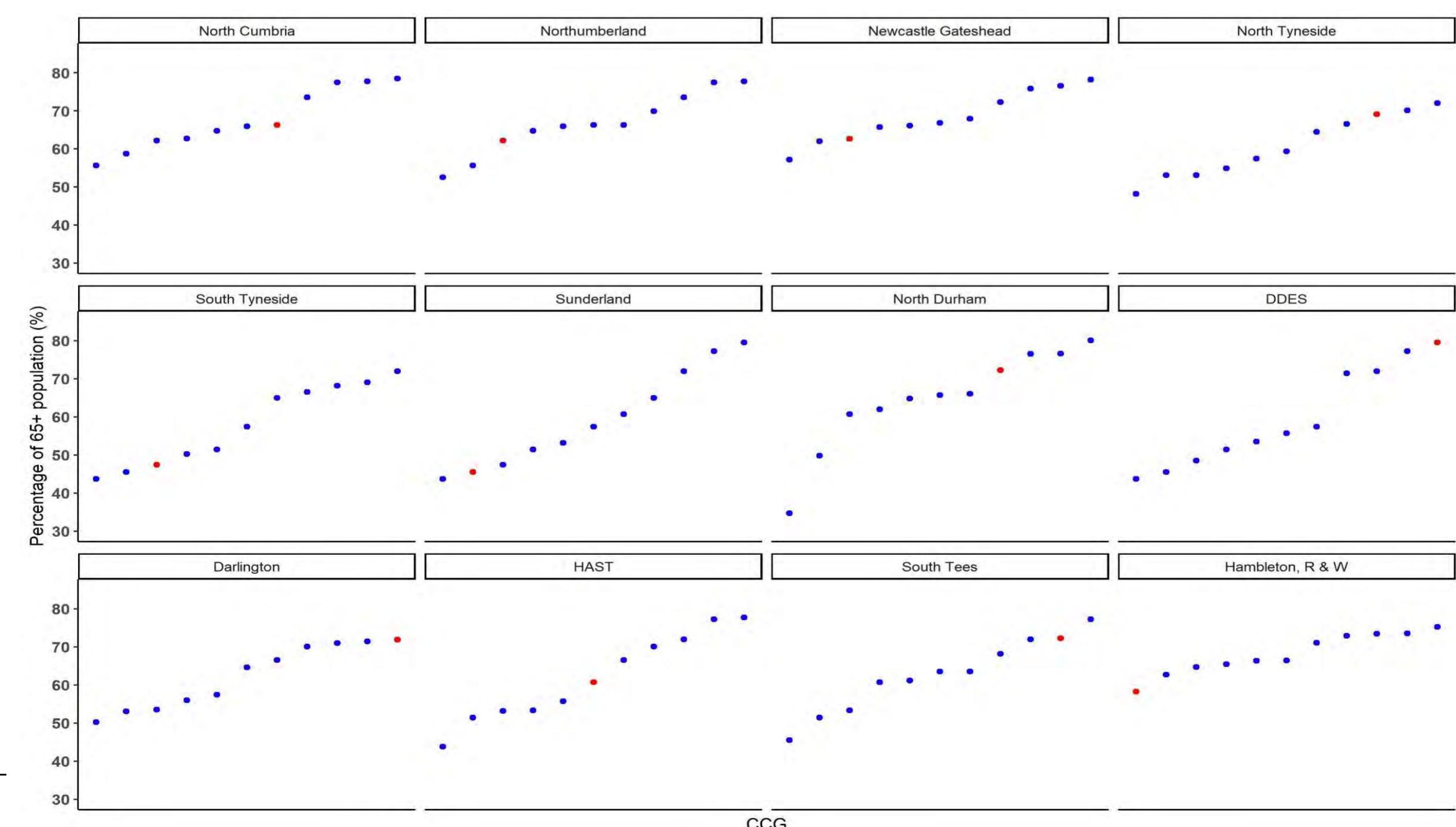
For additional information on this metric please refer to the supplementary appendix document.

5. Patients aged 65 years and over with 10 or more unique medications

Patients aged 65 years and over prescribed 10 or more unique medicines as a percentage of the number of patients prescribed one or more medicines

Data source: ePACT Polypharmacy prescribing comparators[6], *Time period:* Snapshot as at March 31st 2017 and March 31st 2018

Rationale

The impact of polypharmacy on our elderly population is significant. It is associated with poor adherence, drug-drug interactions, medication errors and adverse drug reaction, such as falls, confusion and delirium. Patients are unsure of the reasons for medications, take them haphazardly and often have other medications added to treat side effects.

What is the data telling us?

In March 2018, 44,673 patients aged 65 and over across the CNE region, equating to 9.5% of the population, were concurrently receiving 10 or more unique medicines. This was a decrease from 46,049 in March 2017, a reduction of 3.0%. Despite this recent improvement, the percentage of over 65 year olds receiving 10 or more unique medicines in the region remains higher than that for England as a whole with considerable variation reported between CCGs. In Newcastle Gateshead CCG, 11.2% of the population receive 10 or more medicines while this figure is 6.1% in Hambleton, Richmondshire and Whitby. Significant variation at practice level is also apparent.

What does success or improvement look like?

Improvement would be evidenced by a) Further reductions in the percentage of the population received 10 or more medicines, b) A reduction in the gap between the highest and lowest prescribing CCGs within the CNE region and c) a reduced number of outliers at GP practice level.

6. https://www.nhsbsa.nhs.uk/sites/default/files/2018-02/PolyPharmacy%20Specification%20v1%200%20July%202017_0.pdf

Polypharmacy at CCG level
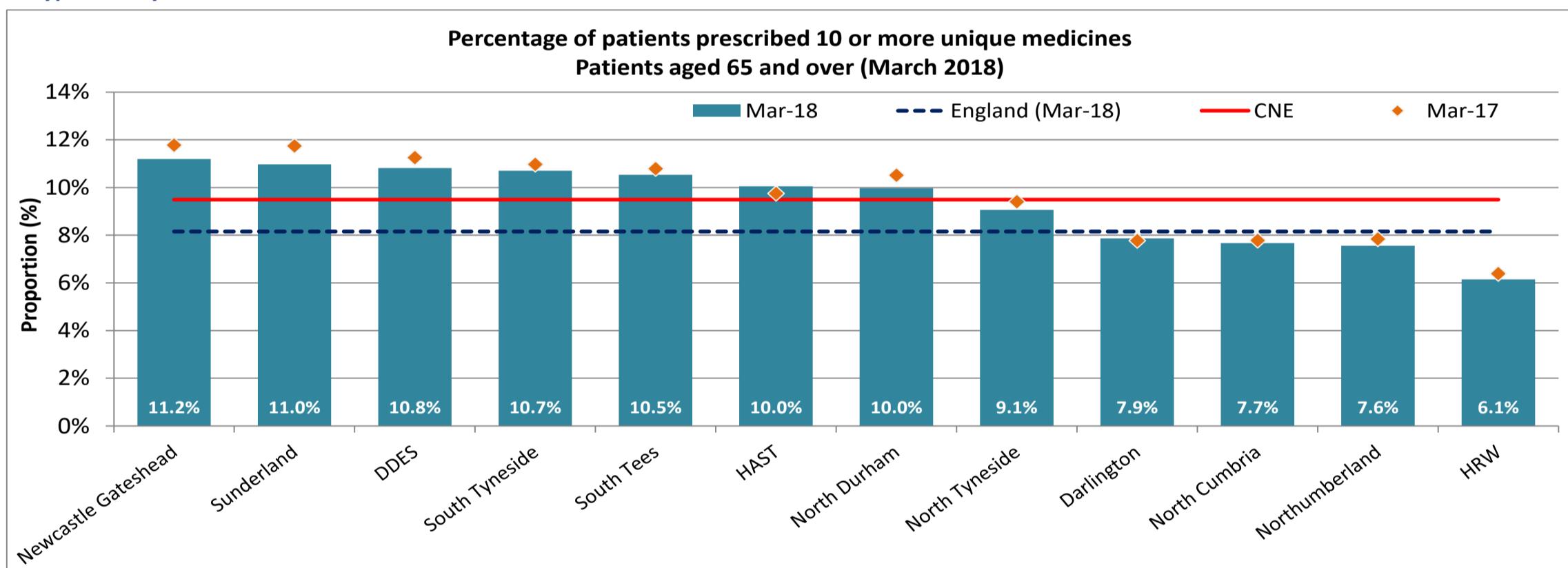
Polypharmacy at CCG level* (Snapshot as at March 2018)
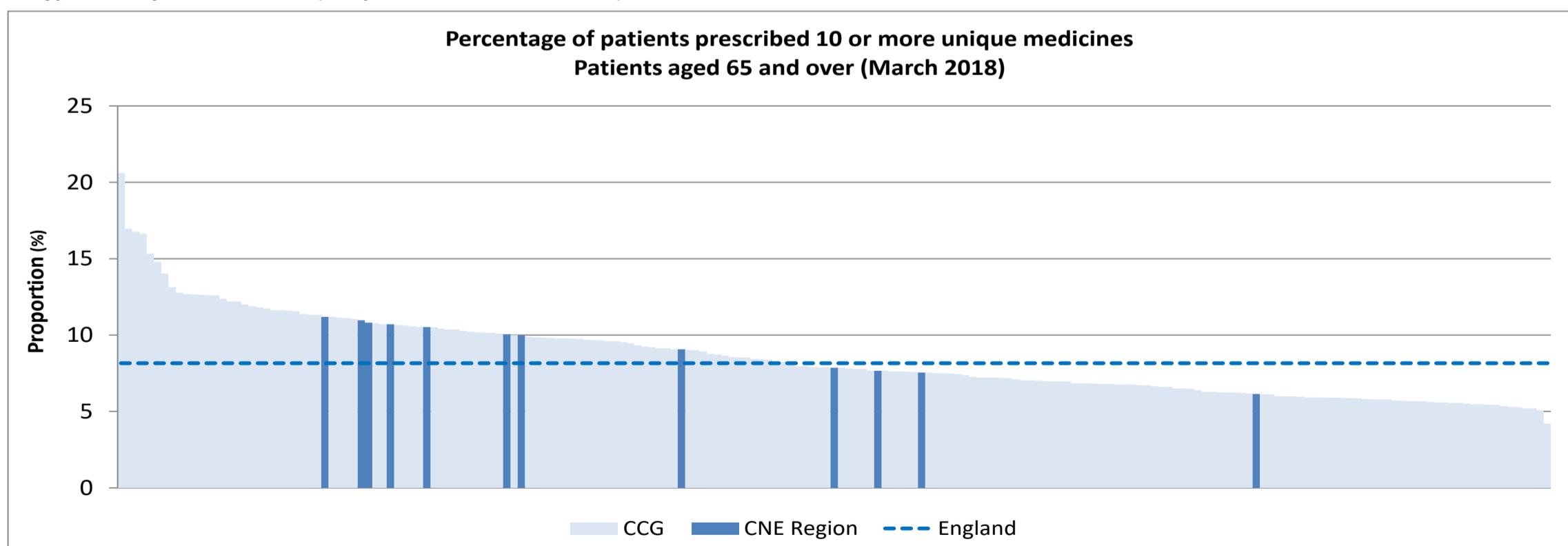
*CCG order is the same as in the chart above

For additional information on this metric please refer to the supplementary appendix document.

6. Flu immunisation rate in people aged 65 years and over

Proportion of patients aged 65+ years who have received the seasonal influenza vaccine

Data source: Public Health England (Seasonal influenza vaccine uptake in GP patients), Time period: To 31st January 2018

Rationale

The purpose of the seasonal influenza immunisation programme in England is to provide protection for specific patient groups (those aged 65+ years, in clinical at risk groups, and pregnant women) from serious illness or death following influenza infection. The ambition for vaccine coverage in 2017 to 2018 was to reach or exceed 75% uptake for people aged 65+ years (as recommended by the World Health Organization (WHO)).

What is the data telling us?

The cumulative influenza vaccine uptake in those aged 65+ years for the latest period (winter 2017 - 2018) for CNE was 74.4%, which is higher than the England rate (72.6%). At CCG level uptake varies, with all but three CCGs reporting a vaccine uptake rate for this age group which is significantly higher than England.

Trend data for the last five years shows that there is variation in the uptake rate over time, and the rate for the latest financial year is an improvement on the data for 2016/17 for all CCGs.

What does success or improvement look like?

- An increase over time in the proportion of patients 65+ years old who have received the influenza vaccine, and an aim to reduce the variation between CCGs.

Proportion of patients aged 65+ years who have received the seasonal influenza vaccine by CCG, winter season 2017 to 2018
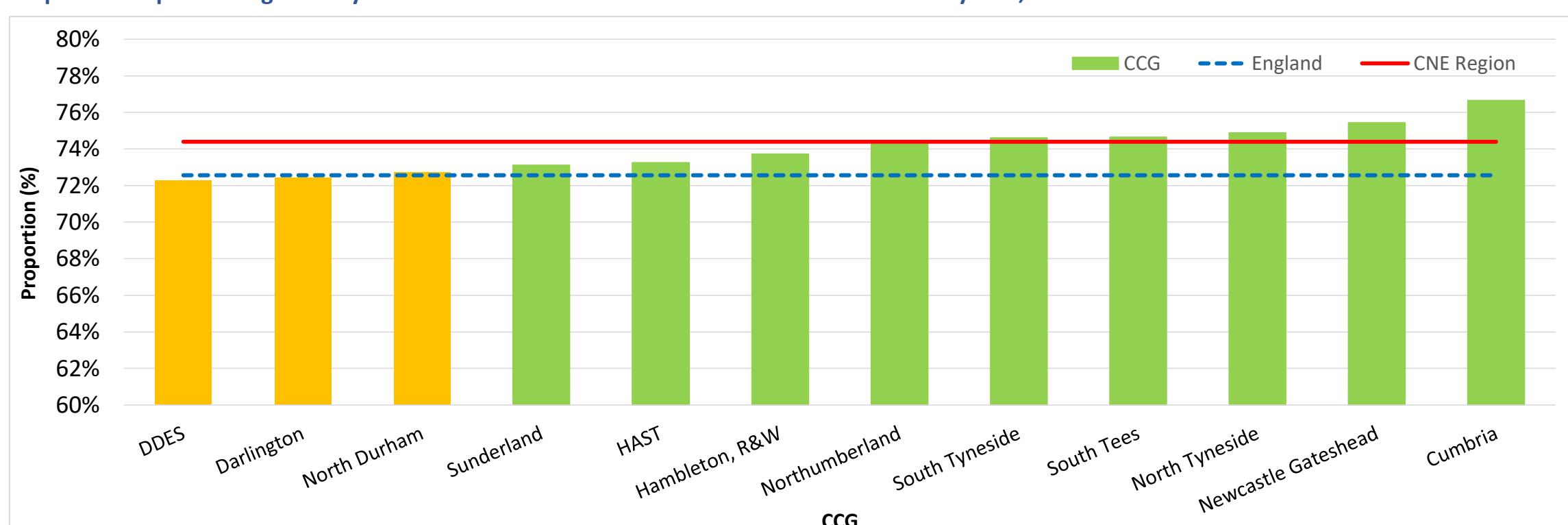
Proportion of patients aged 65+ years who have received the seasonal influenza vaccine by CCG, trend over time
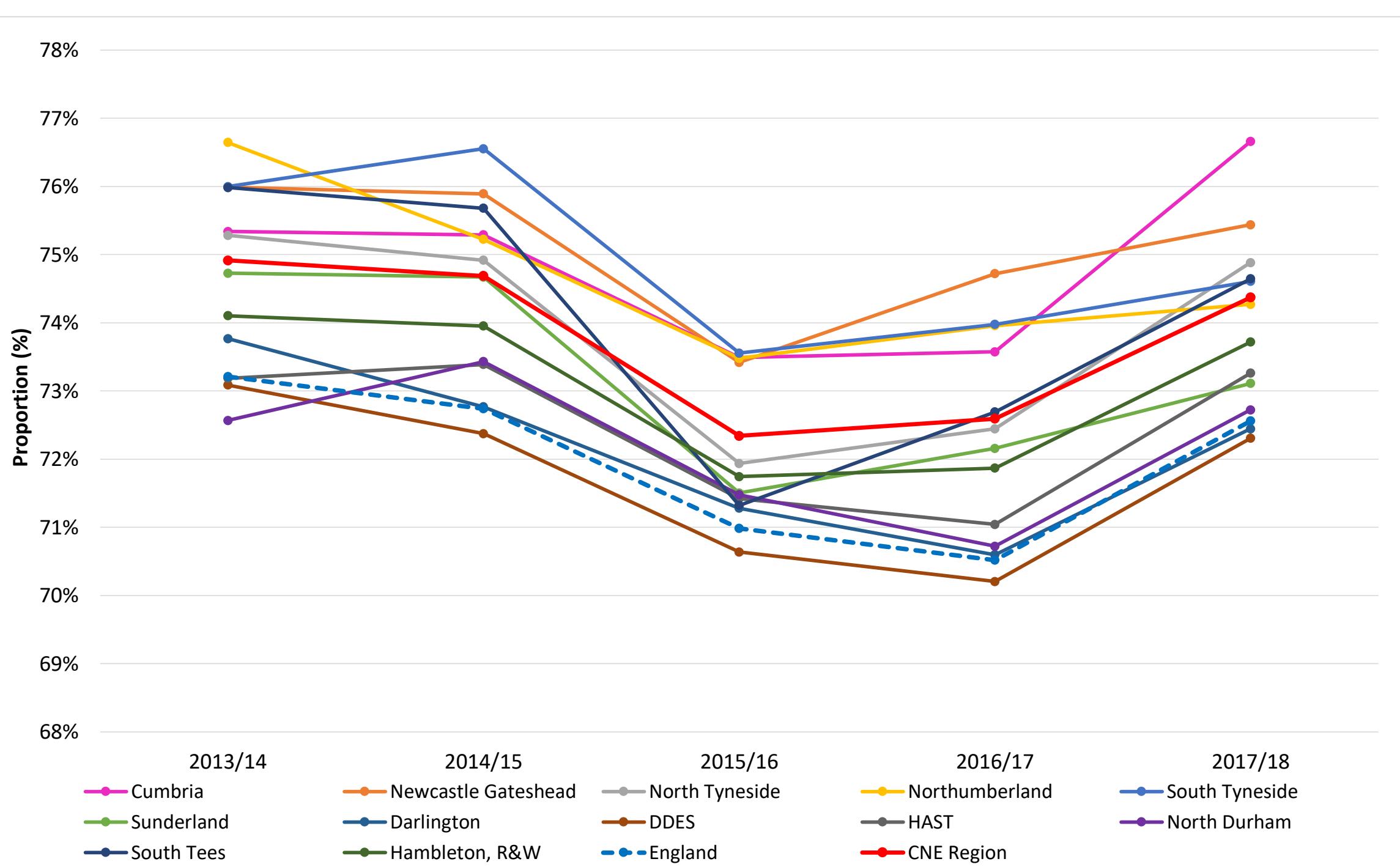
For additional information on this metric please refer to the supplementary appendix document.

7. Dementia: 65+ years old estimated diagnosis rate

The rate of persons aged 65 and over with a recorded diagnosis of dementia per person estimated to have dementia

Data source: NHS Digital (https://digital.nhs.uk/data-and-information/publications/statistical/recorded-dementia-diagnoses/june-2018),
Time period: To end June 2018

Rationale

Not everyone with dementia has a formal diagnosis. This indicator compares the number of people <u>estimated to have dementia</u> (given the characteristics of the population and the age and sex specific prevalence rates of the Cognitive function and Ageing Study II) with the number of people <u>diagnosed with dementia</u> (taken from the dementia QOF registers in general practice), aged 65 and over. The target is for at least two thirds of people with dementia to be diagnosed.

What is the data telling us?

The estimated diagnosis rate of dementia in those aged 65+ years for the latest 12 months (to June 2018) varies across the CNE region from 60.0% in Hambleton, Richmondshire and Whitby CCG to 86.6% in Hartlepool and Stockton on Tees CCG, compared to the CNE region and England rates of 72.6% and 67.6%, respectively. One CCG is significantly lower than the England rate and three CCG are higher.

With regard to the monthly trend data, for some CCGs the rate is relatively constant, however for others there are fluctuations and a slight downward trend.

What does success or improvement look like?

- An increase over time in the proportion of patients 65+ with a record of dementia when compared to the estimated dementia diagnosis rate.

7. http://www.cfas.ac.uk/cfas-ii/

The rate of those aged 65+ with a recorded diagnosis of dementia in the general practice record expressed per person estimated to have dementia (July 17 - June 18)
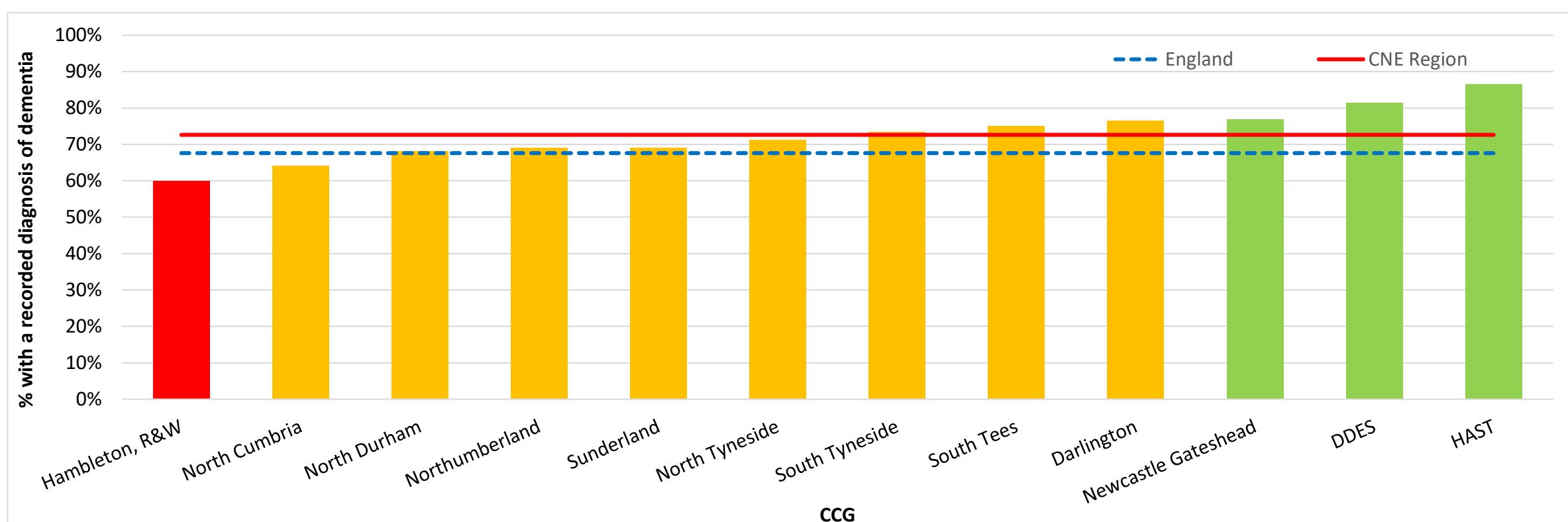
Trend in the rate of those aged 65+ with a recorded diagnosis of dementia in the general practice record expressed per person estimated to have dementia (July 17 - June 18)
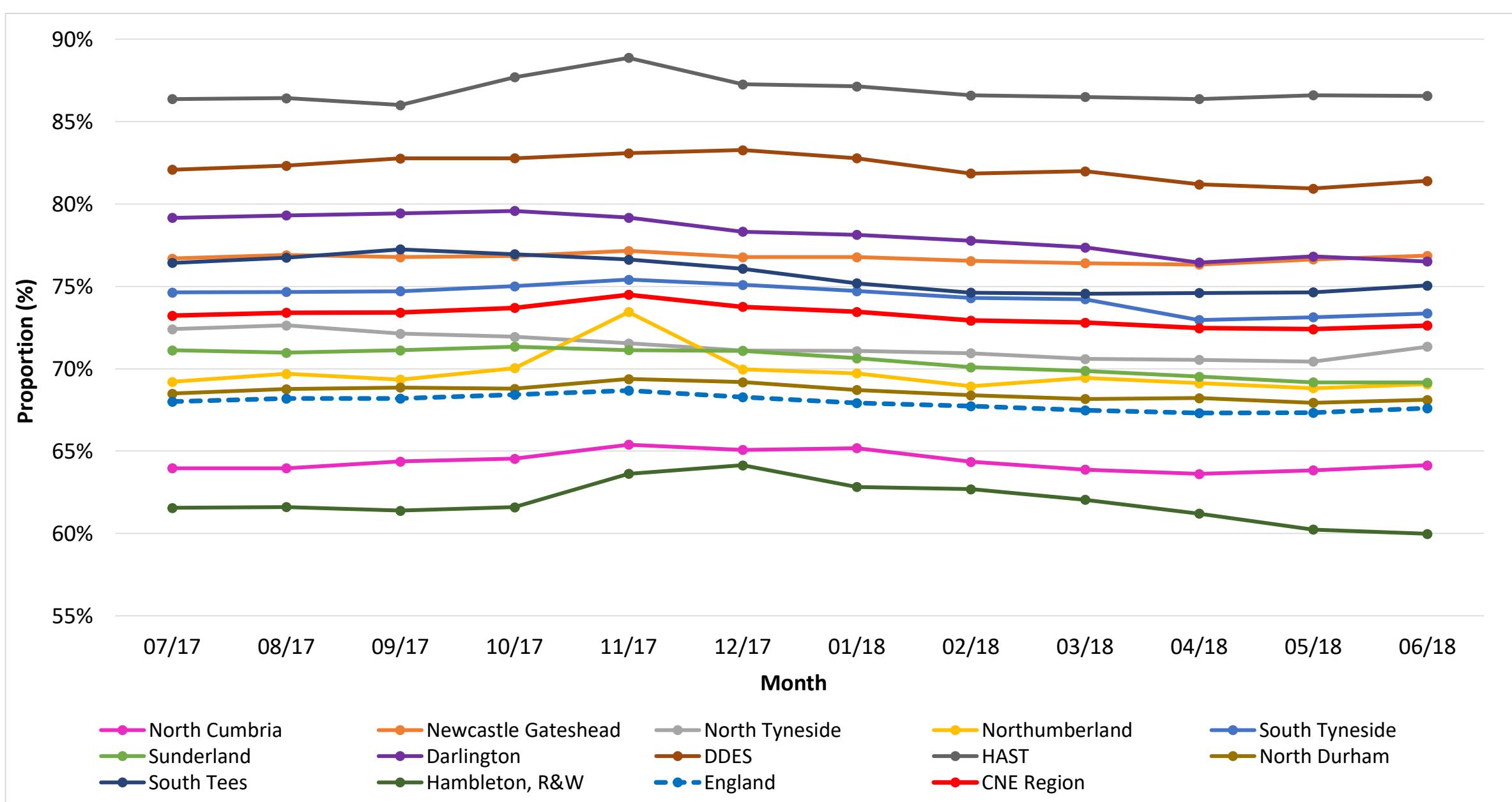
For additional information on this metric please refer to the supplementary appendix document.

8. Patients aged 65 years and over, with depression or dementia, and who have moderate or severe frailty

Proportion of patients aged 65+ years who have depression or dementia, and who have been identified as living with moderate or severe frailty

Data source: Not yet agreed, *Time period:* To be determined

Rationale

A metric to report the proportion of patients aged 65 years and over who are on the dementia or depression QOF registers (or both) in primary care and who also have a diagnosis of moderate or severe frailty has been suggested for inclusion in this framework.

The risk of mental health conditions (such as depression and anxiety) and cognitive decline has frequently been reported to increase as the number of chronic conditions increases (and with age). The relationship of cognitive impairment and depression to care dependency, disability and other adverse health outcomes has been demonstrated in a number of studies[8].

Studies have shown that the frailer an older person is, the more likely they will become depressed, and the more depressed an older person is, the more likely they are to become frail.

Data source criteria

Although data is currently available from NHS Digital relating to QOF registers for depression and dementia, and also to identify those with moderate or severe frailty, these are reported in isolation. In order to produce data for this metric it is necessary to access patient level information to identify those patients with specific combinations of these conditions; this data would then be aggregated and reported at GP practice level or higher.

8. The Academy of Medical Science. (April 2018) Multimorbidity: a priority for global health research.

For additional information on this metric please refer to the supplementary appendix document.

9. The proportion of people (aged 65+ years) who use services who have control over their daily life

Enhancing quality of life for people with care and support needs (taken from ASCOF 1B)

Data source: NHS Digital (https://digital.nhs.uk/data-and-information/publications/clinical-indicators/adult-social-care-outcomes-framework-ascof/current), Time period: 2016/17

Rationale

A key objective of the drive to make care and support more personalised is that support more closely matches the needs and wishes of the individual, putting service users of services in control of their care and support. Therefore, asking service users of care and support about the extent to which they feel in control of their daily lives is one means of measuring whether this outcome is being achieved. People manage their own support as much as they wish, so that they are in control of what, how and when support is delivered to match their needs.

What is the data telling us?

The data presented shows the North East region to have a higher proportion (76.5%) than the England average (74.7%) for this indicator. There is some variation between regional local authorities with Hartlepool achieving the highest outcome (83.1%) compared to Newcastle reporting the lowest outcome (73.0%). Cumbria and North Yorkshire have also been included for the scope of this project, but will not be included in the North East regional figure. All local authorities in the region except for two have reported above the England average for this measure.

What does success or improvement look like?

Improvement would be achieving higher proportions of older people feeling they have more control over their daily lives. In terms of the impact on frailty, increasing proportions of this metric will show that people who feel more in control are likely receiving more personalised support which suits their wishes.

However, there are a range of factors which are likely to have an impact on this measure;
- Severity of needs of users
- Amount of support provided by carers.
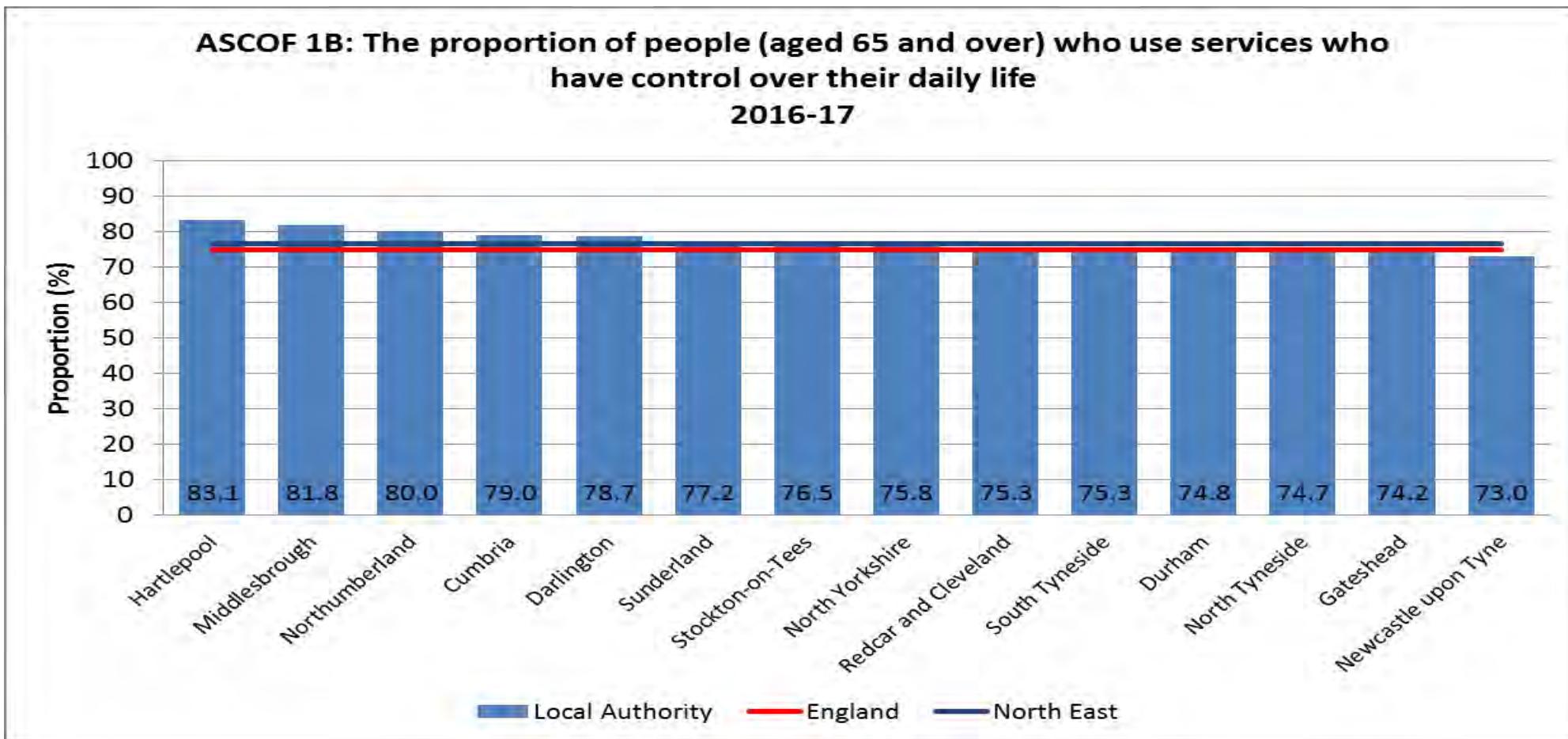
1. Proportion by Local Authority (CASSR Level)

2. Proportion by all Local Authorities in England
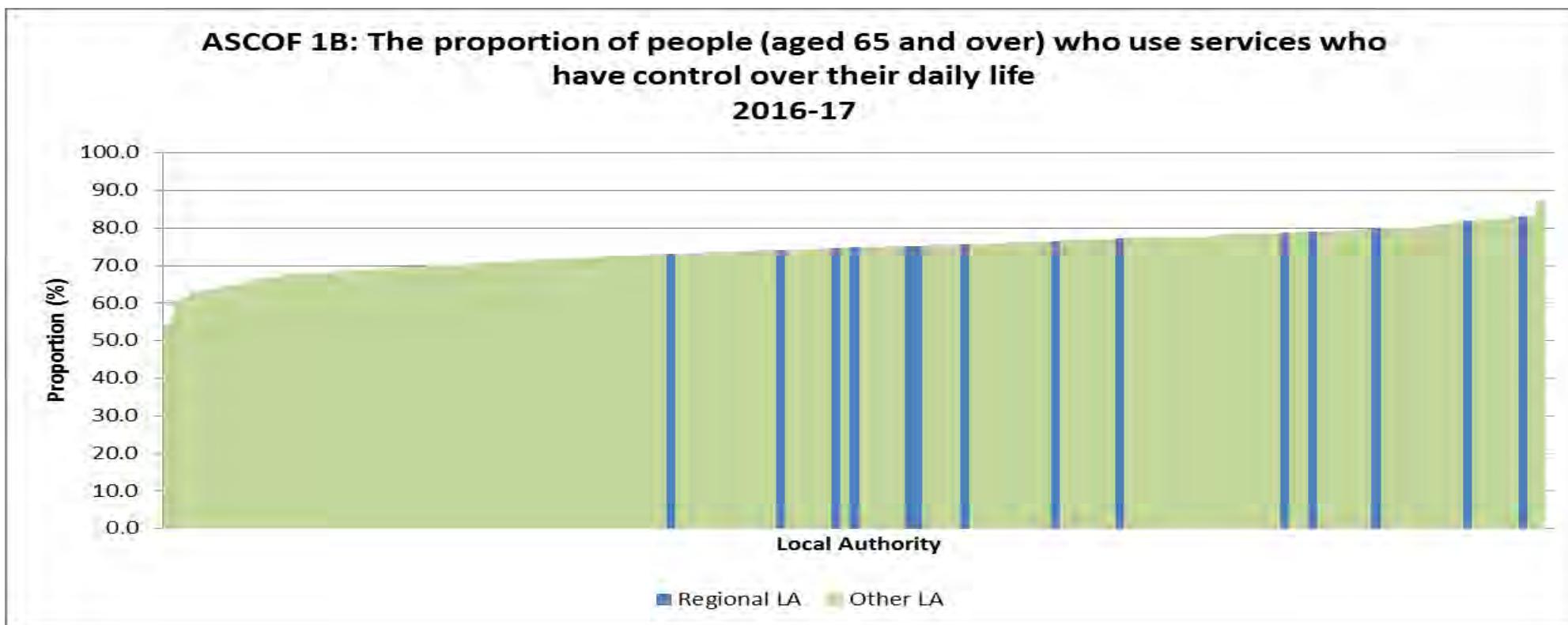
For additional information on this metric please refer to the supplementary appendix document.

10. The proportion of people (aged 65 and over) who use services who reported that they had as much social contact as they would like

Enhancing quality of life for people with care and support needs (taken from ASCOF 1I(1))

Data source: NHS Digital (https://digital.nhs.uk/data-and-information/publications/clinical-indicators/adult-social-care-outcomes-framework-ascof/current), Time period: 2016/17

Rationale

There is a clear link between loneliness and poor mental and physical health. A key element of the Government's vision for social care is to tackle loneliness and social isolation, supporting people to remain connected to their communities and to develop and maintain connections to their friends and family. This measure will draw on self-reported levels of social contact as an indicator of social isolation for both users of social care and carers.

What is the data telling us?

The data presented shows the North East region to have a higher proportion (48.0%) than the England average (43.2%) for this indicator. There is some variation between regional local authorities with Redcar & Cleveland achieving the highest outcome (53.3%) compared to North Tyneside reporting the lowest outcome (45.6%). Cumbria and North Yorkshire have also been included for the scope of this project, but will not be included in the North East regional figure. All local authorities in the region have reported above the England average for this measure.

What does success or improvement look like?

Improvement would be achieving higher proportions of older people feeling less socially isolated. In terms of the impact on frailty, increasing proportions of this metric will show that people are able to access care in the community to address their social needs which will improve mental and physical health for people. However, there are a some factors which are likely to have an impact on this measure such as the severity of needs of users and the amount of support provided by carers.

1. Proportion by Local Authority (CASSR Level)

ASCOF 1I(1): The proportion of people (aged 65 and over) who use services who reported that they had as much social contact as they would like 2016-17

Redcar and Cleveland	Hartlepool	Cumbria	Gateshead	Newcastle upon Tyne	South Tyneside	Middlesbrough	Durham	Northumberland	Sunderland	Stockton-on-Tees	Darlington	North Tyneside	North Yorkshire
53.3	50.9	50.2	49.8	49.8	49.1	48.6	47.3	46.5	46.5	45.7	45.6	45.6	44.4

2. Proportion by all Local Authorities in England

ASCOF 1I(1): The proportion of people (aged 65 and over) who use services who reported that they had as much social contact as they would like 2016-17
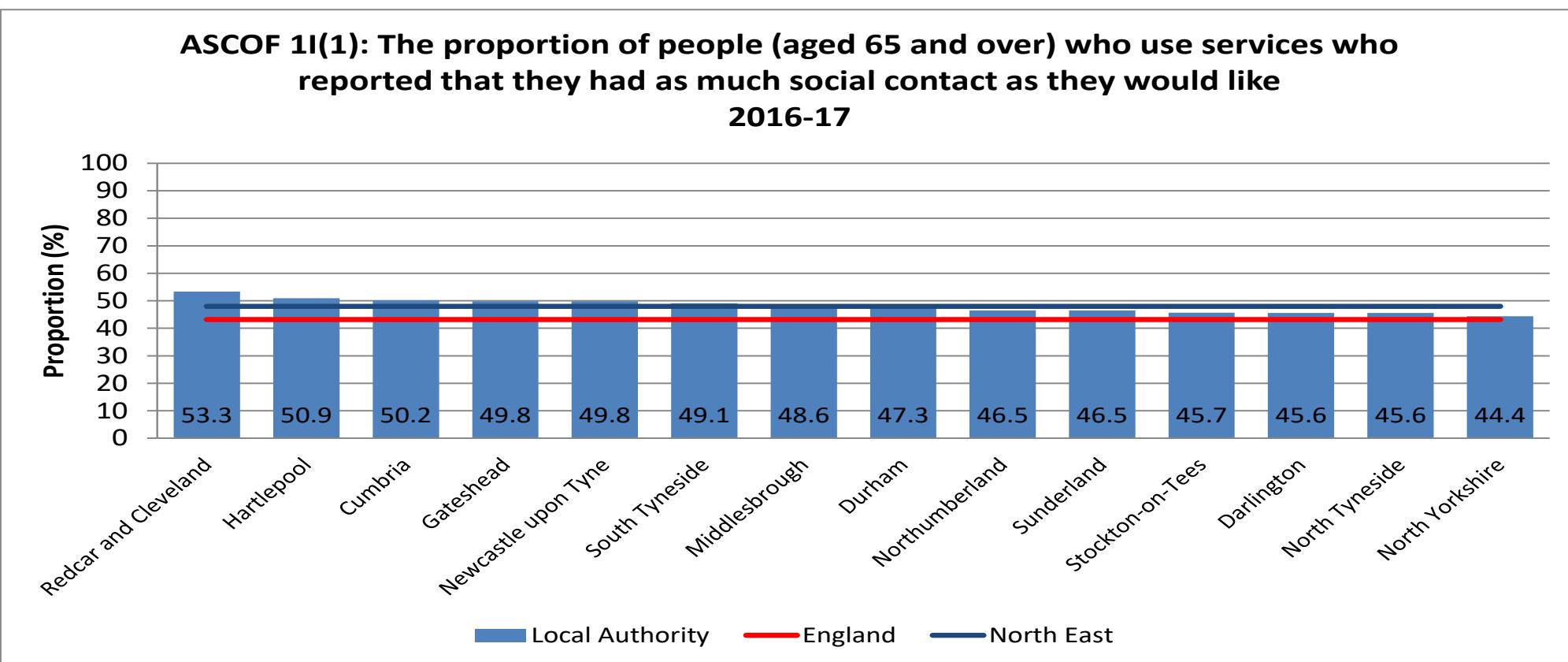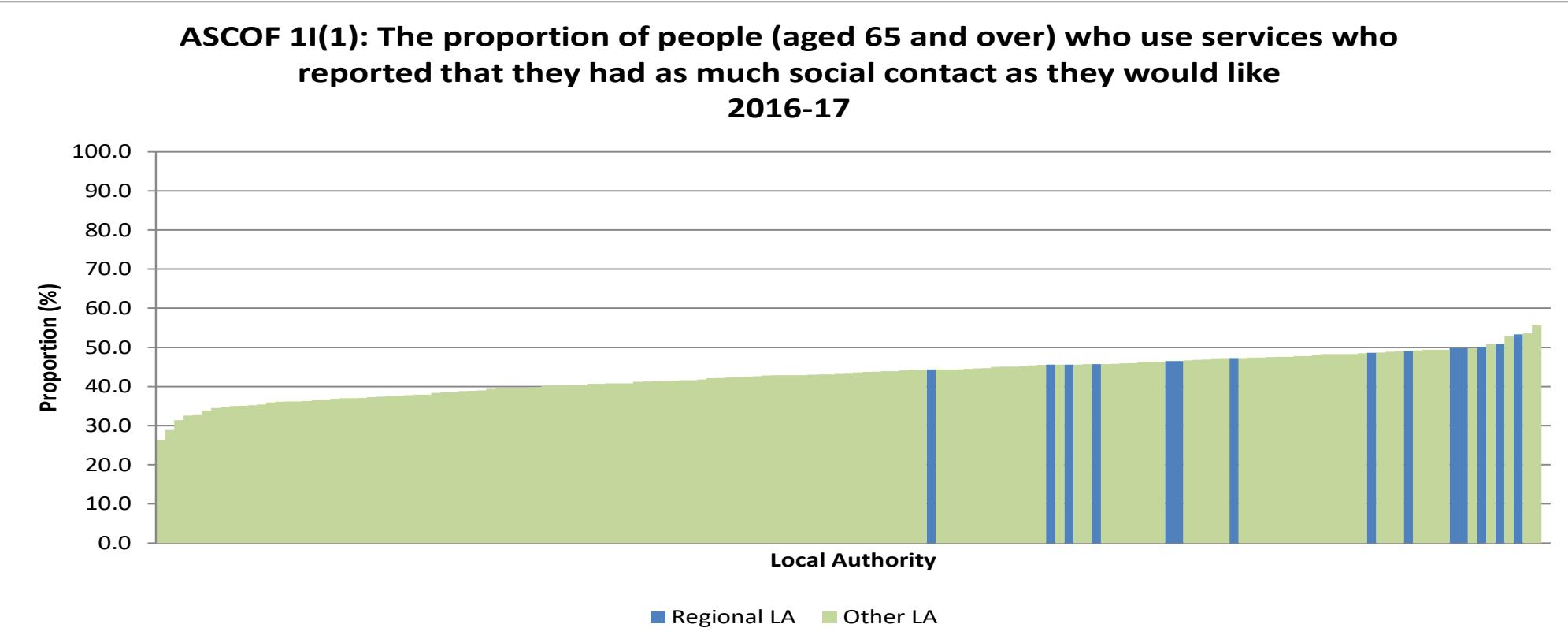
For additional information on this metric please refer to the supplementary appendix document.

11. Carer reported quality of life

Enhancing quality of life for people with care and support needs (taken from ASCOF 1D)

Data source: NHS Digital (https://digital.nhs.uk/data-and-information/publications/clinical-indicators/adult-social-care-outcomes-framework-ascof/current), *Time period: 2016/17*

Rationale
This measure gives an overarching view of the quality of life of carers based on outcomes identified through research by the Personal Social Services Research Unit. This is the only current measure related to quality of life for carers available, and supports a number of the most important outcomes identified by carers themselves to which adult social care contributes.

What is the data telling us?
The data presented shows the North East region to have a higher score (8.6) than the England average (8.0) for this indicator. There is some variation between regional local authorities with Hartlepool achieving the highest outcome (9.0) compared to Darlington reporting the lowest outcome (7.5). Cumbria and North Yorkshire have also been included for the scope of this project, but will not be included in the North East regional figure.

What does success or improvement look like?
Improvement would be achieving a higher score of carer reported quality of life. In terms of the impact on frailty, increasing outcomes of this metric will show that if carers feel they are able to balance their caring roles and maintain their own desired quality of life, this will also result in enhancing the quality of life for frail people they may care for. However, there are a some factors which are likely to have an impact on this measure such as the severity of needs of users and the amount of support provided by carers.

1. Proportion by Local Authority (CASSR Level)
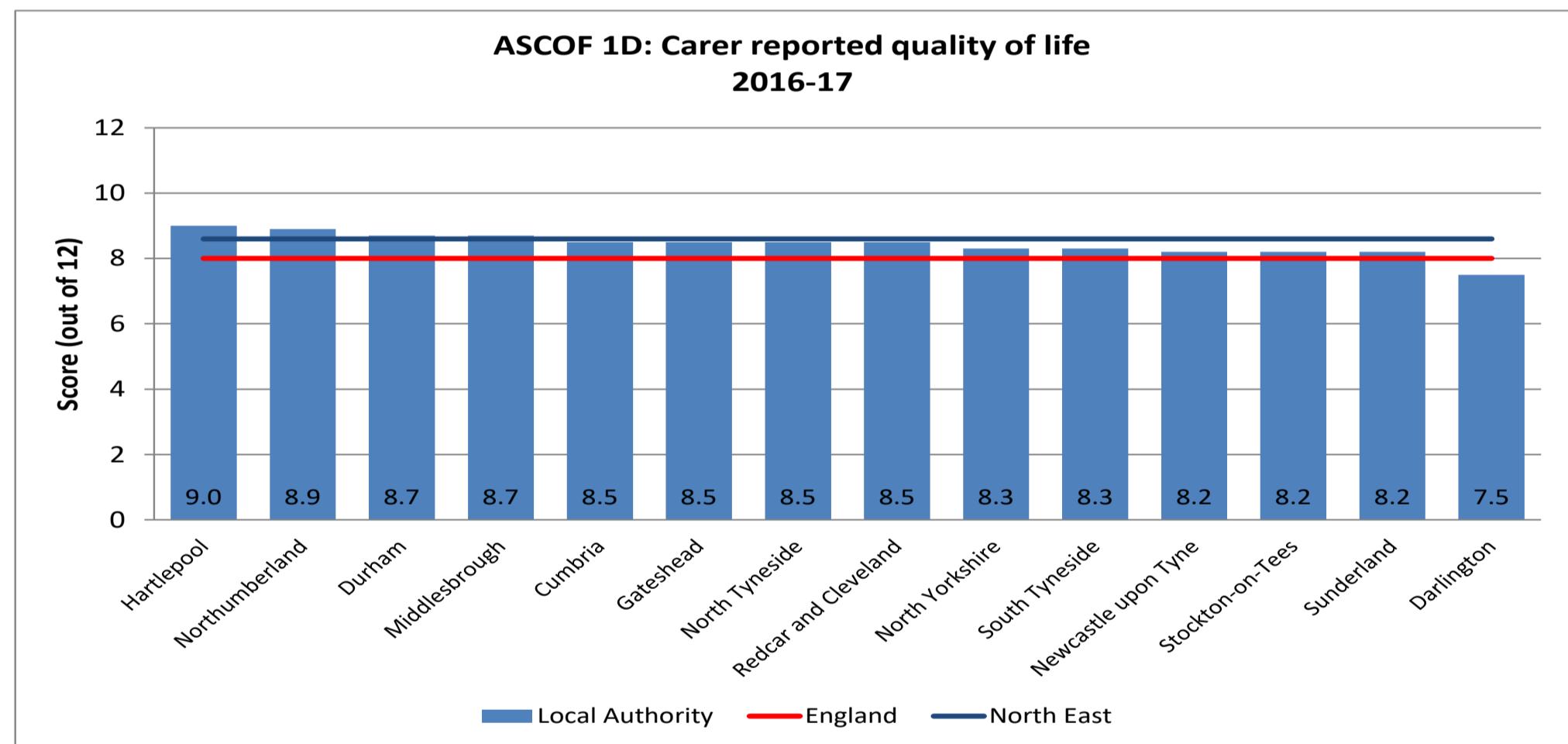
2. Proportion by all Local Authorities in England
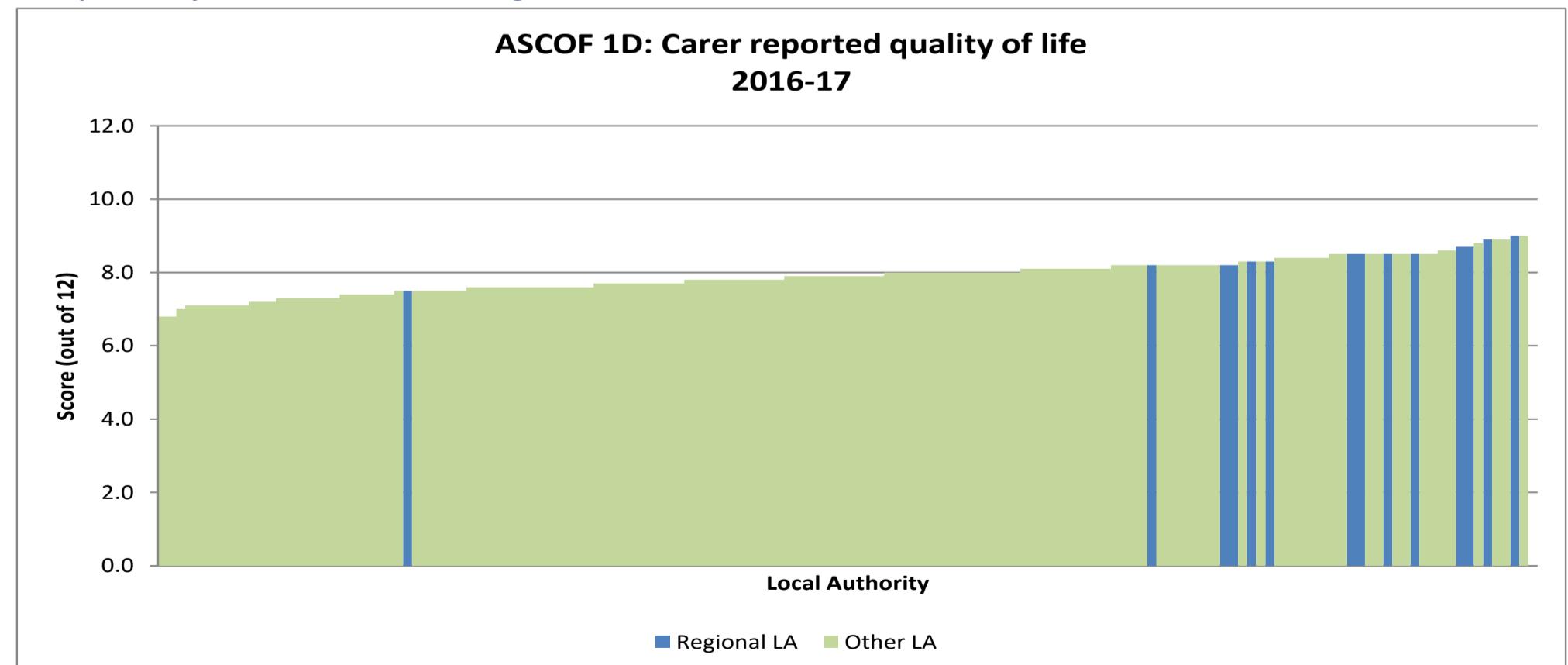
For additional information on this metric please refer to the supplementary appendix document.

12. Proposal to include an indicator to measure loneliness

Data source: Not yet agreed, Time period: To be determined

Rationale

Loneliness and social isolation are widely recognised as among the most significant and entrenched issues facing our ageing society. Social isolation is defined in terms of the quantity of social relationships and contacts experienced, and loneliness is a subjective experience which is a negative emotion associated with a perceived gap between the quality and quantity of relationships we have and those we want (*https://www.campaigntoendloneliness.org/wp-content/uploads/Promising-approaches-to-reducing-loneliness-and-isolation-in-later-life.pdf*).

There is a lack of high quality evidence to demonstrate the impact of different interventions on loneliness and a growing gap between the understanding of what constitutes a 'loneliness intervention' demonstrated in the academic literature and that of those involved in delivering interventions.

13. Proposal to include an indicator to measure the number of people referred into Social Prescribing Schemes

THE INFORMATION ON THIS PAGE IS NOT REGIONAL OR LOCAL DATA - PROVIDED FOR EXAMPLE ONLY

Rationale

Social prescribing is designed to support people with a wide range of social, emotional or practical needs, and many schemes are focussed on improving mental health and physical well-being. It is thought that recognising that people's health is determined primarily by a range of social, economic and environmental factors, social prescribing seeks to address people's needs in a holistic way. It also aims to support individuals to take greater control of their own health.

What is the data telling us?

Data for North East & Cumbria regional social prescribing schemes is not yet available, however the example below is taken from a Social prescribing report produced by the Bromley by Bow Centre (London) - report available here: *https://www.bbbc.org.uk/services/get-support-for-issues-affecting-your-health/social-prescribing-reports/*
The chart below shows the support that was required at initial referral into the Social Prescribing scheme, by client.

What does success or improvement look like?

Improvement would be achieving higher proportions of people with frailty accessing social prescribing schemes. As these schemes are still in development in some regions it is yet to be known how this metric will be measured.

Further information is in development by NHS England for developing a social prescribing standard outcomes framework (*https://www.england.nhs.uk/personalised-health-and-care/social-prescribing/*).

1. Example data - taken from Bromley by Bow Centre Social Prescribing Scheme (Tower Hamlets CCG Network)

Support need identified at initial referral
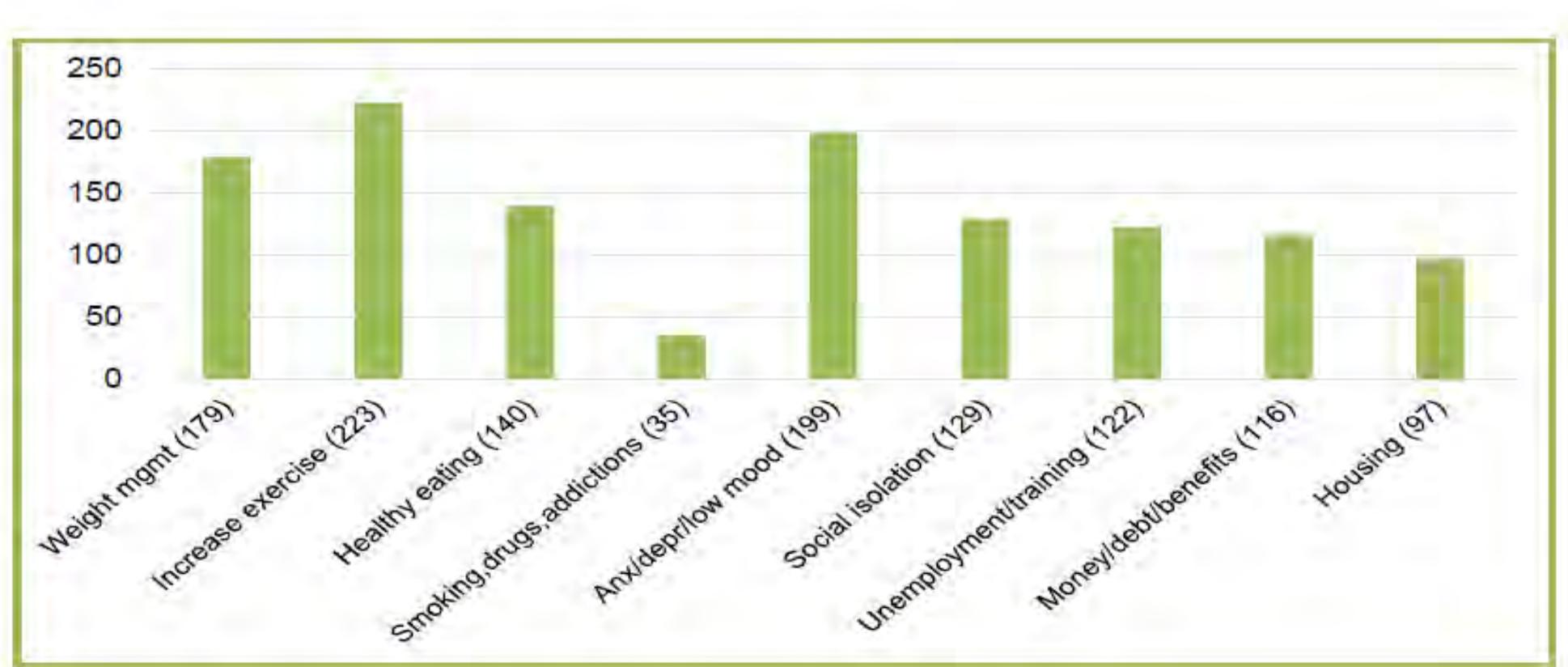
https://www.bbbc.org.uk/services/get-support-for-issues-affecting-your-health/social-prescribing-reports/

For additional information on this metric please refer to the supplementary appendix document.

14. A&E attendance rates for patients aged 65 years and over

A&E attendance rate per 1,000 population for patients aged 65 years and over

Data sources: Hospital Episode Statistics, Copyright © 2018, re-used with the permission of NHS Digital. All rights reserved. 2017/18 data is provisional.
Population for crude rate: https://digital.nhs.uk/data-and-information/publications/statistical/patients-registered-at-a-gp-practice/
Time period: To end of March 2018

Rationale

The volume of A&E attendances in England is increasing over time, and as a proportion of all attendances, the biggest growth is for those aged 65 years and over, which has increased from 17.7% in 2007/08 to 20.8% in 2016/17 (national data)[9]. A&E departments are under increasing pressure and some struggle to meet the target that 95% of people are seen and treated within 4 hours. There is a changing case-mix in recent years due to an ageing population and increasing numbers of people with long term conditions. Integrated care for vulnerable older people spanning GPs, social care and A&E departments has been shown to reduce unnecessary A&E attendances in this patient group.

What is the data telling us?

The data presented here relates only to attendances at A&E Type 1 departments (consultant-led, 24 hour service) and Type 3 departments (Other A&E / minor injury departments, doctor- or nurse-led). For 2017/18 there is a wide range in A&E attendance rates across the CNE region, from 294.4 per 1,000 population in Hambleton, Richmondshire and Whitby CCG to 598.1 in South Tyneside. The England and CNE region A&E attendance rates for this period are 419.8 and 439.4 per 1,000 population respectively. For this metric, Newcastle and Gateshead activity are reported separately.

The second chart shows that over time there is an increase in the A&E attendance rate (Type 1 and Type 3 departments) for all CNE CCGs and for England, and for some CCGs there are substantial variations over time, which may be due to changes in services provided by specific Trusts or A&E department Type recategorisation.

What does success or improvement look like?

- Initially a better understanding of the reasons for the wide variation in A&E attendance rates across the CNE region is required. These could relate to differences in patient pathways, the degree of integrated care in local health economies, the proportion of patients in care homes, and also to variations in hospital coding.

9. https://files.digital.nhs.uk/pdf/m/4/acci-emer-atte-eng-2016-17-rep.pdf

A&E attendance rate (per 1,000 population) for patients aged 65 years and over, in 2017/18
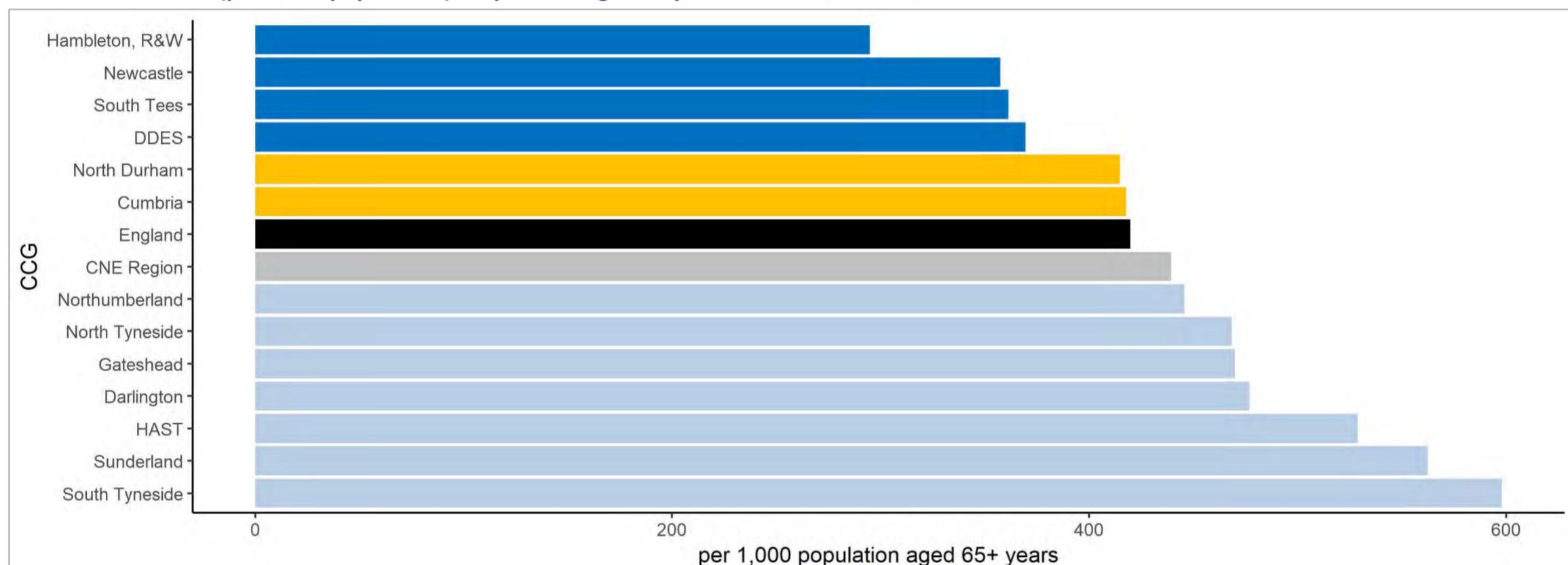
Trend in the A&E attendance rate (per 1,000 population) for patients aged 65 years and over, from 2011/12 to 2017/18
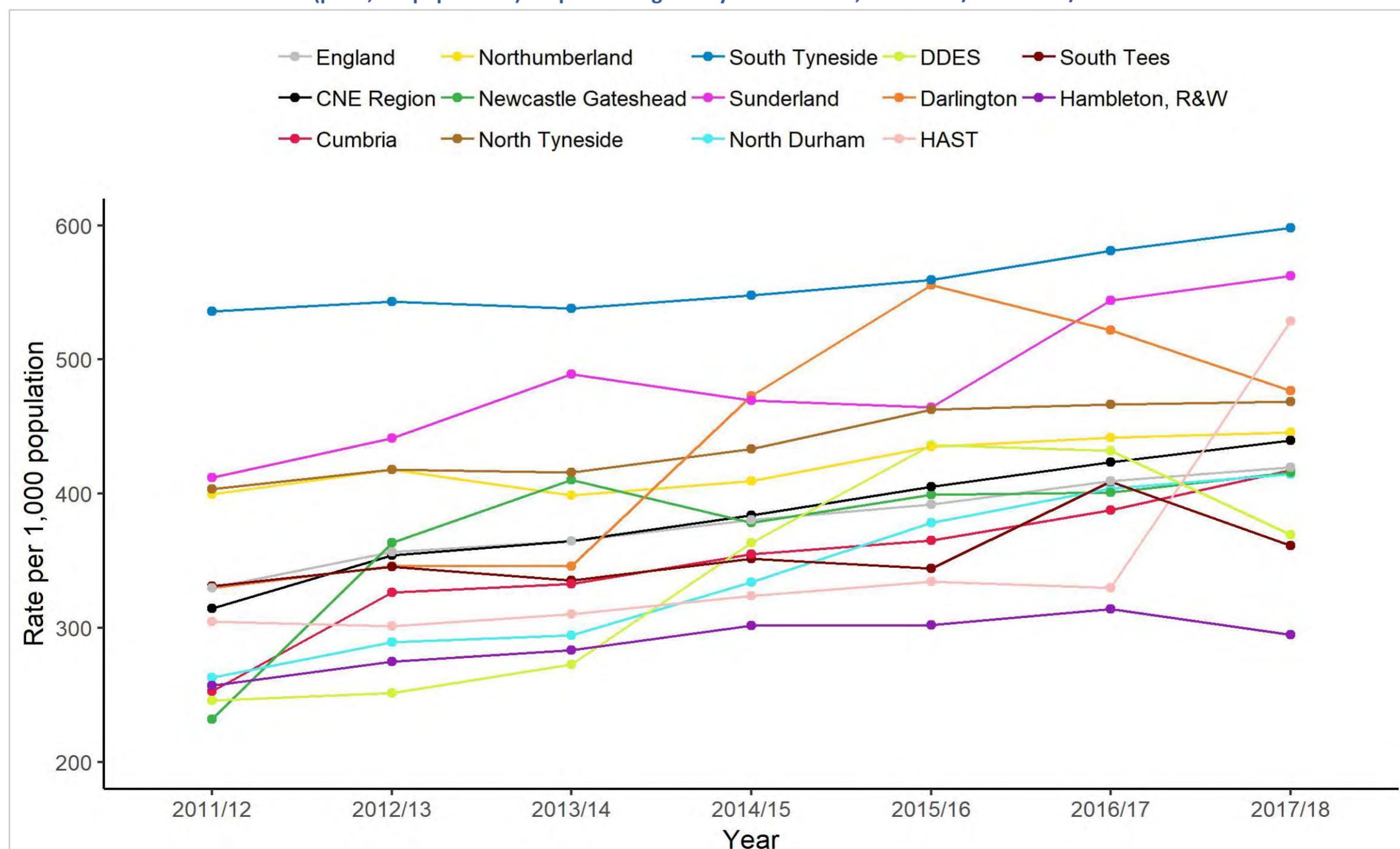
For additional information on this metric please refer to the supplementary appendix document.

15. Emergency hospital admission rates for patients aged 65 years and over

Emergency admission rate per 1,000 population aged 65 years and over (CCG)
Emergency admission rate per 1,000 population aged 65 years and over for injuries due to falls (LA)

Data sources: Hospital Episode Statistics, Copyright © 2018, re-used with the permission of NHS Digital. All rights reserved. 2017/18 data is provisional, and Public Health England (fingertips.phe.org.uk/),
Time period: Various - 2017/18 for HES, 2016/17 for PHE, and trend data from 2010/11.

Rationale

In the last four years, there has been a 12% rise in the number of emergency admissions of people aged 65 and over[10]. Demographic changes account for part of this rise, however it is important to identify the other drivers, such as the health state of the older population.

Falls are the largest cause of emergency admissions for older people, and significantly impact on long term outcomes, being a major cause of people moving to long-term nursing or residential care.

What is the data telling us?

The emergency admission rate at CCG level for those aged 65+ years is 273.4 per 1,000 population (2017/18) for the CNE region which is significantly higher than the England rate of 255.1 per 1,000 population. The rate varies across the CNE CCGs. Over time the trend in emergency admissions is upwards, with the region rate consistently higher than England.

The North East region has a signficantly higher rate of hospital admissions for injuries due to falls than England and the trend over time shows some fluctuation (data from 2016/17, reported at local authority level). At LA level (across CNE) there is wide variation in the emergency admission rate due to falls.

What does success or improvement look like?

- A better understanding of the reasons for the wide variation in activity for these measures across the region.
- Aim for a reduction in the emergency admission rate overall and also the admission rate relating to injuries due to falls.

10. https://www.nao.org.uk/press-release/reducing-emergency-admissions/

Emergency admission rate
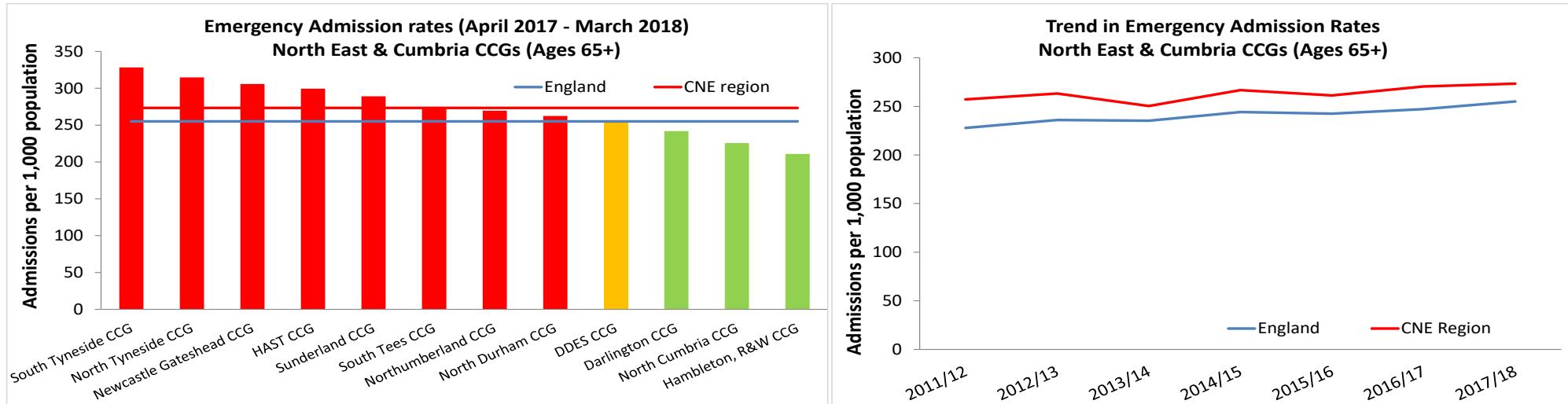
Emergency admission rate - injuries due to falls
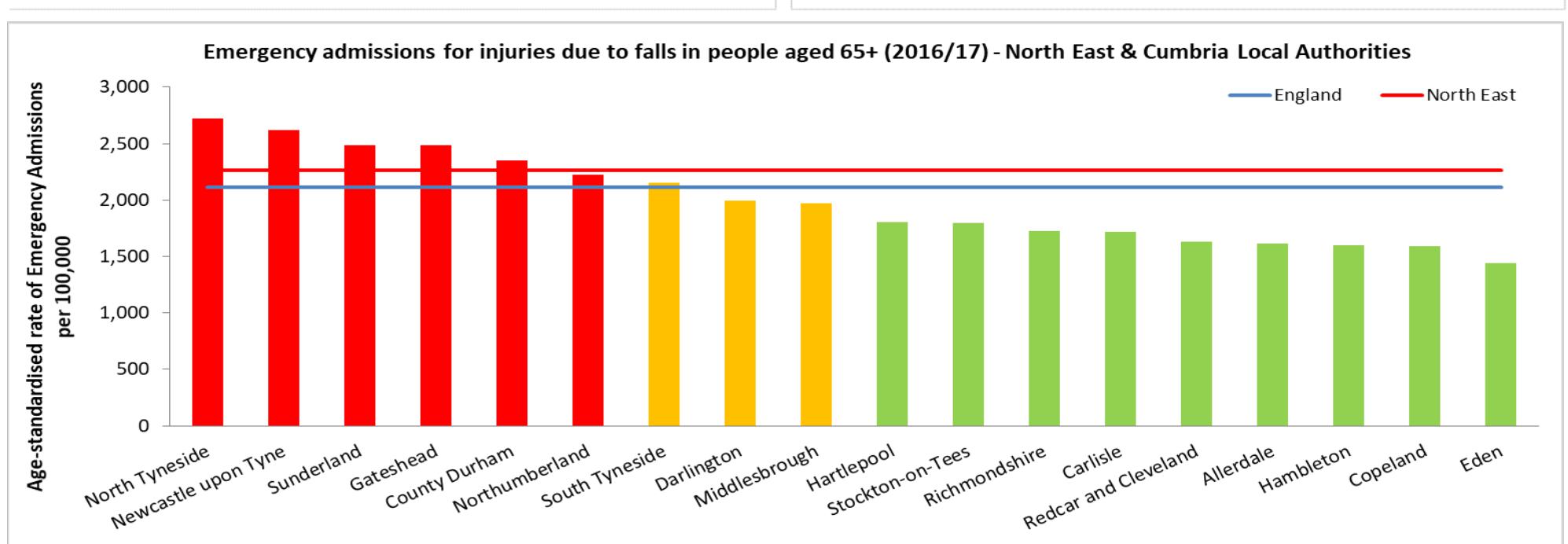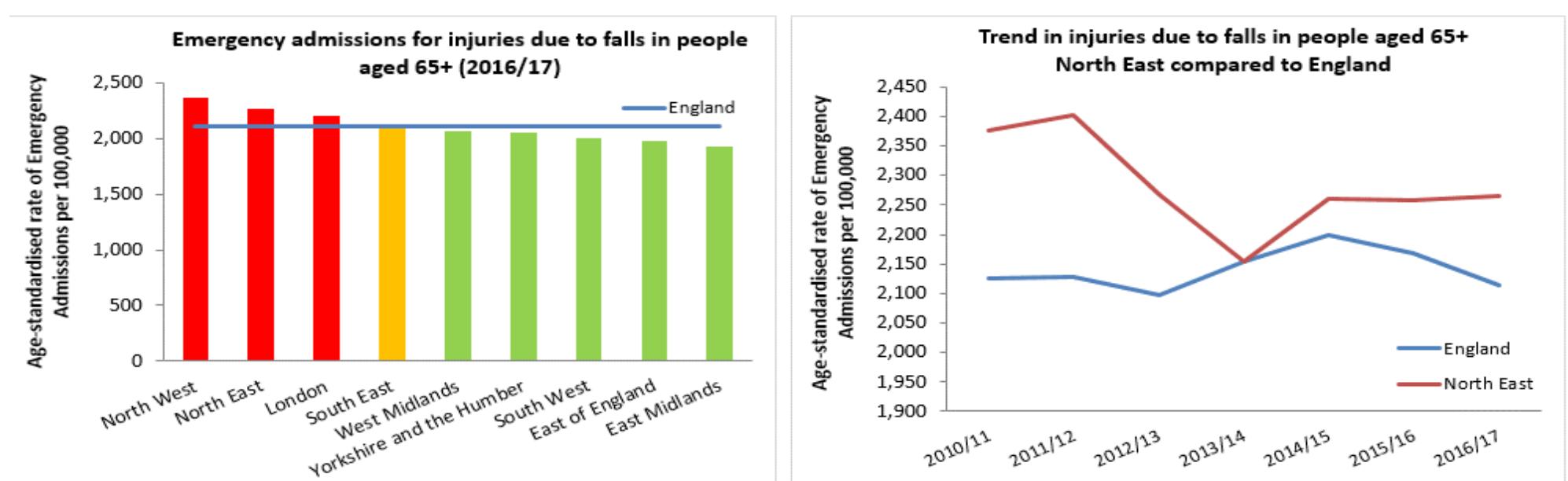
For additional information on this metric please refer to the supplementary appendix document.

16. Emergency readmissions within 30 days of discharge from hospital (patients aged 65 years and over)

This indicator shows the readmission rate relating to admissions of people who returned to hospital as an emergency within 30 days of discharge from their previous hospital admission

Data source: Hospital Episode Statistics, Copyright © 2018, re-used with the permission of NHS Digital. All rights reserved. 2017/18 data is provisional.
Time period: To end of March 2018

Rationale
The aim of this metric is to measure the success of the NHS in helping people to recover effectively from illnesses or injuries. Health and social care can play significant roles in putting in place the right reablement, rehabilitation and intermediate care services to support individuals to return home or regain their independence, so avoiding crisis in the short term.

What is the data telling us?
The 30 day readmission rate varies across the CNE region from 144.6 per 1,000 population in Hambleton, Richmondshire and Whitby CCG to 227.5 per 1,0000 population in South Tyneside CCG. The England and CNE region rates are 193.2 and 188.4 per 1,000 population, respectively. Based on this, the CNE region has a lower 30 day readmission rate than England overall. Five CCGs in the CNE region have rates which are significantly lower than England, and three CCGs have significantly higher rates.

What does success or improvement look like?
- Initially a better understanding of the reasons for the wide variation in 30 day readmission rates across the CNE region is required. These could relate to differences in patient pathways, the degree of integrated care in local health economies, the proportion of patients in care homes, and also to variations in hospital coding.

Directly standardised rate of emergency admissions to any hospital within 30 days of the previous discharge from hospital, by CCG (2017/18)
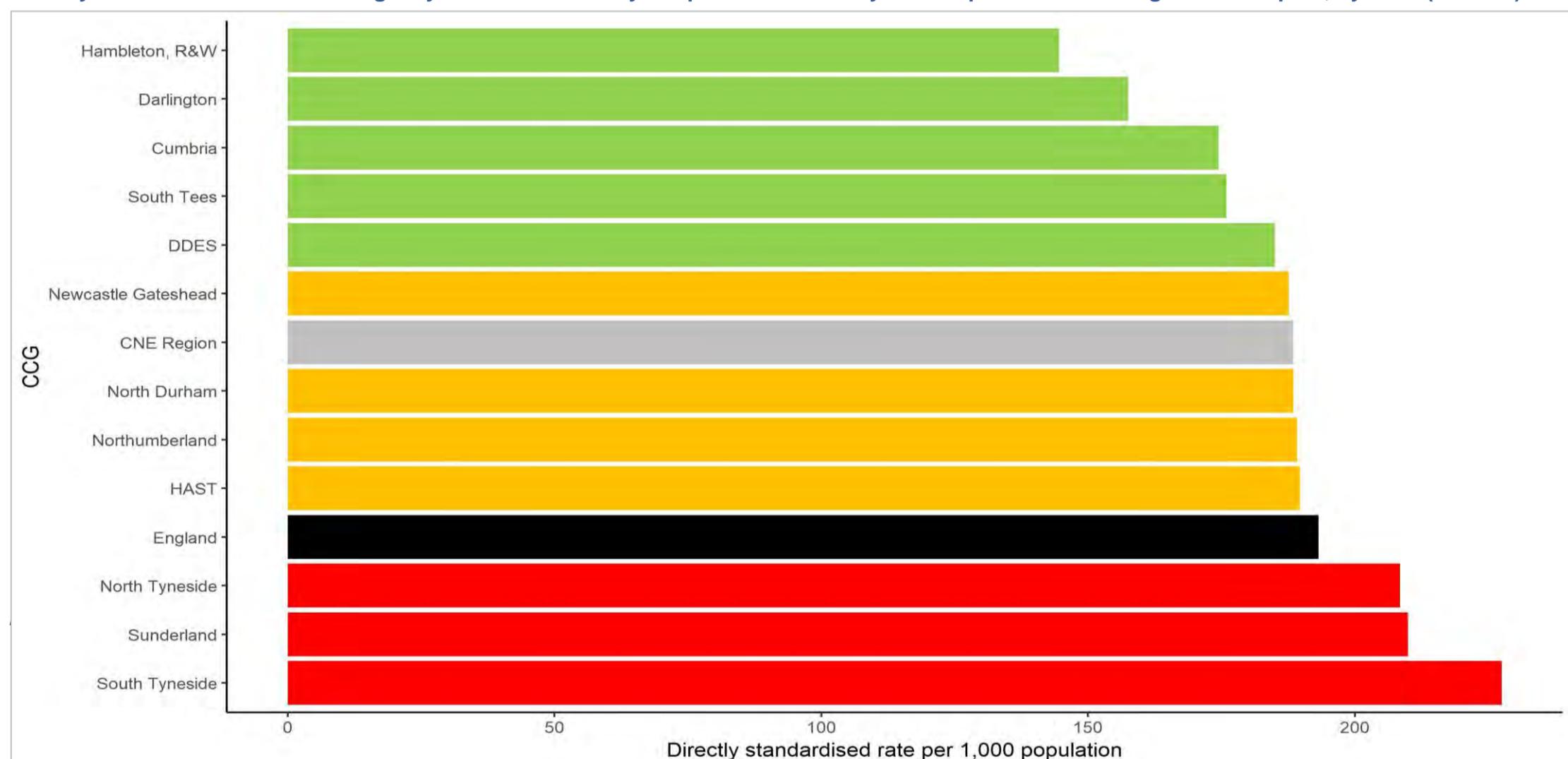
For additional information on this metric please refer to the supplementary appendix document.

17. Proportion of Stranded Patients in Hospital: Length of Stay 7+ and 21+ days

This indicator relates to In-Hospital Delays

Data source: SITREP (daily situation reports submitted by providers), *Time period:* 2017/18

Rationale

There is significant emphasis on reducing delayed transfers from hospitals and identifying clinical or system changes needed to support shorter and safer hospital stays. The 'stranded patient metric' is defined as the number of beds occupied by patients who have been in hospital 7 days or more, or 'super stranded' as 21 days or more. A proportion of these will have a truly significant illness or need which can result in longer stays following admission. However, a significant proportion will have spent 7 or more days in hospital potentially due to unnecessary waits in the system, such as waiting for a decision, a diagnostic test, an intervention, or a referral, for example.

What is the data telling us?

The data presented shows the Cumbria and North East region to have varied proportions of Stranded Patients with Northumbria Trust reporting 44.6% and Gateshead Trust reporting 18.6% for patients with a length of stay of 7 or more days. Note, Newcastle Trust have not yet provided data for this measurement. Super Stranded patient proportions are significantly lower with less variation reported between trusts. South Tyneside Trust reported a low of 2.9% of occupied beds by Super Stranded patients (more than 21 days).

This metric presently does not have a published regional or national benchmarking position for comparison.

What does success or improvement look like?

Improvement would be achieving lower proportions of patients requiring a longer length of stay following a hospital admission and being reported as a 'stranded patient'. In terms of the impact on frailty, reducing proportions of this metric will show that there are processes in place to optimise getting frail or vulnerable patients back into the community as soon as medically fit to avoid the loss of ability to self care and remain at a level of independence.

1. Proportion of stranded patients by NHS hospital Trust, 2017/18
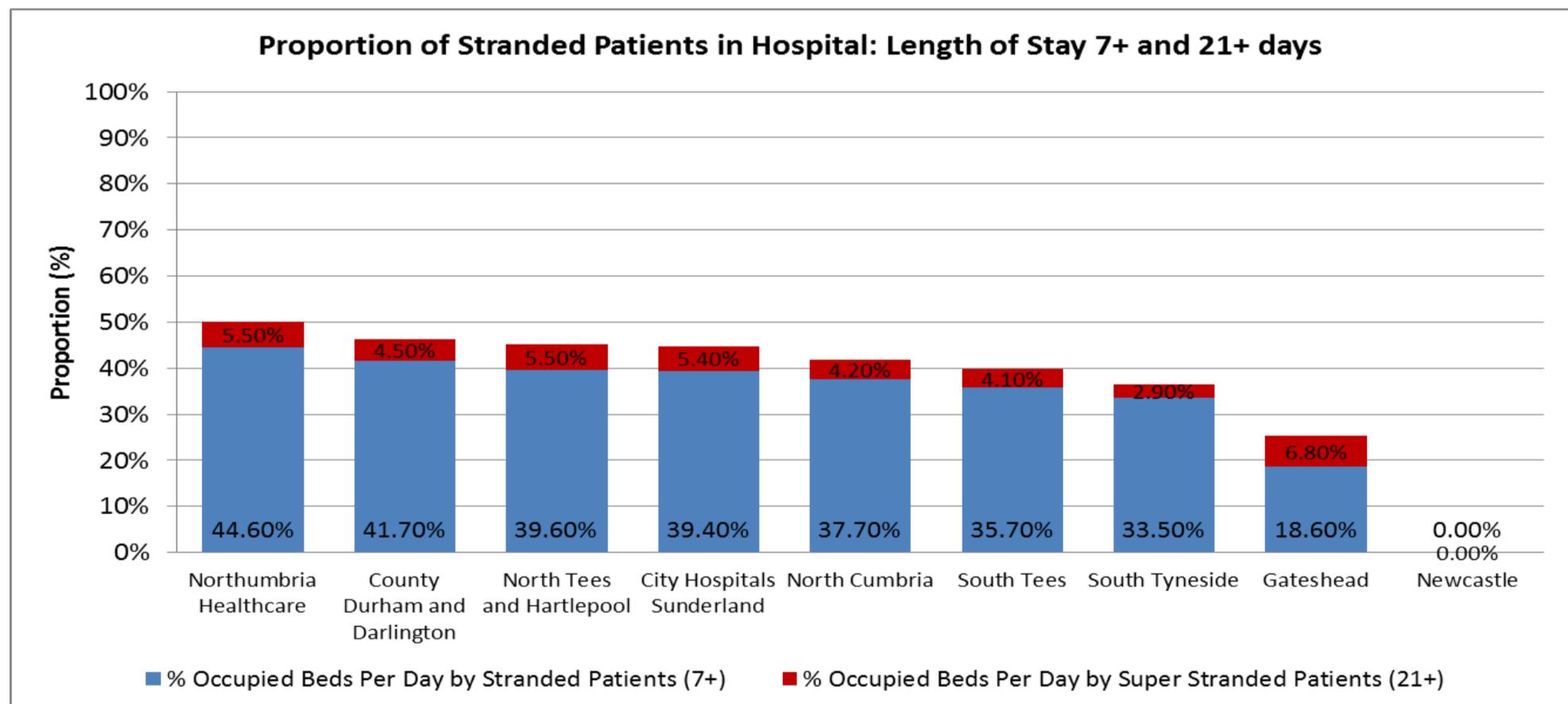
For additional information on this metric please refer to the supplementary appendix document.

18. Conversion rates from A&E attendance to hospital admission

This indicator shows the conversion rate from A&E attendance to emergency admission for patients aged 65+years (FY 2017/18)

Data sources: Hospital Episode Statistics, Copyright © 2018, re-used with the permission of NHS Digital. All rights reserved. 2017/18 data is provisional, Time period: To end of March 2018

Rationale
Conversion rates from A&E attendance to hospital admission vary by hospital and account for variation in avoidable admission rates once demand for A&E has been adjusted for. The conversion of an A&E attendance to an admission has a considerable impact on the cost of care. Conversion rates could be reduced by ensuring that support services are available to allow for discharge or by evaluating clinical decision-making in their A&E departments to ensure that it is optimal.

What is the data telling us?
The A&E attendance to emergency admission conversion rate for 2017/18 varies substantially across the CNE region from 19% in Sunderland CCG to 44% in South Tyneside. The England and CNE region conversion rates for this period are 41% and 35% respectively, and the majority of CNE CCGs have a conversion rate lower than the England rate. For this metric, Newcastle and Gateshead activity are reported separately. It is possible that variation can be due to differences in patient pathways and data recording across the hospital Trusts and the availability of services such as ambulatory care within the inpatient setting.

The second chart shows that over time there is a steady decrease in the conversion rate for all CCGs and for England, although fluctuations are observed for some CCGs. For the latest financial year the conversion rate for patients registered within Sunderland CCG has reduced by half. This may be due to changes in pathways or data recording and may need further investigation.

What does success or improvement look like?
- Initially a better understanding of the reasons for the wide variation in conversion rates across the CNE region is required. These could relate to differences in the case-mix seen at A&E, differences in patient pathways, the degree of integrated care and access to primary and community services in local health economies, and also to variations in hospital coding.

- Sharing of good practice from areas with lower conversion rates, such as where services and schemes in place to improve access to alternative community or primary care services that care for long-term conditions at the time of need, or alternative settings for effective treatment that reduce the need for hospital admission.

A&E attendance to emergency admission conversion rate (patients aged 65+ years, 2017/18)
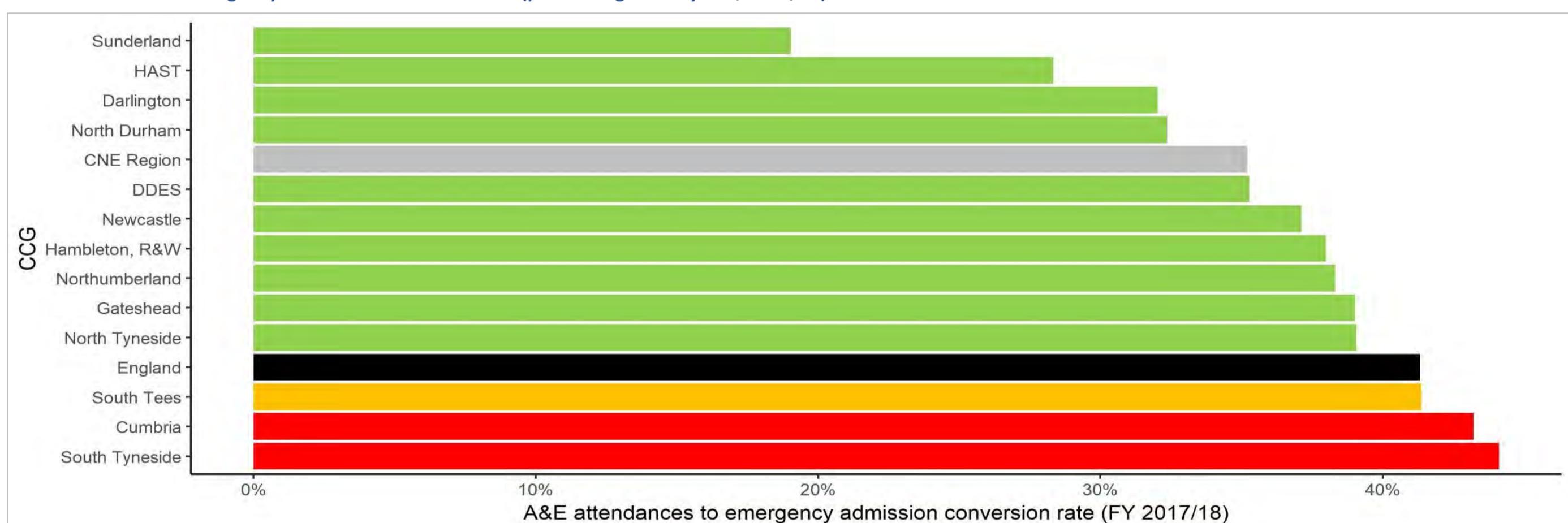
A&E attendance to emergency admission conversion rate (patients aged 65+ years, trend over time)
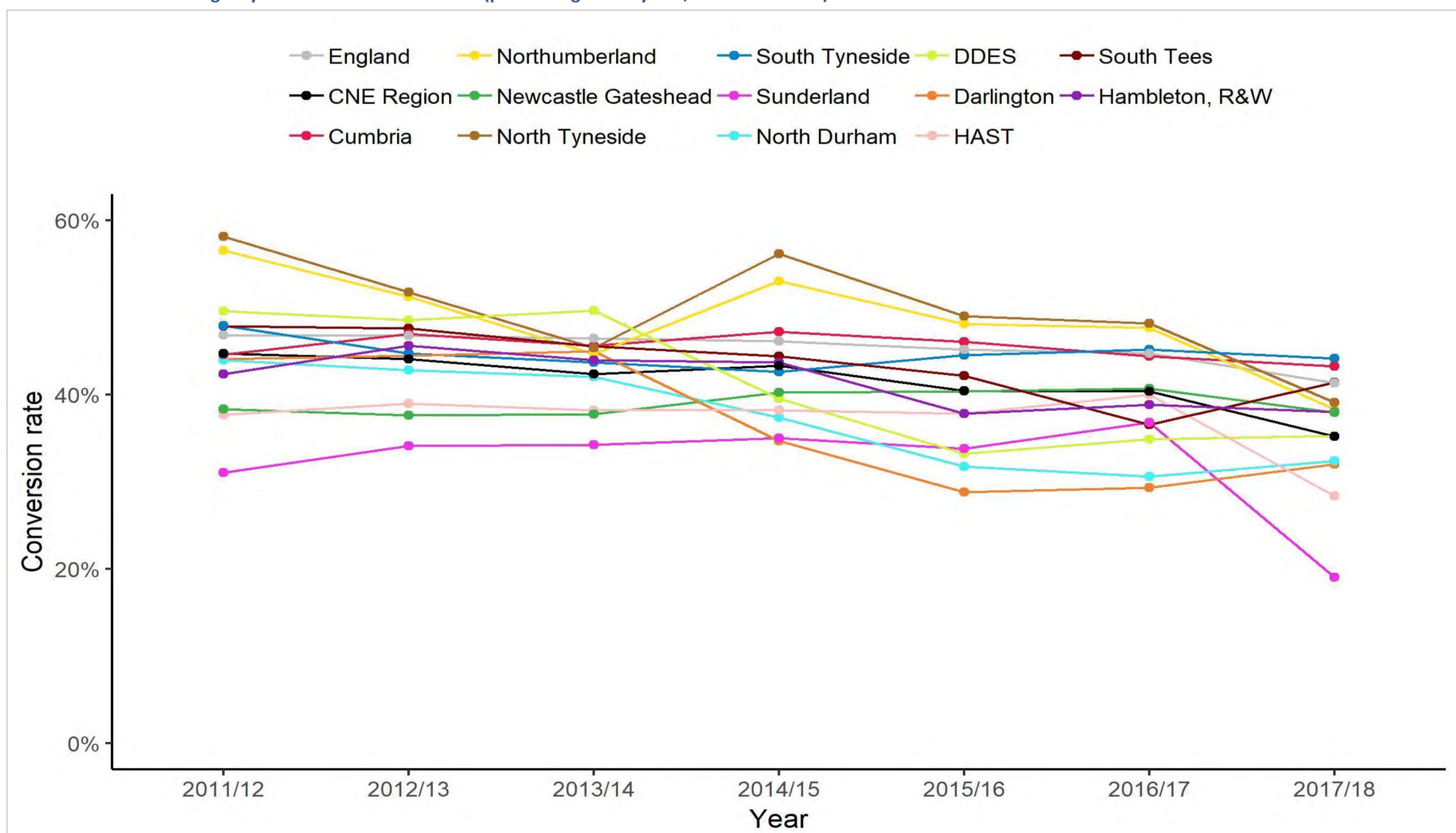
For additional information on this metric please refer to the supplementary appendix document.

19. Hospital activity in the last year of life

The aim of this indicator is to present hospital activity in the last year of life by CCG, for patients aged 65 years and older who died in hospital

Data sources: Hospital Episode Statistics, Copyright © 2018, re-used with the permission of NHS Digital. All rights reserved. 2017/18 data is provisional. Time period: 2017/18

Rationale

Emergency admissions to hospital for people in the last year of life are a substantial and often avoidable burden on the NHS. In 2016, there were over 1.6 million emergency admissions for people in the last year of their life, amounting to around 11 million days in hospital, costing the NHS £2.5 billion. While emergency admissions for people in the last year of life are sometimes necessary, they can often be avoided entirely if adequate care in the community is provided[11].

The data described here relates to patients aged 65 years and over who died following an emergency admission in hospital at Trusts in the CNE region in 2017/18, and the proportion of their last year of life that they were an admitted patient is presented. Patients who spent the whole year in hospital have been excluded from the 'max' part of the chart.

At this stage the data has been presented for *discussion only*, to gain an understanding of whether this is a useful metric to retain, based on both what it is telling us and the interpretation of the chart, and what 'good' looks like.

What is the data telling us?

The box and whiskers chart below indicates, for each CCG in the CNE region, the average percentage of days spent in hospital in the last year of life (for patients aged 65 years and over who subsequently died in hospital). This ranges from 6.03% (22 days) in North Durham CCG to 9.45% (35 days) in North Tyneside CCG, compared to the CNE average of 7.35%. No national benchmark is available.
The lower and upper ends of the 'box' represent the 25th and 75th centiles, and the lower and upper lines indicate the minimum and maximum proportion of days in hospital by patients in this group in each CCG.

What does success or improvement look like?

An understanding of the reasons for variation across the CNE region, such as patient pathways at end of life, primary and community service availability, and other factors which may affect this measure. This links to indicator 23 (deaths in the usual place of residence).

11. https://www.mariecurie.org.uk/globalassets/media/documents/media-centre/2018/emergency-admissions-report.pdf

The percentage of the last year of life spent in hospital, for patients aged 65 years and over who died in hospital in 2017/18
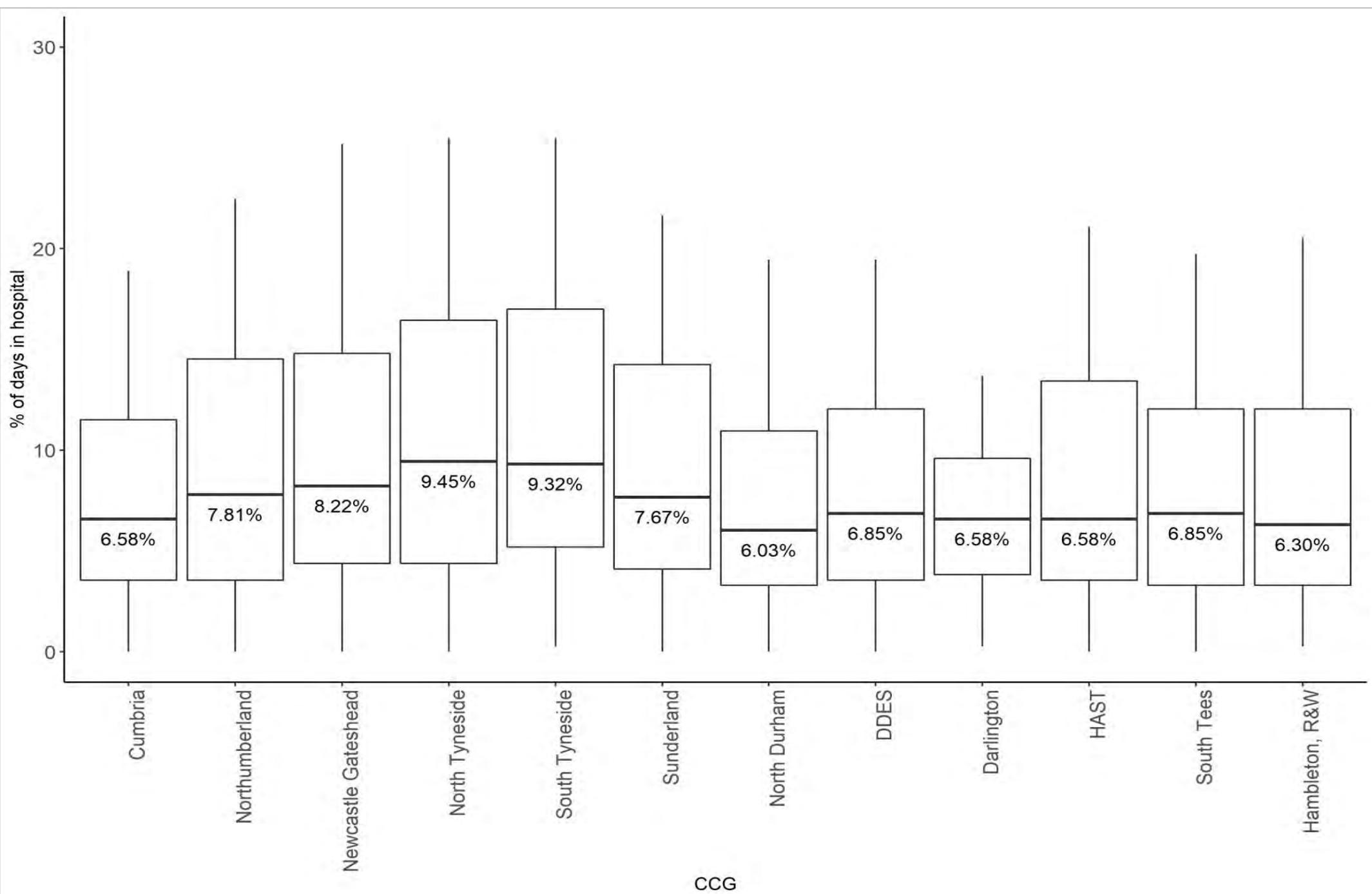
For additional information on this metric please refer to the supplementary appendix document.

20. Hospital Trust indicator set

The indicators presented here relate to Falls with harm, Pressure ulcers, Patient experience of hospital care and A&E waiting times (<4 hours)

Data sources: NHS Digital (NHS Outcomes Framework Indicators - August '18 release), NHS Safety Thermometer (https://www.safetythermometer.nhs.uk/), NHS England (https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/), *Time period:* Covers 2017/18 and 2018/19

Rationale

Two metrics are from the Safety Thermometer, the aim of which is to provide a tool to support and help drive local improvement initiatives involving common harms. Falls and pressure ulcers are especially pertinent to older people who, experiencing more healthcare intervention, are at risk of multiple harms. Patient experience of hospital care is a qualitative measure based on scores from the National Inpatient Survey, and patients waiting less than four hours in A&E before admission, transfer or discharge relates to rights and pledges in the NHS Constitution.

What is the data telling us?

The proportion of falls with harm varies across the CNE region Trusts from 0.15% at Newcastle hospitals to 0.87% at Northumbria FT, compared to 0.46% for the Region. Regarding pressure ulcers (all), the proportion reported ranges from 0.22% at North Tees FT to 9.15% at South Tyneside FT. There is an England average for each category of Trust to enable a fair comparison. Lower rates of falls with harm and pressure ulcers reported are linked to better patient safety, care quality and experience.

All nine hospital Trusts in the CNE region have a higher rate of patient experience than the England rate, with 7 Trusts in the top quintile for this measure.

The proportion of patients waiting less than 4 hours in A&E ranges from 85.9% at Sunderland FT to 94.9% at South Tees FT. This data has been plotted against the total A&E attendances in the period, to provide the waiting time in the context of the total number of A&E attendances.

What does success or improvement look like?

- An awareness of the variations at Trust level across the region for these four measures and identification of priority areas to focus.

Falls with Harm (July 2018)

| Trust	Falls with Harm Number	Falls with Harm %	England Average	Region Average	England Worst	England Range	National Trend
CDD	9	0.74	0.34	0.46	1.24		
Gateshead	4	0.54	0.49	0.46	2.27		
Newcastle	3	0.15	0.28	0.46	1.04		
North Cumbria	2	0.43	0.49	0.46	2.27		
North Tees	3	0.34	0.49	0.46	2.27		
Northumbria	15	0.87	0.34	0.46	1.24		
South Tees	6	0.41	0.34	0.46	1.24		
South Tyneside	3	0.31	0.49	0.46	1.78		
Sunderland	1	0.17	0.34	0.46	1.24		
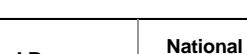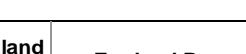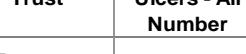
Pressure ulcers (all) - July 2018

Trust	Pressure Ulcers - All Number	Pressure Ulcers - All %	England Average	Region Average	England Worst	England Range	National Trend
CDD	25	2.06	4.39	4.28	9.55		
Gateshead	17	2.28	4.28	4.28	14.20		
Newcastle	77	3.79	3.65	4.28	8.13		
North Cumbria	17	3.68	4.28	4.28	14.20		
North Tees	2	0.22	4.28	4.28	14.20		
Northumbria	91	5.27	4.39	4.28	9.55		
South Tees	85	5.85	4.39	4.28	9.55		
South Tyneside	89	9.15	5.13	4.28	17.01		
Sunderland	29	4.99	4.39	4.28	9.55		
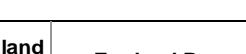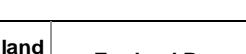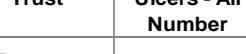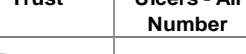
Patient experience of hospital care (score out of 100), 12 months to January 2018)
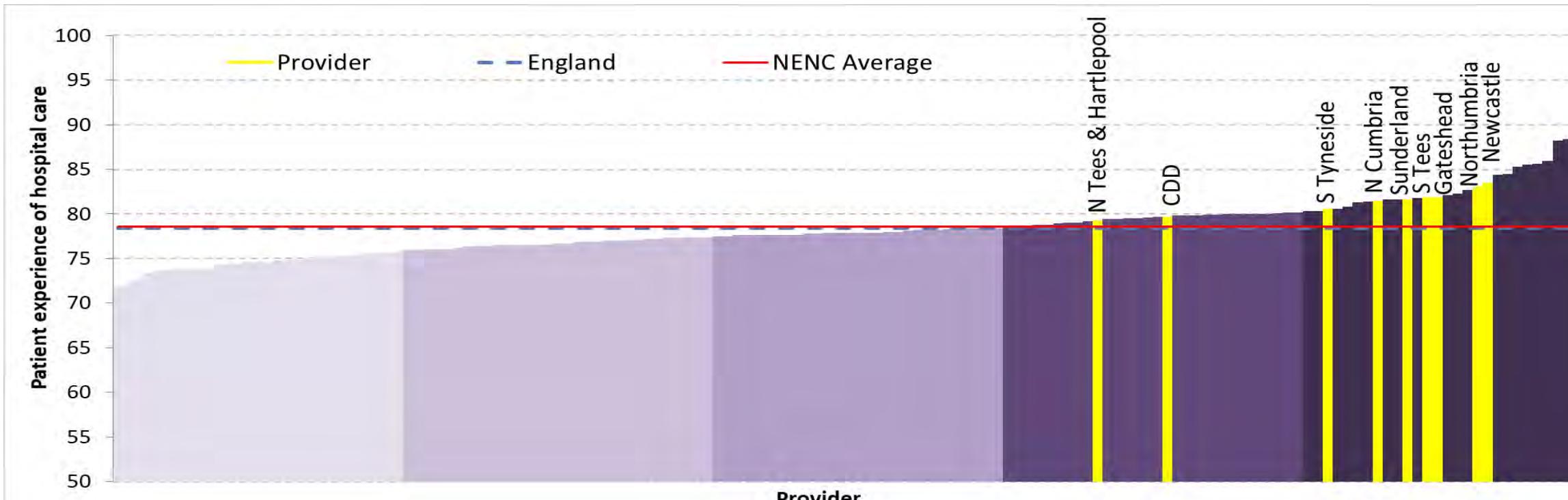
The proportion of patients attending Type 01 A&E departments where the time waited from arrival to admission, transfer or discharge was less than 4 hours (2017/18)
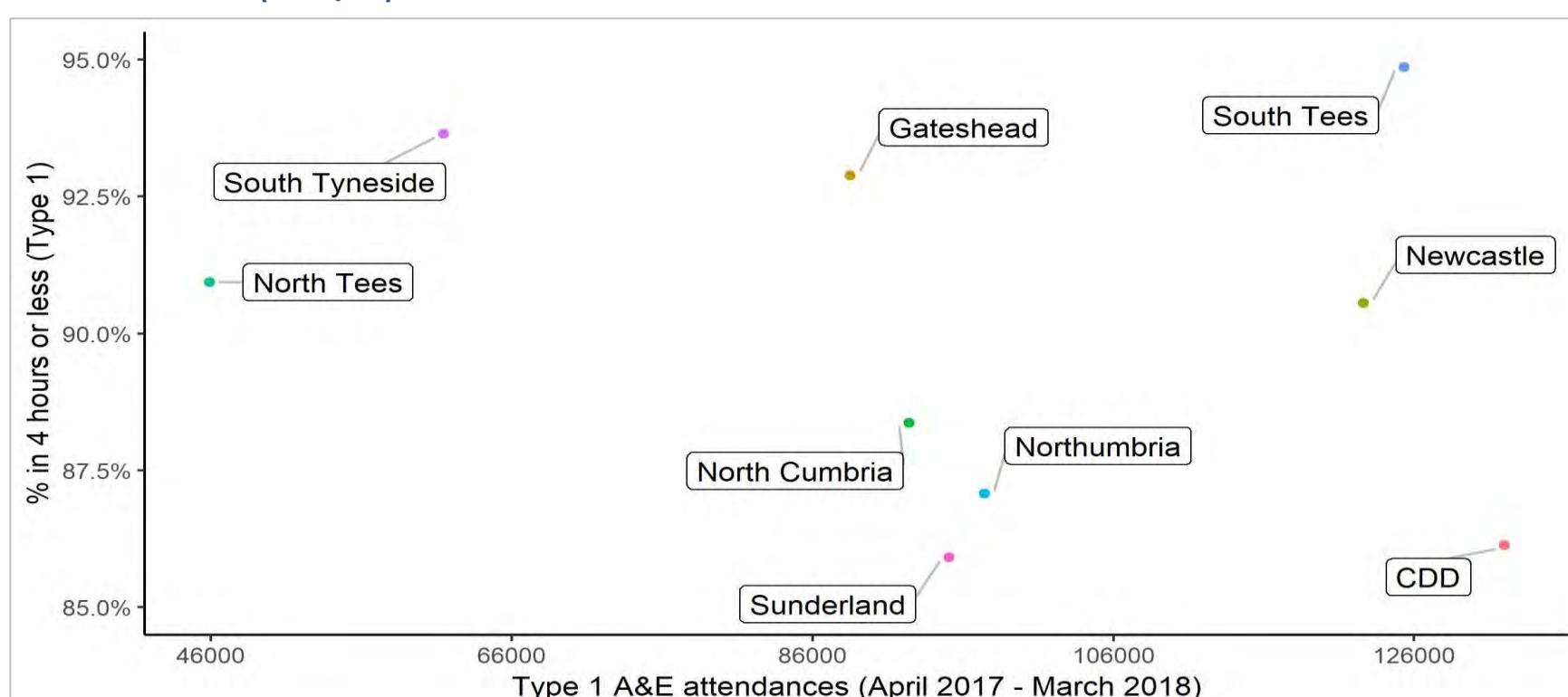
For additional information on these metrics please refer to the supplementary appendix document.

21. The proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services

Delaying and reducing the need for care and support (taken from ASCOF 2B(1))

Data source: NHS Digital (https://digital.nhs.uk/data-and-information/publications/clinical-indicators/adult-social-care-outcomes-framework-ascof/current), Time period: 2016/17

Rationale

There is strong evidence that reablement services lead to improved outcomes and value for money across the health and social care sectors. Reablement seeks to support people and maximise their level of independence, in order to minimise their need for ongoing support and dependence on public services.   This measures the benefit to individuals from reablement, intermediate care and rehabilitation following a hospital episode, by determining whether an individual remains living at home 91 days following discharge – the key outcome for many people using reablement services. It captures the joint work of social services, health staff and services commissioned by joint teams, as well as adult social care reablement.

What is the data telling us?

The data presented shows the North East region to have a higher proportion (85.3%) than the England average (82.5%) for this indicator. There is some variation between regional local authorities with North Tyneside achieving the highest outcome (92.3%) compared to Stockton-on-Tees reporting the lowest outcome (75.3%). Cumbria has also been included for the scope of this project. Challenging targets have been set for some local areas in this measure.

What does success or improvement look like?

This indicator is currently included in Better Care Funding reporting for the North East and therefore likely to be high priority across Local Authorities in maximising independence for service users following a spell in hospital. The aim is to achieve high proportions of older people being independent in their own homes, which helps to reduce or delay any further needs for Long Term services. In terms of the impact on frailty, increasing proportions of this metric will show that there are effective Reablement services in place enabling people to stay in their own homes for longer.

1. Proportion by Local Authority (CASSR Level)
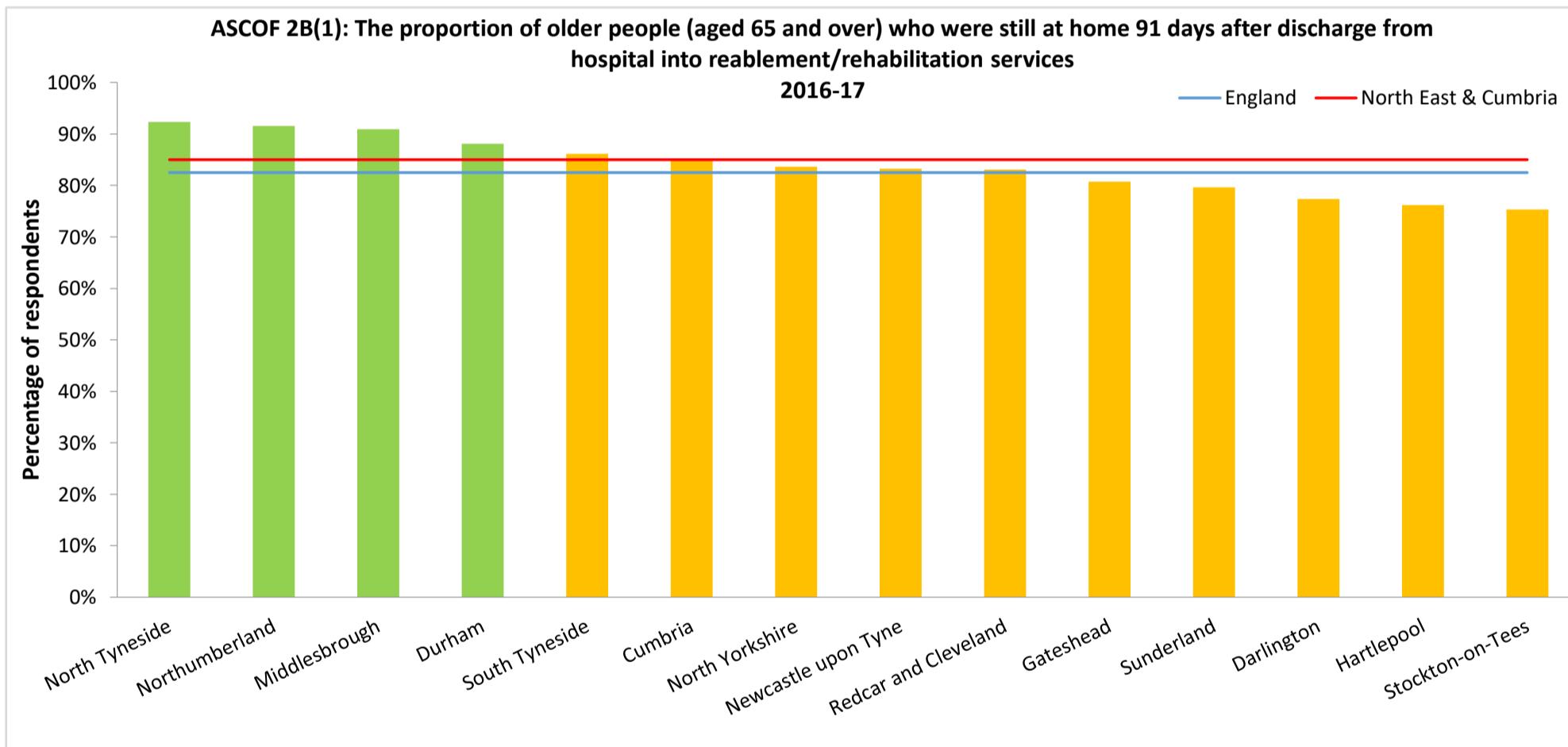
2. Proportion by all Local Authorities in England
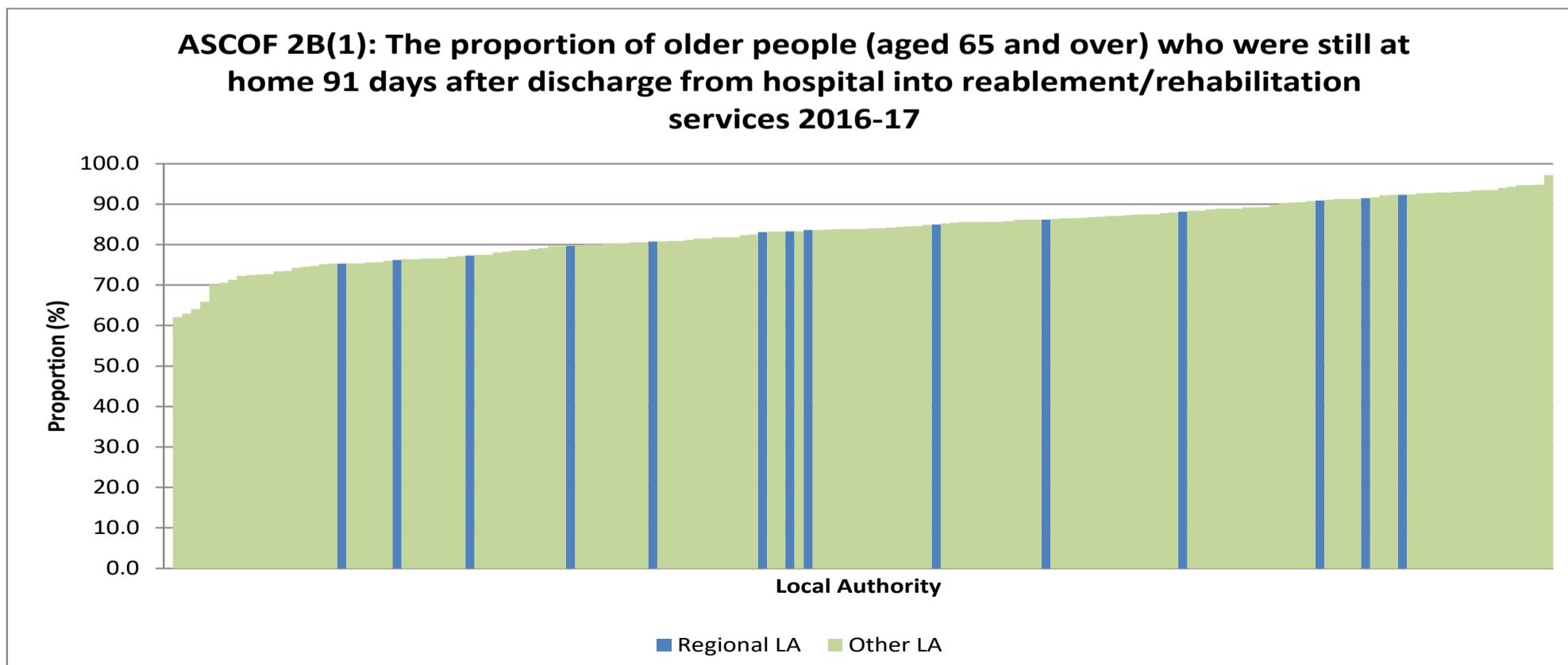
For additional information on this metric please refer to the supplementary appendix document.

22. Long-term support needs of older adults (aged 65 and over) met by admission to residential and nursing care homes

Delaying and reducing the need for care and support (taken from ASCOF 2A(2))

Data source: NHS Digital (https://digital.nhs.uk/data-and-information/publications/clinical-indicators/adult-social-care-outcomes-framework-ascof/current), *Time period:* 2016/17

Rationale

Avoiding permanent placements in residential and nursing care homes is a good measure of delaying dependency, and the inclusion of this measure in the framework supports local health and social care services to work together to reduce avoidable admissions. Research suggests that, where possible, people prefer to stay in their own home rather than move into residential care. However, it is acknowledged that for some client groups, admission to residential or nursing care homes can represent an improvement in their situation due to a significant care need.

What is the data telling us?

The data presented shows the North East region to have a higher proportion per 100,000 population (837.9) than the England average (610.7) for this indicator. There is variation between regional local authorities with Redcar & Cleveland reporting the highest proportion of permanent admissions (959.3) compared to Durham reporting a low proportion of admissions (762.7). Cumbria and North Yorkshire have also been included for the scope of this project, but will not be included in the North East regional figure.

What does success or improvement look like?

Improvement would be achieving lower proportions of older people being admitted into a permanent residential or nursing placement. In terms of the impact on frailty, reducing proportions of this metric will show that there are alternative services in place for support needs enabling frail people to stay in their own homes for longer. It is recognised however, that for some people with significant care needs an admission to a care home may be the most suitable option.

1. Proportion by Local Authority (CASSR Level)
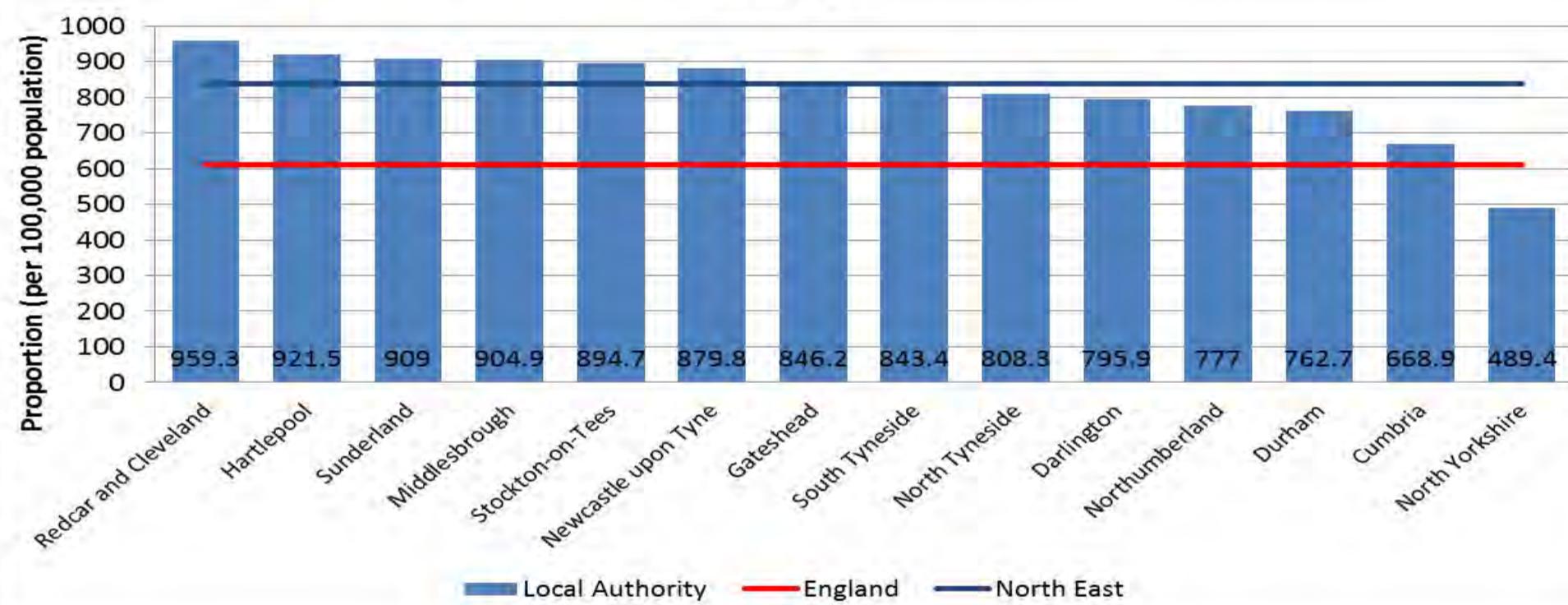
2. Proportion by all Local Authorities in England

For additional information on this metric please refer to the supplementary appendix document.

23. Proportion of deaths in usual place of residence

Number of deaths registered in each area where the place of death is recorded as the usual place of residence for the patient (i.e. at home, care home or religious establishment)

Data source: www.endoflifecare-intelligence.org.uk/data_sources/place_of_death, Time period: 2017/18

Rationale

Survey data suggest that many people would, given the choice, prefer to die at home, with few wishing to die in hospital. The proportion of deaths in 'usual place of residence' is a key indicator for end-of-life care and acts as a proxy quality marker for choice and access[12]. Usual place of residence includes deaths that occurred at home, in a care home or a religious establishment. It must not be assumed however that the patient died in their preferred place of death, which may not have been their usual place of residence.

What is the data telling us?

The data presented in the top left chart shows the proportion of deaths in the usual place of residence and relates to ALL deaths, not limited to those aged 65+ years. The North East and North Cumbria area has a higher rate of deaths in the usual place of residence than England overall however there is variation across the CCGs from 43.1% in both Sunderland and South Tyneside CCGs to 53.7% in North Tyneside CCG.

The top right chart shows all deaths for each CNE region CCG in the period by place of occurrence and shows that just over 25% of deaths (8,532) in the period occurred at home, which is higher than the England rate of 23.5%.

The trend over time charts underneath indicate an increase in the proportion of deaths in usual place of residence for the region, but not for all CCGs. There may be specific local reasons for this.

What does success or improvement look like?

Increase in deaths in usual place of residence to continue.

12. http://www.qualitywatch.org.uk/indicator/dying-home

Proportion of deaths in usual place of residence (2017/18)
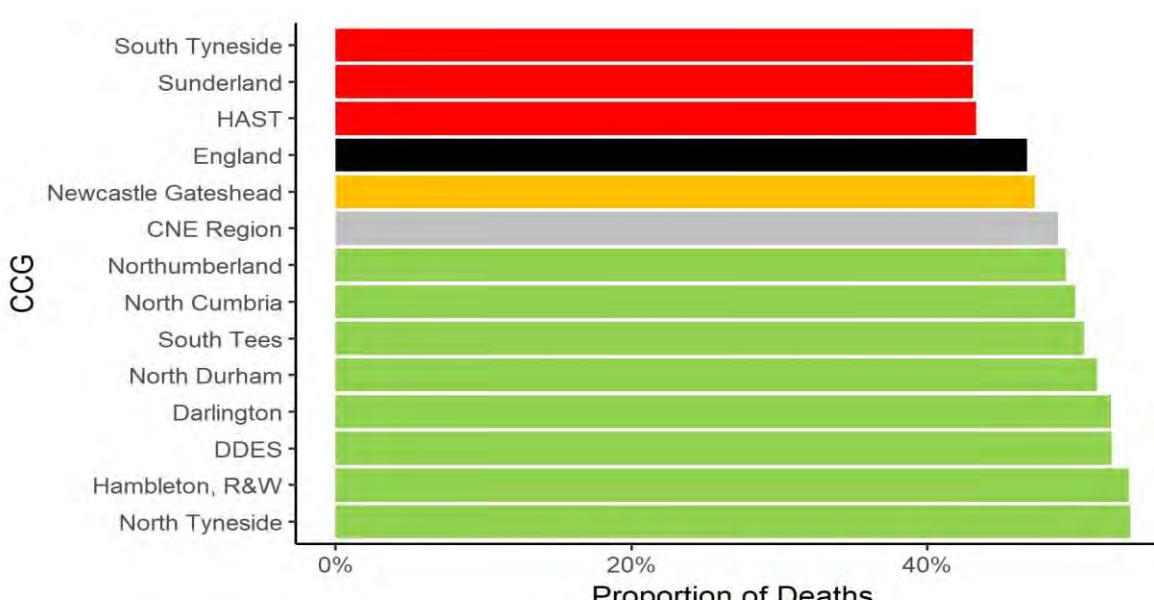
Proportion of deaths by place of occurrence (2017/18)
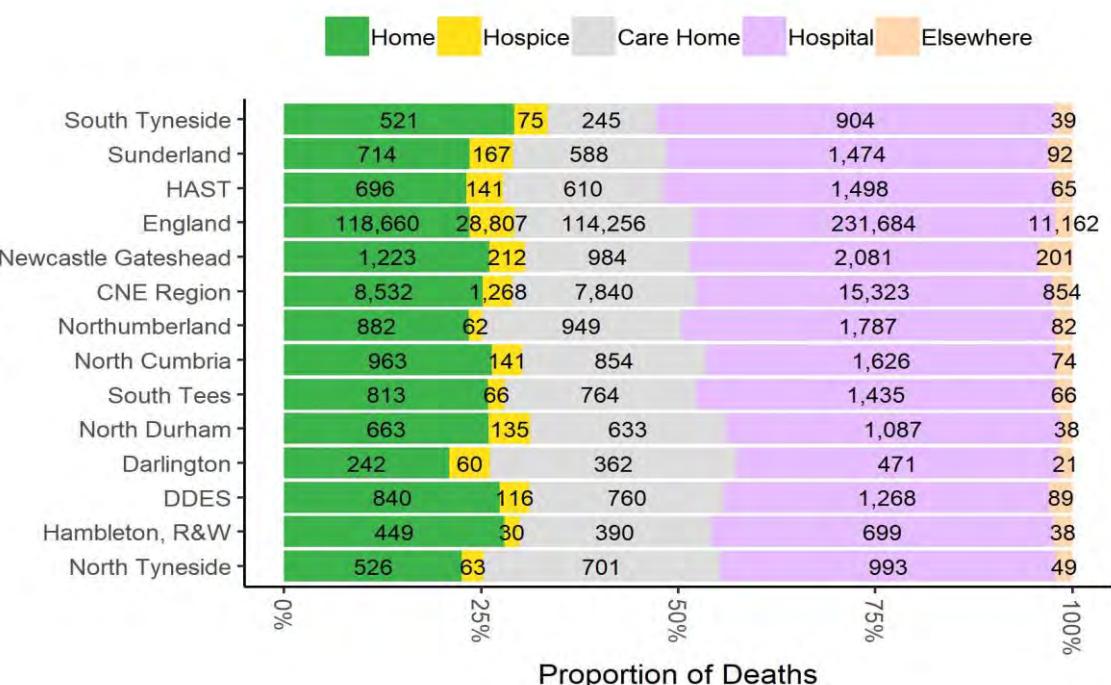
Proportion of deaths in usual place of residence (trend over time by CCG)

For additional information on these metrics please refer to the supplementary appendix document.