Expert series

Right care, first time

Services supporting safe hospital discharge and preventing hospital admission and readmission
Document purpose: To disseminate examples of positive practice in avoiding hospital admission, supporting safe discharge and preventing readmission for older people.

Title: Right care, first time: Services supporting safe hospital discharge and preventing hospital admission and readmission

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Target audience: Health professionals, providers and commissioners of services from the NHS, GPs, local authorities, foundation trusts and local Age UKs.

Description: Policy drivers relating to NHS QIPP (Quality, Innovation, Productivity and Prevention) Programme and older people, practical examples of local Age UK services.

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Introduction

At Age UK we still hear too many stories of older people and their families being forced to make a decision about permanent residential care while they are in an acute hospital bed. How many of us would like to plan moving home in such circumstances? While we know that there is lots of excellent practice, we also hear of many poorly planned discharges without the basics being in place.

The Parliamentary and Health Service Ombudsman’s report Care and Compassion?: Report of the Health Service Ombudsman on ten investigations into NHS care of older people¹ (February 2011) highlights themes that emerge from complaints. The report states that:

‘The theme of poor communication and thoughtless action extends to discharge arrangements, which can be shambolic and ill-prepared, with older people being moved without their family’s knowledge or consent. Clothing and other possessions are often mislaid along the way. One 82-year-old woman recalled how, on being discharged from hospital after minor surgery, she was frightened and unsure of how to get home. She asked the nurse to phone her daughter. “He told me this was not his job”, she said.’

Age UK held two successful national conferences – in London on 27 September 2011 and in Leeds on 16 November 2011 – which brought together over 270 providers and commissioners of services from the NHS, GP practices, local authorities, foundation trusts and local Age UKs. The events provided delegates with an opportunity to discuss what is currently working well in the system, and to share experiences and examples that are helping to reduce unnecessary hospital admissions and that result in a safe discharge from hospital for an older person. Following on from the Conferences, this booklet gathers together some local Age UK solutions and examples across the pathway from admission prevention to safe hospital discharge.

I hope you will find the practical examples of flexible and timely help offered by local Age UK services useful and informative in your work to help support safe hospital discharge and to prevent unnecessary admissions for older people.

Heléna Herklots
Services Director
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What is the problem?

The NHS faces an unprecedented challenge: making £20 billion in efficiency savings at the same time as improving quality.

As the main adult users of most NHS services, older people will be the population group that is most affected by these changes, yet the service is not currently organised to recognise or respond to older people’s needs.
Older people represent the main in-patient group, at any one time occupying more than two-thirds of acute hospital in-patient beds. Many are living with a number of long-term conditions, including mental health problems. Up to 60 per cent of older people in general hospitals have a mental health problem, or develop one while they are there.  

Providers and commissioners need to put in place cost-effective, community-based services, which can both prevent the need for hospital admission and safely reduce length of stay for older people. This will enable savings to be made from hospital-based services.

The number of emergency admissions to hospital in England has continued to grow rapidly, increasing by almost 12 per cent between 2004–05 and 2008–09 (an additional 1.35 million admissions), while emergency readmissions to hospital for people aged 75 or over increased by 50 per cent between 1999–2000 and 2007–08. Kings Fund has identified that focussing on shortening the length of stay for older people in hospital has the most potential for reducing hospital bed use. This will help to achieve both savings and benefits for older patients.

As well as causing distress to patients, emergency readmissions now represent a significant and growing income loss to NHS trusts, as new rules on non-reimbursement start to take hold. Emergency admissions account for 35 per cent of all admissions to hospital, but they take up over two-thirds of in-patient beds, as people admitted in an emergency tend to have a longer stay. Older people are more likely to have an emergency admission to hospital than any other group in the population.

Available data on hospital admissions for older people presents only a partial picture. It tends to emphasise the main or presenting condition as the key problem. But this may be less relevant to the older person than problems that have been building up before admission: social circumstances (such as living alone or having caring responsibilities) or general frailty.

A hospital admission can occur when an older person has reached breaking point because of a combination of circumstances. It is at this point that simply fixing the main medical problem does not put the older person back in a position to cope. Addressing the problem therefore needs to take account of social rehabilitation and practical help. This can help to improve confidence, motivation and social engagement, working alongside clinical rehabilitation and personal care services.
There are many examples of successful partnerships involving the NHS, local authorities and the voluntary and community sector, working to create innovative and cost-saving solutions, which produce good outcomes for older people and offer potential for savings in NHS and local authority budgets.
Local Age UKs offer a range of services, which support older people’s independence and enhance their quality of life, including:

• identifying older people in the community who may be at risk
• supporting older people who are in A&E
• providing ‘home from hospital’ services that support and help older people to become independent again.

For us at Age UK it is not just about an older person being able to perform an ‘activity of daily living’, but about them being able to enjoy life. To do this, people need a mixture of different services and support at different times.

This publication highlights five examples of local Age UK services, charting the ‘pathway’ of prevention – from avoiding admission to hospital through to supporting discharge from hospital and preventing unnecessary readmission.

All local Age UKs see these services as a gateway to other Age UK and community services, which support independence and wellbeing, help to prevent isolation and loneliness, and rebuild social networks in later life. Ultimately, these are all services that enhance the quality of life for all older people and reduce the likelihood of, or delay the need for, more intensive and expensive health and social care services.

Local Age UK services such as these impact positively on hospital admission and readmission, as well as helping older people to recover quickly and regain their independence at home. They help to:

• reduce hospital admissions and readmissions
• prevent loneliness and social isolation
• ensure that the older person regains as much independence as possible and knows where to turn if they have a problem in the future.
Examples of local Age UK services

The services highlighted in this publication span the whole spectrum from identifying older people in the local community who may be at risk, to supporting people who are in A&E, and ensuring that discharge from in-patient care is safe and well co-ordinated.

Many local Age UKs offer a wide range of transitional services, which bridge the gap between having a safe hospital discharge and fully regaining independence and getting back to leading a full life at home.
1: Case-finding service – Age UK Waltham Forest

‘I wish to express gratitude to the team from Mr D... who, as you may recall, is a lovely 90-year-old gentleman who is partially-sighted. He walked into the surgery today, something he struggled to do many months ago, exclusively thanks to the balance class team and staff from Age UK Waltham Forest.’

GP

‘We have seen patients at the surgery and have seen the benefits of this excellent service... which has helped to reduce hospital admissions and has provided encouragement and support along with materials to enable patients to live independently at home. We also have information that bears this out from other surgeries.’

GP, Waltham Forest Community & Family Health Services

Age UK Waltham Forest runs a case-finding service, which identifies older people who are known to local social services and who may be at risk of functional decline. The service aims to make contact with these older people and to offer them services that can help solve problems before they escalate – it is an ‘upstream’ intervention.

GP’s are invited to give Age UK Waltham Forest a list of patients aged 65 and over, along with GP-signed permission to contact older people who may have fallen or who may be at risk of falls, or who are suffering from incontinence, memory loss, depression, functional decline or social isolation.

Older people on this list return completed questionnaires to Age UK Waltham Forest, which then analyses the results. People who are identified as being in need of significant intervention are contacted for a single assessment interview, to assess needs and arrange appropriate services, equipment or minor adaptations. If the assessment highlights more specialist needs, the older person will be referred on for a specialist assessment or to other local services. An Asian-speaking assessor is available for assessments in Asian communities where English is not the first language. There has been a successful response rate from the questionnaire, with a 60 per cent return rate. Nearly 2,000 questionnaires were sent out in 2010–11. All patient information is held securely.
The case-finding service is free to both the surgery and its patients, and there is no charge for equipment and minor adaptations.

Age UK Waltham Forest also provides participating GP practices with a detailed statistical report of patients interviewed and services provided. During 2010–11, some 442 older people were identified as requiring single assessment visits.

There has been no adverse impact on day-to-day clinical activity at the GP practice, with only half an hour required by the practice to supply this data to Age UK Waltham Forest. Through their participation in the process, GPs have gained awareness of the impact of (to them) often quite small interventions for older people, such as providing transport or household safety checks, and the positive impact on people’s independence – with resulting reductions in surgery appointments.

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The ‘A Little Help’ service provides low-intensity practical support to older people in the community. It is funded by the innovative Northamptonshire Integrated Care Partnership (part of Nene Commissioning, a practice-based commissioning group), and builds on existing joint working to develop new models of long-term condition management to help patients remain independent for longer, and to have more choice in their end-of-life care.

The service creates personalised care plans for people identified as being at high risk, and aims to reduce admissions to hospital. Referrals to the service are only via healthcare professionals. Support can be provided with:

- shopping
- establishing an exercise regime
- prescription collection
- accompanying to health appointments
- promoting social inclusion
- signposting and referral to other services.

When accessing the service an older person may only want one telephone call a week, or may agree to several visits and phone calls. The service is geared to adapt to such individual needs. It is available for up to 12 weeks, with some flexibility built in. If an older person wants telephone contact simply for social reasons, they may be referred to the befriending service.

Those older people struggling to manage long-term conditions well, and who are also frequent users of primary care services in the community, can be referred to Age UK Northamptonshire under ‘Pro Active Care.’ Discussions are currently under way with funders to develop the service, if possible, to include personal care and longer hours of operation over seven days a week. A hospital aftercare service is also available.

During extreme weather warnings, the ‘A Little Help’ service can also check that people with chronic obstructive pulmonary disease, asthma, diabetes and heart disease have enough food, essentials and medication brought to them in advance, to avoid unacceptable risk. Older people at risk of loneliness and isolation are also offered information about other Age UK, statutory or voluntary opportunities, and can be accompanied to sessions, to help promote confidence. End-of-life support is also available through the Extra Help Service and is only via medical referral.

‘Brilliant people. A1, gold star. I would be lost without them.’
Bill, service user
When the service was originally set up, case managers and community matrons mainly referred frequent users of services. The primary care trust (PCT) had identified almost 500 people at high risk of readmission, nearly all of whom had significant social care and health needs and who had been admitted inappropriately to hospital many times in the preceding years. Anxiety and depression were also identified by the PCT as significant factors for many emergency admissions. Typically, an older person who was having ten admissions to hospital a year had this number reduced to three admissions a year, following support from Age UK Northamptonshire.

There are eight paid staff delivering the service and supporting approximately 100 people a month. In a six-month period, the service is contracted to provide support to 50 patients, offering visits, telephone calls and support to attend appointments or go shopping. This potentially saves 250 admissions per annum.

Helping Bill to cope

Bill, aged 50, has multiple sclerosis and receives twice-daily visits from carers. He is struggling with the housework.

During the day, Bill goes to town or the resource centre on his scooter. He finds evenings difficult to cope with since his wife left, and has been hospitalised following suicide attempts.

Bill’s case manager referred him to the ‘A Little Help’ service. At the initial visit with the co-ordinator, Bill agreed that he needed a change of activity in the evening. He enjoys watching sport but his television was broken, and he is unable to do crosswords as his hand shakes uncontrollably. The co-ordinator suggested learning how to use a computer to play games, do the crossword and download songs. They drew up an action plan with goals and how to achieve them.

The team obtained a second-hand television and Bill now watches sport on Sky TV. He attended a free local IT course, and now has a computer, obtained at minimal cost, with a key guard fitted to enable him to press only the required key.

The team arranged for Bill to attend a Living Well course and set up weekly domestic care to help with the housework. He was given assistance with financial issues, following a benefits check.

Over Christmas and New Year, the team visited and phoned regularly to support him through his first Christmas without his wife.

Bill no longer worries about his housework and is happy to invite friends to visit. He watches sport, and plays games and does crosswords on the computer. He has made new social contacts through the Living Well and computer courses. He is more content and has a new outlook on life. Bill has not needed to go to hospital for several months.
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3: Community Intervention Service and Home from Hospital Service – Age UK South Staffordshire

‘I felt much more confident coming home from hospital knowing that someone was calling in for three days to see how I was doing. The lady was lovely and very helpful.’

Mrs D, service user

‘It helped having someone to explain my new tablets to me.’

Mr F, service user

‘The girls were very professional and helpful following my fall. I was so relieved. I didn’t have to go into hospital.’

Mrs J, service user

**Community Intervention Service**

This short-term service aims to support people to overcome crises and to continue to live in their own home, while being able to maintain and manage their daily life with dignity and autonomy.

The service is tailored to specific needs of older people, providing appropriate support and access to a wide range of information and advice. Assessments are holistic and include a benefits check, a falls assessment and home safety checks. All older people using the service are provided with a contact number for future reference.

The service is funded by South Staffordshire PCT, registered with the Care Quality Commission and delivered by the Age UK South Staffordshire Penkridge Resource Centre. Referrals for the service come from any health or social care professional. There is no charge for the service.

**Home from Hospital Service**

The Home from Hospital Service offers low-level support for two or three visits – periods of assistance that can be used on consecutive days or spread over two or three weeks, as the older person requires.

Assistance can include help with tasks such as:

- collecting older people from hospital
- settling them in at home
- ensuring that the house is warm, if required
- emergency shopping on the day of discharge
- a general tidy-up of the home and a change of bed linen.
Follow-up visits can include:

- shopping
- safety-checking calls
- liaison with pharmacies and GPs, to resolve any medication issues that the older person may have.

More intensive input to assist with personal care tasks over two or three days is available, when discharge is delayed due to domiciliary care agencies not being able to start care immediately. The same criteria apply as with facilitating hospital discharge, but for four or five days instead of two or three days.

More than 250 new referrals were made in the six-month period from April to September 2011.

**Helping Mrs R with her diabetes**

Mrs R was referred to the Home from Hospital Service by a social worker. She had been discharged five days prior to referral from an out-of-area hospital with no support, having said that she would manage when she got home.

When the social worker rang to check how Mrs R was coping, she discovered that assistance was required and referred Mrs R to the service. At the assessment, Age UK South Staffordshire discovered that Mrs R was diabetic; she had not eaten for 24 hours and had not taken her insulin for three days. She was in a distressed state and had been incontinent. The assessor contacted the local pharmacy, who instructed her on the insulin dosage to be taken immediately. A medication plan was drawn up and Mrs R was encouraged to take her insulin. The assessor then contacted the GP, who agreed to visit immediately. Mrs R was then admitted to a step-up bed in the local immediate care facility.

Following Mrs R’s discharge, Age UK South Staffordshire revisited her, provided low-level care with shopping and signposted her to the Department for Work and Pensions for a benefits application. She continues to live at home.

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4: Hospital Aftercare Service – Age UK Rotherham

‘Someone [has] got me in mind, so [I] don’t feel so isolated and on my own.’

‘The service helped me regain my confidence with walking up the path.’

‘My daughter could not go on holiday as she was worried about leaving me, but as the hospital aftercare were seeing me most days, she felt she could leave me at home safely.’

Older people using Age UK Rotherham’s Hospital Aftercare Service

The Hospital Aftercare Service provides enabling support on discharge from hospital for older people who need assistance to regain independence after a stay in hospital, but who do not meet eligibility criteria for social care.

Seven staff and eight volunteers run the service between 8.30am and 8.30pm every day of the year. Trained staff carry out assessments and co-ordinate support to older people, and four enablers provide hands-on support. Volunteers provide additional support and befriending to very isolated older people and their carers.

More mobile users can access transport to get home, and a medicine collection scheme reduces waiting time and enables earlier discharge, avoiding the need for an older person having to wait for the pharmacy to dispense medication.

Staff escort older people home and ensure that there is food in the house and a safe environment. They offer a thorough assessment of any potential needs, with signposting and referral to other Age UK Rotherham services or to other sources of support locally and to statutory services if required.

Support from an enabler is for up to seven visits, to help the older person to regain independence and confidence. An assessment is carried out at the end of this period, and further support is offered if it is needed, including a befriending service which makes one or two visits per month.

The Hospital Aftercare Service was developed in close collaboration with NHS Rotherham and Rotherham Foundation Trust, including ward staff and hospital managers, with ongoing shaping and development of the service informed by Age UK Rotherham’s experience. For example, the service was reconfigured in year one, in response to the fact that originally older people using the service were offered seven follow-up visits after discharge. In reality, two categories of older people emerged: those who had little requirement for follow-on support; and those who needed greater input. This allowed a flexible response from Age UK Rotherham.
Annual audits and an independent evaluation by Sheffield Hallam University have demonstrated the effectiveness of the service against key outcomes for service users (including independence, motivation, mobility, financial and confidence), all measured using a mental health resource called the ‘outcomes star’ process. The evaluation also demonstrates value for money and efficiency savings for public sector organisations and the wider community, including cost savings in relation to bed days and transport costs and other economic impacts, such as welfare benefits increases. Currently around ten bed days per week are saved, and the ward experience is easier to manage when people are not waiting for transport and/or medications. Also, the older person’s discharge experience is improved with this reduced waiting time.

Enabling Miss H to retain her independence

Miss H was a patient who was ready for hospital discharge. Unfortunately, she could not be allowed home by the occupational therapist until she had a suitable bed in her home. She was referred to the Hospital Aftercare Service and was taken shopping to buy herself a bed. Miss H had no family to help her do this.

Once the bed was delivered the hospital aftercare worker transported her home, so that she did not have to wait around for hospital transport. She was settled in with a cup of tea, her bags were unpacked and washing was put on. There was little food in the house, so the home support enablers did some shopping for Miss H.

At first, Miss H refused any care package, but eventually she realised that she needed some support with personal care, and she was referred appropriately. She is now in receipt of one visit per day. Age UK Rotherham cleaning services restarted and she was also referred to Rothercare Direct (the emergency contact pendant alarm service).

The hospital aftercare team then visited twice a week, to encourage Miss H with walking and to build up her confidence with walking outside. Arrangements were made for the local café to deliver a hot meal every day, as Miss H did not feel strong enough to cook. At this stage Miss H was also referred to the falls team. Miss H continued with the service for approximately one month and managed to regain her independence.

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‘The assistance enabled me to walk, move and so improve my mobility and fitness following a stroke.’
5: A&E Support Service and Home from Hospital Service – Age UK Hillingdon

‘I found the service very helpful; it made me feel as if I wasn’t on my own and there was someone I could turn to.’

‘The assistance enabled me to walk, move and so improve my mobility and fitness following a stroke.’

Older people using Age UK Hillingdon’s services

A&E Support Service

Age UK Hillingdon worked with Hillingdon Hospital to design the evening A&E Support Service when it was first set up in 2004. Most referrals to the Home from Hospital Service (see below) come from the A&E support staff. The daytime A&E service offers support from 12.15pm to 5.15pm and the evening service runs from 5pm to 10pm, with a 15-minute handover.

Currently A&E support workers occasionally escort people home from hospital by taxi. It has been suggested that Age UK Hillingdon could extend this, by linking up with the Urgent Care Centre at the hospital, thereby preventing the need to unnecessarily admit someone overnight because they are too unwell to travel home alone by public transport.

Home from Hospital Service

This service is run with eight volunteers, one full-time co-ordinator (who also makes assessments) and one assistant working 30 hours per week. It reaches 200 older people every year.

Older people in need of the service can be identified via the weekly multidisciplinary team meetings attended by staff on the two rehabilitation wards at the local hospitals. Referrals can also come directly from social services or from the older person themselves or from family members. There is no charge for this service, which lasts for six weeks from discharge. A date is arranged for a home visit to assess need; ideally staff also meet the older person when they are still in hospital.
The older person’s practical and physical needs are addressed, including getting shopping and putting on the heating. If there is a care package in place, or home equipment has been arranged, staff can follow up any discrepancies and can help the older person to undertake exercise routines, if these have been prescribed following an operation. Staff might also typically help an older person to regain their confidence, by going out to the shops with them for the first time. They also tell the older person about other support services at Age UK Hillingdon, such as welfare benefits and the handyperson service, which can continue after the Home from Hospital Service ends.

Anyone who is identified as being socially isolated or lonely is offered a befriending service, as well as a range of other services offering social contact.

Readmissions of older people are monitored – the person is ‘tracked’ for six weeks, to see if they have been readmitted. These statistics show that the rate of readmission is lower if the person has received the Home from Hospital Service and that, where readmission does occur, this is due to medical (rather than social) reasons.

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Notes

1 Available at: www.ombudsman.org.uk/__data/assets/pdf_file/0016/7216/Care-and-Compassion-PHSO-0114web.pdf
2 See www.rcpsych.ac.uk/PDF/WhoCaresWins.pdf
3 See www.nuffieldtrust.org.uk/sites/files/nuffield/Trends_in_emergency_admissions_REPORT.pdf
4 See https://indicators.ic.nhs.uk/webview
5 Kings Fund Data briefing: Dec 2011 “Emergency bed use”.
7 Pro Active Care is a GP-led, multi-agency case management model, which aims to identify.
8 C. Dayson and I. Wilson (2011) Demonstrating the Value for Money of Third Sector Activity in Rotherham. Case study report: Age UK Rotherham Hospital Aftercare Service, Centre for Economic and Social Research, Sheffield Hallam University. Available at: www.ageuk.org.uk/rotherham
9 Age Concern England (2003) So Much More Than Just Walking! Evaluation of pilot programme of social rehabilitation projects provided by Age Concerns in five areas, University of Birmingham
‘All we did, we walked up the street and back again, and then we walked as far as the park at the end of the road. I can’t do that on my own yet, but I hope to God I do. I like to take my dog, and we always meet someone we know... it means so much more than just walking!’
The Age UK expert series is for people influencing, designing, commissioning and delivering services for later life. The reports present evidence, lessons from experience and practical solutions.