



UNIVERSITY OF
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SCHOOL OF
SOCIAL POLICY

Health Services Management Centre
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Who knows best? Older people's contribution to understanding and preventing avoidable hospital admissions

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ABOUT HSMC AND THE DEPARTMENT OF SOCIAL POLICY AND SOCIAL WORK

The School of Social Policy at the University of Birmingham has a mission 'to understand the world – but also to change it' (that is, to carry out high-quality research, but also to use this to make a practical difference to policy and practice). The School comprises two departments: the Health Services Management Centre (HSMC) and the Department of Social Policy and Social Work (SPSW).

HSMC is the leading UK centre for research, teaching and consultancy with regards to health and social care integration. The Centre has previously advised Downing Street, the Department of Health and the Cabinet Office on these issues, and edits the *Journal of Integrated Care* and the *Better Partnership Working* book series. HSMC has also undertaken research into the outcomes of joint commissioning and the integration of older people's services across 14 EU countries, and is currently evaluating the role of community hospitals. The Centre has previously worked with the NHS Future Forum and the 2012 social care White Paper team to advise on the creation of more integrated health and social care. In 2013, HSMC was asked by the Care Services Minister to contribute to the identification of the government's new 'integrated care pioneers' and has also worked with the Local Government Association and the Department of Health to run regional simulation events to support new Health and Wellbeing Boards.

SPSW is an internationally leading centre for research, teaching and learning in social policy and social work. The University has been providing social work education since 1908 and has the oldest continually running social work education programme in the country.

Research undertaken by the Department seeks to explore how policy and practice can contribute to making a difference to people's lives – particularly those who may face disadvantage or social exclusion. Participative research, in which service users or citizens become partners or 'co-researchers' in the research process, is a core characteristic of SPSW's approach to social research. Rosemary Littlechild and Jon Glasby have recently completed an SDO-funded project, exploring older service user and carers' experiences of transitions in care. The research was designed, carried out and analysed in partnership with 23 older people as co-researchers. They were both involved in an ESRC-funded project 'Does Smaller Mean Better? Evaluating Micro-Enterprises in Adult Social Care' which also used a similar participatory methodology to interview service users and carers who use adult care services.

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Summary

With an ageing population and with pressures mounting on acute care, the emergency hospital admission of older people has become a key policy issue and the subject of significant media debate. Often, the assumption appears to be that potentially large numbers of older people are admitted to hospital without really needing the services provided there, but because there is nowhere else for them to go or because other services are not operating effectively. In response, there is a growing body of research around what is often termed as 'inappropriate' hospital admissions, with recent studies either drawing on clinical opinion or using more structured clinical review instruments in order to calculate rates of 'inappropriate' admission. However, such studies tend to overlook the importance of local context, do not always draw sufficiently on the tacit knowledge of front-line professionals and, above all, fail to include a patient perspective. The latter is particularly important given that other areas of policy are actively promoting the notion of 'nothing about me without me' and given that older people and their families are the only people with a long-term sense of how their health has deteriorated, what happened to necessitate a hospital admission and what options there might have been at various stages for different interventions and outcomes. As we have previously argued (Glasby and Littlechild, 2000, p.116):

'[Previous methods need] to be accompanied by research methodologies which include and empower the individuals involved. Patients admitted to hospital are often... the best qualified people to talk about their own conditions, the circumstances of their admissions and possible alternatives to hospital... A patient perspective can also provide a more holistic, long-term view of the factors that contribute to hospital admissions, helping to build a picture of how best to respond to the needs of people starting to experience ill-health.'

Put simply, older people have lived experience of the issues at stake, and we neglect their expertise at our peril.

To our knowledge, this is the first study in the UK to calculate a formal rate of 'inappropriate' hospital admissions and to engage older people meaningfully in this process – and quite possibly the first English-language study to do so internationally. The inclusion of the perceptions and experiences of front-line staff also allows us to build on the tacit knowledge of local practitioners and to calculate a rate of 'inappropriate' admissions from their perspective as well. While our findings make a significant service contribution, there is also academic significance in approaching a longstanding and very topical policy problem in new more user- and staff-focused ways.

Against this background, the study includes:

- Initial interviews with health and social care professionals in three local case study sites in order to explore the extent to which 'inappropriate' admission is perceived to be an issue locally, the nature of local service responses and some of the key opportunities and challenges
- Interviews with older people with recent experience of emergency hospital admission to understand what caused the admission from their point of view, what alternatives might have existed and opportunities for different approaches in the future
- A survey sent to these older people's GP, a hospital-based doctor and, if applicable, a social worker
- Multidisciplinary focus groups in the three sites to explore the response of people from different professional backgrounds to real-life case studies of older people admitted as emergency patients

In the process, the study was advised by a sounding board of national health and social bodies, and materials were designed with the guidance of an Older People's Reference Group and local clinical leads. In addition to this report, the project will also lead to a national guide to good practice which draws directly on older people's experiences and which will be distributed to every hospital trust in England.

As highlighted previously, the significance of this study lies in its contribution to key national and international debates around the best use of scarce hospital resources, and to the policy and media debates prompted by an ageing population and escalating pressures on hospital services. Crucially, we believe that it is the first study of its kind to explore these issues in a way which is sensitive to local context and professional expertise, but which seeks to focus primarily on the lived experience of older people. The latter in particular is a vital source of evidence which has the potential to generate new insights and solutions – but one which has been almost entirely neglected up until now (see Chapters 1–3 for further discussion of this contribution). Accessing such expertise in a way that encourages older people (including people with dementia) to talk about potentially distressing experiences without placing undue pressure on people to participate is highly sensitive, and several sections of this report reflect on the careful design, attention to ethical issues and professional awareness of the complexities of older people's services needed to conduct such a study in a rigorous and appropriate manner. Academically, the study also makes a contribution by reinterpreting the perceived 'problem' of 'inappropriate' hospital admissions from a service user and staff perspective, reframing traditional policy and media debates.

Overall, the study found **that most older people were admitted to hospital appropriately**. Only nine of our 104 older people (**almost 9%**) felt that hospital was not the right place for them – and even these nine people sounded very unwell at the time of admission. None of the GPs or hospital doctors who took part felt that these (or any other) admissions in the study were 'inappropriate' (making a rate of 'inappropriate' admissions of **0%** from a medical perspective).

In addition:

- There has been relatively little previous research, and this can only provide limited insights due to a series of methodological challenges, local contextual factors and a lack of rigour in identifying potential solutions.
- While we do not like the term, some of this research describes admissions as either 'appropriate' or 'inappropriate' – and so we adopt the term 'inappropriate admission' (in inverted commas) where an admission is deemed not to be medically necessary. This is potentially different from the notion of preventable admissions (where earlier action could have prevented someone's health deteriorating to the stage where admission was required) – and this original insight came from older people themselves.
- Rates of 'inappropriate' admission are usually compiled with the benefit of hindsight, and the reality for the front-line clinician deciding whether or not to admit may well be very different.
- In particular, we found no previous study which calculates a rate of 'inappropriate' admission and which engages older people in a meaningful way (in the UK or beyond). Given the importance of user involvement and co-production in other areas of health and social care, this is a shocking finding.
- Local practitioners feel that there are problems with 'inappropriate' admissions, but there was no consensus as to the extent of these issues (with workers in the same local area having potentially radically different views about the levels of 'inappropriate' admissions).
- There was consensus that hospital can remain a default, with the various initiatives set up to reduce the number of emergency admissions creating a complex situation where services are difficult to access in a timely way (for staff, let alone older people). Poor communication between different services was also felt to be problematic.
- Social care was largely absent, and staff felt that it needed much more national funding and capacity to be able to play a more preventative role.
- Some people delayed seeking help when a crisis had occurred, and it is possible that negative media headlines about older people's use of NHS resources could deter some people from seeking help in a timely manner.
- A number of people were in touch with health and social services (particularly their GP) in the run up to their admission, and the ambulance service was involved in a significant number of admissions. It is therefore worth exploring whether future attempts to develop a more preventative approach could begin with the role of GPs and paramedics. There was certainly a feeling that early action might be required if admissions were to be prevented – once people arrived at hospital and were admitted, it was sometimes difficult for people to be able to leave in a timely manner, and other aspects of people's health could deteriorate in the meantime.
- A small number of people feel that an earlier hospital stay or assessment might have resolved an underlying problem sooner, without the need for a subsequent admission.
- People taking part on behalf of family members with dementia felt that some health services are not set up to work well with people with dementia and that social care support is currently insufficient.

Overall, this study argues that older people have a crucial role to play in understanding the issues at stake in terms of emergency admissions. Any attempt to generate solutions which does not value and draw on this expertise misses a major opportunity and is unlikely to be successful.

1. Introduction

Every year, the NHS experiences more than 2 million unplanned admissions for people over 65 (accounting for 68 per cent of hospital emergency bed days and the use of more than 51,000 acute beds at any one time) (Imison et al., 2012; Poteliakhoff and Thompson, 2011). With an ageing population, a very challenging financial context and the legacy of major structural upheavals throughout the English health service, such pressures show no sign of abating – and the NHS is having to find ways of reducing emergency hospital admissions (in situations where care can be provided as effectively elsewhere). However, this is by no means a new issue. For many years, a common concern for policy makers has been that high levels of emergency hospital admissions run the risk of concentrating too many resources in expensive, acute care, leaving insufficient funding to invest in community-based alternatives and in rehabilitation for people recovering from ill health. Under successive governments, this has led to a series of attempts to make more effective use of hospital beds, recognising that these are scarce resources for which demand outstrips supply. Over time, this has included the creation of a national ‘Change Agent Team’, the advent of intermediate care, additional funding, the introduction of financial penalties for social care-related delayed hospital discharges, new reablement services and significant emphasis placed on hospital waiting times and prompt hospital discharge – to name but a few developments (see, for example, Glasby, 2003, 2012).

More recently, the emphasis has been on trying to develop payment mechanisms to disincentivise emergency admissions for acute conditions that should not usually require hospital admission and reduce the number of emergency readmissions within 30 days of discharge following an elective admission (Department of Health, 2011). To help develop this policy further, the Department of Health – with the Foundation Trust Network – jointly sponsored a number of sample audits of emergency readmissions, designed to help to inform more detailed guidance on the operation of the policy in future:

‘Emergency readmissions need to continue to reduce as patients receive better planned care and are supported to self-care more effectively. Commissioners need not reimburse hospitals for admissions within 30 days of discharge following an elective admission with locally agreed thresholds for other readmissions. The savings made need to be invested in clinically driven initiatives to support improved outcomes through reablement and post-discharge support’ (Department of Health, 2011, p.17).

Linked to this are current and previous policy initiatives such as the marginal tariff for emergency admissions (with savings to be invested in preventative services and care closer to home), the greater integration of acute and community services through ‘Transforming Community Services’, work to improve early identification and support of people with dementia and a series of ‘whole systems demonstrator’ sites for new approaches to telehealth and telecare (linked to the subsequent ‘3 million lives’ campaign – since superseded by the Technology Enabled Care Services programme (NHS England, n.d.)). More generally, national policy continues to explore scope for community alternatives to hospital via the long-term conditions agenda, the advent of clinical commissioning, the focus on more integrated care, new health, social care and public health outcomes frameworks and the previous Quality, Innovation, Productivity and Prevention (QIPP) agenda. The latter included a national programme on long-term conditions management, with an emphasis on risk stratification, integrated locality teams and case co-ordination, where prevention of unplanned admissions is a key outcome. There has also been significant national work underway to better understand and resolve considerable variation in the probability of emergency admission or bed utilisation in over 65s between localities, with a desire to achieve greater efficiency and better outcomes for patients by tackling any unwarranted variation (see Imison et al., 2012 for further discussion).

More recently, a national Better Care Fund (see NHS England, 2014) has sought to promote more integrated health and social care to reduce non-elective hospital activity, and commissioners across the English NHS have been under significant policy pressure to reduce urgent hospital activity and set challenging access targets of four hours. A greater focus is also being placed on the role of GPs in co-ordinating care for older people with complex needs as a way of averting a crisis in their care and an unplanned hospital admission.

While all these approaches have sought to reduce potentially avoidable admissions, pressures on acute care remain intense and the received wisdom is that admissions continue to be influenced in part by the help-seeking behaviour of patients, of their carers, and sometimes of paid care workers in the community (with patients and professionals alike still ‘defaulting’ to hospital in a crisis). Against this background, experts have questioned the extent to which current policy is based on evidence of what is actually possible, or whether it is overly aspirational and unrealistic in terms of what can be achieved (see, for example, Oliver, 2014). For all these changes and initiatives, the independent Commission on Improving Urgent Care for Older People concluded that older people can still be diverted inappropriately towards Accident and Emergency (A&E) due to a lack of alternatives in the community, there remain problems with how older people move through hospitals, there are difficulties in putting in place social care packages and there is a lack of focus on prevention and early intervention (NHS Confederation, 2016).

Moving from national policy to public perceptions, negative headlines continue to appear in the national press around the pressures facing acute hospitals (Boseley, 2012; Prynne, 2014) and perceived shortcomings in community services which are seen as contributing to excessive and unnecessary emergency admissions

(particularly of frail older people) (Campbell, 2012). In different accounts, the culprits range from the growing pressures of an ageing population (Donnelly, 2014) to too many reductions in the overall bed base (McArdle, 2013), and from difficulties accessing GP services (especially out of hours) (BBC, 2013) to delays in adult social care (Triggle, 2012a). These reports suggest a growing crisis and a lack of quality care for older people across a range of health and social care services (see Box 1).

Box 1 Media coverage of emergency admissions and the pressures facing acute care

'NHS services outside of hospitals are struggling to cope with growing demand brought on by the ageing population, hospital bed shortages and staff cutbacks' (Campbell, 2012).

'Sir Bruce [Keogh – NHS England Medical Director] believes a system-wide transformation is needed to cope with the 'intense, growing and unsustainable' pressures on urgent and emergency care services... Every year millions of patients seek emergency help in hospital when they could have been cared for much closer to home' (Pryne, 2014).

'Elderly care is being jeopardised by the increasing numbers of older people being moved to non-specialist wards to clear beds for new patients' (McArdle, 2013).

'Nearly two-thirds of the patients now being admitted to hospital are over the age of 65 and many are much older. Their needs are increasing – they are frail and many have dementia. Many arrive in hospital because of a sudden crisis in their health: over the last 10 years, there has been a 37% increase in emergency hospital admissions' (Boseley, 2012).

Behind many of the headlines is an apparent assumption that potentially large numbers of people (often older people) are attending and being admitted to hospital as emergency patients when there is scope to prevent people's initial health from deteriorating and/or to provide an alternative emergency response in alternative settings. For example, Triggle (2012b) reports that 2.3 million overnight stays could be prevented were there better organisation of urgent care, with GPs and other healthcare providers working together to prevent patients getting to the stage of crisis requiring hospital. Wright (2013) reports that half a million older patients could avoid hospital if they were cared for appropriately by community services, while a recent study by Cowling et al. (2014) found just over 26% of people attend the emergency department because they could not access a GP appointment. Underpinning both policy and media accounts, therefore, is an assumption that scarce resources could be being used more effectively if we could reduce the number of 'inappropriate' admissions to hospital, thereby freeing up existing hospital beds for those people who genuinely need them.

Despite common policy and media perceptions of a 'problem' of significant 'inappropriate' emergency hospital admissions, these accounts mask a number of underlying questions:

- What actually is the rate of 'inappropriate' admission for older people?
- How is this defined and who decides?
- What causes such a situation?
- What solutions might help to make more appropriate use of current resources?

These questions form the basis of our present study, which aims to be a part of finding answers to some of the problems facing acute care and the overall health and social care system, as pressures increase. In particular, the study seeks to identify greater scope for preventing potentially avoidable admissions by more fully understanding **the experiences of older people and their**

families, and of front-line staff. As we argue below, these are neglected resources, and the present study makes a significant and original contribution to the literature by shedding light on this (often hidden) expertise. Too often, potential 'solutions' have been devised from the perspective of the health and social care system or of national policy makers or researchers – without adequately understanding the perspective of older people and of front-line staff. Within this, it is the perspective of older people which seems to be particularly lacking, and to be completely out of kilter with other attempts to promote greater user involvement in health and social care. In contrast, we believe that the issue of avoidable emergency admissions is complex and multi-faceted – and that an equally diverse and multi-faceted response is required. As we will discuss in Chapter 3, we believe that this may be the first study nationally (and possibly even internationally) to engage older people in a meaningful way in analysis of 'inappropriate hospital admissions' (unlike other areas of health and social care, where there is significant emphasis on recognising the lived experience of people using services).

2. Methods

Building on a previous local pilot (Glasby and Littlechild, 2000, 2001; Littlechild and Glasby, 2000, 2001), on prior research and on existing good practice locally, this study sought to:

- More fully understand the rate and cause of potentially avoidable emergency hospital admissions for older people from different perspectives (including from the point of view of older people themselves)
- Identify scope for preventative measures, drawing in particular on the lived experience of older people and their carers
- Contribute to ongoing policy and practice attempts to understand and reduce the number of emergency admissions

Overall, the study included:

- A review of the literature on the appropriateness of emergency admissions identifying the rate and cause of potentially avoidable admissions and any potential solutions proposed
- Interviews to identify clinical and managerial views on actions being taken locally to reduce the number of admissions (with 15–20 interviews per site in three case study areas)
- Detailed insights into the cause and experience of admission from older people and their carers (approximately 40 older people and/or their carers per site in three case study sites)
- Additional information from a lead medic, GP and/or social worker (where appropriate) about whether or not the admission could have been avoided (for each of the older people interviewed above)
- A multidisciplinary focus group in each site to explore the response of people from different professional backgrounds to real-life case studies of older people admitted as emergency patients

The research was overseen by a national 'sounding board' of key stakeholders (the NHS Confederation, the Association of Directors of Adult Social Services (ADASS), the Social Care Institute for Excellence (SCIE) and Age UK), has been advised by a local advocacy organisation working with older people (Agewell) and has been filmed by SCIE in order to create a resource for 'Social Care TV.' Findings have also been incorporated into a national good practice guide, drawing directly on the experience of older people themselves and sent to all hospital trusts across England.

As well as being unique in terms of its focus on older people's lived experience of emergency admissions, therefore, the study also makes an original contribution in bringing together such key national and local partners in order to identify and disseminate subsequent good practice.

Reviewing the literature

A structured literature review was undertaken between May and June 2014, seeking to explore: the rate of in/appropriate emergency admissions of older people in the UK; the way this is defined in the literature; solutions proposed to reduce the rate of 'inappropriate' admissions; and the methodological issues particular definitions of 'inappropriateness' raise. Importantly for our present study the extent to which patient or family perspectives are included in these definitions of inappropriateness was also noted. The literature search was undertaken by the Health Services Management Centre's specialist health management library and documents identified via the following databases: the Health Management Information Consortium database; Medline; the Social Science Citation Index; the Applied Social Sciences Index and Abstracts; AgeInfo; CareData Abstracts; Social Care Online; and Social Care Abstracts. The reference lists of articles included in this study were also searched. Each abstract was reviewed independently by two members of the research team and selected for relevance to the overall aims and objectives of the study. Studies were included if they explored the rate and causes of 'inappropriate' emergency hospital admissions for older people in the UK. Specifically excluded were:

- Material published and/or based on data collected prior to 1993 (the date of the implementation of the NHS and Community Care Act 1990 – a key piece of legislation in terms of promoting more community-orientated alternatives to institutional forms of care)
- Local inspections where findings have been summarised in a national report
- Additional articles reporting findings from studies already included in the review
- Admission to non-acute care
- The admission of people aged under 65 (unless a significant proportion of the sample are older people)

Following this, each article was summarised in the pro forma set out in Appendix A and data extracted around rates of inappropriateness, the definitions of appropriate/inappropriate admissions, and potential solutions identified. When this initial UK search revealed no previous studies which had sought meaningful engagement with older people, we conducted a second search of the international literature, repeating the above steps for studies published in English but focusing on health systems outside the UK (see Chapter 3 for further discussion).

Our case study sites

This study focused on three hospital trusts, chosen to provide a mix of different local characteristics (for example, in terms of different levels of affluence/disadvantage, different ethnic make-ups and a mix of urban/rural catchment areas) and to reflect a significant degree of clinical engagement in seeking to reduce the number of potentially avoidable admissions.

Although the three lead clinicians from each trust consented to be named as part of the core research team and for their trusts to be identified in this section of the report, we have reported all findings from Chapter 4 onwards on a generic basis (so that individual sites are not directly identifiable by the general reader). Where there may have been a specific local factor at play, we have anonymised the site concerned so that participants are not identifiable and so that any data contributed is used in a non-attributable way. At the request of participating trusts, this includes distinguishing staff quotes by the professional background of the participant, but not including a code for the three different locations.

The three sites included:

- The Royal Berkshire, a large DGH in an affluent shire county. It has previously undertaken internal audits which suggested that around 20 per cent of older people admitted to the hospital did not need the services provided there (had alternative services been available in the community). In response, the Trust conducted a more detailed local study to identify and explore potentially avoidable admissions. Defining an 'avoidable' admission as 'any admission that would have been avoided in an ideal system that may be due to medical factors,

social factors or a combination of both', the study then reviewed all relevant clinical documentation and, where possible, conducted an interview with the patient's GP and family (and some older people). Overall, this research suggested that between one in five and one in three medical admissions to the hospital among older people were avoidable with optimal medical and social management. Although the study offered an important insight into potentially avoidable hospital admissions, a key limitation was the failure to involve more older people and their families (which was more labour intensive and complex to organise than was possible in the initial audit). As the final report noted, additional work with older people and their families might offer rich additional insights (Mytton et al., 2011, pp.13–14):

'We spoke with 25 patients or relatives... It was apparent that many relatives realised that the patient was struggling at home, often for several weeks or months before admission. Relatives thought that help was needed, either a medical opinion, or more often increased support or care at home. Sometimes relatives had been trying, often with limited success, to arrange for more care. Sometimes the family were unsure which way to turn for help, and found both the 'care system' and 'health system' difficult to navigate... A more complicated picture tended to emerge from speaking to relatives, from that which first appeared on the ward round. This might include a patient declining a care package, or attendance at hospital outpatient, or simply greater complexity and longer list of problems than had been identified on the initial clerking and ward round. This underscored the importance of establishing a good collateral history, particularly when the admission might appear 'avoidable'.'

The lead clinician here, Professor David Oliver, is a former National Clinical Director of Older People's Services and is currently President of the British Geriatrics Society, thus maximising the potential impact of our study.

- Heart of England Foundation Trust (HEFT) covers a number of geographical sites, with a main hospital in a very deprived inner-city,

multi-cultural area. Over time, the Trust has conducted joint research with social care colleagues into ways of making best use of scarce hospital beds (dating back to the mid-1990s) and has recently developed a 'front-door' geriatrician post in A&E to review older patients and identify scope for alternative services. Available during office hours only, it has been successful in discharging 543 of 848 frail older people assessed by the project (64%), but the early success of the post demonstrated the potential to divert a number of potential admissions at other times of the day and in a more systematic and embedded manner. During winter 2014–15, the Trust struggled with intense pressures in A&E, and has since experienced additional high-profile performance and financial challenges. The participating hospital for the current study was Heartlands Hospital, on the edge of Birmingham's inner-city.

- Surrey and Sussex Healthcare NHS Trust (SaSH) covers a large geographical area with a catchment of over 500,000. Older people constitute around 62% of acute admissions, and the Trust has been developing its geriatric services over time, increasing the Consultant team from four to 11 physicians. In addition, within the Acute Medical Unit, there are three consultants who are geriatricians. In the run-up to the current study, SaSH and local partners had been exploring ways to reduce 'inappropriate' care home admissions, to further develop frail elderly services and community geriatrics, and to work with social care, voluntary groups, older people's patient groups, palliative care, primary and secondary care to improve the management of complex care for people in care and nursing homes.

Telephone interviews and focus groups with local professionals

In each site, we carried out between ten and 20 telephone interviews with local clinicians and managers involved in hospital services for older people and/or in services seeking to divert admissions (including participants from acute care, community health, primary care/general practice, social care and voluntary sector providers of hospital after-care services). These professionals were asked whether they felt more older people could be cared

for outside of hospital in their area, how many admissions they saw which they felt could have been avoided, what policies and/or services exist to help reduce these avoidable admissions, how easy such services are to access, what they felt could be done locally to reduce avoidable admissions, and what three things they would recommend to be done at the national level to reduce avoidable admissions. Clinical members of the research team identified a range of professionals employed in their hospital and local area that had involvement with services for older people to help us recruit participants who would be actively involved in delivering and organising local services, and in ongoing debates about emergency admissions. Each person was contacted in the first instance by email and invited to take part, being asked to read attached information sheets and to sign a consent form. They returned this by email and an appointment was made for interview. Interviews were audio recorded and transcribed, and lasted anywhere up to one hour. These data were used to provide professional context to our subsequent interviews with patients (read on for further discussion) and to give the researchers insight into the perceived nature, history and context of emergency admissions of older people and of local responses. It was made clear to participants that the purpose of the research was not to compare or judge individual trusts but simply to gain a holistic understanding of how the process of emergency admission for older people worked from their point of view, and how it might be improved in future. The interview schedule for these interviews can be found in Appendix B.

Later on in the project, additional professional perspectives were sought via three focus groups – one per trust – with a multidisciplinary group of front-line staff from that study site. These professionals were sometimes people interviewed at the start of the project, but also included a number of other colleagues from different professional backgrounds. They were recommended by local clinical leads as having a key role to play in meeting the needs of older people and being able to comment on the appropriateness of admissions and possible alternatives. Despite approaching a number of named social workers suggested by local clinical leads, a number did not respond to our approach and the rest declined to take part (see Chapter 4 for further discussion).

At the focus groups, professionals were given three vignettes created from the narratives of patients and their carers (see below for further detail), and asked to consider whether each admission was necessary in their professional opinion, what might have been done differently and what the older person's overall experience might have been like. The focus group schedule and the vignettes can be found in Appendix C.

The transcripts were initially read and coded, using NVIVO data analysis software, by two members of the research team, one working on the telephone interviews, and the other on the focus groups. The transcripts were coded using a coding frame that consisted of the respective interview questions, which in turn were informed by the study's research objectives. Table 1 provides a description of the full range of initial codes, as well as additional themes that began to emerge from the data. Throughout, the main focus was on seeking to understand participants' experiences of working with older people admitted to hospital as emergency patients and their view of the causes of and solutions to the 'problem' of emergency admissions of older people.

Thematic analysis (Braun and Clarke, 2006; Robson, 2011) was used to identify recurring threads of meaning in the data; the purpose was not to generate theory (Littlechild et al. 2015, p. 23) but to 'describe and understand how people feel, think and behave within a particular context and relative to a specific research question' (Guest et al., 2012, p.13). Emerging themes were discussed by the whole research team and we sought in particular to identify where there were common themes across one or more of the sites that may be suggestive of universal aspects of emergency admissions. Findings were then written up as two draft narratives, and shared between the two researchers who discussed the drafts and suggested changes. It became clear in analysis that the findings from the interviews and focus groups contained many themes in common, and as many of the participants in the focus groups had also taken part in the telephone interviews, it was decided to present a discussion of findings as a single section.

Table 1: Codes used in analysis of interviews and focus groups with professionals

Telephone interviews	Focus groups
<p>Codes relating to interview questions:</p> <ul style="list-style-type: none"> ■ Emergency admissions of older people as an issue ■ Proportion of emergency admissions that might be preventable ■ Policies/services to help reduce emergency admissions ■ Ease of access for professionals and public ■ Recommendations to improve practice 	<p>Codes relating to interview questions:</p> <ul style="list-style-type: none"> ■ Appropriateness of admission ■ What could have prevented admission ■ Quality of health and social care experience
<p>Emerging themes:</p> <ul style="list-style-type: none"> ■ Advance care plans ■ Assessment ■ Communication ■ Community alternatives (or lack) ■ Hospital as default option ■ Internalisation ■ Residential and nursing homes ■ Risk ■ Roles of patients ■ Social admissions 	<p>Emerging themes:</p> <ul style="list-style-type: none"> ■ Initial response to call ■ Who assesses in A&E ■ Day and time of arrival ■ Admission avoidance ■ Length of stay ■ Discharge/care planning/follow up ■ Communication between professionals ■ Communication with patient ■ Cultural expectations ■ 'Professionals know best'

Face-to-face interviews with older people and their families

The key component of our research took the form of face-to-face interviews with a proposed sample of 120 patients aged 65 years and over who had been admitted to one of the three case study sites during a four-week period (around 40 people per site). Participants were interviewed to explore their experiences of emergency admission, asking them specifically to consider their journey from 'healthy to hospital' and what, if anything, happened during this period which, had it been dealt with differently, could have prevented their subsequent admission. The population from which samples were drawn was patients aged 65 and over admitted as emergencies (ie, non-elective admission admitted at least overnight) during a given four-week period to any ward in each case study hospital site. Each trust then wrote to every eligible older person four to six weeks after their discharge. This period was chosen so that people were not placed under any pressure to take part in the study while still in hospital (while they might be feeling vulnerable, ill and possibly beholden to local clinicians), so that people had sufficient time to

recover and reflect on their experience and so that insights could be gained into the success of people's discharge and aftercare.

For ethical reasons, trusts did not write to people receiving end-of-life care; people assessed by a local clinician as unable to give informed consent and with no relevant person to act as a potential consultee (see page 11); and patients who were unlikely to be contacted (eg, who had no address or were in prison). Where a local clinician felt that, in their professional opinion, an older person would not be able to consent to take part, the trust identified a relevant family member or carer to contact as a possible consultee under the Mental Capacity Act (see page 14).

Letters sent out by the participating trusts provided information on the aims of the study and the rights of participants. This assured people that data would be used in a non-attributable way, that interviews could take place in a setting of the person's choosing, that participants could choose to have a friend or family member with them if they wished, that there would be no negative consequences for

not taking part and that relevant translation and interpretation services would be provided if someone who did not speak English as a first language wanted to take part. Anyone who wished to participate was asked to contact the research team by posting back their consent form in a pre-paid envelope. The research team then contacted participants directly to arrange a suitable time for interview. This meant the research team at the University of Birmingham only saw contact details of those willing to take part and that the trust was unaware of who had consented.

Recruitment continued in each site over a four-week period until up to 40 older people per site had agreed to take part, at which point the trust was contacted and the research team informed further potential participants who contacted them that the necessary sample size had been reached. This sample size represents a reasonable number of patients to achieve a broad range of experiences, while at the same time remaining within the limits of resources available to the study. It is also larger than any similar study we are aware of that has sought to draw upon interviews with patients. In practice, we suspected that the number of people wanting to take part from different sites might vary, and that it would be difficult to recruit this many older people with recent experience of emergency admission. Our eventual sample of 104 (see Chapter 5 for further details) therefore feels appropriate.

If patients were deemed unable to give consent, a 'consultee' (for example, a next of kin) was approached to consent on their behalf. This person was also identified by a lead local clinician and sent a consultee letter (which asked them to consider whether or not the patient would have given consent had they been able). If the consultee believed that the patient would have given consent, they were asked to nominate someone who had good knowledge of the patient and could undertake an interview on his or her behalf. That person could be the consultee themselves, a carer (paid or unpaid) or a relative. That person was then contacted by the research team and invited to take part. In practice, all consultees who took part on behalf of an older person were a next of kin.

Participants were asked throughout the research process to confirm that they understood their rights, the aims of the study, and that they continued to consent to take part; this was especially important when dealing with those

with fluctuating capacity. As well as the initial consent form that participants were asked to sign, they were also asked to sign a consent form at the time of interview and a satisfaction form at the end of the interview to state whether they felt comfortable with what had occurred. At each stage they were informed of their right to withdraw data from the study, or to withdraw entirely, without consequence for their treatment. Members of the research team were experienced researchers with substantial experience of conducting research interviews, particularly with older people, including those who have cognitive impairments and whose experiences are consequently poorly represented in research. The aforementioned invitation letter, consent forms and satisfaction form were all designed with input from older people who were members of Agewell, a local older people's forum in Sandwell (see Appendix D for copies).

Interviews were based on a semi-structured topic guide (see Appendix E), together with four visual aids to prompt discussion around the factors which may have influenced the admission: medical, social, formal support and informal support (see Appendix F). This is an approach which we have used in previous research with older people with recent experience of hospital admission (Ellins et al., 2012), providing a visual prompt for older people (if needed). These were used flexibly so that all interviews covered the same underlying topics, while also enabling interviewers to draw on these additional resources as necessary to suit the circumstances and participant, rather than following a 'one-size-fits-all' approach.

Participants were asked to describe what were the most important factors leading to their emergency admission; what services, if any, they were receiving at the time; and what they felt might have helped to prevent their admission (if appropriate). The interviews were recorded and lasted anywhere between 30 minutes and two-and-a-half hours. In order to minimise the risk of distress at the interview, participants were able to have someone of their choosing with them if they so wished. It was made clear in writing and in the verbal introduction to interviews that the interview could be stopped or that the participant could withdraw at any time. These interviews were then transcribed and coded.

Our study began with some pre-defined codes we were interested in and wanted to capture in the coding process (for example,

'appropriateness of admission' and 'prevention solutions') – hence the use of a semi-structured interview schedule – and was therefore broadly deductive in approach. These pre-defined codes arose from the pilot study outlined above, the literature on 'inappropriate' admissions, and the resulting research questions crafted for this project: we wanted to find out whether older people in our sample defined their admission as appropriate or not to create a rate of in/appropriateness and to hear from them about possible preventative solutions. However, we wanted to have a degree of flexibility and allow interviewees to explore their own experiences and stories with us; hence we left room for more inductive coding of the data also, returning to the data as we refined our codes to examine new categories emerging and how best to formulate codes to describe them. This was achieved through a process of team discussion as the data was worked through. Following Gale et al. (2013), we used the 'Framework Method' and Excel to help us manage this process.

As Gale et al. state (2013, p.117), the Framework Method allows for the individual variation of each case to be seen in the framework, but also cross-case comparisons to be made; it also aims to summarise and reduce the data so that the overall research questions can be answered, as with all qualitative coding and sorting. Gale et al. (2013) recommend coding a section of the transcripts first to create the overall analytical framework to be applied to all of the data, though they propose always returning to the data to ensure the framework continues to represent it and not to see the framework as 'finished' until the final transcript has been coded. Thirty transcripts were therefore coded initially with the team members involved at this stage looking for the pre-defined codes, while also considering whether other significant themes appeared to be emerging which required coding. Once coded, this initial analytic framework was discussed by the full team, with codes refined, added, or excluded through in-depth discussion of the data and process of coding (see Table 2). As Gale et al. (2013, p.122) note this process is time-consuming, but brings out the variety of perspectives a team will have about the data and allows for these to be explored and potentially incorporated into the final analysis. Once agreed the analytic framework is then applied to the full dataset: thus, we worked through the entire set of transcripts, ensuring interviewees' responses were coded according to the framework.

Table 2: Codes used in analysis of interviews with older people

Deductive codes	Inductive codes
<ul style="list-style-type: none"> ■ Sex ■ Age ■ Personal circumstances ■ Pre-existing conditions ■ Reason for admission ■ Contact with health and social care professional in the four weeks leading up to admission ■ Most significant factors leading to admission (medical/living conditions/informal care/formal care) ■ Previous emergency admissions (up to 12 months before) ■ Appropriateness of admission ■ Alternatives to acute care considered ■ Prevention solutions ■ Quality of experience: room for improvement or different/better action 	<ul style="list-style-type: none"> ■ Time and day of admission ■ First action after incident to seek help ■ Time elapsed between crisis/seeking help

As stated above, our approach was broadly deductive, as this study arose from previous exploratory work and literature which resulted in us having research questions which required specific answers around appropriateness and prevention. By allowing a more flexible approach to the data, however, we produced other important codes we had not pre-defined around, for example, 'time and day of the week the admission took place' and 'time elapsed before seeking help.' These codes, along with participant variables such as sex, age, and living circumstances, provided responses which could be counted and indeed, part of our aim was to provide a rate of appropriateness as defined by the sample of older people to compare with the rate given by professionals in our study and in other research studies, thereby adding the patient voice to this research on rates of inappropriateness.

We therefore set our approach apart from Gale et al. (2013, p.122) at this point, as they do not advocate the quantifying of qualitative data. By quantifying some of our data, we are not suggesting its generalisability, as we recognise that it is a small sample by quantitative standards, but wish to provide an overall sense of our data: what our sample looked like and what the views of participants were, as well as which variables and codes interacted with one another in potentially significant ways. This is

described in more detail in Chapter 5. We only use descriptive statistics to present our data in another way – not just through qualitative quotes – and agree with Fielding (2001, p.228) that '*preliminary analysis [of an interview transcript] may benefit from quantitative methods such as frequency counts of occurrences of certain phrases or words or the codes you have assigned to your data.*' The data were therefore coded numerically using SPSS with simple numerical codes, for example, 1 = 'Yes' and 2 = 'No' or by applying numbers to different health conditions or reasons for admissions (for example 1 = 'Heart condition' and 2 = 'Diabetes'). Space was left within these numerical codes to represent the complexity of participants' lives by using, for example, 'Other' or 'multiple concerns' which were also given numerical codes. We maintained the ability to look across the sample for sample patterns but also to refer back to individuals by ensuring the individual's case code was included on the Excel and SPSS datasheets.

The Framework Method allows for this flexible approach to deductive/inductive coding and provides a useful form of data management, letting us see individual cases but also across cases to explore the data. The Framework Method can be used with thematic and content analysis (Gale et al., 2013, p.118) and our approach to the analysis of our data sits within qualitative content analysis approaches.

Our descriptive statistics – providing counts, percentages and patterns within our sample – mean that our analysis of the data is based on counting and linking numerical data together to understand the connections between variables and codes. As Vaismoradi et al. (2013, p.403) argue, qualitative content analysis is an approach which lends itself to a quantification of qualitative data; this is what sets it apart from a thematic analysis of data. Our qualitative content analysis allowed us to describe and explain the findings (see Chapter 5). Our approach to qualitative content analysis sits towards Altheide's (1987) ethnographic content analysis approach, which allows for an iterative process of returning to the data to refine it as analysis progresses and to constantly ensure the data is speaking out through the process of analysis rather than researcher views.

The processes of analysis, description, and interpretation of data were not wholly separate in our study and, as Altheide argues (1987, p.68), cannot be wholly separate in ethnographic content analysis; it is not a linear process. This description presents a more sanitised version of the complex interaction between coding, analysis, description and interpretation. However, once the coded, quantified data were analysed, themes emerged from this interpretation of data which have been used to structure Chapter 5 on patient views: these themes converge around patient background, the admission process and prevention but are more nuanced and complex than these labels suggest, giving insight into help-seeking and what affects it; patient understanding of the current crisis in NHS resources; a desire not to be a burden on the NHS; a lack of clarity around what services can be accessed; important relationships with GPs; and the need for a more proactive, preventative approach. These themes arising from interpretation of the data speak to one another also, and do not stand alone; their interaction provides significant insight into patient experience of admission to acute care in an emergency. Specific qualitative quotes were sought from the interviews to illustrate these themes and provide the words of the participants themselves. Chapter 5 will introduce and unpack these themes in more depth.

As stated throughout this report, the main focus of this project was the experience and expertise of older people with direct experience

¹ As set out below, 104 older people and their families took part in the study, alongside 40 professionals who were interviewed, with 22 professionals taking part in focus groups and 45 GPs/hospital doctors returning a survey on their patient's admission. Given that some professionals took part in both interviews and focus groups, this nevertheless amounts to just over 200 people taking part in the study overall.

of emergency admission. However, we did also include the perspective of carers when older people were deemed unable to consent to take part in the project by the lead clinician in each trust. Thus, the bulk of our interviews focused on the experience of older people, but a small number included the perspective of a carer acting as a consultee. Some older people also chose to be interviewed with a carer present, and sometimes asked a question of the carer during the interview or sought their opinion. This enabled us to gain additional insights from some carers, albeit the research team are experienced at working with both service users and carers, and were able to make sure that carer perspectives did not dominate or cloud the user voice in these situations.

In practice, only a small number of consultees were interviewed, most caring for someone with dementia and all coming from a single site. These people were therefore a small, but nevertheless highly important, group as they provide insights into the experiences of people with dementia, who are a significant but under-researched group among the more general older population. As Carmody et al. argue (2015), there is little qualitative data on dementia and the experiences of dementia patients, despite the increasing prevalence of this condition and the possibilities for improving the quality of patient care which qualitative work offers. They point to several barriers, including a lack of funding reducing the possibilities for research in this area (Carmody et al., 2015). There is much discussion in the literature around what constitutes informed consent and what processes are legal and safe in various settings (see, for example, Baskin et al., 1998; Dewing, 2002; Warner et al., 2008). We chose a route of using clinical judgment to decide whether a person could provide capacity, for the safety of patients and researchers, while including the families of dementia patients to attempt to get at their experiences and thoughts, allowing this under-represented group a chance to be heard.

Though our sample is small by quantitative standards, it is a large sample for qualitative work¹ and takes into account a multitude of different perspectives and therefore has a wider resonance than to just the sample studied. To use Mason's (2009, p.196) well-known arguments for qualitative data, our work provides data of a specific sample, giving an understanding of the experiences of that

sample in detail, but also a flavour of how the rest of the population within the three NHS Trust sites we worked with may experience emergency admission there. We also argue that this study has wider applicability to NHS England, as trusts across the country face similar difficulties around reducing emergency admissions of older people to acute care and that the findings in this report can offer insights into these challenges even if, as we recognise and argue throughout, context is always important and needs to be taken into account.

Surveys sent to GPs, social workers and hospital-based doctors

Mirroring our interviews with older patients, an email survey was sent to the GP, social worker and/or hospital doctor of each older person taking part (see Appendix G). These surveys were only sent with the patient's consent (or that of a consultee), which was asked for at the time of interview. Surveys asked the GP, social worker or hospital doctor whether they thought the admission in question was avoidable and what could have been done to prevent it, as well as to provide a sense of what they thought the most important factors contributing to the admission were (with the use of a numerical scale). The administrator working on the project at each trust was asked to assist in helping us locate the hospital doctor who had worked with the older people taking part; wherever possible and appropriate, details for GPs and social workers were requested from the older people during interviews. The aim of this element of the study was to provide a professional perspective on the issues at stake, comparing and contrasting the insights gained from the older person themselves with professionals from different parts of the health and social care system. Given the complexities of identifying, contacting and recruiting their potential participants, we anticipated in advance that we would achieve low numbers here – but believed that it was nonetheless important to access this perspective wherever possible.

The surveys were analysed by comparing the numerical scale answers provided by the professionals with those of the patients to a similar question and exploring the similarities and differences between them. Proposed possibilities for prevention are set out later in this report and are used to triangulate with patient thoughts around prevention. This was not intended to represent a 'check' on the views of older

people (with the professionals' view trumping those of the individual older person) – but did provide an opportunity to see whether older people and their health and social care professionals agreed with each other or not.

Working with the Older Person's Reference Group: Agewell

This project aimed to include the voices of older people at all stages of the study, working with an Older Person's Reference Group throughout. Agewell, based in the Sandwell region of the West Midlands, describes itself as 'a social enterprise led by older people for the benefit of older people' (Agewell website). They advocate and campaign on behalf of older people at local, regional, and national level, with the aim of changing both policy and attitudes towards older people for the better. Agewell were approached to assist us with this project because the research team has a long-standing relationship with the group through previous research projects and therefore knew they had the appropriate knowledge and capacity to work on this project in an advisory role. They were also not based in any of our case study sites, and so were better able to comment more independently than a group working directly with one of the three sites might have been.

An invitation to Agewell to take part in the research had been made and accepted prior to the start of the project. This was followed up by a meeting between two of the research team and the management team at Agewell to discuss the process of collaboration. The group was given an honorarium as thanks for their participation: this could be used to pay participants or participants could choose to return it to the central Agewell fund. A Job and Person Specification was developed by the research team and circulated to Agewell members by their administrative staff (see Appendix H). The basic criterion for membership of the group was that they or someone they cared for should have experienced emergency admission to hospital within the last 12 months. It was agreed that Agewell should be free to select members to approach on the basis of their knowledge of the person's fit with the aims of the study and the Person Specification. Once this group was in place, an initial meeting was set up, with further meetings arranged as the study progressed.

The work with Agewell done in preparation for collecting empirical data framed our thinking and ensured that older people's voices were included in the design of the research from the start. Three members of the research team worked with the group and meetings were held every two to three months between April and September 2014. There was a gap in meetings after September 2014, while final ethical approvals were sought and work on the interviews begun, before resuming meetings every two to three months until the end of the project in March 2016. As many group members as possible came to each meeting, but numbers fluctuated over time due to ill health and other commitments (but with a core group of at least five people at all times).

In order to ensure that documents being sent to participants were clear, inviting and would encourage people to take part, Agewell group members examined the invitation letter, commenting on font size, colour, layout and the information included. They also discussed the best possible means of attracting people's attention to the fact this was a research project (rather than general sales material or other unimportant post). The group advised emphasising the importance of the project to health care for older people (thereby using your own experience to help others) as a way of encouraging participation, and also made a series of practical changes to wording and design to make project documentation more accessible and clear. At times we had to make compromises given detailed feedback from the NHS research ethics system – and it felt ironic that insertions by different levels of the research ethics system meant that we could not always be as accessible in our written information as we would have liked.

The group's own experiences were intended to feed into the kind of questions to be asked to participants, to frame our thoughts and to guide the overall project. To this end, Agewell group members were asked to relate their experiences to a member of the research team in small groups of three or four. This allowed each person to have the time to tell their story in-depth and for recurring themes to be documented and stored for feeding into the structure of the interview schedule. Once the questions for the interview were finalised, participants from the Agewell group agreed to take part in

one-to-one pilot interviews to test our draft interview schedule and to highlight any final confusions or omissions. Three pilot interviews were undertaken and no adjustments were requested: this suggested that, due to the prior and ongoing discussions with the group, their thoughts had been suitably taken into account.

The group was also asked to test our approach to multidisciplinary focus groups, reviewing the vignettes which the research team had developed from interviews to date. In response, Agewell colleagues felt that the vignettes provided a helpful framework for discussion, and provided feedback on the length of each case study, the amount of information provided and the extent to which they felt realistic (given their own experience of emergency admission).

The sounding board

Alongside the Older People's Reference Group, the research team met and worked with a 'sounding board' throughout the study. This included the Chair of Agewell and a senior member of Agewell staff, but also included representatives from the NHS Confederation, the Association of Directors of Adult Social Services, Age UK and the Social Care Institute for Excellence. This group met face-to-face on two occasions (with additional email contact in between), advising us on feasibility of our proposed approach, helping us to place emerging findings into a broader context and advising us on future dissemination and implementation.

Ethical issues

This study received sponsorship from the University of Birmingham research ethics service and a favourable ethical approval from the Coventry and Warwickshire NHS Research Ethics Committee, as well as support from the Thames Valley and South Midlands NIHR Clinical Research Network and the local Research and Development offices in each of our three case study sites. Securing these approvals took approximately one year of our two-year study. From the beginning we were conscious that seeking to interview older people with recent experience of emergency hospital admission raises a series of ethical issues, and we tried to design the approach outlined throughout this chapter in order to ensure that:

- Our approach sought to hear the voices of individual older people (who, as Chapter 3 suggests, are seldom heard in these debates) and to involve older people's organisations in shaping our research materials.
- We tried to design recruitment to the study in such a way that as many older people as possible (including people not able to consent and people who do not speak English as a first language) could choose to take part – but without placing people under undue pressure to participate (for example, when still feeling unwell or dependent on services in hospital). Striking this balance and ensuring we reflected in detail on issues of capacity (without unnecessarily excluding people) was significantly aided by the inclusion of local clinical leads from each case study site as core members of the research team. We are also fortunate to have been able to conduct a small-scale local study into similar issues (see Glasby and Littlechild 2000, 2001) – and our concern in this initial pilot was that older people with dementia and other cognitive impairments might have been excluded from participating by a less than well designed method of recruiting participants (which had been stipulated by the predecessor of the current NHS research ethics system and prior to the current Mental Capacity Act). A key concern in this national study has therefore been to ensure that a wide range of older people could take part if they wished, working with complex issues of capacity and consent in a thoughtful and sensitive way.
- We compiled a research team which included significant experience of carrying out sensitive research, of working with older people with recent experience of using services and of the pressures and realities of front-line clinical practice.
- We worked with national partners to ensure that findings are well disseminated to a policy and practice audience, thus ensuring that people's experiences and contributions to the research can play a role in bringing about positive change.

Despite this approach, any interviews on such a topic are likely to raise additional 'in the moment' ethical issues as older people reflect on sometimes painful and distressing experiences and the researcher becomes a

temporary part of the person's life. As planned in advance, the researchers provided each participant with a Patient and Liaison Services (PALS) number at their local trust – and this seemed to be appreciated by a number of participants (several of whom suggested they would contact PALS to raise concerns more formally). However, as our knowledge of local areas grew, we took a decision that we would mention possible local services and how to contact them in situations where people specifically asked us for information, but that we could not recommend particular courses of action. Our written information made clear to potential participants that all information provided would be used in a non-attributable way, unless an allegation of abuse was made. In the one case where someone did talk about perceived abuse, they were clear that the issue was already being investigated by local safeguarding processes and that the research team did not need to do anything else.

SUMMARY

As suggested in the introduction to this report, the issue of potentially avoidable emergency hospital admissions is long-standing, complex and contested. We believe that the present study represents one of the most in-depth and multi-faceted research projects ever undertaken, seeking a series of different contributions from the perspective of:

- Previous research (with studies based on a range of different methodologies) (Chapter 3)
- The views of local clinicians and managers in contrasting case study sites (Chapter 4)
- The responses of multidisciplinary focus groups to user-centred vignettes (Chapter 4)
- The lived experience of older people and their families (and the extent to which this triangulates with different professional perspectives) (Chapter 5)
- The advice and guidance of our Older People's Reference Group and our national sounding board

Of all these, Chapter 3 suggests that it is the involvement of older people themselves in identifying scope for alternatives to emergency hospital admission that represents the most significant innovation – albeit approaches which seek to understand local context and which engage front-line staff are also highly significant.

3. Previous Literature

Despite significant media and policy debate (see Chapter 1; see also Department of Health, 2011; Poteliakhoff and Thompson, 2011; Boseley, 2012; Campbell, 2012; Imlison et al., 2012; Prynne, 2014), our review identified only ten studies that met our inclusion criteria (see Chapter 2). These are summarised in Tables 3 to 5 over the following pages, with a final discussion section on our proposed methodological approach and the gaps in the literature which this fills. We also carried out a search of the international (English language) literature, following the same process as for the UK search but adding an additional search term around patient experience/participation (see Appendix A for further details). However, this found no studies matching our criteria, making the current study unique nationally and internationally.

Rates of in/appropriate admission

The literature does not provide a simple answer to the rate of in/appropriate admissions to hospital (see Table 3): rates of 'inappropriate' admissions vary widely depending on what tools are used to judge the admission or whether it is based solely on the decisions of health professionals (see column two for further discussion). Rates also depend on geography, with differences between rural and urban hospitals (Coast et al., 1996); time of year – winter seeing an increase in the overall admissions rate and increasing the likelihood of 'inappropriate' admissions (Beringer and Flanagan, 1999); which services are available in a particular area and whether they can be accessed as true alternatives to hospital; and who saw the patient in terms of what knowledge and experience they had in caring for older people (Leah and Adams, 2010). These findings reflect the difficulties facing acute care in terms of staffing and resource availability, as well as differences occurring due to environment and how these can all impact on the appropriateness of emergency admissions. These varying rates make comparisons difficult and suggest a critical need to take context into account when researching and creating policy around emergency admissions: one blanket response, without appropriate research evidence, will not necessarily deal with the problem (which manifests itself very differently in different local contexts).

Definitions of 'appropriate' and 'inappropriate' admission

The literature shows there is no accepted standard definition of what it means to be an 'inappropriate' admission (see Table 4), with studies tending to adopt one of two approaches. The first is based on professional opinion, with studies defining admissions as appropriate/inappropriate on the basis of the author's opinion or with reference to some sort of expert panel of medical practitioners. This makes it difficult to compare results with findings elsewhere and some studies are unclear as to whether they are measuring the number of people who, in an ideal situation, could be cared for in alternative settings or those inappropriately placed within the context of existing local services. Furthermore, the criteria and process used to judge an admission 'inappropriate' are often unclear, making it difficult for readers to judge and compare results.

The second approach uses clinical review instruments. Initially developed in the US to decide which hospital admissions were appropriate for insurers to fund, these are standardised lists of criteria which might necessitate a hospital admission, usually relating to the severity of a patient's condition and the type and intensity of service provided. The two tools used in our studies are known as the Appropriateness Evaluation Protocol (AEP) and the Intensity-Severity-Discharge Review System with Adult Criteria (ISD-A), and both produce easily quantifiable results and help health professionals to structure their decision making.

However, there are a number of potential criticisms of these tools in the broader literature, including that the AEP does not take into account the fact that there may be no other option in the local area for the patient except hospital (Glasby and Littlechild, 2000). It is for this reason that some commentators have referred more to 'avoidable' than to 'inappropriate' admissions (Mytton et al., 2013; see Glasby and Littlechild, 2000 for more on problems with terminology), as well as the fact that the AEP can be used in 'pure' or amended form and that this can make a difference to what is then deemed appropriate or otherwise (Houghton et al., 1996). Appropriateness

also depends on when the AEP or ISD-A are applied to each patient's case: only when there is more knowledge of the person and what actually went on to happen to them can they be properly judged an 'inappropriate' admission (see Coast et al., 1995; Tsang and Severs, 1995). In other words, these tools are helpful up to a point, but are applied retrospectively and take no account of local circumstances or the availability of alternative services.

All this reveals the complexity which surrounds decisions on who is appropriate to admit to hospital. While some studies draw heavily on professional (often medical) discretion but lack consistency and transparency, others are more standardised but lack the insights which local professional judgement can bring to understanding the issues at stake. In contrast, our study aims to gather a wider range of viewpoints and perspectives to take account of the complexity and competing demands surrounding emergency admissions for older people and to guard against the danger of overly simplistic pronouncements on the issues at stake.

Table 3: Rates of in/appropriateness in different localities

Author/date	Location	Sample	Rate of in/appropriateness
Beringer and Flanagan (1999)	Northern Ireland	1,300 acute medical beds surveyed to identify patients from nursing homes admitted on one day in June 1996 and another single day in January 1997. 84 patients over the age of 65 from nursing homes admitted in June and 125 in January. Only asked in January if admission could have been avoided.	9.6% of studied admissions deemed unnecessary (12/125 people).
Coast et al. (1995, 1996)	South-west England	Two hospitals: 700 individuals in each. Hospital 1: 64% were aged over 65 and of this group 41% were aged over 75 Hospital 2: 58% aged over 65 and of this 33% aged over 75.	In both hospitals, 20% of admissions were defined as 'inappropriate' using a clinical review instrument (see below for further discussion). GP panel (1995 study): 9.8% – 15% (after looking at the 'inappropriate' cases themselves).
Houghton et al. (1996)	Homerton Hospital, East London	572 admissions reviewed for their appropriateness (77% were aged 55 or over).	31% of admissions 'inappropriate'.
Leah and Adams (2010)	Broomfield Hospital, Chelmsford in Essex	666 patients seen between June and September 2009. They ranged in age from 60 – 103, but the majority were over 80.	27% of the admissions could have been prevented by sending to a specialist geriatric team like the one discussed in this study.
Littlechild and Glasby (2001)	South Birmingham	52 participants aged 65 or over who responded to participation letter (self-selecting). These 52 people accounted for 63 emergency admissions during the period.	All admissions deemed appropriate – but may still have been scope for longer-term preventative work.
Mayo and Allen (2010)	Five primary care trusts in London	1,814 patients seen by a rapid response nursing team between October 2009 and March 2010 (63% of sample aged 80 or over).	Overall, only 6% of patients needed immediate referral to the ED.
McDonagh et al. (2000)	Systematic review (UK and international)	Articles found through a literature search in English using MEDLINE, Health Star, HMIC, and the Cochrane Library CD-ROM for the years 1988–1998. The bibliographies of included studies were also searched. Studies had to assess use of acute hospital beds to be included.	20% of admissions deemed 'inappropriate' in studies specifically relating to older people (for the population overall, the range was between <1 and 30%).
Menon et al. (2000)	Royal Berkshire and Battle Hospitals, in Reading	A random sample of 261 of the 447 patients over 80 admitted as general surgical emergencies was studied (median age 84).	9% of admissions to the surgical ward (24 patients) were deemed 'inappropriate'.
Mytton et al. (2012)	Royal Berkshire Hospital, Reading	January–February 2011. 131 admissions reviewed (median age 84).	20.6– 2.0% of admissions were avoidable, depending on who was making/which tool was being used to make the decision.
Tsang and Severs (1995)	Queen Alexandra Hospital, Portsmouth	146 admissions analysed in May 1993 (age range 67–100, with 79% over 75 and 34% over 85).	According to consultants: 13% of admissions 'inappropriate'. According to the AEP: 11% of admissions 'inappropriate'.

Table 4: Defining inappropriateness

Author/date	Method of defining in/appropriateness
Beringer and Flanagan (1999)	Opinion of a local assessing doctor
Coast et al. (1995, 1996)	Intensity-Severity-Discharge Review System with Adult Criteria (ISD-A). In the 1995 paper, GPs then commented on those cases perceived to be 'inappropriate' according to the ISD-A.
Houghton et al. (1996)	Appropriateness Evaluation Protocol (AEP)
Leah and Adams (2010)	The opinion of the Assessment Team for Older People
Littlechild and Glasby (2001)	Older people commented as to whether their admission was the result of their medical condition, social and living conditions, formal, or informal support. The opinions of GPs and social workers also sought.
Mayo and Allen (2010)	Opinion of the Rapid Response Team
McDonagh et al. (2000)	N/A: systematic review of the methods used to define appropriateness, including the ISD-A and the AEP
Menon et al. (2000)	The researchers themselves, who judged in their professional capacity as surgeons
Mytton et al. (2012)	Opinions of two consultant geriatricians and one GP
Tsang and Severs (1995)	AEP and also the opinion of one of six participating consultants

Table 5: Proposed solutions to 'inappropriate' admissions

Author/date	Proposed solutions to 'inappropriate' admissions
Beringer and Flanagan (1999)	More support for GPs in providing appropriate medical care for older people; enhanced investment in community services; and reinvestment in acute hospital care for older people
Coast et al. (1995, 1996)	More funding for alternatives to hospital (for example, GP beds and urgent outpatient assessment)
Houghton et al. (1996)	Better liaison between health and social services and more timely provision of community care services; more non-acute bed provision (or an acceptance that acute beds are actually a mixture of acute and non-acute)
Leah and Adams (2010)	Further evaluation of teams like the Assessment Team for Older People described and further investment in their creation in hospitals around the country
Littlechild and Glasby (2001)	Broad range of potential solutions, including: more preventative work with older people to prevent falls, improve the detection of established illnesses and to help people manage and treat identified illnesses more effectively; health and social care services need to work more closely together; preventative social work strategies for those needing only small amounts of support at an earlier stage than they might have been referred; more integrated service delivery to users; and more communication and information about where people can go for help
Mayo and Allen (2010)	More investment in Rapid Response teams such as the one described
McDonagh et al. (2000)	Suggests greater methodological clarity and transparency when studies are written up so that results can be better compared and understood; also suggests not using subjective opinion to judge appropriateness of admission and length of stay. For older people specifically, more intense outpatient services or sub-acute beds could be provided. Continued research is needed to produce definitive conclusions.
Menon et al. (2000)	No detail given on how to reduce 'inappropriate' admissions
Mytton et al. (2012)	High-quality, integrated decision making at admission and across health and social care services; changing the view that hospital is the default care setting; investing in community services to provide viable alternatives; and further education for patients who have long-term illnesses so they can better manage their condition
Tsang and Severs (1995)	Patients being offered outpatient or domiciliary visit assessment; better placing of patients within the hospital; more patient education around understanding and accessing what services are available to them; and continued monitoring of rates of in/appropriate admission locally and nationally. If an admission is quickly judged 'inappropriate' there should be swift action to discharge the patient with a suitable care package.

Possible solutions

As Table 5 suggests, different authors suggest a very broad range of potential solutions (or developments that might help reduce the scale of the problem). While some studies focus on particular alternative service models (Leah and Adams, 2010; Mayo and Allen, 2010), the authors were a part of the institutions setting up and evaluating these services – and more independent verification may be needed to develop a more robust evidence base. However, many of the rest of the recommendations have more of a ‘scatter-gun’ feel and are certainly a lot less focused or definitive. Indeed, the impression in the majority of the literature is of authors who have identified a problem and are then speculating on potential ways forward – rather than a series of studies which are able to point unambiguously to specific solutions. There is, however, general agreement that high-quality decision making is needed when deciding whether to admit an older patient to hospital care or not and that health care professionals in different parts of the system should be supported and trained to be able to do this more effectively than at present. This leads us back to our current study, as we feel that the perspective of older people and their families could be a crucial – albeit often neglected – part of this process (see also Littlechild and Glasby, 2001). Indeed, in the one previous study that has sought meaningful involvement of older people to date (our pilot for the current research), Littlechild and Glasby (2001) emphasise the distinction derived from older people’s accounts between two inter-related but different issues:

1. ‘Inappropriate admissions’ – where someone is admitted to hospital when they do not need the services provided there.
2. ‘Preventable admissions’ – even where an admission is appropriate, there may still be scope to have acted differently at an earlier moment in time so that the person’s medical condition does not deteriorate to the stage where an admission is required.

To us, this is a more nuanced approach to the issues at stake – and this insight was only possible because of the experiences and insights of older people themselves.

Our approach: the importance of patient perspectives

As Glasby et al. (2004) argue, a major limitation of research into emergency admissions is the failure to include a patient/carer perspective. In our opinion, including a patient perspective is crucial to understanding the context within which the older person is using health and social services and to developing an appropriate response – particularly at a time when government is emphasising its commitment to the concept of ‘nothing about me without me.’ As we have argued elsewhere (Glasby and Littlechild, 2000, p.116):

‘Clinical review instruments [need] to be accompanied by research methodologies which include and empower the individuals involved. Patients admitted to hospital are often... the best qualified people to talk about their own conditions, the circumstances of their admissions and possible alternatives to hospital... A patient perspective can also provide a more holistic, long-term view of the factors that contribute to hospital admissions, helping to build a picture of how best to respond to the needs of people starting to experience ill-health.’

From this patient perspective the question of ‘appropriateness’ becomes more a question of ‘appropriate for whom?’ The patient may have a different view from his or her GP, a hospital doctor or a hospital manager. This makes the issue more difficult to unravel, but shows the important need to include patient perspectives in discussions of appropriateness.

Patient involvement is thus central to the current study – seeking to boost understanding of the emergency hospital admissions of older people by building on the lived experience of older people themselves. This is very different to previous studies, with only two of the ten studies included in our review describing the research team actually engaging with patients about their health and social care needs (Houghton et al., 1996; Littlechild and Glasby, 2001). Of these, one study was conducted by the current authors, while the other does not describe this qualitative element in any depth and the team did not go on to write up further articles about their qualitative work. In contrast, our current study focuses specifically on the experiences of older people and their families, and also includes the views and experiences of different health and social care professionals at local level. In this way, we hope to produce a more nuanced and multi-faceted account of the issues at stake, thereby filling a clear gap in the literature identified above.

SUMMARY

This review of the relevant literature has shown that emergency admissions are a complex topic, for which there are few, if any, straightforward answers. Varying rates of inappropriateness across contexts allow for few comparisons, but instead highlight the critical need to take context into account when researching emergency admissions and suggesting possible practice and policy solutions. These varying rates in part rest upon the initial definition of in/appropriateness given in the literature, which is defined in two ways: using expert perspectives or by using a clinical review instrument such as the AEP or ISD-A. Neither approach is perfect: the former rests on potentially opaque decision-making processes of professionals, inevitably subjective and partial, while the latter approach, though guided by criteria of a more objective nature, is arguably overly simplistic, informed by hindsight and ignoring the realities of what resources are available to medical practitioners. Though no approach may be entirely without its faults, the aim of our study is to include a wider range of patient, carer and practitioner perspectives, thereby producing a more nuanced account of the issues at stake than is currently the case in the existing literature. To our knowledge, this is the first time this has been attempted in the UK, and quite possibly beyond. If this is indeed the case, we find it genuinely shocking that an issue such as the emergency admission of older people can be such a high-profile policy and media issue, without meaningfully engaging older people themselves in understanding the issues at stake and proposing potential solutions. Beyond the service contribution which this study makes, it also makes a broader academic contribution by seeking to re-examine and reinterpret the issue of ‘inappropriate’ hospital admissions from a more user- and staff-focused perspective, producing a different insight into a long-standing issue by asking different questions of different stakeholders.

4. Local Context and Multidisciplinary Perspectives

Although the main focus of this study is the experience of older people (see Chapter 5), we also sought to build on the tacit knowledge of local professionals – both via initial interviews (to help us understand the local context) and via subsequent multidisciplinary focus groups (to illicit any differences of opinion and/or consensus around the key issues from the perspectives of different professions). As outlined in Chapter 2, similar themes began to emerge from both these elements of the study – and so findings are presented in a single chapter.

LOCAL CONTEXT: THE VIEW OF LOCAL PROFESSIONALS WORKING WITH OLDER PEOPLE

In total, 40 health and social care professionals took part in individual interviews across the three sites, including consultants, therapists, clinicians in admission avoidance teams, voluntary sector staff, hospital managers and GPs (see Table 6). Most were hospital-based, working either at the front-door of the trust and/or with older people subsequently admitted to hospital – but five worked in the community. Though we invited representatives from local authority social services departments in each of the three areas, none responded to our invitations for individual interviews.

To what extent is there a problem?

To gain an early insight into the extent to which participants perceived 'inappropriate' emergency admissions to be an issue locally, we asked them roughly what percentage of older people need not have been admitted if alternative services had been available (see Table 7). This was intended to evoke a very rough 'guesstimate' of the extent of the issues at stake, and we anticipated that the extent to which local colleagues agreed with each other (or not) might be more important than the actual figures cited.

Table 6: Interviewees

Professional background/role	Site 1	Site 2	Site 3	Number
Consultant geriatrician	2	2	1	5
Occupational therapist	1	3	1	5
Physiotherapist	1	1	1	3
Senior nurse		3		3
Head of a voluntary organisation	1	2		3
GP	1	1	1	3
A&E/Emergency Department (ED) consultant	2		1	3
Matron (hospital)	2			2
Matron (community)	2			2
Service navigation team leader		1		1
Admissions avoidance team leader			1	1
Consultant surgeon (elderly care)		1		1
Senior mental health practitioner (social care)		1		1
Dementia nurse consultant	1			1
Consultant (acute medical unit)	1			1
ED therapies team leader	1			1
Community nurse practitioner (located in hospital)			1	1
Falls sister			1	1
Strategic manager			1	1
Deputy medical director			1	1
TOTAL				40

Table 7: Estimates of the proportion of emergency admissions of older people to acute hospital that might have been avoided had alternatives been available

Estimated proportion	Number of respondents
Don't know/not specified	11
1–2 admissions a day	1
1–10%	4
11–20%	7
21–30%	8
31–40%	3
41–50%	4
'Lots'	4
TOTAL	40

As can be seen from Table 7, there was little consensus among professionals as to the extent of the issue (and this was true within sites as well as across sites). Although only very basic estimates, figures nonetheless ranged from 1–2 admissions per day or 1–10 per cent (at one end of the spectrum) right the way through to four people who felt that between 41–50 per cent of admissions were avoidable. Chapter 3 highlighted the different rates of 'inappropriate' admissions that can be produced from different definitions of the issues at stake – and our interviews with local professionals certainly seem to bear this out. Of course, this was a very broad and imprecise introductory question, but the fact that there was such a range of responses feels significant nonetheless. If one person feels that the vast majority of admissions locally are appropriate, while another feels that half could be avoided, then there may be some fairly fundamental (and potentially incompatible) differences of opinion.

In answering this question, a number of participants also highlighted an additional dilemma from the literature in Chapter 3 – that answers might vary depending on whether participants were talking about an 'ideal situation', or were basing their response on

their knowledge of what was actually available: *'If you put everything together... 1 in 3 of the people who come in could have been handled in a different way. All things being ideal though, and the reality isn't ideal.'* (Consultant Geriatrician)

At the same time, a number of respondents drew a distinction between 'medical admissions' and 'social admissions.' Whereas the former term seemed to refer to those for whom the clinical services of an acute hospital were deemed to be necessary (such as admissions for surgery and other intensive medical interventions), 'social admissions' seemed to be those that were caused at least in part by a breakdown in family care or shortfall in community health care and/or social care. While some medical intervention might be needed (particularly to alleviate acute symptoms from a flare up of an underlying chronic condition) and access to diagnostic technologies might be called for, there was a sense that this input did not necessarily have to be in hospital. There were also concerns expressed that there were risks to being admitted to hospital (such as infection, or loss of mobility, confidence and independence) – and that admission for more 'social' reasons may not be worth the risk.

However, other participants felt that distinguishing between medical and social admissions provided a degree of false certainty about a more complex reality – with a potentially fragile balance between an older person's health, environment and support networks, each of which is deeply intertwined: *'People talk about social admissions, and that does happen, but it's often a mixture of social [factors linked to] a change in medical condition. So a social crisis might be precipitated by, say, a broken wrist, because they could manage fine with the zimmer-frame when they had both hands but now they've broken their wrist, they can't use the frame and they can't get to the toilet on time; and suddenly the carer can't cope. It's more common to have a mix of minor medical niggles and a social crisis: that's very common.'* (Consultant Geriatrician)

Often an admission to hospital was felt to mark a key stage in an older person's decline, after which they might need greater levels of care than they had before. If this was not available in a timely manner, then delays could occur and people might be discharged home

with inadequate support – thus contributing to future admissions. A perceived shortfall in social care was common, and this was felt to be a major factor in the growth of emergency admissions. While no social care staff took part in our interviews (and so, in one sense, did not get chance to offer an alternative view), the fact that very few social care staff engaged with this study (and that the older people who took part had little contact with social workers – see Chapter 5) may well derive from the observation above that being admitted to hospital marks a key threshold at which other forms of support begin to be provided following a crisis:

'The care agencies don't have enough carers. People are coming out with greater dependency. We need more carers. We have a number of people in the hospital waiting for discharge, and we have no start date. All the time they're in hospital they're losing their independence. And some people, the maximum they will get is four times a day. The carers whizz in for 15–30 minutes, they don't have time to do much for that individual. We often see people in A&E who have been found in the morning by the carer. There's nothing at night. We also find the ambulance crews get calls to an elderly person who really doesn't have a big health problem but have lost a lot of function, and what they actually need is social care and an emergency assessment to go to respite or an emergency package of care. But there isn't that sense of emergency in the community, so they end up coming to A&E so that we can try and pick it up from there by the hospital social work team. And that's a big problem.' (Community Matron)

So-called 'social admissions' were seen to be on the increase, and seemed to be resented by some as an 'inappropriate' use of resources. There was a certain sense of 'us and them' in the responses of some practitioners and an awareness that the perceived shortcomings of one sector were having a negative effect on another. From the point of view of some professionals at least, the system seemed to be very fragmented, with some people accessing particular forms of support to make up for deficiencies in other services:

'A lot of our patients come for long-standing conditions, they're coming to us to help them sort out their social support, really.' (OT)

Older patients were seen to be on the whole remarkably resilient in the face of adversity,

and often reluctant to seek help until absolutely necessary. There was not much support for the notion that older people used hospital casually as a 'first port of call'; on the contrary, many older people and carers were felt to struggle on for a long time till things got too much for them. In part this was seen as characteristic of this particular generation of older people:

'I think that often elderly people don't seek assistance until they can no longer cope with what they've got, and I guess that's the way they've been brought up.' (Consultant ED)

However, when older people did seek help it was often with a sense of deference that some professionals felt might be somewhat misplaced:

'And from a patient's perspective, for me, the very telling words are 'they're the experts', and so patients don't question, because they assume we're the experts.' (OT)

A&E services were seen as being on the front line of these conflicts, and there was some resentment expressed that some older patients might be actively encouraged to seek emergency admission as a strategy to get increased support. For example, one respondent felt that she had evidence of this happening via access to a database recording the assessment and advice of other workers:

'Patients are misled and told that if they come into hospital they're going to get an increased care package quicker, or they'll get a social work assessment quicker... We have access to the social work database within my team, and we clearly see recordings where they're actually telling patients to do such a thing.' (OT)

The sorts of medical conditions or issues that participants felt could be treated elsewhere included problems to do with catheters, minor infections and urinary tract infections (UTIs); minor fractures and bruising resulting from falls; shortness of breath as a result of chronic obstructive pulmonary disease (COPD); changes in behaviour as a consequence of infection; delirium or dementia; changes in health as a consequence of changes in medication; conditions requiring palliative care in the last stages of life; or carer burn-out. However, participants acknowledged that each of these conditions, although sometimes relatively straightforward medically, might involve a mix of complex social and psychological factors well beyond the capacity or expertise

of acute care to deal with alone – particularly given the risks that face older people once in hospital:

'It usually comes down to... people becoming unable to cope alone or their carers can't cope or their care falls through and they end up coming in... There are a lot which are preventable. The mind-set is to go to hospital... [But] once patients come in they fall into the 'ill role' and they deteriorate in terms of independence and confidence... Everything should be tried before hospital.' (Senior Staff Nurse)

Local service responses

In response to a series of national policy drivers and local pressures, all three trusts had developed a series of initiatives to help divert older patients away from hospital. Some of these were based within the emergency department itself, as a form of triage and diversion at the 'front-door', while others were more community-based (either reaching out from the hospital into the community, or in from the community to the hospital). Overall, there seemed to be three broad service types:

- 'Rapid Response' initiatives, made up of various professions and usually led by occupational therapists or physiotherapists, and including nurses, community matrons, care assistants and rehabilitation assistants. These teams can carry out assessments in the emergency department or in the community, and are typically set up to provide a response within a few hours of referral with a view to preventing the need for a hospital admission. Sometimes they were called directly by paramedics attending a patient in their own home. They are able to liaise with GPs and to refer to other agencies (including social care and the third sector).
- 'Discharge to assess' teams, which can provide a thorough assessment at home for older people who have been assessed in A&E as not requiring acute admission.
- Specialist community teams, including community respiratory services, community falls services, community intravenous (IV) teams, and so on. These may consist of a range of professionals, but are primarily nurse-led. Their aim is to help to enhance older patients' abilities to live independently in the community, and thereby help avoid or delay hospital admission.

Some hospitals had also developed specialist short-stay wards for frail older people who

might not need an admission for medical or surgical reasons, but who might need observation and support (perhaps for up to 48 hours) before being potentially ready for discharge.

Key to the effectiveness of these services was felt to be a broad understanding of the sorts of physical, mental and social problems older people face in the context of their daily lives; teamwork; and a detailed knowledge of local resources outside the hospital:

'I would massively commend the therapy services within the department; they've forged huge links with their colleagues and services in the area. They have real intelligence about what's out there and who to talk to. It would take me a long time to talk to someone to work out what's there.' (Matron Hospital)

Also significant was access to consultant geriatricians. Such expertise, when available, was seen to have a 'trickle down' effect, and to complement and build the skills of other staff: *'I think having the elderly consultants in A&E has developed the juniors' approach to frail elderly people, there's a greater wealth of knowledge among our own team that has come from them... Our nurses now have a greater awareness of the importance of cognitive assessment of patients and how to manage delirium and that sort of thing. So I think it does have a knock-on effect and hopefully an on-going effect.'* (ED Consultant)

However, this expertise was felt by many to be in short supply compared to the extent of local need:

'We can't see every older patient who comes to hospital – 30,000 patients aged over 75 come to us a year – so we are tickling the surface really.' (Consultant Geriatrician)

Accessing alternatives to hospital

Participants felt that the wide range of different services which existed to prevent admission to hospital were extraordinarily complex – both for staff and for older people and their families. Some were felt to have long waiting lists (which effectively defeats the point of a service seeking to prevent admission), and many seemed to have different operating hours and eligibility criteria. Many professionals who took part clearly did not know about the services which other participants (sometimes in the same trust) told us existed locally, and lots of people found the current array of different initiatives bewildering.

Such a situation attracted significant frustration and anger from a number of participants, who felt that hospital might often be the only option if the potential alternatives were simply too complex to access in a timely manner.

Many people also expressed sympathy for older people who might proactively be seeking alternatives to hospital or help in a crisis:

'People just don't know where to go. If you're from a healthcare background, you may have a small chance, but other than that, they've absolutely no idea where to begin. Even the GP surgeries aren't providing them with the information. There doesn't seem to be any public information out there... What if you're just struggling and life is getting harder? No-one knows where to begin.... There's a massive assumption that the elderly person can pick up the phone or has a computer... And once you get through... the telephone waiting time is horrendous. We have clocked up 90 minutes of waiting.' (OT)

In particular, the process for accessing different services was felt by some to deter all but the most resolute people. We heard many stories of older people who had tried to get help but had lost heart, sometimes with serious – and often wholly avoidable – consequences:

'I'll give you a simple scenario, I know a woman who came to the hospital. She was a dementia lady and she was struggling at home; she was being looked after by her husband. He'd been given a contact number for a social worker, he'd been trying to get hold of social services just to arrange some support at home, some sort of care, and he was trying to look after her at home but she was incontinent, she was confused, so he was trying to look after her but he waited so long and didn't get any contact that she had to be admitted. Now that's a scenario where if we had a better service where social input could be provided quicker, that scenario could have been avoided. And she hasn't gone home now; she had to go into a home. If she'd had care in the home environment then that whole scenario could have been avoided.' (Physiotherapist)

Each of the trusts in our study operated across a number of local authority and other service boundaries, and services that were available in one area might well be unavailable in adjoining ones. This made referrals difficult:

'We have certain services which are provided for the patients of [names two adjoining areas]. They are geographical areas which don't mirror the geography of the hospital and so you end

up trying to make referrals for patients only to be told "well, they're not in our postcode area so we don't provide this"... You get batted backwards and forwards.' (Consultant ED)

Of course, a counter argument to this might also be that large hospitals may fail to mirror the boundaries of local authority and community partners – meaning that one council or community service may have to work with multiple acute providers, each with different access points, criteria and approaches. However, the fact remains that the picture painted in our interviews was of a health and social care system which was incredibly dense (on the one hand), yet also seemed to have lots of holes. For many participants, it was often easier to admit someone to hospital than it was not to – because an alternative either did not exist or was perceived as too complicated to access.

Practical suggestions for the future

In each interview, participants were asked to suggest up to three things they thought would improve practice. A wide range of responses was offered, most of which can be broken down into a number of overlapping groups:

- The call most frequently made was for more – and more easily accessible – social care. Examples included a call for more and better trained carers, more social care services, easier access to social workers, better integration of health and social care services, more efficient 'single points of access' and shared information systems: *'I think, if you start at the bottom, it's about improving access to social care and assessments for social care... Social care has to change radically... so, rapid response from social care is the first thing that would help avoid admissions significantly.'* (GP)
- Communication between health and social care – and better advance information on patients' health, wishes and needs, were also mentioned. Different aspects of communication were highlighted: *'We need responsive, credible alternatives outside hospitals for when things are going wrong; so if you're the daughter, district nurse, GP or a care worker you need to be able to pick up a number and something will happen within the next few hours to assess the person and provide the additional support they need to remain in their own home. All of this could help*

but they are not mainstreamed and are patchy. We have services which, if we had the capacity, could be used more.' (Consultant Geriatrician)

Communication was also crucial in terms of access to information for older people and their families:

'When you talk to the elderly about what they want to know, they want to know what to expect, what are the options They don't know the pathway they would be following... All of our complaints are about communication problems: someone hasn't communicated what the problem is and what's being done. So for the elderly population we need to make that information more accessible. If you are having problems with your mobility go and see your GP, and this is what you can expect. Making that information available for the elderly and their younger carers or family would take a lot of those dependencies away.' (ED Consultant)

Many professionals referred to advance care plans as a valuable strategy to help them understand what patients want in the event of crisis, particularly as they near the end of their life:

'We need to talk to patients and families about their choices and put advanced care plans in place at the earliest possible time. Hospital isn't always the best place to be: you can be treated at home in your last days and opt for that if you want it. Sometimes it is very clear they are not going to be fixed; the hospital cannot do anything for them. They need to go back home or to the nursing home. In these situations we need to be more forthcoming in sending them home. We can use comfort treatments to make people comfortable and many of these don't need hospital at all: these treatments are equally as valid as more aggressive ones.' (Senior Nurse Hospital)

More generally, a number of participants felt that there could be some merit in having a plan to follow in an emergency, with details of current services, who to contact and a sense of the person's wishes to help make informed decisions in tight timescales:

'A "Plan B" of sorts on patient records, so if something goes wrong or one part of their care breaks down everyone would know what the contingency plan was.'

'Then everyone is ready to move as quickly as possible. It would be like a care file social workers may have, but be wider for their health and [social] care needs... people are of course people and one plan cannot cover all the reasons their plan may break down or they may need or wish to come into hospital, but having something there, someone to call, someone ready to step in to help would be beneficial in preventing crisis and patients coming into hospital because there is simply no other support.' (Physiotherapist)

- There were calls for increased provision of services currently available in hospital in community settings – for example, more day hospitals, access to transfusion, IV antibiotics:
'My experience is that the more criteria you put in the way, the less effective services are. You don't know what every patient needs until you get them. So the whole point of reducing barriers to accessing services is going to be critical for the NHS as a whole... Not many people get admitted when they go to out-patients. And yet if you have exactly the same patient with the same symptoms going through an

acute medical take, it's amazing how often that patient would end up being admitted briefly.' (Consultant AMU)

- It was not just a question of quantity of provision, however. Crucially there were calls for hospitals to act differently and for their skills and resources to be made more widely available. At the heart of this call was a reconsideration of how ambulatory care should work:
'We must look at doing things we normally would use a hospital bed to do, but do them differently... It's a push towards proper ambulatory care and having the hospital involved in the community... It's never quite worked because of that word avoidance. You don't want to avoid the hospital; you just want to avoid being in it overnight... We don't admit anyone with TIAs for example... You need the hospital to be extremely responsive to the medical needs of the patient, and you need the community to be extremely responsive to those patients to pick them up instantly when required. I've never seen anything work that fast. Confidence and responsiveness, that's what is necessary to make it work' (Consultant AMU)

- A key link in the chain of events that can lead to emergency admission is the person who first responds to the emergency call. Paramedics, including 'rapid response' teams, are able to make decisions on the spot about a patient's needs and have an insight into their home environment. Some are more highly qualified than others, and there was concern that some staff, particularly ambulance crews, sometimes deferred too easily to hospital admission. Many professionals felt that in some cases a home assessment could give a better understanding of the patient's condition and needs than one in hospital:
'We see some whom we do turn around the next day and send home, so you wonder if they need to be admitted in the first place, or could a high-end paramedic assess them? Maybe they don't need to come in at all. Perhaps they just need their toilet seat raised or the bed downstairs whatever. But once they come to the medical department they are by definition medicalised.' (A&E Consultant)

MULTI-DISCIPLINARY PROFESSIONALS: FEEDBACK ON CASE STUDIES

One focus group was held in each of the three hospitals in November 2015, with a total of 22 people (see Table 8). Fifteen of these people had also taken part in the telephone interviews, and seven were participating for the first time.

The aim of the focus groups was to explore the issue of 'in/appropriate' emergency admissions by examining the experiences of individual patients through three case studies, based entirely on extracts from interviews with patients in our study (see Chapter 5 for further details of the experiences of older people). Each was chosen because it depicted a key theme raised in a number of our interviews (for example, being admitted to hospital after a fall). Each focus group was presented with the same three case studies (see Appendix G). There was recognition by all participants that what they were presented with was not necessarily the full picture and that patients could be forgetful or selective in what they said about their experiences. Nevertheless, there was general agreement from all participants that the case studies were familiar scenarios which they might encounter in their own hospital on a regular basis.

Table 8: Focus group participants

Professional background/role	Site 1	Site 2	Site 3	Number
Consultant geriatrician	4	2	1	7
Consultant (palliative care)	1			1
Consultant (acute medical unit)	1			1
Matron/ward sister	1	1	1	3
OT manager/OT	2	1	2	5
GP		1		1
Service navigation team leader		1		1
Senior mental health practitioner (social care)		1		1
Community nurse practitioner			1	1
Falls sister			1	1
TOTAL				22

What follows is a brief commentary on the reactions of the professionals to each case study.

Mr G

Mr G is an 86-year-old man living alone, who was admitted to hospital following a 999 call from his neighbours. They had been summoned after he pressed his pendant alarm and found him lying in the garden having fallen while hanging out some washing. Mr G remained in hospital for four nights. A community matron did a follow up visit on his return home.

Although we do not what caused his death, the research team were contacted a few weeks after his interview to say that Mr G had sadly died. This may be entirely unrelated to the admission described in this case study, but it does suggest at least a possibility that he was more unwell than his account suggests (which might have made his admission more justified than perceived by our focus groups in the current case study).

There was unanimous agreement from all the professionals that, on the information available, Mr G did not need to be admitted to hospital and that his four-night stay was unnecessarily long. Professionals in each area talked about the different responses which may have been made depending on who arrived at the scene following the 999 call. They felt that ambulance crew or paramedics with less experience and training would be more likely to take Mr G to hospital without seeking alternative assistance. They suggested that assessments in the home could have been done by Mr G's GP, a district nurse or community matron. If none of those people were available, an assessment could have been requested from some kind of rapid response team. Knowledge of and ability to access local resources at this initial stage was therefore critical.

Similarly, once in A&E, the knowledge and expertise of the person who assessed Mr G might determine what happened next. Early access to a geriatrician was regarded as desirable. One geriatrician commented that staff without experience of older people and their conditions are sometimes 'frightened' by them and are more likely to be risk-averse and admit them because of their seeming frailty. The day and time of admission to A&E was also identified as significant. Although one hospital said it was trying to extend OT presence in A&E until 8.00pm, they recognised in many hospitals most therapists would not be available after 5.00pm. Given that Mr G did not arrive in A&E until about 4.00pm the professionals were not surprised that he had been admitted, although some felt that in their areas, even at that time, resources could be set up in the community to enable him to go home and not be admitted.

All the professionals who took part were concerned about Mr G's four-night stay in hospital. One focus group talked about him being 'driven into the deeper hospital' and their belief that 'every ward move puts a day on your length of stay.' Another group confirmed that ward staff would have less knowledge and less access to some of the admission prevention services than A&E staff. For example one participant said: *'Our admission-prevention beds in intermediate care units, the moment you've hit the ward, you no longer fit the criteria.'* (Hospital Matron)

One consultant identified a patient's family as a critical factor in determining length of stay: *'You need family in my experience to be fighting your corner sometimes or else things just roll on and you just wait.'* (Palliative Care Consultant)

One focus group speculated that communication between different parts of the hospital may have been poor and contributed to a delay in Mr G's discharge. They wondered whether different specialists had had conflicting views and asked for more investigations to be done. In terms of Mr G's overall experience, all the participants were concerned about what appeared to be the lack of communication between the hospital and Mr G. They thought that no one had taken time to talk to Mr G about what had happened, his condition, why he was being kept in hospital and what he might like to happen next. They all commented on his seeming deference to the medical staff from the point of admission when he said:

'If you're in that situation you can't refuse, because if they think it's the best thing, well, they're the experts.'

A consultant described it slightly differently: *'It looks like the old fashioned Health Service approach of "we know what's best for you" applied here; he didn't seem to have much say in what happened to him which I think is very wrong as well.'* (Consultant Geriatrician)

Mariam and Hamza

Mariam was diagnosed with dementia six years ago. She has lived with her son, Hamza and his wife, Noor, for 20 years. Mariam received four hours of support per week from a local carers support network. Mariam had three recent visits to A&E, resulting in two admissions within the space of three weeks, having deteriorated physically and become doubly incontinent. After the third visit, Mariam was in hospital for five weeks. In hospital, Mariam received physiotherapy, had her medication reviewed and on discharge she now attends a day centre three days per week. Hamza and Noor report they continue to struggle and feel very alone in a complicated system.

All the participants agreed that Mariam's second admission to hospital was appropriate but may have been a result of inadequate investigation during her previous stay.

One participant reflected:

'When you pick it apart and you think actually the patient ended up in A&E twice, being assessed twice, taking up twice as much resources, so actually by trying to avoid it you end up doing more.' (Consultant Geriatrician)

All the focus groups felt the final admission was a reaction to a crisis which to some extent was predictable. They felt that, had Mariam and her family received more support in the past six years by way of care, regular review, peer support and access to information via organisations like the Alzheimer's Society, this crisis may not have occurred in the same way. Although Mariam's admission to hospital was primarily medical, once a comprehensive medical assessment had been done, they wondered whether community services could have supported her more quickly. Suggestions of those services included a Rapid Response Community Support Team, Home Treatment Team for Mental Health and voluntary organisations.

Mariam's case was seen as a prime example of the 'silo mentality' within which different specialisms within the NHS and between the NHS and social care agencies work.

One participant summarised:

'I think this really highlights how unjoined up the system is because you come in and you get what looks like a reasonably good medical outcome for what was happening and she's a bit calmer and so on. But it's not joined up in any way with the chronic disease and the psychiatric aspects of it and the social aspects... It solved a problem but it wasn't holistic was it?' (Consultant AMU)

The focus group members were concerned that although Mariam may have been in a better physical condition when she left hospital, it did not appear that Hamza and Noor felt any happier about her care and the complexities of negotiating a complex system of services. There was some discussion in one focus group about the way in which care planning is better established within palliative care, cancer care and within community mental health services for younger adults. In this situation, they felt someone to help 'navigate' the system would have been helpful. Some people felt that accessing services from hospital was easier

than from within the community and often easier via a professional than from a self-referral.

Mariam's case stimulated a lot of discussion about the advantages of specialist dementia units within hospital, as Hamza had stated he felt his mother should not have been in acute care but a more specialist unit. Some people reported that the evidence for the success of specialist dementia units was inconclusive and gave examples of units they had known. On the one hand, there were strong arguments for having dementia-friendly environments, open visiting and staff with specialist training to improve the experience of/outcomes for patients with dementia. On the other hand, when older people are acutely unwell, participants felt they need access to acute hospital care, regardless of a diagnosis of dementia or not. The lack of specialist training in dementia care for all staff was identified as a concern in each focus group.

Cultural expectations about care of family members was a topic for discussion in each of the focus groups. While participants made clear they did not want to fall into making the stereotypical assumption that people from minority ethnic groups want to 'look after their own' family members to the exclusion of other care, there was a statement from Hamza that, as the eldest son, this responsibility fell upon him. He had also given some indication that his mother's care caused some friction between him and absent family members. It was unclear in the case study, therefore, whether care had been offered and refused and to what extent more care would be accepted in the future. However, there was a suggestion in one focus group that early discussion at the point of diagnosis of dementia about how the condition was likely to progress, what kind of care may become necessary and how that care and support could be shared between family and other agencies might facilitate a more open discussion between family members about roles and expectations.

In terms of Mariam's experience of the health and social care system, there was general agreement that the quality of health care she received in hospital appeared good, with her physical health improving. However, there was concern that there did not appear to be sufficient support for her from health or social care services prior to her admission and little evidence of co-operation between services upon discharge. The sense of isolation and confusion

conveyed by Hamza and Noor at the end of the case study worried focus group members.

Mrs F

Mrs F is a 71-year-old woman living with her husband. She was admitted to hospital for one night via A&E with breathing problems related to COPD.

Opinions were mixed about the appropriateness of Mrs F's admission to hospital. The initial response of some people was that the admission was definitely not necessary and that Mrs F could have received support from community specialist services, such as a respiratory nurse. In some places, this included a 24-hour phone line staffed by a clinician. This view was supported by Mrs F herself saying:

'There isn't any real alternative. It's not an emergency in the sense of emergency. But you're not given any other choice. You either sit at home or suffer, or you go too hospital I suppose.'

Other people supported an alternative view: *'Well, yeah, but it's very hard to make a call. I mean, you and I, if we were stood next to her and she couldn't breathe in the middle of the night, we would send her to hospital.'* (Consultant AMU)

Some participants picked up on the fact that this admission was on a Sunday and Mrs F stated her problems often happened when medical staff were not easily available. They speculated that this may have meant some additional anxiety on the part of Mrs F and her husband that made admission more likely.

What concerned all the participants was whether Mrs F had an existing care plan and what the follow up arrangements were from this admission. One participant summarised his concerns:

'It doesn't sound to me like that loop has been closed. You know let's assume she needed to come to hospital, she's come, she's got better, she's gone home. But what's been done to stop her coming next time?' (Consultant Geriatrician)

There was no indication in the case study whether anyone had discussed fully with Mrs F what COPD involved, how it might limit her activities, what support she could access to live well and how the condition might progress.

The convoluted referral of Mrs F to the respiratory clinic on discharge astounded most participants. Mrs F described the process as:

'The doctor in the hospital gave it to the respiratory woman in the hospital, to give to me, for me to give to the practice nurse, but she's got to refer to my doctor to send off to these people.'

The staff saw this as both an inefficient referral process and one which Mrs F was not inclined to engage in. They thought that after two months of hearing nothing, Mrs F would have begun to lose her trust in her GP.

There were varying opinions about Mrs F's view of hospital as *'a bit of a sort of factory production line.'* Some people acknowledged that in an emergency situation she could have been on the receiving end of a barrage of tests and treatments which may have felt a little impersonal, but were not too worried if it was an effective process which gets the patient out quickly. In one focus group, the comment led to further discussions about the pressure experienced by staff in A&E departments to achieve rapid throughput of patients, which sometimes changes the nature of communication with patients. They felt the public's expectations of A&E services need to be managed, and feared that in some cases emergency services were being used to alleviate longstanding health problems rather than for genuine emergencies.

One person commented:

'We hope within that production line we try and retain our empathy and sensitivity and compassion, but we don't always get it right, do we, and people feel that de-personalisation.' (Consultant Geriatrician)

This de-personalisation may have accounted for Mrs F commenting that she would have preferred to go to *'a more local, smaller, cottage-style hospital.'* However, some staff felt the emergency care she needed would not be available in such a unit, but acknowledged that a more local facility may perhaps have felt *'kinder and more personal.'*

In terms of Mrs F's experiences of health services, the majority of focus group participants thought the quality of care appeared good and appropriate at the time of admission. However, they were concerned that the patient may not have known of other alternative resources prior to or post admission, and that a further re-admission may have been likely at a later date.

SUMMARY

The telephone interviews and focus groups drew upon a wide range of experience within acute and community services (in case study sites who have been working on the issue of emergency admission for a number of years). Overall, a number of common themes emerged in terms of perceived problems and potential solutions.

1. PROBLEMS

A drive towards 'the deeper hospital': there was broad agreement that the key stages at which meaningful alternatives to admission could be offered were before or at the time of assessment in A&E. Once older people were admitted from there into the medical wards of the acute hospital, most professionals felt they had entered what some referred to as *'the deeper hospital'*, where the advantages of specialist medical interventions could be outweighed by risks of loss of independence. If older patients were to be deflected from admission and/or discharged quickly then the ideal place for intervention was in those early stages of the pathway into hospital, ideally before they got to the hospital door, but certainly soon after. This of course depends upon correct identification of those patients for whom alternatives are viable, which is itself a matter for skilled assessment of a sort more likely to be offered by specialist geriatricians than more junior doctors or those without particular expertise in the needs of frail older patients. There was universal agreement that the sorts of services that might help, particularly those involving some kind of social care, were difficult to access for professionals and patients alike.

Communication: establishing effective communication with patients and between professionals is a key factor in both preventing admissions and reducing hospital stays, but is subject to a number of problems. Patients need to be kept informed about the nature and prognosis of their condition and what specialist community resources might be available to them to help them manage long-term conditions. Once in hospital, patients have a right to know what is going on with their care and what the future options are, in particular regarding discharge and ongoing support.

However, communication between services is no less important. We heard of many problems in accessing services, particularly across the health-social care divide. Services were felt to be poorly co-ordinated, and patients as well as

professionals experience them as fragmented. The idea of a single *'navigator'* for patients with complex health problems was mentioned by several participants, akin to those staff assigned to patients receiving palliative care or community mental health services (albeit the potential irony of this is that it might add one extra layer – and hence even more complexity – into an already bewildering system).

The nature of older people's circumstances and admissions: most participants said that their hospitals experienced a number of avoidable admissions, although there was no consensus on the extent of this. Moreover, while some admissions were felt by some to be unnecessary, initially simple categorisations of *'social admissions'* or *'inappropriate admissions'* quickly became more complex as participants reflected on the inter-related nature of medical, social and psychological factors at play and the need for some sort of emergency response and/or further investigations (which might be provided in another setting, but were often easiest to provide quickly in hospital). Even where an admission might not be needed on paper, participants could often see how it might have happened in practice depending on which person carried out early assessments, when older people reached hospital and/or how easy local alternatives were to access. The decision to admit a frail older person (or not) was felt to be difficult (and sometimes seemed contested in our focus groups), often being seen as the best option at the time, given the nature of the crisis, the clinician's knowledge of the patient and of what constitutes a normal state of health for them, the person's personal circumstances, and the range of alternatives available at the time. This is true during *'office hours'*, but might especially be so at other times.

Access to community services: there was a strong feeling that it need not be like this. The main obstacle to reducing emergency admissions for frail older people was felt to lie in the complex landscape of community health and social care services, both upstream and downstream of the emergency department. The problem was not so much that such services did not exist, but that they are too few and that what exists may be insufficiently resourced, insufficiently co-ordinated and/or difficult to access when needed quickly. Hardly surprisingly, many participants seemed to lack comprehensive knowledge of alternatives to hospital, and many speculated that this

complexity must make it impossible for older people to navigate their way through community alternatives. In particular, participants were critical of the current availability of social care, which was seen as vital to the safety of frail older people at home, but also difficult to access and unlikely to respond quickly enough to ward off a crisis. With only one person from social care participating, we were unable to obtain a counter view – although the difficulty we experienced recruiting participants from a social care background may be a case in point of the pressure social care services are under.

2. SOLUTIONS

As with the literature in Chapter 3, a number of potential solutions were put forward, although again these had something of a 'scatter-gun' feel (that is – there might be scope to reduce admissions if we had more of X, Y and Z – and if it was better/easier to access). While these views were strongly held by a number of individual participants, some felt a little speculative (we think it would be better if we had X, but nobody really knows for sure). With these caveats in mind, however, there were three common themes:

Expansion of community services: upstream, there was a strong call for better access to health and social care for more people in the community. This would require an expansion of social care, which was seen as chronically understaffed and underfunded. There was also a perceived need for older people themselves to be more aware of what they can ask for and how they can get it, so that they do not reach crisis in the first place. GPs may be crucial links in this chain, but participants raised broader questions around how best to increase confidence in older people to ask for help in good time. There were also calls for the greater availability of diagnostic technologies, blood transfusions and IV antibiotics in community settings.

Good assessment and post-assessment decision making: whatever alternatives to hospital are in place locally, they cannot work well without skilled and experienced assessors to identify the needs of older people in a timely, comprehensive manner and signpost people accordingly. Access to senior decision makers with expertise in working with older people and

detailed knowledge of local services was felt to be paramount. Geriatricians were felt to be a particularly important but scarce resource in this respect – but other types of worker were also mentioned (for example, OTs). Some participants felt that easily accessible care plans could help professionals who came in contact with the older person at the point of crisis to make better, more informed decisions about their care and help avoid a hospital admission. If the care plan provided details of the older person's health and social needs, services currently in place and who to turn to in an emergency or for advice, the older person may feel their wishes were respected and they would be more likely to get appropriate care.

Discharge to assess: downstream, there was a call for services such as 'discharge to assess,' which could allow for a patient to be discharged without having been admitted to acute care with a thorough assessment of needs to follow shortly afterwards. There was a perception that rapid response services, although valued, could sometimes be too slow to mobilise.

There was also a desire for more social care services, as well as better liaison between health and social care so that patients could be discharged more quickly and with the right levels of care in place.

Overall, the picture of emergency admissions that emerged was of rising levels of need and demand, with a series of sometimes piecemeal community initiatives/alternatives developed over time. Although these were valued in their own right, there was nevertheless a feeling that existing alternatives to hospital were not sufficient (in terms of capacity, consistency of approach or speed of response) to divert potentially avoidable admissions. As a result, hospital still seemed a default response to many participants, with insufficient community alternatives to bring about a genuine shift in service provision. Whether a similar view would have emerged had a greater number of social care participants taken part is not clear – although the fact that we were only able to recruit one person from a social care background may suggest a situation of 'chicken and egg.' With these findings in mind, we now turn to older people's lived experience of emergency admission (see Chapter 5).

5. The Experiences of Older People

This chapter explores insights gained from our interviews with older people and consultees. After some brief demographic data below, we review people’s experience of admission and their views around scope for prevention, comparing and contrasting this where possible with the views of the older people’s GPs, social workers and hospital doctors.

In total we spoke to 104 people aged 65 and over across the three trust areas between June and December 2015. This included 91 older people and 13 family members acting as consultees (although all quantitative data below is reported on the basis of 104 participants, irrespective of whether data came from the older person themselves or a consultee). There was an almost even divide between men and women, with 51 men and 53 women taking part. Despite the fact that one of our case study sites was based in a multi-ethnic inner-city area, the majority of the sample was white (101 out of 104 people), with two people from a Pakistani background and one from an African-Caribbean background. The age range of our participants is provided in Table 9. Sixty people (58%) lived with a spouse, while another 27 people (26%) lived alone. Eight people (8%) lived in sheltered accommodation, six (6%) with a family member other than their spouse, two (29%) in a care home and 1 (1%) with a live-in carer. Thus the vast majority were living with someone else or in a setting which ensured they had professional help around them.

1. ADMISSION TO HOSPITAL

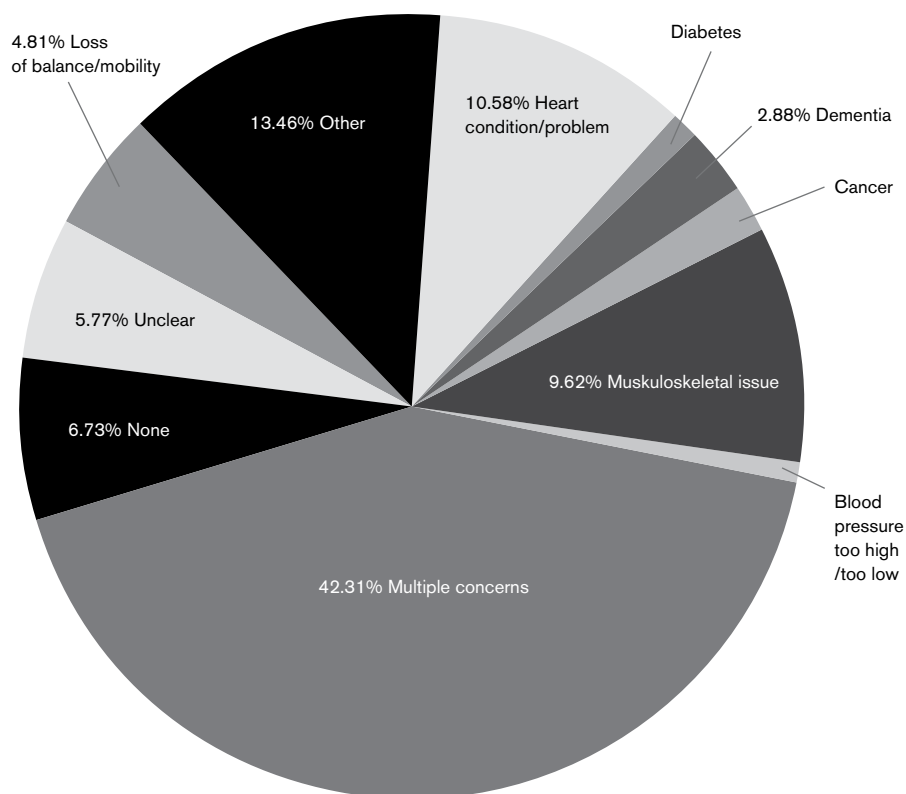
Pre-existing conditions

Forty-four people in our sample (around 42%) had multiple, pre-existing health concerns at the time of admission. The complexity of these cases and their ongoing health concerns often played into their need for admission and could be both medical and social at the same time (for example, limited mobility due to arthritis or increasingly poor eyesight, making it hard for the person to cope alone at home – before a final medical emergency led to hospital admission). Other people had single health concerns, for example heart problems or musculoskeletal issues (see Figure 1). However, seven people (just under 7%) had no pre-existing health conditions at all at the time of their admission. This suggests a spectrum of situations, from full health to living with a single condition to living with a series of multiple and potentially deteriorating conditions.

Table 9: Age range of participants

	Number	Per cent
65–74	31	29.8
75–84	32	30.8
85–94	26	25.0
95–104	4	3.8
Unknown/refused	11	10.6
TOTAL	104	100.0

Figure 1: Pre-existing health conditions of sample



Whatever prior health concerns participants had at the time of admission, 46 had no contact with health and social care professionals in the four weeks leading up to this (see Table 10). Another 45 people continued to have their regular interaction with health and social care services in these four weeks. While six of these people were admitted as emergencies after such planned visits or appointments, there

is no indication from the remaining 39 older people that the likelihood of a subsequent crisis had been picked up on during these contacts. This means that only 11 people in our sample had one-off or unusual contact in the four weeks prior to admission – this contact we have defined as something unusual sought by the patient in response to their growing health concerns, most frequently accessing their GP

Table 10: Pre-existing conditions and contact in four weeks prior to admission

Pre-existing conditions	Contact in four weeks prior to event				Total
	No contact	Regular contact with health and/or social care professionals	One-off or unusual contact	Unclear	
Heart condition/problem	4	5	1	1	11
Diabetes	0	1	0	0	1
Dementia	0	3	0	0	3
Cancer	1	1	0	0	2
Musculoskeletal issue	7	1	2	0	10
Blood pressure too high/too low	0	0	1	0	1
Multiple concerns	13	24	6	1	44
None	7	0	0	0	7
Unclear	4	2	0	0	6
Loss of balance/mobility	1	4	0	0	5
Other	9	4	1	0	14
Total	46	45	11	2	104

Table 11: First action after the event to seek help (number and percentages)

	Number	Per cent
Called 999	24	23.1
Called 111	12	11.5
Referred to daytime GP	23	22.1
Referred to out-of-hours GP	4	3.8
Used call centre help system	10	9.6
Self-referral to A&E	3	2.9
Family/friends/neighbours took to A&E	3	2.9
Admitted after planned appointment with or visit from a professional	6	5.8
Friends/family/neighbour called 999	12	11.5
Friends/family/neighbour dialled 111	2	1.9
Unsure or unclear	1	1.0
Spoke to care home/residential home/sheltered accommodation staff	2	1.9
Went to a walk-in centre	1	1.0
Called consultant	1	1.0
Total	104	100.0

Seeking help

Twenty-four people (23% of our sample) called 999 as their first course of action on deciding to seek help. This means that the majority of people either did something else as their first action rather than turning straight to the emergency services, or that a family, friend or neighbour called 999 on their behalf. Overall, roughly similar numbers of people dialled 999 (23%), contacted a daytime GP (22%) or sought help via 111/a call centre (21%) (see Table 11 for full overview). In around 13% cases, family, friends or neighbours called 999 or 111 on the older person's behalf. In contrast, few people went to a walk in centre (one person), went direct to A&E (three people) or contacted an out-of-hours GP (four people).

In terms of the speed of seeking help and the relationship with living circumstances (Table 12), 59% of those living alone sought

immediate help, compared to 75% of those living with a spouse. Eighteen per cent of those living alone left it more than one day or overnight to see if their condition improved on its own, while ten per cent of those with a spouse waited this long. Rather more of those with a spouse waited one day or overnight to see if their condition improved (6.67% compared with 3.7%; the equivalent to four people and one person respectively). Almost the same number of people from each group (three with a spouse and four living alone) waited for advice from family, friends, or neighbours before seeking help. Thus, living with a spouse might encourage one to seek help quicker than when living alone, perhaps because there is someone else to help make this decision or because another person can physically dial 999 while the older person is incapacitated. In contrast, some people living alone seemed to have been more likely to wait a little before requesting help.

Table 12: Participants' living arrangements and time elapsed before seeking help

Participant's living arrangements	Time elapsed between event and seeking help					Total
	Sought immediate help	Waited to see if family/friends/ neighbours could help	Waited to see if it improved itself (one day or one overnight)	Waited to see if it improved itself (more than one day or one overnight)	Unclear	
Lives with spouse	45	3	4	6	2	60
Lives with family member (other than spouse)	5	0	0	1	0	6
Lives alone	16	4	1	5	1	27
Lives in sheltered accommodation	7	0	1	0	0	8
Lives in care home	2	0	0	0	0	2
Lives with live-in carer	0	0	0	0	1	1
Total	75	7	6	12	4	104

Calling 999 and calling a GP were the two most likely first courses of action in a crisis whether the person lived alone or with a spouse at the time of their admission. Those living alone were far more likely than those living with a spouse to have a pendant alarm or other call centre system in place to use to call for assistance (six people living alone and one with a spouse), while roughly the same percentage of people from each group (13% for those living alone and 14% for those with a spouse) had a family, friend or neighbour dial 999 for them.

While the majority of people in our sample sought help immediately, there were still significant numbers of people living alone – over 18% – who left it longer than one day or overnight to seek help. For example, one woman in her 90s had a bout of shingles, but then also fell downstairs. Despite living alone, she did not seek help and it was only when her daughter visited that the woman was admitted to hospital. Another person talked about trying to avoid dialling 999 if at all possible (*'just gritted my teeth and waited till I saw a doctor'*) or about being conscious of being perceived as a potential burden on the health service:

'But I did feel as well – I know having [a] heart problem, whatever, I thought if I'd have had

that x-ray and they detected it wasn't a heart attack, I could have come home... Instead of taking beds up.'

A similar sentiment was raised by a consultee who, while discussing his mother's admissions to hospital, felt that she ended up staying in too long on most occasions:

'Yeah, you get her home more quickly. So, yes, but maybe there's underlying things there, we're still testing and you don't know and things might be taking time their side, but it's just a general feeling of, yeah, this bed blocking as they call it in the press.'

Although only a one-off comment, this use of jargon such as 'bed-blocking' and a reference to how these issues are discussed 'in the press' raises at least the possibility that some attitudes to hospital admission (from older people or their family) might be influenced at least in part by the policy and media debates discussed in Chapter 1 of this report.

Rather than older people being admitted to hospital unnecessarily, therefore, at least some older people seem to have delayed seeking help as much as they possibly could, possibly in response to internalising broader debates around appropriate usage of NHS resources.

Day and time of admission

Nearly one-third of our sample was admitted during 'office hours' – Monday to Friday, 9.00am–5.00pm – with just over another third admitted 'out of hours' (weekends and 5.00pm – midnight on weekdays). Otherwise, around 16% were admitted between midnight and 9.00am ('night') and around 17% were unclear or could not remember the date and/or the time of their admission (see Figure 2).

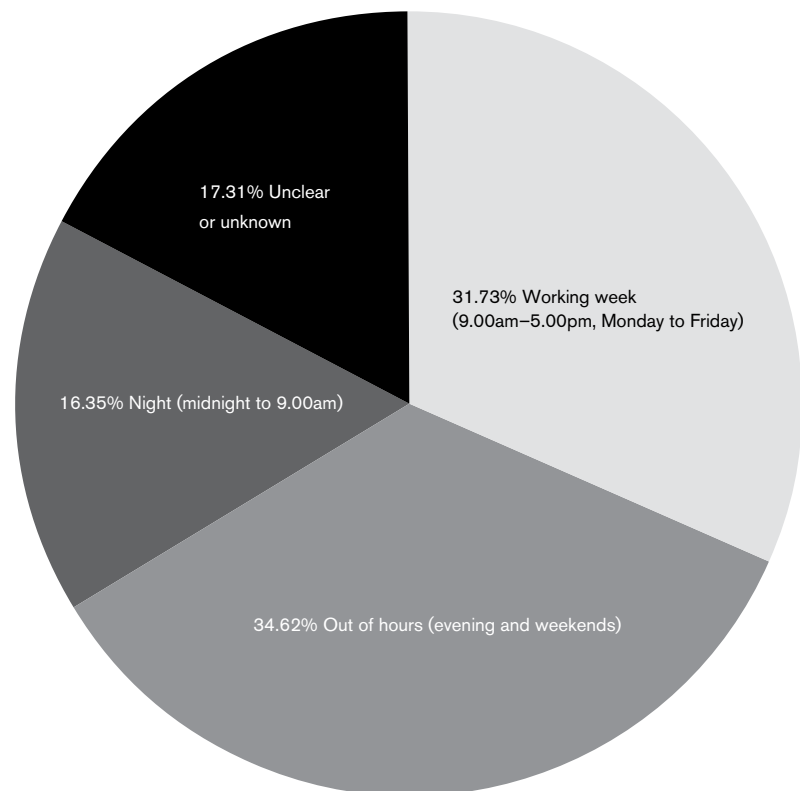
Appropriateness

The vast majority of participants (91 out of 104; just under 88%) felt that hospital was the most appropriate place for them (see Table 13). Four people were unsure, with only nine people feeling that hospital was not the right place for them (see Box 2 for more detail). Returning to the previous literature reviewed in Chapter 3, our study suggests a rate of 'inappropriate' admission (defined by older people themselves) at just under 9%.

Table 13: Whether patients felt hospital was the best and most appropriate place for them to be at the time of admission (number and percentages)

	Number	Per cent
Yes	91	87.5
Unsure	4	3.8
No	9	8.7
TOTAL	104	100.0

Figure 2: Day of the week and time of admission



Box 2: Older people who felt their admission was 'inappropriate'

Person 1: began to bleed acutely a week after a haemorrhoidectomy. The patient, on the advice of 111, went to A&E and was told they had been booked in. They were not asked what was wrong and spent a long time waiting in A&E, continuing to bleed. After examination the doctor told the patient the bleeding had stopped and the patient was left alone for some time further. The bleeding had not stopped, however, and became much worse during this time (with the person's blood pressure dropping severely). This person feels that if they had been seen earlier the bleeding could have been stopped in A&E and they could have gone home.

Person 2: felt unable to stand while washing up the dishes and dragged themselves to a chair. The postman arrived shortly after this and called an ambulance. The older person felt they should have been left to come round on their own at home and does not accept the diagnosis of stroke (which they received from the hospital), feeling instead they were 'off legs' due to anxiety and stress.

Person 3: was having breathing problems and associated chest pain. The person's daughter called an ambulance and the patient was taken to hospital. This person feels that the paramedics should have been able to assess how serious the problem was and let them stay at home to recover; they felt admission was ultimately unnecessary.

Person 4: had been experiencing acute vomiting and diarrhoea and was taken to hospital by a family member as they were in a lot of pain. The patient feels they were not given any real treatment in hospital and that follow-up care was poor – they therefore feel they would have been better being sent home from A&E.

Person 5: had been experiencing acute vomiting and diarrhoea and care home staff called an ambulance. This person did not feel the admission was needed as they had experienced similar symptoms before and they had cleared on their own: they felt they were not given a choice.

Person 6: was fighting for breath, and called 111, who dispatched a paramedic. This person was then taken to hospital and admitted, in part because they have a heart condition and staff were concerned the two were related. However the person's condition settled very quickly and the staff admitted everything they could try to investigate the condition had already been explored in previous contacts with the NHS. While the person feels they should have been sent home, tests in the hospital did show up a problem with fluid on the lungs (so the person was nonetheless pleased to have been seen in A&E). The person learned of this fluid after their hospital stay, during a follow-up appointment with their cardiac specialist.

Person 7: fell while bringing in the washing and was found by neighbours, who called an ambulance. The patient felt they could have stayed at home to recover or perhaps been taken to a smaller hospital: they did not feel they needed acute care. This patient was used as a case study for our focus groups and more detail can be found on him in Chapter 4 ('Mr G'). Sadly, Mr G died shortly after taking part in this study, although we do not know if this was connected with his hospital admission, or not.

Person 8: collapsed in the garden and neighbours called an ambulance. The patient understood they were taken in to be thoroughly checked over but contracted a vomiting and diarrhoea bug in hospital and therefore felt it would have been better not to have been admitted but checked over and sent home to recover.

Person 9: had collapsed a number of times and was admitted for tests. The patient's spouse gave the interview as the patient is now no longer able to speak for themselves. In hospital, the person's cognitive health and physical mobility deteriorated and they felt no further forward in understanding the problem. Therefore, the consultee felt the older person should have been sent home.

As the more detailed pen portraits in Box 2 suggest, even these nine cases seem more complex than simply being labelled as 'inappropriate'. Thus, one person seems to have been unable to stop bleeding, one person was diagnosed with a stroke, one person had chest pains, one person was 'fighting for breath' and had a previous heart condition and one person died shortly after their interview (although we do not know if this was connected to their initial hospital admission). Even though these nine older people felt that hospital was not required, there seem few clear cut, easy answers.

The views of GPs and hospital doctors

Although the key contribution of this study is its emphasis on the contribution of older people, we also sought the views of a GP, hospital doctor and social worker (if applicable) as to their

view on the appropriateness of the older person's admission(s). In practice, none of our participants said that they were in current contact with a social worker, and (as set out in Chapter 2) we also anticipated that surveys to busy GPs and hospital doctors some time after the admission in question might elicit a low response. In total, we received survey responses from 32 GPs and 13 hospital doctors (which was a much better response than we were expecting). In every case where an older person felt their admission to be appropriate and where we have data from a GP or hospital doctor, all parties agree that an admission was needed. Although we have fairly low numbers, this still seems significant. From the policy and media debates in Chapter 1 or the literature in Chapter 3, we might have expected cases where as older person felt they

needed to be in hospital, but where a health professional disagreed. However, we did not find a single case of this in practice.

Unfortunately we only have two cases (out of a possible nine) where the older person felt admission was unnecessary and where we have a view from a health professional (a GP in both cases). Interestingly, both disagree with the older person, stating that nothing could have been done to prevent the admission (Person 4 and Person 5 from Box 2) – albeit neither provided further detail beyond a statement that, for example, '*none; she needed admission.*' Thus, the 45 responses we have from health professionals suggest that none of the admissions in our study were 'inappropriate' from their point of view (a rate of 0% to compare with the literature in Chapter 3).

Factors contributing to admission

In addition to asking about perceived appropriateness of admissions, older people, GPs and hospital doctors were also asked for their views on which factors caused and/or contributed to the admission in question (medical, living conditions, informal support, formal support) (see Tables 14 and 15).

Table 14: Patients' views on factors most relevant to their admission

	Number	Per cent
Medical only	90	86.5
Medical and informal care	2	1.9
Medical and formal care	2	1.9
Medical and living conditions	9	8.7
Unclear	1	1.0
TOTAL	104	100.0

Table 15: GP and hospital doctor views on factors most relevant to patient admission

	Number	Per cent
Medical only	33	73.3
Medical and formal care	2	4.4
Medical, informal care, and formal care	1	2.2
Living conditions and formal care	1	2.2
Living conditions, medical, and informal care	1	2.2
Formal care and informal care	1	2.2
Unclear	6	13.3
TOTAL	45	100.0

In the vast majority of cases (87% of our sample), older people felt that their medical condition alone was the most significant factor in their admission. Nine people felt that their medical and living conditions were the main cause: all of these participants suggested that living alone had contributed to their admission, either because they had no one to call for help or because they felt the medical professionals had taken this into account when deciding to admit them. For example, one person felt that her medical concerns were the predominant reason for admission (chest pains) but that living alone contributed as she had no one to turn to for help, while another person suggested that he felt the professionals involved had not wanted to send him home potentially still bleeding when there would be no one to care for him or check on his condition. Only two people felt that their medical condition and informal care contributed to their admission, with one stating that her husband was unable to help with any of her ill-health concerns as he himself was very unwell and another consultee saying that she was unwell and so unable to provide extra support to her mother when her mother became unwell too. Another two people felt it was their medical condition and formal care that necessitated admission, with one feeling that the care home in which he lives is too heavy-handed in calling for an ambulance (even when the older person themselves may not want one to be called), and another mentioning that his carer did not arrive that day so he was doing things around the house which would normally have been done for him when he fell.

In all but eight cases GPs and hospital doctors felt the older person's medical condition was highly significant (scoring it '1' on our 1 to 5 scale). However, in only two of these eight situations was another factor assessed as '1.' In one case, the hospital doctor believes both formal and informal support were equal factors in determining this particular hospital admission, writing: *'GP home visit would have avoided ED admission and possibly having family lend support while [they] recovered from migraine' (hospital doctor).*

This doctor felt that this admission was not down to medical condition, giving it a significance factor of 5. In this case, the patient identified their medical condition and living

conditions as equally important factors in the admission, so the professional and patient were somewhat at odds. In the other case, the patient felt only their medical condition contributed to their admission, while the GP felt that their living conditions and formal support were most significant:

'Availability of social support and care [may have contributed], but needed to be available at short notice' (GP).

In the remaining six cases, GPs/hospital doctors were unable to see any one factor as highly significant to the admission.

In the one case where we have data from an older person, a GP and a hospital doctor, all three agree that the person's medical condition was the main factor in their admission.

The experience of people with dementia

A minority of participants in our sample had some kind of cognitive impairment: in each case a consultee gave an interview on their behalf. Most of these people came from one site (six participants, with a seventh person where dementia was queried but not confirmed), with one person coming from our second site and none from the third site. These consultees felt that the admission of their family member was appropriate at the time, except in one case (highlighted elsewhere in this chapter) where the consultee felt her husband's condition had deteriorated during his stay in hospital and they were not any closer to finding a clear answer as to why he was collapsing (see Box 2). All consultees felt that nothing could have prevented the admission, except in one case where the consultee highlighted the fact that the admission in question was a readmission and that the previous hospital stay should have dealt with her husband's concerns (which were not specific to his dementia) (see Box 2).

Despite this, consultees felt that admissions could be influenced by a perceived lack of awareness of dementia within A&E departments and the potential for older people with dementia to be admitted in part as a precaution. Often, the older person in question went on to have a long stay, which consultees felt was not always beneficial:

'I don't think that week in that particular ward did him any favours, and particularly when at the end of the week I was no wiser, and he was no better.'

'I think the dementia ward is good. But I think the rehab unit, if they've got dementia, they give up on them. And the rehab unit had him sent home. They discharge – oh, it was horrendous, actually. They sent him home. The ambulance people had a job – two of them – to transfer him from a wheelchair into his chair, and I said, "How am I going to manage?"'

Older people with dementia were also often part of a cycle of readmissions, which consultees frequently did not understand:

'You know what I mean? I mean surely they could have said: well, enough is enough. I mean how can that be cost effective, seriously? I mean if you want to be more pragmatic about it you can just say look, well you know one, two, three, four, five, six, seven, seven admissions in eight months, of which probably, of those eight months... say two-and-a half months was spent in [hospital]... Where do you draw the line?'

Two consultees told us their parents had vascular dementia and, in both these cases, there had been particular problems with repeated admissions. They also felt that standard 'dementia tests' are not geared towards vascular dementia, and so that the older person can pass the test and is not necessarily recognised as having dementia.

Once older people were given a diagnosis of dementia, social work professionals might have some involvement (although usually only after a crisis had occurred). Typically, however, this input was perceived to be very brief – often just a leaflet with information on dementia or about dementia awareness courses for carers (which at least three consultees had taken up), and then nothing further. Social support of any more depth was hard to come by and was seen as taking a long time to access:

'Well, I went on to social services... We've still not heard [six weeks later]. I wanted a home visit because... we're coping at the moment but I need somebody to come and see...'

Only one participant spoke positively of social service input, although this seemed to have been brokered by a community nurse and a carers' support network:

'No, but the nurse was – one of the district nurses put me onto [unpaid carers' support network]. I think she said, "Phone this number", and then it started from [unpaid carers' support network]... but I think once you get a problem like [my husband] has, you have to dig, and I just – well, I don't know.

He had to go to the hospital... to be assessed and, yes, he did have Alzheimer's. And they gave him a brain scan... But after that, there was sort of silence. And then the social worker – social services get involved. They sent me a letter: he's going to get this money every week. I thought, "Fine." Then, very slowly, ...[the] district nurse said, "Are you getting any help?" I said, "Yes, they send us this money for – you know, him being – having Alzheimer's." And she said, "Oh, you should do this; you should do that." So I did, and then I got a lot more help. But nobody actually – at the hospital, where they say, "Yes, he's got dementia", say, "Try this." You come out blank. You've just got the diagnosis.'

2. SCOPE FOR PREVENTION

As suggested in Chapter 3, our previous research into older people's experiences of emergency admission (the pilot for this national study) suggested a key distinction between debates around appropriate/inappropriate admissions (whether or not the person needs the services provided in hospital) and the notion of preventable admissions. Even where an admission is medically appropriate, there may still have been scope for a different course of action at an earlier stage to prevent the person's health from deteriorating to the stage where hospital is (legitimately) required. While only nine participants felt that their admission was 'inappropriate', we were also keen to ask about older people's views as to the scope for prevention.

The majority of our sample – 59 people (almost 57%) – felt that nothing could have prevented the admission (see Table 16). Interestingly, this includes one of the nine people who felt that they did not need to be in hospital at all (Person 9 from Box 2). This participant was a consultee, speaking on behalf of her husband. She felt that his admission to hospital had been a negative influence on his overall health (for example, in terms of a deterioration in mobility) and that the admission had not led to an answer as to why he was collapsing so frequently. While she could not identify any preventative measures, she did not feel that hospital was the right place for her husband.

Of the remaining eight people who felt that they did not need to be in hospital, four suggested what we have termed a 'better response earlier.' Thus, one person felt they should have had an earlier diagnosis allowing for planned treatment; one person felt there was scope for better use of an earlier attendance at A&E where they feel the problem should have been

dealt with; and the other two people were readmissions who feel their earlier admission should have resolved their concerns and that they should not have reached another crisis needing another hospitalisation. Another of these 'inappropriate admissions' wished to be allowed to stay at home and recover, feeling they were given no choice but to go to hospital, while another person felt that care home staff should not have called 999, ignoring the patient's own decision-making ability. The final two people in this group of people who felt that they were inappropriately admitted to hospital said that their own 'individual action' could have prevented the admission. This includes Mr G from Chapter 4 (who feels he may not have fallen had he not been trying to bring his sheets unaided) and one person who also felt that doing too much had caused her to fall, saying: *'Well, I should have behaved better. I think, really, that's the top and bottom of it.'*

As Table 16 shows, the largest preventative category from across our sample – whether the participant felt their admission was appropriate at the time or not – was a 'better earlier response'. This group of 12 people included:

- Six people who felt that an earlier diagnosis of their problem and/or subsequent planned treatment would have prevented admission – thereby saving subsequent distress and making better use of scarce NHS resources.
- Three people felt that an earlier attendance at A&E should have resolved their concern and that it was not used well enough by staff to do so (for example, as a result of failing to conduct a thorough assessment and/or not listening to the person's concerns fully).
- Three people feel that a previous hospital admission could have resolved their health problems, preventing the need for their subsequent admission.

As one person stated:

'This time yes, while I was taken in and dealt with straight away, the person that was assigned to me to take tests and things just did it for angina which I know I have and the end of the afternoon they said "Nothing wrong with you. Everything's alright." They didn't sort of even go into the part of the gall bladder type pain at all. Go home. So I did... and then the next day didn't feel much better so I phoned – they said phone the doctor. So I phoned... my GP and she came out and straight away said "You must go back because your [very high] temperature..." and things.'

Table 16: What could have prevented the admission (cross-tabulated with whether participants felt hospital was the best place for them)

What could have prevented the admission	Whether participants felt hospital was the best place for them at the time			Total
	Yes	Unsure	No	
Nothing	57	1	1	59
Better response earlier	8	0	4	12
Individual action	8	1	2	11
Easier access to GP or other community services	4	1	0	5
Review of medications	3	0	0	3
More proactive GP	2	0	0	2
Access to advice	2	0	0	2
Better or different care package	1	0	0	1
Better response from care home staff	0	0	1	1
Being given choice to stay at home and recover	0	0	1	1
Unsure/unclear	6	1	0	7
Total	91	4	9	104

'Individual action' was the next largest category (mentioned by 11 people). This includes people saying they should have taken more exercise over the years, drunk less alcohol or taken their GP up on the offer of tests to check the state of their health at various stages in the past. These suggestions tended to relate to long-term behaviours and/or the consequences of previous events – and seemed to us almost impossible to prove one way or another. While it is possible that drinking less might have stopped a subsequent health problem deteriorating and necessitating a hospital admission many years later, it just as easily might not have had this impact. For us, such responses may be more to do with broader debates about public health and lifestyle choices than genuinely/direct preventative measures – and these 11 people thus feel different to the 12 above (for example) who felt an underlying problem could have been dealt with upfront before a subsequent admission took place.

The next largest category (five people) was access to a GP or other community services. In the illustrative example below, the older person pointed out that she found getting appointments with her GP very difficult, despite her chronic health condition, and therefore sometimes ended up in hospital because she could not see her GP in time; in the case of her most recent admission she feels she had been given incorrect medication by a GP also. In general she felt her GP surgery did not proactively help her manage her chronic condition in the community:

'If I could get an appointment with my doctor... But it's just impossible. Even though I'm a renal patient, I'm prone to urine infection and I was admitted once because I couldn't access my GP to get the antibiotics. So they have to take me in to do intravenous.'

A review of medications – where incorrect medications were felt to have been given and/or where medications were perceived to be interacting in ways which produced an unwanted reaction in the patient – was suggested by three people as a possible preventative measure. For example, one person described the impact that she feels the combination of medications she was taking was beginning to have on her blood pressure. She says that she was recommended to go for a medication review with her GP by her eye clinic, but that the GP refused to carry this out, saying it was unnecessary and that she should wait for her six monthly review as normal. She was subsequently admitted to hospital as a result of high blood pressure and a stroke, which she attributes to the way her different medications interacted with each other: *'Because I feel that could have been – it could have been prevented... That's what I felt about it. Had he – had he given me the review I wanted of my whole tablets... because – and that's all it needed.'*

Two people also felt that more general access to advice could have prevented them from being admitted to hospital in a crisis, as they would have been better able to manage their own conditions:

'I think what one needs is easy access to someone who knows what they are doing... Or getting taken to a place where there is an informed professional [for advice]...'

Along with other more individual responses, given in Table 16, one respondent mentions that if their care package had been more robust this might have prevented them from going into hospital for a fall:

'I was, the only problem was, as I say, that evening I got up, I had a carer used to come in twice a day. And for some unknown reason that evening he hadn't turned up. So I know it's all ifs and buts but if he'd been here I wouldn't have got out of the chair.'

Box 3: GP and hospital doctor preventative suggestions

GP 1: *'Availability of social support and care, but needed to be available at short notice.'*

GP 2: *'Emergency outpatient clinic on the same day.'*

GP 3: *'If the medical team had an access to the patient's blood test results done in the community or discussed admission with the patient's GP.'*

GP 4: *'Better community care with management of COPD.'*

GP 5: *'Live-in carer or a move to a nursing home (which is now taking place).'*

HD 1: *'I know this [person] very well, having seen [them] frequently in outpatients. If we had the resources/capacity it may potentially help to reduce admissions if such complex patients who are already very well known to a service could contact us directly with any deterioration and be seen on the same or next day by the team that already know them.'*

HD 2: *'GP home visit would have avoided ED admission and possibly having family lend support while [they] recovered from migraine.'*

HD 3: *'If GP had telephoned the patient's infectious diseases consultant for advice rather than just sending [them] directly to AMU [Acute Medical Unit].'*

GP and hospital doctor responses

As with questions around the appropriateness of admission, we also collected data from GPs and hospital doctors in terms of their perception of the scope for prevention. Although all 45 of the GPs and doctors who took part felt that admission was appropriate, eight of these professionals could also suggest measures which might have prevented the person's medical condition from deteriorating to the stage where admission was required (see Box 3).

In two of the above cases we had a response from both GP and a hospital doctor for the same patient, but with the two disagreeing. GP 4 suggests that better community care to manage COPD would have prevented the admission, while the hospital doctor wrote that the patient's medical condition drove the admission and they saw it as unavoidable within the current system, the financial implications of their care being *'insurmountable'*:

'At the time patient required antibiotics, diuretics and appropriate fluid management and rate control; medication for [removed].

While it is possible to envisage a home service with sufficient resources to cover all these problems (as well as difficulties with mobility etc.) in practice this would look like a "hospital at home", which would have insurmountable financial implications.

This [person's] admission was due to medical

factors, and I think it unlikely that with care provided in anything resembling the current model [they] could have avoided admission. I therefore do not feel it was influenced by home circumstances, informal/formal support etc.'

Hospital Doctor 1 (HD1) also wrote that they feel the older person should be able to access their specialist team directly for support to prevent crisis admission. The GP, however, wrote nothing in the section on possible prevention solutions.

To some extent, the professionals listed in Box 3 mirror the findings of our interviews and focus groups in Chapter 4 by suggesting there may sometimes be scope for preventing an older person's medical condition from deteriorating to the stage where a hospital admission is required. With a quicker response, better communication and/or the better availability of social support, it is possible that some admissions – deemed appropriate on the day they took place – could nonetheless have been prevented. However, there seem to be few easy answers – and even the small number of cases cited in Box 3 involve an array of different circumstances and possible service solutions. Nor do the professionals always agree (as was the case in Chapter 4). While there may be some scope for prevention, therefore, it seems more complex than the policy and media debates highlighted in Chapter 1.

SUMMARY

Despite the different rates of 'inappropriate' admission cited in Chapter 3, the vast majority of our sample was admitted appropriately to hospital in the view of most older people and all health professionals who took part. The rate of 'inappropriate' admissions from our study is thus just under nine per cent (from the perspective of older people) or zero (from the perspective of the smaller number of health professionals who took part). Even where nine older people felt that hospital admission was not needed, many still seemed very unwell and/or this judgement is based on the benefit of hindsight. In the two cases where the older person felt admission was 'inappropriate' and where we also have a perspective from a health professional, the latter disagrees and feels that admission was the only option. Given the care with which we tried to design our methods of recruitment (see Chapter 2), we still did not find the potentially significant numbers of 'inappropriate' admissions implied in policy/media debates (Chapter 1), in some previous studies (Chapter 3) or 'guesstimated' by local practitioners (Chapter 4). Overall, very few people went direct to A&E, and a number of people sought alternatives before phoning 999 (even if living alone and sometimes seemingly very unwell/injured). While it is still possible that lots of 'inappropriate' admissions take place in our three sites (or that some older people allegedly access hospital too readily), we found no evidence of this.

As suggested in Chapter 3, even admissions which take place as a result of a medical crisis and where hospital is the only option might still be prevented if different actions were taken at an earlier stage. Discounting the 11 people who felt that longer-term lifestyle changes might have prevented their admission, 27 older people identified potentially preventive actions (mainly around a more thorough/proactive approach during previous assessments, A&E visits or hospital stays, or better access to their GP). Access to information and medication were also mentioned in a small number of cases. GPs and hospital doctors seemed in broad agreement, with a quicker response, better communication and/or the better availability of social support possibly making a difference to some older people.

If any current services are to adopt a more preventative role, then there may be scope to consider the role of:

- The ambulance service (given that a number of our participants – or their families – dialled 999, paramedics may have a key role to play in terms of initial assessment and diversion from hospital). This links to the points made by local professionals in Chapter 4 about the need to consider alternatives to hospital at an early stage, avoiding admission into the 'deeper' hospital.
- GPs, who were often contacted by older people prior to admission and who were felt to be able to adopt a more proactive approach in a small number of cases.
- Social care which, throughout various stages during this study, has seemed crucial but largely absent/lacking capacity to respond. Although it must remain speculation, it is possible that admission to hospital represents a key threshold for older people with deteriorating health, with little contact with social care prior to this.

More generally, a number of older people had a number of pre-existing conditions and/or had a series of contacts with services in the four weeks prior to admission – perhaps suggesting some sort of opportunity for prevention.

Despite this, most admissions were felt to be appropriate, and, at face value, there seemed few easy answers or single service solutions that could significantly reduce the number of hospital stays experienced by older people in this study.

Of wider significance may be the small number of consultees who took part in this study on behalf of an older family member with dementia. These participants felt that the needs of people with dementia may not be sufficiently taken into account by health workers who can sometimes lack the skills and knowledge to work effectively with people with dementia. Although only mentioned by two people, the needs of people with vascular dementia seemed a specific gap. Access to social care also seemed problematic, with very brief support only available after a crisis had already occurred and with little ongoing assistance (see Chapter 6 for further discussion).

6. Conclusion

In this research study we set out to understand the appropriateness of hospital admission for older people, looking at the issue from different perspectives, identifying where there may be scope for preventative measures to avoid admissions and contributing to key policy and practice debates. As we have reiterated throughout the report, these issues are long-standing, complex and contested and, as the literature review revealed, there is relatively little previous literature, providing only limited insights into potential solutions (see also Thwaites et al., 2015). We believe that this research study makes a unique contribution to understanding the issues by engaging older people in a meaningful way to gather their longer-term perspective on their health and what underlay their hospital admission, together with their views about what might have been done to prevent it. While this makes a significant service contribution, we also feel that it makes an important academic contribution by helping to re-frame a long-standing policy issue and to challenge the narratives put forward in policy and media debates. In this final chapter we summarise the main findings of the research and identify a number of overarching themes which may well have wider applicability to other health and social care services across England. Finally we identify the limitations of the research study and how they could be addressed in the future.

The professionals involved in this research study all perceived 'inappropriate' emergency admissions to be an issue in their locality, but there was little consensus among them as to the extent of the problem. Their responses also reflected those in the wider literature of the dilemma between admissions that were appropriate, given the range of resources currently available, but which nevertheless may have been preventable had other resources been available. While some professionals drew a simple distinction between 'medical admissions' (for which the clinical services of an acute hospital appeared necessary) and 'social admissions' caused in part by a breakdown in family support or community services, most participants were aware of a much more complex mix of medical, social, psychological and environmental factors which contributed to many emergency admissions.

Local service responses to divert older people from hospital were many and varied, sometimes apparently developed in a piecemeal manner over a period of time. While professionals saw them as valuable, there were concerns about their accessibility to professionals and older people alike, their capacity to respond and their speed of delivery. The perceived shortage of adult social care was also felt strongly by many participants, and it may be that national funding problems have reduced the ability of social care to play a key preventative role. Equally, it is also possible that admission to hospital represents a key stage in the decline in some older people's health, and that services such as social care might only become involved after this has taken place.

The key to the effectiveness of services to prevent admission to hospital was seen by professionals to be access to specialist staff (for example, geriatricians) who had an understanding of the complexity of the medical, social and environmental problems which some older people face. Key players from our interviews with older people seemed to be GPs and the ambulance service, who had a role in a significant number of admissions and/or (in the case of GPs) had sometimes seen the older person in recent weeks prior to admission.

The vast majority of the older people thought their admission to hospital had been appropriate, and only nine people felt that they did not need to be admitted (a rate of 'inappropriate' admission as defined by the older people themselves of just under nine percent). In contrast, all 45 health professionals commenting on specific older people/admissions felt that admission was required (making the rate of 'inappropriate' admissions from a medical perspective zero).

Overall, there was no evidence that a large number of 'inappropriate' admissions were taking place in our sample, or that older people were accessing hospital too readily. Indeed, only three people went directly to A&E and in only about a third of cases did the older person or their family or friends call 999 as a first response. Rather than people seeking hospital too readily, our impression was sometimes of people delaying seeking help, perhaps because of fear of being perceived as being a burden on scarce health resources.

Despite the majority of older people feeling their emergency admission was appropriate, about a quarter of the older people we interviewed could identify earlier action which might have prevented their admission, mainly to do with earlier intervention following previous health assessments or earlier access to their GPs. However, as both Chapters 4 and 5 highlight, suggested responses (by both older people and professionals) which might reduce the number of emergency admission to hospital were complex and multi-faceted, with no evidence of simple solutions. This seems to run counter to some of the suggestions in recent media debates (see Chapter 1), where apparently clear-cut problems and solutions are presented with what we would see as insufficient nuance and local context.

For the purposes of this conclusion, we identify four overarching themes which emerged from all three case study sites:

1. Despite the low level of the rate of 'inappropriate' admissions found within the study, there was still a sense that hospital remained a 'default' option in many cases. While there were accounts of a wide range of health and social care services available in the community, there was some doubt from local professionals as to whether these were really viable alternatives to hospital admission for frail older people, particularly in very rapid timescales. While hospital could provide rapid access to specialist assessment and treatment, there were also concerns that, once an older person is admitted to hospital, there may be some impact on their confidence and independence which may have a detrimental effect on their psychological and physical well-being.
2. While many of the health and social care services which may have prevented hospital admissions were valued in their own right, there was concern from front-line staff about difficulties with access, capacity and response times. Overall, there was an overwhelming view that social care services were underfunded and insufficient, a view recently supported by doctors, led by the President of the Royal College of Surgeons in England, who wrote to the Chancellor in March 2016, asking for further funding for social care and outlining the impact that gaps in social care can have on timely hospital discharge (BBC, 2016).

3. The absence of social care in this study seems significant. As detailed in Chapter 5, none of the older people who took part talked about being in regular contact with a social worker, and we found it difficult to recruit social care staff to the study. We have speculated elsewhere in this report that this may be because of national funding and service pressures; because of a sense of emergency admission being an NHS rather than a social care priority; and/or because emergency admission to hospital is a key threshold and social care services may become more involved afterwards. Whatever the explanation/s, it appears to us that potential solutions to reducing the number of emergency admissions to hospital of older people can only be addressed by health and social care services working together in collaboration, and that further exploration of the potential role of appropriately funded adult social care services is needed.
4. In this study we paid careful attention to ensure we heard about the experiences of older people with dementia, who formed a small but significant group of participants. Although this was not a key focus of our research questions, there were concerns raised that many hospital staff are not adequately trained to work with people with dementia and that ongoing social care support is difficult to come by, often leading to a sense of frustration and isolation.

As with any study, there are limitations to this research which should be acknowledged. First, there is the limited social care perspective on the issues of emergency admissions as outlined above. Significant efforts were made to access and engage social care staff but these were unsuccessful, meaning we only have a partial view of an issue which critically involves both health and social care services. While this is also a finding in its own right, it may mean that some professional perspectives in this report may adopt a more hospital-centric approach than might have been the case with greater social care participation.

There is also question of the extent to which the findings can be generalised across other parts of the country. The three case study sites were not chosen because they were representative of hospitals in England,

but rather to provide a range of different characteristics in the sample population (in terms of levels of deprivation, ethnicity and rural/urban catchment areas). In addition, the involvement of the three lead clinicians in the research team, who had all recently instigated local initiatives aimed at reducing emergency admissions, ensured active staff engagement in the project and meant that we were visiting sites where these issues were 'live' and/or that might have significant lessons learned to share with others. There is also a risk with a study like this that we might attract a sample of highly engaged and/or relatively healthy older patients who are not representative of the make-up of the local older population. As the participants in this research study were self-selecting, the research team had no influence over who agreed to take part. However, as we outline in Chapter 2, we went to significant lengths to ensure that as many different people as possible could take part and to try to prevent particular groups (for example, people with dementia) from being excluded from the study. As discussed in Chapter 4, moreover, all the professionals in the focus groups thought the three case studies they examined were familiar scenarios which they might have encountered in their own hospitals, which suggests our findings have wider national relevance. The advice of Agewell and of national partners from our sounding board has also confirmed that the themes we identify are not just confined to our three case study sites or to more engaged, healthier older people.

Despite all this, we remain concerned about the small number of people from black and ethnic minority communities taking part in this research, despite the multi-ethnic make-up of one of our sites in particular. In an effort to be inclusive, our introductory letters offered the opportunity for participants to receive further information in their own language and to participate in an interview using an interpreter if necessary, but the majority of our participants were nonetheless white. Our experience in a previous research study is that working in much greater depth with specialist local voluntary and community organisations can help to overcome these potential issues, and that these agencies are often much better at engaging older people from minority ethnic groups than some public services or a university-based research team (see Ellins et al., 2012). However this takes

significant time and resource, and perhaps needs to be a core feature of the initial research questions. Any future research on emergency hospital admissions may therefore need a specific outreach focus to gather the views of older people from more marginalised groups whose voices are seldom heard.

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Appendices

APPENDIX A: LITERATURE REVIEW

Search terms

Term 1 – Emergency admissions

Keywords:

- Emergency admissions*
- Admission*
- Patient admission*

Descriptors (subject headings/index terms used by the different databases):

- Patient emergency admission
- Admission rates
- Patient admission
- Emergencies
- Hospitalisation

Term 2 – Elderly

Keywords:

- Elderly*
- Geriatric*
- Old*

Descriptors:

- Aged
- Aged 80 and over
- Frail elderly
- Frail elderly people
- Elderly people with disabilities
- Elderly people with handicaps
- Elderly people with hearing impairments
- Elderly people with mental disorders
- Elderly people with physical disabilities
- Elderly people with visual impairments
- Elder
- Elderly
- Elderly–
- Elderly–men
- Elderly–patients
- Elderly–people
- Elderly–persons
- Elderly–women
- Geriatric
- Geriatric–patients
- Geriatrics
- Geriatrics–
- Old
- Old–age
- Older
- Older–people
- Older–women
- Elderly disabled people (de)
- Elderly–mental–infirm–people (de)
- Elderly–mentally–ill–patients (de)
- Dementia

Term 3 – Appropriateness

Keywords:

- Appropriate*
- Inappropriate*
- Prevent*
- Unnecessary

Descriptors:

- Appropriateness of care
- Preventative measures
- Unnecessary procedures

When reviewing the international literature, the same terms were used but with the addition of a fourth term (to help identify studies that focus in particular on older people's experience or which seek to engage older people in identifying potential solutions).

Term 4 (international search only) –

Patient experience

Keywords:

- Patient involvement
- Patient/user experience
- Patient participation
- Patient/user views
- Patient satisfaction

Descriptors:

- Patient experience
- Patient participation
- Patient satisfaction
- Patient/consumer views
- User involvement

Pro Forma for extracting data from the literature

Authors and Year	
Brief summary	
Location and sample	
Main findings (rate of appropriate/inappropriate emergency admissions)	
Definition of appropriate/inappropriate	
Solutions proposed	
Inclusion of practitioner views?	
Inclusion of the views of older people or their families?	

APPENDIX B: INTERVIEW SCHEDULE (LOCAL PROFESSIONALS)

Who Knows Best? Older people's contribution to understanding and preventing avoidable hospital admissions
Topic Guide for Professionals

Respondents: NHS Managers, social care managers, clinicians from medicine/nursing/physiotherapy/OT/general practice/pharmacy, social workers etc

Preamble

We are conducting a study, funded by the RfPB and with the involvement of [name of lead clinician] to investigate the part older people play in the process of emergency admission to hospital. We will be interviewing a number of older patients admitted as emergency admissions to this hospital and two others in (give period).

Before we do that it is important we understand the way the process of emergency admission for older people works in this hospital. I'd like to ask a few questions about that, please.

- Nationally, there is a belief that a potentially large number of older people are admitted to hospital as emergencies when they could be better cared for in other ways/in other settings. How much do you feel this is an issue here?
- Of all the older people admitted to hospital on an emergency basis, what % would you guess could avoid admission if appropriate alternatives were in place [we are looking for a very rough 'guesstimate' here as a way of gaining the person's view of the extent of the issue]
- What policies/services exist to help reduce potentially avoidable emergency admissions?
- How easy are these for local health and social care professionals and/or older people and their families to access?
- What could be done differently to reduce the number of avoidable admissions?
- We will be drafting national good practice guidance as a result of this study – what 3 recommendations would you make?

Thank you. We will be arranging to provide summaries of the research and our findings towards the end of the project and can arrange for you to have one if you wish.

APPENDIX C: FOCUS GROUP SCHEDULE AND VIGNETTES

Who Knows Best? Older people's contribution to understanding and preventing avoidable hospital admissions

We have prepared some case studies, each based on the transcripts of interviews given by patients who took part in this study.

One is of Mr G, an 86-year-old man living alone, who was admitted after a fall. We would like to play you an audio recording of his words, voiced by an actor and edited for conciseness. The text of his words will also be available.

The other is called Mariam and Hamza's story. It is a more formal, third person narrative based on an interview with the son of a woman, Mariam, who has dementia and was admitted after a series of events, with visits to A&E and input from her GP.

The third is of Mrs F, a 71-year-old woman who lives with her husband and was admitted for one night with breathing problems related to COPD.

In each case we would like you to reflect on the following three questions:

1. Was this hospital admission appropriate?
2. What, realistically, could have helped prevent this admission?
3. What do you think of the quality of the older person's experience of the health and social care system?

Thank you.

Mr G's Story

Well, I'm eighty six. On the day in question my cleaner came, washed the sheets in the morning, put them on the line and said 'Bear in mind it might rain'. So, about three thirty I went outside to get them in again and I was worried about them being creased up. And I was folding them over the line and the wind got up, and stupidly instead of letting them drop on the floor I tried to stop them. And the net result was that I slipped and landed on the floor. Now of course, it's easy to get down but it's a lot more difficult to get up without assistance. So I struggled for a while and then I thought, well, I'd better let somebody else know. Luckily I've got this call thing round my neck, so I pressed it and that is when my neighbours came. They were furious I hadn't contacted them earlier. And they called the ambulance. And they asked: 'Did you hit your head?' 'No,' I said. 'Did you hurt yourself?' 'No. Only my pride.' At the end they said 'Are you on your own?', and when I said 'Yes' they said, 'Well we'd better take you to hospital.' Which they did.

If you're in that situation you can't refuse, because if they think it's the best thing, well, they're the experts. Anyway, I was put in a wheelchair, ofloaded, and about three quarters of an hour afterwards they came to me and said 'We're going to keep you in over-night.' I told them what happened: I'd not been concussed or anything like that. But I thought, well I'm here now, better go to bed. That was the easy part. The difficult job was trying to get out again. And what I mean, on the fourth day I was put in something like an emergency little hospital ward. And they said to me 'Well the doctor will have to make a decision tomorrow'. So I thought, that sounds reasonable enough. But when I went to see him the next day and said, 'When are you going to release me?' And he said 'Well, I'll let you know. It's not up to me'. And so I said, 'I want you to organise transport to take me home'. Nobody said anything to me then, and eventually I thought well this is stupid. But then I saw they were packing up my belongings, and I was pushed out to transport and brought home. And that's what happened.

I don't know why they wanted to keep me in. To be honest with you I didn't really ask. I think it was because I'm living on my own. But as I've cooked my own food for sixteen years I'm not unable to look after myself, am I?

They've got a matron now who goes round and visits patients. And she knows her stuff all right! She did all the tests on me, breathing, blood pressure, you name it, the lot and she said 'You pass every one'. So that's it. I'm here.

It might have been better if I'd gone somewhere smaller where you could just recuperate a little. I think that could have been arranged, but there we are. I've got an irregular heartbeat but I'm on drugs. They got me down to three now, which is going the correct way. I was in hospital last November for pneumonia.

This matron did all the tests on me, breathing, blood pressure, you name it, the lot and she said 'You pass every one'. So that's it. I'm here. Next time I'll just let the sheets get dirty and re-wash them!

Hamza and Mariam's Story

Hamza and Noor have been married for 20 years; since they married, Hamza's mother Mariam has lived with them. Six years ago Mariam was diagnosed with dementia, at which time she briefly had some contact with the social work department who gave the family their contact details, and has been getting progressively worse over time. Hamza works full-time and the everyday caring for his mother usually falls on the shoulders of his wife, Noor. Hamza feels that, within his Asian community, it is up to the eldest son to look after ageing parents, but he feels uncomfortable doing any intimate care for his mother. Noor cooks for the three of them and cleans the house on top of her care for Mariam. Noor and Hamza have three children, one of whom lives close by and has four small children to care for herself. The other children keep in touch and visit when they can, so Noor and Hamza can see their grandchildren.

Hamza has two siblings who live in another country and do not come to visit. He feels they should do more to care for and help with his mother, but instead they complain about Noor's care of her and do not offer solutions. They have become estranged over the last six years and Hamza feels they agitate his mother with their complaints, which she cannot fully understand. She becomes distressed and anxious at these times and Hamza is resentful of his siblings for causing this reaction.

They have some voluntary carer respite – around four hours a week, arranged by a local carer support network – but otherwise cope alone with Mariam's condition. She has been known to be aggressive towards Noor and has wandered outside during the night, though both these phases have now passed. Hamza finds seeing his mother deteriorate painful, as she calls to 'go home', despite being there, and loses her bearings on reality.

Over a period of months Mariam was becoming more agitated as relationships between the siblings deteriorated, and began to be increasingly not 'with it'. She got a Urinary Tract Infection (UTI) and, as she already had diabetes, it was decided, with social work input, to send who Hamza describes as nurses every day to administer all the various medications, as she was refusing them from her son and daughter-in-law. But she began to pass out, vomit, and lose control of herself, soiling her clothes. The nurse was there the first time she began to be unwell and they began to call 111, but when she lost control of her body Hamza changed this to dial 999. Mariam was taken in but discharged early in the morning with no diagnosis. When things continued not to be right with his mother he called their GP who thought it might be worth testing for a UTI; this test came back negative, but Mariam was given antibiotics anyway. On passing out again a few days later Hamza again called 999 and she had various tests in A&E, but nothing was found and she was sent home. Hamza and Noor felt very alone during this time and the nurses who came to see Mariam expressed their surprise that nothing more was

happening. Two weeks went by since his mother went to A&E and she deteriorated again, soiling herself but also losing her balance. Hamza insisted the GP come out to see her, which she did and immediately had Mariam taken by ambulance for hospital admission.

Mariam was then in hospital for five weeks: she was given physio and her medications were reviewed and reduced. Since this admission she has been calmer and is no longer soiling herself; she now goes to a day centre three days a week also. Hamza doesn't feel this admission was preventable, but feels his mother shouldn't have been in acute care but in a specialist unit for dementia patients. He and Noor continue to struggle and feel very alone in a complicated system; the situation continues to put stress on their marriage and is seeping into every aspect of their lives.

Mrs F's Story

Yeah, it was the early hours of Sunday morning. I woke up in bed and was struggling to breathe, which I have this problem from time to time. I've had it since... oh, I don't know when. I was diagnosed with COPD and breathing problems. They say my lungs aren't much good and my arteries are all furred up. Things like that, they just don't get any better, do they? But from time to time I get these flare-ups where breathing becomes difficult. It's worrying, especially at night. And it always seems to flare up when there aren't any medical people around, you know, weekends or bank holidays, you know, when the doctors are shut?

There isn't any real alternative. It's not an emergency in the sense of emergency. But you're not given any other choice. You either sit at home or suffer, or you go to hospital, I suppose.

They're all very good, and they do what they can once you get there. You have all the usual sort of check-overs but it is a bit of a sort of factory production-line, lately, hospital, isn't it? You know, they want to get you in and get you to move through as quick as possible, I think.

This lady comes for me with a booklet thing, which they'd filled in with whoever the doctor was that treated me, and various bits, but she said, who did I see in the community about the problem? And I said, 'Well, just the practice nurse that deals with it in the doctor's surgery.' And she said, 'Oh, well, I'll give you this book. And you get in touch with these people that deal with this problem and they'll arrange for you to go and see them, or they'll come and see you.' It's like a respiratory clinic.

But she said, 'Instead of me contacting them, you'd do best to give it to the nurse in the practice and let her contact them on your behalf.' So I made arrangements, and she said, 'Oh, yeah, we can do this, but your doctor will have to sign it.'

So that's how it went on. The doctor in the hospital gave it to the respiratory woman in the hospital, to give to me, for me to give to the practice nurse, but she's got to refer to my doctor to send off to these people. And I'm assuming this has been done, because it's been two months and I've still not heard anything. So I seem to be getting nowhere. I suppose I could go and see my doctor to ask him what's going on. I've got to go for another test. But I keep putting it off.

I probably would have preferred it if somebody could have come here and treated me. Or even a more local, smaller, cottage-style hospital that they used to have in every town, where you could go on a non-emergency basis, but go just the same, and get treated in some way, possibly the same as what they done in hospital. But somebody has got to decide what is wrong with you, what's causing the problem, and what's the best treatment. In hospital today, it's basically done by technicians with machines. It's not done by what you'd normally – or what older people would call a doctor, is it?

APPENDIX D: COPIES OF INVITATION LETTERS, CONSENT FORMS AND SATISFACTION FORMS

SECTION 1: FOR STAFF

Dear xxxx

I am writing to you on the recommendation of Dr xxx

The Health Services Management Centre (HSMC) at the University of Birmingham is working with XXX NHS Trust on a NIHR funded study, titled:

Who Knows Best? Older people's contribution to understanding and preventing avoidable hospital admissions

The study aims to understand the part older people play in the process of emergency admission to hospital. We will be interviewing a number of older people admitted as emergency admissions with a sample period in XX. We also wish also to interview a number of professionals who are associated either as clinician or in a management role with emergency admissions, or who are involved in community services for older people. We would be very pleased if you would agree to a short telephone interview with either myself or Dr Rachel Thwaites from HSMC. The interview will seek to understand the ways in which assessments for emergency admissions are managed in xx Hospital, and how the number of avoidable emergency admissions could be reduced.

The interview will be confidential. Nothing will be shared that will identify you personally. You may withdraw either yourself or the information you provide at any time. If any direct quotes are used they will be anonymised (e.g Manager / Clinician).

The research has been approved by National Research Ethics Service and has CRN approval. A list of questions to be used in the interview is included below.

If you are willing to give an interview please return this letter / email with the completed consent form below and we will get back in touch to arrange a convenient date and time. We estimate the interview should take 15-20 minutes.

If you have any questions to ask before you decide whether or not to take part, please get in touch with either myself or Dr Thwaites, or Dr X

Thank you

Nick Le Mesurier / Dr. Rachel Thwaites
Research Fellow, Health Services Management Centre, Park House, 40 Edgbaston Park Rd
Birmingham, B15 2RT. Tel: 0121 414 8982 Mob: 07947 724974

Who Knows Best? Older people's contribution to understanding and preventing avoidable hospital admissions

INFORMED CONSENT FORM

Name of Principal Investigator: Dr X, YY Hospital

Please initial each box if you agree

I agree to take part in the above study

I confirm that I have read and understood the information for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my legal rights being affected

I consent to the University of Birmingham holding my contact details for the purposes of this research, and understand that they will be destroyed as soon as the research is completed.

I consent to the use in reports and other forms of dissemination of quotes from my interview and understand that these will be presented anonymously

SECTION 2: FOR OLDER PEOPLE USING SERVICES

Who Knows Best? Older people's contribution to understanding and preventing avoidable hospital admissions'

Would you like to help with some research?

What's the research about?

Dear,

I am Dr X, Consultant Geriatrician at XX Hospital.

I and my colleagues are working with a team of researchers from the University of Birmingham. We want to find out what it is like for older people to experience an emergency admission to hospital, and whether they think something might have been done to prevent or delay it. The research is being conducted in three separate areas of England.

You have been identified by our records as someone who was admitted as an emergency within the last XX weeks. The University has asked us to contact you on their behalf to invite you to take part in an interview. We have not told them who we have written to.

The research team want to talk to over a hundred and twenty older people about their experiences of being admitted to hospital. They will not tell doctors or anyone else what you say, but will report on what they find out generally. We hope that in future this will help doctors and others to understand better why older people seek help in hospital and what, if anything, might help them to find alternatives to keep people safe at home.

Would I be able to take part?

- Are you aged 65 or over?
- Were you admitted to XXX Hospital as an emergency (ie. an unplanned admission).
- Are you willing to talk to researchers about your experiences?

If you have answered 'yes' to these questions, then it is likely you will be able to help us.



What would I have to do?

If you agree, one of the researchers will contact you to arrange an interview. This can be at home or another place of your choice and at a time to suit you. They will ask you about why you went in to hospital, how you or someone close to you came to decide that hospital was the best option for you at the time, and what if anything might have helped you to choose an alternative way of getting help.

If you want, you can ask somebody such as a friend or relative to be with you when you talk to the researcher. This person could be there to support you – or could also take part in the interview by giving their views as a family member or friend. It is entirely up to you whether you want someone present and/or to take part in the interview alongside you.

The interviewers will carry University of Birmingham ID and have been DBS (Disclosure Barring Service, formerly CRB) checked and approved.

When will this happen?

If you agree to take part, one of the researchers will contact you within two weeks of receiving your completed form. They will probably telephone you but can use email if you wish. They will make an appointment to meet with you at a place of your choice when they are in your area within certain dates. They will try to be as flexible as possible.



What will happen during the interview and to the information I give?



One of the interviewers will meet with you and ask you a series of questions. The questions will be open ended and you can answer them as you wish. In order to make it easier for the researcher to store and analyse the interview they will ask you if you are happy for them to make an audio recording. This recording will be destroyed once the research programme is over. You do not have to agree to an audio recording, in which case the researcher will make hand written notes. The questions will cover the episode during which you were admitted to hospital. We are particularly interested in what led up to your admission to hospital and what, if anything, you feel might have helped to prevent it or to have improved the experience for you.

After the interview the researcher will take what you tell them and put it together with what other people have said in order to help them better understand the experience of going in to hospital was like and what alternatives might be useful in delaying or preventing that. They will then use this information to make recommendations to us about how services can improve and to write a national good practice guide. They will not say who has taken part in the study or who has said what. If direct quotes are used they will be anonymized (eg. Patient 1, area 2). They will store the records of what you have said safely. They will not share it with anyone else unless they have concerns for your safety or that of someone in the household. They would always tell you first if they were going to report something you said that might identify you so you were aware of this and knew who they were going to tell. They are not intending to check up on you or pry into your personal circumstances.



Do I have to take part?

No. But if you do, it could help others to have a better experience of emergency care. You are also free to withdraw your consent for any reason and without anyone's medical or legal rights being affected. If you wish to do this at any time, all you have to do is tell the researcher.

**Is there anything else?**

We would also like to ask your GP or Social Worker, and your Hospital Doctor to take part in a survey about the reasons for your admission. We will only contact him / her if you explicitly consent to this in the attached Consent Form.

**What if I say I'll take part but then find I can't?**

You can change your mind at any time and for any reason, without any medical care or legal rights being affected. If you find you wish to withdraw after you have given your consent, all you have to do is tell the researcher.

**How do I find out more about the project?**

If you would like more information about the project or have any questions, please contact Nick Le Mesurier on 0121 414 8982 / 07817 123801 or n.j.lemesurier@bham.ac.uk; or Rachel Thwaites on r.thwaites@bham.ac.uk. Nick and Rachel work at the University of Birmingham and they will be leading the research in your area.



Alternatively, if you wish to talk to someone at the hospital about the research, please contact the Patient Advisory Liaison Service at the Hospital (tel xxxxxxxx).

What if English is not my first language?

Please tick the relevant box on the Informed Consent Sheet if you think you would like to take part but wish for this invitation letter to be sent in another language.



If you would like to take part but wish for an interpreter to be present at the interview we can arrange for this. Just tick the relevant box on the form, or tell the researcher when they call.

What do I do now?

If you think you would like to take part in this project, please complete the Informed Consent Form at the end of this letter and send it to the University in the pre-paid envelope attached. Nick or Rachel will then get in touch with you to talk about the project in more detail.



If you do not wish to take part, please ignore this invitation. Please do not return it to the Hospital.

Thank you

[name of lead clinician at each site]

INFORMED CONSENT FORM

Name of Principal Investigator Dr X, YY Hospital

Please initial each box if you agree and complete the contact details on the next page.

I agree to take part in the above study

I confirm that I have read and understood the information for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without any medical care or my legal rights being affected

I consent to the University of Birmingham holding my contact details for the purposes of this research, and understand that they will be destroyed as soon as the research is completed.

I agree to my GP / Social Worker / Hospital Doctor being informed of my participation in the study and asked to answer questions about my admission to hospital.

I understand that direct quotes might be taken from my interview and used in reports, and that these will be anonymized (e.g. Patient 1, Area 2)

I would like this invitation letter to be sent in.....
(please tell us which language you prefer) before I decide.

I would like to take part in this research but would like to have an interpreter (please state which language)

IF YOU WISH TO TAKE PART PLEASE ALSO COMPLETE THE FORM OVERLEAF AND RETURN THIS INVITATION TO THE UNIVERSITY OF BIRMINGHAM USING THE ENVELOPE PROVIDED

CONTACT DETAILS

Name.....

Address.....

.....

Telephone

.....

Email.....

Signature.....

Date

Thank you

Please return this invitation using the envelope provided. We will be in touch again as soon as possible

Thank you.

Nick Le Mesurier / Rachel Thwaites, Research Fellow, Health Services Management Centre, Park House, 40 Edgbaston Park Rd, Birmingham, B15 2RT

SECTION 3: FOR CONSULTEES

Who Knows Best? Older people's contribution to understanding and preventing avoidable hospital admissions (information for consultees)

Would you like to help with some research?

What's the research about?

Dear,

I am Dr X, Consultant Geriatrician at XX Hospital.

I and my colleagues are working with a team of researchers from the University of Birmingham. We want to find out what it is like for older people to experience an emergency admission to hospital, and whether they think something might have been done to prevent or delay it. The research is being conducted in three separate areas of England.

We are keen to interview as many people as possible, and particularly to include the views and experiences of those who, for various reasons, are not able to give consent themselves or to take part directly in the interview. This includes people with dementia, delirium, acute depression or other forms of cognitive impairment.

We are writing to you to ask you to consider acting as a Consultee under the Mental Capacity Act 2005 on behalf of a XXX who was admitted to XXX hospital recently as an emergency admission. Our records show that you are the next of kin of xxx.

Under the Act a Consultee is someone who can speak on behalf of a person who is unable to give consent. They should be a person who knows the patient well in an unpaid capacity, and they should be able to say whether or not he or she would give their consent if they had the capacity to do so.

The University has asked us to contact people in your position on their behalf to invite them to take part in an interview, or to recommend someone who can. We have not told them who we have written to.

If you agree, we would like to ask you to respond directly to the research team at the university by via the attached reply slip and pre-paid envelope. You can give an interview yourself but you do not have to; or you can recommend someone else who knows XX well. They can be a paid or unpaid carer or a friend or neighbour of XX.

What would I have to do?

If you agree, one of the researchers will contact you to arrange an interview or to find out who you would like to nominate. The interview will be done at your or their convenience. They will ask about why xx went in to hospital, and how the decision was made that hospital was the best option. We are particularly interested in finding out what alternatives might have helped at the time.

If you choose to give the interview, you can have a friend or relative with you at the time. Our researchers will carry University of Birmingham identification and have been DBS (Disclosure and Barring Service, formerly CRB) checked and approved.

When will this happen?

If you agree, one of the researchers will contact you within two weeks of receiving your completed form. They will probably telephone you but can use email if you wish. They will ask your preference for who can give the interview and will take any contact details.



What will happen during the interview and to the information that is given?

One of the interviewers will meet with you or the person you nominate and ask a series of questions. The questions will be open ended and there are no right or wrong answers. In order to make it easier for the researcher to store and analyse the interview they will ask if it is ok for them to make an audio recording. This recording will be destroyed once the research programme is over. If no audio recording is made the researcher will make hand written notes. The questions will cover the episode during which X was admitted to hospital. We are particularly interested in what led up to his / her admission to hospital and what, if anything, might have helped to prevent it or to have improved the experience.

After the interview the researcher will take what has been said and put it together with what other people have said in order to help them better understand the experience of going in to hospital was like and what alternatives might be useful in delaying



or preventing that. They will then use this information to make recommendations to us about how services can improve and to write a national good practice guide. They will not say who has taken part in the study or who has said what. If direct quotes are used they will be anonymized (eg. Patient 1, area 2). They will store the records of what you have said safely. They will not share it with anyone else unless they have concerns for someone's safety. They would always tell the person being interviewed first if they were going to report something that was said that might identify them, so they were aware of this and knew who they were going to tell. They are not intending to check up on or pry into anyone's personal circumstances.

Do I have to take part?

No. But if you do, it could help others to have a better experience of emergency care. You are also free to withdraw your consent on X's behalf for any reason and for any reason, without anyone's medical or legal rights being affected. If you wish to do this at any time, all you have to do is tell the researcher.



Is there anything else?

We would also like to ask X's GP or Social Worker, and your Hospital Doctor to take part in a survey about the reasons for his / her admission. We will only contact him / her if you explicitly consent to this in the attached Consent Form.



What if I say I'll take part but then find I can't?

You can change your mind or withdraw your consent at any time and for any reason, without anyone's medical care or legal rights being affected. All you have to do is tell the researcher.



How do I find out more about the project?

If you would like more information about the project or have any questions, please contact Nick Le Mesurier on 0121 414 8982 / 07817 123801 or n.j.lemesurier@bham.ac.uk; or Rachel Thwaites on r.thwaites@bham.ac.uk Nick and Rachel work at the University of Birmingham and they will be leading the research in your area.



Alternatively, if you wish to talk to someone at the hospital about the research, please contact the Patient Advisory Service at the Hospital.

What if English is not my first language?

Please tick the relevant box on the Informed Consent Sheet if you think you would like to take part but wish for this invitation letter to be sent in another language. If you would like to take part but wish for an interpreter to be present at the interview we can arrange for this. Just tick the relevant box on the form, or tell the researcher when they call.



What do I do now?

If you think you are able to consent on xx's behalf, please complete the reply slip at the end of this letter and send it to the University in the pre-paid envelope attached. Nick or Rachel will then get in touch with you to talk about the project in more detail.



If you do not wish to take part, please ignore this invitation. Please do not return it to the Hospital.

Thank you

[name of lead clinician]

INFORMED CONSENT FORM (CONSULTEE)

Name of Principal Investigator Dr X, YY Hospital
Please initial each box if you agree

- I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
- I understand I am being asked to give consent as a Consultee under the Mental Capacity Act because XX is unable to give consent him / herself
- I understand that I may either recommend another person to give an interview, or I may give an interview myself
- I understand that my consent on behalf of XX is voluntary and that I am free to withdraw it at any time without giving any reason, and without any medical care or legal rights being affected
- I consent to the University of Birmingham holding my contact details for the purposes of this research, and understand that they will be destroyed as soon as the research is completed.
- I agree that XX's GP / Social Worker / Hospital Doctor may be informed of my participation in the study and asked to answer questions about XX's admission to hospital.
- I would like this invitation letter to be sent in before I decide (please state which language)
- I would like to have an interpreter (please state which language)
- I understand that direct quotes might be taken from an interview and used in reports, and that these will be anonymized (e.g. Patient 1, Area 2). Nothing will be reported that will identify any individual
- I agree to take part in the above study

CONTACT DETAILS

Name.....

Address.....

.....

Telephone

Email.....

Signature.....

Date

Thank you

Please return this invitation in the envelope provided. We will be in touch again as soon as possible.

Thank you

Nick Le Mesurier / Rachel Thwaites, Research Fellow, Health Services Management Centre, Park House, 40 Edgbaston Park Rd, Birmingham, B15 2RT

INFORMED CONSENT FORM (to be completed at interview)

Name of Principal Investigator: Dr XX, Hospital YY

Please initial each box if you agree

I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without any medical care or my legal rights being affected

I consent to the University of Birmingham holding my contact details for the purposes of this research, and understand that they will be destroyed as soon as the research is completed.

I agree to take part in the above study

I agree to an audio recording being made to this interview. I understand that it will be destroyed once the research programme is over.

I agree to my GP / Social Worker / Hospital Doctor being informed of my participation in the study and asked to complete a questionnaire about my admission to hospital

I agree that quotes may be extracted from the transcript of my interview and presented in reports and papers written by the research team. I understand that these will be anonymised.

Participant.....Signature.....Date.....

Interviewer.....Signature.....Date.....

SECTION 4: POST INTERVIEW SATISFACTION FORM

Who Knows Best?

Older people’s contribution to understanding and preventing avoidable hospital admissions

Satisfaction form

This is to confirm (please tick all that apply)

- I have given an interview as part of the above research project
- I am happy with the conduct of the interview.....
- I am aware that I may withdraw my data at any time.....
- I understand that if I have any concerns or queries I can contact PALS (phone number) at YY hospital.....

Name.....Signature.....Date.....

InterviewerSignature.....Date.....

Thank you.

Rachel Thwaites

Research Fellow, Health Services Management Centre, Park House,
40 Edgbaston Park Rd, Birmingham, B15 2RT. Tel: 0121 414 7069. Email:
r.thwaites@bham.ac.uk

APPENDIX E: SEMI-STRUCTURED TOPIC GUIDE (OLDER PEOPLE OR THEIR FAMILIES)

Who is giving this interview?
patient / consultee / other

1 Patient details

Patient details

Name

Sex

D.O.B.

Personal circumstances (eg. Lives alone / with carer / has a significant disability / other)

Preamble: thank you for agreeing to take part in this interview. We are interested in the way older people are admitted to hospital as emergencies, and what, if anything might have been done to prevent it. We would very much like to hear about your experience. As we explained in the invitation, this interview is confidential, and we won't report anything you say that will identify you, unless you say something that raises concerns for your safety or that of someone else. It will be of great help to us in analysing all the interviews we are doing if we can audio-record this interview, but if you don't want us to, or you want to stop the recording or the interview at any time, that's ok.

2 Reason given for emergency admission (include when/where/how did the admission come about)

3 Prior to the emergency admission

Did you contact any other professionals (GP, social worker, other) during the four weeks before your admission?

Did you have any other hospital admissions in the 12 months prior to this one?

What for? (were they related or similar to this admission?)

Were you receiving any other services immediately at the time you went into hospital? If possible please describe what you were receiving, what for, where and how long had you been having this service) Examples might include:

- District nursing
- Day care
- Domiciliary care service
- Physiotherapy
- Meals service
- GP visits
- Others (please specify)

Do you think hospital was the best place for you or could you have been looked after in another way? (Please explain your answer)

What alternatives (if any) to hospital were considered? (eg, social worker contacted, GP called out, family support enlisted...)

How significant do you think the following factors were in causing your admission? Please rank each of them 1 to 5: 1 = very important/fundamental, and 5 = irrelevant. You can rank two or more the same.

Why do you say that?

Did you find your admission to hospital upsetting or re-assuring?

Can you describe why?

Do you think it might have been done differently or better?

4 Preventative measures If you had to name up to three things that might have helped to prevent your admission, what might they be?

Please comment as freely as you wish. You do not have to restrict your answers to purely medical or resource issues.


Your/Patient's medical condition ²	Your/Patient's living conditions	Your/Patient's informal support (or lack of it)	Your/Patient's formal support (or lack of it)	Other

² Definitions

- Medical conditions – any directly health related reason such as onset of ill health, injury resulting from an accident, etc
- Living conditions – relate to any environmental factors that may have caused / contributed to the decisions, such as inadequate heating, 'inappropriate' or poor quality housing, difficult access, social isolation. Include the patient's ability to self-care, manage medication etc)
- Informal support – relates to any breakdown, change or failure in the support or care provided by friends, family, neighbours or a partner.
- Formal support – relates to any breakdown, change or failure in the support or care provided by statutory or voluntary sector sources such as Primary Health Care, Domiciliary Care, Day care, Meals on wheels, social services etc

APPENDIX F: VISUAL AIDS

Medical Condition




The illustration shows a doctor and a nurse standing together, one holding a clipboard. To their right, a patient is lying in a hospital bed, being attended to by another person. The scene is set in a clinical environment with medical equipment visible.

Formal Support: household member, carers, social worker, meals delivered, voluntary centres




The illustration features the 'MEALS ON WHEELS' logo, which includes a car and a person in a wheelchair, with the slogan 'deliver a difference'. Below this is a photograph of a woman, identified as a social worker, talking on a mobile phone. A sign in the background of the photo reads 'Social Work Department'.

Social and Living Conditions: living alone, housing, feeling lonely or isolated



The illustration shows a row of five simple houses. Below the houses is a black and white photograph of an elderly man looking thoughtful and somewhat lonely, with his hand to his chin.

Informal Support: friends, neighbours, acquaintances, family



The illustration consists of two parts: a circular inset showing a group of people in a social setting, and a silhouette of a family consisting of a man, a woman, and a child.

APPENDIX G: GP, SOCIAL WORKER AND DOCTOR SURVEY

1. Patient details
 - Patient's name:
 - Age:
 - Approximate date of admission:
2. Prior to the emergency admission, what alternatives (if any) to emergency admission were considered?
3. Please rate the following factors in terms of their significance in causing the emergency admission. Please add any additional relevant information.
 - 1 = very important/fundamental
 - 5 = irrelevant.

You can rank two or more the same.

- The patient's medical condition – any directly health related reason such as onset of ill health, injury resulting from an accident, etc.)
 - The patient's living conditions – any environmental factors that may have caused/contributed to the decisions, such as inadequate heating, 'inappropriate' or poor quality housing, difficult access, social isolation. Include the patient's ability to self-care, manage medication etc.)
 - The patient's informal support Informal support – relates to any breakdown, change or failure in the support or care provided by friends, family, neighbours or a partner.
 - The patient's formal support Formal support – relates to any breakdown, change or failure in the support or care provided by statutory or voluntary sector sources such as Primary Health Care, Domiciliary Care, Day care, Meals on wheels, social services etc
4. In your judgement, what facilities or resources might have helped to reduce the need for admission in this case?

Thank you for your help.

All responses remain confidential to the study.

Please return the form in the envelope provided.

APPENDIX H: JOB DESCRIPTION AND PERSONAL SPECIFICATION FOR AGEWELL ADVISORS

Who Knows Best? Reference Group Membership

Job and Person Specifications

Background to the project

The Health Services Management Centre (HSMC) and the Institute of Applied Social Studies (IASS) at the University of Birmingham are carrying out a two-year project to find out about older people's experiences of emergency hospital admissions. We want to learn from those experiences to help reduce the number of these admissions where there might be better alternatives for care at home.

We will be working in three sites across England. We plan to talk to older people and/or their carers who have experienced recent emergency admission to hospital to find out what circumstances led up to the admission and what, if anything, might have helped them avoid it. We will also be talking to local clinicians and other professionals.

As a key part of our research programme we wish to recruit a Reference Group to help steer the research programme. Agewell have kindly agreed to work with us to help recruit six to eight older people who have experienced emergency hospital admission within the last year, either themselves or someone they care for. They have recommended you as someone who might be able to take part.

Definitions

- An older person is anyone aged 65 years or over
- An emergency admission is any admission to hospital that was unplanned (non-elective) for any reason
- A hospital is any hospital except psychiatric hospital
- An admission is any admission to a ward for any period, excluding admissions that resulted in examination or treatment in A&E only

What will members of the Reference Group do?

We wish to convene up to ten meetings of the Reference Group over the course of the project, which will run for two years. Meetings are expected to last between two and three hours. We will provide refreshments. In partnership with Agewell we will arrange a suitable venue. Travel can be arranged if necessary or travel costs reimbursed. In addition a fee of £40 per meeting per person can be claimed via Agewell. We will be seeking to recruit a group of older people from a broad range of backgrounds and experience.

The primary role of the Reference Group is to help us shape the questions we will ask patients, carers and professionals so that we do not miss vital information, and to help us reflect on the answers that people give. We will therefore seek to hear your experiences of emergency hospital admission, and will circulate draft documents two weeks in advance of each meeting and ask you to consider them in the light of specific questions. We will share with you draft copies of questionnaires and ask you to consider the way we have worded the questions and whether we have asked the right questions.

All our work has to be approved by various Ethics committees to ensure good practice. Your help will be very important in ensuring we conduct our research to good ethical standards. We would like to hold our first meeting in early May 2014.

Who can be a member of the Reference Group?

We are looking for people who:

- Are aged 65 years and over
- Have experienced either an emergency admission to hospital themselves or who are a carer (spouse / partner; family member; friend) to an older person (age 65 and over) who has experienced an emergency admission up to one year before receipt of this invitation.
- Are likely to be able to take part in the work of the reference group over the next two years. This work will include attendance at up to ten meetings (time and place tbc)
- Are able to draw upon that experience in support of the aims of the Reference Group
- Are able to take part in meetings and discussions that may include information exchanged in confidence
- Enjoy working as part of a team

Are you interested?

If you are interested in taking part in this Reference Group would you please sign the attached slip below, giving your contact details, and return it to Agewell in the envelope provided.

**Who Knows Best?
Reference Group Membership**

I am interested in taking part in the Reference Group for this project YES / NO

If yes
Name.....

Telephone

Email.....

Signature.....

Are you someone who has experienced emergency admission to hospital within the last year
YES / NO

Or

Carer of someone who has experienced emergency admission to hospital within the last year
YES / NO

Please include a short statement why you would like to be involved in this project
.....
.....
.....
.....
.....

Please continue on the back of this sheet if necessary

Thank you

Nick Le Mesurier
Research Fellow
Health Services Management Centre
Park House
40 Edgbaston Park Rd
Birmingham
B15 2RT

Tel: 0121 414 8982
Mob: 07947 724974

