Research Report

Older people’s experience of emergency hospital readmission

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Executive Summary

Over the past decade, rates of emergency hospital readmission (defined as an unplanned readmission within 28 days of leaving) have risen; the increase has been particularly steep for those over the age of 75 (the readmission rate for this age group is now about 50% higher than for 18–64 year olds). Reducing the occurrence of emergency hospital readmission for older people is a key issue for the NHS.

There is little evidence about the causes and effects of emergency readmission (for example, understanding why there is such wide variation in its rate across the country). The voices of older people who have experienced an emergency readmission have been largely silent in the debate about the problem, which has tended to focus on who is to blame in the system. Without listening to this experience it is likely that solutions will not address real problems. Age UK commissioned this research in order to understand these issues from the perspective of those most affected—older people who have experienced an emergency readmission.

GHK undertook the study. It began in January 2012 and concluded in May. The methodology comprised: qualitative interviews with 18 older people who have experienced an emergency readmission (and in several cases their families); a brief review of the key policy documents and research; and four semi-structured interviews with senior stakeholders whose role or organisation is connected to the issue of emergency hospital readmission amongst older people.

Key findings

Interviewees were asked to share their experience, beginning from their first admission to hospital through to the discharge and return home, and then their experience of the readmission to hospital. Interviewees gave a range of reasons for their original admission. The majority were unplanned admissions, although five were for operations.

When asked about their ‘first stay’ in hospital, interviewees described a mixed set of experiences. Around half outlined particular incidents (or poor overall experiences) which they thought were examples of poor care. This included cases where interviewees felt their dignity was not preserved, where language difficulties caused problems, and a range of specific issues relating to the care received and the hospital environment. However, interviewees generally displayed understanding of the challenges facing hospital staff, and an appreciation that in their condition at the time, hospital was the best place to be.

Experiences of discharge from hospital were, in the majority of cases, quite poor. Several interviewees felt that they had no control over the timing of their discharge (including people who felt that they were discharged too early). The provision of information at the point of discharge was also considered to have been poorly managed. A minority of interviewees reported a comprehensive and high quality discharge process; in these cases, interviewees were provided with confidence.

Interviewees described a variety of different care packages put in place to manage their care once they returned to the community. This ranged from individuals who were referred to intermediate care wards where they stayed for several weeks, to people who were discharged without any formal care in place.

Despite the varied set of care packages described, a common theme reported by interviewees was a desire for more personalised care once they had left hospital. This was noted by the majority of interviewees who had formal support after leaving hospital. Elements to this included: having a greater say over the content of their care; ensuring that health professionals respected personal preferences; and, ensuring that they received a coordinated package of care, especially where several professionals were involved.

Interviewees also reported examples of good practice in the care they received once they had left hospital. Several felt that staff in the community were able to give more time to their care than staff in hospital.

Interviewees cited a range of reasons for their readmission. In most cases, they did not think there was a connection between the first and second admission. Where they did see a connection, there were two broad causes: the initial admission not dealing with the underlying health problem; and a poor quality discharge or issues in the primary care setting contributing to the readmission.

In a majority of cases, readmission had a negative impact. This included contributing to feelings of depression and frustration about being back in hospital.
Stakeholders’ views supported many of these findings, as well as reflecting upon the broader policy and service response. They described why the issue of emergency readmission is so important: it can have significant impacts on the health and wellbeing of the individual; it often suggests that something has gone wrong within the system; it has significant cost implications. As a result, emergency readmission is addressed in a wide range of policies and initiatives. This ranges from responses focussed on the acute setting (such as the policy of non-payment for emergency hospital readmissions) through to more locally devised methods of improving the management of patients’ discharge.

Conclusions and implications for Age UK

Several key messages emerge from a consideration of each element of this research. Primarily, emergency hospital readmission is a complex issue with multiple potential causes which range across an individual's care pathway. However there are particular challenges to be addressed in the transition between secondary and primary care, and ensuring that a personalised care package is put in place in the community.

There are several implications for Age UK both at the local and national levels. At the local level, interviewees articulated a demand for enhanced support in three areas: low-level practical support during the first few days after discharge from hospital; befriending services (to support people after their discharge which is often an emotionally vulnerable time for them); and, advocacy services (ranging from provision of support in ‘navigating’ complex health and social care systems in the community through to support in resolving problems or making complaints).

At the national level, several clear messages also emerged with stakeholders considering that Age UK were in a useful position to make important contributions on this issue. These were:

- Age UK could develop a statement of good practice on what older people and their carers can expect on discharge from hospital.
- Age UK could further contribute to the debate on the policy response to this issue, based on an understanding of the complex causes of readmission.
- Age UK should continue to articulate older people’s demands for more personalised services in the community (and in transitions between care settings), linking this explicitly to the issue of emergency hospital readmission.
1 Introduction and method

Age UK commissioned GHK Consulting Ltd (GHK) to undertake a research study into older people’s experience of emergency readmission to hospital. This is the final report.

1.1 Background to the study

Age UK is the UK’s largest charity focused on older people. A wide range of services at the local level are provided by local Age UKs; in addition, the national Age UK carries out a range of lobbying and influencing activities to improve policies which impact on the lives of older people.

One of Age UK’s strategic goals is to improve health services for older people. Within this broad goal, it has attached a key indicator to the issue of emergency hospital readmission. This piece of research sits within this goal.

The voices of older people who have experienced an emergency readmission have been largely silent in the debate about the problem, which has tended to focus on who is to blame in the system. Without listening to this experience it is likely that solutions will not address real problems.

1.3.1 Purpose of the study

The purpose of the study was two-fold:

1. To inform Age UK’s health strategy, specifically the theme of improving experiences and outcomes for older people using hospital services.

2. To provide Age UK with a greater understanding of the issue of emergency hospital readmission from the perspective of the older people themselves, to be used in influencing activities and in service development support for local Age UKs.

1.3.2 Summary of the methodology

The study methodology had two main components:

- qualitative interviews with a sample of 18 older people who have experienced an emergency readmission; and,

- semi-structured interviews with four senior stakeholders.

The research briefing stated that all interviewees were to be over 75 years of age (to correspond with the NHS’s key indicator in this area) and that interviewees should not have been in receipt of any voluntary sector hospital aftercare services (as Age UK was keen to capture the views of those who may need further support). In order to ensure that a varied group of people were interviewed, further sampling criteria were set (see Table A2.1 in Annex 2 for further detail).

There were a number of ethical issues to consider in carrying out this piece of research. Having reviewed the DH Guidance, it was decided that the study did not need a formal NHS/SC review, but that it was important to have a clear and robust approach to deal with issues relating to research ethics. This approach was based on GHK’s research ethics policy, bolstered by an internal ethics panel (see section A2.1.3 in Annex 2 for more detail).

1.2 Structure of this report

The evidence gathered using the method described above is summarised in the following sections:

- Chapter 2 presents the main findings from the fieldwork.

- Chapter 3 is a summary of interviews with key high level stakeholders and the policy context for the issue of emergency hospital readmission.

- Chapter 4 presents a set of discussion points based on the fieldwork, policy review and stakeholders interviews.
2 Findings

This chapter sets out the analysis of the interviews conducted with people who have experienced an emergency hospital readmission. It is structured chronologically, beginning with the reasons for people’s original admission and their perspective on their initial stay in hospital. It then presents an analysis of interviewees’ experiences in relation to discharge and transition to care at home. Finally, the chapter presents an analysis of interviewees’ experience of readmission to hospital, including causes and effects.

2.1 Reasons for original admission and perspectives on the stay in hospital

Interviewees gave a range of reasons for their original admission. Most were unplanned admissions with a range of causes (the two most common being falls and heart conditions). Of these, a long term condition, such as diabetes or an underlying heart condition was present in most cases. For those who had an unplanned initial admission most had to call an ambulance, however one interviewee had her admission arranged by her GP. Five out of the eighteen interviewees experienced an initial admission which was planned; these were for operations.

Interviewees had a mixed set of experiences of hospital during their first stay. Relationships with staff were of particular importance; for example, one interviewee valued the way that the staff kept him fully appraised of progress, even though it was not clear when he would be discharged:

“You’re not fobbed off with medical mumbo jumbo”.

Another interviewee described how she appreciated that staff responded quickly if she needed attention; she felt safe in the hospital and was quite anxious about going home.

However approximately half of interviewees also outlined particular incidents (or overall experiences) which they thought were examples of poor care. In a few of cases, this negative experience tainted an otherwise positive view of their stay in hospital and the care they received. Such examples included:

- **Cases where interviewees felt their dignity was not preserved.** One interviewee described how she was left sitting in a chair all day and because she had recently had an operation on her knees she said, “I couldn’t move”. She considered this was not the level of care she would expect. Another interviewee felt that her dignity was not respected when it came to bathing.

- **Language difficulties causing problems.** Three interviewees did not speak English fluently and each related how this had caused them difficulties during their stay in hospital. The language barrier meant that nuances of communication between patient and clinician (both in relation to their care needs and in explaining individual preferences) were somewhat lacking.

- **Detailed points of care and the environment, such as:**
  - the quality of the food, which one interviewee thought was so poor that, unless her family brought her something, “I stayed hungry”;
  - differing quality of care at different times of the day; one interviewee suggested that she received far poorer care during the night relative to daytime; and,
  - one interviewee who explained how dirty her room was when she arrived.

Despite these examples, interviewees, in general, displayed understanding of the challenges faced by staff in hospital setting:

“They [hospital staff] have so many people now that they haven’t really got time for you”.

Moreover, a few interviewees felt that they understood the reasons why they had been admitted to hospital and that, at the time, they accepted that it was the best place to be.
2.2 Experiences of discharge from secondary to primary care

The majority of interviewees described that they thought the transition from secondary to primary care (and, in particular, the process of discharge from hospital) was, on balance, poor.

2.2.1 Timing of discharge

Several interviewees considered that they lacked control over the timing of discharge from hospital. A few interviewees thought they were discharged too early:

“The doctor said 'you have to go out [of hospital]' and she said to him 'I'm not alright doctor, I have to stay more days'... If the doctor says I have to go, I have to go. But I cry this day because I didn’t feel alright”.

[Quoting the interpreter]

Another interviewee was discharged before she felt comfortable using her walking aid:

“I said 'I haven't had practice of walking on my frame yet'... So I said 'I can't go home until I've walked on my frame.' Anyway [without having had a practice] they decided it was time for me to go...If you’ve got to go home you’ve got to be able to walk... because otherwise, how are you going to be able to get up and go to the loo”.

Interviewees’ perceptions of why they were discharged were also important; one interviewee noted:

“I feel like you should be there to get better, but I felt like they just wanted the bed and shoved me from place to place…It was too early”.

A minority of interviewees appeared to have had more control of the timing and nature of their discharge. For example, one interviewee was very anxious about going home when she was told she was to be discharged. After explaining this to the staff she was able to stay in the hospital for an extra night.

2.2.2 Provision of information at the point of discharge

Several interviewees had a poor experience of being discharged from hospital. One interviewee who was admitted to hospital because of problems with his diabetes was given a ‘parcel’ of medicine; he noted that:

“They don’t tell you what to do with the parcel... they think you’re supposed to know all about it, but while you’re in hospital they don’t tell you nothing about what you’ve got.”

One interviewee who was discharged from hospital into a ‘step down’ residential care home also thought that she was not provided with appropriate information about the next stage of her care pathway. She noted that:

“All they [the clinicians] said is you’re going to somewhere else so you can feel better”.

Two interviewees reported significant delays between being informed of a discharge, and having a final consultation with clinical staff. One interviewee was informed of a discharge in the morning and then was left sitting in a “side room” waiting for the doctor until six in the evening. He recalled that:

“Nobody comes and sees you, there’s no medication... I didn’t even have a cup of tea or a sandwich all day. Nothing at all”.

Another interviewee described:

“Waiting for a long time [to see the discharge doctor]... he didn’t come in until near dinner time... the whole day I was there”.

A minority of interviewees reported a comprehensive and high quality discharge process. Where this was the case, it provided confidence at a time of uncertainty; as one interviewee who had been in hospital for several weeks following a fall recalled:
“They [discharge staff] had time to listen to what you had to say... they discussed how you’d be when you get home and what care you’d receive”.

Another man who had been admitted to hospital with a heart attack said that his discharge had been informative and involved his wife, who was his principle carer. He was provided with medication, tools and information to monitor his condition at home (including a symptom list).

2.3 Experiences of community-based care

Interviewees also reflected on the care they received once they had returned to a community setting or home.

2.3.1 Coordination and transition

Interviewees reported having a range of care plans after discharge. These ranged from a couple of interviewees who were referred to intermediate care services, where they stayed for several weeks, to a few who were discharged without any formal care package in place. Pre-existing conditions are one of the key factors here. Interviewees who had long-term conditions such as diabetes had more formal arrangements in place (such as district nurses who came in to the home to give injections), whereas those who did not have a significant long-term condition prior to the initial admission had fewer homecare services in place.

A few interviewees wanted care to be better coordinated between secondary and primary care settings. In two cases where interviewees were discharged during the evening, both people were left without care for the evening once they had arrived home. One of these interviewees described how they were unable to call their carers at this time because they had finished for the day. This lack of co-ordination was frustrating to the interviewees, particularly as they thought it could have been easily avoided.

Other examples of poor coordination include an interviewee who had diabetes and was instructed to attend his local pharmacy upon being discharged from hospital where he was told there would be some medication waiting for him. When he arrived at the pharmacy, they were not expecting him and his course of treatment was not available.

2.3.2 ‘No decision about me without me’

Despite the varied set of care packages that interviewees described, a common theme running through the majority of the discussions (with those that had a formal care package in place after leaving hospital) was a desire for a more person-centred experience. Several aspects of this were made clear:

- A couple of interviewees thought they were not given the opportunity to be involved in their treatment, even though they would have liked to.
  - An interviewee described how she thought that staff underestimated her ability to participate in her own care: “Young people see old people as all having dementia.”
  - An interviewee who was referred to a care home from the hospital thought that she was not in control of this process. She was upset by the fact that she was not able to bring personal items, including particular items of clothing, which she said she, “like[s] for my own dignity”

- Several interviewees described cases where their preferences were not taken into account in the provision of care after they had left hospital:
  - One interviewee asked staff not to use the word ‘geriatric’ however it continued to be used.
  - Another interviewee, who was very immobile after an operation on her knees, described how she had been asking social services for modifications to be made to her home to help her move around more easily; she has found them to be unresponsive.
After discharge from hospital, a couple of interviewees described the challenges of having several different health professionals visit them in their homes and the difficulty in ensuring continuity of care (indeed, one interviewee considered that the lack of continuity may have contributed to her condition worsening).

Interviewees also described several examples of good practice with regard to the care they received after leaving hospital. These included an interviewee whose cardiac nurse is able to provide care he thought was personalised to his needs but who was also able to book appointments for him at the GP and with a specialised cardiac gym. He reflected that: “You need someone like [the cardiac nurse] to tell you your own personal condition”. Moreover, he thought it was important that a positive relationship was built up between them: “You don’t have to call her nurse – she feels like a friend”. Another interviewee thought that the “Aftercare was very good... most of them had time to spend on you”.

2.4 Experiences of readmission

Interviewees reflected on their experience of readmission to hospital.

2.4.1 Potential causes of readmission

Interviewees cited a range of reasons for their readmission. In most cases, interviewees saw no connection between the two admissions, or a direct link was not made clear in the interview. However, where interviewees drew a connection, they cited two broad causes:

- The first stay in hospital not addressing the underlying health problem. For example, one interviewee and her daughter (who also contributed to the interview) considered that the clinicians who treated her on her first admission to hospital were not thorough enough. They thought that had clinicians provided her with the course of treatment which she received on her second admission to hospital, the problem would have been dealt with earlier.

- ‘Poor quality’ discharge or primary care contributing to a readmission. A small number of interviewees thought that a lack of clarity at the point of discharge had left them confused about the care they should be receiving once they left hospital. Two interviewees reported a direct link between this and their readmission:

  “They just gave me the wrong medication to take... didn’t explain what it was for and often time I got muddled and took the wrong tablets”.

  “They don’t give you any advice on diet and anything like that. You’re out [of hospital] and that’s it. [It’s like they say] ‘You’re nothing to do with us. You’re a number and that’s it’... There might have been [some instructions provided] but I couldn’t read them anyway... If they’d have told me to take this and do that, I would have done it”.

Lastly, in a small number of interviews it seemed that greater support / action in the community may have led to a reduced likelihood of a readmission to hospital, although this is far from certain. For example, one interviewee had not had adjustments made to her home such as hand rails; the cause of her readmission was a fall during the night.

2.4.2 Experiences and consequences of readmission

The experience of the readmission itself, in the majority of cases where it was discussed, was reported to be “terrible”. As one interviewee described, it was:

“Dreadful... it was traumatic, believe me. It was bad enough having the haemorrhage all on my own and then to get over that and get it all sorted [and then be readmitted]”.

Another interviewee admitted feeling frustration at repeated readmissions:

“I am frustrated about my health problems not being resolved, being in pain and being in and out of hospital”.


Specific consequences of readmission are challenging to tease out amongst a client group who have a broad range of experiences. A few interviewees noted that they felt ‘low’ and ‘depressed’ as a consequence of their readmission. For example, one interviewee, whose mobility had been significantly reduced after the hospital admissions described how she felt:

“Some days I just sit on the chair and cry, there’s no one to talk to”.

It was clear that the stress caused by repeated readmissions also affected the health and wellbeing of the principal carers. One of the carers (the interviewee’s sister) commented that the “stress and anxiety” of caring for her brother contributed to her collapsing and being admitted to hospital.

However, a few interviewees gave positive feedback about their experience of a readmission. In these cases, it was clear that interviewees were content in calling an ambulance and that this was even preferable to being admitted to hospital through a planned in-patient appointment or through a primary care provider. A couple of interviewees also described how they thought hospital was the best place for them in cases where they were afraid of or anxious about the health concern they were facing. The failure in responsiveness could be anything from a GP being unable to visit someone in the home (as was the case with one of the interviews) to poor care being provided in the home.

Lastly, a couple of interviewees also noted that, having been readmitted to hospital, they were feeling much better and had their condition dealt with; one stated:

“The doctors were very good to me and treated me very well. I felt better”.

3 Context to the findings

This section provides a summary of the broader context to the research findings outlined in chapter 2. It draws upon a brief review of literature, a consideration of the main policy responses to date, and interviews with stakeholders.

The section begins by defining what an emergency re-admission is, before summarising the nature and scale of the problem and trends over recent years. It goes on to outline what is known about the potential causes and effects of emergency readmission, before concluding with a description of the main elements of the current policy response.

3.1 Emergency hospital readmission

Definition of an emergency hospital readmission:

An emergency hospital readmission is defined as re-entering hospital within 28 days of leaving in an unplanned admission. The NHS uses the relative risk of a readmission within this period (the ratio of the observed number of emergency readmission at a given Trust against the expected number of readmissions within 28 days) as a key indicator.\(^1\)

Older people represent a significant and growing section of the UK’s population; they also represent the largest user group of the NHS. Recent figures suggest that two-thirds of general and acute hospital beds are in use by people over the age of 65.\(^2\)

Emergency hospital readmission is an important issue for the health of older people. Figure 3.1 illustrates that hospital readmission is higher amongst people aged 75 and over than it is for people aged under 75. In 2009-10, readmissions were 5.1% higher for people over the age of 75 than for people aged between 16 and 74. Indeed, the older someone is, the more likely it is that they will be readmitted more than once within a year (for example, 7% of patients older than 85 are readmitted three or more times in a year).\(^3\)

Figure 3.1 also shows that hospital readmission has increased for all ages over the past decade and the proportion of readmissions of people over the age of 75 rose more steeply than for people aged between 16 and 74 (a rise of 3.9% as opposed to one of 2.5%).

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2. Department of Health (2010), Improving Care and Saving Money
Figure 3.1  Emergency readmissions to hospital within 28 days of discharge from hospital: adults aged 16 – 74 and adults aged 75+

3.2 Causes of emergency readmission

There is little definitive evidence about why readmissions occur\(^5\) (which is echoed in the findings from this study, in which several causes were clear). Department of Health research published in 2008 described the complexity of attributing causes of readmission: “Equating the increasing rate of emergency readmissions to reductions in the quality of hospital care was far too simplistic.”\(^6\) Nevertheless, interviews with stakeholders and a review of the available literature suggested a number of possible contributing factors.

3.2.1 Individual factors

There are several factors related to individual cases which contribute to variation in readmission. These include:

- **Age**: readmissions increase with age, which is caused by a greater complexity of health needs, an increase in frailty and a greater prevalence of long-term conditions.
- **Gender**: males have higher readmission rates than females.
- **Method of admission**: readmissions following a non-elective admission (such as emergency admission, emergency transfer and other urgent cases) are higher than those following an elective admission.
- **Diagnoses and procedure**: there are different rates of readmission for different clinical conditions\(^7\).

Stakeholders noted that the presence of multiple and/or long term conditions often contributed to readmissions. This was particularly important where the treatment of a long term condition has been changed after an initial admission.

\(^{6}\) Data from NHS Information Centre for Health and Social Care  
\(^{5}\) CHKS (2010), *Hospital readmissions and the 30 day threshold*, p. 8  
\(^{6}\) DH (2008), *Emergency readmission rates: further analysis*, p. 8  
\(^{7}\) DH (2008), *Emergency readmission rates: further analysis*
Points of transition and provision of information

Recent studies have noted the importance of ensuring a high quality of care across transitions:

“Continuity of care matters to patients and their carers at every step of the journey within the hospital environment, but arrival in A&E or on to a ward and the moment of discharge are often particularly associated with high levels of anxiety and stress. These ‘touch points’, sometimes called ‘moments of truth’, are key times and / or places at which people’s contact with a service shapes their subjective experience in a global way.”

Stakeholders noted that discharge from hospital is a vital point in the care pathway. This is particularly true where a “risky discharge” has occurred, either because a patient has discharged themselves early (as is their right – as one stakeholder put it: “Older people deserve the right to take risks as well... we need to support this”) or if a clinician discharges someone before they feel ready. It was also noted that there can often be a tension in this with family members or carers disagreeing with the opinions of clinicians or the patient themselves. Analysis of readmission rates indicates that over the past twenty years there has been a considerable increase in the proportion of readmissions that occur within one day of the original admission. This may suggest that some patients are being discharged too early.

Another important component of discharge is the provision of information or the development of a care plan for the patient’s care in the community (if relevant) or simply the provision of advice for self-care. One stakeholder suggested that this is often poorly done:

“They [hospitals] overestimate people’s capacity to take in information when they are in hospital... [Older people will often say] I didn’t ask the right questions when I was in hospital but who do I ask now?”

Stakeholders noted several challenges to doing this effectively. Factors included: ensuring that carers are fully involved (given that they may be responsible for providing continuing care once the person has gone home); providing information in a person’s first language (and if this is not possible, ensuring that the patient understands the information provided in some way); and ensuring that information is provided in a sensitive way, given that at the point of discharge the individual patient may still be in some pain or discomfort. Where there has been a ‘change in dependency’ (for example, a change in a patient’s long term condition), providing clear and accessible information at the point of discharge to the patient and/or their carer was also cited as being important.

On this point, analysis of the National Inpatient Survey indicates that several metrics of relevance to provision of information to patients have got worse between 2002, when the survey began, and 2010. For example, more patients report:

- a delayed discharge;
- not feeling like they are provided with enough information about their treatment or condition; or
- that they thought the purpose of their medication was not clearly explained in a way they could understand.

Evidence from the fieldwork agrees with the stakeholders’ comments in this area.

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8 Including, for example, Cornwell, J (2012), Continuity of care for older hospital patients: a call for action
3.2.3 Community care

Stakeholders suggested that variable quality in the care provided in community locations may also contribute to emergency readmissions. Specifically, there may be:

- A planning failure between the acute and community setting.
- Community providers may not be able to meet the needs of patients.
- A failure in responsiveness/capacity of community care.

Where there are failures in the responsiveness or capacity of community care, one stakeholder noted that people will often “default to the place of safety” which is often a hospital. There is some evidence from the fieldwork with older people which supports this. One stakeholder agreed and cited a 4% rise in 999 emergency calls in each of the last ten years; they attributed this, at least in part, to a loss of trust in local community services. Many of those who present at Accident and Emergency, it was suggested, are then (re)admitted needlessly. This factor along with the others described would tend towards an increase in emergency readmissions.

Another stakeholder noted a need for a more creative service response here; in particular to use ‘intermediate care’ as a means of ‘stepping down’ care, supporting particular patients to make a more gradual transition back into the community. Furthermore, they noted the importance of integrated care – perhaps using multi-disciplinary teams spanning social care and health care (primary and secondary).

3.3 Key features of the current policy response

There are several reasons why the NHS is keen to reduce emergency hospital readmissions amongst older people. As one interviewee summarised it:

“From the perspective of the person, it’s pretty catastrophic – no-one wants to be re-admitted...From the perspective of the system it suggests something has gone wrong – in discharge or after care...and it’s a massive cost driver.”

Stakeholders noted a range of policies and initiatives which could impact on readmission rates:

- An important component of the Coalition Government’s response to try and reduce readmission rates has been, “The policy of non-payment for emergency readmissions [which] applied to all readmissions following an elective admission and to a locally agreed proportion of readmissions following a non-elective admission”11. Based on feedback and significant challenges in implementing the policy at a local level, changes were introduced in 2012-13 which led to, amongst other developments, more clinical reviews to determine the level of non-payment for readmissions.

- The Quality, Improvement, Productivity and Prevention (QIPP) agenda. Several of the workstreams set up to help deliver QIPP within the NHS are likely to affect emergency readmission. For example, the long-term conditions workstream aims to reduce unscheduled hospital admissions by 20% and maximise the number of people controlling their own health through the use of supported care planning12. Within this workstream, a new model of funding for people with long-term conditions is being examined. The ‘Year of Care funding model’ aims to incentivise the delivery of integrated health and social care for people with long term conditions.13

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11 DH (2012), Payments by Results guidance for 2012-13, p. 33
13 DH (2012), QIPP Long Term Conditions: Supporting the local implementation of the Year of Care Funding Model for people with long-term conditions
▪ NHS Outcomes Framework: several of the domains within this framework are linked to emergency hospital readmission, for example, Domain 2 ‘Enhancing quality of life for people with long-term conditions’ and Domain 3 ‘Helping people to recover from episodes of ill health or following injury’ (within which sits the indicator for emergency readmission described at the start of this chapter).

▪ In 2011-12, £648 million was allocated to Primary Care Trusts for transfer to councils to spend on social care services which also impact on health which is likely to have implications on emergency readmission. The primary use of this money has been on re-ablement services (short-term, intensive, home-based support)\(^\text{14}\).

▪ Initiatives which test new ways of managing patients’ discharge. Examples cited include:
  – Wandsworth Community ward: this initiative, which is based around the London borough of Wandsworth, provides multi-disciplinary care to patients with chronic conditions in one location. Through the provision of co-ordinated GP, nursing, occupational therapy, mental health and pharmacy services (amongst others) in one location the wards seek to reduce hospital admissions\(^\text{15}\).
  – Integrated care in Torbay: the model of care developed by Torbay Care Trust is regularly cited as a model of good practice. Key innovations, including the integration of health and social care teams, pooling of budgets and the appointment of care co-ordinators aim to improve the care provided to older people in the area. The results of integration include low rates of emergency hospital admissions for those aged over 65, and minimal delayed transfers of care\(^\text{16}\).

▪ There is also a range of NICE guidelines as well as profession-specific publications which deal with the readmission.

The issue of readmission is often viewed in isolation, however it is integral to one of the major policy agendas in the NHS at present: that of trying to move care closer to home. As one stakeholder put it:

“The answer is to shift resources out of hospital and into the community. But the big service challenge with that is that no-one wants to see their local hospital reducing its services...the message needs to be about shifting services into the community to prevent emergency readmissions”

As a result, the NHS, public health, and social care all have some responsibility for the issue of emergency readmission. The emerging local Health and Wellbeing Boards will have a role here, linking social care and NHS services with the aim of reducing hospital readmission of people with dementia (an example which is already underway).

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\(^{14}\) Local Government Information Unit (2011), *Policy briefing: Health, Public Health and Social Care Round-up: October and November*  
\(^{15}\) [http://www.stgeorges.nhs.uk/services_cs_commward.asp](http://www.stgeorges.nhs.uk/services_cs_commward.asp), accessed 20 April 2012  
\(^{16}\) Thistlethwaite, P (2011), *Integrating health and social care in Torbay Improving care for Mrs Smith*
4 Conclusions and discussion of implications for Age UK

This final chapter presents a number of discussion points emerging from the evidence presented above. It draws out implications for Age UK, both in terms of the services it offers at the local level, and key messages to be delivered at the national level.

4.1 Conclusions

The evidence presented in this report leads us to the following main conclusions:

4.1.1 Readmission is a significant challenge for care services to address: its causes and effects are various and complex

One of the major themes to emerge from the research is that there are several causes of emergency readmission and they range across an individual’s care pathway. In the fieldwork with older people who have had this experience, if a cause for the readmission was discernible, it was just as likely to have been an issue in the community as the acute setting.

The impact that readmission can have on people also became clear in the interviews. In a couple of cases, it was clear that being readmitted to hospital so soon after having been discharged had impacted on people’s confidence and self-efficacy; in other cases, the experience had contributed to depression. Where interviewees felt that their readmission was avoidable, they felt frustrated that they had had to go through the experience of readmission due to perceived incompetence or a breakdown in coordination. Finally, it is clear that the health and wellbeing of family who cared for the interviewees was also affected by the issue of readmission.

These findings were similar to comments made by stakeholders who noted that readmission to hospital within a short period of leaving could affect people’s aspirations for the care they receive (as people are keen, where possible, to receive care in their home), and their health (because repeated readmissions can often foreshadow a longer term institutionalisation, for example, moving into residential care).

4.1.2 There are particular challenges to be addressed in terms of transition between secondary and primary care settings

This research highlights the importance of ensuring that older people (who may be vulnerable or frail) experience a smooth and safe transition from hospital back to their home. A lack of clarity at this point was a clear contributor to negative outcomes amongst a couple of the interviewees; others described being dissatisfied with being left in a waiting room for several hours to be discharged, not being given clear and accessible information, and not feeling that the community and acute services were well coordinated.

These findings were echoed in discussions with stakeholders who considered the point of transition to be a key point of risk for an older person as well as an element of the care pathway which was often poorly managed by acute and community services.

4.1.3 Providing person-centred care in the community is also a priority

Finally, a few interviewees were dissatisfied with the care they received once they had left hospital. Particular issues include feeling that their care had not taken their own views and preferences into account and feeling excluded from decisions about their own care. In some cases, this lack of involvement in their own care contributed to their readmission.

4.2 There are several implications for Age UK which arise from this research

The research sought to inform Age UK’s future strategy in two areas: its support for service development by local Age UKs, and its national influencing strategy.
4.2.1 Implications at the local level

The fieldwork with people who have experienced an emergency readmission as well as comments from stakeholders, indicate that a range of home from hospital services would be valued. While it is noted that many of the services below already exist, provision is far from universal. Three types of services were noted:

- **‘Low-level’, practical support**: in several interviews it was clear that practical support in the first few days after returning home would have been helpful. Interviewees often faced a lack of mobility, restricting access to local services. Other practical services, such as buying food, would be valued at this point, and are unlikely to be provided by the statutory services.

- **Befriending services**: several interviewees described how they were depressed and felt lonely after returning from hospital. Interviewees would value more informal befriending support at this time of increased vulnerability. Such a service may also be able to identify some of the issues with community care, and the lack of clarity that interviewees described they had after being discharged from hospital.

- **Advocacy services**: interviewees described several examples where they needed support in dealing with issues they had with the health and social care services. These support needs ranged from someone to help them ‘navigate’ the health and social care systems through to someone who could support them in making complaints or resolving any issues they have.

There are clear links between these needs – for example, a befriending service would probably uncover issues which a more proactive advocacy service would act upon – therefore partnerships between services are important.

4.2.2 Messages to deliver at the national level

Stakeholders considered that organisations within the VCS sector such as Age UK could have an important role to play in delivering clear messages on complicated issues such as how to reduce emergency hospital readmission. One stakeholder noted that because Age UK is not a ‘disease specific’ organisation it is well placed to contribute to these debates. In addition, Age UK’s broad outlook should allow it to form alliances with other VCS organisations which may lead to more effective influencing on the issue.

A few key themes emerged in terms of message that Age UK should be delivering at the national level in order to move this agenda forward.

*Age UK could develop a statement of good practice on what older people and their carers can expect on discharge from hospital*

This might include details on issues such as what questions should be asked, minimum standards that these consultations should reach, and where people should go for advice if they still have questions once they have left the hospital. It could sit within Age UK’s established information and advocacy function and be seen as a means of empowering older people at this vital stage of the care pathway. In cases where care is not up to the expected standard, this would be made clearer by the good practice statement and action could be taken to address this.

*Age UK could further contribute to the debate on the policy response to this issue*

The causes of emergency readmission are complex. The policy response to the issue should recognise this. Section 3.3 outlines several examples of initiatives which may have had an impact on hospital readmission rates. As well as highlighting good practice examples the wide variety of initiatives listed also illustrates that the issue of readmission is integral to several other policy agendas in the NHS (for example, QIPP).

Age UK occupies a unique position. It is a large and trusted organisation, providing it with some authority in policy debates. Moreover, given the lack of simple answers in relation to emergency readmissions, there is a role for Age UK to become further involved in the
generation, piloting and provision of possible solutions. Success in this area would represent a clear and valuable contribution to improving the lives of older people.

There is a demand for more personalised services in the community (and in transitions)

Where interviewees articulated dissatisfaction with their care in the community, at root, it was often caused by a lack of a personalised approach to their care. This took many forms, including the need for better co-ordination in home care (where several health professionals were involved) and a desire to be involved in decisions about discharge and community care. In delivering messages to stakeholders and government, Age UK could link the debate around the personalisation of services for older people to emergency hospital readmission.
Annex 1 Interview summaries

This annex provides interview summaries. Each write up includes:

- A background and context section outlining factors which may have impacted on the interview;
- A section outlining the individual’s story;
- A small number of key learning points to be drawn from each interview (which may have been suggested by the interviewee or may be the interviewer’s interpretation if this was not possible);
- A short summary drafted by the interviewer drawing out the main analytical points.

Please note that all names have been changed. Also, where interviews were short due to interviewees being unable to recall full details, some of the sections outlined above have not been included.

Alf

Background to the interview and key contextual points
Alf has speech difficulties and becomes quite tired when talking for a long time so this was a very short interview. On a few occasions during the interview, communication was difficult because of the speech problems. It took place in a quiet room at a day care centre. A member of staff was present towards the end of the interview.

Alf’s story
Alf has been in hospital three or four times over the last four years. The first time, he was experiencing chest pains and had to be taken to the emergency department of the hospital. When he was discharged from hospital he “did not feel quite ready to go home and wasn’t quite well”. Arrangements were made for Alf to receive care services at home, to help him wash and dress. He did not receive any support with walking but did not feel he needed this.

Since then, Alf has been re-admitted to hospital for different health problems.

Key learning points
Alf emphasised that “good carers are important”.

Interviewer’s summary
Alf appreciates the support and care he has received at home. As he does not consider that he was quite ready to go home, the community care package is likely to have been important in terms of providing both practical and emotional support.

Caroline

Background to the interview and key contextual points.
The interview was carried out at a day centre and a member of staff interpreted between Greek and English.

Caroline’s story
This passage of care took place three or four years ago. Caroline’s initial admission was a result of ongoing heart problems. She stayed there for three weeks for the first time which she felt was too long: “It felt like one year had passed”. However Caroline recognised that she had to stay for this

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17 are included here. 18 interviews have been carried out however one of the interviews has not been included as the participant was unable to recall any details of the experience.
length of time.

During the first visit there were language difficulties: “I don’t understand English so anything they said to me, I didn’t understand”. This was particularly difficult in relation to medical language or instructions which were related to taking tablets. Caroline was upset by how dirty the hospital was when she arrived: “It was so dirty I cried.” Her family was upset by this as well and said that they were going to write to the newspaper about it. However she said that it was an old hospital and now it has been refurbished and is much better (she has been back to the same hospital in the past year).

The language barrier caused other difficulties. Caroline felt that hospital staff may have thought that she was saying insulting things about them in Greek. This caused other problems and made it difficult to build up good relationships with staff.

At the point of discharge, Caroline said she had a consultation with the doctor but “I didn’t understand what the doctor was talking about”. There were particular misunderstandings about her clothes. Caroline made sure that her family, who have a better standard of English, were present for the discussion about the care package which would be in place once she returned home.

Once she returned home, she was supported by a friend and her son. Caroline felt this was sufficient for her needs and that there was no requirement for any other professional support. Her second stay in hospital lasted for three weeks too but Caroline was not keen to discuss this.

Key learning points
This interview emphasises the importance of involving family and carers in an individual’s care, particularly where there are language difficulties.

Danilo

Background to the interview and key contextual points

Danilo is 76 and lives with his 84 year old sister. He was diagnosed with colon cancer around nine years ago and since then has been readmitted to hospital on several occasions. A face to face interview was carried out with Danilo at a day centre and a telephone interview was carried out with his sister, Elisabetta. Danilo has some speech difficulties.

Danilo’s story

Danilo was diagnosed as having colon cancer in 2003. Subsequently, he had chemotherapy and surgery. Since his surgery, he has had a stoma. Danilo and Elisabetta felt they were treated relatively well during this period and that hospital staff “did what they had to”. An operation some time later to reverse the stoma was not successful. The surgeons were unable to complete the surgery and Danilo was left with a second stoma. The day after the operation, Danilo had a severe heart attack. The combination of health problems led to him staying in hospital for approximately five months. Both Danilo and Elisabetta considered this time in hospital to have been extremely difficult. Elisabetta feels that the “the nurses did not give the attention they should have”. Danilo considered that he was not treated with respect and that staff told him what to do without consideration of his needs and feelings. “They just say, ‘get up, get down, here, sit down, not there’.

After Danilo’s long stay in hospital, he was keen to go home but neither he nor Elisabetta felt in control of the discharge process. “They just said we’re going to discharge him, we want him to go home”.

A package of community care was established for Danilo. A community nurse visited him twice a day to administer injections and medication; occupational therapists provided grab rails and walking frames to support mobility in the home; and he received four or five visits from a physiotherapist. Elisabetta valued the nurses who came to administer injections but commented that they were rarely on time. She also felt under a great deal of pressure to agree to administer the injections herself even though she felt unable to do this. Elisabetta and Danilo would have welcomed additional support to help Danilo to wash and dress and particularly to improve his speech, which was severely affected by his heart attack. In addition, although some help was provided in relation to managing
the stoma and colostomy, Danilo considered that he really needed more support in this area. “It’s me who has to have it, to change it”.

After being discharged from hospital, Danilo had a fall and banged his head and was readmitted to hospital for 2 days. Elisabetta highlighted how “scary” this was. Sometime after this, Danilo had another fall and Elisabetta had to call an ambulance to take Danilo to hospital. He was not kept in.

The effects of long periods in hospital, readmission and, for Elisabetta, caring responsibilities, have impacted on Danilo and Elisabetta. Danilo described feeling extremely low. Elisabetta collapsed and was in hospital for 12 days. She considers that the “stress and anxiety” of caring for Danilo took its toll on her and contributed to her collapse.

Key learning points

Loss of his full speech capabilities has been distressing for Danilo. He appreciates the activities he is able to access at the day centre but commented that “what I want is one to one speech [therapy], not singing a song or throwing a ball”.

Long periods in hospital are likely to be extremely distressing for patients and their carers and can make any subsequent readmissions particularly nerve-wracking. Emotional support through the hospital stay and afterwards could be valuable.

Interviewer’s summary

Danilo’s experiences of long stays in hospital and subsequent readmissions have led to significant emotional stress for both him and his sister. Additional support, both practical community care and support, and emotional support could potentially have alleviated their stress. Furthermore, it appears that hospital and community care staff have not always taken a collaborative approach based on co-production, which has left them both feeling disempowered and quite negative about health services.

David

Background to the interview and key contextual points.

This interview took place at a local luncheon club. There was quite a lot of background noise but this did not affect the interview. It refers to an episode of care that took place within the last year.

David has diabetes and had a leg amputated in 2010. He spent a substantial period in hospital and rehabilitation following this. The interview does not relate to this stay in hospital but two more recent admissions. However, this is obviously important contextual information.

David is 87 and lives alone in supported housing. Diet is very important for David’s health and he receives care in the home to ensure he is eating the right sort of food.

David’s story

David’s initial admission to hospital was caused by his diabetes however he was not sure of the exact reason. He spent three days in hospital and, on the whole, he felt he received good care from the staff. The only problem was the “atrocious food”.

David feels that the discharge from his initial stay in hospital was a poor experience. In particular, he considered that there was no information provided (“They didn’t tell you nothing”). David was given a ‘parcel’ with his medicine in. This was part of his diabetes treatment. But, as David put it: “they don’t tell you what to do with the parcel... they think you’re supposed to know all about it but while you’re in hospital they don’t tell you nothing about what you’ve got.”

David also felt that the timing of his discharge was poorly organised. On the day of discharge he was left waiting in a ‘side room’ all day which he thought this was so “they could get other people in my bed”. He did not arrive home until 7.30pm on the day of his discharge having waited in the side room from 10am: “Nobody comes and sees you, there’s no medication”. “I didn’t even have a cup of tea or a sandwich all day. Nothing at all”. On arriving home on the evening of his discharge David explained that he had to contact his own carers: “There was no coordination whatsoever”. However because they did not expect him home, he said that he had “nobody to phone because they’d gone
Three days later he had a relapse. He had collapsed in his home and the warden found him. He thought that this was caused by his sugar levels dropping too low. David considered that he was not well enough informed to care for himself once he was discharged: “They don’t give you any advice on diet and anything like that. You’re out [of hospital] and that’s it. [It’s like they say] ‘You’re nothing to do with us. You’re a number and that’s it.’” He remembers being given medicines on discharge but did not know when or how to take them. David noted that “there might have been [some instructions provided] but I couldn’t read them anyway... If they’d have told me to take this and do that, I would have done it”.

The emergency readmission led to a four day stay in hospital. Again, he felt that the care he received was of a high quality (apart from the food). However the discharge was “just the same” as the first discharge with little information provided. David noted, in particular, that he was told by hospital staff that they had arranged for his pharmacist to provide him with medicines but when he went to collect this from his pharmacist they did not know anything about it. “There’s no contact whatsoever”.

Key learning points

Ensuring a smooth discharge procedure is vital. David felt his experience of hospital on both occasions in question was quite positive. However the poor nature of the discharge procedure had left him with a poor overall impression. “To these hospitals you’re a number... that’s why I keep my wrist band on me just in case.”

Given that David was discharged late in the evening, he was unable to call any of his own carers. David was unable to understand why he was not discharged earlier in the day, as he had left his bed during the morning.

Interviewer’s summary

David has experienced what he felt to be two very poor discharges from hospital. This caused him to leave hospital feeling poorly informed about how to care for himself once home and this may have been a cause of the readmission.

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**Doreen**

**Background to the interview and key contextual points**

The interview with Doreen took place at a day centre. Doreen struggled to remember details about her admission, discharge and readmission to hospital so the interview was short.

**Doreen’s story**

Doreen was first admitted to hospital with knee problems. She cannot remember if this was for planned treatment or in an emergency. She felt the care she received was “ok” but noted that sometimes she had to wait a long while for staff to attend to her. Doreen could not recall any details of the discharge process.

Doreen has been in hospital several times since then but cannot remember why or the chronology of events.

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**Dorothy**

**Background to the interview**

This interview took place at Dorothy’s home, where she lives alone. The readmission occurred within the last month. Prior to the events described below, Dorothy had been admitted to a stay in hospital after having lost consciousness and suffering a fall. Six weeks after the discharge, Dorothy attended a follow-up clinic, where the doctor diagnosed a heart defect. He warned Dorothy that a collapse
Dorothy’s story

In April, Dorothy was admitted to hospital for the pacemaker operation. Complications with the surgery made a second operation necessary the following day, and so Dorothy stayed for two nights in total.

Despite the stressful nature of the extended stay, Dorothy was happy with the quality of care provided. She said that staff clearly explained her condition to her and she felt in control of the discharge process.

Dorothy was sent home with information and contact details for understanding and managing her condition. She did not feel well enough to leave the house, and fortunately had a neighbour to help with shopping, along with some support from Age UK.

“I do have a cleaning lady from Age UK who always asks if there’s anything else I need.”

She had not been asked at the hospital whether she would need support of this type.

A few days after leaving hospital, Dorothy had an episode of labyrinthitis, an inflammation of the inner ear causing severe vertigo and nausea. After receiving no response from a call to the GP practice, she contacted NHS Direct. She was offered a relief doctor visit within two hours, but after asking for a more urgent response, she was told the doctor would be there within half an hour. Dorothy was then taken to hospital.

Again, Dorothy appreciated the genuine care and attentiveness of the nurses and doctors. For example, making sure to always close the doors of her ward to keep the noise out, and closing the curtains when the light would be too harsh for the patients. As with the first admission, Dorothy praised the open communication of the hospital’s staff.

The discharge was suggested by the doctor and agreed by Dorothy.

Key learning points

Dorothy found it difficult to quickly get medical attention during her episode of labyrinthitis. She felt that speaking with NHS Direct was more difficult and time consuming than it would have been to speak with her GP practice. “They need to be sure you’re not having them on. “GPs would be more understanding and would have knowledge of her particular case – “they get you up on their screen.”

As a person living alone, Dorothy was pleased to be in hospital both times where support is always at hand. She appreciated not being discharged until she felt ready to return home.

Dorothy was not asked about her capacity to provide for herself. This might suggest a role for Age UK to ensure older people discharged from hospital have access to support. Dorothy noted that she would have been comfortable asking her Age UK cleaner to do her shopping.

Interviewer’s summary

Dorothy has a very positive view of her admissions, due in large part to the personal qualities of the doctors and nurses who treated her. It is fortunate that Dorothy, who lives alone and has no family in the country, could rely on her neighbour to buy food for her while recovering from her operation, since support was not offered at discharge. This suggests a potential role for Age UK in ensuring appropriate support in the home following a stay in hospital.

Gerald

Background to the interview and key contextual points.

The interview took place in a quiet room at a luncheon club that Gerald attends regularly. He appeared quite tired at the time of the interview. Gerald is in his late 70s.

Gerald’s story

Last year Gerald had a fall because his walking stick snapped. He went in to hospital and was kept...
in so that tests could be carried out. He felt he was treated well while in hospital. At the point of discharge, very little was explained to him and no community care package was put in place. Gerald said that if he had been offered help, he would have taken it. “Maybe if someone would have cooked some hot food for me”.

Sometime later Gerald was out shopping when he “started to feel giddy”. He had a bad fall and hit his head. He was taken to hospital in an ambulance and stayed there for two weeks. While he was there, he had another fall while in the shower room. Gerald reported that the quality of care in the hospital was “alright”. He appreciated that the staff bathed him, gave him good food, were friendly and treated him with respect.

This time, upon discharge, Gerald was provided with care in his home, with somebody coming to help him get out of bed in the morning, dress and wash. He has a forthcoming hospital appointment when further tests will be undertaken to try and understand why Gerald is experiencing dizzy spells. Gerald values that the hospital are making efforts to diagnose his health problems. “It’s good of them to assist me”.

Key learning points

Aftercare support that offers help with cooking and other basic household tasks can make a significant difference to the wellbeing of people who have been discharged from hospital.

Interviewer’s summary

Gerald experienced two falls within a relatively short period of time. The fact that he did not receive any care after his first spell in hospital may have contributed to the second fall.

Gladys

Background to the interview and key contextual points.

This interview took place at a local luncheon club. There was a lot of background noise but this did not affect the interview. Gladys lives on her own in a flat in an urban area.

Gladys’s story

In November 2011, Gladys experienced chest pains and difficulties in breathing. She visited her GP, who admitted her to hospital, where she was diagnosed with a chest infection. Although she was quite dazed while in hospital, she found the staff helpful, the hospital clean and considered that she did not have to wait long to receive help and attention.

The hospital suggested that Gladys should go home on the second day. She was very anxious and frightened about going home alone and when she expressed her concerns, the hospital made arrangements for her to stay in for another night and also said they would arrange appropriate community care.

Despite being able to spend an additional day in hospital, Gladys was anxious when she was discharged. “It was frightening when I was discharged. When I can't breathe, I panic. Coming home knowing there was no one there to help me. When you have a chest infection you get very ill, you can't do nothing. My family’s got their own life to lead, I can't depend on them”. A carer was allocated twice a day for six weeks for one hour in the morning and one in the evening. The carers helped her shower, dress and have something to eat. One carer was particularly helpful and did housework if it was needed. Although she appreciated this support, she requested for the carer to stop coming after two weeks because she preferred to try to be independent. “I didn't want to be sat in a chair waiting for them to come, I thought, I might as well get on with it”. When she was discharged the hospital had told her that a district nurse would visit her but this did not happen.

A month later, Gladys was readmitted to hospital for a different health problem. One morning, as she was adjusting her bed covers, her “back went and I was in a lot of pain”. Gladys was not sure what had happened so called her GP, who visited her, helped her to her feet and gave her some pain relief. The GP was not sure but thought she might have pulled a muscle. Over the next three days
the pain became worse so Gladys's sister took her to the GP. Her GP referred her to the hospital, calling a taxi for her to get there. When she arrived at the hospital, an X-ray was carried out, which revealed a fractured bone in her back.

Gladys stayed overnight in hospital and was then sent home. Again, Gladys felt that the hospital wanted to send her home earlier but when she expressed that she was frightened about being alone, she was permitted to stay for the night. Gladys considered that the explanations and communication from the hospital at the point of discharge were clear. She was offered community care support to help her wash and dress but she declined to take this up. Gladys's twin sister comes to help her when she can and Gladys also stays in touch with her GP who has prescribed pain relief as required. This helps her to sleep better and alleviates the pain to some degree.

Although Gladys has felt supported by the hospital and community care services on both occasions, being readmitted to hospital with her back problems has been difficult for her. She described feeling very low (“some days, I just sit on the chair and cry, there’s no one to talk to”). Because of her back problem and her breathing difficulties, she is not able to take the bus easily and so is more isolated than previously. She has a mobility scooter but this has not been working properly recently.

Key learning points

Gladys considered that being home sent too early can contribute to significant emotional stress and anxiety and noted that hospitals need to ensure patients are well enough to leave before they are sent home.

She also highlighted that the community care services she received are important and suggested that providing high quality community care should be a priority.

Interviewer’s summary

The reason for readmission in Gladys’s case was an unrelated health problem. The cumulative stress of being in and out of hospital over a short period of time has left Gladys feeling very low. Her limited mobility because of a back injury and breathing difficulties make it difficult to go out and see people, contributing to her sense of isolation.

Hazel

Background to the interview and key contextual points.

This interview took place in a day centre. Hazel lives alone in supported housing. She has speech problems so some on a few occasions during the interview, communication was difficult.

Hazel’s story

Hazel was admitted to hospital to have an operation on her knee. Hazel had fallen on several occasions and broke both of her knees. This happened in 2011. As a result of the operations, Hazel is in a wheelchair. She said that she had a poor experience of the hospital, and in particular the food. Because of the nature of the operation, she had to stay in hospital for quite a long time. She said “I wanted to go home, but they wouldn’t let me... not ’til my legs were better”. Hazel considered that it was unfair that staff would leave her alone all day (“They sat me in the armchair and I couldn’t move”).

On the day of discharge following the operation Hazel said she had to spend a long time in the waiting room as she waited to see the doctor. She said: “I was waiting for a long time... he didn’t come in until near dinner time... the whole day I was there.” After she was discharged from hospital following her operation, Hazel had to go “backwards and forwards to hospital by ambulance” for check-ups. She also had a carer who came to her house in the morning and evening. Hazel felt that she needed more help once she had returned home (“I was in that room all on my own, in my front room waiting for the nurse to come but they never turned up”).

Hazel was readmitted to hospital a few days after being discharged. The readmission was caused by falling out of bed which caused bruising on her arm. She had to call an ambulance as she could not get up from the floor. Hazel felt “terrible” about having to go back to hospital so soon after
leaving. “I was there for ages waiting for the doctor”.

Hazel also wants to have railings and other assistive technologies installed in her home: “I’ve got nothing to hold on to... I need railings in my toilet... I keep asking and asking and asking”.

Key learning points

Hazel felt that provisions to enable her to return home from hospital sooner were not made. In particular, she wants railings installed in her home but this has not happened (one of her key workers is taking this up on her behalf).

Interviewer’s summary

This interviewee felt that the health and social care system was not responsive enough to her preferences (either in the care she received in hospital, wanting to move her care closer to home, and having her home adapted to allow this).

Irene

Background to the interview and key contextual points.

The interview took place at a day centre that Irene tries to attend when her health allows. Irene is Greek Cypriot and speaks very little English so a member of staff at the day care centre interpreted. Irene has asthma and heart problems.

Irene’s story

In November 2011 Irene had a fall and broke her hip bone and knee. A family member called an ambulance and Irene was admitted to hospital, where she stayed for three months.

In general, Irene considered the nurses in the hospital were “really nice”. She recalls though that on one occasion she was moved into a new bed, which she found very uncomfortable. “It felt like stone” and exacerbated her pain. Even though she was crying and could not sleep she said that “they were taking no notice”. The situation was resolved when a night doctor came to see her. Irene explained the situation and he immediately ensured the bed was changed. Irene also reported that in general during her long stay in hospital, there was no explanation about the medication she was taking. “It was just put in front of me”.

After three months, Irene was discharged and allocated a ‘step down’ bed in a residential care home. Irene considered that the discharge process was not explained clearly to her. “All they said is, you’re going somewhere else so you can feel better.” She did not understand where she was going and did not feel ready to leave hospital. She was upset and felt she had little control over her situation. In particular, she was upset because she was not advised to pack the few items of personal clothing she had brought with her to hospital, which she said she “like[s] for my own dignity”.

Irene stayed in the intermediary care home for around six weeks. She reported that she did not feel free to do what she wanted to do there. “If I wanted to stretch my leg and go for a small walk, they were shouting at me to go back to my room”. She said she found this upsetting. She would also have liked the opportunity to have her meals with other residents. “They wouldn't take me to sit with the other patients to eat- I had to eat with my plate on her lap”. She did not have regular contact with a nurse while in the home.

Irene was glad to be able to go home but shortly after leaving the residential care home, was readmitted to hospital as a result of problems with her heart. She stayed a few days and was positive about the care she received. “The doctors were very good to me and treated me very well. I felt better”.

When she left the residential home, Irene was provided with community care services. She has help twice a day to wash and dress and occupational therapists have provided her with a lot of helpful equipment so she can move around at home. Although she was told she would be provided with physiotherapy, she has not so far received it. Irene also has to attend the hospital once a week to have an injection. This causes her some difficulty because even though it is a weekly appointment,
she has to re-book transport to the hospital each week. Because of her limited English, she has to ask staff at the day care centre to help her. In addition, the lack of an interpreter at these appointments is frustrating.

This experience of being in hospital and then readmitted makes Irene feel sad. When she was in hospital, “some days I worried about not coming out”. Compared to when she first went into hospital, Irene is a lot slower on her feet and requires much more help with personal care.

Key learning points

Ensuring that discharge takes place at an appropriate time in the care pathway is vital. In relation to her discharge and move to the residential home, Irene said, “I feel like you should be there to get better but I felt like they just wanted the bed and shoved me from place to place…It was too early”.

It was also important to Irene that care was clearly explained to her, for example, what medication she was taking and why she was being moved to an intermediary care home.

Irene recommends providing interpreting services if possible as not being able to understand makes hospital appointments very difficult.

Finally, after discharge, regular visits from a community nurse “just to keep an eye” on her would have helped.

Interviewer’s summary

Irene experienced a poor discharge, with very little information about the intermediary care home she was being taken to. She felt a loss of control and dignity. Her readmission to hospital was shortly after she left the intermediary care home, where she did not receive regular visits from a community nurse.

Jane

Background to the interview and key contextual points.

This interview took place at a local luncheon club. There was quite a lot of background noise but this did not affect the interview. It refers to an admission that occurred within the last year. Jane lives alone in supported housing. She was in quite good health prior to this episode of care.

Jane’s story

The first admission was caused by a fall which occurred at the luncheon club. Jane broke her hip as a result of this fall and had to stay in hospital for “quite a while”, though she could not remember the exact duration. During this stay in hospital she felt that the care she received was not what she would have expected. Jane said: “I've got a weak bladder and ... they couldn't be bothered with keep getting me up because I got up too often... I thought it was terrible.” She has already made an official complaint about this. She had never been to hospital (for a significant period of time) until this point. She felt that the nurses “work very hard... it must be very hard to look after all those patients in one go”.

Jane felt that the discharge procedure after her first admission was comprehensive: “They had time to listen to what you had to say... they discussed how you’d be when you get home and what care you’d receive”. She was really happy to be leaving: "I couldn’t get out quick enough!"

On the other hand, Jane found “the aftercare very good... most of them had time to spend on you.” She had a district nurse come to visit her. She was also provided with a walking aid but it was the wrong size. “As luck would have it my daughter got me a new one because what they brought me was too high and too wide... she got it from a car boot sale.”

Jane was readmitted a short time after coming home from hospital. She got up during the night and fell and cut her head. She called an ambulance (“I've been in an ambulance more often than not [recently]... Mind you, I must say I find the ambulance people very caring”) and was taken to hospital. Jane did not think the readmission was related to her first admission.

The second stay in hospital lasted for a couple of weeks. She felt that the staff on her second
discharge from hospital were attentive, for example, “they made sure I had my keys to get back in the house”.

Interviewer’s summary

Jane was fairly positive about her experience of an emergency readmission. She felt that the two admissions were not linked. Indeed she suggested that she had received good quality care and support while in hospital and back at home (apart from a couple of key notable oversights).

Maria

Background to the interview and key contextual points.

Maria’s first language is Greek and she opted to use an interpreter during this interview. The interpreter was a friend of Maria’s who had been present at the hospital during key moments in the care (such as the discharge) and was therefore able to add some more detail. Maria lives alone.

Maria’s story

The episode of care in question took place in 2011. She had to spend around two weeks in hospital due to heart problems. Maria said that she did not like that she was in hospital but accepted that she had to stay there. On the day of the discharge, Maria’s interpreter said there was a delay between when they told her to prepare to go home, and when she was actually sent home. There was a delay in waiting for some medication but Maria said that this was okay.

Maria felt that her discharge was too early: “The doctor said ‘you have to go out [of the hospital] Maria’ and she said to him ‘I’m not alright doctor, I have to stay more days’”. Maria said “If the doctor says I have to go, I have to go. But I cry this day because I didn’t feel alright”.

When Maria got home she had family stay with her and other friends come to visit. Once they had left, they made sure she was aware of how to call an ambulance if needed.

Maria was readmitted after one week and this lasted 9 days. She said she caught the flu which left her feeling short of breath. During her second stay, Maria was keen that she was treated by the doctor who had treated her during her first stay as she felt he did a good job. There was also an incident during the night in which she tried to get up to go to the loo but the nurse did not respond to her request. She said that this caused her to fall. Maria also said that the care was much better during the day as she said there was a particular nurse who was doing the night shifts who was not very good.

Maria said that she felt much better after the second admission to hospital. She noted that despite a couple of poor experiences, she felt it was worthwhile. They also changed her medication which has left her feeling a bit healthier. She said that she was happy to call an ambulance whenever she felt ill.

Key learning points

Maria felt that the care received during the night in both hospital stays was the main area where improvement is needed. She felt that the nursing staff who were on duty during the evening were less attentive and under-resourced.

Interviewer’s summary

Maria is comfortable in calling for an ambulance if necessary and, generally speaking, was happy to be in hospital if she was worried about her health.

Mary

Background to the interview and key contextual points

The interview took place in Mary’s home, where she lives alone. Prior to the initial admission for leg
surgery, Mary had previously undergone surgery multiple times on her legs. Mary was admitted to hospital multiple times and the chronology of events was not clear. However, her recollection of particular events was vivid.

Mary’s story

Mary was first admitted to hospital for a scheduled operation on her leg. Following the operation, she stayed in a rehabilitation centre and it was here that Mary noticed felt there were complications. The doctor told her it was just eczema. “I tried to tell them but they’ve got one liners to put you off. You’re not qualified to argue with them.” Mary felt that the doctor’s diagnosis was based on certain assumptions about older people. “Doctors write you off if you’re old. I told the doctor I was feeling weak and he said ‘oh you will do.’”

Mary later collapsed and had to go to hospital, where she learned that she had multiple infections in both legs. She stayed for three weeks.

Mary was unhappy with the attitudes of many staff during her stay. “I get really angry with the attitude of the younger nurses and other staff with people of my age. I told one, ‘I don’t like the word ‘geriatric.’” She said, “You’re a geriatric, so get used to it.” She felt that staff underestimated her ability to participate in her own care. “Young people see old people as all having dementia.” Mary did not understand why her medication was changed while in hospital, and suspected a lack of coordination between services. She was happy to be discharged from hospital, but did not feel she was part of the decision. “They rely on the stats as I call them, and not at all on your opinion.”

Mary also described the intermediate care she received at home following the discharge. She felt that occupational therapy is an excellent idea in principle, but the support she received from these professionals was very prescriptive and did not accommodate her preferences. For example, Mary tripped over a chair that was installed in her kitchen against her wishes, causing injury.

Mary was supported by teams of carers who helped her in and out of bed, made her meals and dressed her wounds. One of the teams was appreciated for their sense of humour and genuine willingness to help. By contrast, Mary felt that the second team of carers worsened her situation. One reason given for this was the large number of carers working in rotation. The lack of consistency in support meant that it was not possible for any one carer to identify changes in Mary’s condition over time. This was particularly important as Mary felt the blemish on her leg may have been growing in size or changing in colour but she felt the carers were not able to observe this change.

This was compounded by what Mary saw as a ‘clock in, clock out’ attitude and general lack of respect. Sometimes multiple members of the carer team would hold a personal conversation at length in her front room, as if she wasn’t there. “One of them said to me ‘you’re a quiet lady, you don’t interfere.’”

Mary was complimentary about support from her Age UK carer. Her limited mobility has meant that shopping support has been essential.

“I had three lots of carers but the only people I’d recommend to anyone is Age Concern. All the others do is wake you up at the wrong time, make you a slice of toast and they’re gone in half an hour.”

Mary was readmitted again, as a bowel infection was causing diarrhoea. The quality of care was generally good, due to friendly and approachable staff who would “pop their head through the door even though I was in the isolation room.”

Key learning points

Intermediate care was crucial to the management of Mary’s condition. However, the large size of the carer team and their lack of attention to detail may have resulted in a failure to monitor the worsening of Mary’s infection. Mary would have appreciated a smaller team of carers with better interpersonal skills.

Support with shopping has been vital for Mary’s wellbeing, not least as she has relied on this to receive medication from the chemist. Currently, she receives this support from Age UK.
Interviewer’s summary

More than anything else, Mary felt her condition and general wellbeing would have been improved by a higher level of respect and kindness from the range of healthcare professionals she has seen.

Mrs Smith

Background to the interview and key contextual points.

This interview took place in Mrs Smith’s home. Her daughter was also in attendance. Mrs Smith was the main interviewee but her daughter contributed about certain key issues where she was able.

Mrs Smith lives alone in a block of flats in an urban area. She is 89 years of age and feels in quite good health in general, although she has had issues with her heart in the past and was quite immobile at the time of the interview due to a recent fall.

Mrs Smith’s story

For a few days in October 2011, Mrs Smith was experiencing intermittent nose bleeds. After three days of this, her nose haemorrhaged and she had to call an ambulance. She is on medication for a heart condition which Mrs Smith thought might have contributed to the severity of the bleeding. Upon arriving at Accident and Emergency (at a hospital she has been to several times) the doctors told her she had to be transferred to another hospital as they were not specialists in ear nose and throat conditions. After a couple of hours, they admitted her and stopped the bleeding. She stayed in hospital for five days and, in general, she felt “the care was quite good” with staff attentive to her needs. Mrs Smith’s daughter then came to take her home.

There were very few community care arrangements made upon being discharged. Mrs Smith considered that this was because her daughter had come to take her home and intended to stay with her for a couple of days. “I didn’t get any information or medication when I came out because they said it would be fine.” Mrs Smith also said that she felt ready to leave and “Was glad to come out... Let’s face it: no one wants to be in hospital”.

Mrs Smith “felt quite good” for the first week back at home but, in the second week back she felt short of breath which caused her to feel quite unwell. She went back to hospital for a pre-arranged heart check-up but was not readmitted: “I was sitting there [in the hospital] and I thought ‘this is madness, I feel ill and I’m going to get up from here in a minute and go home’”. Mrs Smith told a nurse about this who said that she would get someone to take her to Accident and Emergency. She said that she did not want to go: “I’m not going to the A&E again when nobody knows where I am”. Instead, she went home, called a friend and her daughter to inform them that she was going to hospital, and then called herself an ambulance.

When she was readmitted to hospital, Mrs Smith said she “felt so ill... I couldn’t get off the bed to get on the commode”. After several tests, a doctor came round and advised that Mrs Smith should have a blood transfusion. The next day she was discharged and felt much better. Her primary concern was that: “I wanted to know why I didn’t have the blood transfusion in the other hospital [on the first admission] to save me going through all that trauma again.” Before the blood transfusion, Mrs Smith said she “couldn’t walk from here [her kitchen where the interview took place] to my street door and then I had the blood transfusion and I could not believe how well I felt.”

Mrs Smith considered the experience of the readmission to have been “dreadful... it was traumatic believe me. It was bad enough having the haemorrhage all on my own and then to get over that and get it all sorted it [and then be readmitted].”

Key learning points

Mrs Smith regretted that the she had to go through what she described as the “trauma of going back to hospital”. She felt that the first hospital she visited was not thorough enough in diagnosing what the problem was.

Mrs Smith’s daughter also noted that once a readmission has taken place, they need to quickly ascertain what has happened to that person in the previous admission. This would help hospital
staff to more quickly ascertain whether the two admissions are linked.

Interviewer’s summary

Mrs Smith described that the experience of readmission was upsetting and traumatic for her and her family. The cause, in Mrs Smith’s view, was an oversight by medical staff in her first admission. However, she also felt that being readmitted had sorted the problem quite quickly and left Mrs Smith feeling much better.

Polly

Background to the interview and key contextual points.

The interview was carried out at a day centre and a member of staff interpreted between Greek and English. Polly has multiple health problems and has been in and out of hospital over the last 10 years. It is therefore difficult for her to remember the exact chronology of events. Polly has diabetes.

Polly’s story

The first time Polly was admitted to hospital was for a planned stomach operation. A few years after that she had some heart problems and also surgery on her left breast. More recently, Polly had a stroke. She was at home when she started feeling pains in her heart. She called for help through her community alarm system and was taken to Accident & Emergency.

She spent six weeks in hospital. Polly considered that her experience of hospital on this occasion was negative. She commented that she was not treated with respect: “They were rude to me, they were frustrated with me because of my language. They used to get really sharp with me. They were ignoring me, telling me to be quiet. I was really upset”. In particular, she felt that her dignity was not respected when it came to bathing: “they tried to put me on a hoist but said it doesn’t work because you’re too heavy”. Staff at the hospital only tried to use the hoist once and their lack of persistence upset Polly. It was also difficult for Polly to feed herself and she considered that unless a visiting family member helped her, “I stayed hungry”.

Polly considered that after some of her stays in hospital she was discharged too early. For example, she perceived that after her stomach operation, she should have been kept in longer to allow her wound to heal. When she was discharged after her stroke, Polly reported that her medication was not clearly explained. “They just gave me medication to take- didn’t explain what it was for and often time I got muddled and took wrong tablets”.

Polly considers that as a result of this, she ended up in hospital shortly afterwards. Her GP contacted the hospital and emphasised on her behalf the importance of medication being clearly labelled in blister packs to prevent confusion.

Since her stroke, Polly’s daughter and son have been her main carers. In addition, her GP has made community care arrangements for her and she receives support to wash and dress every day. In addition, she received one visit from a physiotherapist.

Recently, Polly’s blood pressure and sugar levels dropped, she collapsed and had to go again to A&E. She was in hospital for two days and was positive about the care she received there. She is still not fully well and doctors are unsure about why she collapsed.

As a result of frequent readmission to hospital, Polly says she is “frustrated about her health problems not being resolved, being in pain and being in and out of hospital”.

Key learning points

From her experiences, Polly believes that it is important to ensure people “receive care as soon as they are out of hospital”. She suggested a weekly visit from a district nurse to check how they are coping. “At the moment, they just chuck you out and my daughter has to deal with it all”.

She also noted that language is a barrier and that it “is very difficult when you don’t speak the language”. Interpreting support would be extremely helpful.

Interviewer’s summary
Polly has experienced what she feels to be poor discharges from hospital. This meant that she was not well informed about the medication she needs to take. This may have led to readmission to hospital.

Suzanne

Background to the interview and key contextual points.

This interview took place at a local luncheon club. There was quite a lot of background noise but this did not affect the interview. Suzanne has been into hospital quite a lot over recent years. She has diabetes and she feels that this is a key cause of these admissions (“I have to have an injection every day to keep the sugar down and sometimes it gets really bad and I end up in hospital”). She had to move into supported housing due to mobility problems. Suzanne has experienced several emergency readmissions. While I tried to focus the interview on one of these experiences, the interview was more of a composite reflection on these experiences.

The person’s story

Suzanne was recently admitted to hospital as a result of complications resulting from her diabetes. She feels that in recent years she has received high quality care in hospitals: “In the past, it’s [the care in hospitals] been really really marvellous. Everything they’ve done for me. I’ve been so grateful”. However, more recently she felt that: “At the moment I think it’s not too good with the hospital. I think it’s getting really bad. I used to get good treatment... they’ve got so many people now that they haven’t really got the time for you.”

The discharge after this initial admission was quite poor. Suzanne was informed that she could go home but she did not feel like she could until she had practiced with her walking frame: “I said, ‘I haven’t had a practice of walking on my frame yet’... So I said ‘I can’t go home until I’ve walked on my frame’. Anyway [without having had a practice] they decided it was time for me to go.” Suzanne’s son then came to the hospital and said that she should not be going home until she had practiced walking with the frame. Suzanne continued: “They all started arguing and I felt really embarrassed... So at the end I just said ‘Jim [her son], take me home, I’ll have to manage however I can because I feel such a fool with all this arguing going on’”. Her son then had to stay overnight to ensure Suzanne was able to walk with the frame. “I feel so silly [with] all this arguing going on”.

Suzanne also felt that she was not given clear information about how to care for herself once she got home. This is particularly important due to her diabetes. She receives care in the home every day from a district nurse. She has poor mobility in her hands so she is unable to give herself injections. A carer also visits everyday and helps Suzanne to have a shower and prepare some food (which is of particular importance due to her diabetes – “I have to be careful what I eat”). She also has a supportive family.

Suzanne also has heart troubles and this caused a recent admission to hospital. She had to go to a specialist hospital which she said was: “Really posh... they come round with your lunch all dressed like waiters! They make you feel very good.”

Key learning points

Suzanne wanted to emphasise how important it is that people feel comfortable before they go home from hospital: “If you’ve got to go home you’ve got to be able to walk... because otherwise, how are you going to be able to get up and go to the loo.” “You feel they want you to hurry up and die!” She receives good quality care at home because of her diabetes, and this, she feels, has been a real benefit when she has left hospital.

Interviewer’s summary

This interview followed a non-linear path and was a set of reflections on recent hospital readmissions. A key point from this interview is that she has been asked to go home before she felt ready and had she not had a comprehensive package of care in place (due to having a supportive family and an infrastructure in place to support her diabetes), there may have been issues.
Walter

Background to the interview

This interview took place at Walter’s home, where he lives with his wife. The readmission occurred within the last month.

Walter’s story

Walter went hospital in the middle of the night with chest pains. He spent eight days in hospital, and found the quality of care to be high. He felt staff were efficient, useful and responsive, and Walter had his own room throughout.

Staff could not promise when Walter would be discharged but were helpful in explaining in laymen’s terms how his condition was developing. “You’re not fobbed off with medical mumbo jumbo.” It is clear that being kept in the loop was very important to the wellbeing of Walter and his wife. Ultimately he felt in control of his discharge when it came.

Walter was given medication, tools and information to monitor and control his condition at home. This included a heart monitor and leaflets containing dietary and exercise information, as well as a symptom list so that they could recognise a reoccurrence.

He also received the support of a cardiac nurse through home visits and by telephone. The nurse provides personalised exercise advice, and books appointments on Walter’s behalf with the GP and with a specialised cardiac gym. This bespoke support was welcomed. “You need someone like [the cardiac nurse] to tell you your own personal condition.”

Shortly after his discharge, Walter had an emergency readmission caused by another heart attack. He stayed in hospital for five days this time, as hospital staff aimed to lower his heart rate naturally. While the quality of care was generally high again, shorter visiting hours and less personable staff negatively impacted Walter’s experience.

Key learning points

At the time of interview Walter had been out of hospital two weeks since his emergency readmission, and his condition was improving. He continues to be grateful for the ongoing support of the cardiac nurse.

As well as the services provided, the nurse’s personal attributes are a clear factor in the quality of care and in Walter’s wellbeing. As Walter does not feel comfortable with asking for help, the friendliness of the cardiac nurse is an essential condition of help being asked for and received. “You don’t have to call her nurse – she feels like a friend.” Walter feels he can contact the nurse at any time, day or night. She also stays in touch with his wife, to ensure the message gets through. This is important as Walter’s memory can be inconsistent.

Interviewer’s summary

Walter’s feeling of wellbeing has been greatly supported by the cardiac nurse, who provides home visits and is accessible by telephone at any time. The strong personal rapport that has developed is key to Walter’s feeling of control over his condition as he feels able to approach the nurse with any questions or concerns he has as they arise.
Annex 2 Research methodology

A2.1 Research methodology

A2.1.1 Scoping phase

The study began with a brief scoping phase which included consultation with Age UK and a brief policy review. This informed the research tools which were used in the fieldwork (see Annex 2 for topic guides). The scoping phase also involved an internal ethics review.

A2.1.2 Fieldwork

There were two main fieldwork tasks:

1) Stakeholder interviews

The following people, who are working on the issue of emergency hospital readmission amongst older people, were interviewed:

- Professor David Oliver, National Clinical Director for Older People, Department of Health;
- Jo Webber, Deputy Policy Director and Director Ambulance Service, NHS Confederation;
- Paul Streets, Director of Patient and Public Experience, Department of Health; and,
- Peter Hay, Strategic Director, Adults & Communities Birmingham City Council.

These interviews took place over the telephone and focused on the causes and effects of emergency hospital readmission. The existing policy response and how Age UK can best contribute to the debate both at the local and national levels was also examined in these interviews.

2) Interviews with older people

The set up process used for this study involved contacting voluntary sector organisations who may have existing relationships with older people who have had this experience. These organisations were able to help us identify potential interviewees and begin the process of informing them about the research.

A total of 18 interviews with applicable individuals were conducted against a target of 20. All interviewees were offered a £20 gift voucher as a thank you for their time. During the scoping phase of research, a set of sampling criteria was decided upon to ensure that a mix of different interviewees was contacted. The research briefing stated that all interviewees were to be over 75 years of age (to correspond with the NHS’s key indicator in this area) and that interviewees should not have been in receipt of any voluntary sector hospital aftercare services as Age UK was keen to capture the views of those who may need further support. Further sampling criteria were set, based on the scoping work. These criteria and what was achieved are set out in Table A2.1.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Original criteria</th>
<th>Achieved criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>All interviewees will be over 75; and, a minimum of 5 people will be over the age of 85.</td>
<td>All interviewees were over 75. 5 interviewees were over the age of 85.</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td>A minimum of 4 individuals will be from an ethnic minority.</td>
<td>6 interviewees were from an ethnic minority.</td>
</tr>
<tr>
<td><strong>Living situation</strong></td>
<td>A minimum of 8 people will live alone in their own home. The remaining interviews will be a mixture of older people living with others (for example,</td>
<td>4 interviewees lived with someone else. The remaining interviewees were with people who lived alone in various situations (for example, in supported</td>
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</table>
A2.1.3 Ethical considerations

There were a number of ethical issues to consider in carrying out this piece of research. Having reviewed the DH Guidance, it was decided that the study did not need a formal NHS/SC review, but that it was important to have a clear and robust approach to deal with issues relating to research ethics. This approach was based upon GHK’s research ethics policy, bolstered by an internal ethics panel. The internal ethics panel examined the methodology and all research tools in depth. The following issues were considered:

- **Providing information to participants throughout the engagement process** which was done, primarily, through the provision of a participant information sheet which outlined clearly the reason for the interview, what the project sought to achieve, that the interview would be confidential and that involvement is voluntary. This was provided to participants in advance of the interview.

- **Gaining informed consent at the start of the interview** which was achieved by outlining the most important points in the participant information sheet at the start of the interview, and asking interviewees for verbal consent to take part in the interview.

- **Exceptions to confidentiality.** Interviews were confidential and this was outlined throughout the set up process. However, it was made clear that exceptions would be made if the interviewee told us something that suggests a serious, ongoing risk to themselves or someone else. A procedure for reporting was established, escalating the issue to the research director and then to the individual at Age UK responsible for safeguarding.

- **Involving carers / family members in the set up process and the interview itself** was a key element of the set-up process, particularly where the interviewee was in a potentially vulnerable situation.

- **Ensuring fieldwork takes place at a time and place chosen by the interviewee** was vital; flexibility was emphasised throughout the set-up process.

### Challenges and reflections on the fieldwork process

The set up process was far more challenging than anticipated and recruitment took several weeks longer than planned. In total, over 150 organisations from the voluntary and community sector (VCS) in more than 10 local authority areas were engaged with. These organisations ranged from national charitable organisations such as Independent Age through to locally-based organisations offering services to older people in their own

<table>
<thead>
<tr>
<th>Rural / urban location</th>
<th>One of the local authority areas in which recruitment will be focussed is a rural area which will ensure that a number of our interviewees live in rural areas. A minimum quota for this criterion was not set however, it was expected that 4 interviewees would be from a rural area.</th>
<th>2 interviewees were from a rural area; interviewees came from 6 local authority areas.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Original reason for admission to hospital</td>
<td>Broadly, these reasons will be either an emergency or for a planned operation. Given that the lines between the reasons for admittance are likely to be blurred, minimum targets were not attached for this criterion.</td>
<td>5 interviewees’ original admissions was planned, 10 interviewees were unplanned admissions; 3 were not clear.</td>
</tr>
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community, including local Age UKs. Networks such as voluntary sector councils were also used as a means to provide information about the study to as many VCS organisations as possible.

Engaging with the VCS organisations and achieving initial sign up to the project was relatively straightforward. Organisations were aware of the issue of emergency readmission and were typically keen to assist with recruitment. However they found it difficult to identify suitable candidates for interview. There were two reasons for this:

- By excluding individuals who had received aftercare services, the number of possible interviewees was greatly restricted. Many contacts in the VCS organisations noted that this meant they were unable to identify any potential interviewees from their contacts and service users.

- Once VCS contacts had identified suitable interviewees, many decided that they would prefer not to take part. This meant that in order to carry out the 18 interviews, a much larger number of applicable individuals have had to be identified.

Given the client group there was always a risk that some of the interviews may not be useable in research terms (because, for example, the interviewee may be unable to recall the experience in depth). However, the vast majority of the interviews have been useful with only two having to be stopped early.
Annex 3  Topic guide for the interviews with older people

Introduction / instructions for interviewers

This topic guide is designed to support a semi-structured interview, which should feel like a ‘conversation with a purpose’, allowing maximum flexibility for the interviewee to tell their story. The introduction will be very important. Please cover the following issues with interviewee:

- **Why are we conducting this interview?** Age UK wants to know about older people’s experience of having to go back into hospital soon after they have just come out. They have asked GHK to do these interviews on their behalf. GHK is an independent research organisation and is experienced in conducting research with older people. Age UK wants to use this research to improve the way local services are provided and to try and influence the government's approach to this issue.

- **What do we want to discuss in the interview?** We would like to talk to people who have had to go back into hospital one month or less after having just come out. We will ask you to think about why this happened, and what impact you think it had. We will ask what happened and whether it could have been made better. **Above all, it is a chance to tell us your story.**

- Then researchers need to clearly outline a number of issues relating to research ethics:
  - If they do not have it already, please give the interviewee the 'participant information sheet' and go through it with them.
  - Highlight that all comments made in the interview are totally confidential. If any comments / quotations are used in the report, they will be included anonymously: no one who takes part will be named in the report under any circumstances. Ask if they would like a copy of the report once it has been finished.
  - Outline that taking part is voluntary and that the interview can end at any point if they wish.
  - Explain that we would like to record the interview. This will allow us to focus on what the interviewee is saying, rather than writing things down. Again, emphasise that this is not compulsory if they would prefer it was not recorded. Emphasise that no-one but the research team will have access to these recordings, and that they will be erased.
  - Once all of these key points have been discussed, ask the interviewee to provide verbal consent. This needs to be recorded at the start of the interview so explain that: “I'm starting the recording now. To begin this interview, this is to confirm that this is Michael Lawrie from GHK and I am with Mr / Mrs Smith for our research for Age UK. Mr / Mrs Smith, could you confirm that the research has been explained to you and you are happy to take part.” We have also produced a written consent form, but this is only necessary if they would prefer that the interview is not recorded.

- **Involving carers / families members in this interview.** Interviewers should be aware of who they will be talking to prior to the interview (i.e. is it going to be just one individual who has experienced hospital readmission, or will they be accompanied by someone else?) At the consent stage of this interview, GHK staff will establish the role of each interviewee. This is likely to be one of two options:
  a. A joint interview where we are seeking to capture the experience of two individuals, one of whom has had an emergency readmission to hospital. The other individual is likely to have a view on the cause and effects of this experience. In addition, they will be able to reflect on how the experience affected them.
  b. An interview with an individual who, for a variety of reasons, is there as support for the interviewee (e.g. a carer, friend, partner or family member). This will be particularly important in cases where interviewees might not have the capacity to consent.

Whether this is a single or double interview is unlikely to have a significant impact on the content of the discussion; we will still be focussing on the individual’s reasons for and experience of hospital readmission. However researchers will need to take a moment at the beginning of the interview to establish the terms of the interview, which interviewees are providing consent, and what they are consenting to do.
Additional points for the interviewer to note:

▪ These interviews should be very open discussions with the interviewee being able to talk about their experience in their own way. The topic guide reflects this. It includes a number of key questions / areas for discussion within which there are a set of prompts and questions which should be used to guide the interviewee.

▪ We will produce short ‘case study’ write ups of each of these interviews which will be appended to the main report. The write ups should be a standalone document outlining the experience of the individual(s) interviewed. They will be structured by the topics listed below.

▪ Remember, we are not conducting a service evaluation; this is a piece of qualitative research into the experiences of a key health and social care service user group. There is an important distinction between interviewing people as patients and interviewing them as people who have had a recent experience which could inform the development of Age UK’s activities. We are doing the latter therefore we should avoid discussions which veer towards evaluating the services they have received.

▪ Nevertheless a situation may arise whereby an interviewee describes an episode of care that seems negligent / was upsetting to them / that, upon discussing as part of the interview, they decide that they wish to pursue a complaint. GHK should not provide specific advice here. The researcher should provide the interviewee with their local Age UK’s contact details (e.g. the Age UK staff member that set the interview up) and suggest that they seek their advice. Where the researcher thinks that any disclosure might constitute abuse, they should inform the research director, who will document the episode and inform Age UK.

Establishing the relevant episode of care

We will have gained some information on the episode of care in question during the set up process (described above). This should include the reasons for the initial admission to hospital and the reasons for the emergency readmission. This will ensure that we do not spend too much time in the interview establishing the episode of care that we would like to talk about – and that the interviewee fits the sampling criteria. Rather, we will be confirming information which has already been provided.

Original admission to hospital

1. Why did you go into hospital the first time?
   Probes: e.g. admitted to A&E, admitted by GP, admitted for an operation / outpatients’ appointment.

Care received while in hospital

2. What was it like being in hospital that first time? For example, what was good about it and what could have been better?
   Follow up questions / probes:
   ▪ nature of services received,
   ▪ length of stay,
   ▪ quality of care (including treatment by staff, communication, dignity, whether they got their own room etc).

Discharge and subsequent care

3. What was it like coming out of hospital?
   Follow up questions / probes:
   ▪ What was the process like? Did you ask to leave or did someone tell you?
• Did they feel in control of the nature and time of the discharge? Did you feel ready to leave hospital?

4. What sort of help did you receive when you came home?
   Follow up questions / probes:
   • What was the care package put in place? What services were provided (e.g. social care, OT, physios, district nurses, GPs)?
   • Were there any adaptations installed in your home?
   • How well was the discharge process and subsequent support explained?
   • How well supported did you feel once you left hospital?
   • How far was the original problem resolved?

Circumstances around readmission

5. And then you had to go back into hospital. Please can you tell me about this experience?
   Follow up questions / probes:
   • How were you readmitted to hospital? GP referral / attending A&E / something else?
   • What do think were the main reasons for your readmission?
   • Do you think this was the same reason or something different?
     Then repeat question 2 in order to allow the interviewee to tell you about their experience of hospital on their readmission.

Effects of readmission

6. Looking back on the whole experience, what impact do you think the readmission to hospital has had on you?
   Follow up questions / probes:
   • Was the original health issue dealt with? Did it have an impact on your health and wellbeing?
   • Examine this question beyond merely health outcomes: how do you feel going back into hospital has affected your quality of life?
   • What you are able to do / not able to do now that you were / were not able to do, previously? (adapt as necessary).
   • Have the reasons for your readmission been resolved?

Concluding points

7. We are doing the research for Age UK. They want to understand people’s experiences so that they can try and ensure better support is provided for those who find themselves in similar situations. What do you think your experience tells us?
   Follow up questions / probes:
   • Prompt interviewees to consider what sort of aftercare services might have been helpful to them. What sort of help might have stopped you from going back into hospital so soon after you had just come out?
   • How might this sort of help be best provided?
   • Have you got any questions for me?
   • Is there anything you would like to add?
   • Thank you very much for your time.