NIHR | Collaboration for Leadership in Applied Health Research and Care West

CLAHRCBITE

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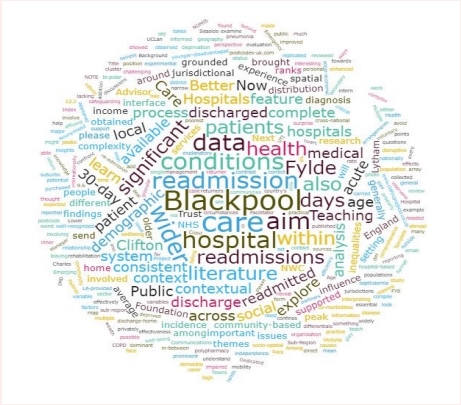

What was the aim of the project?

The aim of *Better Care Now* was to explore the reasons behind the readmissions and to learn from this to explore where it is possible to intervene at significant points in the process. In addition to questions of efficiency and effectiveness for the hospitals, the wider aim for patients was to find ways to support enhanced independence on discharge home and to avoid the disruptive effects of readmissions while safeguarding their health and wellbeing. A wider aim was to examine how the interface between the hospitals and the community-based services could be improved.

Emergency readmission to hospital within 30 days of discharge is reported widely both in the UK and abroad. The issue for *Better Care Now* was to understand why patients from the Fylde discharged from the acute hospital to Clifton hospital for rehabilitation were back at Blackpool Victoria within 30 days. Dedicated data collected for the evaluation showed that around 15% of the patients discharged through Clifton were readmitted to Blackpool Teaching Hospitals within 30 days of leaving.

What did we do?

A comprehensive literature review was carried out both for the UK and internationally. This set the context for the analysis. Anonymised data was obtained on patient readmissions within 30 days to Blackpool Teaching Hospitals NHS Foundation Trust from patients discharged from Clifton Hospital. An array of public data sources was also obtained from Public Health England, NOMIS and postcodes-uk.com. The aim was to position the observed 30-day re-admission process in its wider socio-spatial and demographic context for the Fylde sub-region and to look for explanatory variables outside the narrow confines of medical reporting (something seen to be lacking in the literature reviewed).

The research is supported by the National Institute for Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care West (CLAHRC West) at University Hospitals Bristol NHS Foundation Trust.

How did we involve people?

An informed CLAHRC Public Advisor was essential to the project. Only through direct knowledge and personal experience of the local health care system (in this case as a dementia carer) could the wider context for the analysis be effectively brought into play. This was critical in discussions around the management of the readmission process and in interpreting the available data from a practical and grounded local experience.

What we found and what does this mean?

Emerging themes and findings:

- Age was by far the dominant variable - with a significant bias in the data towards older people being readmitted to hospital;
- The average age of a readmitted patient was 84. This brought with it a cluster of well-recognised readmission issues from the medical perspective involving multiple co-morbidities, polypharmacy and impaired mobility;
- By diagnosis, the most prominent causes for readmission were pneumonia (12.2%) and septicaemia (9.6%). Other conditions with a high incidence were COPD, UTI and heart disease – again consistent with the wider literature;.
- A significant feature of the spatial distribution of readmissions was a peak in a single postcode district (FY8) Lytham St Anne's, Lower secondary peaks appeared for the deprived inner suburbs of Blackpool.
- While age was important generally, socio-economic status made for very different patient populations among 30-day returners;
- Among the contextual factors with a potential role on discharge-home was the relationship between income and either local authority-provided or privately purchased social care with issues for those falling in-between (across a system of different jurisdictions);
- The interface between hospital-based and community-based care and its influence on home conditions on discharge was thought be significant but more work is needed properly to research it;

The themes of age, diagnosis and time to readmission are consistent with the published medical literature. The "return rate" of 15% for the Fylde sample was also consistent with what would be expected from an older demographic across the UK (against a general average of 7%). The "surprise" feature of the project findings was the incidence of the "peak" in the spatial distribution of the 30-day returner population. A more granular analysis of the contextual conditions (not available to us in this project) might be able to reveal some important insights.

What next?

The Fylde Sub-Region is an interesting experimental setting for research to inform practice that takes in the complexity of the contextual conditions and their influence on health, well-being and inequalities. Blackpool has the worst Index of Multiple Deprivation in England in (IMD, 2015) and ranks as a one of the country's poorest communities. By complete contrast, Lytham St Anne's ranks among the more affluent. This is a feature replicated for many "Seaside Towns". This tends to map a bi-polar demographic – very old and younger-disadvantaged across its complex local and jurisdictional geography. An acute hospital and social care system that has to face these challenging circumstances has much to learn and to teach us generally about health inequalities in a *grounded setting.* "Next" – should be a major cross-national study to explore what wealth and income differentials; jurisdictional arrangements for social care; acute hospitals and community care services and the voluntary sector would have to learn to deal with the complexity of the conditions they confront every day.

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