FINAL REPORT

Age UK and The VCSE Health & Wellbeing Alliance –

'Understanding older people's experiences of urgent and emergency care'

age UK
Let's change how we age

VCSE
health & wellbeing alliance

Contents

1. Introduction

At Age UK we know that older people in crisis account for a significant proportion of activity across urgent and emergency care. On any given day over 2000 people aged over 65+ are admitted to hospital in an emergency for a condition that could have been treated earlier in the community or possibly prevented altogether (such as a fall). The statistics in Age UK's recent report The State of Health and Care of Older People in England (2024) show just how many older people are arriving in hospital in ambulances, sometimes for reasons that could have been prevented; waiting for long periods in A&E; staying in hospital longer than they should, and then quite often having to return to hospital within a short period of time post-discharge

Emergency admissions have grown particularly rapidly for older patients, compounded by the increasingly complex needs of patients requiring an admission. Emergency admissions for specific long-term conditions that should not normally require hospitalisation increase with age and are increasing across the oldest-old age groups. Despite the fact that the great majority of ill health is concentrated in this population, older people's voices are rarely centred in debates about how to tackle these challenges. This project aims to draw on some of most important wisdom available to us: the lived experiences of ordinary older people and their carers.

The purpose of this research

Older people, and those who care for them, have a crucial role to play in understanding the issues around urgent and emergency care and attempts to generate solutions will be strengthened by valuing and drawing on this expertise. The aim of this study was to use qualitative research methods to generate a better understanding of what the experience of unplanned care is like for older people and their carers, to ensure policymakers are equipped with knowledge and experiences to build a picture of how better to respond to their specific needs. By providing system leaders with 'real world' insights about what older people themselves think may or may not have changed their trajectory into hospital, we aimed to:

1. Help to build a picture of the specific experiences of older people and their carers accessing UEC in the winter of 2024/2025
2. Explore what more can be done to identify older people who are at high risk of an unplanned hospital admission and what, if anything, might be done to prevent such admissions
3. Identify key issues and effective solutions for improving outcomes and experience across the UEC pathway

A note on the format of this report

This report offers a highly detailed account of the stories of the 29 older people who volunteered to share their experiences. It has been left unedited for length to preserve the richness of insights and detail across the different parts of the care pathway.

Background: what we already know about the scale of the challenge

An emergency admission is one where a patient is admitted to hospital urgently and unexpectedly. Emergency admissions often occur via A&E but can also occur directly via GPs or consultants in ambulatory clinics. Some emergency admissions are clinically appropriate and unavoidable, but others could be avoided by providing alternative forms of urgent care, or appropriate care and support earlier to prevent a person becoming unwell enough to require an emergency admission.

- In 2022/23, there were just over 1 million emergency admissions to hospital involving older people that could have been avoided.
- These include 290,000 for acute conditions that could be prevented with the right care in the community and 250,000 for people over 75 that were readmitted within 30 days of a previous admission. There is significant variation across the country suggesting more could be done to address this.
- While older people do not account for the majority of A&E attendances, they account for a large % of the highest acuity patients and are significantly more likely to be admitted.
- Your chance of arriving in A&E increases substantially with age, with seven attendances for every 10 people over 80 in England.
- People aged 65+ represent around 29% of all adult A&E attendances but account for half (48.8%) of A&E attendances arriving by ambulance.
- 40% of people arriving by ambulance go on to be admitted.
- A 2024 analysis of over 2 million primary care records (2006-2017) found that people with severe frailty are nearly 6 times more likely to be admitted to hospital than those who are not living frailty; their average hospital costs are 9 times greater.

2. Study design

29 semi-structured qualitative interviews with 25 people aged 65+ and 4 family carers

Two phases of fieldwork – 12 interviews Nov-Dec 2024 and 17 interviews Jan – Feb 2025

All participants had experienced an unplanned or emergency hospital admission / readmission in previous 4-6 weeks

This was a multi-stage insight project:

- Participants were selected to complete a long form interview and survey across 5 local geographies and a detailed interview guide for participating sites was developed
- Interviews were conducted by a total of 15 local Age UK professionals across 5 local Age UK services
- Fieldwork was conducted at two time points across the winter period, phase 1 (Nov-Dec) and phase 2 (Jan-Feb)
- Interviews were audio-recorded and transcribed and lasted approximately 1 hour each
- Interviews were analysed by the Age UK national Health Influencing team
- Follow up interviews were conducted with local Age UK professionals with triangulation of perspectives to inform final analysis
- Our aim was to interview between 25 and 30 older people. We interviewed a total of 29 older people for this project

Selection criteria

Selection criteria for this project focused on identifying older people who had been recently admitted to hospital for ambulatory or urgent care sensitive conditions (ACSCs/UCSCs). These are conditions that are generally thought to be manageable with the right care in the community and include conditions like asthma, diabetes, COPD and urinary tract infection. They are also a category of conditions that represent high volume pathways for older people through UEC.

Care was taken to ensure that as far as possible the older people's characteristics were representative of a range of ages, gender and socio-economic characteristics. Local Age UK's were asked to the extent possible, to:

- Aim to include spread of ages from 65+
- Aim to include people with lower social/economic advantage
- Ethnicity – aim for representative sample of local population demographics
- Aim to include at least 1 family carer per geography
- Aim to include at least 1 participant per site admitted for acute mental health condition
- Aim to include range of living circumstances

Table 1. Selection criteria for older people

Inclusion criteria	**Acute presentation**
• **Person admitted for ambulatory or urgent** care sensitive condition (ACSC/UCSC) • Person must have had an unplanned admission in the past 2 months (includes A&E zero-day) • Person must be 65 years and over (aim for mix of 65-74, 75-79 and 80+) • Person admitted living with multiple long-term conditions (2+ long-term conditions) • Person admitted identified as living with frailty • Person admitted identified as disabled	Fall Fractures Acute Respiratory infection UTI Malnutrition / Dehydration Delirium Cognitive impairment Mental health crisis
Exclusion criteria	**Example**
• Person undergoing active medical treatment • Person receiving palliative care or admitted for dementia • Any person lacking capacity for informed consent	Chemotherapy or surgical intervention

"Ambulatory Care is clinical care which may include diagnosis, observation, treatment and rehabilitation, not provided within the traditional hospital bed base or within the traditional outpatient services, that can be provided across the primary/secondary care interface."

– The Royal College of Physicians – Acute Medicine Task Force and endorsed by The Royal College of Emergency Medicine.

Methodology

- Thematic analysis is a qualitative research method used to identify, analyse, and interpret patterns of shared meaning within a given data set and explore different perspectives, with findings presented thematically.
- In this analysis, we use ‘many’, ‘most’, ‘generally’ or ‘commonly’ when views were more frequently expressed and ‘some’ to reflect views that were mentioned less frequently. ‘A few’ or ‘a small number’ reflects views that were mentioned occasionally.
- As the participants in this research study were self-selecting, the research team had no influence over who agreed to take part.
- We have included verbatim quotes from the study participants – these have been selected to illustrate different perspectives on topics, expressed at a point in time, and should not be interpreted as defining the views of all participants.
- We have also included more detailed case studies where we seek to illustrate a sequence of events.

Interview questions

During the interview we used a set of questions and prompts to ask participants about:

- Their general health and wellbeing
- What caused them to be admitted to hospital
- Their experience in hospital
- Their experience settling back at home
- What went well
- What could have improved the experience / outcomes
- Whether they felt hospital was the best place for them to be cared for or if they could have been looked after in another setting
- Whether anything might have helped them avoid an admission to hospital

We asked family carers additional questions about:

- Whether they felt actively involved and acknowledged in their caring role by the hospital care team
- Whether they were kept clearly informed about the care and progress of their loved one during their hospital stay
- Whether they felt they had the support they need now to support the person they care for

Research ethics

- Written consent for sharing was obtained from all participants.
- Participant identities were pseudonymised in this final report to protect identities.
- The numerous quotes and audio included in this report also aim to give the participants themselves sufficient voice in this study as well as allowing the reader to check the interpretations being made.
- Acknowledging the potential emotional impact of the nature of seeking or supporting someone seeking UEC, we carefully considered minimising potential for distress or causing harm in the study design.
- All participants were pre-briefed and offered the opportunity for additional support, if they wished and informed that they were able to freely withdraw from the process at any time.
- As the participants in this research study were self-selecting, the research team had no influence over who agreed to take part.
- There is also question of the extent to which the findings can be generalised across other parts of the country. The five case study sites were not chosen because they were representative of areas in England, but rather to provide a range of different characteristics in the sample population.
- Evidence indicates that a 3-month recall period can be used to estimate experiences of older people, but one month is more accurate in the context of urgent and emergency care. We aimed to get a balance between the person feeling recovered enough to participate and have time to reflect, whilst still remembering key details.

3. Findings from survey data

Participant demographics

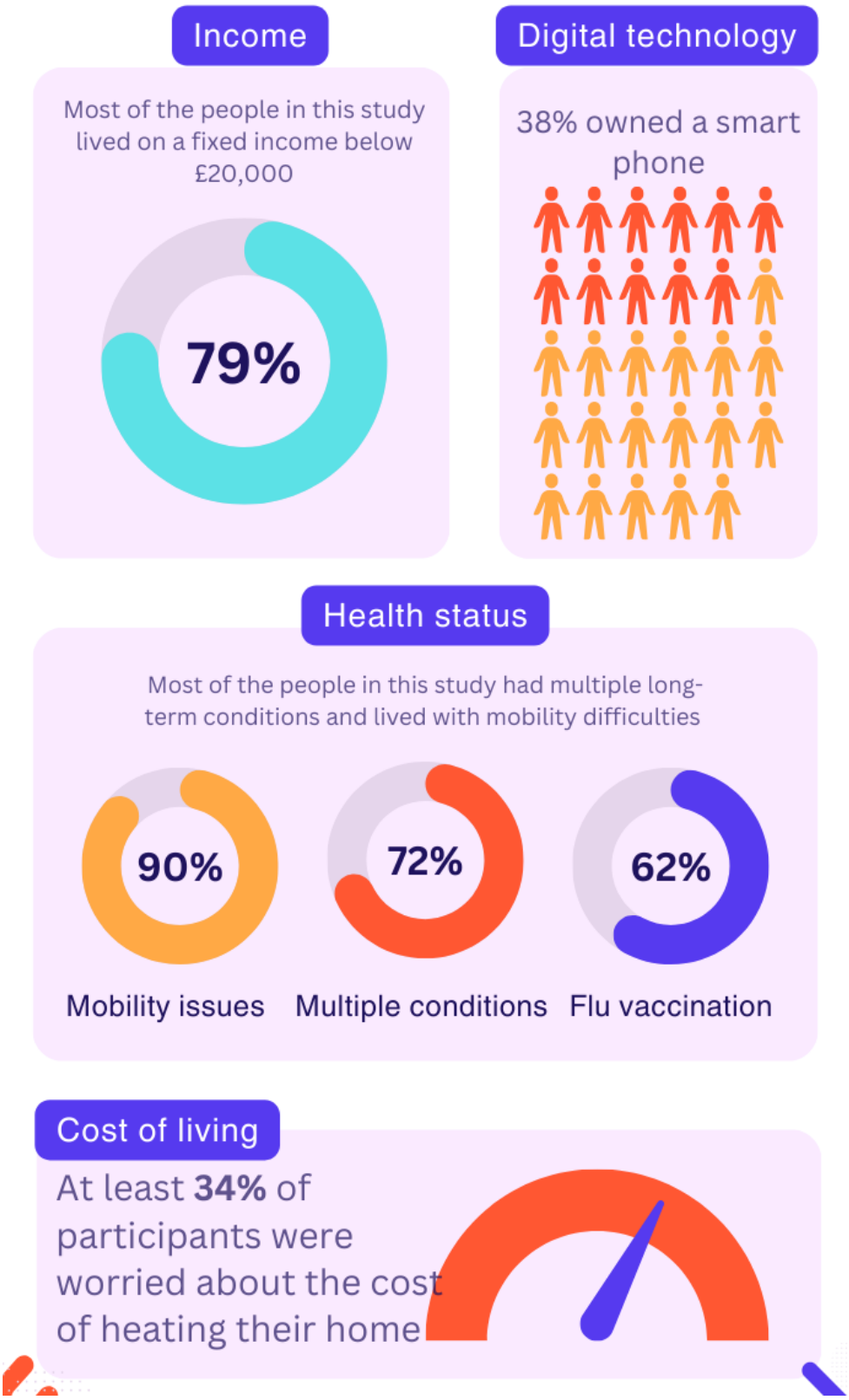
A total of 29 participants made up the sample for this study. 25 were interviews with older people about their own experiences and 4 were interviews with family carers of older people. Interviews 1-12 were conducted in the first phase of the study (November-December), interviews 13-29 were conducted deeper into the winter of 2024-25 (January-February).

Table 1. Participant demographics

Person	Age	Sex	Home	Reason for admission (self-reported)	Length of stay
1	80-84	F	Lives alone	Fall	1
2	80-84	M	Lives alone	Fall	21
3	75-79	F	Lives alone	Groin injury	7
4	90-94	M	Lives alone	Panic attack	1
5	85-89	F	Lives alone	Fall	1
6	75-79	F	Lives alone	Delirium	14
7	75-79	F	Lives alone	Broken back	9
8	85-89	M	Lives alone	Pneumonia, Sepsis	14
9	90-94	F	Lives alone	Fall	2
10	95-100	F	Lives alone	Fall	31+
11	90-94	M	Lives alone	Haemorrhage	10
12	90-94	F	Lives alone	Fall	31+
13	75-79	M	Lives alone	COPD	4
14	70-74	F	Lives with husband	Heart problems	10
15	90-94	F	Lives alone	Heart problems	1

16	65-69	M	Lives with wife	Seizure	3
17	80-84	F	Lives alone	Fall	14
18	70-74	M	Lives alone	Cellulitis	14
19	75-79	F	Lives with granddaughter	Mental health emergency	31
20	75-79	F	Lives alone	Fall	14
21	95-100	F	Lives with daughter	Fall	5
22	75-79	F	Lives alone	Breathlessness	7
23	65-69	F	Lives with husband	Sepsis	27
24	65-69	M	Lives with wife	Sepsis	27
25	90-94	F	Lives alone	Heart problems	7
26	75-79	F	Lives alone	Fall	0
27	85-89	M	Lives alone	Fall	12
28	85-89	F	Lives alone	Fall	0
29	75-79	F	Lives with partner	Dementia, overdose	Not known

Figure 1. Summary of survey data



Age breakdown of sample

There was a wide age-range captured in this sample:

- Three people were aged 65-69 years
- Two people were aged 70-74 years
- Nine people were aged 75-79 years
- Three people were aged 80-84 years
- Four people were aged 85-89 years
- Six people were aged 90-94 years and two people were aged 95-100 years

Social circumstances

- 18 participants (62%) owned their own home, 9 (31%) participants lived in rented housing association accommodation and one participant lived in an assisted living facility and one person's housing status was undisclosed
- At least 23 participants (79%) were living on an annual fixed income below £20,000 (two people did not answer this question) and only one participant had an income above £30,000
- At least ten participants (34%) were worried about the cost of heating their home
- 6 of twenty-nine participants (21%) had received a social care needs assessment, 6 participants (21%) were unsure if they had received an assessment, and 17 participants (59%) had not received a social care needs assessment
- Just 11 participants (38%) confirmed that they owned a smartphone

Pre-admission health status

- At least 21 participants (72%) had multiple long-term conditions (2+ long-term conditions), with at least 10 participants having four or more long-term conditions
- Polypharmacy was the norm, with fourteen participants (48%) taking between 6-10 daily medications, with three participants (10%) taking 20+ daily medications
- Even the three participants who stated they had no long-term conditions were taking between 2 and 10 medications daily
- Mobility amongst participants was mixed with just three participants able to get out and about independently (10%). The remaining twenty-six participants (90%) had mobility difficulties. Eight participants were able to get out and about 'with some difficulty', twelve participants 'with great difficulty' and six participants were completely confined to their home
- Eighteen participants (62%) had received an annual flu vaccination, and twenty (69%) participants had received a Covid-19 booster

Hospital admission

- Length of hospital stay ranged from two zero-day admissions (where the person was seen in A&E and discharged home within 24 hours, without being admitted to a ward) to four+ weeks in hospital. The average length of hospital stay was 10.24 days
- Participants had been admitted for a range of conditions, with 12 participants (41%) admitted because of a fall
- At least 23 participants (79%) had been previously admitted to hospital in the past 12 months and several people had been admitted to hospital multiple times in the past 12 months. One participant had been admitted to hospital six times since September 2024

Table 2. Health status of participants

Participant	Age	No. daily medications	Long-term conditions	Mobility	Support prior to admission
1	80-84	1 to 5	4	Yes- independently	Physiotherapist Day Centre Age UK Befriender Cleaner
2	80-84	1 to 5	2	Yes - with some difficulty	Home care agency
3	75-79	1 to 5	0	Yes- independently	UCR once weekly
4	90-94	6 to 10	3`	Yes- but with great difficulty	Voluntary support GP home visits Age UK befriender
5	85-89	1 to 5	5	Yes- but with great difficulty	Home care agency Age UK befriender
6	75-79	6 to 10	3	Yes - but with great difficulty	Housing association
7	75-79	Not stated	5	No – confined to their home	Home care agency GP home visits Age UK befriender
8	85-90	20	5	Yes - but with some difficulty	Physiotherapist
9	90-94	6 to 10	1	Yes - but with some difficulty	None
10	95-100	Unknown	1	No – confined to home	None
11	90-94	6 to 10	3	Yes - with great difficulty	District nurse Social workers GP home visits Age UK befriender Carers daily
12	90-94	6 to 10	0	Yes – independently	Gardener (pays privately)

13	75-79	6 to 10	6+	Yes - but with great difficulty	Housing Association - Warden Age UK Befriender
14	70-74	6 to 10	Not answered	Yes - but with some difficulty	None
15	90-94	6 to 10	6+	No - confined to home	Housing Association - Warden Age UK Befriender Social worker District nurse
16	65-69	11 to 15	6+	Yes - but with great difficulty	None
17	80-84	1 to 5	0	Yes - but with some difficulty	None
18	70-74	20+	6+	No - confined to home	District Nurse Age UK Befriender Home help (cleaner)
19	75-79	11 to 15	Not answered	Yes - but with great difficulty	None
20	75-79	11 to 15	2	No - confined to home	Home care Age UK Befriender
21	95-100	6 to 10	2	Yes - but with great difficulty	District Nurse GP home visits Day care service
22	75-79	6 to 10	2	Yes - but with great difficulty	Occupational therapist
23	65-69	6 to 10	4	Yes - but with great difficulty	None
24	65-69	1 to 5	4	Yes - but with great difficulty	None
25	90-94	1 to 5	2	Yes - but with some difficulty	None
26	75-79	6 to 10	2	No - confined to home	None
27`	85-89	6 to 10	1	Yes - but with some difficulty	District nurse
28	85-89	20+ (26)	3	Yes - but with some difficulty	Home care agency
29	75-79	Unknown	3	Yes - but with great difficulty	None

4. Interview findings

Of the total interviews conducted, twenty-five interviews were with older people themselves. Four interviews were conducted with family carers of an older person. All quotes included below are attributed to the older person directly, unless otherwise indicated ('Family carer').

Overarching themes

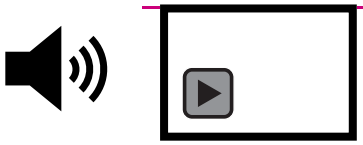
When analysing the interview data, several overarching (and interconnected) themes were identified that occurred in primary, secondary and community care settings. These were: 'getting the basics right', 'dignity and respect', 'understanding the whole story', 'community support needs' and 'fragmented care'.

It is interesting to compare the findings from phase 2 with findings from phase 1, the second cohort of admissions occurring deeper into the winter of 2024/25. The similarity in overall experiences is striking, and in the second cohort, we saw previous themes reinforced. We have also identified three further (interconnected) themes that came out more strongly in the second round of interviews: 'observing a change in care quality', 'concerns for staff wellbeing', and 'the empathy gap'.

In this chapter, we explore each of these themes in more detail, across each stage of the admission process, following each person's experiences from pre-admission through to their first action to seek help, experience in hospital, experience of discharge and settling back at home. We conclude this chapter with some reflections on scope for prevention and spotlight the particular challenges for carers.

Overarching themes identified in interviews	
1	Getting the basics right
2	Dignity and respect
3	Understanding the whole story
4	Fragmented care
5	Community support needs
6	Observing a change in care quality
7	Concerns for staff wellbeing
8	The empathy gap

Pre-admission health status



Click the audio file above to listen to an account of a family carer raising the alarm several times over a few weeks

Many people described noticeable changes to their health, or signs that their health had been deteriorating, in the weeks or months leading up to the admission.

Some felt this was apparent only in hindsight, whereas others had a clear sense that their health was waning and had been waiting on an appointment in primary or secondary care. Examples of failing health cited included feeling weaker, reduced mobility, loss of appetite and finding daily activities harder to manage.

"It was on the cards to be checked by the cardiology department, but nature took over before that"

“Within the last three years my mobility has decreased, has gone down to nil really"

Two people had experienced big life changes in the months preceding their recent hospital admission (both were bereavements), which had affected their appetite, sleep and general ability to care for themselves.

"I'm the only one left (of eight grandchildren), there has been a lot of loss in the past year”

Formal and informal support

Alongside a wide spectrum of pre-existing health needs, was the range of formal and informal support participants had access to. The level of formal and informal support networks available varied significantly across the sample, with some people describing a strong network of informal and formal support to call upon, others very little.

"I've only got two friends, they've all gone before me, I'm afraid"

"Spend a lot of time on my own, thinking, puzzling out what to do"

Most people relied on a mixture of both informal support (from friends, family, neighbours, voluntary services and modest amounts of paid help) alongside formal support (from primary care and social services) to manage their health and activities of daily living. Several people interviewed expressed a desire for additional support, specifically in the form of companionship, bereavement support, support with practical tasks around the house and with digital enablement.

"In an ideal world, I would like someone to come and help me with IT"

Unsurprisingly, where people tended to report better experiences, and seemed generally better able to cope, they had a stronger network of friends and family to call upon.

“I go to my niece every Sunday morning; she does everything for me. If I want anything from town, she’ll get it for me. It’s too far for me scooter”

Access to primary care

Most people interviewed cited challenges in accessing primary care, with long telephone waits and lack of continuity of care the norm.

"I never see him (GP). I don’t bother with him, it’s too much rigmarole getting hold of him love"

“You ring (GP) at eight, dead on eight, ‘you are 25th in the queue’. How does that work? Not easy to contact. I know it’s hard work for ‘em, but its hard work for us and all”

“I think the doctors are run off their feet. They should phone every patient, it’s only 2 minutes. If I go down on my scooter, it’s awful. I put in for a phone call each time if I can”

Two people described first seeking help from their GP in relation to their emergency admission. Of these, one patient was referred on to hospital. The other person, who was eventually diagnosed with a broken back, did try to first access their GP, but was unsuccessful. It appeared that the receptionist did not triage their call as urgent.

"GP wouldn’t come out and I couldn’t get to him. But I do feel the receptionist should have more consideration when people ring up” “He said, ‘it’s not urgent’… it might not have been urgent to him, it were urgent to me."

Generally, many of the people we spoke to felt disinclined to reach out to their GP, anticipating problems in access or feeling that their concerns were deprioritised.

"…it’s like getting hold of the Pope"

“It’s a few years since they’ve been out to see me”

"It's a long-winded process at the best of times. It’s a very busy practice. There's a front desk that's always crowded. I have never seen the GP"

There was generally better feedback around community care services, although delays were still reported.

"They are very good. Ring them up any time"

“District nurse came in to check a few times”

"To be quite honest, the community services are better than the hospital services, but it was made difficult for me to contact people like the catheterisation team who would have been very very useful to have at my fingertips"

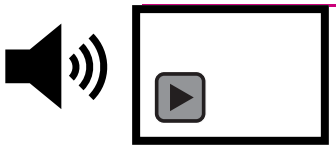
There were also positive accounts of GP access, but these tended to correlate with people with lower overall intensity of support needs or better overall health.

There were also some inconsistencies in individual accounts, seeming to highlight the goodwill and gratitude generally shown towards staff in the health system, despite access issues. For example, in the same account describing access to their GP service one person explained:

"*I've got difficulty in getting to them",* going on to add; *"Been at current GP practice since 1980. That surgery, [pause] absolutely bloody marvellous".*

Another person, when asked about the quality of care they received from their GP replied:

"Same doctor, yes. Full satisfaction…they're always there to help", despite not seeming to be receiving any ongoing support following their discharge following a mental health emergency admission.



Click the audio file above to listen to an account of a patient who had broken their back, struggling to make an appointment with their GP

Many of the older people interviewed were not confident using the triage telephony system and relied on family or friends to make appointments on their behalf.

"Oh yeah, time and again," "I've no idea myself (what would help)" "I've had GPs out. I don't like ringing 'em, I get my niece to ring 'em. I hate the telephone now, because I can't tell what people are saying"

Other examples included challenges when urgent issues occurred over the weekend and the practice was closed, resulting in a hospital admission because of a lack of community alternatives.

"Other times it's been weekends, and I've rung 111, and they've cart me into hospital"

There were also a couple of excellent experiences described, where the person didn't feel rushed, and their comfort and essential needs were attended to. For example, one GP on a home visit noticed that their patient was hungry, dehydrated and unable to make herself a drink or something to eat.

"They said would you like a cup of tea? I'd love a cup of tea, (then he said) 'You've got a cuppa soup, do you want one of those?' Oh, he was lovely"

Another person described how much they valued their local GP service.

"Always there to help, you wouldn't expect it, because they're under so much pressure"

But unfortunately, these examples were rare. Difficulty in getting an appointment and lack of care coordination were more frequently reported.

"We haven't had one (letter) as such, for this last episode in hospital. Presumably if we haven't got one, he (GP) hasn't got one either"

Ambivalence about seeking help

It seemed that for some of the older people interviewed, there was ambivalence towards help-seeking which may have led to avoidance or delay in raising the alarm at an earlier stage. Reasons for this were not always explicit, but we inferred that they broadly fell into one of three categories: 1) lack of awareness that their health had been waning, 2) previous negative experiences of UEC, and 3) not wanting to be a burden.

"When the carer came, well I was in a hell of a state. I pressed that [the pendant alarm]. The carer said, 'you should have called earlier!' I'm a stubborn old bugger. I won't trouble people if I can help it"

"I had such a bad experience with the last ambulance. They didn't even steady my head (spinal injury, and I was flopping all around the place, and I thought I'm not confident. It didn't fill me with confidence. It was freezing cold in the back. She sat and filled out a form and didn't even talk to me. "So, [pause] they're naughty, people are naughty. It was nearly midnight at the time, and they'd had enough"

Previous work on this topic has noted that it is possible that negative media headlines and ageist public discourse about older people's use of NHS resources (e.g. narratives around 'bed blocking') could deter some people from seeking help in a timely manner. Although there was no direct reference to the term ('bed blocking') by participants, there were some references that indicated people may feel stigmatized and blamed for current system problems. There is a risk that older people will moderate their health-seeking behaviour as a result.

Others were clear that the need to call for help was unavoidable and didn't delay raising the alarm, but these accounts of more decisive action tended to be where the person had fallen or injured themselves, or where the person was so unwell they were unable to raise the alarm themselves (i.e. someone else had noticed a problem and raised the alarm on their behalf).

"I knew nothing [about the fall], I was out. Two lads saw through the window and saw me on my back. They think I'd been on my back for 3 hours. Ambulance had to take out a window from my kitchen into the conservatory"

One person described a long ambulance wait after a fall where they were conscious, but unable to raise the alarm. This person lay on the floor for 2.5 hours before her daughters found her and called 999. They were informed of a 6-hour wait for an ambulance, so drove her to the hospital themselves.

"Didn't have alarm to hand. I crawled on my hands and knees across the landing and up to the steps to the bathroom (to raise alarm)"

Experience in hospital

We asked participants if they felt that hospital was the best place for them to be cared for or if they felt that they could have been cared for in another way. Most of the people we interviewed felt that hospital was a place of safety and the right place for them to be cared for, and found the experience reassuring as opposed to upsetting.

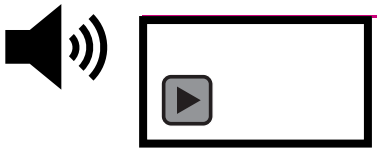
“Oh aye, I couldn’t have got right on my own. They put me on a drip and all of that.”

"I think she needed the hospital. I needed her to be assessed. Hospital was the best place" (Family carer)

"The second time when I fell and hurt my neck, I don’t think I could have been in a better place"

“I would imagine because he was so unwell he probably needed to be in hospital. He was having IV antibiotics and things like that. If he had spoken to a doctor, that might have prevented the admission. The second admission, I'm really glad he went back in, because now we know he had a stroke" (Family carer)

However, several people described their experiences as leaving them frightened to return to hospital or feeling that they would not return in the future.



Click the audio file above to listen to an account of a patient who would not want to return to hospital

There were only a few people who felt that they could have been cared for differently, although these people had presented at A&E with serious conditions that required urgent care (broken back, fall) and recognised they needed urgent medical attention. However, they felt that the ongoing support they needed to recover could have been better delivered in a different setting.

"I could have been dealt with in A&E rather than hospitalisation. I had had a fall but had recovered from that. What I needed help with were problems that were caused by being in hospital"

"I feel because of the situation [broken back] I could have gone into a care home or rehabilitation centre [instead of hospital]"

"When I spoke to the physiotherapist, she said ‘really I don’t think this is the right place’"

One person admitted to hospital as a result of a mental health emergency felt that a general hospital ward wasn’t the right place for them.

"No, hospital wasn’t the best place for me. If I could of got home with carers it would have been a lot better. I was just taking a bed up that someone really ill (could use) and I didn’t consider myself (really ill). I could trot off and take a shower myself”

Long waits in A&E

The challenges associated with long waits in A&E were evident and particularly stark in the second phase of interviews. Many participants described long and uncomfortable waits, with several people waiting for long periods in the ambulance outside the hospital, before making it into the A&E department or corridor to then wait again.

"Nothing was moving in the hospital. I was in the ambulance 6-7 hours. I didn't actually get in until 6pm and then when I was in, they took me up on the ward about 2 o clock in the morning. But that was how it was, nothing was moving in the hospital"

"I couldn't get no rest on me"

During these waits in temporary settings people went without frequent monitoring, access to adequate pain relief or food and drink.

I kept telling them I were in pain, all they give me were paracetamol" "It were just like, putting a knife through you"

"The doctor only come to me about twice. That was to check me the first time, and the next time, to tell me I were going to the ward"

For some, it was a relief for people to get out of the corridor and on to a ward. However, several other people described being unable to sleep because they were on a ward with dementia patients or patients with severe mental illness who were extremely unwell and found this disturbing and frightening to witness.

"I was away from the maddening crowd of people waiting to be seen in the corridors"

The fact is that long waits are a life and death issue. The Royal College of Emergency Medicine claims that more than 250 A&E patients are dying each week because they waited more than 12 hours to be admitted, based on analysis published by the Emergency Medical Journal in January 2022. For waits of more than five hours mortality rises with every extra hour of waiting. More recent evidence suggests this stark figure of deaths linked to long waits may yet be an underestimate.

Deterioration in hospital

Evidence shows that in hospital, older people living with frailty are at high risk of deconditioning and are more prone to rapid loss of independence during an acute illness. Unfortunately, we heard accounts of people deteriorating whilst in the hospital, particularly those who had longer stay.

"It's the worst I've ever seen him. He's really unwell. He barely opened his eyes. His condition has deteriorated a lot, obviously because of what's been happening with him. But also, it's sad to see him lying in bed the whole time, on this ward I haven't seen him up at all. I know the OT has helped him to the toilet, but I don't know if he's been up at all other than that" (Family carer)

Once admitted, older people typically have longer length of stay, increasing their risk of hospital-acquired infection and other complications

"I got a chest infection from mixing with incoming patients which prolonged things"

"On my first discharge, I was discharged with pneumonia which brought me back in as the medicine prescribed by the hospital had reacted badly and laid me low. So, it was one problem becoming two or three problems and not treated well by the hospital. It caused me to wonder if hospital was the best place for me and I discharged myself eventually"

Getting the basics right: medicines management

Medicines mismanagement in hospital was frequently identified by participants. This information is concerning, particularly when you consider that at least 48% of participants were taking between 6-10 daily medications, with three participants (10%) taking 20+ daily medications.

Several people described challenges including being unclear what medication they had been prescribed and why, or distress at the erratic timing of medication rounds whilst in the hospital, impacting on sleep and mealtimes.

"I thought they made a mess of my tablets, they took 'em away and started giving me in dribs in drabs. I had no painkillers at all I was in" "The thing were half past ten at night they came with [sleeping] tablets. Half 12, where's me tablets?"

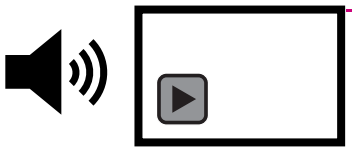
"I had 'em there and they took 'em away from me. I have a set time to take my tablets. I have a set time to take up, supper and the like. But supper isn't 1 in the morning."

There was another example of a carer explaining that her family member hadn't been given her regular medication for the two weeks she was in hospital. This participant went on to explain that this communication breakdown continued beyond the point of discharge.

"I'm finding it very scary about anybody going into hospital at the moment because one doesn't know what the other one's doing". "When they discharged her [from the hospital] I got back home. It was the nurse [from the hospital]. She wasn't right pleased. They'd whisked her home without her new medication. So, they had to send it by taxi and send it back here. And I thought, 'I thought you were in trouble with costs?', sending a taxi all the way here" (Family carer)

This patient would not have had the opportunity to ask any questions about how to take their new medication or discuss any concerns, and nor would the carer. Inappropriate polypharmacy can lead to

symptoms including dizziness and nausea, heightening falls risk, so it is very important that medicines are correctly prescribed and taken. Despite this, the older people we interviewed were not empowered to take their regular medications themselves despite hospitals themselves not having a record of all medications a patient was currently prescribed.



Click the audio file above to listen to an account of being given the wrong information about their medicines

Getting the basics right: nutrition and hydration

Many participants described difficulties with accessing food and drink, particularly in A&E settings.

"I was in a bay, but no water, no nothing. And you didn't get meals there"

Interestingly, several participants commented that they did not perceive food and drink as part of the hospital's responsibilities or a component of health care.

"Well, that's not in the hand of them"

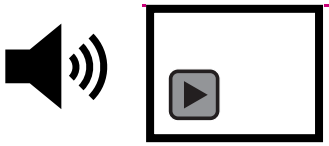
One person (a diagnosed coeliac) was not given gluten-free food when he was in the hospital, but said he didn't mind as he is not able to afford the special diet for coeliac disease outside of hospital.

"They give me normal food. I've been on normal food all the time. I've never been on a special diet because it's too dear"

Several participants remarked that they had been struggling to maintain their nutrition in the weeks leading up to their admission to hospital either because of low mood, loss of appetite, because they were struggling with mobility problems or a combination of these factors.

"I couldn't be bothered to eat (low mood). I couldn't be bothered to make owt"

Getting the basics right: dignity and respect



Click the audio file above to listen to an account of care that lacked compassion and responsiveness

There were other examples of very serious breaches of care practice, neglectful care and safeguarding failures. This included a distressing example around failure to deliver dignified toileting and continence care, a key component of high-quality frailty care in hospital.

"When she was taken in the first time they popped her in a wheelchair for 20 odd hours in A&E. She had to scream for somebody to help her to the toilet. It's very degrading for 'em if they mess themselves..." (Family carer)

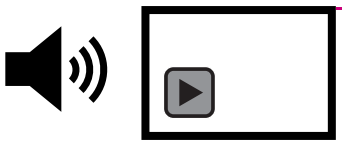
"I know how busy they are. I do understand that nurses are overworked and everything. But they are there to look after patients and there's no need for how she's been tret" (Family carer)

Other examples related to disrespectful and bullying communication, including one person describing a nurse shouting at them.

"They were alright, but the main one, oh my god. I said, 'I've got pneumonia' and she said, 'yes you bloody well have'. She said you need to stop taking those tablets. I said, 'it's no good you shouting at me'"

Another person felt afraid to ask for help with getting washed (she had broken her back).

"I didn't know what was going on! I didn't like it." "I felt like a leper. I felt like, frightened to ask anybody, if I asked for help they'd say 'you can use your hands, wash yourself'"



Click the audio file above to listen to an account of lack of support for a patient with a broken back to wash in hospital

There were also several examples of poor communication around changes to medication and fear of asking any follow-up questions seeking clarification about what medication had been prescribed and why.

"Last year when she was in hospital a nurse came round. She had 2 yellow tablets, and she asked what they were for. [The nurse replied] 'You know something you've given me 5 bad nights this week' [Older person replied] 'you're lucky cause I've only been in 3 days'. I don't know if anything was done about it, she were very nasty were that nurse. They weren't her normal tablets you see." (Family carer)

It should also be noted that there was variation in care experiences even within a single hospital. Of three participants at the same hospital, two described very negative experiences, and one a very positive experience.

Too many of the older people interviewed described a general lack of reassurance about their treatment plans and were left with no idea of likely trajectory towards recovery, and a better quality of life, so were left with huge anxiety.

"Like everything else in life, if it's explained to you and you understand it, then you don't worry about it"

Getting the basics right: what matters to me

This lack of time for staff to build relationships with patients lead to a lack of trust and misunderstanding the goals and motivations of the patient and clinician. Several people's stories revealed an obvious mismatch between what was important the person, what was feasible once they were back home, and the treatment plan proposed. This had the effect of causing several of the older people we interviewed to disengage.

"They wouldn't listen" "I let 'em get on with it"

"They think they knew what it were, and I know what it is, and I couldn't get through to 'em. They got their idea, I disagreed"

Several older people described being treated in hospital, but not for the thing that mattered most to the person. This included one participant whose continence issues went unaddressed during her hospital stay to their deep distress. Sadly, these concerns remained unaddressed by the district nurses at time of interview.

Praise for hospital staff

When asked to reflect on the positive aspects of their experience, many participants gave agreeable accounts of the care that they received in hospital and were appreciative of the doctors and nurses they encountered. Several people commented on how hard the staff were working and on the efficiency they observed.

"How hard the nurses work, and doctors, wonderful people"

"I did get very good care. All I remember is they cared for me in the best possible way"

What was clear in all positive accounts was that feeling well cared for was about relational as well as technical care. Small gestures of friendliness and compassion made a big difference.

"I was admitted for 10 days. The hospital staff in there were good as gold to me."

"The thing that stood out to me was that everybody in the ward was so friendly, the staff were so friendly, it was like a holiday"

"They were wonderful. Absolutely wonderful" "Whether it was male or female, it didn't matter to me. They're there to get you well."

Minimising discomfort

Alongside this high praise for staff, the overall picture of care was mixed. Many participants described a high degree of stoicism and patience when it came to their experiences waiting for care.

“People have got to realise there are people in front of you, so you're the one who has to have patience. And I'm pretty patient like that"

"I was impressed by the apparent efficiency with which everybody was working. I could see comings and goings, everything seemed to be running very smoothly, it was just a case you had to wait your turn”

“I felt grateful I suppose is the word. I was there, opposite people who were a lot worse off than me"

However, many of these same accounts appeared to minimise discomfort and poor experiences or indicated that they had lower than average expectations of care.

“They put me on a trolley bed in the corridor overnight (before they found a bed). It was alright, I just couldn’t get to sleep because of all the people”

"I thought they were rushed off their feet as they always are. I felt sorry for the nurses as they always are. Having been a nurse, I had sympathy with ‘em"

Another participant described feeling sidelined by hospital staff who did not appear to consider his insights into his condition or experience as a retired medical professional.

"The fact that I have an IQ of 180 and 40 years of experience was totally ignored. It would have taken some rattling of head bones for people to get their heads around that."

Several participants seemed reluctant to make negative comments. For example, was one participant mentioned that they weren’t given anything to eat whilst in A&E.

“Not that I felt like it, I can’t remember being offered food, and I wouldn’t have had anything to eat all day” “I think I must have had some water there”

However, after mentioning this they seemed to become very worried and doubted whether what they had said was true, stating several times that they might have got that wrong and questioning their memory. Most of the people we interviewed were reluctant to be perceived as criticizing staff.

"Wasn’t offered anything to eat when I was in hospital. I don’t think?” “I can’t remember that (pause), I may have had a sandwich at lunchtime”

Safeguarding incident

One very serious safeguarding incident was raised by a participant regarding the alleged theft of her jewelery whilst undergoing treatment (for wound care). It was unclear from the transcript when this alleged crime took place, the exact circumstances or which professionals were involved.

“When I came around, they had stolen my rings." "I had a good old cry, I gave a whole set of these [rings] in gold to my daughter in law the first Christmas after that."

This was clearly a very distressing incident, and one that was returned to when we asked for final reflections.

"It broke my heart with the rings. Disgusting that was"

We have raised this safeguarding concern with the relevant local Age UK team so that this incident can be investigated. We include this anecdote here as an illustration of the increased vulnerability to abuse frail older people face and the need to highlight and guard against it in all care settings.

Getting the basics right: communication

Lack of communication was another recurring theme, with several participants describing frustration at the lack of clarity around their treatment plan.

"It would have been nice for a treatment programme to have been initiated at an early stage"

"I became a bed patient in a ward with very socially pleasant staff, but no effective medical direction given"

Others, when asked about the quality of communication, gave favourable opinions but then went on to describe poor or mediocre experiences. For example, most of the participants did not seem to have a clear sense of their ongoing treatment plan on discharge. Few people could describe what plans, if any, had been made for follow up or what they should do if they noticed their health deteriorating again.

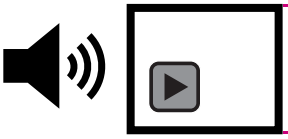
"Because of my experience in the NHS I knew it would take some time for the system to fall into place. I gritted my teeth and waited to see what would happen"

This included several people who had described being prescribed new medication(s) at the time of discharge. No-one confirmed that they had been given the name of the person who was their main point of contact and there were only a few mentions of people given information about where to go to learn about how to self-manage or access aftercare to aid their recovery.

"I have seen letters sent from the hospital to the GP. They have been infrequent and haven't really covered the complications I've run into"

"Information, that's the one thing. Somebody sitting me down and explaining it to me and like the reason behind it, and if I'm told that, I'm fine"

"I'm on that much, many tablets (not clear if new or same)"



Click the audio file above to listen to an account poor care whilst waiting in A&E

Lack of responsiveness and communication from hospital staff had a negative effect on older people's confidence in the system.

"Looking at it, a lot of it, wasn't what I thought doctors and nurses should be"

"I don't think they respond enough"

"When I've gone in and me blood pressure's up, all they do is keep taking my blood pressure, until it's down, then, 'oh you're alright', and send me home again"

It was striking to reflect on how much of a difference simple, effective communication could have made to ease anxiety and help people gain the confidence and necessary information to manage their condition(s) independently once back at home.

"If they'd told me the truth, if they'd explained, if they'd told me the truth"

Fragmented care

Another person described the challenge of how siloed his experience of care was whilst admitted to hospital. Ironically, whilst eyesight was not seen as an 'urgent and emergency care' issue, poor eyesight represents a significant falls risk.

"But I was told, oh, that's the eye department"

Whilst older patients are in hospital, there is a golden opportunity to address patients holistically, and make efforts to review some of the wider health challenges and safety risks whilst they are already in hospital. Whilst a person is physically present in one place (a hospital bed) their admission offers systems a valuable opportunity to enact a holistic, person-centred and multidisciplinary review.

Older people tend to face a range of practical barriers accessing care via outpatient hospital appointment so a system being flexible enough to organise wraparound care whilst a person is physically in one place makes a big difference.

"When you have to get up and dressed and in via patient transport an early appointment it is difficult"

Another participant was struggling with hearing loss causing her to become less able to connect with family by telephone, and she was becoming very lonely. This was not addressed, but clearly a missed opportunity to mitigate a future crisis. Addressing her clinical need (hearing loss), would also address her social need (companionship), which would in turn help her better manage her health.

"Yes. Increasingly with the hearing. Even on the telephone I can't hear. (My daughter) gets very frustrated when I keep saying pardon, pardon" "A lot of people speak very quickly now"

Age related hearing loss can lead to isolation as older people withdraw from social and community activities. This can also exacerbate cognitive decline, as people with hearing loss disengage with stimulating activities. These are missed opportunities to provide more holistic care, but clinicians need

the time to build a relationship with each person, if they are to have the opportunity to read these cues as to what help will be most impactful and effective for a particular patient.

Getting the basics right: empathy gap

Where care was delivered attuned to older people's emotional as well as physical needs, it was hugely valued.

"I don't think there's many other industries that work as hard as those (nurses and doctors) in hospitals"

However, many participants shared that the psychological aspects of long waits in A&E and the distressing experience of admission to hospital went largely unacknowledged by hospital professionals. Participants identified time pressures on staff sometimes leading to a lack of empathy.

"Oh, you're ill, deal with it, (that's the way it comes over) but you can't deal with it if you're ill. We all need help now and again, we're human not robots"

For some older people in this study, particularly those with self-described mental health problems, this lack of empathy led to feelings of despair and was linked to suicidal ideation.

"Now since I've been ill, I keep sometimes, taking overdose, kill myself off. I think sometimes, they're not helping me like they should do"

"Tablets, you give me tablets, what for? It's not working. I might just chuck 'em in the bin, because they're rubbish" "Can't do nowt for me, so it's a waste of time"

Many of people we spoke to did not feel that their hospital admission had taken account of the emotional toll associated with the experience of becoming acutely unwell and being away from home for an extended period. This empathy gap left older people feeling side-lined, further compounded by the sense they were not being well listened to, which impacted on their emotional wellbeing and lead to a loss of faith in the system.

For one person whose admission led to life-changing heart surgery, hospital staff didn't acknowledge the profundity of the life event and the lack of aftercare has left her extremely frightened.

"Nobody explained anything to me. I still don't know exactly what went on, even now. She was more concerned with training this chap up, they were talking over me all the time, and I don't understand all the jargon they use"

For many of the older people we interviewed, this most recent admission was one in a series of admissions to hospital in recent months and years. This layering of experiences appeared to have a compounding or telescopic effect, whereby many participants conflated their recent admission with negative memories and anxieties from previous hospital stays.

"Really upsetting. When I had heart attack (a previous admission) I was doubled up, on a bed, not on a cubicle just outside in the A&E (corridor) and I was praying to them to help me"

As these interviews reveal, some of the small things like a warm welcome (or the opposite) have a big impact on how safe and comfortable people feel, a set in a motion a positive or negative recovery trajectory. Whilst a focus on clinical need is understandable, it seems that some staff have become desensitised to what the admission might represent (and actually feel like) to the older person. Culture, attitudes and behaviours really matter.

"I wish I could have a day without illness. I'd love that, just one day"

Experience of discharge

Click the audio file above to listen to an account of a negative experience of hospital discharge

Rushed discharge

There is a difficult balance for systems to strike between implementing a 'home first' principle (to avoid the risks of a long hospital stay on the one hand), and ensuring patients are well enough (and well supported enough) to recover on the other. In both rounds of interviews, we encountered older people who felt that they had been rushed out of hospital before they were ready, subsequently ending up back in hospital within 24/48 hours.

"I appreciate they need the beds, but in this case, it was 'save a minute, lose a couple of weeks'" (Carer of wife admitted with sepsis who was readmitted to hospital within 48 hours of first discharge)

"I felt like (rushed), like oh, that's another one off the list"

For others, it was the lack of empathy in the way care was being delivered that made their discharge stressful and upsetting. Several people described being made to feel like a nuisance with hospital staff appearing to have no emotional awareness of what it would feel like to be told 'you're in the way'.

"They (hospital staff) were moaning about it (me waiting in corridor) when they came round. They said, 'why you sitting here?' I said, because I've been put here! I wanted to get home to my husband, you know, I'm his full-time carer"

"At 8 o clock in the morning they said that they needed, not necessarily my bed but the space in the bay, so they put me in the corridor"

This same person had been admitted in an emergency, was recovering from serious heart surgery, and had no personal belongings and no money for a taxi home.

"I was told about transport getting home, and I really didn't have anybody to pick me up. They said, 'we can get a taxi, but you'll have to pay for it' and I said, 'well I don't have any money on me'. All of that was very stressful"

Another person described how on discharge, the nurses would not escort wheelchair patients out of the building. This is a particular challenge for older people who may be reliant on a carer who is themselves frail and unable to take this on.

"You've got to have a dependent to push you around, the nurses won't push you. So, if you haven't got a well person come to meet you, that's quite terrible I feel"

Observing a change in care quality

Most of the older people interviewed had generally low expectations of care and high tolerance levels of unsatisfactory care.

"Cause they're in a rush, they haven't got time to spend two seconds with you, and it's not their fault"

What was more obvious in the second phase of interviews was the number of participants who commented on an observed change in care quality from their experiences of care years ago. For example, one person commented on waiting in corridor bed from 2pm until after midnight to be admitted to a ward.

"Not just me, other people behind me. You don't realise how things are now until you experience it love, and what they have to cope with now in the hospital"

Long waits for a hospital bed were frequently reported and as previously mentioned, long ambulance handover delays were reported by several participants.

"Stayed in ambulance from 5.30pm until 7am next day, so ambulance and two staff had to wait, that really worried me a bit, I was thinking, this is a bit daft. All corridors full with people. Near enough all ambulance at hospital at stand still"

Discontinuity of care was the norm, with even patients with very short lengths of stay experiencing multiple changes of consultant.

"I wish the matrons were still in charge, it was better run"

"Go back 20-30 years (nursing) absolutely brilliantly, today (politicians) they've wrecked the national health service. And all they care about is money, money, money, money"

There was a shocking story of negligence of a woman in her late 80's who fell whilst alone in a hotel room on Christmas eve. She was found unconscious by hotel staff with a head wound and taken to hospital by ambulance.

"I wasn't offered anything to eat and drink. It got to 2am and I said I really could use a drink of something, and they said, 'Oh yeah (as if remembering). I hadn't had my tablets or anything'"

Despite a concussion, the hospital discharged her at 3.30am that (Christmas) morning by taxi to the hotel, who wouldn't take her back to the room she had booked. She ended up back at her own home, where she lived alone. The house was cold, and she had no food in for Christmas as she had been planning to be away for the festive period.

Another story, from the same hospital, described a 78-year-old woman who had also fallen and was also discharged with a severe concussion and head abrasion at 2am the following morning. She was discharged with no-one to collect her so was sent home by taxi, with no-one at home to observe her whilst she slept, no-one to care for her the following day, and no aftercare advice.

Both of these patients described breathlessness and health deterioration in the months leading up to these falls, but no investigation was initiated in primary care prior to the falls, and no further investigation was initiated following the hospital admission.

Delayed discharge

At the other end of the spectrum, evidence shows that older people represent the majority of those experiencing delayed transfers of care. It was challenging to assess the extent to which the participants interviewed for this study experienced delays in discharge as they were not always clear on the reasons for the length of their stay.

"Discharge was not well planned. They told me she was coming home. And then she wasn't. But they didn't let me know" (Family carer)

Of participants who were in hospital for week or more, one participant became frustrated by the length of his stay and ended up discharging himself. This caused problems in accessing the community support he needed from the catheterisation team.

"It was all a bit of a muddle because in the end I discharged myself against advice. The advice was based on fallible thinking, but nonetheless it did delay the support I received"

The time of day and day of the week could also affect whether they received a coordinated approach. For example, lack of access to the community team to address urinary catheterisation lead to one of our participants becoming housebound for far longer than necessary.

"I'm still waiting for the catheter team to contact me. I need them to come in and support me getting back to not needing that thing"

This was one of several examples of apparent inflexibility in NHS services, whereby protocols were rigid and if not followed precisely, the person ended up at the back of a queue, delaying support they received. This is of particular importance around urgent and emergency health events, as swift action makes a big difference to recovery trajectories. In the case of catheterisation, prompt access to the community nursing team is essential to minimise risk of catheter-acquired UTI and associated falls risks.

Waiting for medications was an often-reported source of delay at discharge and several people in this study had been discharged without new medications or understanding how to take them.

Another issue raised by several participants was around failure of care during a previous admission leading to readmission. This was the result of insufficient or siloed medical investigation that failed to address the complexity of the person's needs (in essence, a type of 'failure demand').

"The first time she had the hallucinations, right, they sent her home the next day, they hadn't looked into them. So, she was back there the day after because her blood pressure was through the roof. And then the 3rd time (with the UTI)" (Family carer)

"If the hospital had spent a little more time, the recurrent admissions might not have happened"

Care transitions and absence of aftercare

There was a mixed picture as to whether people felt they had the support they needed to recover once back at home. Where services worked together well, they made a huge difference to people's ability to settle back at home and recover.

"It (discharge) was really well planned. The OTs were really good and explained exactly what they would put in place for him. They were all I think really excellent actually" (Family carer)

But the overall picture was mixed, revealing a patchwork of offers across the different geographies, with a wide spectrum of experiences described. There were some dreadful instances described where the transition between services led to steep cliff-edges in care.

"I didn't know if there were going to be carers here when I got home." "I left that hospital at 11.30am and never saw a soul until I begged them to come next morning. I rang social services, because I was frightened"

"My neighbour got me some milk and some bread. I lay on the settee all night" When you walked in after 8-9 days in hospital, house freezing, had no food in, they just kicked me out"

Evidence from wider recent investigations indicates that there is currently no systematic way of learning about cross-boundary safety risks and where and how responsibilities passed between them ("there is a problem but it's someone else's problem").

All participants praised the quality of voluntary sector support received at discharge.

"They had usually the answer to the problem or running it down so that it could be attended to"

Those participants who had access to voluntary 'home from hospital' support described the positive difference it had made to them.

"I was flabbergasted that he could do it on his own (lift me up and take me home)"

“It's made a lot of difference; I knew I had someone to contact. Even if it’s just a number, it makes you feel relieved, you know it’s there. It makes a lot of difference"

"I think your funding needs to be increased so you can actually step into the breach left by the hospital"

At every stage of life trajectory, there are opportunities to prevent complication and slow the progression of illness, and aftercare is very important to prevent avoidable readmission. Unfortunately, aftercare was minimal for the majority of participants.

"No, I've had no aftercare. They give you a sheet, oh, if you've got a problem ring a number up. My scar was very painful, and I rang them about it. When I had this second incident, I rang the cardiology (team) up and they didn’t want to know. They never got back to me, or my son, and that was the first port of call before 111. They never followed up"

All of the people we interviewed expressed a desire to recover so that they could preserve their independence as far as possible.

"I find it hard, but they have offered me to go to a nursing home, but I've said no, I have been here 39 years, and I've spent a fortune to have it done up. I don’t wanna leave here. And I'm happy, and that would just finish me off if I went to a home you know?"

Scope for prevention

Warning signs

We asked participants if they felt that their most recent admission could have been avoided if different or earlier action had been taken. When participants were asked to reflect on whether they felt there was scope for prevention of their hospital admission, opinions were mixed. Some participants were immediately able to identify warning signs that their health had been declining leading up to their unscheduled admission to hospital.

“As time's gone on, I've gradually got worse and worse. Basically, trying to get to my local shop, it was half a mile and took me seven stops to get my breath back to do it"

For example, one person who had fallen because of heart problems felt that had his request for cardiac follow up been met earlier, his heart problem would have been identified earlier, and he would not have collapsed.

"Definitely yes. My type of work in engineering has been to prevent things happening. With my own medical problems, with my heart, I did feel that I was being let down by the cardiac department"

For others, it was difficult to identify in real-time warning signs that their health was declining, without the benefit of hindsight. This was often hard for the person themselves to identify in real time, because

the incident was a tipping point, but the slow decline had been built over days, weeks, months and years.

"I suppose, looking back at it, I wasn't so well before, it had been building up that I wasn't well. I wasn't aware how sick I'd been".

It is notable that 79% of participants had experienced a previous unscheduled admission to hospital within the past 12 months. We also discovered during the interviews that several of the participants describing their most recent experience also described a readmission within the past month, perhaps indicating that they were not coping as well as they might have been.

"I think it was a gradual decline, slight deterioration over the last three weeks before she had to be admitted. Couldn't put my finger on any one thing, but it was a general downhill slide shall we say"

Where people had experienced recurrent bouts of illness in the preceding months, this could also alert primary care services of increasing frailty and need for enhanced involvement, although it did not seem that our participants had received such enhanced support.

"I was poorly, I've had pneumonia seven times in one year"

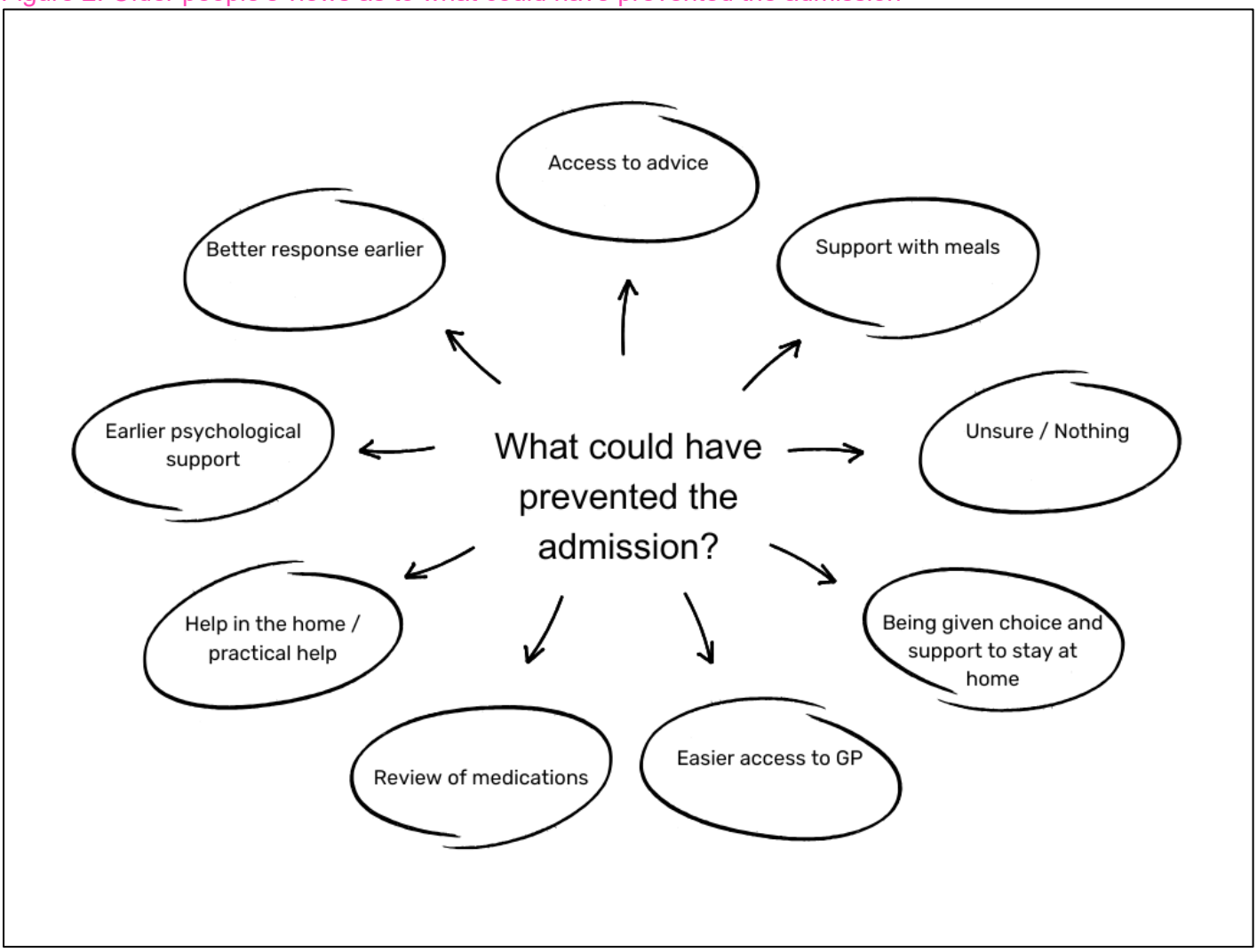
For others, the speed of deterioration or sudden escalation in need came as a shock.

"Difficult really, because sepsis comes on so quickly, even if we'd gone to the GP, he wouldn't have been able to pick that up"

"Well, it was a Saturday afternoon, I had been doing chores around house. Next thing I know I'm looking at the white ceiling, laid out straight on the floor. Took a bit of time, found that my teeth were up the passageway where I'd hit the floor"

We saw some encouraging examples of new assitive technology in use to raise the alarm. For example, one of the participants used Alexa to ring for help after a fall. It is promising to see technological tools like this already in use to help older people retain independence, particularly for the many older people living alone.

Figure 2. Older people's views as to what could have prevented the admission



Alternatives to hospital

Click the audio file above to listen to an account of a carer and patient's distress at hospital staff's attitude to them calling 999 for help

One participant's wife and carer became audibly upset explaining that when he was recently admitted, the hospital staff made her feel like she shouldn't have called the ambulance for her husband's seizure.

"They said, 'what you called 999 for?' (crying) well, I couldn't leave him fitting, could I?"

Instead of feeling validated in seeking help, both patient and carer felt chastised by hospital staff and described feeling helpless as to how to manage these unpredictable fits. They generally found interactions in hospital distressing but could see no other way to seek help, trapped in a cycle of emergency admissions.

For most of our participants, hospital was seen as the default option, with most people having no awareness that alternatives to in-hospital admission existed (e.g. no concept of new models of care such as ambulatory clinics, virtual wards or hospital at home services). The NHS framing of 'out of hospital' care was unclear to the older people we interviewed.

Another setting? "What do you mean? Another setting would be home, love"

It is also possible that asking the question as to whether the admission could have been avoided may have (unintentionally) led some participants to feel defensive and the need to justify their decision to seek help.

"Well. You got to go to hospital to get help. Cause no other way to get help"

It was clear from these interviews that newer concepts like hospital at home and virtual wards are not services that are familiar to or trusted by everyone and would not automatically be thought of in times of emergency.

Malnutrition and dehydration

Inadequate nutrition and hydration were warning signs in the lead up to an unscheduled hospital admission for several of the participants. One person was admitted due to a hemorrhage, but looking back, can see that he had lost weight in the months prior to this emergency admission.

"Well, I'd been getting tired. Well, I called it tired. I was just, just, you can't do no more. I'd come to a full stop." "I had lost weight"

Similarly, a carer described looking back at her father in law's recent admission for clues that his health had been deteriorating. She reflected that, with the benefit of hindsight, he had not been using his regular pots and pans leading her to believe that he had not been cooking for himself in the usual way and was perhaps relying on snacks as his meals.

"Increasingly he'd want us to buy him a lot of snacks. and made me wonder if he was grabbing snacks as he wasn't managing as well as we thought he was" (Family carer)

Another account described how their carer had noticed that they were losing weight and becoming frail, so had started to make them more substantial meals to help build them up.

"My carer thinks I'm getting shaky, losing weight because I'm not eating enough. I had pasta for my lunch, mushroom pasta, which if she hadn't been coming, I'd have had a cuppa soup"

Preventative action

Many participants initially said that their situation could not have been avoided, but with prompting, went on to describe preventive action they had since taken to avoid a recurrence. For example, in the case of a patient who had fallen, this person now leaves their bedroom light on at night to reduce the risk of falling enroute to the bathroom. Prompted by their carer, this is proving a successful strategy for getting safely to and from the commode in the night.

"I don't think so, because I was being careful you know? I do have dizzy spells but I was in too much of a hurry (to get to the commode). Since then, my carers bought me pyjamas that are much easier to pull down quickly. I had a nightdress before"

Another had since installed a range of home aids and adaptations with the help of Age UK.

"Very good. They came out to the house, sorted out where to put handrails and got her some aids to hold onto, a walking frame type thing" (Family carer)

However, some of the measures people had since implemented, were less positive. There were several accounts of people becoming more risk averse and taking measures that would limit their opportunities for social interaction and potentially reduce their quality of life. For example, one person said that they were avoiding going out in the icy weather for fear of falling, and another that they would remain inside until Spring for the same reason.

"I'm leaving everything now until Spring. I just don't feel safe in the ice and snow"

These actions may minimise the risk of falling, but limit opportunities for social support, which themselves are protective against ill-health. This highlights that positive risk-taking is important for older people's quality of life and should be supported.

Others felt that earlier action might have led to treatment for other issues, but that the cause of the admission itself would not have been avoided.

"If he had gone to the GP, the UTI would have been treated, but I have a feeling he might have fallen out of bed because he had a stroke, and that couldn't have been avoided" (Family carer)

"I have had problems with continence related to taking away my catheter. But this would not have improved my ability to manage or prevented the fall"

It is important to balance admissions avoidance efforts with quality of life, as older people may have much to gain from managed risk-taking in favour of an earlier discharge or less medicalised interventions.

Preserving independence

Click the audio file above to listen to an account of loss of mobility and chronic pain leading to low mood

For some participants there was an apparent disconnect between their assertion that they were coping well at home and couldn't identify any preventive measures, and the circumstances they went on to describe.

"I'm very satisfied with everything. Apart from my home, which I find very difficult"

In part, this could be because the issues described are complex, and it is not immediately obvious what support would be most helpful or what support is even possible. As one participant noted, it was Age UK support that made them aware of various local support services. Without this signposting and help to connect with various resources, they wouldn't have known they existed or how to access them.

"It's helped me with the financial side, for council tax, benefits I didn't know about, you know?"

"Excellent. Its opened avenues, I know I can get my eyes tested, my ears done, all thanks to you"

Another way to interpret in these responses is possible fear that admitting the need for help at home could be perceived as an admission that they were not coping and so threaten their independence.

"No, I love my home. I thoroughly enjoy being here"

Some felt that there was little that could be done to help them or found it hard to imagine what kind of support could help to address these challenges.

"I just want to get rid of the pain"

The majority of the older people we interviewed associated support with personal care, and did not have a concept of what else might be available, although in their interviews there were lots of challenges that community services are well-equipped to meet.

"I don't know what they (Age UK) would do for me, I don't need personal care"

"I don't want someone to get a bowl out of the cupboard to put my cornflakes in because I can still do that. It sounds a bit clever, and I want to be too self-sufficient, but that's not what my approach is, I want to get as much help as I can, but what's really needed. I'm still trying to figure out what that is"

For others, community support on discharge had made a big difference. As one participant since life-changing pacemaker described;

"I tell everyone about Age UK, I've just introduced (Age UK support worker) to my friend and she's helping her. I can't speak highly enough of things"

Many cited the benefits of joining Age UK community groups to support their emotional wellbeing.

"I never talked to anybody about how I felt. Until I came here, I've never talked to anybody about my feelings"

"Neighbours, nowadays they don't come to borrow a cup of sugar like they used to"

In some of the interviews it was clear that some 'big' things had been put in place, but the 'little' things hadn't been prioritised which were also important to minimise things like trips, slips and falls. In this way, supporting older people to safely carry out their activities of daily living may be as important as having a pendant alarm (which they may or may not actually wear).

"I have lots and lots of alarms, straight to the doctors, the fire brigade and everything" "The only thing is, I can't get the dustbins up the steps outside"

People commonly described the social support they need to manage their health, highlighting how interdependent the two systems are.

"I can manage my health. What does worry me is that I feel now that since I had a fall in 2023 and again now, that I'm not coping as well with running a house"

"As I get older, I think I would like to stay at home and have care at home so of course I'm worrying about the cost. The income I have now will be the same income until I die unless I get help from the Government"

Impact on older people's mental health

It was clear that for some of the participants, complex mental health challenges were at the core of their presentation to A&E. There are unique challenges around mental health that come with older age, including that trauma from early life can re-emerge, triggered by a stressful life event. This was the case for one of our participants, who described a psychotic break following some big life changes, that led her to A&E.

"No, it all stems from when I was like 16, 17 because my mum killed herself. My dad was dead a couple of months after"

Others described the challenges associated with managing their long-term physical health conditions as impacting their mental health. For example, one person described low mood and suicidal ideation, which he linked at least in part, to feeling unsupported to manage his health. He described frustration

at not having a clear understanding of his conditions and not having the support he needs with symptom control.

"I keep try to tell people, it's not as easy as you think. All your problems, getting to yer" "Way it's going, I'm being honest with yer, if they can't find out, can't find any problems, I can't go through it no more"

There were others whose lower-level mental health problems were generally attributed to loss of social connection in their home environment and feelings of loneliness and disconnection.

"Well, I went through, I don't know whether you'd call it, but it was like a depression"

"I should never have moved around here, you don't see anybody, you don't talk to anyone"

Many participants described the impact that loss of mobility had on their lives, leading to low mood and loneliness.

"I was down on meself, because I can't get about" "Just down on meself all the time, I like to go out and I can't get out"

"I want to get back to normal. I have to use a taxi, I can't do owt else. I can't go on bus, more walking about (taxi comes to door)"

"I'm home by myself most of the time, and I used to be out most of the time"

Mental health struggles are a risk factor for deteriorating physical health in older people and social support is crucial alongside clinical support in protecting against this.

"Stress. Weight loss. Not eating. Not sleeping…so hard to carry on"

The examples in this report show that there are red flags linked to big life changes (e.g. recent bereavement) that signal enhanced support is likely to be needed and could prevent more serious escalation in need if addressed rapidly.

Crisis as turning point

For some participants, the emergency admission represented a kind of tipping point whereby lots of different (but interconnected) factors had reached crisis point. Commonly, this was also something of a psychological turning point, and for several participants the perception of increased vulnerability induced by hospital admission unlocked a willingness to accept more help.

"I'm saying yes to help, rather than I will try and do it myself. I've given in and said I will accept what help is available. I've realised I just cannot do it. I've got to be sensible"

"I'm happier now having contacts in the community that can take me forward in becoming more mobile, more shoppable, just more human. That's going forward quite well"

This seems to be a powerful time to offer additional support to challenge fatalistic or harmful health beliefs (e.g. ‘I can’t change at this age. I don’t want to burden anyone'). However, the flip side of this is that if help is not forthcoming at the time of crisis such negative beliefs can be reinforced, and faith is lost in the system.

Getting the basics right: access to routine care

Commonly, participants described system pressures that were leading to routine care falling by wayside. It was noticeable that few participants were clear on their ongoing treatment plan, and no-one mentioned having access to rehabilitation or reablement support.

“I need to get this appointment taken for cancer what men get. I forget what it’s called, GP knows all about it”

"I've been trying to get this injection out of [the hospital], still on the waiting list. I've been told to go back to the GP to give it a shove"

Other people highlighted the need for person-centred care, and the importance of service offers being available in a menu of formats. For example, another person was very keen for companionship and bereavement support but needed this to be offered face-to face.

“I can't talk on telephone. I did try Silverline but didn’t know what to say, like, hard to find words of comfort, you know?

Challenges with paid carers

Many of our participants described problems with their paid carers arriving at unpredictable or inconvenient times. Several people in this study wanted help getting out of bed in the morning, but support was not available until late in the morning. This would leave them in bed until lunchtime.

"I need to get up and get going"

Other people found that the timings were unreliable and would often be hungry and end up making their own lunch or dinner whilst waiting for carers to arrive. Several people interviewed had very high support needs, so this type of occurrence increased their risk of accidents or falls in the kitchen that the care was designed to avoid.

"I was trying to mash potatoes the other day, and I couldn't mash potatoes!” (loss of muscle strength)

Several older women described feeling uncomfortable with personal care carried out by male carers, but had been told there weren’t alternatives available. Generally, home care services appeared stretched to the point that considerations around quality of life could not reliably be met, when they are the very thing the care is supposed to improve.

Spotlight on workforce

Concern for staff wellbeing

Overall trust in professionals was high amongst participants but it was noticeable how many participants raised concerns for the wellbeing of hospital staff. Many participants commented on the pressures hospital staff faced and extremely busy working environment.

"They were run ragged. I'll be honest with yer, I don't know how they do that job"

"They were nice but they were too busy. The only nurses I saw were the ones on the drug trolley"
"They were all in grey (uniform), because they were training but they weren't (yet) trained"

Most participants expressed a reluctance to blame staff for shortcomings in care.

"You do get a few nurses a bit nasty, you do. And I'm not talking out of turn, but they can be very funny with you, they're under so much pressure they can't cope with it. They can't help that, that's all down to the government 'cause they've wrecked everything"

"Nurses can be under so much pressure, snapping at you, but they do their best. You don't get enough time with them any more as you used to"

Most participants minimised their own discomfort, expressing deep gratitude for the NHS as a system despite the inconsistencies in care described.

"I would not knock the hospital; they work bloody hard, and they do their best. I would never knock the hospital"

"How can I sue the NHS when I know things do happen and I'm not going down that path.I'm so grateful for 'em. I don't want to complain. Alright, it aint gone right with me, but they saved him (my husband), and they probably saved me. And we get transport, and it's all free"

There were very moving examples of all kinds of care professionals going above and beyond to provide comfort. Praise was offered alongside real concerns for the wellbeing of the staff delivering care in a stressed and overstretched system.

"They were all working 13 hours, not 12, and having to pay for their parking! They still carried on doing it and smiled. But I did think that side of it was a bit of a letdown considering what they give to the industry. When the staff gets to a bit more fuller level, they want to think about getting back to an 8-hour shift at the most. I *think this is why a lot of people say, oh I can't do that anymore"*

Spotlight on family carers

Some of the people we spoke to had been caring for most of their lives, including the 100-year-old woman who still cared full-time for her disabled 74-year-old daughter.

“They were good as gold, couldn’t be better. I was only worried about (my daughter)"

All the participants interviewed who themselves had caring responsibilities cited this as their most pressing concern on admission to hospital and worried that the person they cared for would not be supported in their absence. Sadly, this fear was justified in several cases, where there was no support system in place to step into the breach.

“NHS didn’t help to support (my husband) at all, I am his main carer. I kept saying to them, I need to be home. I mean, he was my biggest concern. If it wasn’t for my two sons, one of my sons he had 3 days off work to look after (my husband) and my other neighbours come in to give (my husband) a meal. For any personal hygiene, nothing”

Impressions of how hospital staff interacted with carers was generally negative. No accommodations had been made to acknowledge their caring role e.g. a Carers Passport, visiting out of normal visiting hours, providing drinks and meals or a visiting plan.

"They were better in the second ward he's in now. In the first, they were very poor at their communication, even to the point where they would walk away” (Family carer)

“There was a point when I was talking to a member of staff (requesting more information). the other signalled 'don’t get the file’. We're not demanding, it was very difficult” (Family carer)

No-one had taken the time to explain to our participants their rights as a carer and how to access social and community support.

"Did not keep up to date on progress. Just things like 'he's fine, he's eaten something today’, nothing meaningful” (Family carer)

At hospital I was identified as next of kin, but thinking on, I only got to visit her twice because hospital stopped visiting (norovirus outbreak). I couldn’t get through the hospital by phone. And when I did it was all 'you need to speak to a doctor'" (Family carer)

While there were a few examples of good communication there were not many.

"I spoke to a staff nurse, she was fantastic. She did listen to me. She was the one who did the tests” (Family carer)

Generally, it seemed that carers were left with no option but to attempt to bridge the gaps in a fragmented system. This backs wider research identifying hospitals assuming relatives could care for patients on discharge or transport patients’ home without checking first.

"I've got COPD, osteoarthritis, severe arthritis in both knees, my hands, my shoulders. So, if I had to lift her, I can't"(Family carer)

"I'm a daughter. I try to do the best I can for her." "As time's going on, I am finding it a lot harder [because of own health condition]" (Family carer)

"My work has been brilliant. I probably didn't go to work for 2 weeks...they have been very supportive" (Family carer)

These interviews show that there are limits to what carers are able to do. One carer explained the difficulties in supporting someone who did not want to engage with health or care professionals and declined Flu vaccination and Covid-19 booster. This person had full capacity, and the family carer found it hard to strike a balance between identifying unmet health and care needs and respecting their autonomy and personal choices.

"Apart from him allowing us to call the doctor, this person has their own independence, we have to allow this person to make their own decisions" (Family carer)

Another described similar challenges, with her family member not wanting carers *("strangers")* in the house but struggling to support with the level of caregiving required.

"I was very annoyed with her when she got rid of carers last time, but for getting in and out of the shower she's a bit scared she might fall" "(I say to her) "I can't physically get you in that shower. I can't do it" (Family carer)

We asked if carers were involved in the planning of their discharge from hospital and whether anything could have helped make the transition smoother. Suggestions all related to better communication.

"Having emergency contacts on record is so key, in my work I experience that, but that was the most frustrating thing, that I was dealing with stuff, and they didn't have my details. I do understand about data protection but surely having someone you can speak to would be more useful that my husband who can't pick up the phone" (Family carer)

"The only thing, they (the OT) didn't have caller ID, so you can't call back. That part of it was really difficult." (Family carer)

Examples in hospital included slow response times to alarm or buzzer calls, leading to loss of dignity for patients reliant on help with toileting and other personal care.

"Not wiped properly on bed-pan, left with arse out, not good enough at all" (Family carer)

"I'm having to force information out of nurses, very poor communication once in hospital" (Family carer)

Several carers described the same challenges older people themselves described when trying to coordinate home care agencies, and the lack the timely support, for example, consistency of timings around mealtimes.

“They’d turn up on the morning for breakfast and then, that was a time between 7am and 9am, and then lunch were between 10am and 1pm. So, they’d come at ten to nine to do his breakfast and then come at half past ten to do his dinner! It’s like, he don’t eat that much anyway”

Sadly, it was clear that the stress of ongoing caring responsibilities was leading to carers’ own health and wellbeing was also declining.

"I have this ability to be super strong in these situations. I'm not expecting anything to happen now, it will be when everything’s resolved. I'll probably just have a freak out and then I'll be fine.” (Family carer)

"I don’t feel well actually. Sometimes I don’t sleep very well I know I've got to go round and check she's ok. Sometimes I just want to go to bed myself, but I can’t do it. I suppose sometimes I do get a bit low in myself, but sometimes it seems like sometimes it’s just me who's trying" (Family carer)

None of the carers in this study had access to respite care or the ability to take a break from caring for their loved one in the near future and were living with a lot of stress and anxiety.

"I think to myself, well, when is going to be the next episode?" (Family carer)

"I weren't like this before, I could do it, but now I can’t" (wife's health and mobility also declining)”

Family carer’s experience in hospital - vignette from Sid’s story

"There was 37 beds in a corridor, and my sister was number 10" “It’s a broken system. You’ve got an analogue system in a digital world. Part of my role was going into failing business to turn them around. I just look at it, and it’s not fit for purpose”

Sid doesn’t think mental capacity assessments carried out in hospital are thorough enough (the assessment he described was for the patient to be able to say their name and data of birth and nothing more).

“It just really scared the living daylights out of me. It’s the first time in my life I’ve had to deal with the NHS”

Sid went to great lengths to explain to hospital staff that his sister, who had been admitted with dementia and health complications from alcoholism, did not have capacity and begged staff to ask more questions. *"I had to introduce myself every day, as there were new staff on. I don’t blame them, but there was no continuity. It was a constant battle me trying to convince ‘em of my sister’s state of mind" (Family carer)*

Carers who are themselves patients – vignette from Diana's story

Diana is 73 years old and lives in Norfolk with her disabled husband, who she cares for full time following his cancer diagnosis and associated leg amputation. She was recently admitted to hospital with heart problems and an emergency operation was carried out to fit a pacemaker.

"No, I'm not in a good place with my health. Since I've had this procedure, it's knocked me for seven actually."

Diana called 999 after becoming suddenly unwell at home. The paramedics conducted an ECG and determined that there was a problem with her heart. On admission to hospital, she was told she needed an emergency operation to be fitted with a pacemaker.

"I was very concerned about leaving (my husband) as I didn't really have anyone to look after him, but I was told I'd be home Sunday, at the very latest Monday. It was just, like, a day procedure"

Unfortunately, there were serious complications with the operation (heart and lung puncture), resulting in Diana being rushed back into emergency surgery, which was very frightening, particularly as this was not disclosed to Diana at the outset.

"NHS didn't help to support (husband) all, I am his main carer. I kept saying to them, I need to be home. I mean, he was my biggest concern"

Diana was kept in hospital for a further 9 days, which caused her great worry not just for her own health, but also for her husband who was left without support at home.

5. Long-form case studies

Case study 1 – The importance of early intervention

Joseph's story

Joseph is between 90-94 years of age and lives in Wakefield District. He enjoys walking, golf and gardening. He adores his family and spending time with his granddaughter. Joseph lives with a physical disability, visual impairment, 3 long-term conditions and takes between 5-10 medications daily. He is recently widowed

Emergency admission

Joseph called an ambulance late at night, when he found he was having breathing difficulties. He was seen in A&E where he was diagnosed having had a panic attack and was discharged the following day. Joseph explained that in the lead up to his admission he had experienced several debilitating panic attacks following the recent death of his wife. He found his experience in hospital reassuring, and it was in hospital that he learned breathing techniques to help cope with the anxiety.

"I miss my wife just now. I miss her a lot, I'm struggling to come to terms with it, it's really hard. I miss her terribly"

Joseph is now back at home but still feeling very lonely and struggling with being in the house on his own. He would like more companionship, particularly in the evenings. He is focused on eating more to build up his strength and taking the medication prescribed to help with his anxiety. Joseph is on the waiting list for an Age UK Befriender and would like to find some face-to-face bereavement support. He tried Age UK's Silver Line support but struggled with it being a telephone service.

Clues and warning signs

Looking back, Joseph sees clues that his health has been deteriorating in the months leading up to his hospital admission. He had not been eating or sleeping much, had lost a significant amount of weight, and was generally feeling very low and anxious.

"Stress. Weight loss. Not eating. Not sleeping… so hard to carry on".

Despite having nothing but praise for his GP and the hospital staff who cared for him in A&E, he has not been offered any follow-up support for his mental or physical health, beyond anxiety medication.

"I did have tendency for suicide, once. I'm strong enough to overcome it, I think I will do, I'm sure I will do"

At face value, Joseph attended A&E because of a mental health emergency. A closer look at his history reveals that Joseph was recently widowed, leading to him becoming extremely low in mood, anxious, lonely and socially isolated. Consequently, Joseph was not eating or sleeping and becoming increasingly frail. These mutually reinforcing factors all negatively impacted his mental and physical health.

"It's the nighttime's the worst. From dusk 'til dawn, I suffer. I sit alone."

Affecting the function and recovery of every organ system, malnutrition is a cause and effect of illness and is a silent and, all too often, hidden problem that can lead to long-term health issues in otherwise healthy and independent older people.

There was a missed opportunity to identify these warning signs that Joseph's health was rapidly deteriorating. Older people who are depressed are at increased risk of frailty, functional decline, and cognitive decline and evidence shows that across the board, mental health symptoms in older people are far less likely to be disclosed, detected, or treated. Bereavement is a common risk factor for ill health and had community care services been better age-attuned to notice these warning signs, action could have been taken earlier that may have avoided Joseph reaching a crisis point.

Scope for prevention

For Joseph's ongoing recovery, and to avoid a readmission to hospital under similar circumstances, a coordinated response is needed. A range of social and clinical support services could help Joseph rebuild his health. For example, Age UK Wakefield District have made contact via the Home from Hospital service and are looking to find Joseph a befriender to provide companionship and to help him manage his loneliness. The hope is that this intervention will also help his loss of appetite and enable him to address his malnutrition, which will also be important to his mental health recovery. Joseph was also worried about the cost of heating his home, another factor fuelling his anxiety. Age UK have helped Joseph to access financial support that he was unaware he was entitled to.

"It's helped me with the financial side, for council tax, benefits I didn't know about, you know?"

Alongside this type of VCSE support, input from a dietician could help support his nutritional needs. A carer could support his nutrition and hydration in practical terms with meal preparation (including adjusting to cooking habits for only one person instead of two) and encouragement to eat and drink, helping Joseph to regain his physical strength. Psychological support could help Joseph learn techniques to better manage his panic attacks and provide bereavement support as he processes his loss. A social prescribing referral could help Joseph with making links to local community groups to increase his social contacts in a way that works for him. He loves golf and gardening so those are two obvious places to start. Closer monitoring of his general health by his local GP would be beneficial until he is feeling better able to cope. These separate but linked interventions could be coordinated via his local Integrated Neighbourhood Team.

"Companionship would be a big help, just to break the night up"

Case study 2 - The importance of identifying, involving and supporting carers

Susan and Bill's story

Susan cares for her father-in-law, Bill, who is 97 years of age, and lives alone in an assisted housing facility in Norwich. Bill has a physical disability and hearing impairment.

Until recently, Bill had been living independently and able to manage all day-to-day activities by himself, but after a fall two years ago, Bill has lost his mobility and with that his confidence. He now rarely leaves his home. Susan provides around six hours of unpaid care per week to support him with daily tasks like cleaning the house, laundry and food shopping.

Emergency admission

Bill was recently admitted to hospital after the care warden of the housing association found him on the floor of his home and called an ambulance. It is unclear how long Bill waited for help to arrive, as he was unable to raise the alarm himself. Bill was found at 8am, meaning he could have been on the floor for up to 12 hours.

"The housing association gave him a personal alarm, but like 99% of people who have them, he didn't have it on him or even near him"

When he reached the hospital, he was diagnosed with a UTI and sepsis. It was later discovered that Bill had had a stroke, something that Susan thinks is most likely to have caused him to fall. This was not picked up by the care team at the time of first admission, and it was Susan that raised the possibility after noticing changes in the function of Bill's right hand and speech difficulties that were unusual. Bill was discharged but unfortunately readmitted to the same hospital within 24 hours after another fall. It was on this readmission that a stroke diagnosis was made. At the time of interview Bill was still in hospital, and his rapid health deterioration means it is likely he will be discharged into a full-time care facility.

Scope for prevention

Susan recognised that Bill's admission to hospital was necessary, but also recognised that, with hindsight, there were clues that his health had been declining in the months leading up to his fall:

"*I only noticed this after he'd been taken into hospital. We made sure he had plenty of things like tinned soup if we couldn't get there for any reason. I noticed after that the soup pan didn't look like it had been used for a long time...that made me wonder whether actually he'd felt able to eat."*

Susan felt that the hospital did not make enough effort to understand what had caused Bill's fall, nor to put in place sufficient supportive measures to prevent the rapid readmission to hospital. As it was, Bill ended up back in hospital within 24 hours of his first discharge.

"They decided what the issue was. No curiosity, no follow up"

Caring for the carers

Alongside caring for Bill, Susan has also been caring for her husband, who had also been recently admitted to hospital. She has a strong family network to call on but admits that it has been a very stressful time for her too. Whilst local authorities have a duty to provide Carer's Assessments, care packages are often devised without due consideration of the ability and willingness of family members to provide the intensive levels of support many older people require.

"My son and my daughter, they don't live locally, but they've been here quite a lot to be as supportive as they can be"

She is grateful to her employer who she describes as being very accommodating when she's had to take time off work at late notice. Susan would like some respite support and is planning to connect with Carers Matter Norfolk once the current emergency is over.

"…my previous manager, she was talking to me about my father-in-law, and she said to me it would be good to register with Carers Matter Norfolk"

Many carers of older people are themselves living with health conditions and may be struggling with the emotional and physical toll of caring for their loved one. It is important that carers like Susan are clearly signposted to any help that is available locally. Social workers may be able to offer respite support or help to make connections in the community.

Identification and involvement of carers

"Having emergency contacts on record is so key"

Evidence also shows that carers like Susan can struggle for recognition and support from health professionals. Susan was not identified as a carer by the hospital, found communication with healthcare professionals difficult, and struggled to get a clear picture of Bill's likely health status and future support needs.

"They didn't exactly invite me in, I sort of forced my way in"

Involving carers in decision-making and recognising their role as expert partners in care serves to benefit patients, carers and the NHS alike. Carers have rich insights into the person they care for and are often the first to notice signs that a person's health is deteriorating. For example, Susan was the person who identified that Bill may have had a stroke because she was able to pick up on more subtle cues in his speech and cognition. The care team did not initially pick up on this, attributing it to the UTI and sepsis, but Susan knew Bill well and felt that something else was wrong.

Update March 2025: Sadly, Susan has since been in touch to let us know that Bill has died. Susan felt it was important to include his story here, to help improve care for others in similar circumstances.

Case study 3 - The importance of timely aftercare and ongoing support

Ralph's story

Ralph is 80 years of age and lives in West Sussex. Ralph lives with a physical disability, 2 long-term conditions and takes between 2-5 medications daily. He can get out and about independently, but with some difficulty. Ralph does not have access to the internet at home.

Emergency admission

Ralph has recently moved to the area and is finding it hard living further away from his son and feels he lacks a local support network. Ralph fell at home in what he described as a 'simple trip fall'. He activated his home alarm and was taken to the hospital by ambulance and admitted for approximately 21 days.

"What led me to go into hospital was a fall that left me bruised but was only a short-term problem. That problem was made long-term by the various attempts in the hospital to put a different interpretation on things"

Unfortunately, Ralph acquired a chest infection whilst in hospital, which prolonged his stay. Ralph felt that he waited a long time to be seen by a consultant and that hospital was the wrong place for him to be cared for. This was Ralph's second admission to hospital within a few months, having been previously admitted with a UTI. Extended hospital stays can lead to deconditioning, as opportunities to be physically active are drastically reduced.

"I was the subject of repeated blood tests and blood pressure checks, but no information was given about how my admission was being handled"

Ralph describes his frustration at the lack of communication from hospital staff about his treatment plan and explanation for why he needed to stay in the hospital. He felt that he wasn't being listened to by clinical staff and was worried about his health deteriorating on the ward. Ultimately, this communication breakdown meant that he lost trust in those caring for him which led to him discharging himself from hospital against clinical advice. This caused Ralph delays in accessing the aftercare and community support he needed.

"So, it was one problem becoming two or three problems and not treated well by the hospital. It caused me to wonder if hospital was the best place for me and I discharged myself eventually"

Evidence shows that, like Ralph, there is long history of patients describing assessments that are brief, with a tendency to focus on the presenting problem, rather than explore wider concerns which many felt impacted on their current illness or were a higher priority to them. A comprehensive assessment could help to identify the types of support that Ralph would have found most beneficial to improve his quality of life. This might have included specialist nurses – e.g. continence nurses and physiotherapists, who working together could support his mobility and confidence in social settings.

Newer care models such as ‘discharge to assess’ teams can provide a thorough assessment at home for older people who have been assessed in A&E as not requiring acute admission.

Scope for prevention

Ralph’s biggest medical challenge on discharge was accessing the community catheterisation team to help support him towards not needing to use a catheter. His community referral was delayed as Ralph discharged himself from hospital, leading to administrative confusion. Unfortunately, this also delayed Ralph’s recovery as he became effectively confined to his home whilst waiting for nursing care. This was particularly unfortunate as his main goal for his wellbeing is to build up his community support network now that he is back at home.

"I have a small network. I would like to increase it. My son lives many miles away, so I am thrown back on my own resources an awful lot."

For Ralph, access to prompt catheter care on discharge was essential to protect against the risk of catheter-acquired UTI (which would also raise his falls risk) as well as supporting his goal to increase social activities and manage day to day tasks like food shopping and attending outpatient appointments. Urinary incontinence may lead an older person to rush to the toilet, increasing their falls risk. It may also raise anxiety about social activities or managing day to day tasks like food shopping and attending outpatient appointments.

"The hospital is not aware of what is possible" (regarding local social support services)

Age UK has since been able to step into this breach and help make community connections with various services and networks. What these services have in common is helping to make day to day life a little easier and avoid small things escalating into big problems.

"I'm happier now having contacts in the community that can take me forward in becoming more mobile, more shoppable, just more human. That's going forward quite well".

Timely aftercare and support at home is vital if people are to achieve the best possible recovery. Ralph’s story highlights the importance of shared decision making to ensure that older people are partners in the care they receive at every stage of their journey.

Case study 4 - The importance of multidisciplinary approaches in hospital

Peter's story

Peter is 94 of age and lives in Cornwall. Peter is widowed, has no children, and lives independently with support from daily carers. He is registered blind, has 3 long-term conditions and takes between 5-10 daily medications.

Emergency admission

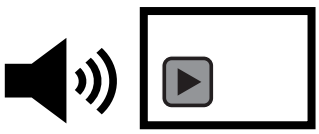
Peter was recently admitted to the hospital for 10 days following a haemorrhage. This came as a shock to Peter, as it did not appear to be directly related to any his pre-existing long-term conditions. Peter is registered blind, and it therefore took him some time to realise that he was losing blood.

"I got an infection or something…and I had to get up during the night, and this particular night I'd got out of bed and went to the bathroom and thought, I'm leaking, I'm wet. I went out to the bathroom and come back and went out again but come to realise…they called it a haemorrhage. I was plodding around in that during the night."

Peter was admitted to hospital for 10 days and felt very well cared for by the hospital staff. However, whilst in hospital, Peter's routine healthcare fell by the wayside. For example, he was due to attend an outpatient appointment for his eyesight. The team were unable to see him on the ward, so he missed this appointment. This was a significant set-back for Peter who is registered blind and relies on these appointments for sight-loss support.

"*But I was told…oh, that's the eye department*"

Whilst a person is physically present in one place (a hospital bed), the system has a golden opportunity to coordinate around them to deliver wraparound preventative care.



Click the audio file above to listen to Peter's account of raising the alarm

Scope for prevention

"I'm the only one left. There has been a lot of loss in the past year"

Uncovering a more detailed history, it emerged that Peter had been getting very fatigued and was losing weight in the months and weeks leading up to his emergency admission. These are warning signs of increasing frailty, and this change in our way of coping can mean that a minor problem for someone who is frail, could become a serious illness. There are clear benefits of taking a proactive

approach for early identification of pre-frailty and acting to arrest or slow pre-frailty can help older people maintain their independence. Evidence shows that those who underwent Comprehensive Geriatric Assessment as a hospital inpatient had a 30% higher chance of being alive and being in their own home at 6 months likely because it ensures that older people with frailty are diverted to the most appropriate services within the hospital as quickly as possible.

The right support once back at home can often make a big difference too. For example, input from the local council's Sensory Impairment team would help Peter to safely use his oven and microwave, allowing him to live independently and remain in her own home), Once back at home, Age UK's Hospital to Home and Home Care teams conducted a guided conversation to assess his home needs and set Peter up with an Age UK befriender. Alongside clinical interventions, enhanced support could look like help to get on the Power Grid priority register, get access to Talking Therapy support or arrange a needs-based assessment for increasing care at home.

"I've got everything that's going I think, and I'm very grateful"

This type of lower-level support is designed to help people to cope better with their daily lives, offering a patchwork of services designed to meet the specific needs of each person. Types of support are necessarily wide-ranging, but lower level doesn't mean of lower importance.

There were missed prevention opportunities in hospital too; a more holistic and multidisciplinary assessment in hospital would have benefited Peter and set him up to make a positive recovery at home.

Case study 5 - The importance of a well-planned discharge

Sarah's story

Sarah is between 75-79 years of age and lives alone in Blackburn with Darwen District. She has 5 long-term conditions and takes 20+ medications daily. Sarah has very limited mobility and receives support from a Home Care agency and Age UK Befriender. Sarah does not have a smart phone and does not have internet access at home

Emergency admission

Sarah recently arrived at A&E at Blackburn Royal Hospital where scans revealed she had broken her back. She was subsequently admitted to hospital where she spent approximately 9 days on a ward. Unfortunately, Sarah had a very negative overall experience of nursing care in hospital, describing staff members speaking to her rudely and not receiving the support she needed with essential care.

"I felt like, frightened to ask anybody, if I asked for help they'd say 'you can use your hands, wash yourself". "I didn't know what was going on! I didn't like it." "I felt like a leper"

This was very different to a previous experience in the same hospital where Sarah felt that her care was much better.

"I can't explain how I felt but when I was in hospital before on another ward they treated me like a human being."

Discharge support

Sarah's discharge was badly planned, and she was left alone and unsupported. This type of failure of care transfer between hospital and social services or step-down care services can have a profoundly negative impact on recovery.

"I didn't know if there were going to be carers here when I got home. I left that hospital at 11.30am and never saw a soul until I begged them to come next morning. I rang social services, because I was frightened"

"They just kicked me out" "No, they just went! It wasn't their job was it really? It's not their job to make sure I'm nice and warm"

Sarah's mother and sister, who she was very close to, have both recently died and she has very little informal support around her. Thankfully, after Sarah had raised the alarm herself, the social services crisis team arrived the next morning to help her get washed and prepared her breakfast.

"They were so kind; I was so grateful to them. I wouldn't have known what to do".

Scope for prevention

Appropriate safeguards must be in place before vulnerable people are discharged from hospital. Sarah's story supports wider findings suggesting room for improvement in discharge decision making so patients receive the most appropriate support in the right place at the right time, and don't bounce back into hospital because they haven't got the necessary support in place at home.

For people like Sarah, 'settle-in' services are essential to ensure patients feel safe supported on arrival home. This also provides an opportunity for post-discharge follow-up interventions including onward referral to 3rd sector support services.

"I feel because of the situation (broken back) I could have gone into a care home or rehabilitation centre (instead of hospital)"

Despite having broken her back, Sarah was not offered any form of rehabilitation and has not been followed up by her GP. Optimal rehabilitation helps prevent avoidable hospital admissions or readmissions, reduces hospital length of stay, reduces the need for long-term social care at home and reduces rates of admission to long-term care facilities. The British Geriatrics Society described rehabilitation, reablement and recovery for older adults is an important 'invest to save' approach for health and care systems as it reduces the impact of acute or chronic conditions, illnesses or injuries by preventing or delaying long term disability and dependency and reducing carer burden.

Maintaining someone's mobility for longer will not only keep them better socially connected and emotionally resilient, but may also slow down their arthritis, COPD or diabetes for many years, reducing the risk of frailty. Of course, better discharge decisions depend on community services being available when needed.

When we asked Sarah if she had been hospitalised before her recent admission, she explained that she had previously admitted to hospital in the last 12 months for what she described as 'an accidental overdose', raising safeguarding concerns about whether Sarah had been getting the support she needed. These examples illustrate why hospitals, GP practices, intermediate care services, should all be aware of what happens to older people after they leave their service and pay attention to these interfaces and hand-offs.

Case study 6 - The importance of listening to what matters most to the person

Mary's story

Mary is between 90-94 years of age. She has lived alone for the past five years, following the death of her husband, and misses her children who all live far away. She lives with 6+ long-term health conditions and takes between 5 and 10 daily medications

"Annoyed, fed up. There is something wrong. I'm not one that wants to pretend I'm ill, I'd rather be out there doing my own shopping and things"

Mary was at a low ebb when we spoke to her because of her health conditions. Specifically, she was struggling with pain from pressure sores and incontinence, both of which were causing her a lot of discomfort and distress. The district nurses are aware of these sores, which need to be regularly dressed, but didn't check them the last time they visited. She is waiting on a gynaecology referral, although this news came as a surprise as the information wasn't conveyed to Mary directly (instead, health professionals told her niece who had accompanied her to a healthcare appointment).

"*I didn't know, no-one told me"*

Emergency admission

Mary didn't want to go into hospital but felt that there was no other option for her. She described the hospital doctors remarking on her reticence to be admitted.

"It's down on your note that you didn't want to come in"

Mary feels frustrated that the hospital discharged her without getting to the root of her problems and was discharged without being told what was happening. When she asked, she felt she was not a priority, with staff explaining they were busy.

"Well, we're busy, we've got a lot to see to"

During her time in hospital, Mary felt uninformed and felt that staff didn't explain what was happening or fully investigate her concerns. She didn't see a gynaecologist and no-one addressed the sores around her bottom that remain a cause of significant pain and discomfort.

"I'd like to be more involved in knowing what was happening" "Why couldn't somebody come and tell me what [test results] were"

Scope for prevention

Mary relies on daily carers to help her manage at home, but since her care has been reduced from four to three times a day, struggles with the limits of their support. She never knows which carer is coming or at what time. Mary finds daily tasks a struggle, for example, administering her own medication is often not possible because she can't administer the syringe herself. She often misses meals because she

can’t prepare them for herself as she is often dizzy and unsteady on her feet, and so if a carer is late or doesn’t arrive, she has no support.

"They've took me one carer off, and I'm not able to do a lot, losing me balance I lean against everything"

Mary can no longer climb up the stairs and into bed, so sleeps in an armchair downstairs.

"I have to find a certain way to sleep. The carers have to be careful [because it hurts]"

Mary is doubly incontinent and very unsteady on her feet, her involuntary shaking making it hard to manage day to day activities like lifting a kettle. Mary is worried about falling and this challenge is compounded by her sight-loss.

"I'm leaking all the time, I stand up and it just pours out of me, and I'm leaking from my back passage"

"Because of feeling dizzy and what not, I can lose my balance, and I don’t want to fall. I've got involuntary shaking of me arms, so if I pick something up (shaking)"

Scope for prevention

Mary is looking forward to getting new glasses in the next week, commenting that getting her glasses prescription is very expensive.

"£400 odd at SpecSavers”

Getting the right prescription is essential for Mary who is visually impaired, and so at increased risk of trips and falls. Unfortunately, financial constraints can lead to older people not getting the aids and adaptations they need. This is where VCSE services can help, to make sure that older people are accessing all of the support they are entitled to. During the interview, Age UK suggested that a benefits check might be helpful and will follow up to explore this with Mary.

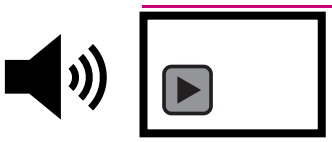
This is important to improve Mary’s quality of life and help her maintain independence. But this support doesn’t address the Mary’s biggest health concern, her pressure sores and continence issues. These were not picked up during her emergency admission with breathing difficulties, despite being a priority for Mary. At the time of interview, she is still waiting for a referral to gynaecology.

"Well, I've still got the pain and trouble, they've never found out what it is”

Unfortunately, in a system stretched at the seams there is less time for ‘noticing’ what matters through caring interactions that are expansive enough to encompass both the biological and the biographical aspects of health.

For Mary, care that is personalised to offer her more control and choice in the way their care is planned and delivered would have been preferable, facilitated by healthcare professionals involving her in key decisions about her care and outcomes. Most important of all, care would be tailored to what matters to her as an individual.

6. Views from local Age UK professionals



Click the audio file above to listen to an account of difference Age UK service has made

General reflections on interview findings

An interim report from the first phase of interviews was shared with participating local Age UKs. We asked local leaders to share their reflections on the findings, summarised here.

There was consensus amongst Age UK local professionals that that the findings reflect local experiences more widely. Local professionals felt that the importance of getting the basics right for older people was routinely underestimated, with medicines management a frequent example.

"Lots of pharmacies will refuse to blister meds now. A lot of people have mucked up their medication or not taken it because they don't understand the boxes, whereas when it used to come out with days of the week and everything, brilliant. But its really hard to get anyone to do that anymore. The pharmacies say they don't have the time, resources or funding to do that anymore, so we literally have to grovel if we want that done"

Geeting the basics right is particularly important in the context of increased levels of need and/or increased frailty in the older population in the wake of the Covid pandemic.

"I think people have underestimated the impact of the pandemic. Frailty is higher, and your results shows that with falls. There is a lack of emphasis on physical mobility at all parts of healthcare, and the basics that increase risks like dehydration, malnutrition, medication control, sleep. Too many people are missing the basics" (Age UK Norwich Senior Leader)

The challenges around medications were well recognised, as were the increased risks for older people living alone. Several people highlighted that older people living by themselves were often lacking a strong social support network, and consequently, often picked much later than would be optimal by services.

As well as older people being in generally worse health than pre-pandemic, it was felt that services had not recovered to their pre-pandemic standards either.

"I am wondering how much of the shift to crisis mode is still relating to the pauses on services during covid and the fact that processes never seemed to recover the same standards. I feel that more patients on pathway zero were receiving hospital care previously and now their needs are more complex before meeting criteria for hospital admission" (Age UK WSBH Manager)

Several professionals highlighted that the threshold for accessing care and support was now too high, meaning that people can now deteriorate to a place of crisis before they can get access to the help they need, meaning opportunities for prevention are missed.

"…the changes in criteria of services meaning circumstances have to be worse before intervention kicks in and generally how poorly people seem to have to be to receive the care and attention they need" (Age UK WSBH Manager)

Several Age UK professionals also described in-hospital discharge support being stripped back so that patients are being discharged in a less fit state than previously.

"In addition to this patients used to be deemed medically fit for discharge and then had further rehabilitation type input on the ward before receiving fit for discharge status, meaning that a lot of what is now required to be provided by community (UCR) teams would have been provided in hospital resulting in fitter and healthier patients being discharged home so less services were (later) required" (Age UK WSBH Manager)

Another issue raised was hospital services not involved Age UK earlier in the discharge planning process to enable them time to put in place measures to ensure a smooth transition back to home.

"We can have shopping waiting for them, we can turn their heating on, we can look at the property (with earlier involvement in discharge planning)"

"We see this [medication mismanagement] dramatically increase as people leave hospital, where meds are normally changed, with little support around the impacts like nausea, toileting, dizziness, lack of sleep, which can all be a falls factor. The power of white-coat syndrome is overlooked and too many people are left guessing, and 80 year old carers taking the strain, as shown in your findings" (Age UK Norwich Senior Leader)

One suggestion was that social prescribers could address some of this need if they were made available inside of hospitals and better data to document the early stages of frailty (at which patients are most receptive) would help focus efforts on community referral pathways.

"In my opinion, social prescribers should be used for inpatients. They can signpost and ensure the patient gets the best support once home, to prevent failed discharges and readmissions"

Challenges in delivering admissions avoidance service(s) locally

Age UK professionals across different geographies identified similar challenges, which grouped mostly around funding and commissioning insecurity. They described services directly linked to healthcare pathways at threat (such as social prescribing, adult social care waiting lists and hospital discharge), as well as those linked to the wider determinants of health that are critical to tackling health inequalities, (such as accredited advice, food and debt services).

"This unsustainable situation stems from fewer funding opportunities, below-inflation uplifts, rising costs, and increasingly short-term commissioning practices and churn." (Age UK Norwich Senior Leader)

Taken together, these types of community services form the bedrock of independence for older people, helping them to manage health conditions, prevent crises, and support positive recovery and routes back to independence when things go wrong.

"NHS procurement process is burdensome and can feel like it is designed to exclude smaller organisations. The Local Authority does use grants as a way of funding services – this is positive in that the money does flow out but also high risk in terms of no uplifts and no easy route to make funding recurrent" (Age UK Wakefield District Service Lead)

Wider national finance policy decisions such as National Living Wage, changes to employers National Insurance contributions have also had a negative impact. Local services are taking a range of actions to address these challenges. For example, in one locality there had been some positive developments with new procurement rules being used to re-commission high quality value for money services, avoiding the need for a full re-procurement process.

"(We're) looking to secure funding to have a formal presence in the Integrated Transformation of Care. Funding for this was previously in place but pulled at short notice even though there was evidence of an effective service" (Age UK Wakefield District Service Lead)

Unfortunately, there were several examples of these types of cuts being made even where there is very strong evidence of quality, impact and cost avoidance.

"They only do it on a year's contract, and we never hear until the last minute about funding, and it's hard to retain staff on a year's contract. We do a good job, we know we do a good job, and we support far more discharges that we're commissioned to do" (Age UK Cornwall Senior Leader)

Age UK professionals feel there would be value in NHS services getting to know the VCSE offers in their local patch and NHS and other professionals to help signpost those who would benefit from this support. Understanding what is available locally is particularly important given that increasingly, the high turnover of staff at the hospitals and the use of agency staff often means NHS services are not aware of community support services that do exist. This is made more difficult because of the issues of short-term funding and services closing, which makes it harder for NHS staff to keep up with what's currently available.

Where to focus to reduce avoidable admissions and improve older people's experiences of care

Generally, it was observed that investment isn't flowing in the direction of preventative services, with most of the funding concentrated at the acute end of the system, admitting people to expensive and busy A&E departments, when it could be better deployed upstream, preventing ill health and treating people in their home or community. High-quality services like those described in this report transform

lives but are not receiving corresponding investment to support their growth, whilst there are examples of duplicate services being created at higher cost in other parts of the system. For example, a recent survey of the Norfolk & Waveney Later Life Provider Network highlighted rising demand on their services, with increasing referrals from the NHS, Social Care, and District Councils, whilst their Membership reported an average funding reduction of 16% in 2024, with a projected decrease of 36% in 2025. As one local senior leader explained:

"We do not see this commissioning priority [preventative spend on community services] reflected locally. To the contrary, there has been a reduction in grant and contract opportunities, with annual increases below inflation or even zero"

This is a problem because it is these upstream approaches that offer a lower level of day-to-day support that is vital to prevent escalation of need and stop older people sliding into a crisis that could have been avoided if clues and warning signs had been acted on earlier. Such approaches also tackle immediate pressures in readmissions by prioritising sustained outcomes for people, including those recently discharged from hospital, which improves wider system flow.

Focus on intermediate care

There was consensus that older people need more intermediate support as their needs escalate (step up care) and to support them when they come out of hospital (step down care).

"The time before and after a hospital stay is where the focus needs to be"

However, many older people find themselves discharged with short-term support that ends before they are fully recovered and confident to cope on their own. Several Age UK leaders reflected that the consequence of this can be a readmission to hospital and that, whilst crisis services are important, the corresponding support for a longer-term transition back to independence is often lacking.

"If you have a fall, as an example, you will get a SWIFT team come out – to avoid the hospitalisation. But, underlying reasons causing that fall are not routinely covered, or solutions funded. We also have people repeatedly in crisis, due to their general ability to cope in today's world. Regular, low-level support helps avoid this, but a lot of this type of community support work has been reduced" (Age UK Norwich senior leader)

Unfortunately, available short-term discharge care packages too often leave many older people at a cliff edge when this is withdrawn. For example, one Age UK service lead reflected that;

"There are very limited care providers in this area with capacity beyond 4 weeks. We extend support up to 8 weeks, and we never leave people until we know they are managing. We are very passionate about the fact that even after their allocated number of sessions, if they are still not coping, we will

extend their support until we and they are confident that they are able to manage independently" (Age UK Cornwall senior manager)

Investment is needed in support that helps people to stay well and recover well and includes things like care coordination, home from hospital support, checking that discharge meds are correct and appropriate, booking follow-on calls to check progress and monitor, acting quickly when there are early warnings of an exacerbation, helping with access to rescue medications and more.

The pace at which help is available is also important. Often people need time to digest information and advice and to think through the options that are right for them. Once back at home, a paced recovery is important, which may take longer than the any assigned short term support package allows. Offering gentle support to help older people to manage low mood, regain confidence and increase ability to take part in social activities can take time. Readmission could be avoided with a longer-term support offer addressing those lower-level needs, and in some cases, might avoid the wait for a care package.

"I think commissioners are understanding the value of VCSE services. (In discharge planning) you can take away the necessity of a care package, the person might not need personal care. VCSE services can provide that lower-level support that might avoid the need for a lengthy wait in hospital to agree a care package. Often, the person can be discharged straight away and be back at home with the support we can provide" (Age UK Cornwall Senior Leader)

Earlier identification of unmet need

Age UK professionals pointed out that frailty is not an inevitable part of ageing and preventative measures can delay its onset and progression.

"In my opinion, in the community low level response, is key. If we can keep people at home, that will be a vital part of preventing a hospital admission, which can be highly disorienting, comes with its own sense of challenges and often goes against people's wishes"

Age UK professionals recognised the challenge that for too many older people, the presenting issue at is taken at face value (in hospital or primary care) and older people tend not to press the issue, often for fear of being a burden and trusting that, for example, the hospital will put the right support in place. Recognising very real efficiency pressures, this is a false economy. Investing in rehabilitation and intermediate care services to aid older people's recovery and independence delivers better health outcomes and is ultimately a more sustainable and efficient use of resources.

"We've tried to compensate for this, we have someone in the hospitals now every week (an Age UK staff member). We've built a really good relationship with the hospital progress coordinators, so we sent them documentation, we're face on, we go round the wards, we speak to people, so we're trying to get more education out there about the services we provide so at least we can fill that small gap" (Age UK Cornwall senior manager)

One leader gave an example of an older couple, both living with dementia, struggling alone in the community and not on the radar of any health, social care or VCSE professionals.

"It's such a shame we didn't get to them sooner. One of things we struggled with was because they had dementia, they wouldn't authorise us to spend money on their behalf. They were sleeping on a mattress they were using as a toilet, for example. Wouldn't it have been nice to have access to funding to take immediate action there. Early intervention and the lack of resources and funding is hard (and the wait for adult social care) are the main challenges"

Social support is needed alongside clinical support. It was also pointed out that a given service can address more elements of need that the title may suggest. For example, evaluation data from Age UK Norwich shows that 51% of Health Coaching clients benefited from two services from Age UK Norwich and 39% benefited from 3 services (this can address wellbeing, finance, befriending, loneliness, etc). 85% of falls prevention class members reported improved confidence, and 75% improved mood. However, local Age UK partners describe inconsistent engagement and collaboration with different parts of the health and care system.

For example, ICB Ageing Well programmes tend to be clinically weighted. What happens in the community when people go home to their real lives is not part of the normal conversation. The risk is this means that systems continue funding the clinical road, without challenge.

The effectiveness of keeping Mrs Miggins on anti-depressants for 25 years for her/NHS/tax-payer is not a good return, when the underlying issue may be money, debt, loneliness or inactivity – which could be supported in the community via VCSE" (Age UK Norwich Senior Leader)

Lack of funded social care (funding not resource problem)

Social care remains the elephant in the room. Whilst bed capacity exists in many parts of the system, the requisite funding from local authorities does not. In efforts to contain social care costs, older people are not getting access to the support they need. This impacts right across the system, including hospital flow.

"If I could influence policy I would stress that more social care is needed urgently. I visited one hospital and attended a discharge meeting. On that day a third of patients (around 150) had been in for over a month and were medically fit for discharge. All the patients were waiting either for a community bed or a package of care at home. Some of the more complex patients that needed 2 carers 4 times a day had been in hospital for over 3 months. Care agencies just cannot meet current demand. One patient was refusing to leave, the hospital were considering legal action to evict. It transpired he was lonely and very anxious about going home and seeing nobody" (Age UK West Sussex senior manager)

Using technology to drive population health prevention strategies

Several professionals commented on the use of technology such as door, movement and activity sensors around an individual's home provide an overview of daily activity to help professionals make

proportionate care decisions. For example, Age UK professionals described a number of projects and programmes across the Cornwall and Isles of Scilly Health and Care Partnership to update and embed Technology Enabled care (TEC) for Adult Social Care and Health across Cornwall.

"A really good resource I've picked up recently is called 'Just Checking'. We've used it for a few people who have been discharged and we're not sure how they're managing. It does door monitors, bed monitors and motion detectors and gives you a pattern of overall behaviour. Have they opened the fridge, have they turned the tap on, are they going out wandering at 1am? A really good tool for preventing admissions, and monitoring how they are managing"

TEC includes a range of technology that helps people to live at home independently, including: lifeline personal alarms, fall detectors, movement sensors and carer pagers.

"There has been some funding in Cornwall to put free technology into people's houses for a trial period. We've been working with Call Serve. Age UK don't have time to fill in a 20-page document, but they've been brilliant. They say, 'you're Age UK, just send us an email with the name and address of the person and we will do all the legwork for you.' How good is that?"

"We've given Alexa for medications prompts, to remind them to eat, and to link them in with family members. They've been really useful. And a lot of older people really love the fact that they can have their radio on, their lights and heating, and really useful for relatives to be able to (help monitor remotely)"

Another risk assessment approach ("Brave AI") is a tool that helps primary care health professionals identify individuals who are at risk of going to hospital next year but who may otherwise go under the radar. The device uses an algorithm to look for patterns in registered patients' records and assesses an individual's risk of unplanned hospital admission in the next year. Health and care professionals (including nurses, pharmacists, therapists, health coaches, social prescribers, and doctors) will use the information to reach out to those individuals who may need more support. This approach encourages conversations with patients who might not otherwise contact their GP, spotting health conditions that might otherwise go unnoticed. Roll-out in Cornwall follows the successful "Brave AI" pilot scheme, where NHS Somerset partnered with the North Sedgemoor Primary Care Network (PCN) to analyse data from more than 500 care home residents. The results found the number of resident falls were reduced by 35%, visits to emergency departments by 60%, and ambulance call-outs by 8.7%.

7. Discussion of findings

Scope for prevention

An ‘avoidable admission’ means scope for earlier or different action to prevent older people’s health from deteriorating to the extent that hospital is required. As the examples in this study indicate, it is possible for an unscheduled admission to be entirely appropriate, but also to have been preventable had different or earlier action been taken. This is supported by wider evidence that for many older people the cycle of readmissions is avoidable with the right processes, support systems, integration and communication.

It was interesting to observe the mixed picture around participants’ own thoughts and beliefs about scope for prevention and how this perhaps reflects wider cultural attitudes towards healthy ageing. Some of the people interviewed did not think there was anything that could have prevented their hospital admission, despite going on to describe tangible steps that might have helped.

At the same time, whilst it was possible in each case to consider opportunities where support may have been put in place earlier, it would not have necessarily led to the admission being avoided. Many participants had complex, pre-existing health conditions and it was challenging to parse a causal chain of responsibility for cause and effect. This does not mean we can’t learn from more proactive approaches, which can teach us much about anticipating risk, delaying health deterioration, reducing avoidable exacerbations of ill health and helping people to maintain independence, thereby reducing use of unplanned care. However, we must keep in mind that people will always need urgent and emergency care services as accidents happen, conditions can suddenly deteriorate, and urgent care will always need to be available however well managed the tertiary prevention.

Opportunities across the care pathway

Scope for prevention begins, but does not end, in primary and community care. There is currently no failsafe mechanism to join the dots between services to ensure that people are not falling through the gaps. For some older people, a hospital admission will be the first time they hit the radar of healthcare professionals and should serve as trigger to all parts of the system that the person may not have been coping as well as previously thought at home. As several interviews highlighted, emergency admission also appeared to be an important psychological turning point for some older people, who were more receptive to help and support than previously. Emergency admission is a golden opportunity to ensure they have the support they need once back at home to help set up a positive recovery trajectory.

Recognising capacity pressures, the time invested at first contact to establish a comprehensive picture of older people’s individual needs and preferences, is time well spent (and likely to yield rewards in terms of avoiding future health exacerbation, crisis and complication), thereby reducing use of unplanned care.

Age UK diagram 1. Examples of proactive and reactive admissions/readmissions avoidance approaches

Category 1 **Community prevention services**	Category 2 **Urgent & emergency response**	Category 3 **Discharge / prevent readmission**
○Enhanced access to primary care ○Routine community care (podiatry, sensory impairment, mental health) ○Prehabilitation ○Community diagnostics ○Proactive Care services (e.g. frailty interventions, falls prevention, medicines management) ○Health coaching, nutrition, psychological support ○Independent living support e.g. home help / maintenance services ○Digital enablement ○Meals service / hydration / dietetics ○Social prescribing (e.g. peer support, befriending services, physical activity groups / classes) ○Day centres (e.g. cognitive stimulation activities) ○Information and advice services ○1:1 casework (e.g. ongoing support and assessment, financial advice) ○Complex community support (e.g. Care coordination, community navigation, psychological support) ○Community transportationEnhanced care in care homes ○Advance Care Planning ○Palliative and end of life care	○GP Liason service ○Short term intensive support package ○Ambulatory emergency care ○Acute Frailty Services / Frailty in-reach ○Acute Respiratory Hubs ○Alternative to Admission Single Point of Access ○Crisis response services ○Intermediate care (step up and step down) ○Ambulance services ○Mental health ambulances ○Mental health crisis services ○A&E support team ○Home First / Discharge to Assess ○Multi-disciplinary Team review ○Same Day Emergency Care ○Enhanced recovery programmes ○Virtual wards / Hospital at Home ○Hospital in-reach / Transfer of care services ○Family liaison ○Respite care (family carers)	•***Includes category 1 services, plus:*** ○Personalised pre/post discharge support ○Financial needs assessment ○Home from hospital services (patient transport, take home and settle) ○Reablement / rehabilitation / recovery/ strength and balance services ○Initiation of domicilliary care or other social support package ○Initiation of carers support package ○1:1 casework (support to apply for newly qualified benefits e.g Blue badge) ○Home repairs and adaptations identified in hospital ○Enhanced recovery support ○Enhanced welfare and wellbeing checks ○Enhanced mental health support ○Enhanced dietetics / hydration support ○Medicines review / support with new medications

Seeing the whole picture

These interviews show how the presenting issue rarely tells the whole story and, even when the surface presentation appeared straightforward, deeper questioning often revealed a more complex picture. Time to explore all of a person's concerns is particularly challenging in the hurried and high-stakes encounter of an emergency room or in a 5-minute GP appointment. Unfortunately, a side effect of a stressed and resource constrained system seems to be reluctance to probe deeper into what else might be going on for an older person. These interviews support a long history of patients describing assessments in both primary and secondary care that were brief and tended to focus on the presenting problem, rather than explore wider concerns, which many felt impacted on their current illness.

However, as many of these examples show, an incomplete assessment of older people's health and social care needs is counterproductive and associated with repeat attendance and adverse outcomes on discharge. There were several examples where escalating frailty had not been picked up in primary and community care in the months leading up to emergency admission. This is consistent with evidence that frailty might not be apparent unless actively sought out, particularly when long-term conditions can serve to overshadow this generalised state of increased vulnerability and loss of in-built reserves. Similarly, the same was true in hospital settings, as we see in several of the 'failed' discharges described here. This may serve to prevent recurrence/readmission for the same condition, and it may also help prevent a different crisis, by identifying a more holistic set of risks and managing them proactively.

Research shows that patients who feel most confident in managing their long-term conditions have 38% fewer emergency admissions and 32% fewer A&E attendances than those who feel least confident[i]. However, it was apparent that a high proportion of participants interviewed did not have the confidence, support or ability to manage their long-term conditions day to day in the community. We know that there has been reduced access to the day-to-day health and care services that are imperative for older people to manage pre-existing health conditions and access essential services and support vital to their welfare. This includes community services including day centres, peer support groups, occupational therapists, community rehabilitation and district nursing. If we are to interrupt the cycle of readmissions, we must not regard these types of support services as 'less important'.

Getting the basics right

Interview findings make clear that we significantly underestimate the importance of getting the basics right for older people and the different this can make to recovery. Multiple insights around older people's experiences in A&E revealed that food and drink did not appear to be a priority or described impeded access because care was being delivered in the corridor or other temporary setting. Staff frequently had to be prompted by patients for a drink of water, sometimes many hours after arriving in A&E. Interestingly, several people felt that food and drink was not in scope of the hospital to get right, and it was not perceived as an essential element of care. What is perhaps more worrying is that some hospital staff or systems seemed to take the same view.

The importance of getting the basics right when it comes to the essential nutrition and hydration needs of older people, particularly for patients who are older and patients who are frail, cannot be overstated. This is a huge institutional blind-spot that says something profound about how we are delivering care day to day. Age UK is working in partnership with the Malnutrition Task Force to raise this awareness and provide information. Simple tools like the Patients Association Nutrition Checklist can be used to help start a conversation about eating and drinking, and signpost people to support. Age UK also produce a Healthy living guide to help older people stay active, independent and eat and drink in a way to keep them healthier for longer.

Looking out for frailty

It's important that people living with frailty have access to proactive, joined-up care to maximise health and wellbeing and prevent problems arising in the first place. Equally important is access to rapid, specialist services in the event of a health crisis. Guidance from the "Silver Book", outlines best practice for older people living with frailty receiving all types of urgent and emergency care and recognises many of the scenarios identified in these case studies including that the Emergency Department and Acute Medical Unit are well placed for opportunistic case finding by virtue of their interface position. Whilst it may be difficult to deliver comprehensive geriatric assessment outside inpatient wards or outpatients settings, the process can and should be initiated from an urgent or emergency care episode attendance, particularly when many older people with falls or cognitive impairment will first appear on the radar of healthcare professionals under these circumstances.

Effective communication

Another basic but important facet of delivering high quality urgent and emergency care relates to effective communication. As these personal stories show, it was not always made clear to the older person who was in charge of their care or responsible for coordinating across blurry borderlands between primary and secondary care, social services and the VCSE. Sadly, many people did not feel well listened to, or safe to ask questions, and we identified several serious issues related to dignity and respect. There were too many examples of older people left without a clear understanding of their treatment, what was wrong with them, or who to speak to. Most people would have preferred to have been more involved in their treatment plan and lacked clarity around their aftercare. Every older person should understand their condition, prognosis for recovery and their preferences respected.

The damage done by poor communication is supported by wider evidence. An analysis of feedback from 609 patients across 12 hospitals (2020), found that current communication, particularly on admission, first assessment, and at discharge, could leave people with frailty feeling distressed. Linked to this, recent evidence highlights the pivotal but undervalued role of good admin to drive care continuity and coordination[ii]. It is not just what is done, but how it is done that counts. Effective communication is an essential component of kind and careful care; its absence makes a huge difference to people's experiences and outcomes.

Recognising mental health needs

It was clear that for some of the participants, despite physical health being the presenting issue, complex mental health challenges were at the core of their presentation to A&E. Ageism can a lead to a lack of understanding of, or sensitivity to, the specific needs of older people including recognising that mental illness in older people may present differently (e.g. depression in older people may be more likely to manifest in somatic symptoms[iii]) or that older people may exhibit different help-seeking behaviours. This can lead to fatalistic assumptions about what people can expect for their mental health in later life, undermining the provision of effective support. We need to continually challenge misconceptions and stereotypes that prevent older people from getting the psychological help they need and deserve, with a particular focus on the challenges that cluster in older age including bereavement and loss of independence. And for patients presenting to A&E with physical health needs, their mental health matters too. The intrinsic link between physical health and mental health is important. For people who are managing multiple physical health conditions or who have a disability, living with pain every day or no longer being able to do favourite activities can significantly affect mental wellbeing.

The power of the debrief

Many participants reported that they have found participating in the interview process for this study beneficial. The unpacking of the events with a trusted person seems to be a helpful exercise both for processing what's happened and for identifying where the current support gaps are (crucially, from the older person's perspective, rather than what support happens to be on offer locally). It takes time to understand a complex story and try to make sense of competing narratives and challenges – having time to parse out some of this in retrospect has been positive for participants and Age UK professionals alike. This finding suggests that for older people who have been through a health crisis, it is important to build in time to talk about the psychological impacts alongside clinical to unearth concerns that UEC staff may not always have the time, resources and confidence to address. Currently though, this type of reflective practice is not the norm. Finally, the emotional toll of emergency admission(s) themselves appears to be underestimated and efforts to address this 'empathy gap' in the experience of care would be well rewarded.

New models of care

Several participants said they would have preferred an alternative service had one been available and known to them indicating that there is work to be done to enable people to 'choose well'. Older people have grown up with the hospital-based system of delivering acute care, and emerging and innovative ways of delivering traditionally hospital-based services haven't necessarily been communicated to them. This research shows that older people tend to present at the service they are most familiar with. This is understandable but may not necessarily be the service that could most effectively meet their needs, so people will need help to understand what is on offer to them in the future. Raising awareness of alternative routes to access high-quality care is a part of a culture change, so that these community-based service models are well known, come to mind immediately, and are well trusted. Currently, particularly in an emergency, hospital is the obvious first port of call.

8. Conclusion

A steady stream of recent reports acknowledge that our ageing population presents new challenges, making the case for more proactive, preventative and personalised care in response. Most hospital admissions in frail older people relate to actual or impending 'frailty crises' (such as sudden loss of mobility, delirium, or falls). This certainly speaks to the profile of the people we interviewed for this project. As the examples in this work highlight, amongst older people living with frailty, multiple or complex health needs, 'small' events, or a series of them – often ones related to their living conditions or life circumstances – can quickly escalate or accumulate into an acute medical crisis. Unfortunately, the result of lack of access to high quality primary and community care (both low level support to maintain health, and enhanced support to stay well) is a costly overreliance on urgent and emergency care.

For some of the people we interviewed for this study their emergency admission came as a shock. For others, with the benefit of hindsight, there were warning signs that their health had been waning. From the ancient observation ('life can only be understood backwards, but it must be lived forwards') to the modern derivation ('hindsight is always 20:20') these stories point to considerable uncertainty for the individual around whether their admission could have been avoided due to the complexity of their conditions. This makes getting the basics right, at every stage of the care pathway, even more important. Rather than avoid the need for urgent care altogether, which may not be realistic, the greatest opportunities seem to be in interrupting a vicious cycle of avoidable readmissions. There are opportunities to do this at every stage of the care pathway.

This work seems to ask a further question of the notion that *'problems wash up in hospital but originate in the community'.* This research complicates that idea, showing that for frail older people hospital will sometimes be an inevitability and may highlight problems that wash up back in the community. How an older person passes through the system counts, and the focus should be on uniting all parts of the system in a shared endeavour of end-to-end care to combat a cycle of readmissions. As these interviews show, the system fails or succeeds for older people as one entity. It is the combination of the right age-attuned interventions delivered at the right time that make the difference.

This research tells a clear story of many care professionals right across the sector going to extraordinary lengths to care for older people, but who appear to many of those older people, tired and stressed. Obviously, this is not good for patients, but as many of the older people we spoke to pointed out, it's not good for the health and care workforce either. Working within fragmented, under-resourced and impersonal health systems makes the identified 'empathy gap' that much harder to bridge. Getting the basics right for patients and professionals alike seems to be the obvious place to start.

Unfortunately, these stories reveal a status quo that appears wired to make it easier for resources to be consumed by expensive late interventions, rather than helping the people to prevent or manage illness and avoid crises in the first place. But there is much that can be done. This study suggests that a better balance needs to be found to support all parts of the health hand care system to work more

harmoniously. Presently, primary and community services are the least adequately resourced and hospitals continue to attract the greater share of NHS resources, despite evidence suggesting this lower-level support is key to manage flow. In turn, some intermediate (step up/step down) services tend towards a cliff-edge where support is abruptly withdrawn after a short period. Investment in a gentler taper back baseline community support is likely to mitigate against avoidable readmissions. To rebalance these elements, funding must be restored so that capacity exists so that lower and intermediate level care sits either side of a hospital admission.

The good news is that many of the challenges identified are well recognised in national guidance, and if existing frameworks and recommendations were properly funded and implemented, would address many of these challenges. We have a very strong evidence base for what would help (including the fundamentals of the Ageing Well programme and Proactive Care framework and associated blueprints for preventing and managing frailty in older people, alongside many of the recommendations of the Fuller Stocktake and Hewitt Review. Backing and scaling these new care models aimed at keeping people well and living independently for as long as possible is key to delivering joined up care, well-planned discharge and community-based support and rehabilitation if they are admitted to hospital.

Transforming attitudes to how we care for older people both inside and outside of times of emergency offers a mirror to how society sees older people, and how older people see themselves. With this work we hope to raise the voices of older people and family carers who are too often muted in debates about what can be done. The vicious cycle of readmissions casts a shadow over the lives of too many older people, but with systems working in concert, it doesn't have to be this way. And despite the challenges this work highlights, these interviews show that there is a lot of good will to work with. Every older person deserves to feel safe and held by health and care services, both at home and in the hospital, and to be given the best possible chance to live well. And it is clear from these interviews that older people and family carers themselves have a wealth of wisdom to contribute, largely untapped by system leaders

The final word on this goes to Anthony, who reflects on his ambition at 87 years of age to live to be 104 years old:

"Sadly, it took me to have a heart attack (for healthcare services) to realise I'm still in the world and I need some help, rather than looking at me like I'm an old pensioner and I don't really matter. It's not true, but it's how aged people feel these days, especially with the government. It does catch on to you a bit them feeling this way"

9. Recommendations

National leaders

1. Deliver on Proactive Care principles

Commit the necessary resources to back and scale existing blueprints for ageing well and preventing and managing frailty in older people. There are opportunities within the shift towards Integrated Neighbourhood Teams aimed at keeping people well and living independently for as long as possible as well as ensuring joined up care and well-planned discharge and community-based support and rehabilitation if they are admitted to hospital. Demonstrate clear leadership in taking whole-systems approaches that target rapid response through joined-up primary, community, and secondary care services and standardised intermediate pathways of care for individuals who are at risk of or recovering from a rapid deterioration in their health. Review funding flows to improve the balance between proactive and reactive services.

2. Find a way forward for social care

Recognise and resource the interdependency of the health and care system which in practice is indivisible for many older and disabled people. It is impossible to conceive of the new care models described working to reduce avoidable admissions to hospital unless social care plays an equal part alongside the NHS, because so many older people who live at home and who are unwell have care needs that are essential to managing health. Develop a system-wide strategy and costed implementation plan that articulates a shared vision for preventing and managing frailty and multiple long-term conditions in older age.

3. Build workforce wellbeing, skills and capacity

The health and care workforce will increasingly need enhanced knowledge and skills to be able to deliver care and support for older people, regardless of their specialty, including education and training in frailty as a specific condition. A focus on staff wellbeing and workplace and team cultures is also essential to ensure that all staff are well-led, cared for, and therefore have the capacity, culture, skills and confidence to deliver compassionate care to others. NHS workforce needs to include integration of VCSE for multiple reasons, including to reduce duplication. Knowledge and awareness of the wider determinants of health and the role of the VCSE should be part of training, including awareness of the commissioned services locally that should be used by the clinical workforce.

Integrated Care Systems

4. Focus on getting the basics right

Local integrated care systems should not wait for the outcome of the Casey Commission, NHS 10-year plan or other national strategy to prioritise getting the basics of care right for older people in place now.

This includes incorporating social care into their delivery model. A focus on support for the activities of daily living, nutrition and hydration, skin integrity and wound care (at home and in hospital), support for sight and hearing loss, medicines management, effective and respectful communication and sound administration including attention to how the older person passes through the system (closing feedback loops, focused on care transitions and picking up dropped balls) are all essential. People with chronic, especially multiple, conditions hugely value continuity of relationships.

5. Identify, involve and support patients and carers

Many carers are not aware of the support that is available, from both a national level and from organisations in their local area. All institutions should help raise awareness of available local support and help to sustain it where necessary. Good urgent and emergency care should take a holistic approach to family support systems and ensure that carers are supported as far as possible (and that includes older people admitted in an emergency who may themselves have caring responsibilities). Ensure patient and caregiver involvement and empowerment including communication via a known point of contact, shared decision making and awareness and prevention of caregiver stress and burnout.

6. Invest in VCSE support for early intervention

Local voluntary sector community groups have a vital role in doing the kind of detailed, targeted support work that emergency services cannot and as such the voluntary sector should have a key role in support that helps reduce the risk of hospital admissions. Outside of hospital, equipping older people with the right information to help keep warm, eat well, get vaccinated, stay active and socially connected all make a huge difference – as can a place to turn for a little extra help and support before a problem escalates into a crisis. Evaluate commissioning frameworks for long-term service stability with the goal to move from pockets of excellence towards meaningful VCSE partnerships becoming fully embedded throughout the health and care system.

7. Review approaches to delivering preventative support

The NHS must recognise the shift left and articulate how success will be measured on broader outcomes like supporting people to maintain independence and safety at home. This should include examining any existing criteria or thresholds that trigger preventative care or early intervention, ensuring older people don't deteriorate to a place of crisis before they can get access to the help they need. Routinely document the early stages of frailty to help focus efforts on community referral pathways and make use of technology and population-health approaches to identify those at high risk of unscheduled admission. Investment in step up/step down care creates opportunities for interventions that pay off for a long time, continuously generating value for the person and the provider. These support packages need to be available for longer to ensure a safe period of tapering back to independence.

10. Appendix. Local area profiles and Age UK case studies

Local area profile 1 - Norfolk and Waveney[iv]

- The population in Norfolk and Waveney is generally older than the England population. **1 in 4 are over 65**
- Norfolk and Waveney population is expected to grow by about 116,500 people between 2020 and 2040, the largest growth is expected in the older age groups, with those aged **65+ increasing by 95,000**.
- The Norfolk and Waveney population is **less ethnically diverse than average** in England. The most diverse areas across Norfolk and Waveney are Norwich, Great Yarmouth and Breckland
- **20% of people** in Norfolk and Waveney have a disability defined under the Equality Act
- In Norfolk and Waveney healthy life expectancy is about 63 years for males and 64 years for females, **lower than England and has decreased** over the last few years. This means that the time people spend in ill health is getting longer and is 17 years for males and 20 years for females
- The districts of Great Yarmouth, Norwich and former Waveney have the **highest preventable mortality rates**. It is the Core20 most deprived communities in these areas which experience the highest rates, sometimes more than double the England rate
- On average there were about 1,900 preventable deaths each year across Norfolk and Waveney. This means almost **1 in 6 deaths are preventable**
- NHS Norfolk and Waveney Integrated Care System (ICS) has a **budget of 2 billion a year** to support over 1 million citizens who reside in eight districts across rural, urban and coastal geographies
- Ambulance Response times across Norfolk and Waveney have been challenged, in part due to rurality of Norfolk and Waveney, but they have also been impacted by **delays in ambulance handover at acute hospitals**
- Norfolk and Waveney has been in the **tier 1 national UEC recovery programme** and this has identified other areas impacting patient flow and performance. These areas are admissions avoidance, front door operating practices, effective use of data and leadership/culture. NSFT mental health trust had been in “special measures” for a number of years, only exiting these in February 2025, with senior leadership admitting there is still much work to be done.

Case study - Age UK Norwich

Age UK Norwich supports community prevention and admissions avoidance via a range of services including Complex Community Support and holistic health coaching. The two case studies below outline the approach to keeping older people safe, well and independent at home for longer.

Both of these examples were referenced in Professor Chris Whitty's Health in an Ageing Society Report, 2023

Age UK Norwich Health Coaching 2024

Health coaching is a holistic approach to health, targeting not only physical activity but the social and environmental factors that impact health, particularly amongst older adults with multiple long-term health conditions. The Age UK Norwich health coaching service leverages community networks to deliver services directly within local neighbourhoods, sheltered housing, hospitals, care homes and people's own homes.

"Before you and Sam (Health Coach), I felt like killing myself. Everything is looking a lot brighter now"

The service provides qualified health coaching support to help increase physical activity, strength and balance. Staying physically and socially active helps reduce the risk of many conditions such as heart disease or dementia, plus boosts mental health. It also helps older people to improve mobility, be steadier on their feet, and reduces falls risk. This service also addresses wider factors including loneliness, mental health and access to local resources. Qualified coaches will visit older people in their home or somewhere local to target the practical determinants of health like food security, housing and financial advice.

"Tina [Support Worker] is a life saver. If I didn't have her to talk to I think I would have gone nuts! Extending my health coaching would be great. It has been a great help and better than any tablet!"

Value of health coaching

- The average inpatient cost of every fall is £3,373* (2024) with an estimated system impact the Norfolk & Waveney of £13m
- Norfolk saw 3,505 emergency admissions due to falls among individuals aged 65 and older in 2022-23 alone
- Following Health Coach intervention 92% of clients avoided hospital admissions, and 87% did not require emergency GP visits post-enrolment
- Age UK Norwich's Early Health coach intervention showed 22% reduction in reported pain and a 17% reduction in anxiety scores (EQ-5D-5L)
- Evidence shows the intervention has significant effects on systolic and diastolic blood pressure, predicting a reduction to the risk of mortality from Stroke by 14%, Coronary Heart Disease by 9% and all-cause mortality by 7%
- Health Coaches costs 25%-30% less than an NHS Physio, NHS Care Co-ordinator or Social Worker
- When Age UK uses community assets, it is providing social value to those centres, gyms and halls, keeping the vibrant and supporting their populations
- See impact report here with UEA/Gaitsmart evidence

Complex Community Support

C.H.E.S.S stands for Complex Health and Enhanced Social Support and is a holistic support model provided to older people for up to 12 weeks. These approaches target immediate risks that if left

unchecked could result in urgent and emergency care. Through practical and emotional support, the service aims to increase independence and enable positive changes to protect quality of life or enable life goals. Everyone's case is unique, and this model is able to flex to the individual's level of required support, ability to self-help, working with wider system partners to help people make improvements to their lives.

"Thank you for everything you have done. I did not really leave the house for three years before I met you and now I go to the weekly coffee morning. I feel like a new woman…thank you!"

The service helps people living with complex health and/or social conditions who need regular practical and emotional support to live as independently as possible. Results demonstrate a positive "left shift" in outcomes in all daily living activities. These areas support increased independence, quality of life and reducing health risks. Age UK Norwich provides enhanced support including regular welfare checks via phone/home visits to monitor health and risks and a wide range of personalised interventions, including:

• Cognitive stimulation activities
• Physical activities to prevent deconditioning, aid recovery or falls prevention
• Arranging transport/companionship to healthcare appointments
• Practical support for home/garden and arranging adjustments for independent living/care
• Practical support to understand/arrange formal care packages
• Ensuring living essentials such as adequate food, drink, medication
• Companionship for loneliness, carers support and mental health
• Accredited advice to obtain entitlements or local services

Value of enhanced community support

- 15% Mobility, 19% Toileting/washing and 14% Shopping for food without help.
- 31% improvement in overall health (EQ-5D-5L)
- 92% not hospitalised in emergency
- 86% had no increase in care packages at home
- 87% had no emergency GP visit during time of support
- 98% had no emergency stay in a residential care home
- 80% did not have a trip or fall
- £800K welfare benefits tackling wider determinants of health across 540 support clients
- See impact report here

"Nobody gave a damn, until you contacted me, you are top of the range making all the arrangements you have made"

This service is currently funded by the Better Care Fund/Norwich Health and Wellbeing Partnership, but funding expires in March 2025.

** Chartered Society of Physiotherapist research in 2017, adjusted for inflation*

Local area profile 2 – Wakefield District[v]

- In 2023 there were **68,996 (19.1%) people aged over 65** living in Wakefield and 8,067 (2.2%) aged 85 and over, this is projected to increase to 94,603 (23%) people aged 65 and over and 15,443 (4%) aged 85 and over by 2043
- **1.6% of people aged 65 and over in Wakefield are BME**, compared to 6.7% for England
- In the three year period 2020-22 **life expectancy at age 65** in Wakefield was 17.5 years for men and 19.7 years for women, and 18.4 years and 20.9 years respectively for England.
- In Wakefield the **disability-free life expectancy at age 65** is 8.9 years for men and 6.9 years for females. In England it is 10.5 years and 10.7 years respectively
- As of August 2021, 7,907 people in Wakefield District were in receipt of pension credit. If national statistics are correct, then as many as many as **4,000 people in Wakefield could be missing out** on additional financial support in later life (All invested DPH report)
- Wakefield district has a **progressive approach to integrated working** across health and care, led by the Wakefield Health and Wellbeing Board and delivered through the Wakefield Integrated Care Partnership, which links into the Wakefield District Health & Care Partnership
- In July 2024 the ICB West Yorkshire Integrated Care Board: West Yorkshire Health & Care Partnership set out a forward plan, highlighting its ambitions for urgent and emergency care:

  "We want to ensure that an individual's urgent care needs can be met in a timely way from the most appropriate service – ranging from lower acuity episodes that could safely be handled the same day within primary care (including through enhanced access), through various models of urgent community response and urgent treatment centres, virtual wards, to (where most appropriate) hospital-based and ambulance services"

Case study - Age UK Wakefield District

Age UK Wakefield District supports community prevention and admissions avoidance via a range of services. The two case studies below outline some of the available approaches to keeping older people safe, well and independent at home for longer.

Age UK Wakefield District Connecting Care

Having a long-term condition or poor health generally means lots of visits to the GP or hospital. For some, it can also mean a struggle with everyday tasks such as taking medication or having a bath. Getting help can be frustrating because health care and social care aren't joined up and people find themselves telling their story over and over again to different professionals.

Connecting Care is a programme of person-centred care in the Wakefield District designed to address these challenges. Centred around the needs of people and their carers, local leaders have pooled resources, built multi-professional teams known as Connecting Care Hubs and are in the process of creating systems that allow people's health and social information to be easily shared.

"I feel relieved that I will no longer have to worry about money in the same way, since losing my wife finances have been so tight"

There are two Connecting Care Hubs across the Wakefield District made up of specialist workers from different health and social care and voluntary organisations across Wakefield. For the first time, they work seamlessly together as a team, from the same location and provide joined up care to help those people most at risk stay well and out of hospital. Age UK Wakefield District is now submitting person level data to a local data warehouse so it can be linked to other health data for analysis at patient/client level. This will support analysis on the impact of Age UK Wakefield District services on re-admissions, A&E attendances, primary care services and mental health services.

"Thank you I did not realise so much support was available to me, the difference it will make to me is unbelievable"

Age UK Wakefield Wraparound Service

Age UK Wakefield's Wraparound Service supports people who may be feeling low, anxious, experiencing loss and grief or emotionally vulnerable and withdrawn. The Wraparound team is made up of Age UK Wakefield District staff with expertise in managing mental health and wellbeing in older people. This team offer time to listen to the needs of older people by providing the space to express their feelings and concerns. The aim of the service is to help to increase resilience, with ideas for coping and self-managing emotional health. Signposting to specialist organisations and/or mental health services can be offered, and support can also be given to make referrals into additional Age UK or community services.

"I feel so much better since getting out more and talking about the way I'm feeling, I feel safer and happier at home and when I go out"

The service specifically aims to help older people who:

• Are aged over 50 and would like some emotional wellbeing support
• May be struggling with low level mental health needs e.g. anxiety, low mood, loss or major life changes
• Are not currently accessing higher level services e.g. Community Mental Health Teams
• Would benefit from a short-term intervention of 6 sessions
• Are able to engage with the support worker to identify and work toward goals

The Wraparound Team will:

•Provide 6 sessions of wellbeing support, either by telephone, at home or at another community location
• Make any adjustments necessary to help an older person access the sessions e.g. adaptations for cognitive difficulties or support for hearing difficulties
• Signpost and refer to mental health services, support for loss and bereavement or any other community services that will help improve a person's quality of life
• Refer to expert members of staff where there is an unresolved issue or a mental health concern, for a follow up phone consultation

"I am glad there is support to help keep me at home, I don't want to go into a care home"

Local area profile 3 – West Sussex, Brighton and Hove[vi]

- West Sussex has a total population of 900,900 residents. 19.9% of the population are aged under 18, and **23.2% of the population are aged 65 or over**
- **6.2% of the population** are from a black or minority ethnic (BME) population, and **11.1% of the population** described themselves as non white UK (i.e. not white British, English, Northern Irish, Scottish, or Welsh) at the last Census (2021).
- West Sussex is ranked **129 out of 152 Local Authorities** in England on overall deprivation and is ranked 128 out of 152 local authorities on income deprivation
- The **life expectancy at birth in West Sussex** is 80.4 years for males and 84.4 years for females. This compares with 79.1 years for males and 83.0 years for females for England overall
- At the last Census (2021) **4.5% of residents in West Sussex** reported their health as poor or very poor, and **17.2% reported a long term illness or disability** that impacts on their day to day activities
- People in West Sussex can expect a **healthy life expectancy** of 63.8 years for males and 64.9 years for females. This compares with 61.5 years for males and 61.9 years for females nationally
- Sussex Health and Care brings together NHS and local authority health and care providers from across the county to work in a more joined up way, supporting the 1**.7 million people** living in Sussex
- Sussex is one of six national **systems selected as Discharge Frontrunners**, which involves health and social care partners locally working together, and with carers and wider partners, to rapidly find innovative solutions and new approaches to hospital flow and discharge planning
- Sussex ICS has also set goals for improving urgent and emergency care performance including that patients waiting for or undergoing emergency treatment or awaiting admission will be cared for in appropriate clinical settings at all times. This target will be measured so that **no patients will be cared for in corridors within Emergency Departments** while awaiting treatment or admission.
- Sussex ICS has set a goal that the number of patients and their carers waiting in Emergency Departments for more than 12 hours will **reduce to below 2%.**

Case study - Age UK West Sussex, Brighton and Hove

Age UK West Sussex, Brighton and Hove supports community prevention and admissions avoidance efforts via a range of facilities including their 'Take Home and Settle', 'Support at Home After Hospital' and 'Community Link Worker' services.

Take Home and Settle

The Take Home and Settle service team build a relationship with acute hospitals and ICUs in West Sussex. Funded by West Sussex County Council, this service supports hospital discharge and aims to relieve stress on the hospital transport service where possible. The Take Home and Settle coordinator can support both during the journey home and with practical support once back at home to ensure the older person feels safe and comfortable on discharge from hospital. This service provides older people with a second layer of safety netting as time is spent with the person to check they have everything in place at home to make a steady recovery. Support can include:

- ✅ A safe journey home
- ✅ Unpacking hospital bag
- ✅ Checking food in fridge is still in date
- ✅ A small light local shop
- ✅ Checking care line is working
- ✅ Signposting or referrals to other support services

Impact of these services

- Between April 24- Dec 24 this service took home 1190 patients over 65 and ensured they were safe once home

"Mr R was very happy to get home and was very grateful for support given"

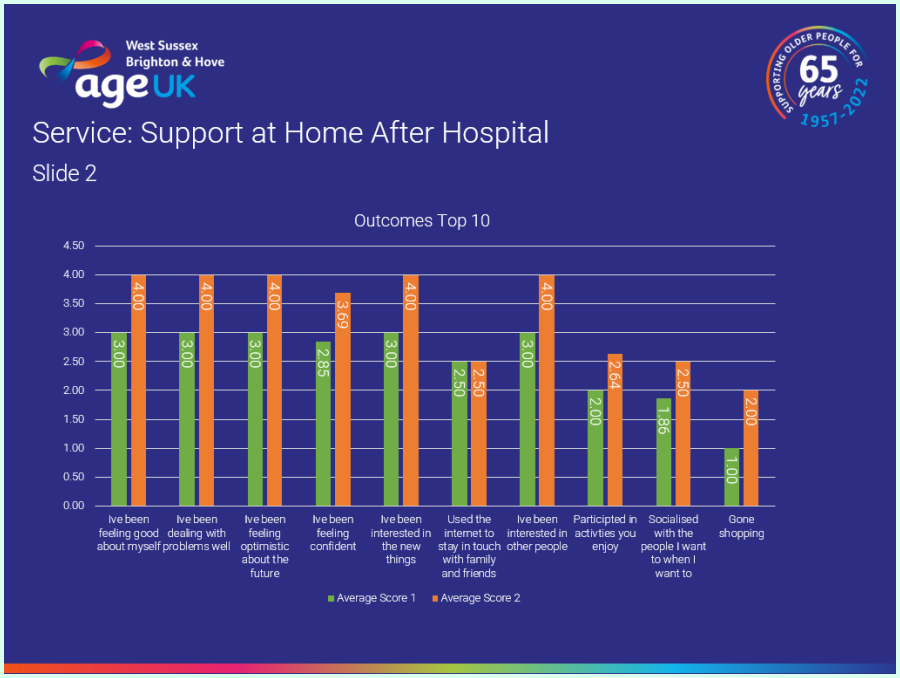
Support at Home After Hospital

Support at Home After Hospital is also funded by West Sussex County Council, offering follow-on support from the hospital discharge service described above. Age UK WSBH can arrange for one of its volunteer co-ordinators to visit for up to 6 weeks following discharge from hospital. The service will support the older person to regain confidence and independence and provide emotional and practical support to carers or the person they look after. The aim of the service is to match the patient with a volunteer to receive weekly visits to support them with low level practical tasks. For example, volunteer can support people to do the things they did before their hospital stay such as help to get prescriptions and shopping, support you to attend hospital or doctor's appointments and assistance with finances, paperwork and benefits entitlements through AUKWSBH Advice service or Carers Support WS Benefits Advisor. This service works alongside Urgent Community Response support.

Impact of these services

"One client, who initially felt she was nearing the end of her life and had nothing left to live for, shared how her perspective completely changed during visits from a volunteer. Through the volunteer's support, the client regained her confidence and now feels she has many more years to enjoy"

"This feedback is a wonderful reminder of the meaningful connections we help create"



Community Link Worker Service

The Community Link Worker Service provides low level practical support and signposting/referrals to services and organisations that can support older people to reach their goals and objectives. It is considered to be both an admissions avoidance and discharge support service. The link workers are embedded in the UCR and ICUs in West Sussex, they attend the MDT and handover meetings and have also been granted access to SystemOne, enabling efficient documentation of patient notes to enhance continuity of care and support the patient journey. This service can only accept referrals from the UCR and ICU teams. The service is funded by Sussex Community Foundation Trust.

Impact of these services*

- Received total of 765 referrals
- Provided 3036 customer appointments / interventions
- Resulted in 972 hours of customer contact via either phone / email / home or hospital visit.

*Community link worker (CLW) service end of year 1 evaluation report Dec 2024

Local area profile 4 – Blackburn with Darwen[vii]

- Blackburn with Darwen is a unitary authority in East Lancashire that **covers 137 square kilometres**
- In 2023 there were **22,904 (14.5%) people aged over 65** living in Blackburn with Darwen and 2,596 (1.6%) aged 85 and over, this is projected to **increase to 28,217 (19%) people aged 65** and over and 3,866 (3%) aged 85 and over by 2043
- In the 2021 Census, **15.0% of people aged 65 and over** in Blackburn with Darwen are BME, compared to 6.7% for England
- The results of 2021 Census revealed a picture of **a multi-faith society**. Among older residents Christian aged 65+ had the largest number of followers in Blackburn with Darwen (68.7%), followed by Muslim (13.1%)
- The 2021 Census showed that in Blackburn with Darwen **11.1% people aged 65** and over and **8.9% of people aged 85** and over **do not speak English as their main language** at home
- The Blackburn with Darwen Health Profile, published by Public Health England, reveals that the health of people in the area is **considerably worse than the England average**
- Hospital services are provided by **East Lancashire Hospitals NHS Trust.** The major local hospital is the Royal Blackburn to the south of the town
- The single ICS covering the whole of the Lancashire-14 area is the **Healthier Lancashire and South Cumbria ICS**
- Attendance Allowance provides financial help to people aged 65 or over who are physically or mentally disabled. The **caseload in August 2023 was around 3,000**
- In Blackburn with Darwen **a substantial 17.6% of households were in fuel poverty in 2022.** This was well above the England average of 13.1%

Case study - Age UK Blackburn with Darwen

Age UK Blackburn with Darwen supports community prevention and admissions avoidance efforts via a range of services. The case studies below outline integrated approaches to keeping older people safe, well and independent at home for longer.

Age UK Blackburn with Darwen Integrated Care Service

Living with and managing a long-term health condition independently as you get older can sometimes be a struggle and confusing with lots of different health professionals involved. The Age UK BWD Integrated Care Service offers coordinated support and interventions to help avoid admission to local health and care services and older people to remain at home independently for as long as possible. Age UK BWD can talk to professionals on behalf of the older person and recommend services and support including practical support that can make a difference. Trained staff listen to the individual needs of each person seeking support and help them to remain resilient and take control of their own health. Services include:

- ✅ Holistic assessment of social and environmental needs
- ✅ Early intervention to prevention deterioration of health and wellbeing
- ✅ Information, advice and guidance to support self-care, regain confidence and improve resilience
- ✅ Referral into other health and Statutory services
- ✅ Asian language speakers

'Thank you so much for your help. You have really opened up our eyes about how much help is available'

Befriending Service

Feeling isolated and lonely can have a very detrimental effect on both physical and mental wellbeing. The Age UK BWD befriending service offers friendship and support to older people who may be living alone, confined to their home or who need extra support to help get out and about and attend local activities. Befriending services can be particularly important to older people who may be struggling to cope with changes in their health or who are feeling less socially connected because of hospital admission or loss of mobility. The team of friendly volunteers are in touch regularly to check that the person is managing ok and listen to what is important to that person. Friendships that last a lifetime are often developed. Support includes:

- 📞 Regular telephone call
- 🏠 Home visits with a matched volunteer
- 🤳 Support and encouragement to engage with local activities

'Your calls make my week, I always feel ten times better after we've spoken'

Local area profile 5 - Cornwall & the Isles of Scilly[viii]

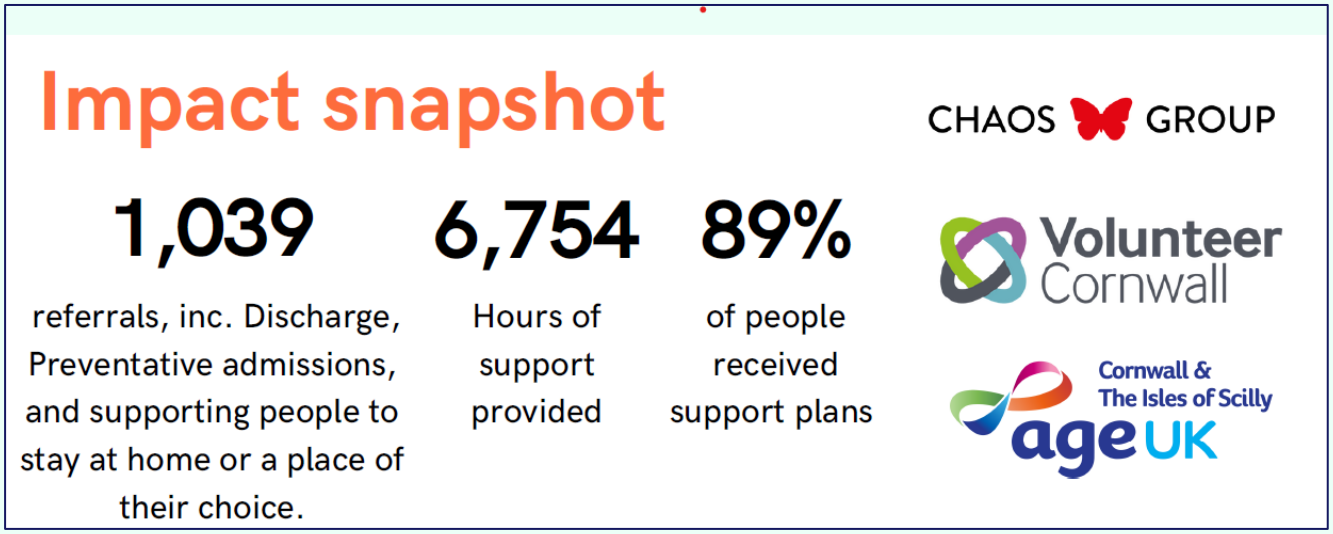
- The Cornwall and Isles of Scilly region of England is one of the **most rural counties** in England. It covers a diverse population with a **mix of rural and coastal communities** and towns and is only county in England bordered by only one other county, Devon
- St Austell, Newquay and Bodmin are just some of the county's towns with a population of over 10,000. **As Cornwall's only city, Truro is one of the smallest in the UK** and home to the Royal Cornwall Hospital
- The area is rural with **significant distances for people to travel to the main hospitals**. The geography also provides challenges in accessing outpatient services, x-ray and travel times for urgent out of hours and emergency service
- In 2023 there were **149,028 (25.8%) people aged over 65** living in Cornwall and 18,729 (3.2%) aged 85 and over. **This is projected to increase to 211,256 (31%) people aged 65 and over** and 35,978 (5%) aged 85 and over by 2043.
- The 2021 Census showed that **just 1.1% of people aged 65 and over in Cornwall are BME,** compared to 6.7% for England.
- The 2021 Census showed that **95.3% of the population aged 50 and over** in Cornwall were retired, higher than the England rate of 94.8%. The 2021 Census showed that among the population of Cornwall **10.9% of people 65+** reported providing some form of unpaid care
- The Cornwall and Isles of Scilly Integrated Care System **(ICS) supports over 600,000 citizens** who reside in Cornwall and Isles of Scilly, as well as responding to the 'tourism effect' of a year-round influx of visitors to the region
- The ICS footprint includes the Integrated Care Partnership (ICP), NHS Cornwall and Isles of Scilly Integrated Care Board (ICB) and **3** integrated care areas (ICAs), **55 GP practices** organised into primary care networks (PCNs) and **12 Community Area Partnerships** (bringing together Cornwall Councillors and town and parish councils alongside the Police, health services and voluntary and community sector organisations)
- **Main healthcare providers,** including general practices: Royal Cornwall Hospitals NHS Trust (RCHT), University Hospitals Plymouth NHS Trust (UHP), Royal Devon University Healthcare NHS Foun dation Trust, Cornwall Partnership NHS Foundation Trust (CFT), and South Western Ambulance Services NHS Foundation Trust (SWAFT), Kernow Health CIC, as well as a wealth of voluntary and community sector organisations.

Case study - Age UK Cornwall & The Isles of Scilly

Hospital and Home Support Services

"The help from the Hospital and Home team has been so special" (Sue)

Cornwall's charities and community groups have combined forces to support people. Volunteer Cornwall, The Chaos Group, and Age UK Cornwall and many local community groups, are working in partnership to provide Hospital and Home Support Services in community hospitals throughout Cornwall. These services work closely with NHS staff, local community hubs and care providers, to focus on reducing admissions by providing practical solutions, person-centred support, and preventative plans which improve physical, mental, and emotional wellbeing. Services are accessed via Kernow Community Gateway, open 8am to 8pm, seven days a week, 365 days a year – including Christmas day. As well as offering a lifeline for members of the community, the Gateway will also offer access to voluntary sector support for people arranging support on behalf of others such as GPs, other healthcare professionals and community groups.



Active Living Home Support

"It felt good to talk to someone who cared, listened and highlighted possible solutions" (A Loving Daughter)

Age UK also provides a range of other services that support admissions avoidance, including Active Living Home Support, a service designed to help older people to remain independent within their own home. Staff deliver a safe and caring service - with an emphasis on promoting independence, health, and well-being. Active Living Home Support service enhances and

enriches the lives of older people by visiting homes to carry out specific, agreed tasks. Support includes a wide range of activities from general cleaning and tidying (hoovering, dusting, mopping, changing bins, oven and fridge clean), changing bedlinen, laundry and ironing, shopping (food and general items), picking up prescriptions, preparing light meals, dog walking, home admin (support with making phone calls, booking appointments, contacting service providers, organising paperwork) and accompanying to medical appointments. The service aims to create personalised plans that prevent hospital admissions, reduce social isolation, and improve wellbeing. Age UK Cornwall staff identify unmet need, connect people to mental health support, community activities and wider winter support including hot food and warm spaces.

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We offer special thanks to each and every older person and family carer that took the time to be interviewed and share their experiences with us. This work would not have been possible without you.

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