GOING HOME ALONE

Counting the cost to older people and the NHS

ROYAL VOLUNTARY SERVICE

Together for older people

FOREWORD

from Royal Voluntary Service Chief Executive, David McCullough

We often hear of an ageing population discussed in negative, or at least in troubling, terms. It is rarely celebrated for the achievement that it is – people living longer lives. An achievement in no small part due to the NHS; and yet this achievement presents a huge challenge for the very organisation that has helped people to live longer lives.

Within the last ten years hospital admissions for those over 75 have been rising at an even faster rate than ageing trends in the population: almost four times faster. Worryingly the growth in hospital readmissions has been higher still, up by 86 per cent for those over 75. We wanted to find out why those readmissions were rising and if something could be done about it.

We know from our own research that many live alone, so return home from hospital to an empty house with insufficient support. They tell us they feel anxious. We believe that older people deserve better and we know the doctors, nurse and healthcare assistants that look after them in hospital want better for them when they return home too.

So can more be done? We think it can. We believe this because an evaluation of our '**Home from Hospital**' scheme in Leicestershire found that it helped achieve very low readmission rates – half the national average. Our **Home from Hospital** volunteers support older people after a stay in hospital, making sure their house is safe and warm, helping with meals, transport to follow-up GP appointments and providing a friendly face that they can always call on to raise their spirits. It's simple, inexpensive and it works.

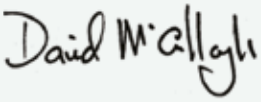
With local authority and hospital trusts facing budget cuts, we believe volunteer support is the cost-effective solution to support older people as they leave hospital. There is a huge amount of affection for the NHS and a desire among many potential volunteers to support it and the people it serves. Placing a caring volunteer at the centre of an older person's

recovery plan dramatically improves their experience, their confidence and their well-being – and helps them continue to live independent fulfilling lives. It also drives important efficiencies in hospitals enabling swift, well-managed discharge from wards.

That's why we're launching our 'Let's End Going Home Alone' campaign.

We believe that by working together we can challenge the rising readmission rates for older people, to the benefit of everyone. We therefore urge everyone to support the 'Let's End Going Home Alone' campaign. Older people and their families, doctors, nurses, other charities, the general public and commissioners can all do something whether it's volunteering, spreading the word or simply signaling your support of our campaign. We believe greater volunteer help through **Home from Hospital** schemes can improve the quality of older people's lives long after a hospital stay and save the NHS millions of pounds. As part of the campaign, we have developed the Six Essentials for older people returning home from hospital, that we can all work towards (found at the end of this report, pg 37).

Let's join together for older people and end going home alone.



David McCullough
Royal Voluntary Service Chief Executive

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10%

population increase in those over 75 years old...

...but

38%

increase in hospital discharges for those over 75 years old

46%

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EXECUTIVE SUMMARY

National data shows that the number of hospital admissions amongst older people is increasing. Over the last 10 years hospital discharges (and therefore admissions) for those over 75 have been rising at a much faster rate than ageing trends in the population; almost four times faster (38% compared to 10%).

The growth in hospital readmissions has been higher still, up by 86% for those over 75. This national picture is supported by the results of research by Royal Voluntary Service: of 401 people over 75 years old who had been in hospital within the last five years, 13% had been readmitted within three months.

While admission to hospital can be a stressful experience for anyone, it is often particularly difficult for older people. The research undertaken by Royal Voluntary Service showed that whilst the majority of respondents were relieved to return home at discharge, many also felt anxious, depressed and frightened. It can be particularly frightening for those living alone and the research identified that nearly half (46%) of the people over 75 who had been in hospital within the last five years were living alone. Some evidence also suggests hospitalisation is in itself associated with negative health outcomes in older people; leading to some types of functional decline, for example.

Policymakers in Britain recognise the problem of increasing hospital admissions, many of which may be avoidable (some estimates indicate 20%[1]), and the importance of tackling these as part of wider attempts to deliver efficiency savings in the NHS. English, Scottish and Welsh governments have all developed strategies that emphasise preventative care, better integration between health and social care, and a shift in care out of hospitals and into homes and communities. All governments in Britain are committed to reducing the level of avoidable admissions.

1 NAO, 2013

Sylwestra and Sara

“

Until Royal Voluntary Service started I had no transport to get to appointments. Now I can just call Sara and she takes me and waits for me. I really like the friendliness and genuine friendship of the volunteers. It's an excellent service.

”

Sylwestra, 89

Appropriate and effective **Home from Hospital** services may be one solution to tackling the increases. Evidence shows that these schemes, which provide emotional and practical support to patients on their return home from hospital, can help ameliorate the effects of isolation and loneliness, and that they are highly valued by users. There is also some evidence these services may reduce the need for hospital readmission and other forms of care by ensuring that older people are supported in settling back into their homes and communities, and that they are able to rebuild their confidence and independence.

Royal Voluntary Service's research found that over a quarter of those who were readmitted within three months had not felt ready to go home at initial discharge, compared to only 5% of people who had not been readmitted within three months. The research also showed that the number of people saying they had support needs which were not met was higher amongst those who were readmitted.

It is also important to note that not all readmissions are undesirable. In cases where hospital admission is appropriate, access to support from friends and family or a volunteer may be fundamental in bringing this about.

Whilst there is good evidence of the positive impact of **Home from Hospital** schemes on users' well-being, determining the financial implications of these schemes is complicated by the lack of clear data, and in particular by the absence of comparator information: once an individual is in receipt of support, there is no way of knowing what the outcomes would have been had support not been available. Consequently, the quantitative evidence in this area is limited and generally inconclusive.

However, various methods have been used to try and demonstrate the economic value of **Home from Hospital** schemes in terms of the value to the user (based on the value they placed on the services received), or by estimating costs avoided elsewhere in the health and care system.

In this paper, building on the findings from the research, and using national data on Hospital Episode Statistics, we explore the possible financial impact of *appropriate and effective* **Home from Hospital** services. This approach, which is restricted to an analysis of hospital readmissions (and excludes wider impacts), takes into account the costs of "excess" admissions. On that basis, *if* **Home from Hospital** services could alter the underlying causes of inappropriate admissions *and* were targeted appropriately with full coverage across England, we conclude they might reduce costs of readmissions by around £40.4m per year. It is important to note that this estimate is dependent on a large number of assumptions.

For these types of interventions to prove successful, research suggests there is a case for social support (including possibly **Home from Hospital**) interventions that use a group rather than individual format, as these seem to be more effective. There is also strong evidence that those interventions that include older people, their target group, in their design are more successful than those that do not. However, there was also a clear message from the research (and a number of experts) that many older people require support for a period for longer than six weeks following discharge, and therefore where it is possible to transition from **Home from Hospital** to other befriending schemes this should be encouraged.

In conclusion, the evidence suggests **Home from Hospital** schemes are a valuable service well regarded by those who use them. Given that many older people who are readmitted to hospital feel they were discharged too early or did not receive enough support, they are likely to play a valuable role. Modelling suggests they could lead to significant cost savings through reductions of readmissions, but their prime purpose is to improve health and wellbeing.

Almost

20%

increase in people aged over 85 in Britain since 2008

Population of 65 - 84 year olds to be

40%

larger by early 2030s

INTRODUCTION

Britain's population of older people is increasing; since 2008, the number of people aged over 85 has increased by nearly a fifth and, according to current estimates, the population of 65-84 year olds is likely to be 40% larger by the early 2030s. This has led to not only an increase in overall demand for health and care services, but also a change in the nature of support required. This is why the priority for policymakers is to address the increasing number of hospital admissions (and readmissions), many of which are accounted for by older people, and to shift care away from hospitals into other settings.

A number of **Home from Hospital** schemes across Britain focus on supporting older people in their homes following a stay in hospital and seek to reduce the likelihood that they will need to be readmitted to hospital. It is likely that demand for these services will continue to grow.

Royal Voluntary Service commissioned The King's Fund to assist with an assessment of the evidence of the need for **Home from Hospital** schemes, as well as their effectiveness and impact - and, as far as possible, to identify the cost implications. In parallel, quantitative research was undertaken among older people about their experiences of admission and discharge.

This paper brings together the findings from each of these areas of work. It also sets out the findings of a cost-impact analysis which draws on national data and results from the research in order to provide an estimate of the potential cost savings for the NHS from **Home from Hospital** schemes.

SECTION 1

THE POLICY CONTEXT

Policy in each of the nations within Britain has increasingly acknowledged the significant needs of the growing population of older people and the impact on the overall demand for services. In England, Scotland and Wales policymakers are responding to this challenge by focusing on preventive care, better integration of health and care services, and on shifting care away from the hospital into homes and communities. There has been a particular emphasis on reducing the number of avoidable hospital admissions (a large proportion of which are experienced by older people), an ambition which is critical to plans to deliver efficiency savings across the NHS.

1.1 ENGLAND

According to a National Audit Office report, approximately 20% admissions are for known conditions that could be managed effectively by primary, community or social care (NAO, 2013). In England the focus on keeping people out of hospital where appropriate is set out in the NHS outcomes framework.

The ambition to reduce avoidable admissions is reflected in the tariff system for 2014/15 which, as in previous years, incentivises providers to prevent unnecessary admissions by paying them 30% of normal payment rates for emergency admissions above an agreed baseline, and offering no payment at all for many emergency readmissions within 30 days (Monitor 2013). In 2014 the Government announced that, of the total £3.8bn Better Care Fund set up to promote closer working between health and social care services, £1bn may be linked to performance in reducing total emergency hospital admissions (NHS England 2014).

Transforming Primary Care (TPC), published by the Department for Health in April 2014, is part of the English strategy for improving proactive, joined-up care for older people and those with complex needs. TPC acknowledges that older people (and other vulnerable groups) account for a large proportion of avoidable hospital admissions and that providing them with proactive and personalised support outside of hospital will be critical in achieving a reduction. This includes taking steps to address some of the wider determinants of health, such as loneliness, malnutrition and cold homes, as well as providing proactive follow up support on discharge (DH, 2014).

Wider health and care policy in England has also recognised the problem of social isolation and loneliness and the impact these can have on health outcomes and service use, particularly amongst older people. Social isolation (based on self-reported social contact) is now included as one of the indicators in both the Adult Social Services and Public Health Outcomes Frameworks.

The role of volunteers in helping to address the health and care needs of older people is acknowledged in TPC, which stresses that GPs will need to work as part of multi-disciplinary teams that include volunteers (DH, 2014). The Five Year Forward View emphasised the crucial role volunteers play in health and social care, and supports the testing of ideas such as that put forward by the Local Government Association that volunteers, including those who help care for older people, should qualify for reduced council tax bills (NHS England, 2014).

1.2 SCOTLAND

The Scottish Government's plan for older people is set out in Reshaping Care for Older People (RCOP); a 10-year programme for change aimed at improving services for older people by shifting care towards anticipatory care and prevention. The emphasis is on moving away from traditional "institutional" care towards care at home and within the community, a shift which is being supported by a dedicated Change Fund. A key priority is to reduce the number of bed days used as a result of emergency admissions to hospital by older people, a metric included as an official target within the national outcomes framework for community care in Scotland (Ham et al, 2013). An update on the policy in 2013 reported a 6.8% reduction in bed days for the over 75s between 2009/10 and 2010/11 (NHS Scotland 2013).

More recently, the Scottish Government passed legislation enabling Health Boards and Local Authorities to integrate health and social care services from April 2015. The newly established Integration Authorities will have responsibility for commissioning for unplanned hospital stays on the basis that a proportion of these are potentially avoidable with the provision of appropriate preventative care (Scottish Government, 2014).

The value placed on volunteering by the Scottish Government is demonstrated in its strategy for volunteering in the NHS, which was refreshed in 2008 with the aim of increasing the focus on volunteering (Scottish Government 2008). A review of the strategy published in 2011 showed it had made a valuable contribution towards the development of volunteering within NHS Scotland, but recognised there were further opportunities (Scottish Health Council 2011). In 2011 the Government appointed a National Group for volunteering to oversee progress.

1.3 WALES

The Welsh Government set out its five year strategy for health in 2011 in Together for Health. This emphasises patient centred care, prevention and quality, as well as the need for better integration of health and care services. Sustainable Social Services for Wales: A Framework for Action put re-ablement at the heart of its approach to older people (Welsh Government, 2011). In 2014 the Welsh Government passed the Social Services and Well-being (Wales) Act, providing a legal framework for collaboration between social services and the NHS, with the aim of increasing the role of the individual in shaping their care.

Earlier this year the Government published a framework aimed at delivering integrated care for older people with complex needs. As with Together for Health, the framework is focussed on preventative services and support to maintain well-being, as well as on ensuring that older people have control over their care. The aim is to strengthen community care and prevent unnecessary hospital admissions, while ensuring that people are not delayed unnecessarily in hospital and that they are adequately supported on their return home (Welsh Government, 2014).

The Strategy for Older People in Wales 2013-2023 also recognises the issues of social isolation and other determinants of well-being. The strategy aims to increase social participation amongst older people through initiatives such as community cohesion policies and funding for community facilities (Welsh Government, 2013).

SECTION 2

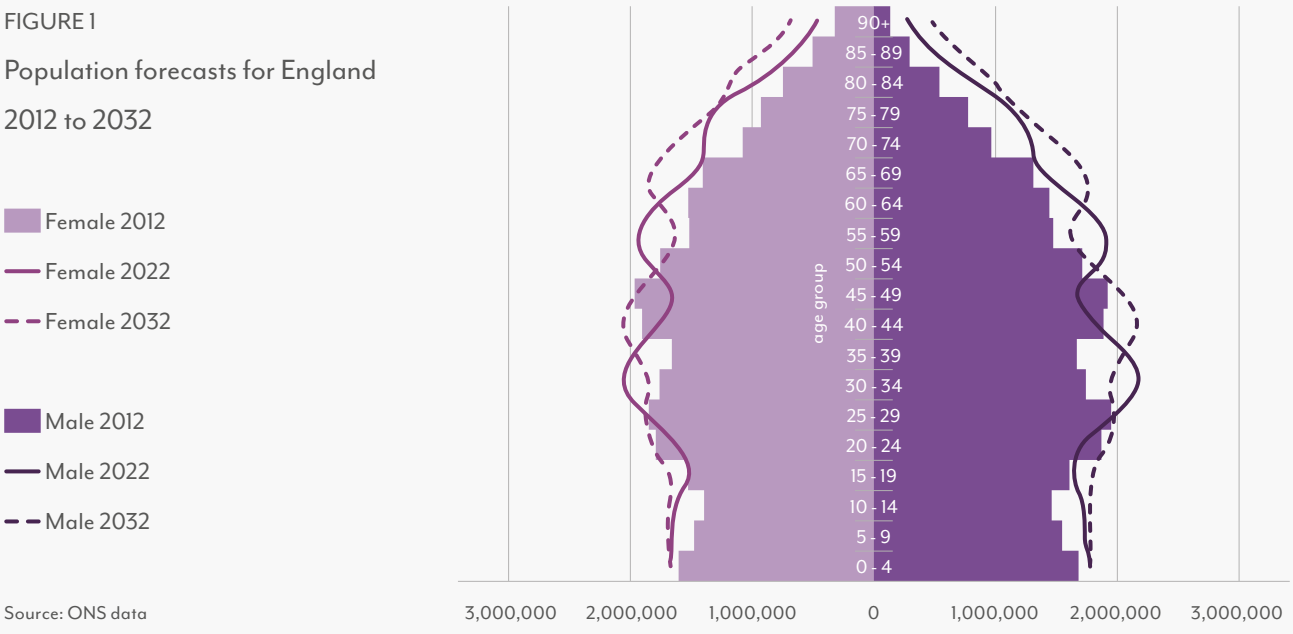
THE POTENTIAL NEED FOR **HOME FROM HOSPITAL** SCHEMES

HIGH LEVEL TRENDS IN HOSPITAL USE BY OLDER PEOPLE COMPARED TO POPULATION TRENDS AND OTHER GROUPS

The population in England and the rest of Britain is ageing, partly thanks to the treatment and care that the NHS provides. Since 2008, the number of people aged over 85 has increased by nearly a fifth and, on the basis of current trends, it is estimated that there will be 40% more 65 to 84 year-olds by the early 2030s and more than twice as many people aged 85 or above.

FIGURE 1

Population forecasts for England 2012 to 2032



Source: ONS data

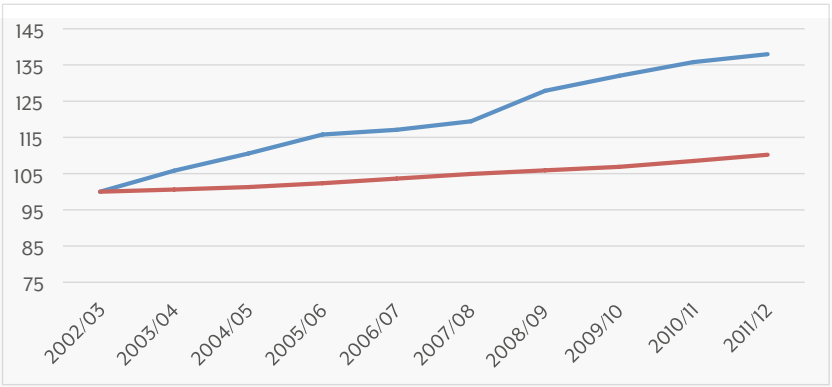
Ageing brings its own problems, including rising numbers with multiple comorbidities and needs, and increasing problems of isolation and loneliness.

The demand for services such as **Home from Hospital** schemes may therefore increase over time. There are several ways to assess the extent to which this is happening and its impact, including qualitative research and information, and more quantitative data. One indicator of growing potential need is the relative use of hospital-based services over time, and how this is changing by age-group.

Background information was put together, as gathered and provided by the Office of National Statistics Health and Social Care Information Centre[2], on the trends in hospital admissions, length of stay and bed usage by those over 75 to provide context to the issues raised in this report.

Figure 2 shows trends in an index of discharges for those over 75 between 2002-03 and 2011-12, where 2002-03 is indexed as 100. By 2011-12, whilst the population of over 75s had grown by 10%, discharge growth (reflecting admissions) was almost four times higher at 38%.

FIGURE 2
Trend in discharges of over 75s

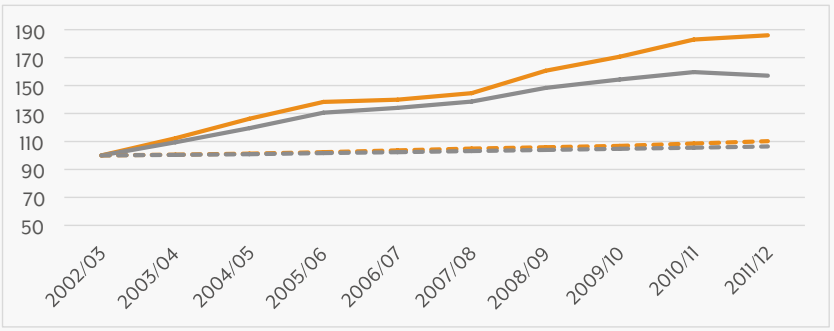


In absolute terms this growth in discharges, and therefore admissions, is related to an increase from 1.15m inpatient "spells" of care in 2002-03 to 1.37m in 2012-13 (growth of 19%) for those over 75.

2 It should be noted that these figures are presented "as is" from the Health and Social Care Information Centre's Hospital Episode Statistics: Admitted Patient Care Summary 2012/13 and extracted from their online Indicator Portal.

Figure 3 show trends in emergency readmissions over time, again baselined in 2002/03 numbers against population demographics. This shows a rising population trend for 75+ (12% to 2011/12) compared to those under this age. For both age-groups, readmission rates grow more strongly than population trends, but for the over 75s, this growth, at 86% over 10 years, is much higher than for those under 75 (57%).

FIGURE 3
Emergency readmission rate index by year



The final three figures translate the above trends in spells, admissions and readmissions into bed usage and length of stay. Figure 4 shows bed usage for the over 75s has actually fallen over the last 10 years (from a total of 20.8m in 2002/03 to 18m in 2012/13), despite the increasing trends seen in readmissions and discharges.

FIGURE 4
Total estimated bed days

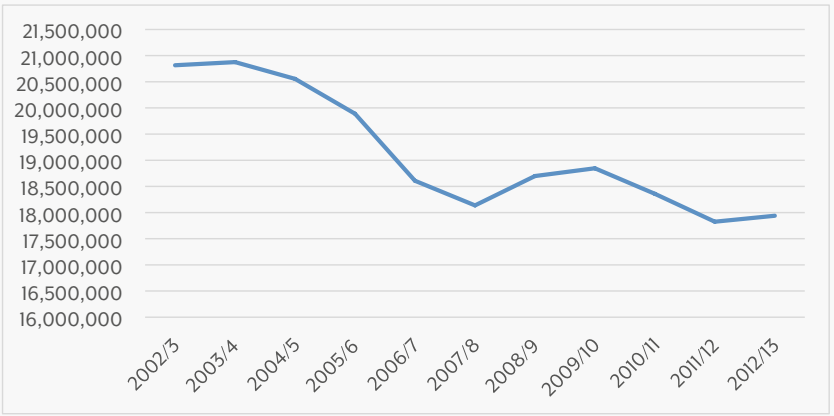
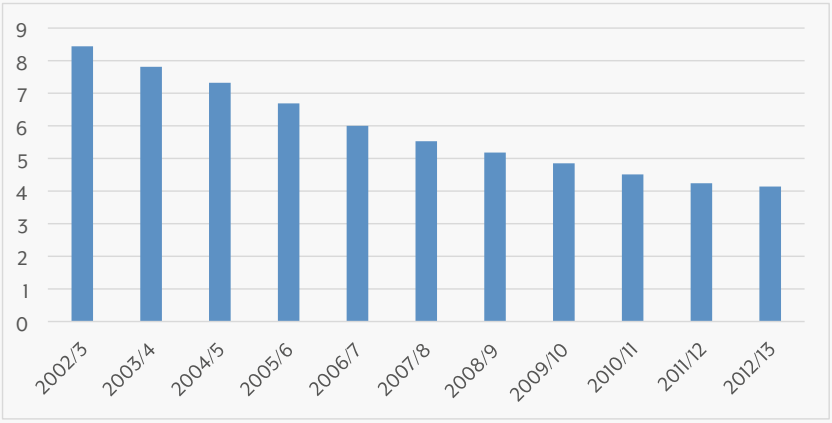


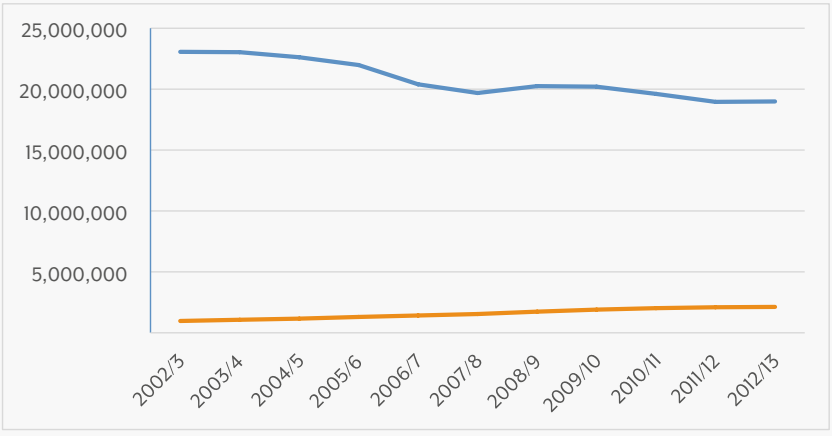
Figure 5 shows a similar trend in the average length of stay per admission, but even more consistently than Figure 4, which had a slight rise in 08/09 and 09/10.

FIGURE 5
Average length of stay



What's driving these conflicting results? One factor is that the number of zero-day length admissions more than doubled from 970,000 in 2002/03 to 2.1m in 2012/13.

FIGURE 6
Trend in total length of episodes 2002/03 to 2012/13



All of this suggests that the pattern of admissions generally has been shifting over time, with more, but shorter episodes in hospital for those over 75.

IN SUMMARY

Over the last 10 years hospital discharges, and therefore admissions, for those 75+ have been rising much faster than aging trends in the population: almost four times faster, 38% compared to 10%.

The growth in hospital readmissions has been higher still, up by 86% for those 75+.

By 2012/13, an estimated 2m fewer bed-days were used by over 75s than in 2002/03.

Length of stay is decreasing, with an increasing rate of zero-day length admissions along with an increase in the total number of discharges seen between 2002/03 and 2012/13.

In this context, *appropriate and effective* Home from Hospital services may be one solution to tackling the increase in readmission rates.

SECTION 3

EXPERIENCES OF OLDER PEOPLE AFTER LEAVING HOSPITAL

Royal Voluntary Service commissioned PCP Market Research to undertake quantitative research among people aged 75 or over in Great Britain. During September, the researchers spoke to 401 people aged 75 or over who had spent at least one night in hospital on one or more occasions within the past five years. Everyone included in the survey was living in an independent household.

The research provided important information for our cost-impact analysis (see section 5) including information on readmission rates for older people who reported low or no support for a previous discharge. The results also provided a valuable insight into patients' experience of admission, discharge and support, and supplemented the evidence from the literature review.

3.1 ADMISSIONS

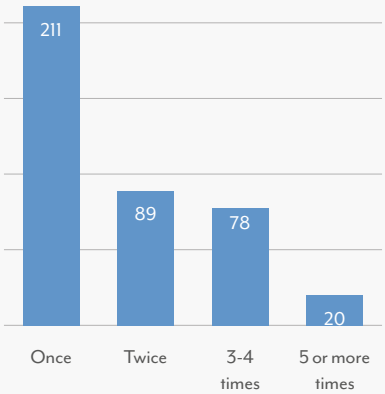
Figure 7 shows that more than half of the research base had been to hospital once in the last five years and almost half had been admitted on more than one occasion.

Of the total sample, 13% had been readmitted within three months of their initial admission. This is broadly comparable to the nationally reported figure for readmissions of those over 75, who have been in hospital, which is 15%[3].

3 http://www.royalvoluntaryservice.org.uk/Uploads/Documents/Get%20involved/avoiding_unhappy_returns.pdf

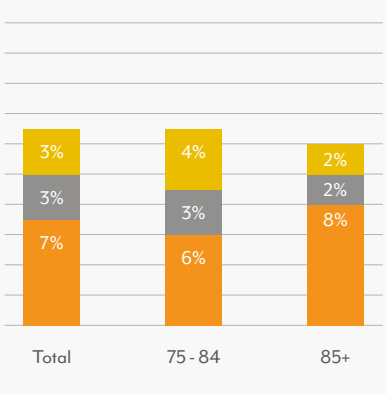
FIGURE 7
Hospital admissions and readmissions

Number of occasions in hospital



- 53% of people interviewed had been to hospital once
- 47% more than once
- Less than 1% couldn't remember

Readmissions by age group



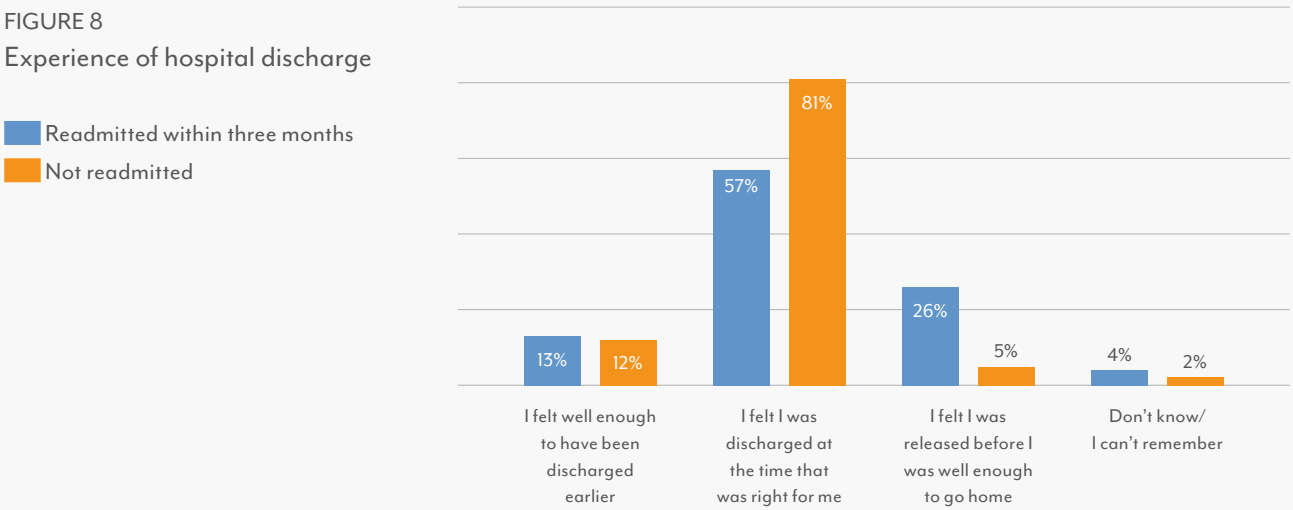
- Of total sample, 13% were readmitted
- Proportion of people readmitted within 3 months was higher amongst 75 - 85s than over 85s
- Higher proportion of people readmitted within 28 days amongst over 85s

3.2 DISCHARGE

The research asked respondents about their experience and views at discharge. Figure 8 shows that over a quarter of those who were readmitted within three months said they had not felt ready to go home at the time of their first discharge, compared with only 5% who were not readmitted within three months. This is a strong warning sign: some patients feel they are being discharged too early and there may well be a link between this and high readmission rates.

Many people said they felt their early discharge had been driven by financial and related pressures: a large number of respondents believed the hospital knew it was discharging too early but "needed the bed" for another patient. This view appeared to be particularly prevalent amongst those who were readmitted within three months (64% cited this as a reason for their early discharge).

FIGURE 8
Experience of hospital discharge



3.3 NEED FOR SUPPORT FOLLOWING DISCHARGE

Findings suggest that many older people feel under-supported on leaving hospital. For a significant minority (11%) this means they didn't have the support in place to meet their needs while they are still recovering in the crucial weeks (or months) after hospital. This lack of support is often the reason why 15% said they felt anxious on their return home after an overnight stay.

Figure 9 provides an insight into the level and type of need reported by the research base, and how this is associated with readmission rates. In general, those who were readmitted to hospital within three months reported a greater need for support at discharge, with 43% of those readmitted saying they had needed "a great deal" or "quite a lot" of support, compared with only 27% of those who were not readmitted. This trend applied across seven out of the eight specific areas of support respondents were questioned about, as well as overall.

The results suggest that needing support at discharge is associated with an increased likelihood of readmission. At least in part, this is likely to reflect the fact that those who return to hospital tend to be more acutely unwell to begin with (as suggested by a greater need for support at discharge).

However, the research suggests readmission is closely related to whether or not individuals actually receive the support they feel they need. As shown at figure 10, amongst those who were not readmitted only 17% indicated they had not received all of the support they felt they needed. But of those who were readmitted, this figure was more than double at 41%.

This suggests there is a link between needing support but not receiving it and readmission to hospital. This finding supports the evidence identified by the literature review (see next section) which suggests that having needs for support with "activities of daily living" (such as bathing, dressing, eating, toileting, and either moving around) which are not met increases the risk of hospital readmission (DePalma et al, 2013).

FIGURE 9
Support required at discharge

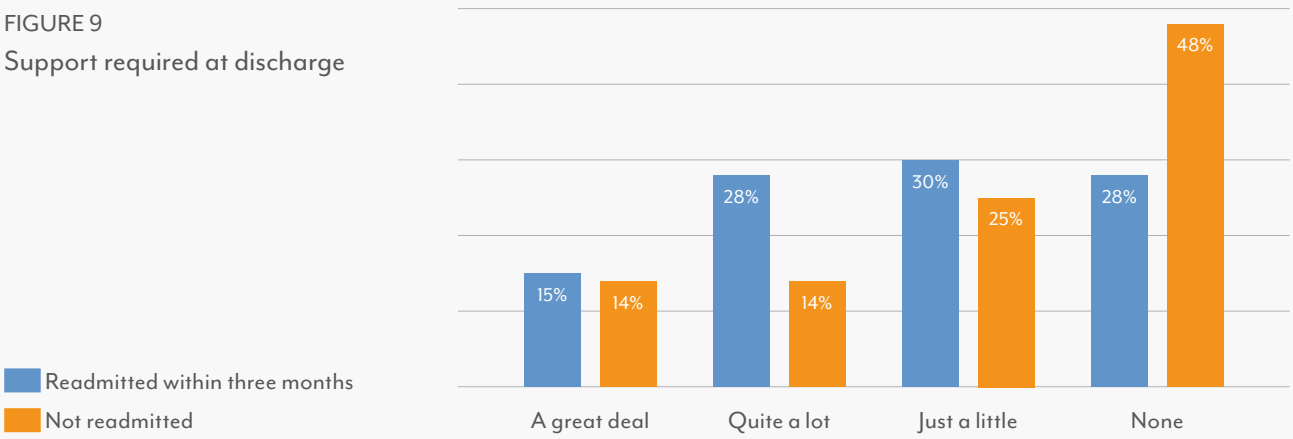
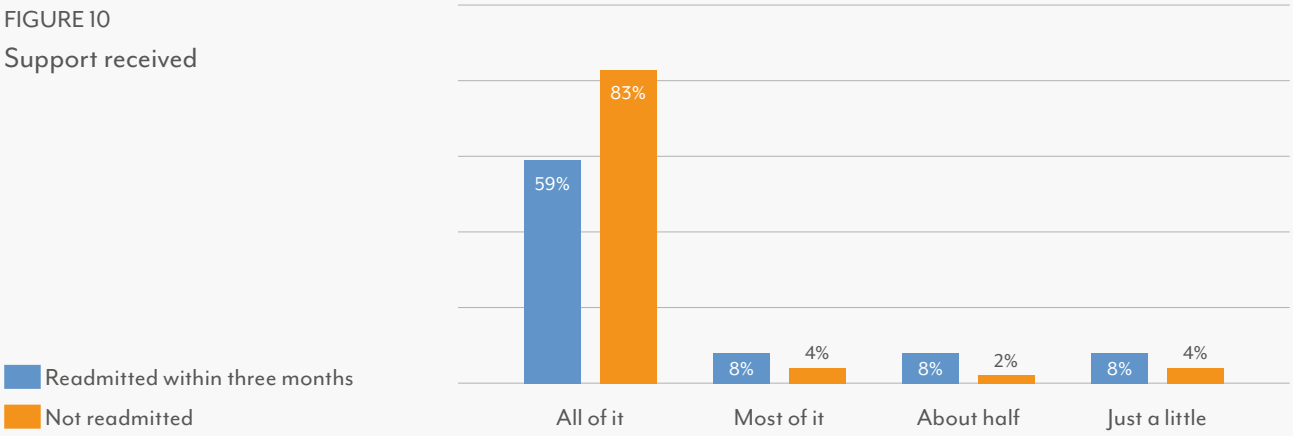


FIGURE 10
Support received



3.4 TYPE OF SUPPORT FOLLOWING DISCHARGE

The majority of respondents did in fact have some form of support at home from friends and family, professional carers and volunteers, and many were living with a partner or spouse at the time of readmission. There is a mixed picture in terms of the link between having support at home and being readmitted to hospital.

This suggests that the relationship between support and readmission is complex. Firstly, there may be some two-way causation here: patients who are identified as needing support are likely to be the most vulnerable either medically or socially and therefore are already at greater risk of a future re-admission. Indeed, as discussed in the following section, not all readmissions are inappropriate, and in some cases support from either friends/family or a volunteer may be fundamental in bringing about a necessary admission to hospital. The fact that the individual is ultimately readmitted does not demonstrate that receiving support was of no

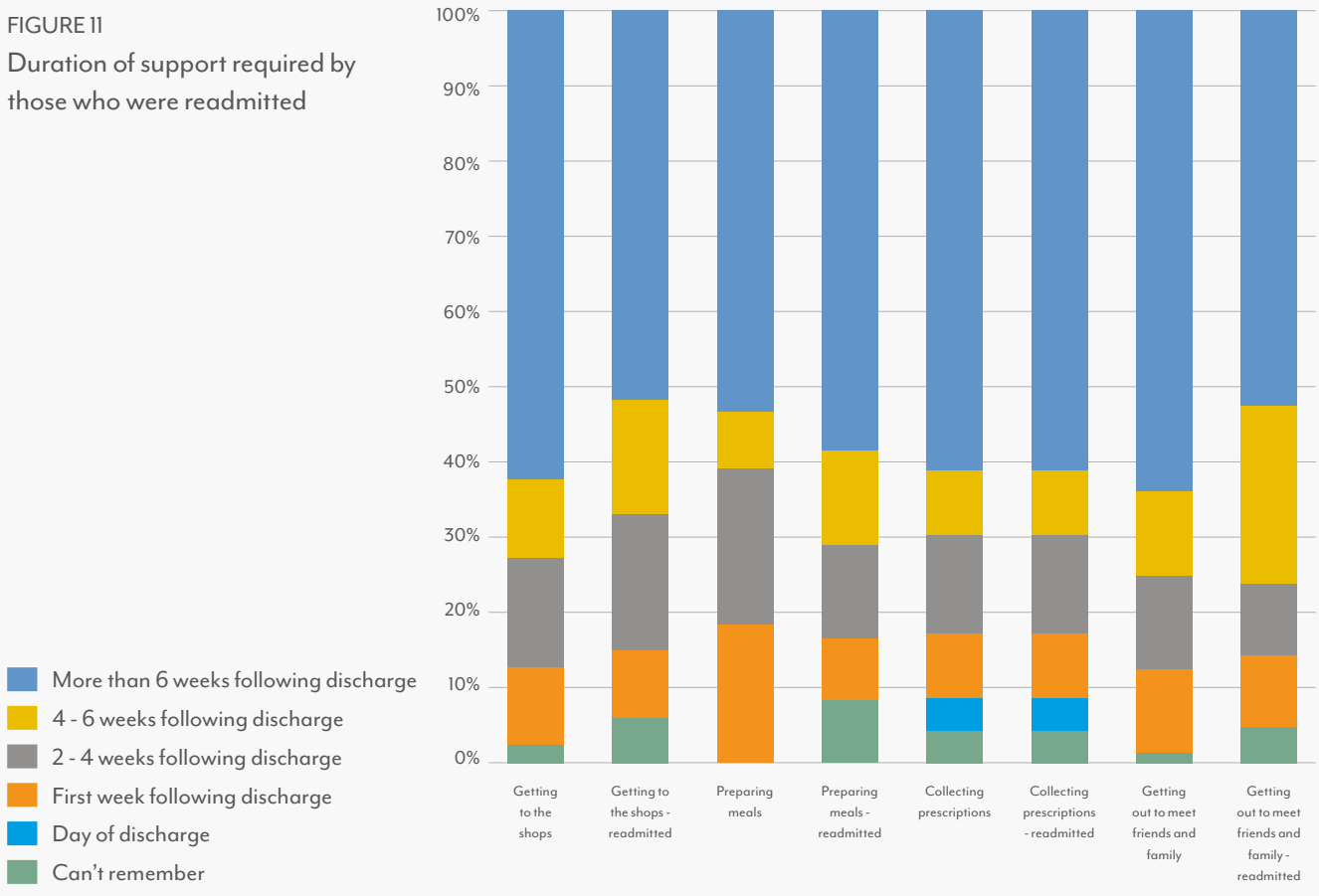
benefit, and it is not possible to tell how they would have fared without the support. Indeed, what is clear, as suggested by Figure 9 above, is that needing support but not receiving it *does* appear to correlate with increased likelihood of re-admission.

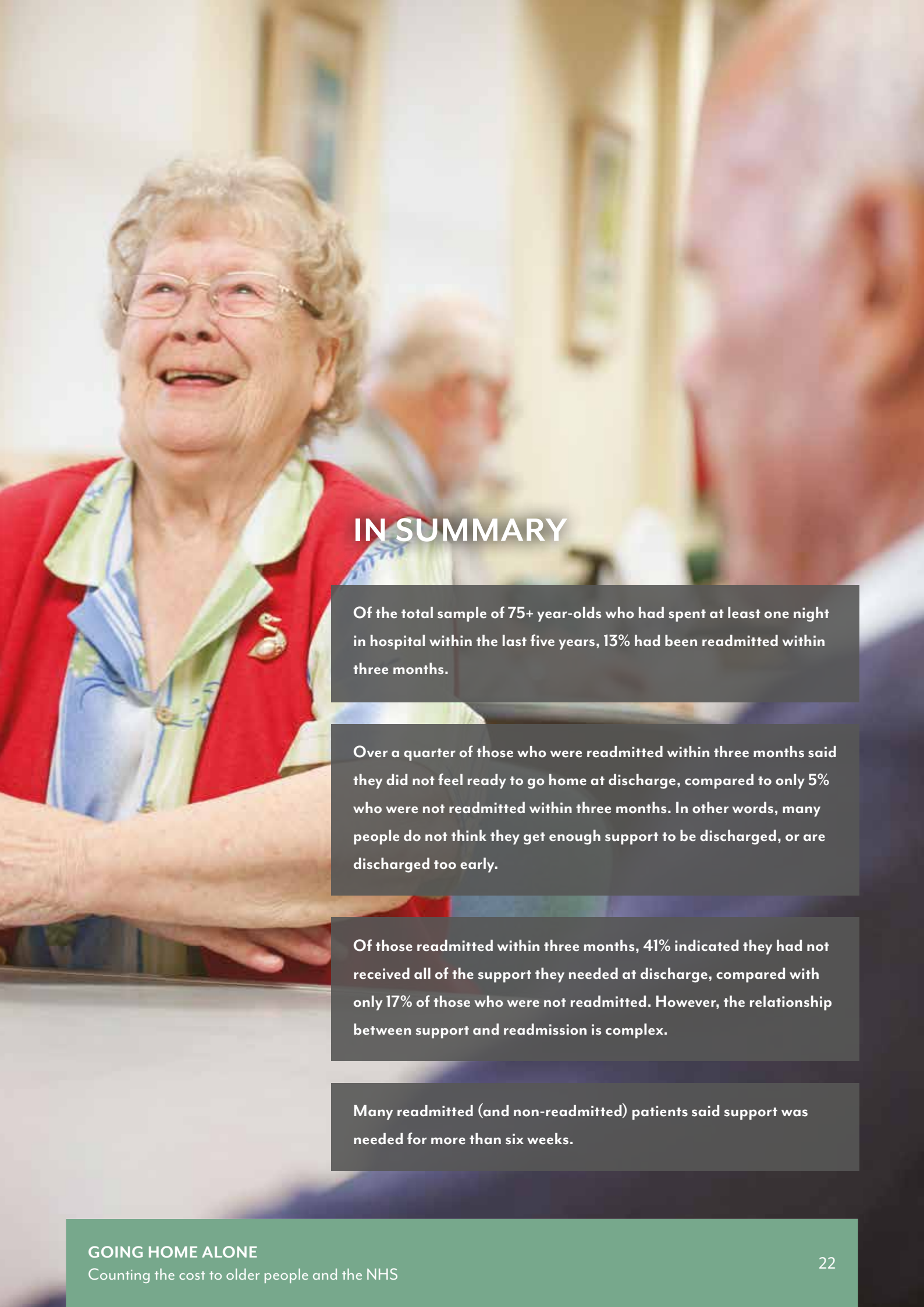
3.5 DURATION OF SUPPORT REQUIRED FOLLOWING DISCHARGE

Figure 11 shows that in all eight areas of support covered by the research, at least half those respondents who required support in these areas felt they required it for a period of longer than six weeks. This applied to both those who were readmitted within three months and those who were not readmitted.

This issue was also highlighted in the literature review (see next section), and through our conversations with experts. It is clear that where support from **Home from Hospital** schemes is followed (ideally seamlessly) by longer term support - for example from a befriending service such as Royal Voluntary Service's Good Neighbour programme - this is highly valued.

FIGURE 11
Duration of support required by those who were readmitted





IN SUMMARY

Of the total sample of 75+ year-olds who had spent at least one night in hospital within the last five years, 13% had been readmitted within three months.

Over a quarter of those who were readmitted within three months said they did not feel ready to go home at discharge, compared to only 5% who were not readmitted within three months. In other words, many people do not think they get enough support to be discharged, or are discharged too early.

Of those readmitted within three months, 41% indicated they had not received all of the support they needed at discharge, compared with only 17% of those who were not readmitted. However, the relationship between support and readmission is complex.

Many readmitted (and non-readmitted) patients said support was needed for more than six weeks.

SECTION 4

THE NATURE AND POTENTIAL BENEFITS OF **HOME FROM HOSPITAL** SCHEMES

Given our findings above, it is important to understand the potential need and benefits of **Home from Hospital** and similar schemes.

Royal Voluntary Service's **Home from Hospital** schemes provide support to older people returning home following a stay in hospital. The service is delivered by Royal Voluntary Service volunteers and its main objectives are to help older people, particularly those living alone, to settle back into their homes and communities, and to reduce the chance they will need to go back into hospital. One of the main objectives of the service is to counter the effects of social isolation and loneliness which we know is a predictor of hospital emergency department use (Geller et al, 1999)

We undertook a rapid review of the literature on the nature and potential benefits of **Home from Hospital** schemes. As well as drawing together existing research, this section incorporates insights from conversations with experts in the area, and highlights some of the main findings from other research undertaken by Royal Voluntary Service.

4.1 SOCIAL ISOLATION AND LONELINESS AND OLDER PEOPLE

Older people are at greater risk of social isolation and loneliness than other groups. Some studies have shown that the likelihood of expressing self-perceived loneliness increases with age (Age UK 2014), (although others have found it to peak in middle age (Humphrey et al, 2011)). This tendency can be explained by reduced contact with friends and family, the loss of mobility and income (Windle 2011), and cognitive and sensory impairment, including dual sensory impairment (Bolton, 2012). Lack of access to private transport and living alone also increase the risk of social isolation in older people (Dickens 2011a), as does becoming a carer to someone else.

In addition, the effects of social isolation and loneliness appear to accelerate age related health conditions. Social isolation is linked to increased susceptibility to dementia (Dickens 2011a), and people with a high degree of loneliness have been found to be twice as likely to develop Alzheimer's as those with a low degree of loneliness (Age UK 2014). A study of the link between loneliness and blood pressure found the association to be greater amongst older individuals, suggesting that the effects of loneliness accrue to accelerate age-related increases in blood pressure (Hawkley et al., 2011). The risk of falling is also higher for those who live alone, and the outcomes can be worse (WHO, 2004).

There is evidence of two way causation. A British Household Panel Survey (BHPS) study found that social participation moderated the general decline in physical functioning with age (Pevalin and Rose 2003), whilst other evidence suggests that socially engaged older people experience less cognitive decline and are less prone to dementia (Age UK 2014).

Studies have also linked hospitalisation to functional decline, or a decline in the ability to carry out activities of daily living, and this is a particular issue amongst older people (DePalma et al. 2013). Hospitalisation amongst older people has also been linked with other negative health outcomes more generally. For example, a Canadian study of older patients discharged from acute medical and surgical care units found that nearly 40% were considered at risk of adverse outcomes, that 11% indicated depression, and just over 62% had a least one nutritional concern. Other evidence shows that older people recently discharged from hospital are susceptible to weight loss (Dixon et al, 2014). It seems likely that these consequences in turn can also increase the risk of social isolation and the associated health outcomes set out above.

Alex

"I'm so grateful for what Royal Voluntary Service has done for me – changing my life and improving it in so many ways. It's a comfort having him as a good friend and I look forward to seeing him every day."

Alex, 73

4.2 HOME FROM HOSPITAL SCHEMES

Home from Hospital schemes provide time limited support to vulnerable people on their return home following a stay in hospital. For example, the service provided by Royal Voluntary Service is targeted specifically at the older population, particularly those living alone.

Home from Hospital schemes are often considered as a form of re-ablement service. These can take different forms, but re-ablement is used to describe an 'approach' within home care that aims at helping people 'do things for themselves', rather than 'having things done for them'. These services provide practical support in such a way as to help users develop both the confidence and skills needed to carry out daily activities themselves (Jones et al, 2009).

In terms of accessing these services, the experts we spoke to explained that referral patterns varied in different areas according to levels of awareness about the service amongst health professionals and the local population. In the case of Royal Voluntary Service's scheme, older people may be referred by a health service professional prior to their discharge, or can self-refer (or be referred by a friend or family member) before or soon after leaving hospital. Many referrals are made by Royal Voluntary Service volunteers based on the ward.

Home from hospital schemes are relatively short-lived and limited in scope. For example, Royal Voluntary Service's support is typically provided over a six to 10 week period and can involve both practical and emotional support. Practical help might include transport to hospital or GP appointments, assistance with food preparation and prescription collection, whilst emotional support is likely to involve befriending and confidence building. But personal care services are not offered.

Not all **Home from Hospital** service providers are able to offer a service beyond the initial period, and some of the experts we spoke to stressed the problem of support coming to an end earlier than the user would have wished, without there always being a clear option for longer term support being available. Ideally if the service user would like to continue receiving support at the end of the agreed period with Royal Voluntary Service scheme they would move on to the Good Neighbours programme.

4.3 EVIDENCE ON THE IMPACT OF HOME FROM HOSPITAL SCHEMES

Evidence on the impact of **Home from Hospital** and similar interventions is relatively limited, and some of the research in this area is inconclusive. As with research on volunteering more widely, making an assessment of the impacts is difficult due to the complexity and variability of the interventions, and the problem of establishing causality. Some of the experts we spoke to stressed the difficulty of measuring the outcomes of these programmes, and highlighted the need for more research in this area.

Recognising these limitations, we have drawn together the evidence available on impacts of **Home from Hospital** and similar interventions. This includes interventions used to tackle social isolation, such as befriending, services which provide support to vulnerable older people in their homes, and other re-ablement services which seek to restore the independence of the individual.

Overall, the qualitative evidence suggests that such schemes can have a positive effect on the well-being of users and on volunteers. Evidence on cost impacts for the wider health and care system suggests there may be some benefits but is largely inconclusive.

4.4 THE IMPACTS OF HOME FROM HOSPITAL SCHEMES ON SERVICE USERS

Most research suggests that **Home from Hospital** and similar schemes can improve the overall quality of life of their users. They also appear to be met with high levels of user satisfaction. A review undertaken for Royal Voluntary Service (previously known as the Women's Royal Voluntary Service (WRVS)) found that 91% of **Home from Hospital** users agreed their life was "a lot better" as a result of the service (WRVS 2012), whilst 74% of users of a similar scheme provided by the British Red Cross (BRC) in London rated the service as 'Excellent', with a further 11% rating it as 'Good' (Deloitte 2012).

In particular, the research shows that **Home from Hospital** and similar interventions can help to reduce social isolation and loneliness amongst users. Given the wider health outcomes associated with social isolation and loneliness, this is potentially one of the most important benefits of these services.

At Royal Voluntary Service's scheme in Bassetlaw, for example, 100% of users contacted by researchers agreed with the statements "I feel less isolated" and "I feel less dependent on others", with 91% also agreeing they felt "more confident". Being able to "get out of the house" was identified as the top benefit of the service (WRVS, 2012).

Similarly, a review across five BRC Support at Home sites (which included support for people following a stay in hospital) found that users' capacity to manage daily activities increased in all sites, with the biggest improvement being in the ability to "get out and about" (Joy et al, 2013). The number requiring help to get out and about reduced from 66% to 32%, and those needing help with daily tasks fell from 57% to 22% (Dixon et al, 2014).

There is good evidence that social isolation and loneliness can also be reduced through befriending, an important feature of the **Home from Hospital** offer. Befriending can take different forms but typically involves one to one contact with the individual in their home on a non-time limited basis. The befriender will provide companionship and will often carry out basic tasks or errands (Windle et al, 2011).

A further user benefit highlighted by the research is effective signposting to other services. This can include supporting individuals to access a range of non- health related services, such as financial advice or support with building maintenance issues. One of the benefits of BRC's Support at Home scheme has been the development of a group of service user "advocates" (Joy et al, 2013).

More generally, some research has highlighted the value to users of volunteer support, compared with services provided by paid workers. Some individuals who would be reluctant to approach social services, for example because they are nervous of having to pay for care or because they fear a downward spiral into increasing dependency, are much happier to accept support from volunteers (Bowers et al, 2006).

Volunteers also tend to be less time constrained and can therefore provide "extras" to help their clients - for example, posting letters (WVRS, 2010). A number of the experts we spoke to highlighted the importance of volunteers being able to provide "ad hoc" support. However, where support is limited to a particular period and there is no prospect of ongoing support (as with some **Home from Hospital** schemes), it can be particularly difficult for both the volunteer and the user when the support comes to an end (Bowers et al, 2006).

4.5 THE IMPACT OF HOME FROM HOSPITAL SCHEMES ON SERVICE USE AND COSTS

Research shows **Home from Hospital** and similar interventions can have an impact on the wider system by affecting the use of a range of health and care services, which can in turn have financial implications.

There is some evidence that schemes focussed on reducing isolation and loneliness amongst older people can result in fewer GP visits and outpatient appointments (Bolton, 2012). One study which adopted a case study approach found that befriending could help reduce demand for higher cost health services, particularly from GPs (MBF, 2010). A study of interventions aimed at tackling loneliness in day centres in Finland found that those involved used fewer healthcare services during the one year follow up period than those in the control group (Pitkala et al, 2009).

There is also evidence that **Home from Hospital** services can reduce the need for longer term care. A study of a Leicester re-ablement scheme, set up under the Care Services Efficiency Delivery programme, found its users had fewer ongoing care needs at the end of the programme than those in the control group. Of those involved in the reablement scheme, 62% were able to discontinue with their home care package by the time of the first review, compared with only 2% of those in the control group. (Kent et al, 2000).

The Leicester research demonstrates some of the general advantages of the reablement approach which focuses on restoring the individual's independence, as compared with more traditional approaches to home care. Indeed, managers of the service interviewed as part of a subsequent study noted that where service users moved from reablement to an on-going package of care, they typically reverted to having tasks "done for" them (Newbronner et al, 2007).

There is also some evidence that, where individuals are admitted to hospital, **Home from Hospital** and similar schemes can help to reduce both the number of days they spend there and delays in transfers of care. NHS staff interviewed as part of a study into a BRC **Home from Hospital** scheme in Wales admitted that many people who were medically fit to go home would have stayed in hospital longer had the service not been available due to concerns about the patient being unsupported (Zinovieff and Robinson, 2010).

Short term **Home from Hospital** schemes might also be expected to have an impact on avoidable hospital re-admissions. A review of Royal Voluntary Service's **Home from Hospital** scheme in Leicestershire found that only 7.5% of users of the service were readmitted as an emergency within 60 days, compared with national rates of 15% for those aged over 75 within 28 days (Royal Voluntary Service, 2013).

Some of the research is more mixed however, and highlights the statistical phenomenon called 'regression to the mean', which means that people who have recently had many hospital admissions are statistically more likely to have fewer admissions in future, even without an intervention. As such, without a robust control group, evidence on admissions following the intervention should be interpreted with caution (Steventon et al, 2011).

Moreover, not all hospital re-admissions are undesirable. Sometimes a return to hospital is the most appropriate course of action, and in some cases a **Home from Hospital** volunteer can be responsible for ensuring this happens.

Different approaches have been used to try and calculate the impact of **Home from Hospital** and similar interventions from a financial perspective. One approach focuses on costs avoided by the health system, in particular as a result of fewer hospital admissions and a reduced length of stay. Savings may also be achieved through minimising the use of residential care or primary care services.

A Deloitte study for BRC Studies using this approach concluded that **Home from Hospital** schemes can release savings. For the two schemes reviewed, it was estimated that savings to health and social care commissioners was approximately £250 per service user. Savings were achieved by a reduction in length of stay and fewer hospital readmissions, as well as fewer admissions to social care and, as a result of the BRC volunteer undertaking a needs assessment, a reduction in the input required from social care services (Deloitte, 2012).

Overall, there is some evidence of cost savings from individual schemes. However, it is important to note that the absence of a real comparator means that it is very difficult to determine how different the outcomes would have been without the intervention, and therefore that some of the evidence in this area is inconclusive.

CASE STUDY

Barbara, 85

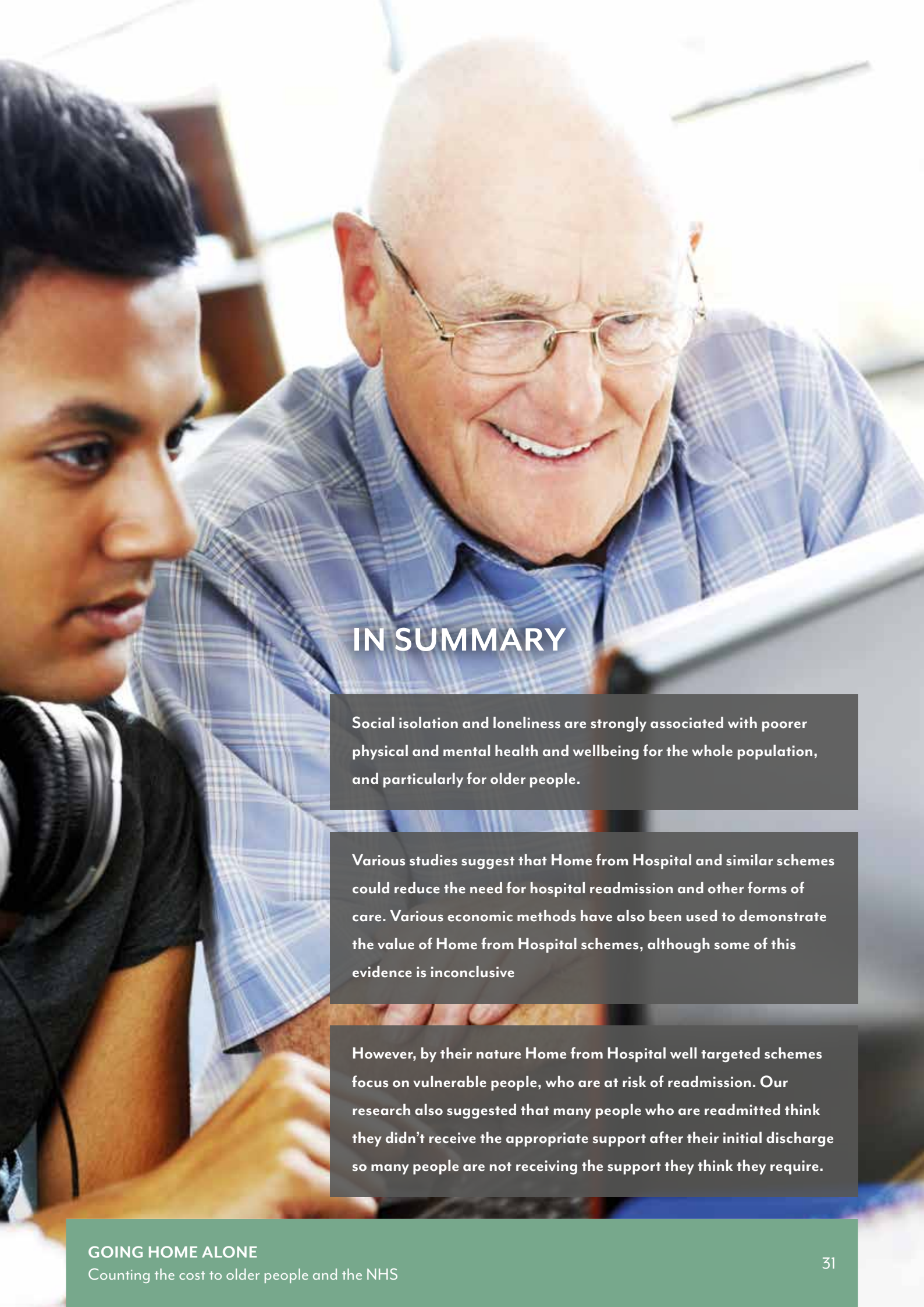
Barbara lives on her own and was hospitalised following a fall. A neighbour got in touch with Royal Voluntary Service due to concerns that Barbara would have no support when she got home.

A Royal Voluntary Service manager visited her following her return home to ascertain how she was feeling and the level of support she needed. Over the course of the next six weeks a volunteer took Barbara shopping, drove her to the local supermarket once a week and took her to her GP and the chemist to collect her prescriptions.

After her fall, Barbara's mobility was very limited and her confidence had dropped. Barbara was too nervous to go out the front door in case she fell again. Over the following weeks, with the encouragement of her volunteer, Barbara gradually became positive and confident. Without the support of Margaret, Barbara was at risk of becoming trapped in her home and isolated from her community.

Barbara decided that she would like to receive continued transport and assistance to the local shops from Royal Voluntary Service.

"I was really satisfied with the support that I received, Margaret my volunteer, was always so kind, friendly and helpful. I would definitely recommend the service to others."



IN SUMMARY

Social isolation and loneliness are strongly associated with poorer physical and mental health and wellbeing for the whole population, and particularly for older people.

Various studies suggest that Home from Hospital and similar schemes could reduce the need for hospital readmission and other forms of care. Various economic methods have also been used to demonstrate the value of Home from Hospital schemes, although some of this evidence is inconclusive

However, by their nature Home from Hospital well targeted schemes focus on vulnerable people, who are at risk of readmission. Our research also suggested that many people who are readmitted think they didn't receive the appropriate support after their initial discharge so many people are not receiving the support they think they require.

SECTION 5

COST-IMPACT ANALYSIS OF "GOING HOME ALONE"

If **Home from Hospital** services could eliminate inappropriate readmissions and were targeted appropriately with full coverage across England, we estimate they could reduce readmission costs by around £40.4m per year.

This figure is based on our exploratory cost-impact analysis of "going home alone". This relies on the Hospital Episode Statistics (HES) data analysed for this project, the survey data collected for it, and on average NHS admissions costs.

Our starting point is the assumption that one of the benefits of *effective* **Home from Hospital** schemes is a reduction in readmission rates and therefore in the costs of readmissions. The reasoning for this is set out in section 4. However, as that section makes clear, this is only a partial view of the potential impact of the schemes. In some cases, they may lead to appropriate readmission, and even where a readmission is averted, the result may be other costs to the health and care system. As those referred to a Hospital To Home scheme are likely to be particularly vulnerable, this is a self-selecting group, who will likely be at greater than average risk of readmission compared to other older people.

Given this starting point we use the data we have collected during the project to set out the pathways that an older patient may take as they go through care. This is similar to a decision tree approach, where each patient goes through a series of steps depending on their characteristics (see annex 1). We base this on the actual data from HES records for 2012/13 and on information from Royal Voluntary Service research, allied with cost estimates of admissions and readmissions. These cost estimates are based on the reference costs (Department of Health, 2014) used by the NHS (for simplicity, we've assumed each admission consists of one episode, which is what reference costs relate to) for admissions for both planned and unplanned admissions respectively.

> My mother was offered everything she needed by Royal Voluntary Service to get settled back at home. It's a great comfort to know that the little things are being catered for. In fact they're not really little things at all for a housebound person. My mother has lived in her house for 50 years, she loves the garden and this wonderful help means she can stay at home which is what she wants.
>
> *Andrew, a service user's son*

In our analysis (See annex 1), the tree tracks patients through a series of steps until they reach a terminal point, such as death in hospital or discharge without a further admission. We start with all people over 75 who have been admitted to hospital, and then separate them according to whether they had a planned or unplanned admission. Note that the maximum number of admissions in the model is two: although there is evidence from the research that some people were readmitted more than twice within 3 months, for simplicity the model focuses on the initial readmission.

At each step, the group is divided according to a set of characteristics - for example, whether they had the support they needed or not. As with a decision tree, this results in a series of "branches" representing the different possible routes or pathways an individual could follow.

There are three numbers associated with each branch: the first is the number of people that reached this branch in the tree from the original total; the second is the probability of this state happening relative to the other branch that could have been chosen at this point, and the third is the estimated cost to a hospital of a patient as they travel through the rest of the model, based on the probability of each future event in the model happening.

There are two overall key findings from the model:

- First, from Royal Voluntary Service's survey into both planned and unplanned first admissions, among patients who report "a lack of support" (as defined by answering "none" or "just a little") there is a more than doubling of the readmission rate from 14% to 35% for unplanned admissions and from 21% to 50% in the planned admissions group.

- Second, the estimated cost of not having support (as defined above) on discharge is £458 more per person for patients with a planned first admission versus those that report support (£2,073[4] vs £1,615[5]) and £315 more on average for patients with an unplanned first admission (£2,144[6] vs £1,829[7]).

[4] 0.5 x £1,317 + 0.5 x (0.333 x (£1,610 + £1,317) + 0.666 x (£1,610 x 2)) = £2,073

[5] 0.79 x £1,317 + 0.21 x (0.75 x (£1,317 x 2) + 0.25 x (£1,610 + £1,317)) = £1,615

[6] 0.64 x £1,610 + 0.14 x (0.333 x (£1,317 + £1,610) + 0.666 x (£1,610 x 2)) = £2,144

[7] 0.86 x £1,610 + 0.14 x (0.333 x (£1,610 + £1,317) + 0.666 x (£1,610 x 2)) = £1,829

These findings give us a ballpark scale for the *possible* impact of "being sent home alone". However, the sample sizes are relatively small for some of the effects extrapolated to the wider population in the analysis and the research method itself is also not perfect. Ideally, the research would follow people over time rather than rely on recall as there are clearly survivor effects and other drop-outs, due to the survey being based in the community (as opposed to also including residential care and hospitals) and the issues we have raised above. Nor have we evaluated the economic benefit and cost of **Home from Hospital** schemes.

For many patients **Home from Hospital** schemes are not needed (in the sense of self-reporting adequate support), and our survey findings suggest that some people may be receiving support that is not needed or appropriate, whereas many others are not getting the support they feel they need. There is therefore a danger of mis-provision – and therefore unneeded costs – as well as under-provision if support services are organised inefficiently. This suggests that great care needs to be taken in targeting **Home from Hospital** offers. Finally, reducing re-admissions may also not be an appropriate indicator or target in all cases, what is important is avoidable readmissions, in some cases **Home from Hospital** schemes may lead to earlier, appropriate re-admission. The value gained from these admissions is not included in this exploratory analysis.

Nonetheless, if our results are applicable to all over-75s who are admitted to hospital, there is potential for a significant cost reduction to statutory hospital services.

The size of that potential cost saving can be computed on the basis of the 2012-13 HES trends. In that year, 82% of admissions were unplanned. Of that group, 87% did not die in hospital and our survey suggests that, 64% needed support after their discharge – 17% of them did not receive enough. On the basis of the saving figures above, if that support was provided, the cost saving would be £36m[8]. Of planned admissions in 2012-13, meanwhile, 84% of patients did not die in hospital while 43% needed support after their discharge – 10% did not get enough. Had they done so, the cost saving would have been £4.4m[9]. That makes for a total potential cost reduction for the NHS of £40.4m.

[8] 1.46m X 0.82 x 0.88 x 0.64 x 0.17 x £315 = £36,004,576

[9] 1.46m x 0.18 x 0.84 x 0.43 x 0.1 x £458 = £4,355,245

IN SUMMARY

Royal Voluntary Service's research suggests that those readmitted are significantly more likely to report lack of support on first admission.

Taking into account the costs of these "excess" admissions, *if* Home from Hospital services could alter the underlying causes of this relationship *and* were targeted appropriately with full coverage across England they might reduce costs of readmissions by around £40.4m per year.

However, this estimate depends on a large number of assumptions.

CONCLUSION AND SUMMARY

This report brings together the findings of a literature review (as well as discussions with relevant experts), the results of the survey undertaken by the Royal Voluntary Society, and the outputs from a cost-impact analysis using national data and results from the survey.

Taken together, the evidence suggests that **Home from Hospital** schemes are likely to become more important as Britain's population continues to age and the rate of hospital admissions increases. The research shows that nearly half of respondents live alone and, more importantly, that amongst those who were readmitted to hospital within three months, approximately 41% said they did not receive all of the support they felt they needed.

In this context, the literature review and discussions with experts suggest that **Home from Hospital** schemes can play a valuable role. These schemes can help to improve the well-being of their users and to reduce social isolation and loneliness; conditions which have been shown to result in poorer physical and mental health outcomes, particularly amongst older people. Research also shows that **Home from Hospital** services are highly valued by patients (they also have a positive impact on the volunteers who provide them).

The evidence also shows these schemes may be able to help reduce the number of hospital readmissions, as well as demand for other health and care services. The research also suggested a correlation between those saying they did not receive all of the support they needed and being readmitted to hospital; those who were later readmitted to hospital expressed a greater need for support at discharge than those who were not readmitted. However, the correlation between accessing support and readmission was not clear, suggesting that the relationship between the two is complex. It is also important to note that not all re-admissions are inappropriate. Indeed, having adequate support may in fact result in an appropriate admission to hospital.

The results of the cost-impact analysis suggested that, were **Home from Hospital** schemes appropriately targeted and effective in addressing "excess admissions", they may produce a saving for the NHS of £40.4m per year. However, this estimate is based on a large number of assumptions and relies on a small sample size.

RECOMMENDATIONS

Royal Voluntary Service is launching its 'Let's End Going Home Alone' campaign as it believes that no older person should have to leave hospital unaccompanied and without support unless they choose to. This report evidences the impact of older people going home alone and as a result, we have identified the Six Essentials we believe every older person should be entitled to experience when they leave hospital. Ensuring these are in place, will improve the discharge process and more importantly, will help older people to get well sooner.

THE SIX ESSENTIALS

1. Every older person should be told the plan for their return home from hospital
2. Every older person should be accompanied home before 10pm from hospital unless their preference is different
3. Every older person needs to be able to collect their prescriptions and get to follow up appointments for a speedy recovery after a stay in hospital
4. Every older person should come home from hospital to a warm, well-lit house with someone asking how they are
5. Every older person should know they'll have help to get some shopping in and won't have to sit hungry after a stay in hospital
6. Every older person should have a friendly face to turn to for help after a stay in hospital

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NOTES

ANNEX 1 AN EXPLORATORY COST-IMPACT MODEL

The objective of the model opposite is to show each possible pathway a patient might take as they go through care.

You start at the left of the tree, and move right until you reach a terminal point. The model starts with people over 75 who have been admitted, and the first set of branches indicates whether they had a planned or unplanned admission.

There are four numbers associated with each branch: to the right of the name of the branch (for example, "Planned" or "Unplanned") is the number of people that reached this branch in the tree. To the right of this is the relative probability of this state relative to the other branch that could have been chosen at this point, based on the numbers listed to the left (for example "Planned"'s probability of 0.18 or "Unplanned"'s probability of 0.82). The estimated cost to the hospital treating the patient is to the right of this number in terminal nodes (to show that the line has stopped), or underneath the label attached to the branch in all other branches (for example, "Planned"'s estimated cost is seen under the label at this point (£1406.76), but the estimated cost for "Death" after a planned admission is at the end of the branch (£1805.57).

The estimated cost is the average cost of each pathway at a given point, based on reference costs for 12/13 (£1610 per unplanned and £1317 per planned admission), multiplied by the conditional probability of each branch ahead of any given point. For example, the final value in the top right of the model shows that a second planned admission after being readmitted costs £1976 instead of £2634 (the cost of two planned admissions). There is only a 0.75 chance of having another planned admission at the final branch of the tree though, based on the probability attached to that branch. £2634 must then be multiplied by 0.75 to show the likely cost to the hospital if they did not know whether the patient was going to have a planned or unplanned second admission (but did know that they were going to have a second admission- the previous branch tells us that they're readmitted after a planned admission, despite having at least most of the support they needed).

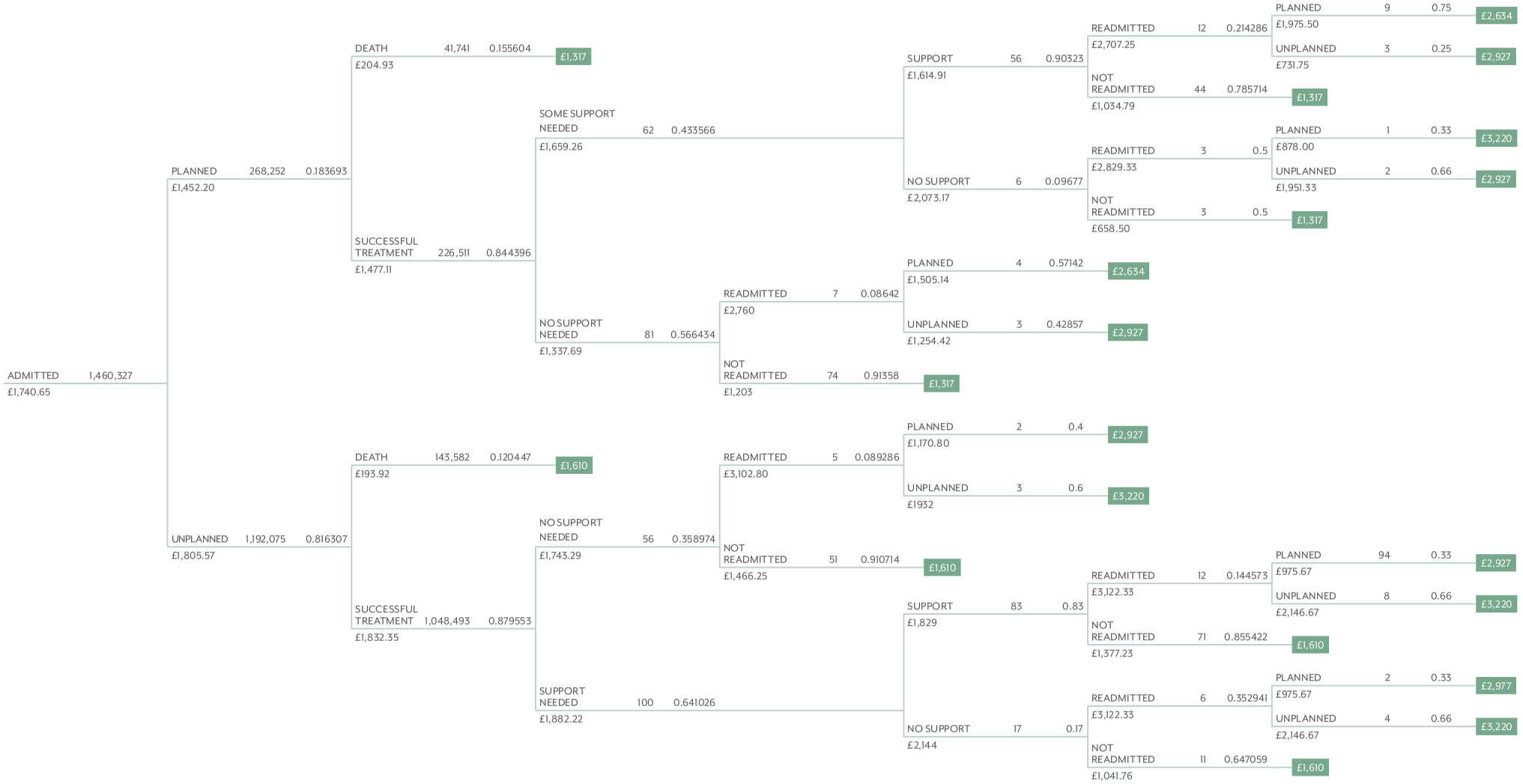
The first set of branches to look at to see the key results from the model are the "re-admitted" branches second to last from the right hand side of the tree, where a patient feels they need support. We're showing in both planned and unplanned first admissions that a lack of support (as defined by answering "None" or "just a little" to Q17) leads to a more than doubling in the readmission rate (0.35 vs 0.14 for the unplanned 1st admission group, and 0.5 vs 0.21 in the planned 1st admission group). The total sample for this is relatively small compared to what we'll be extrapolating to (33 people spread across four categories).

The other key result is at the next set of branches to the left of this: the estimated cost of not having support on discharge, based on the probabilities seen in the survey, is £458 more per person for patients with a planned admission (£2073-£1614) and £315 more for patients with an unplanned 1st admission (£2144 vs £1829), on average. This is coming from the increased likelihood of a readmission in both groups and the increased chance of an unplanned second in the unplanned 1st group. This finding does not apply to all patients in the health service, just those over 75 sent home with at most "Just a little" of the help they need. Furthermore, it says nothing of the value for money (or lack thereof) of this extra expenditure: we might want to pay this amount more to help those in need who can't get this support at home (for example, if we move another branch to the left, we see it costs less to look after people who don't need support, but we don't ask hospitals to ignore people without support in order to save money).

These figures are an initial and tentative estimate of any true cost total. They have not been subjected to sensitivity or uncertainty analysis of any kind. A more scientifically sound figure could be produced by conducting a Monte Carlo experiment on the results of the survey or, if found to be appropriate, fitting a probabilistic distribution to the results.

ANNEX 1

AN EXPLORATORY COST-IMPACT MODEL



Total estimated cost from patients with a planned first admission	£4,355,245.34
Total estimated cost from patients with an unplanned first admission	£36,044,575.89
Total estimated cost	**£40,359,821.23**

Unplanned episode cost	£1,610
Planned episode cost	£1,317

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