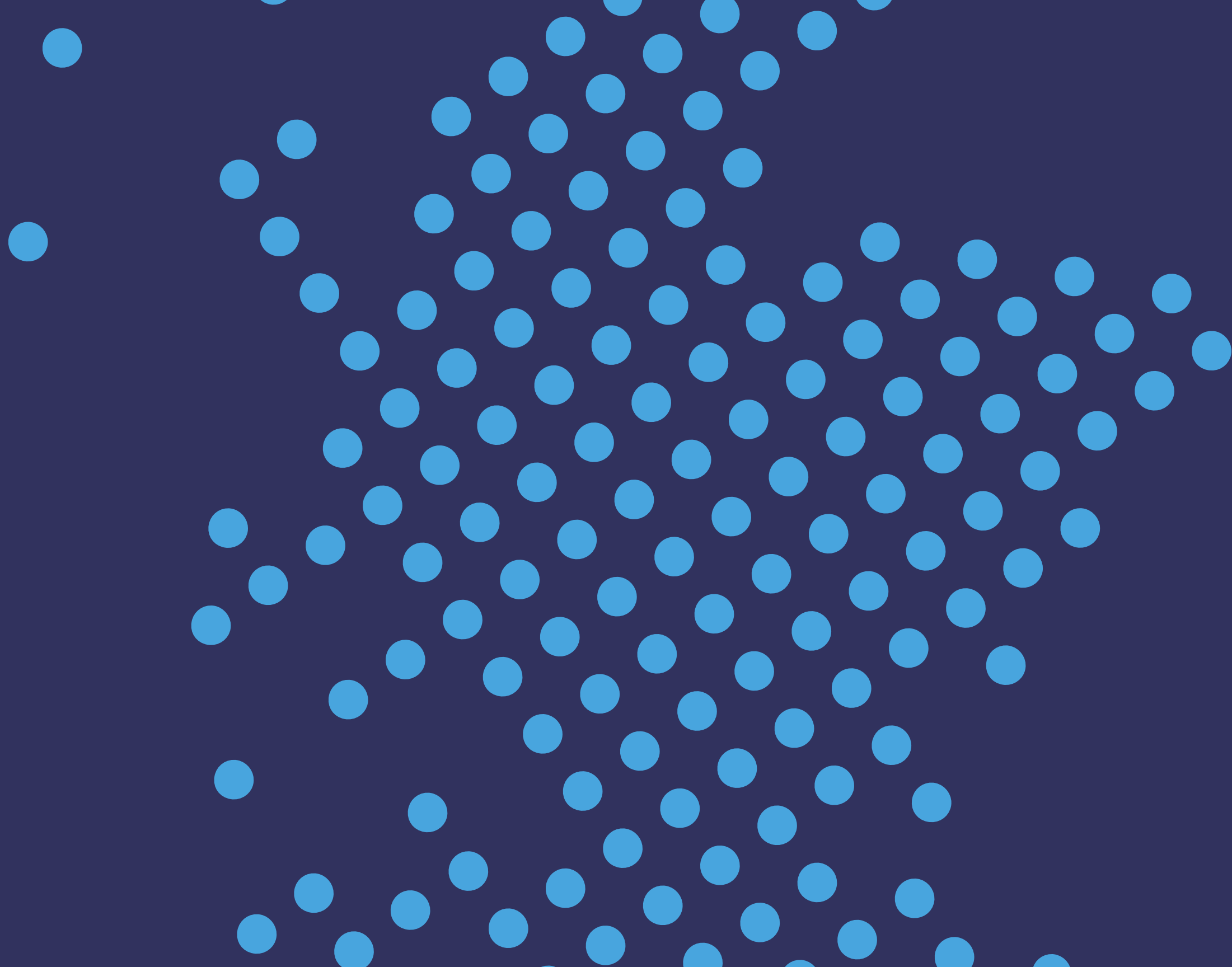


SCOOP

Comprehensive Geriatric
Assessment in Secondary Care
Audit (2019)



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Executive Summary

This report summarises findings from an audit on Comprehensive Geriatric Assessment (**CGA**) provision in acute Scottish hospitals in 2019. This initial analysis highlights variation in the ways comprehensive geriatric specialist care is accessed, structured and staffed across Scotland, with established frailty units only in a quarter of Scottish Hospitals. There were disparities in the number of full time equivalent consultant geriatricians per head of population aged over 65 years with median 1.27 (range: 0.0-2.27), and differences in access to allied health professionals, particularly out of hours.

Further correlation with patient level data is needed to ascertain the influence of these differences on patient care and outcomes. These results should provide a basis for opening discussion between services across Scotland to learn from each other's expertise as we aim to work collaboratively to improve equity in access to high quality acute care for frail older adults in Scotland.

Introduction

The Scottish Care of Older People (**SCoOP**) national audit project was established with the overarching aim to improve care for older people in Scotland (www.bgs.org.uk/scoop). The vision is to provide a knowledge platform that can be built upon for better understanding of standards of care, areas for improvement, and insight into what the determinants are for best outcomes in care for older people. The SCoOP audit runs in partnership with Healthcare Improvement Scotland (**HIS**), who already perform regular inspections of services for older people in acute hospitals and share examples of good practice. Together we need to build on this to develop an understanding of differences in how services are being run, and whether or not this translates into differences in patient outcomes.

An initial scoping audit at Scottish Health Board level was completed in 2018 which showed that differences existed in the acute and community service provision for older adults, and also in the consultant geriatrician provision per head of population aged over 65 (Donaldson, 2019). This initial work demonstrated that we could work collaboratively in Scotland to evaluate and regularly monitor older people's care through the SCoOP network, and confirmed a need to look in a more detailed manner at how care is accessed by and provided for frail older adults in order to achieve excellence and equity in services across the nation. Since the inception of SCoOP multiple subgroups have been developed to focus on specific aspects of care, including surgical and emergency department services for older people.

The focus of this audit is the delivery of Comprehensive Geriatric Assessment (**CGA**) – a multidisciplinary, multi-dimensional diagnostic and therapeutic process (Ellis, 2017). CGA aims to determine the medical, mental and functional problems of older people with frailty, thus facilitating design of a co-ordinated and integrated plan for treatment and follow-up. To date, research indicates that CGA should be the gold standard in providing care for older patients, with a Cochrane Review in 2017 concluding that older patients are more likely to be alive and in their own homes at follow up if they received CGA on hospital admission (Ellis, 2017).

This report summarises findings from an audit of CGA provision in acute Scottish hospitals in 2019. We hope to analyse additional patient outcome data from NHS Scotland's Information Services Division (**ISD**) in due course. Examination of the association between variation in services and outcomes will enable us to inform clinicians, patients and public, service providers, commissioners and policy makers.



Methods

Scottish Health Board representatives on the SCoOP Steering committee were asked to nominate a representative from each hospital in their Board providing acute care to older adults and who would be able to answer questions about their local CGA provision. An audit questionnaire on CGA ([Appendix 10](#)) was designed to gather information on how patients accessed consultant geriatrician led care, the set-up for care of frail older people at each hospital, the number of specialist staff employed, their working patterns, the frequency of multi-disciplinary team meetings and brief details of services linked to geriatric medicine that might influence the workload of the specialist geriatric medicine team such as hospital at home, orthogeriatrics and surgical liaison. A shortened set of questions was provided as an alternative for 'remote and rural' units where there was no or non-permanent geriatrician cover ([Appendix 11](#)).

The audit questionnaire was tested by two representatives and disseminated using the Research Electronic Data Capture (**REDCap**) system of the University of Aberdeen. REDCap is a secure web application supported by academic institutions around the world and compliant with the NHS network requirements (Harris, 2019).

The questionnaire remained open for completion between February and July 2019; data was subsequently transferred into Excel, sense checked and descriptive analysis performed.

Results

We identified 28 Scottish Hospitals which receive acute admissions: of these 7 were located in remote and rural locations in the Scottish Highlands and Islands. Through our Steering Group Members we identified suitable contacts to provide information on how services for frail patients were running in 26 out of these 28 hospitals.

Table 1a: Scottish Hospitals for Acute Admissions

NHS Health Board	Hospital Name	Data obtained
Ayrshire and Arran	University Hospital Crosshouse	Yes
Ayrshire and Arran	University Hospital Ayr	Yes
Borders	Borders General Hospital	Yes
Dumfries and Galloway	Dumfries and Galloway Royal Infirmary	Yes
Fife	Victoria Hospital	Yes
Forth Valley	Forth Valley Royal Hospital	Yes
Grampian	Aberdeen Royal Infirmary	Yes
Grampian	Dr Gray's Hospital	Yes
Greater Glasgow and Clyde	Glasgow Royal Infirmary	Yes



Greater Glasgow and Clyde	Queen Elizabeth University Hospital	Yes
Greater Glasgow and Clyde	Royal Alexandra Hospital	Yes
Greater Glasgow and Clyde	Inverclyde Royal Hospital	Yes
Greater Glasgow and Clyde	Vale of Leven Hospital	No
Lanarkshire	University Hospital Hairmyres	Yes
Lanarkshire	University Hospital Monklands	Yes
Lanarkshire	University Hospital Wishaw	Yes
Lothian	St John's Hospital	Yes
Lothian	Royal Infirmary of Edinburgh	Yes
Lothian	Western General Hospital	Yes
Tayside	Perth Royal Infirmary	Yes
Tayside	Ninewells Hospital	Yes

Table 1b: Remote and Rural Scottish Hospitals for Acute Admission

NHS Health Board	Hospital Name	Data obtained
Highland	Raigmore	Yes
Highland	Lorn and Islands Hospital	Yes
Highland	Caithness General Hospital	Yes
Highland	Belford Hospital	Yes
Shetland	Gilbert Bain Hospital	Yes
Western Isles	Western Isles Hospital	Yes
Orkney	Balfour Hospital	No

The detailed results are presented as a series of appendices at the end of this report to enable individual services to compare themselves to similar sized units.





Key Findings

The key findings for each aspect have been summarised below.

1. Hospitals with and without frailty units (See Appendix 1 & 2)

There were seven Scottish Hospitals out of the 26 which provided data which identified themselves as having an acute frailty unit (7 out of 26 hospitals: 27%). Of these, four were separate units running a 24 hour service every day of the week, one operated only within normal working hours Monday to Friday, and two units have dedicated frailty assessment beds within a general medical ward area.

The majority of these units used a form of frailty criteria as a screening tool (86%) and most also had an age criteria of either greater than or equal to age 65 years (2 out of 7 hospitals: 29%) or greater than or equal to 75 years (2 out of 7 hospitals: 29%).

In the remaining 19 Scottish Hospitals without a frailty unit, patients admitted with frailty received their initial assessment in either a general medical admissions unit (7 out of 19 hospitals: 36%), general medical ward (8 out of 19 hospitals: 42%) or a general ward for older adults (4 out of 19 hospitals: 21%).

2. Routes of admission (see Appendix 3)

Each of the 23 participating hospitals with consultant geriatrician cover were asked about all possible routes of admission of a frail patient into a bed under the care of a geriatrician. The most frequent route was by referral from an acute medicine department (9 out of 23 hospitals: 38%) or by referral from a geriatrician identifying patients in the acute medicine department (9 out of 23 hospitals: 38%); other routes included referrals from an Emergency

Department (8 out of 23 hospitals: 35%) and least commonly direct admission from GP referrals (4 out of 23 hospitals: 17%). Further details for those units not fitting into these categories are included in [Appendix 3](#), all possible routes for each unit have been included and several hospitals had more than one route into consultant geriatrician led care.

3. Specialist Staffing

Senior Medical Staffing (Appendices 4 and 5)

There is a wide variation in the size of the population aged ≥ 65 years served by each health board, with a minimum of 4,686 (NHS Shetland) and maximum of 195,192 (NHS Greater Glasgow and Clyde) ([Table 2](#)). Similarly, the number of FTE geriatric medicine consultants per 10,000 older people aged ≥ 65 years varies widely across the Scottish Health Boards with a median of 1.27 [range: 0.0-2.27] FTE consultant geriatricians per 10,000 population aged ≥ 65 years ([Table 2 and Figure 1](#)).

There was also variation in the number of acute sessions worked by geriatricians in each Health Board with a median of 1.1 [range: 0.0-3.7] acute sessions per full-time equivalent geriatrician. Geriatricians based in Raigmore Hospital and Dumfries and Galloway Royal Infirmary had no sessions specifically for the 'acute take' of frail older adults at the time of the audit, whereas the highest number of acute takes were worked by those based in Aberdeen Royal Infirmary (mean 3.7 acute sessions) ([Figure 2](#)). The mean number of hours per weekday (Monday-Friday) spent by consultants reviewing new patients was 4.6 hours and at the weekend (Saturday and Sunday) this was 3.1 hours. Without including remote and rural hospitals the mean hours per weekday for consultants reviewing new patients were 5 hours and at the weekend 3.6 hours.



Table 2: NHS Scottish Health Board Population and the full-time equivalent geriatrician provision per 10,000 people ≥ 65 years (based on 2019 mid-year population estimates)

NHS Health Board	Population number ≥ 65 years	FTE Geriatrician per 10,000 people ≥65
Shetland	4686	0
Western Isles	6895	0
Ayrshire and Arran	84228	0.62
Dumfries & Galloway	38570	0.65
Highland	53088	0.89
Grampian	107946	1.13
Fife	77024	1.27
Tayside	89691	1.56
Borders	28616	1.75
Forth Valley	59174	2.2
Lanarkshire	121805	2.22
Greater Glasgow and Clyde	195952	2.27
Lothian	148954	2.29

Figure 1: Share of Scottish population ≥ 65 years covered by each health board and the corresponding medical staffing levels at consultant, specialist registrar and speciality doctor grades (*values shown by markers, lines added to aid comparison).

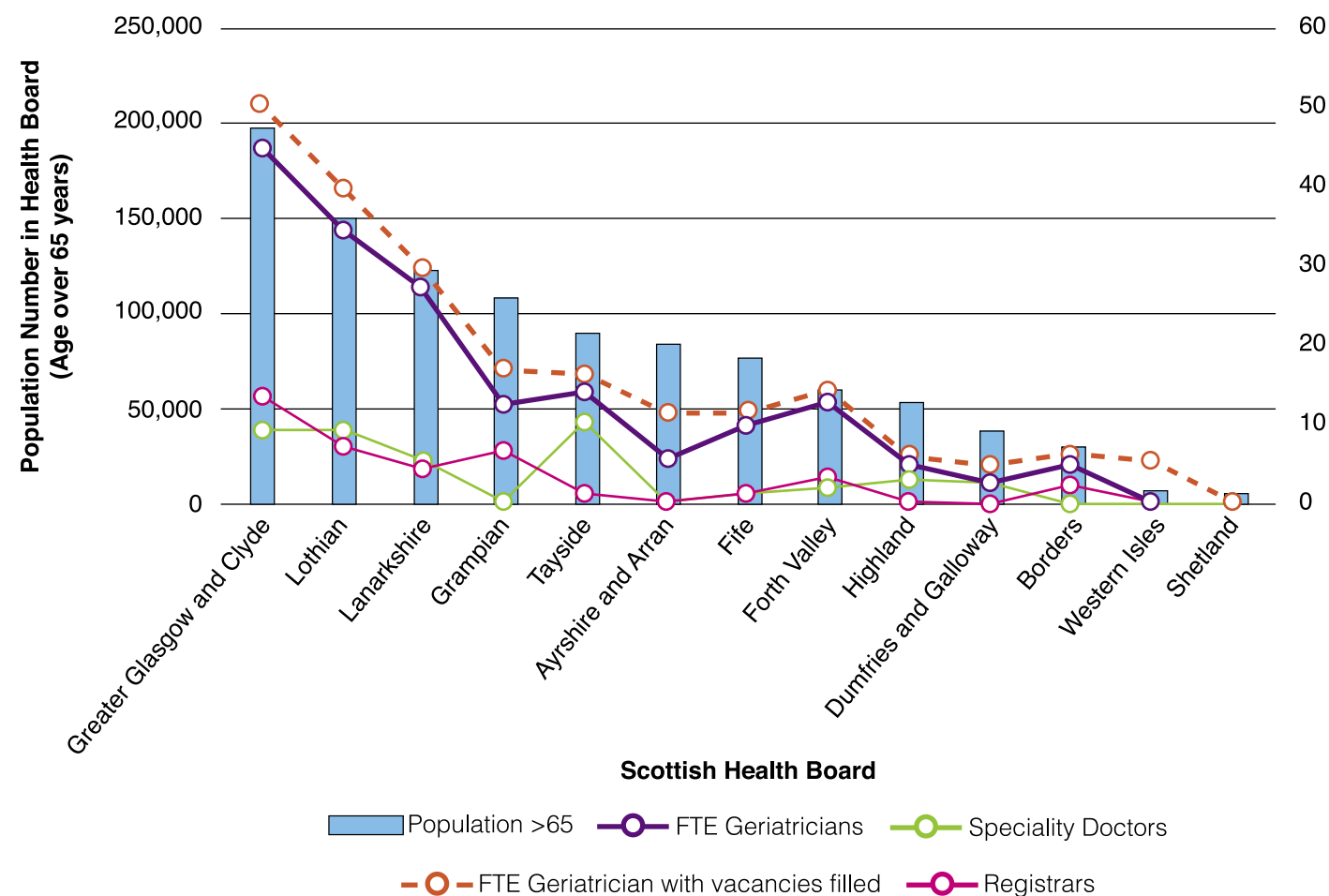
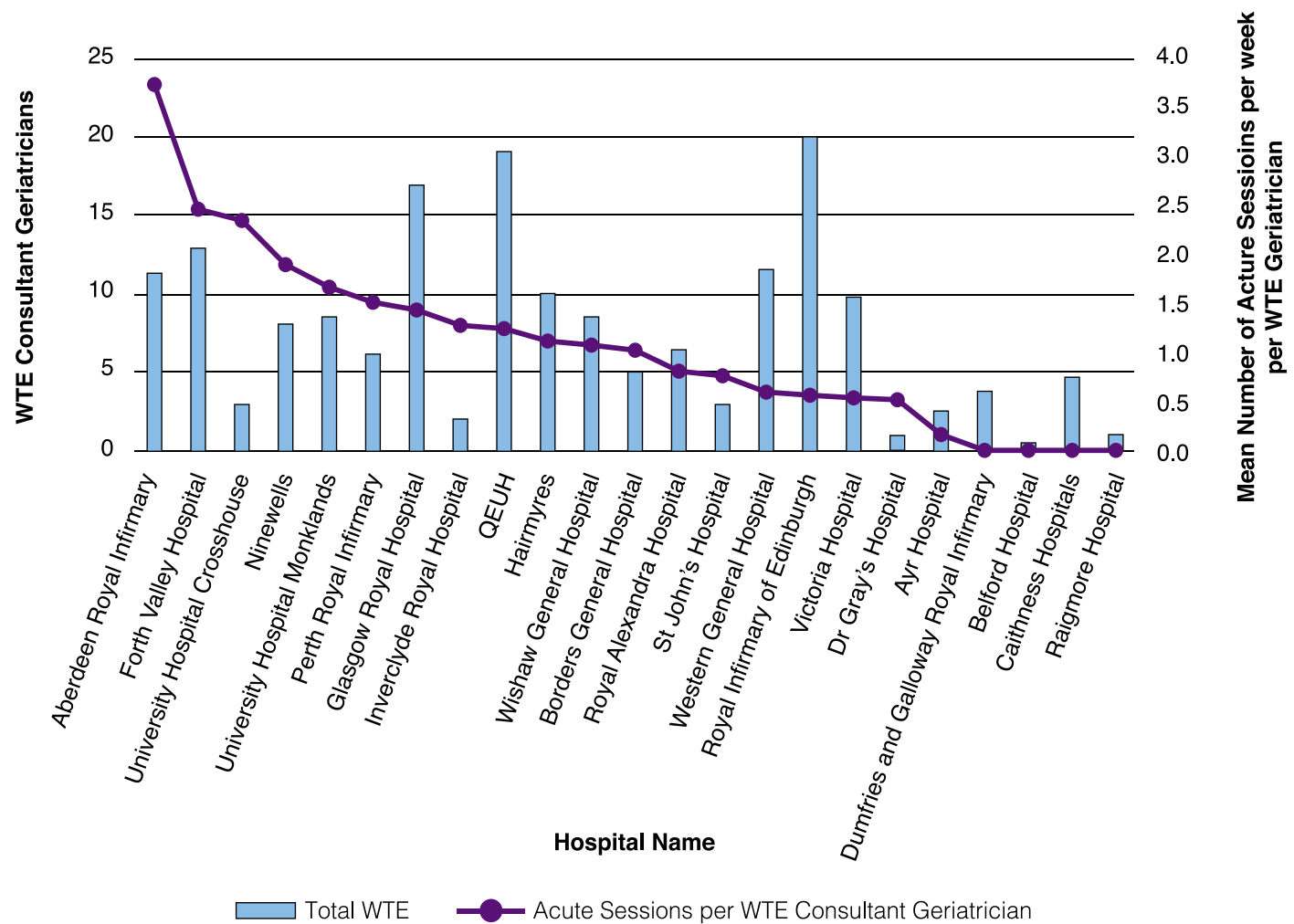


Figure 2: Weekly acute sessions spent reviewing newly admitted frail older adults by consultant geriatricians. Bars show number of whole time equivalent geriatricians (WTE) and purple round data points show acute sessions (line included to aid comparison)



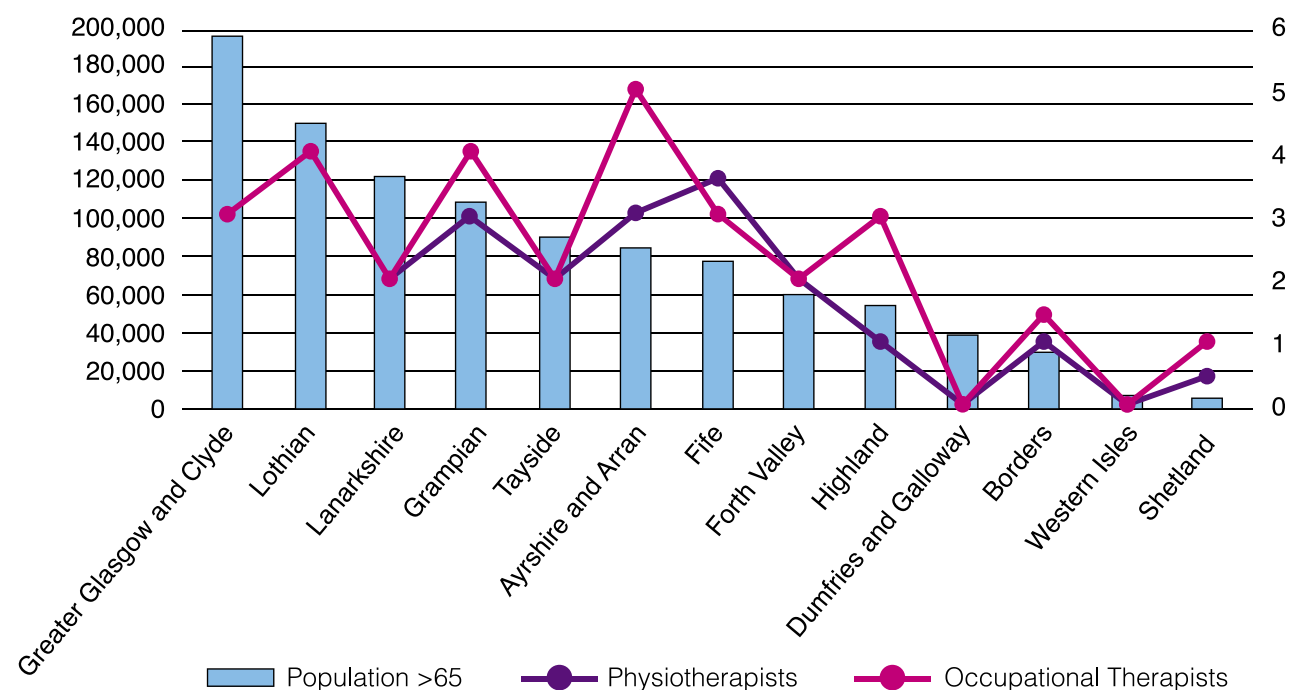
Therapy Staff (Appendices 6, 7 and 8)

The questionnaire asked about the number of therapists specifically employed to review patients admitted acutely with frailty.

The number of specialist physiotherapists per 10,000 older people aged ≥ 65 years varies widely across the Scottish Health Boards with a median of 0.22 [range: 0.0-1.07] physiotherapists dedicated to acute geriatrics medicine per 10,000 population aged ≥ 65 years.

The median number of specialist occupational therapists per 10,000 population aged ≥ 65 years was 0.34 [range: 0.0-2.13]. The mean hours spent by physiotherapists reviewing new admissions to geriatrics were 4.9 hours during weekdays (Monday to Friday) and 1.8 hours at the weekend. Similarly the mean hours spent by occupational therapists reviewing new admissions to geriatrics were 4.9 hours during weekdays and 1.7 hours at the weekend.

Figure 3: Frailty specific physiotherapist and occupational therapist provision for population aged ≥ 65 years



We were unable to correlate the number of frailty specific therapists in each unit with the size of the older patient population covered, but notably there are 8 hospitals without frailty specific physiotherapists and occupational therapists of which only 4 centres are remote and rural.

Access to Liaison Psychiatry

Psychiatrists were based in the admission setting or routinely available to review newly admitted frail patients in 5 hospitals (19%) and the majority of units were able to request a review by a psychiatrist for their frail patients, but this did not usually occur on the same day as requested (69% could access psychiatry review on request, but this was not usually conducted on the same day) (Table 3).

Table 3:

Availability of Liaison Psychiatry	Number of Hospitals
No access on site	3
Review within hospital on request, not usually same day	18
Review within hospital on request, usually same day	4
Psychiatrist based in admission setting	1

Pharmacists

At eighteen hospitals (18 out of 26 hospitals: 69%) acutely admitted patients to geriatric wards will have their medications reviewed by a pharmacist within 24 hours; this is by a pharmacist employed specifically for geriatric medicine in 6 centres and by a pharmacist shared with other units in 12 centres.

Social Work

The questionnaire asked if a member of the social work team would usually be available to review a patient within 24 hours of admission and representatives from seven hospitals answered yes (7 out of 26 hospitals: 27%).



Bed Management

Only one hospital had a dedicated bed manager for the geriatric medicine service - Queen Elizabeth University Hospital, Glasgow.

4. Multi-disciplinary Meetings (see Appendix 9)

Multidisciplinary meetings were held in most centres at least once daily during the week (17 out of 26 hospitals: 65%), but were held at the weekend in only 4 units (4 out of 26 hospitals: 15%) (Figure 4). The most consistent members of the MDT involved in meetings were consultants, physiotherapists and occupational therapists. Shared notes were being used by the multidisciplinary team in 61% of geriatric medicine departments (16 out of 26 hospitals).

Figure 4: Number of multi-disciplinary team meetings (MDTs) held on weekdays and weekends

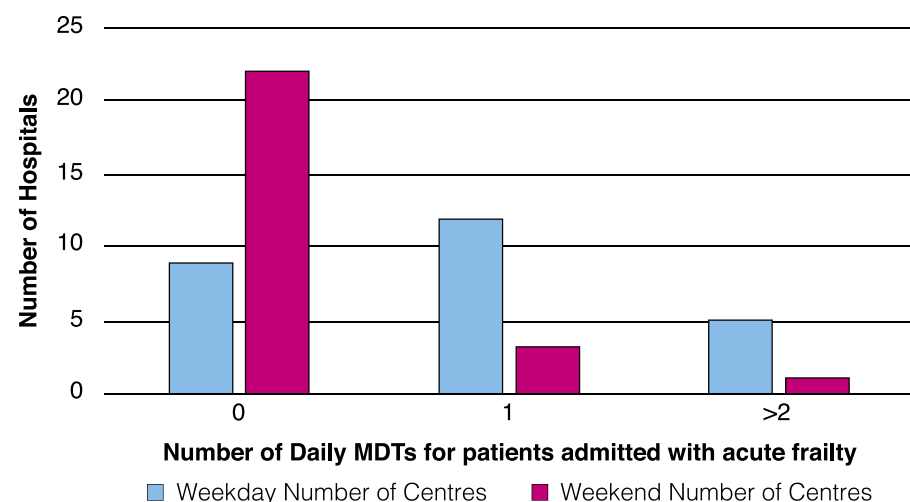
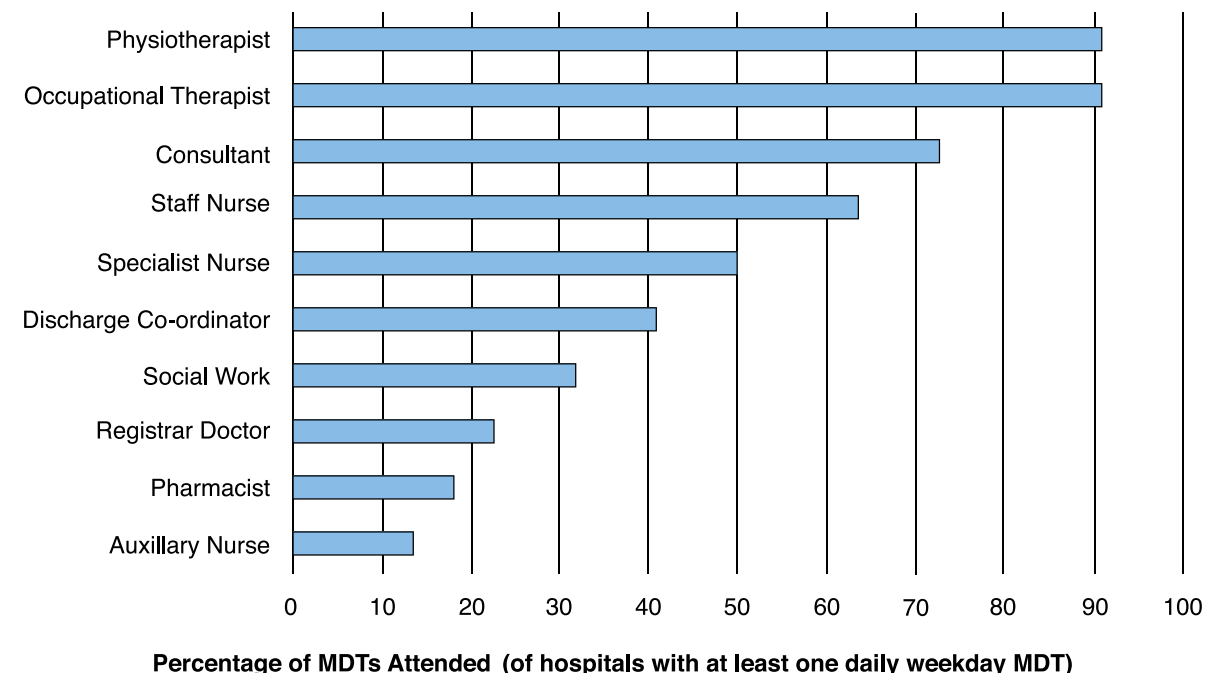


Figure 5: Staff members regularly attending MDTs (in hospitals with at least one daily weekday MDT)



5. Additional Services

Hospital at Home

There were 11 hospitals across 6 Scottish Health Boards who were providing a form of 'hospital at home' service. These are described in [Table 4](#).



Table 4: Hospital at Home Services as described by geriatricians based at each centre

Health Board	Hospital Name	Description of Service
NHS Ayrshire and Arran	University Hospital Crosshouse	No medical staff attached but is described as an 'enhanced intermediate care team' with ANP and AHPs.
	Ayr Hospital	Community rehab team and alternatives to admission, by supporting GP; no geriatrician involved; but ANP is.
NHS Fife	Victoria Hospital	3 bases throughout Fife. Admits step-down patients from acute hospital, to facilitate discharge, and takes direct referrals from GPs. 40-60 patients on virtual ward round on a given day across 3 bases. Consultant virtual ward round 2 or 3 times per week, with middle grade (F2 or above) on other weekdays, and nurses at weekends.
NHS Grampian	Dr Gray's Hospital	Not truly hospital at home but urgent domiciliary visits can be arranged to try and prevent admissions. These are complete by consultant and ANPs

NHS Grampian	Aberdeen Royal Infirmary	Current trial of "acute care at home" service - ANP, AHPs, HCSWs - offering admission avoidance support with medical input from GPs in part of Aberdeen City. No regular geriatrician input to this service.
NHS Lanarkshire	University Hospital Wishaw	Hospital at home team providing multidisciplinary care at home
	Hairmyres	Consultant/nursing/OT/PT takes hospital referrals 7 days/week from community on normal working days. SAS referrals at weekend.
NHS Lothian	Western General Hospital	3 H@H service (Edinburgh, Midlothian, East Lothian)
	St John's Hospital	Hospital at Home team sees around 100 patients per month with length of stay around 4 days.
	Royal Infirmary of Edinburgh	Hospital at Home services across Lothian
NHS Tayside	Ninewells	DECSA. Hospital at home and ECS (enhanced community support) for patients earlier in the journey to prevent crisis. More wrapped around GP practises.



Orthogeriatrics

There were 12 hospitals across 7 Scottish Health Boards who identified themselves as providing active input into orthopaedics. These are described in **Table 5**.

Table 5: Orthogeriatrics service as described by geriatricians based at each centre

Health Board	Hospital Name	Description of Service
NHS Ayrshire and Arran	Ayr Hospital	2 sessions per week by consultant geriatrician
NHS Fife	Victoria Hospital	3.5 consultant sessions per week. All hip fracture patients reviewed, and other patients by request from orthopaedic team. Staff Grade Orthogeriatrician works 6 sessions per week.
NHS Grampian	Dr Gray's Hospital	Consultant ward round Mon and Wed morning. ANP input Mon-Fri morning who review all new hip fractures. No service at weekend
	Aberdeen Royal Infirmary	Twice weekly ward rounds. Support of "orthogeriatric" ANPs

NHS Greater Glasgow and Clyde	GUEH	Consultant cover 5PAs; ECON (elderly care assessment nurses) 3.8wte working across QEUH acute trauma and GGH GORU. Cover at QEUH is 7 days.
	Glasgow Royal Infirmary	2 DCC of consultant time with 2 consultants doing a ward round in trauma wards i.e. X2 visits in total per week. Orthopaedic ECONS collect fairly detailed information on the patients in advance of ward rounds and provide daily input to the wards
NHS Lanarkshire	University Hospital Wishaw	Daily input with Consultants and ACE nurse Mon-Friday and ACE nurse alone Sat-Sunday. Consultants will review patients at request of ACE nurses at weekends.
	Hairmyres	Daily input Monday -Friday via ACE nurse and Consultant Geriatrician
NHS Lothian	Western General Hospital	Orthogeriatric rehabilitation service only - trauma managed initially at Royal Infirmary (see below)
	St John's Hospital	Combined orthopaedic and general rehab ward (30 beds)



NHS Lothian	Royal Infirmary of Edinburgh	Two trauma wards. Two consultant ward rounds and one MDT per week from two consultants aligned to each trauma ward. Daily SD and Clinical fellow input to support orthopaedics. Weekdays only. Consultant Geriatrician on call at weekend can provide input if requested.
NHS Tayside	Ninewells	Run by speciality doctor, team of clinical fellows and FY2 from orthopaedics

Surgical Liaison

There were 5 Scottish Hospitals with scheduled input into older patients under care by surgical specialities, a further two centres described an arrangement of case by case referral (**Table 6**). These hospitals were all based in NHS Lanarkshire and NHS Lothian.

Table 6: Surgical liaison services for frail patients

Health Board	Hospital Name	Description of Service
NHS Greater Glasgow and Clyde	QUEH	No nurse support in 2019 , Specialty doctor 2PAs, Consultant 0.5Pas
	Glasgow Royal Infirmary	0.5 DCC consultant session weekly - they do a weekly MDT and see appropriate patients after that
NHS Lanarkshire	University Hospital Wishaw	Case by case referral
	Hairmyres	Once weekly ward round - patients selected by surgical team for review
NHS Lothian	Western General Hospital	Surgical liaison service and POPs service led by a geriatrician with nurse support. A POPs clinic also operated with surgeons and anaesthetic colleagues to determine better outcomes for patients with frailty pre and post-surgery.
	St John's Hospital	Case by case referral
	Royal Infirmary of Edinburgh	Two consultant ward rounds and one MDT with three consultants delivering POPS service. Daily weekday input from one speciality doctor. Specialist nurse.





Discussion

In this audit of the provision of care for older adults acutely admitted to hospital, we can see huge variation in how services are set-up and staffed, and thus in how comprehensive geriatric assessments are conducted. While understanding the true impact of this on patient outcomes will only be appreciable once this data is available for correlation from the Information Services Division in Scotland, it is important to appreciate where it is already apparent that there may be inequity in service provision for frail older adults. However, this audit also helpfully highlights where individual departments may have useful expertise and experience in service development, such as in running an acute frailty unit or delivering hospital at home. Further collaborative working by sharing this expertise and experience and learning from regular audits, should help us to improve acute care for frail older adults in Scotland and shape Scottish Geriatric Medicine into a world leading service.

One of the main challenges of this audit was overcoming the many differences in how services are set-up to enable comparison. At the time of this audit in 2019, only 27% of Scottish hospitals had a frailty unit, whereas the NHS England Benchmarking Network reported that 52% of trusts had a frailty unit in 2016 (NHS Benchmarking Network, 2017). However, even among hospitals with acute frailty units, there are differences in the service they provide, with some offering an alternative 'front-door' to acute medicine or the emergency department and others limited to providing assessment only within normal working hours. Currently the quality of evidence for admission through frailty assessment units is of low quality, but with suggested benefits in reducing readmissions and costs (NICE Guideline 94 Chapter 25, 2018).

Overall in Scotland admissions into specialist geriatric care are mostly routed via an acute medicine or emergency medicine department with only 17% of units accepting direct admissions from primary care. While there are clearly benefits from frail patients being admitted directly into specialist care, with one in three of the Scottish population aged over 75 admitted at least once to hospital in 2017/18 and a predicted 19% increase in the population aged over 65 over a decade (NHS, Information Services Division, 2018), it is clear that geriatric medicine specialists will need to focus their expertise on those with decompensated frailty, rather than all those in a certain age bracket, with significant implications on demand for geriatric medical care. Indeed, this audit shows that Scottish geriatric medicine services are already aligned more to criteria of frailty than age for accepting patients.

In a similar vein we recognise the limitations of drawing comparisons of the specialist geriatric medicine workforce based on the ISD population of over 65 year olds as a denominator rather than the number of frail individuals in a specific catchment area, but such information is not currently available. Clearly the baseline health of the population, rather than age, will shape the demand for services, and we know that the life expectancy among Scottish NHS Health Boards varies considerably (79.7 years for a male in Orkney compared to 74.5 years in Greater Glasgow in 2010-12), but also within Health Boards (80.1 years for a male in East Dunbartonshire compared to 72.6 years for Glasgow City - both areas within NHS Greater Glasgow and Clyde) (NHS National Services Scotland, 2015). Despite this, with a median of 1.27 full time equivalent consultant geriatricians per 10,000 people aged over 65 years in Scotland but a range from 0 to 2.27, there is a clearly a need to look into this postcode lottery in access to specialist care.



It should be recognised that at least part of the inequities in division of resource among Scottish Health Boards is influenced by the concentration of the population geographically within Scotland's 'Central Belt'. Difficulties with recruitment to the more 'remote and rural' areas may contribute, but even if all vacancies at consultant level at the time of the audit were filled, the disparities would not be fully addressed. Another interesting finding is the variation in the number of 'acute' sessions worked by consultant geriatricians, suggesting the job plans between different Health Boards are quite variable with some units perhaps able to invest more consultant time into community care and admission avoidance than others. This alone would be an interesting topic for a future audit, especially with regard to the influence on consultant recruitment and job satisfaction.

Another challenge for this audit was assessing availability of staff and services which may be shared between departments, especially in smaller centres. The results do indicate a variation in specialist therapist provision between hospitals, but also show a reduction in therapist availability at the weekend. This trend was also seen with the number of hospitals holding daily MDTs at the weekend just 15% compared to 65% during the normal working week. It will be interesting to explore if day of admission has any bearing on outcome measures once ISD data is available.

This audit asked for a brief description of additional services provided by departments, and these will be helpful in guiding future audit cycles. Certainly it will be interesting to note the progression of hospital at home services which have been in development since the audit in 2019. The experience and adaptation of geriatric services over the last year with the influence of Covid-19 on service pressures will undoubtedly have led to changes in the results we present here, and we must recognise this when interpreting them.

Conclusion

This initial presentation of the results of the 2019 SCoOP audit of the provision of CGA in Scottish Hospitals highlights variation in the ways specialist care is accessed, structured and staffed across the country. Further correlation with outcome data is needed to ascertain the influence of these differences on patient care. These results should offer a basis for opening discussion between services to learn from each other's expertise as we aim to work collaboratively to improve acute care for frail older adults in Scotland and shape Scottish Geriatric Medicine into a world leading service.



References

Donaldson, A.I.C., Neal, S.R., McAlpine, C.H., Quinn, T., Shenkin, S.D., Ellis, G., Myint, P.K. & SCoOP Steering Group 2019, **“Variation in acute and community service provision of care of the elderly services across Scotland: findings from the Scottish Care of Older People (SCoOP) initial scoping survey”**, The journal of the Royal College of Physicians of Edinburgh, vol. 49, no. 2, pp. 105-111.

Ellis, G. & Myint, P.K. 2018, **Scottish Care of Older people (SCoOP) Project**. Available: <https://www.abdn.ac.uk/iahs/research/acer/scoop.php> [2018, August 23].

Ellis, G., Gardner, M., Tsiachristas, A., Langhorne, P., Burke, O., Harwood, R.H., Conroy, S.P., Kircher, T., Somme, D., Saltvedt, I., Wald, H., O'Neill, D., Robinson, D. & Shepperd, S. 2017, **“Comprehensive geriatric assessment for older adults admitted to hospital”**, The Cochrane database of systematic reviews, vol. 9, pp. CD006211.

Ellis, G., Whitehead, M.A., Robinson, D., O'Neill, D. & Langhorne, P. 2011, **“Comprehensive geriatric assessment for older adults admitted to hospital: meta-analysis of randomised controlled trials”**, BMJ (Clinical research ed.), vol. 343, pp. d6553.

Harris, P., Taylor, R. & Minor, B et al on behalf of the REDCap Consortium 2019, **“The REDCap consortium: Building an international community of software platform partners”**, Journal of Biomedical Informatics, vol. 95, no. July.

Healthcare Improvement Scotland 2015, **Care of Older People in Hospital Standards**. Available: http://www.healthcareimprovementscotland.org/our_work/person-centred_care/resources/opah_standards.aspx [2018, August 23].

National Institute for Health and Care Excellence (NICE) 2018, NICE Guideline 94 (Chapter 25), **“Emergency and acute medical care in over 16s: service delivery and organisation (Admission through elderly care assessment units)”**, NICE, UK.

National Records of Scotland. Mid-2019 Population Estimates Scotland. Available: <https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/population/population-estimates/mid-year-population-estimates>

NHS Benchmarking Network 2017, **Older People’s care in Acute Settings Benchmarking 2016**. Available: <https://www.nhsbenchmarking.nhs.uk/news/older-peoples-care-in-acute-settings-benchmarking-2016-findings-published> [2018, August 23].

NHS Information Services Division 2018, **Acute Hospital Activity and NHS Beds Information in Scotland Annual –Year ending 31 March 2018**, NHS National Services Scotland, UK.

NHS National Services Scotland 2015, **Health and wellbeing profiles 2015; Scotland Overview Report**



Appendices

Appendix 1 - Frailty Unit

Referenced on Page 9 of the Audit

<https://www.bgs.org.uk/sites/default/files/content/attachment/2021-08-17/Appendix%201%20-%20Frailty%20Unit%20v1.0.pdf>

Appendix 2 - No Frailty Unit

Referenced on Page 9 of the Audit

<https://www.bgs.org.uk/sites/default/files/content/attachment/2021-08-17/Appendix%202%20-%20No%20Frailty%20Unit%20v1.0.pdf>

Appendix 3 - Routes into Geriatrics

Referenced on Page 9 of the Audit

<https://www.bgs.org.uk/sites/default/files/content/attachment/2021-08-17/Appendix%203%20-%20Routes%20into%20Geriatrics%20v1.0.pdf>

Appendix 4 - Medical and ANP Staffing

Referenced on Page 9 of the Audit

<https://www.bgs.org.uk/sites/default/files/content/attachment/2021-08-17/Appendix%204%20-%20Medical%20and%20ANP%20Staffing%20v1.0.pdf>

Appendix 5 - Consultant Hours Reviewing New Admissions

Referenced on Page 9 of the Audit

<https://www.bgs.org.uk/sites/default/files/content/attachment/2021-08-17/Appendix%205%20-%20Consultant%20Hours%20Reviewing%20New%20Admissions%20v1.0.pdf>

Appendix 6 - AHP and psych

Referenced on Page 11 of the Audit

<https://www.bgs.org.uk/sites/default/files/content/attachment/2021-08-17/Appendix%206%20-%20AHP%20and%20psych%20%20v1.0.pdf>

Appendix 7 - Physiotherapy

Referenced on Page 11 of the Audit

<https://www.bgs.org.uk/sites/default/files/content/attachment/2021-08-17/Appendix%207%20-%20Physiotherapy%20V1.0%20%281%29.pdf>

Appendix 8 - Occupational Therapy

Referenced on Page 11 of the Audit

<https://www.bgs.org.uk/sites/default/files/content/attachment/2021-08-17/Appendix%208%20Occupational%20Therapy%20v1.0.pdf>

Appendix 9 - MDTs

Referenced on Page 13 of the Audit

<https://www.bgs.org.uk/sites/default/files/content/attachment/2021-08-17/Appendix%209%20-%20MDTs%20v1.0.pdf>

Appendix 10 - Audit questions

Referenced on Page 6 of the Audit

<https://www.bgs.org.uk/sites/default/files/content/attachment/2021-08-17/Appendix%2010%20-%20audit%20questions.pdf>

Appendix 11 - Remote and rural questions

Referenced on Page 6 of the Audit

<https://www.bgs.org.uk/sites/default/files/content/attachment/2021-08-17/Appendix%2011%20-%20Remote%20and%20Rural%20Questions.pdf>



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