Academic Health Science Network
North East and North Cumbria

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NHS
North East Quality Observatory Service

Regional Frailty Community of Practice

Intelligence for the North East & North Cumbria area

Supporting Information

Version 1.0 FINAL DRAFT

September 2018

Supporting information for metrics report

This paper is to be read in conjunction with the Regional Frailty Community of Practice report, published in September 2018.

This paper contains:

a. A summary table which indicates the current organisational level presented for each metric, whether further breakdown and reporting is possible, and the frequency that the data is made available

b. Additional information at metric level to support the Regional Frailty Community of Practice report.

Metric availability

	Part of system	Metric	Current presentation	Further breakdown possible?	Timeliness
1	Primary Care	Patients aged 65 years or over who have had a frailty assessment	**CCG**	**Yes, GP practice**	**Q**
2	Primary Care	Patients aged 65 years or over who are identified as living with frailty, and the severity of their condition	**CCG**	**Yes, GP practice**	**Q**
3	Primary Care	Patients aged 65 years and over with moderate or severe frailty who are recorded as having had a fall in the preceding 12 months	**CCG**	**Yes, GP practice**	**Q**
4	Primary Care	Patients aged 65 years and over with severe frailty who have received an annual medication review	**CCG**	**Yes, GP practice**	**Q**
5	Primary Care	Patients aged 65 years and over with 10 or more unique medications	**CCG**	**Yes, GP practice**	**M**
6	Primary care	Flu immunisation rate in people aged 65 years and over	**CCG**	**Yes, GP practice ***	**A**

7	Mental Health	Dementia: 65+ years old estimated diagnosis rate	**CCG**	**Yes, GP practice and LA**	**M**
8	Primary Care	Proposed: Patients aged 65+ years, with depression or dementia, and who have moderate or severe frailty			
9	Care in the community	The proportion of people (aged 65+ years) who use services who have control over their daily life	**LA**	**No**	**A**
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	**LA**	**No**	**A**
11	Care in the community	Carer reported quality of life	**LA**	**No**	**A**
12	Care in the community	Proposed: Reduced loneliness			
13	Care in the community	Proposed: Number of people referred into social prescribing schemes			
14	Emergency care	A&E attendance rates for patients aged 65 years and over	**CCG**	**Yes, GP practice**	**M**
15	Emergency care	Emergency hospital admission rates for patients aged 65 and over	**CCG**	**Yes, GP practice**	**M**
16	Emergency care	Emergency readmissions within 30 days of discharge from hospital for patients aged 65 and over	**CCG**	**Yes, GP practice**	**M**
17	In hospital delays	Proportion of stranded patients in hospital: LOS 7+ and 21+ days	**FT**	**Yes, GP practice**	**M**
18	Emergency / secondary care	Conversion rates (hospital A&E attendance to admission)	**CCG**	**Yes, GP practice**	**M**
19	Emergency care	Hospital activity in the last year of life	**CCG**	**No, complex indicator**	**A**
20	Emergency / secondary care	Hospital Trust indicator set (Falls with harm, Pressure ulcers, Patient experience of hospital care, and A&E waiting times)	**FT**	**Yes, GP practice* for A&E waits**	**M**
21	Social care - discharge	The proportion of older people (aged 65+) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	**LA**	**No**	**A**
22	Social care - discharge	Long-term support needs of older adults (aged 65 and over) met by admission to residential and nursing care homes	**LA**	**No**	**A**
23	Mortality	Percentage of deaths in usual place of residence	**CCG**	**Yes, LA or age**	**Q**

***- But not using current data source**

Q=quarterly, M=monthly, A=annually

1. **Patients aged 65 years or over who have had a frailty assessment**
2. **Patients aged 65 years or over who are identified as living with frailty, and the severity of their condition**
3. **Patients aged 65 years and over who are identified as living with moderate or severe frailty, who are recorded having had a fall in the preceding 12 months**
4. **Patients aged 65 years and over with severe frailty, who have received an annual medication review**

The supporting information relating to the four metrics listed above is provided in this section.

Source of metrics and information

These four frailty metrics have been included in the final metrics shortlist as they are part of the GMS Core Contract Data Collection from 1st July 2017. This is collected quarterly directly from GP practices across England, and relates to only those aged 65+ years. The data is reported on the NHS Digital site (*https://digital.nhs.uk/data-and-information/publications/statistical/gp-contract-services/gp-contract-services-england-2017-18).*

There are a number of metrics relating to this data collection, and those listed below are directly related to identification of frailty, the severity of the condition, those who have had a fall and patients who have received a medication review:

CCDCMI10: Quarterly (cumulative) count of the number of registered patients aged 65 years or over, who have had a frailty assessment using an appropriate tool up to the end of the reporting period.

CCDCMI11: Quarterly (cumulative) count of the number of registered patients aged 65 years or over, who have not had a frailty assessment up to the end of the reporting period.

CCDCMI12: Quarterly (cumulative) count of the number of registered patients aged 65 years or over, who have a diagnosis of **moderate frailty** diagnosed using an appropriate tool up to the end of the reporting period.

CCDCMI13: Quarterly (cumulative) count of the number of registered patients aged 65 years or over, who have a diagnosis of **severe frailty** diagnosed using an appropriate tool up to the end of the reporting period.

CCDCMI14: Quarterly (cumulative) count of the number of registered patients aged 65 years or over, who have a diagnosis of **severe frailty** diagnosed using the appropriate tool up to the end of the reporting period, and who have received an annual medication review on or after their severe frailty diagnosis.

CCDCMI16: Quarterly (cumulative) count of the number of registered patients aged 65 years or over, who have a diagnosis of either **moderate or severe** frailty diagnosed using the appropriate tool up to the end of the reporting period and who have had a fall up to the end of the reporting period.

A new metric is available from 2018/19, relating to those who have declined an assessment:
CCDCMI19: Quarterly (cumulative) count of the number of registered patients aged 65 years or over, who declined a frailty assessment up to the end of the reporting period.

Data presentation (relating to Q2-Q4 2017/18 only):

1. The proportion of patients aged 65+ years with a frailty assessment done as at the end of 2017/18.
2. The recorded frailty status of patients aged 65 years and over by CCG.
3. The proportion of patients aged 65+ years with moderate or severe frailty who have had a fall, by CCG.
4. The proportion of patients aged 65+ years with severe frailty who have received a medication review, by CCG.

Alternative data presentation

Data is available at both GP practice and CCG level therefore it is possible to report the metrics at a lower level if considered relevant and the organisational definitions are agreed.

It is not possible to produce a further breakdown by age group for these metrics based on the existing data source.

As the information is available on a quarterly basis, in future it may be possible to provide trend analysis upon request.

Regarding frailty severity, it is not possible to map those patients that shift from one frailty category to another using this source, however if patient level data was available, it may be possible to extract data to demonstrate this.

Data quality:

NHS Digital has designated this data as Management Information. As such it has not undergone any quality checking nor has analysis of coverage been made, however local analysis suggests that approximately 95% of GP practices in England are included in the extraction.

This data collection is relatively new and the data may not yet be robust enough to obtain a true assessment of the baseline position of the number of patients with a frailty assessment done, or the frailty severity of the patients due to batch coding (solely on an electronic Frailty Index score without clinical verification) in primary care. NHS England has released guidance on this which is available here: *https://www.england.nhs.uk/wp-content/uploads/2017/04/gms-contract-batch-coding-statement.pdf*

Any other data caveats, data quality issues or discrepancies? None.

Data availability and update frequency

The data collection provided by NHS Digital is extracted on a quarterly basis although publication dates and data for 2018/19 activity have not yet been released.
Data is reported for North Cumbria specifically.

Future plans / further development of the metrics – to be discussed by Community of Practice.

Links to other key metrics:

Metrics 1-4 are related to each other in terms of the frailty topic, and metric 4 is linked to metric 5 (polypharmacy). This also links to healthy ageing approaches.

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

Source of metrics and information

The data for the metric is reported from ePact2.

Guidance relating to the Polypharmacy metrics is available here:
https://www.nhsbsa.nhs.uk/sites/default/files/2018-02/PolyPharmacy%20Specification%20v1%200%20July%202017_0.pdf

Wessex Academic Health Science Network (AHSN) led a small working group consisting of members of North East and North Cumbria AHSN, NHS BSA, NHS Digital, local GPs, Pharmacists, prescribing analysts and clinical specialists in the development of prescribing comparators. An initial suite of nationally available prescribing comparators at CCG and GP Practice level was developed to highlight the variation in prescribing activity with respect to polypharmacy.

Calculation:
Numerator: Number of patients, aged 65 and over, prescribed 10 or more unique medicines
Denominator: Total number of patients, aged 65 and over, prescribed one or more medicines from BNF chapters 1 to 4 & 6 to 10.

Collection Time Period:
Snapshot as at March 31st 2017 and March 31st 2018.
Data is reported for North Cumbria specifically.

Alternative data presentation

More granular reporting on this metric is available, including:
a) National benchmarking
b) CCG peer benchmarking,
c) GP practice outlier analysis, and
d) Further age breakdown (limited to patients aged 75+ years and 85+ years).

Data quality:

Polypharmacy Dataset

As the polypharmacy comparators focus on patient numbers and specific BNF sections, the data can only be used where this information is available. Patient numbers are based on unique NHS numbers as captured from the prescription forms. This can vary from month to month and for the individual CCG selected.

At April-18 (latest month available) successful identification for the polypharmacy dashboard is around 87%.
Approximately 5% data held in ePact2 related to patients of unknown age. These patients are excluded from this metric.

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

Source of metrics and information

The data is published here *https://www.gov.uk/government/statistics/seasonal-flu-vaccine-uptake-in-gp-patients-winter-2017-to-2018* following the end of the winter season,

A full report relating to the 2017/18 winter season is available from the link below:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/710416/Seasonal_influenza_vaccine_uptake_in_GP_patients_winter_season_2017_to_2018..pdf

The PHE influenza surveillance team has responsibility for collating the data and reporting on the progress in the uptake of the seasonal influenza vaccine. Data is submitted to the ImmForm website from GP practices, and this monitors, tracks and reports provisional vaccine uptake weekly and monthly during the influenza season to provide a snapshot of the vaccination status in eligible groups who are registered at the GP practice on the day of data extraction. It should be noted that the data is collated for surveillance purposes and is not designed to support GP payments.

Data presentation:
The proportion of patients aged 65+ years who have received the seasonal influenza vaccination by the 31st January 2018 (latest winter season) are reported, in addition to the trend in this metric for the last 5 years. Data is reported for Cumbria CCG overall.

Alternative data presentation
Data is only available at CCG level from this data source and cannot be split further by age group. It is possible that using an *alternative* data source in future will allow this data to be disaggregated and reported at a lower level if considered relevant and the organisational definitions are agreed.

Data quality:
This data is a snapshot of the registered GP patients vaccinated at the time of data extraction / end of the data collection on 31st January of each year. This means that patients who are vaccinated, but have not had their electronic patient record updated on the date of extraction, will be included in the denominator, but not in the count of 'number vaccinated'.
It is important to note that patients vaccinated in other healthcare settings or pharmacies is also recorded, however data captured outside of the GP practice may not be standardised and vary between GP practices depending on GP system suppliers.

Data availability and update frequency
This data from this source is available on an annual basis.

Future plans / further development of the metrics
National and regional benchmarking data can be updated for each data iteration.

Links to other key metrics
14. A&E attendance rates 15. Unplanned admission rates to hospital
16. 30 day readmission rates. This also links to healthy ageing approaches

7. Dementia: 65+ years old estimated diagnosis rate

Source of metrics and information

Data as at the end of June 2018, taken from Table 4 of the NHS Digital publication 'Patients in England with a record of dementia diagnosis on their clinical record, June 2018'.

https://digital.nhs.uk/data-and-information/publications/statistical/recorded-dementia-diagnoses

This indicator is within the CCG Outcomes Indicator Set (CCG OIS 2.13), the Public Health Outcomes Framework (PHOF 4.16) and the CCG Improvement and Assessment Framework (CCG IAF 126a). NHS Digital have produced interactive dashboards relating to this indicator at the link above.

It is not possible to tell whether an area is better or worse than another area from the data. If an area has a significantly high or low diagnosis rate, this is only a smoke alarm for further investigation.

Data presentation: This indicator compares the number of people estimated to have dementia (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 diagnosed with dementia (taken from the dementia QOF registers in general practice), aged 65 and over.

This is expressed per CCG for the latest 12 month period, and by month for the 12 month period, to view the trend over time. Data is reported for North Cumbria specifically.

Alternative data presentation

The data is also available at GP practice level and local authority level, therefore in future this can be reported at a lower level if considered relevant and the organisational definitions are agreed.

Data quality: The technical guidance relating to this indicator explains how the rates are calculated and the data sources used.

Data availability and update frequency

The data is updated on a monthly basis from the NHS Digital site.

Future plans for presentation:

National and regional benchmarking data can be updated for each data iteration.

Links to indicators 1-4 (frailty), 5 polypharmacy, and a number of the social care indicators. This also links to healthy ageing approaches.

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

A metric to report the proportion of patients aged 65 years and over who are on the dementia or depression QOF register (or both registers) 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)[1]. The relationship of cognitive impairment and depression to care dependency, disability and other adverse health outcomes has been demonstrated in a number of studies.

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.

A potential data source for this analysis is the primary care record, held by GP practices. In order to access this information a specific request to the practices to query, extract and share this level of data would be required, as this data is not currently available to access via a standard source at present.

9. Patients aged 65 years and over who use services who have control over their daily life

Source of metrics and information

The data for this metric is published nationally by NHS Digital from an annual collection which each Local Authority submits via their Adult Social Care Survey (ASCS) data collection.

Calculation: The relevant question drawn from the Adult Social Care Survey is Question 3a: 'Which of the following statements best describes how much control you have over your daily life?', to which the following answers are possible:

- I have as much control over my daily life as I want

- I have adequate control over my daily life

- I have some control over my daily life but not enough

- I have no control over my daily life

The measure is defined by determining the percentage of all those responding either 'I have as much control over my daily life as I want' or "I have adequate control over my daily life". These two responses have been chosen to focus the measure on those individuals achieving the best outcomes, identifying no or limited need in this area. The intention is that this will allow for better use in benchmarking.

Collection Time Period: The survey is completed annually and sent to a proportionate sample of service users based on a calculated minimum response rate.

Caveats: There are some caveats around this data where there may be local variation in the cohorts of clients used in this indicator and differing recording systems in place within each LA. This is however minimised by regional performance and monitoring groups and workshops around

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

the collation of the indicator. Some local authorities may also have smaller cohorts due to population sizes so small changes in numbers may have a greater impact for some LAs. There is a minimum response rate expected to be achieved for the number of questionnaires sent out to clients, and the number of responses received from this. These response rates can be determined locally by each LA determined by cohort size. The minimum response rates may not be achieved across all areas.

The data for this metric is available at Local Authority level and not produced at CCG level, due to the nature of the indicator being predominantly social care related and reported on via LAs.

Developments: NHS Digital are considering whether it is possible to publish Reported Health Conditions data (from the ASCS Survey) to widen the range of potential analysis.

Further information is available from the ASCOF handbook of definitions:

https://www.gov.uk/government/publications/adult-social-care-outcomes-framework-handbook-of-definitions

10. Patients aged 65 years and over who use services who reported that they had as much social contact as they would like

Source of metrics and information

The data for the metric is published nationally by NHS Digital from an annual collection which each Local Authority submits via their Adult Social Care Survey (ASCS) data collection.

Calculation: The relevant question drawn from the Adult Social Care Survey is question 8a – "Thinking about how much contact you've had with people you like, which of the following statements best describes your social situation?"

- I have as much social contact as I want with people I like

- I have adequate social contact with people

- I have some social contact with people, but not enough

- I have little social contact with people and feel socially isolated

The measure is defined by determining the percentage of users responding "I have as much contact as I want with people I like". These responses have been chosen to focus the measure on individuals achieving the best outcomes, to allow for better use in benchmarking. A better measure of this indicator may also include the response "I have adequate social contact with people"?

Collection Time Period: The survey is completed annually and sent to a proportionate sample of service users based on a calculated minimum response rate.

Caveats: There are some caveats around this data where there may be local variation in the cohorts of clients used in this indicator and differing recording systems in place within each LA. This is however minimised by regional performance and monitoring groups and workshops around

the collation of the indicator. Some local authorities may also have smaller cohorts due to population sizes so small changes in numbers may have a greater impact for some LAs.

There is a minimum response rate expected to be achieved for the number of questionnaires sent out to clients, and the number of responses received from this. These response rates can be determined locally by each LA determined by cohort size. The minimum response rates may not be achieved across all areas.

The data for this metric is available at Local Authority level and not produced at CCG level, due to the nature of the indicator being predominantly social care related and reported on via LA's.

Developments: This measure focuses on social care users, rather than the broader population. The impact of social isolation and loneliness is much wider than the population currently receiving services, and all parts of the health and care system have a role to play in preventing, and reducing, social isolation and loneliness in the broader population. Work on pursuing a measure of loneliness in the wider population has now concluded by the Health and Social Care Information Centre having been unable to identify a suitable measure. As such, the development of this measure has been deferred for the foreseeable future.

Further information is available from the ASCOF handbook of definitions: *https://www.gov.uk/government/publications/adult-social-care-outcomes-framework-handbook-of-definitions*

This also links to healthy ageing approaches.

11. Carer reported quality of life

Source of metrics and information

The data for the metric is published nationally by NHS Digital from an annual collection which each Local Authority submits via their Adult Carer Survey (SACE) data collection.

Calculation: This is a composite measure which combines individual responses to six questions measuring different outcomes related to overall quality of life. These outcomes are mapped to six domains; occupation, control, personal care, safety, social participation and encouragement and support.

The six questions, drawn from the Carers Survey, are:

- Occupation – Q7: Which of the following statements best describes how you spend your time?

- Control - Q8: Which of the following statements best describes how much control you have over your daily life?

- Personal care - Q9: Thinking about how much time you have to look after yourself – in terms of getting enough sleep or eating well – which statement best describes your present situation?

- Safety – Q10: Thinking about your personal safety, which of the statements best describes your present situation?

- Social participation - Q11: Thinking about how much social contact you've had with people you like, which of the following statements best describes your social situation?

- Encouragement and support - Q12: Thinking about encouragement and support in your caring role, which of the following statements best describes your present situation?

Each of the questions has three possible answers, which are equated with having:

- no unmet needs in a specific life area or domain (the ideal state);
- some needs met, and;
- no needs met.

Responses to the questions indicate whether the carer has unmet needs in any of the six areas. The measure gives an overall score based on respondents' self-reported quality of life across the six questions. All six questions are given equal weight.

Collection Time Period: The survey is completed annually and sent to a proportionate sample of carers based on a calculated minimum response rate.

Caveats: There are some caveats around this data where there may be local variation in the cohorts of clients used in this indicator and differing recording systems in place within each LA. This is however minimised by regional performance and monitoring groups and workshops around the collation of the indicator. Some local authorities may also have smaller cohorts due to population sizes so small changes in numbers may have a greater impact for some LAs. There is a minimum response rate expected to be achieved for the number of questionnaires sent out to carers, and the number of responses received from this. These response rates can be determined locally by each LA determined by cohort size. The minimum response rates may not be achieved across all areas.

The data for this metric is available at Local Authority level and not produced at CCG level, due to the nature of the indicator being predominantly social care related and reported on via LAs.

Developments: The research project to develop a value added measure for social care-related quality of life for users also investigated whether it is possible to develop a value added measure for carer-reported quality of life. The report explores the results of the analysis and shows that such a measure may be feasible. However, translating the results into an ASCOF measure for Carers akin to 1J for Users is a piece of development work for future consideration.

Further information is available from the ASCOF handbook of definitions: *https://www.gov.uk/government/publications/adult-social-care-outcomes-framework-handbook-of-definitions*

12. Proposal to include an indicator to measure loneliness

There are no obvious Read codes to use in general practice to record this measure, but this links closely to indicator 10 – social contact.

13. Proposal to include an indicator to measure the number of people referred into social prescribing schemes

This metric is not yet available regionally for North East & Cumbria.

There are Read codes for use in primary care for referral to social prescribing and to measure those being offered a referral but refusing it.

It is necessary to understand what is going on in each local area, how this may be recorded locally and if so, how it could be obtained or extracted.

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

Source of metrics and information

This data is taken from Hospital Episode Statistics, re-used with the permission of NHS Digital. The data for the latest financial year (2017/18) is still classed as provisional.

The number of A&E attendances per 1,000 population, where the A&E Department type is either:

Type 01: Emergency departments with a consultant led 24 hour service with full resuscitation facilities, Type 03: Other type of A&E/minor injury activity, which may be doctor led or nurse led and can be accessed without appointment.

Data presentation:

The A&E attendance rate per 1,000 population for the latest financial year available (2017/18) is shown, in addition to the trend in attendances over the last 7 years.

Alternative data presentation

The data could be split further by department Type, or specific age groups if required (as per NHS Digital report showing 65-79 years and 80+ years separately).
Links to achievement of the 4 hour wait in A&E by hospital Trust.

Data quality: The data is used directly from HES and as this is now a well-established part of the HES dataset, the data quality at summary level should be ok.
Data for Cumbria is identified by CCG code so this is currently reliant on Trusts to record this properly.

Data availability and update frequency

As this data is provided at patient level, it is possible to aggregate this in different ways, such as GP practice, or other sub-CCG level if considered relevant and the organisational definitions are agreed. Here the data in the bar chart contains Newcastle and Gateshead split into two separate groups.

The data is updated monthly and is available approximately 6 weeks after the month end.

Future plans / further development of the metrics

National and regional benchmarking data can be updated for each data iteration.

Links to other key metrics

15.Emergency admissions, 18. A&E conversion rates, 19. Hospital activity in the last year of life, in addition to 12. Loneliness and other social contact metrics.

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

Source of metrics and information

This data is taken from Hospital Episode Statistics, re-used with the permission of NHS Digital. The crude emergency admission rate for patients aged 65 years and over has been calculated, based at CCG level.

In addition to the overall emergency admission rate, the admission rate for injuries due to falls (based on the PHE Fingertips tool indicator 2.24i) has also been presented, by Local Authority (*https://fingertips.phe.org.uk/search/falls#page/3/gid/1/pat/6/par/E12000001/ati/102/are/E06000047/iid/22401/age/27/sex/4*).

Data presentation

The emergency admission rates for patients aged 65 years and over, by CCG, for 2017/18 and trend over time.

The emergency admission rates (age-standardised) due to falls for patients aged 65 years and over, by Local Authority, for 2016/17 and trend over time.

Data quality

This analysis depends on the quality and consistency of Trust SUS data submissions and for admissions for injuries due to falls it will be dependent on the accuracy of the coding.

Data for Cumbria is identified by CCG code so this is currently reliant on Trusts to record this properly.

Data availability and update frequency

It is possible that as this data is available at GP practice level, the data can be disaggregated and reported at a lower level if considered relevant and the organisational definitions are agreed.

The data is updated monthly and is available approximately 6 weeks after the month end.

Future plans for presentation:

It is acknowledged that the overall emergency admission rate for this age group may not be as useful to the Community of Practice as emergency admissions for specific patient groups, such as those admitted due to a hip fracture, ambulatory care sensitive conditions or avoidable admissions therefore presentation of these and other specific categories of emergency admissions could be considered in future.

Links to other key metrics

This links to frailty (metrics 1-4), and also to the Adult Social Care Outcomes Framework indicators (metrics 9-11).

16. Emergency readmissions within 30 days of discharge from hospital (65+ years)

Source of metrics and information
This data is taken from Hospital Episode Statistics, re-used with the permission of NHS Digital. The data for the latest financial year (2017/18) is still classed as provisional. The metric is based on indicator 4.11 from the PHE Fingertips tool but has been adjusted to account for those aged 65 years and over only - technical guidance available here: *https://fingertips.phe.org.uk/search/epilepsy%20care%20and%20emergency%20hospital%20admission#page/6/gid/1/pat/6/par/E12000001/ati/102/are/E06000047/iid/41101/age/1/sex/4*).

The indicator has also been adjusted to be a directly standardised rate, reporting the rate of emergency admissions to any hospital within 30 days of the previous discharge from hospital. A number of exclusions are applied to this measure: day cases, spells with a discharge coded as death, maternity spells (based on specialty, episode type, diagnosis), and those with mention of a diagnosis of cancer or chemotherapy for cancer anywhere in the spell are excluded.

Where there is more than one readmission within 30 days, each readmission is counted once, in relation to the previous discharge.

Data presentation: Directly standardised rate of emergency admissions to any hospital within 30 days of the previous discharge from hospital.

Alternative data presentation
A trend over time could be produced upon request. This data can be split further by reason for admission (based on the primary diagnosis of the admitting episode of the original spell).

Data quality: Based on the Fingertips tool supporting information, there is variation in the completeness of hospital records and quality of coding. Quality of coding shows the proportion of diagnoses not coded. There may also be variation between hospitals in the way that they code diagnoses, in terms of the order in which they appear in the data. Data for Cumbria is identified by CCG code so this is currently reliant on Trusts to record this properly.

Any other data caveats, data quality issues or discrepancies? None

Data availability and update frequency
It is possible that as this data is available at GP practice level, the data can be disaggregated and reported at a lower level if considered relevant and the organisational definitions are agreed.

Future plans / further development of the metrics
National and regional benchmarking data can be updated for each data iteration.

Links to other key metrics:
14. A&E attendances, 15.Unplanned admission rates, 18. Conversion rates from A&E, 1-4 Frailty metrics.

17. Proportion of stranded patients in hospital: length of stay 7+ and 21+ days

Source of metrics and information

The data for the metric is published via Daily Situation Reports (SITREPs) submitted via Trusts.

Numerator:

i) Stranded Patients: Average number per Trust of occupied General & Acute (G&A) beds by patients with a length of stay 7 or more days.

ii) Super Stranded Patients: Average number per Trust of occupied General & Acute (G&A) beds by patients with a length of stay 21 or more days.

Denominator: Average number per Trust of occupied General & Acute (G&A) beds.

Collection Time Period: SITREPs data is submitted daily. For the purpose of this report, the daily average has been calculated and provided per month.

Caveats: The data for this metric is available at Provider NHS Trust level. No data is reported by Newcastle NHS Foundation Trust. No regional or national published benchmarking position is available for comparison.

Developments: NHS Improvement is encouraging commissioners to use the long-stays dashboard as part of its drive to reduce hospital stays of three weeks or more. Around a fifth of hospital beds are occupied by long-stay patients. National bodies want to see the figure cut by a quarter, which would make 4,000 more beds available nationally.

CCG staff can access the dashboard (*https://improvement.nhs.uk/resources/long-stays-dashboard/)* by emailing nhsi.longstaysdashboard@nhs.net.

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

Source of metrics and information

This data is taken from the A&E table within Hospital Episode Statistics, re-used with the permission of NHS Digital. The data for the latest financial year (2017/18) is still classed as provisional. The metric is based on the Efit Indicator Guide from NHS Improvement and has been adjusted to relate to those aged 65 years and over only. Technical guidance is available here: *https://improvement.nhs.uk/documents/1787/Efit_Indicator_Guide.docx*

The numerator is the total number of attendances in A&E for patients aged 65 years and over (A&E department Type 01 only) where the A&E disposal was 01 (admitted to a hospital bed / became a lodged patient of the same Health Care Provider) and the denominator is the total number of attendances in A&E for patients aged 65 years and over, and this is expressed as a percentage.

Data presentation: The proportion of A&E attendances that result in admission to a hospital bed, for patients aged 65 years and over, in the period 2017/18.

Alternative data presentation

The data could look at individual A&E department types (e.g. only Type 01 or only Type 03). Alternatively analysis could focus on the conversion rates at specific times of the day or linked to the length of stay of the subsequent admission. It is also possible to look at trends over time.

The data is updated monthly and is available approximately 6 weeks after the month end.

Data quality: The data is used directly from the A&E tables within HES and depends on the completeness and accuracy of the A&E department type field. Data for Cumbria is identified by CCG code so this is currently reliant on Trusts to record this properly.

Data availability and update frequency

As this data is provided at patient level, it is possible to aggregate this in different ways, such as GP practice, or other sub-CCG level if considered relevant and the organisational definitions are agreed. Here the data in the bar chart contains Newcastle and Gateshead split into two separate groups.

Future plans / further development of the metrics

National and regional benchmarking data can be updated for each data iteration.

Links to other key metrics:

14. A&E attendances, 15.Unplanned admission rates, 16. Emergency readmissions within 30 days of discharge.

19. Hospital activity in the last year of life

Source of metrics and information

This data is taken from Hospital Episode Statistics, re-used with the permission of NHS Digital. Patients aged 65 years and over, who were admitted to hospital as an emergency within the financial year 2017/18, and where the discharge method of the spell = 4 (patient died) were identified. At patient level, the activity in the 365 days prior to patient death was analysed and the total number of days in hospital identified. From this, the percentage of days in hospital in the last year of life, aggregated to CCG level, is calculated and presented.

This information does not include activity for patients who died outside of hospital as it is not possible for NEQOS or NECS to link these datasets together.

Data presentation:

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, also indicating the minimum time and maximum time spent for each CCG.

Data availability and update frequency

Due to the complexity of the calculations required to produce this information, if this indicator is deemed to be relevant and useful, it is recommended that this should be updated on an annual basis.

Future plans / further development of the metrics

It may be useful to focus on the hospital activity in the last year of life for patients who died in hospital with a specific condition.

Links to other key metrics:

23. Deaths in the usual place of residence.

20. Hospital Trust indicator set

Source of metrics and information

The data presented in this section is taken from various sources, including the Safety Thermometer website (*https://www.safetythermometer.nhs.uk/*), the NHS Outcomes Framework (*https://digital.nhs.uk/data-and-information/publications/clinical-indicators/nhs-outcomes-framework/current*) and the A&E Attendances & Emergency Admission monthly statistics (*https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/*).

The aim of the Safety Thermometer is a tool to support and help drive local improvement initiatives involving common harms. Falls (*https://www.safetythermometer.nhs.uk/index.php/contact-support/definitions/48-help-and-support/user-guides/definitions-measures/102-falls-defined*) and pressure ulcers (*https://www.safetythermometer.nhs.uk/index.php/contact-support/definitions/48-help-and-support/user-guides/definitions-measures/101-pressure-ulcers-defined*) are harms which are specifically pertinent to older people who, experiencing more healthcare intervention, are at risk of multiple harms.

The patient experience of hospital care measure is based on the scores from a selection of questions from the National Inpatient Survey, linked to five domains and weighted by age, gender and method of admission (*https://files.digital.nhs.uk/78/27FAFA/NHSOF_Domain_4_S.pdf*).

The A&E waiting time standard that 95% of patients should be admitted, transferred or discharged within 4 hours of arrival at A&E represents the expected rights and pledges for patients within the NHS Constitution.

Data presentation:

The number and percentage of falls with harm, by CNE region hospital Trust (July 2018).
The number and percentage of patients with pressure ulcers (all), by CNE region hospital Trust (July 2018).
The patient experience of hospital care score (/100) by CNE region hospital Trust (to Jan ’18).
The proportion of patients attending Type 01 A&E departments (reported by Trust) where the time waited from arrival to the time of admission, transfer or discharge was less than 4 hours (2017/18).
These measures relate to patients **of all ages**.

Alternative data presentation

It may be possible to calculate waiting times at patient level from the HES A&E data (using arrival and disposal times) and then this can be limited to those aged 65+ years.
Safety Thermometer and Patient Experience survey data is only reported at Provider level.

Data availability and update frequency

Safety Thermometer data and A&E waiting times < 4 hours data are updated monthly.
Patient experience of hospital care is updated annually.

Future plans / further development of the metrics

National and regional benchmarking data can be updated for each data iteration.

Links to other key metrics:14. A&E attendances, 15.Unplanned admission rates, 16. Emergency readmissions within 30 days of discharge.

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

Source of metrics and information

The data for the metric is published nationally by NHS Digital from an annual collection which each Local Authority submits via their Short & Long Term (SALT) data collection. There is a standard definition of this metric as specified in national guidance:

Numerator: Number of older people (aged 65 and over) discharged from acute or community hospitals to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital.

Denominator: Number of older people (aged 65 and over) discharged from acute or community hospitals to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting)

Collection Time Period: The collection of the denominator will be between 1 October and 31 December of the reporting year. The numerator will be collected from 1 January to 31 March during the 91-day follow-up period for each case included in the denominator.

Caveats: There are some caveats around this data where there may be local variation in the cohorts of clients used in this indicator and differing recording systems in place within each LA. This is however minimised by regional performance and monitoring groups and workshops around the collation of the indicator. Some local authorities may also have smaller cohorts due to population sizes so small changes in numbers may have a greater impact for some LAs.

The data for this metric is available at Local Authority level and not produced at CCG level, due to the nature of the indicator being predominantly social care related and reported on via LAs.

This indicator is linked to ASCOF 2B (2) which measures the proportion of older people offered reablement following discharge from hospital and captures the volume of reablement offered, not just the success of the service.

Developments: Over time, the Health and Social Care Information Centre will aim to measure the success of all those offered a reablement service, rather than restricting measurement to those discharged from hospital only. In the future it may be possible to expand the measure to include individuals assessed only on health needs, on the basis that this is a measure of joint working and is due to be replicated in the NHS Outcomes Framework once it comes into use. In addition, even in circumstances where there has been an assessment conducted by the NHS not including social care needs, social care may still be involved in delivering the service to the individual.

Further information is available from the ASCOF handbook of definitions.

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

Source of metrics and information

The data for the metric is published nationally by NHS Digital from an annual collection which each Local Authority submits via their Short & Long Term (SALT) data collection. There is a standard definition of this metric as specified in national guidance:

Calculation: People counted in this measure include:

- Users where the local authority makes any contribution to the costs of care, no matter how trivial the amount and irrespective of how the balance of these costs are met (including full-cost clients) or location of residential or nursing care;

- Supported users and self-funders with depleted funds in the following categories:

i) Those moving to residential or nursing care as a result of an unplanned review

ii) Those moving to residential or nursing care as a result of a planned review

iii) New clients whose request for support was fulfilled with the sequel of "Long Term Support (Eligible Services) – Nursing Care" or Long Term Support (Eligible Services) – Residential Care

iv) New clients, who following receipt, or early cessation, of "Short Term Support to Maximise Independence", entered either Long Term Residential or Nursing care

v) Existing clients, who following receipt, or early cessation, of "Short Term Support to Maximise Independence", entered either Long Term Residential or Nursing care

Collection Time Period: This measure is reported annually via the Short and Long Term (SALT) collection.

Caveats: People funding their own residence in a care home with no support from the council are excluded from this measure.

The data for this metric is available at Local Authority level and not produced at CCG level, due to the nature of the indicator being predominantly social care related and reported on via LA's.

Developments:

Further information is available from the ASCOF handbook of definitions: *https://www.gov.uk/government/publications/adult-social-care-outcomes-framework-handbook-of-definitions*

23. Deaths in the usual place of residence

Source of metrics and information

Deaths in the usual place of residence (DiUPR) can be used to understand the trends and variations in place of death as a proxy indicator for quality of end of life care.

DiUPR can be expressed by LA or CCG as all ages, those 0-64, 65-74, 75-84 and 85+ (Fingertips), it is available per calendar year and for specific condition groups (data from ONS) and also from the EOL intelligence site for place of occurrence and those in usual place of residence (all ages) – the current source used here (http://www.endoflifecare-intelligence.org.uk/data_sources/place_of_death)..

Preferred and actual place of death are not shown here, nor the measure relating to % of patients dying in their preferred place of death. The preferred place of death may change close to death as circumstances change, by patient or relatives. HCPs may not have access to the patient's wishes, or to the latest version of them, depending on their location.

Trend data for South Tyneside CCG and Sunderland CCG over time may have been affected by St Benedict's hospice (and others) in the area, which is recorded as part of South Tyneside FT.

Data presentation:
The proportion of deaths in usual place of residence compared to all deaths, by CCG (2017/18).

The proportion of deaths by place of occurrence, by CCG (2017/18).

A fixed (latest available) point in time and trend over time are both shown, identifying those where the rate is significantly different to England.

Alternative data presentation
This can be split by age group or presented by local authority level.

Data availability and update frequency
This data is reported by quarter and expressed as a rolling annual figure.

Future plans / further development of the metrics
It would be useful to understand what the CoP would find most useful from this data collection. National and regional benchmarking data are included and can be updated for each data iteration. Aim for an increase in the % of deaths in usual place and limit the reporting in future to only those aged 65 years and over by changing the source?

Preventing deaths in hospital requires assessment, partnership working and discharge planning.

Links to other metrics:

19. Hospital activity in last year of life, 16.emergency readmissions within 30 days of discharge.