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TICKET HOME

EVALUATION OF A HOSPITAL DISCHARGE SERVICE

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This report has been co-produced by staff from Uttlesford Community Action Network (UCAN) and social scientists at Anglia Ruskin University (ARU) as part of a consultancy evaluation of a hospital discharge service provided by UCAN. It presents a summary analysis of the academic and policy literature relating to the challenges involved in the safe and timely discharge of patients from hospital, as well as an evaluation of the achievements and challenges entailed by UCAN in supporting safe and timely discharge of patients from Princess Alexandra Hospital (PAH), Harlow, to their homes across West Essex, from December 2022 to November 2023. Detailed information is provided on actions undertaken to support patients who were discharged by UCAN's Ticket Home initiative.

ACKNOWLEDGEMENTS

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BACKGROUND

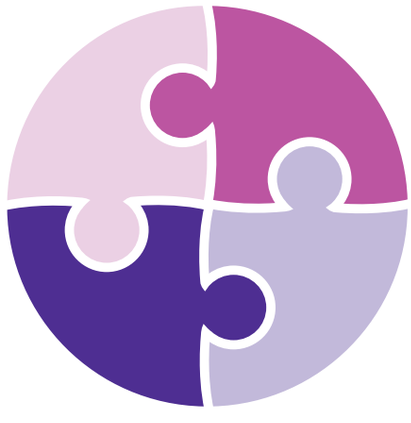
UTTLESFORD COMMUNITY ACTION NETWORK (UCAN)

Uttlesford Community Action Network (UCAN), formerly Council for Voluntary Service Uttlesford, is a community-based charity that works closely with voluntary, community, faith and social enterprise colleagues, statutory services and volunteers to deliver a range of services designed to support residents of the Uttlesford District, who may be vulnerable or living with various life challenges or other needs. Uttlesford is a predominantly rural district with an increasing population size. Recent figures suggest that there are over 91,000 residents (Office for National Statistics, 2023) in the district, 20% of whom are aged over 65 years, and this proportion is set to rise sharply in the next 10 years. UCAN's mission is to support communities within the West Essex localities and to enable local citizens to thrive. They harness their knowledge of the community and community assets to provide solutions to local problems, identified through research and purposeful enquiry.

UCAN developed a 'Ticket Home' pilot initiative in the Princess Alexandra Hospital (PAH), Harlow, in the winter of 2022, in response to severe pressures on hospital bed availability. The Ticket Home model was borne out of an initial hospital discharge pilot started in March 2022; an initiative called 'West Essex Helps' delivered by UCAN to explore the impact of such an approach in a hospital/community setting. Once the project was deemed successful after a three-month period, UCAN developed a scaled-up model called Ticket Home. Ticket Home had more ambitious objectives, whilst incorporating learning from the initial pilot. The initiative was presented to Senior Integrated Care Board Commissioners who, after consideration, funded the Ticket Home initiative as a pilot in PAH. The ultimate aim was to deploy the model in other West Essex acute hospitals, including Whips Cross Hospital, Broomfield Hospital and Addenbrookes Hospital.

UCAN were commissioned to deliver the service between 1st December 2022 and 31st September 2023, and it was then extended to March 2024. The organisation's paid staff and volunteers worked in partnership with other community organisations to ensure a joined-up approach to support patients and help maintain their independence following discharge from PAH. Given UCAN's community-based role, they were well placed to work with patients and their families to find practical solutions to enable safe transition to home by providing home support including food shopping, the collection of medicines, arranging hot meals and welfare telephone calls, along with a diverse range of other interventions and supports.

Using their bespoke online Ticket Home platform to facilitate these processes, they have established a novel community-based intervention designed to complement and extend the existing hospital NHS and social care procedures in situ, using a more focused approach targeting patients deemed to have low or moderate needs. The model might be emulated by other hospital discharge teams.



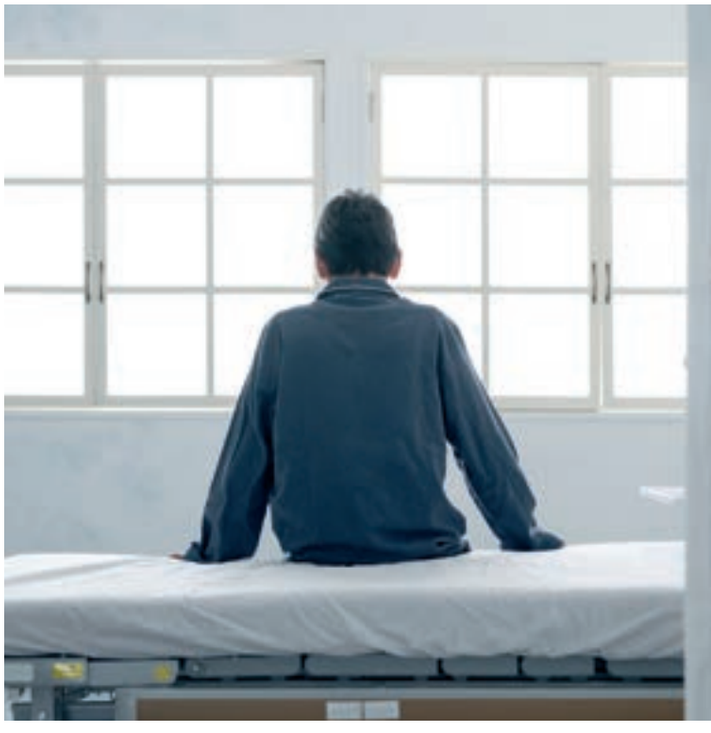
HOSPITAL DISCHARGE CHALLENGES

Undeniably, discharging patients from hospital to home in a timely and safe manner represents a huge challenge for NHS acute hospitals. It presents a complex interplay between the needs of patients, clinicians and managers. Increasing demand for in-patient services puts pressure on hospital bed capacity and the availability of medical staff to treat and care for patients. Maximising bed availability for planned and emergency admissions is now a preoccupation of hospital mangers, as this can have implications for those waiting for treatment (e.g., relating to cancelled operations, prolonged pain and/or debilitation). An additional concern is the effects that prolonged hospital stays can have on the health of older people. Hospitalisation of older people can lead to a decline in long-term health and functioning (Rosman et al., 2015; Sager et al., 1996). Prolonged periods in hospital are also associated with a greater chance of admission to a care home after discharge, or even death (Landeiro et al., 2019). It is therefore important that older people are discharged as soon as practicable after an acute hospital stay.

'Delayed discharges' are also financially costly to the NHS. The Kings Fund (Maguire, 2023) recently considered the monetary costs of such delays. They estimated the cost of delayed discharges during 2022-2023 to be in the region of £1.7 billion. Therefore, once hospital treatment is completed, it is important to ensure patients are discharged in a safe and timely manner. Discharge planning is key, with processes needed to execute an effective discharge process beginning once patients are admitted to hospital and carrying on throughout their stay and beyond (Bauer et al., 2009). It is a negotiated dynamic process involving patients, doctors and other members of clinical and social care teams, along with patients' families. Interventions should commence well before discharge. Bed occupancy pressure, staff shortages, the need to begin the process of hospital discharge at an early stage, and the complexity of processes and number of actors involved mean that a smooth process is extremely challenging.

DELAYS IN DISCHARGE

'Delayed discharge' is a term widely used to describe the status of patients who no longer meet the criteria to reside in an acute hospital. A 'delayed discharge' occurs when a hospital inpatient has been deemed medically fit for discharge but continues to occupy a hospital bed for nonclinical reasons (Landeiro et al., 2019: 86). Avoiding such delays has become a major system priority for the NHS, with numerous recommendations being made to implement effective discharge planning, including joint working between services. However, cases of delayed discharge are rising nationally, with a reported 59% increase in acute hospital settings from May 2021 to April 2023 (Nuffield Trust, 2023). As acknowledged by the Nuffield Trust (2023), this problem has exacerbated already lengthy patient waiting lists and overstretched A&E services, and created unnecessary long stays in hospital for patients. It is recognised that various complex reasons may contribute to patients experiencing delays, with a contributing factor being the rising number of older patients.



OLDER ADULTS

Older people are particularly vulnerable to illnesses during the winter months and 'winter pressures' are also associated with the delayed discharges of people awaiting social care packages (Rosman et al., 2015). As noted, prolonged hospital stay is undesirable for older people as it puts them at increased risk of physical and/or cognitive decline and other complications (Maguire, 2023; Rosman et al., 2015; Sager et al., 1996), potentially resulting in greater care needs. Safe and successful discharge from acute hospital stays for older people must therefore involve due consideration of their medical fitness for discharge (i.e., recovery from acute illness), as well as optimising their chances of regaining any lost physical and/or cognitive abilities. Alongside the growing demands of an ageing population, another compounding factor for increasing delays in older patients' hospital discharges is the under-investment in social care (Nuffield Trust, 2023). The transition to home can be experienced as unsafe and troublesome for older people, and a peak in readmission of acutely admitted elderly patients shortly after discharge is notable (Covinsky et al., 2011; Misky, Wald & Coleman, 2010; Andreasen et al., 2015). Evidence indicates that hospital discharge planning for frail older people can be improved if interventions address family inclusion, communication between health care workers and the provision of ongoing support to patients and their families after discharge (Baur et al., 2009).

Specific problems relating to hospital discharge in Essex have previously led to in-depth qualitative research being undertaken in three acute hospitals across the county. This research, which was carried out by Healthwatch Essex (Corrigan et al., 2016b), found poor communication among hospital staff and between staff, patients and family carers at all three hospitals. The research also found that staff at PAH often did not enquire about patients' home situations and whether their living conditions made it appropriate for patients to be discharged without some form of support (Corrigan et al., 2016a). The authors reported that people's home and social circumstances, such as living alone, being unable to prepare meals, or living with a dependant relative, were such that many patients did not feel ready to return safely to their homes and perform daily activities, despite being assessed as 'clinically safe' to do so (Georgiadis et al., 2017). Some study participants reported having to be readmitted to hospital soon after discharge because they were unable to cope once home. Such social issues, while often not serious enough to require formal social care services, can nevertheless present challenges to a safe and timely discharge and lead to decline in patients' health, leading to unnecessary hospital readmissions.

ADDRESSING THE PROBLEM

The NHS (Department of Health & Social Care, 2023) have issued recent policy to address patients being discharged more effectively. While enabling people to stay well, safe and independent at home for longer has been a long-standing NHS policy objective, a new 'discharge home to assess' model emphasising more joined-up care for older people living with frailty in the community, and greater joined-up working with all system partners to strengthen discharge processes, was introduced (Department of Health & Social Care, 2023). With evidence suggesting that early discharge can be safe and beneficial for patients (Gonçalves-Bradley et al., 2017), the implementation of 'discharge home to assess' is now the NHS-recommended default pathway. Most people are expected to go home (to their usual place of residence) following discharge. The new model emphasises supporting people to be discharged safely when clinically ready, with timely and appropriate recovery support if needed, and with assessment of longer-term or end of life care needs. This guidance allows local authorities and NHS commissioners flexibility to procure more tailored services to meet the needs of their local populations, encouraging multi-disciplinary discharge teams to work closely with professionals from different sectors, including health and care, housing and the voluntary sector (Department of Health & Social Care, 2023).

TICKET HOME INTERVENTION

The commissioning of UCAN's Ticket Home service since December 2022 fulfils the brief of producing more tailored services to meet the needs of local populations. This evaluation examines how the UCAN team enabled patients to experience a timely, safe discharge from PAH, and support their safety and wellbeing once home.

AIMS AND OBJECTIVES

The main aim of the Ticket Home service was to work collaboratively with existing hospital-based staff (and patients' families, where appropriate) to assist patients in the planning and preparation of their safe and timely transition from hospital to home.

An important objective was for the Ticket Home staff to receive referrals or connect with patients as early as possible in their journey through the hospital system. This approach was designed to achieve a coordinated discharge plan that more efficiently manages patient throughput and, most importantly, better meets their wellbeing needs. Other objectives set by the NHS commissioners were designed to:

- Focus on those patients with low to moderate perceived needs;
- Identifying suitable patients through a number of means, including:
  - the PAH Nerve Centre digital system, to which the Ticket Home team had been given access,
  - direct referrals from the Transfer of Care team or other staff based within the hospital wards,
  - attending the wards themselves,
  - patient self-referral,
  - carer or family/friends' direct referrals.

A further critical objective was related to the support and follow-up that patients would receive once home. This was to be achieved through a combination of volunteers, community-based social prescribers and UCAN's voluntary sector network across West Essex. This was to be complimented through drawing in the additional specialist support of other organisations that would be paid for by UCAN's built-in contingency fund. These options were designed to enable a solution-focused approach increasing the likelihood of discharges occurring early or on time, and successfully. These objectives are captured in the 'Success Indicators' below:

TICKET HOME SUCCESS INDICATORS

The success indicators for the Ticket Home service were to demonstrate:

- **value to existing hospital discharge procedures:** number/percentage of patients with a planned discharge date referred to the service;
- **impact on safe and timely discharges:** number/percentage of referred patients actually discharged before midday on the planned discharge date;
- **impact on admission avoidance and ongoing reablement of patients:** number/percentage of discharged patients receiving a 48-hour post-discharge telephone call or other contact by the Ticket Home team.

Several other outcomes have been captured through the Ticket Home Digital Platform in order to inform impact and support analysis of the overall project.

TICKET HOME EVALUATION

The evaluation was carried out by social scientists at ARU and members of the Ticket Home team. A collaborative evaluation approach (O'Sullivan, 2012) involving the ongoing engagement between evaluators and programme staff was adopted. Such an approach is considered to result in 'stronger evaluation designs', enhanced data collection and analysis, and results that stakeholders understand and use (Ibid.).

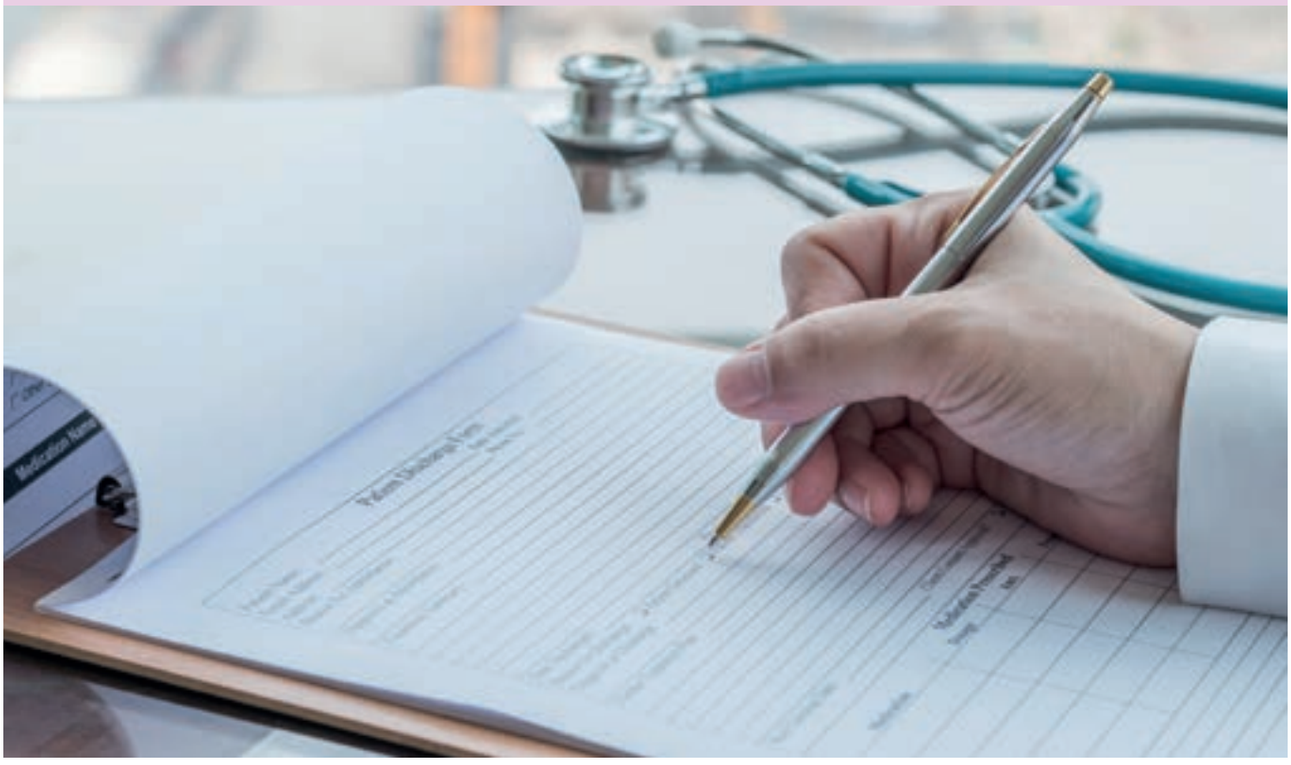
METHODS

MEETINGS, INTERVIEWS, SHADOWING AND OBSERVATIONS

Regular online and in-person meetings took place between the academic consultants and the Ticket Home team leaders. These meetings provided opportunities to discuss the operational aspects of the Ticket Home intervention and to share feedback on the observations made by the academics.

Informal interviews and observations of the acute social prescribers, hospital matrons, discharge co-ordinators and ward nurses were conducted to gather information about their experiences of the work they were doing and to gain an understanding of any challenges they faced. This was to gain insight into the processes that were being used to gather information that could be used to prepare people for a successful discharge.

Data were also gathered from the online Ticket Home platform that the team use regularly to update the status of patient discharge and to log all activities required to support the patient, including when actions have been completed.



FINDINGS

THE TICKET HOME TEAM AND THEIR ROLES

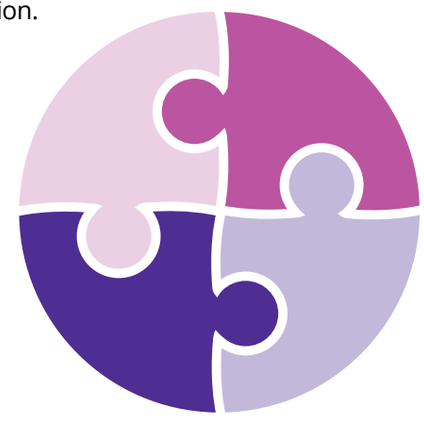
The evaluators found that a team of staff and volunteers were engaged in executing the Ticket Home service. The defined roles were:

- **Three senior leadership staff** overseeing procedures, including the development and update of the online platform;
- **Two community responders** responsible for fitting key safes, arranging house cleaning and moving furniture to accommodate care equipment when required;
- **Three acute social prescribers** working alongside PAH's discharge team, based in the hospital's discharge hub;
- **Community volunteers** who provide follow up welfare phone calls with patients following discharge.

DISCHARGE PROCESS CARRIED OUT BY TICKET HOME TEAM

The formal process of the Ticket Home team's involvement in a patient discharge was found to begin with receipt of a referral form, completed either by a member of the hospital staff (Transfer of Care team staff and/or ward staff) or by a member of the Ticket Home team (acute social prescriber), following identification of a potential patient via PAH's Nerve Centre database. Here, the Ticket Home team glean relevant information and follow this up with a visit to the patient on the ward to assess their need, and their (and/or their relatives') desire, for the service. The Ticket Home acute social prescriber completes a patient assessment proforma which assesses need based on details of the patients' home environment and risks they may face when returning home. It also provides the team with information to assess the person's needs and risks of readmittance, identifying vulnerabilities such as social isolation and the suitability of their home environment, in relation to any new health and/or social issues related to their in-patient stay that may be of concern. Through these assessments and discussions with patients and their families (in accordance with the patient's wishes), relevant support actions are agreed. This includes checking whether there is a working heating system at the patient's home, what social contact/support they might have access to, key safe installations to allow carers or visitors access without the need for the resident to rise and answer the doorbell, furniture moves and digital solutions. Follow-up welfare phone calls are offered to provide reassurance and help to identify any concerns or issues arising following discharge.
The team often provide advice signposting patients and involved family members to services that can assist with household issues like gardening and meal provision.

It was also observed that information was regularly gathered from the online Ticket Home platform (which the hospital Transfer of Care team also have access to) to update the status of patient discharge and to log all activities required to support the patient, including when actions have been completed.



TICKET HOME DIGITAL PLATFORM

The digital platform facilitates the storage of information, the tracking of tasks relevant to the patient's discharge with appropriate prompts for action, and support at home following discharge.

These include:

- storage of patient records, including key data such as contact, demographic and hospital information;
- tagging patients to groups and to organise data such as behavioural issues, safeguarding concerns, if they have a carer, risk to staff, vulnerable persons, and contact with ward before visiting patient;
- tracking discharge status and key dates;
- setting tasks to observe what has been completed or could not be done for the patient;
- recording patient contacts, such as family members or emergency contacts;
- storage of communications with the patient or contacts by text message or email;
- storage of assessment, post-discharge and closure forms;
- listing set tasks to be completed for patients (e.g., shopping, prescriptions, DIY etc.);
- recording notes documenting the history of each task;
- flagging priority tasks and recording risk levels;
- assigning tasks to specific organisations who will be carrying these out.

The Ticket Home digital platform was regularly updated by the Ticket Home team, providing them with a means to make referrals and assessments and to monitor and report on issues including:

- the acceptance of online referrals from patients or hospitals;
- assessing and accepting or declining patient referrals;
- carrying out patient assessments to establish their support needs;
- analysing patients who have been supported by location and hospital;
- monitoring the tasks completed by category;
- monitoring performance in terms of the number of patients discharged on-time, late and early;
- reporting on reasons for late discharge;
- identifying the number of tasks due, outstanding, completed or unable to be completed.

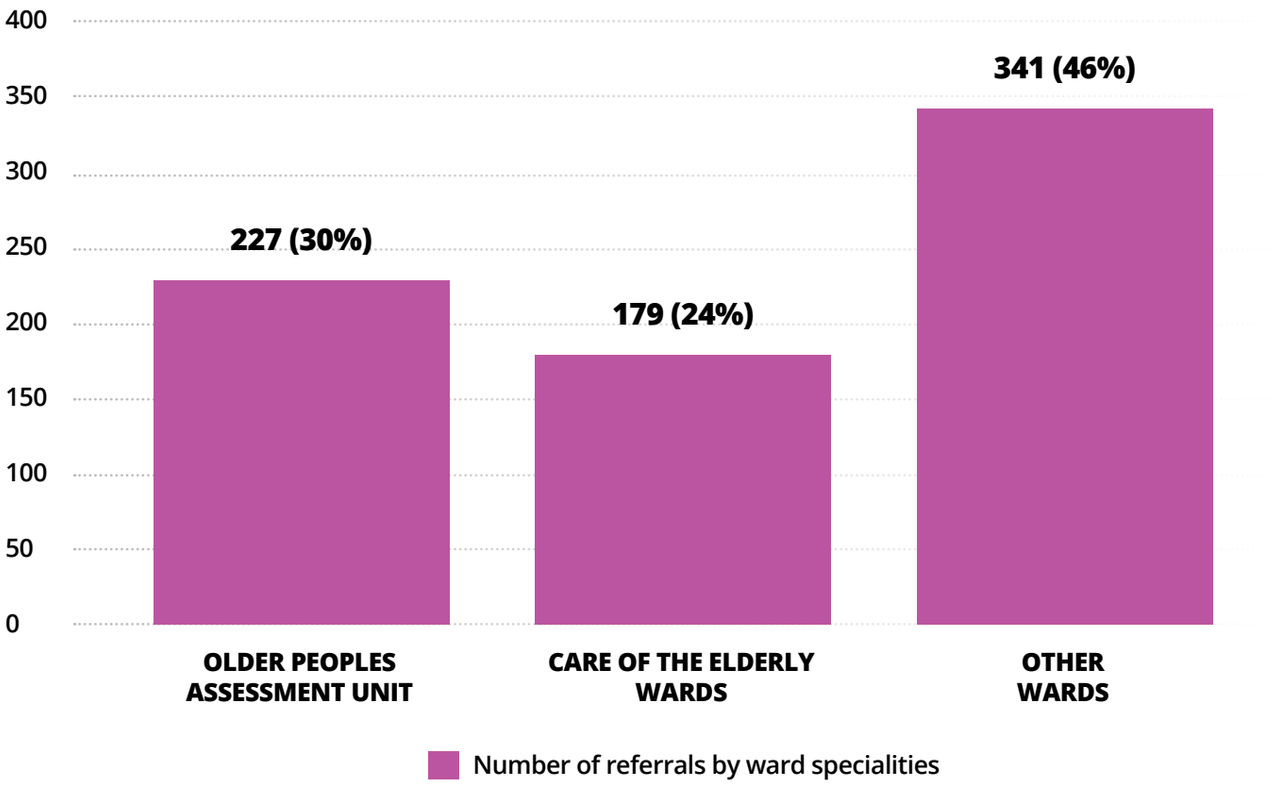
NUMBERS OF PATIENTS REFERRED, ASSESSED, DISCHARGED AND RECEIVING TICKET HOME SERVICES

In this section, we report on data extracted from the online Ticket Home platform. The platform is updated daily by the Ticket Home team, and is used to store key information on referrals and provide reminders of tasks to be completed by the team.

REFERRALS TO THE SERVICE

Seven hundred and forty seven (747) referrals were received in the reporting period (1st December 2022 - 31st November 2023). Of these, the vast majority were from six wards at PAH concerned with the assessment of older people who had attended A&E or had been referred for same-day assessment via GPs (227, 30%), and care of elderly inpatient wards (179, 24%).[1] Other referrals (341, 46%) came from 21 other ward specialities across the hospital (see Figure 1 below).

FIGURE 1: NUMBER OF REFERRALS BY WARD SPECIALITY



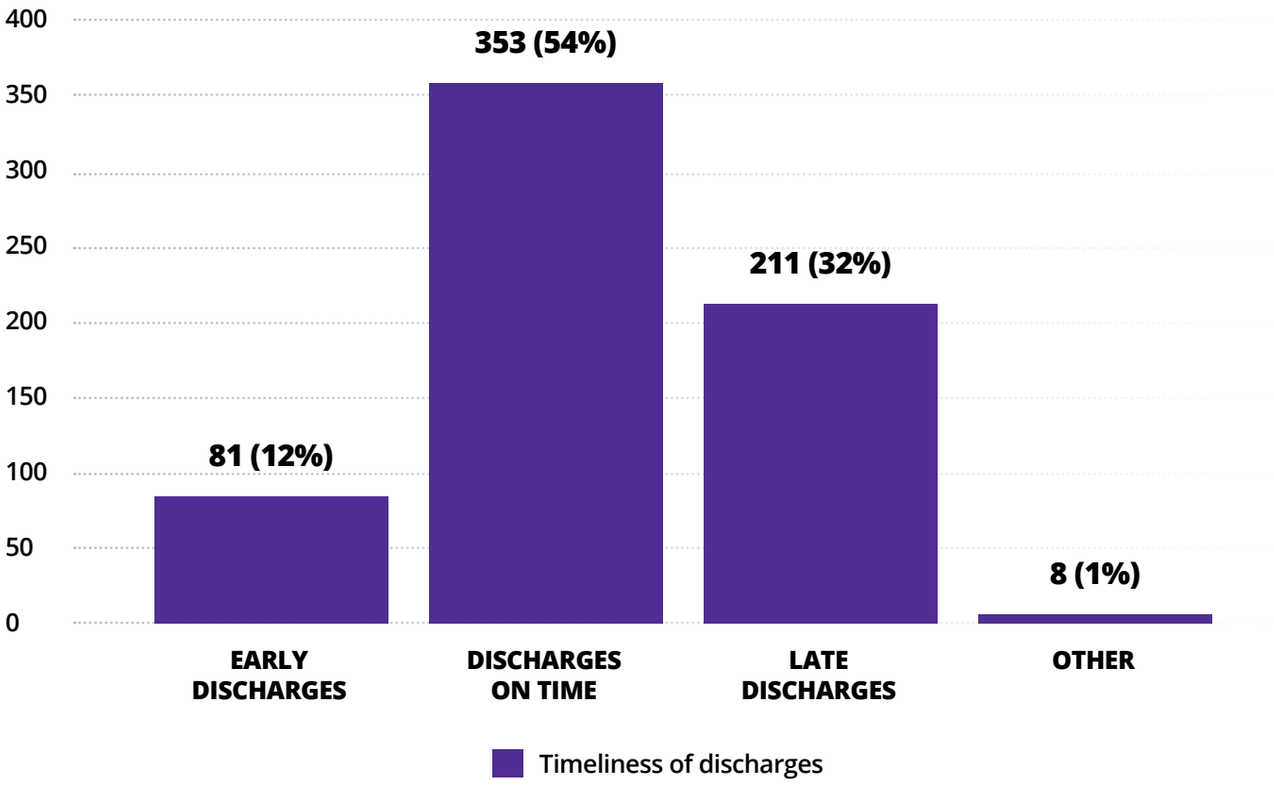
Of the 747 referrals received, 743 (99%) were actioned by the Ticket Home team; notably, some tasks were not actioned as patients either disengaged from the service or died following referral.

1 Information about ward specialities was taken from https://www.pah.nhs.uk/our-wards, accessed on 15 February 2024.

TIMELINESS OF DISCHARGES

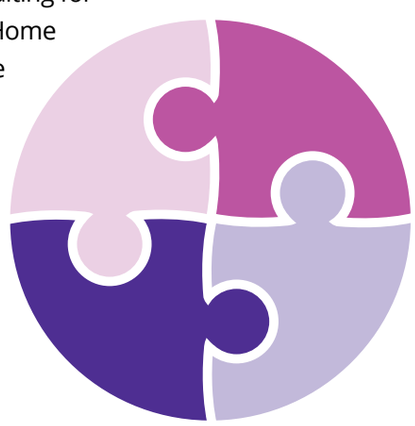
After assessment, the Ticket Home team supported 653 discharges. Of these people, 81 (12%) were discharged early, 353 (54%) were discharged on time (i.e., before 12 noon the estimated date of discharge), and 211 (32%) were discharged late. A further 8 people (1%) were not categorised, at the time of reporting.

FIGURE 2: TIMELINESS OF DISCHARGES



LATE DISCHARGES

Reasons for late discharges were captured in the Ticket Home digital platform. Most people (108, 52%) were delayed due to a medical reason; 69 (33%) people were discharged late because they were waiting for a care package to be implemented (that is arrangements for social care provision beyond the scope of the Ticket Home team); 17 (8%) people were waiting for equipment to be installed in the home (again beyond the scope of the Ticket Home team); 5 (2%) were awaiting input from the housing department; 3 (1%) people were reluctant to leave hospital; 2 (1%) people were delayed due to family issues; a further 2 (1%) people were delayed due to transportation issues; and a further 5 (2%) people were also delayed but the reason was not captured in the system at the time of reporting.



EARLY DISCHARGE AND COST SAVINGS

Of the 81 (12%) people that were discharged early (i.e., before the estimated date of discharge provided by the hospital discharge team); procedures and tasks were expedited such that these patients were able to go home sooner than had been planned. These 81 early discharges amounted to a total of 337 days of bed vacancy, which could be used for the treatment of new patients rather than being occupied by medically fit patients waiting for the above services. Using a recent Kings Fund model that estimates the cost of hospital bed stay per night as £395, this represents a minimum cost saving of £133,115.

TICKET HOME TASKS COMPLETED

Table 1 shows the range of tasks that were completed by Ticket Home to support patients' timely and safe discharge and readmission avoidance. In total, 2,211 (93%) tasks were completed out of 2,370 tasks that were planned. These can be categorised as follows: tasks to enable a safe home (including furniture rearrangement and cleaning); tasks to support patient safety and reassurance (including fitting of key safes and alarm pendants, handyman services and heating services); tasks to provide hospital after-care (including providing warm meals, collecting prescriptions and shopping for essential items); advice and signposting; and, ongoing contact and reassurance after hospital care (including welfare calls and 48-hour post-discharge calls).

TABLE 1: EXAMPLE OF TASKS COMPLETED TO FACILITATE PATIENT DISCHARGE AND TRANSITIONAL SUPPORT (DECEMBER 2022-NOVEMBER 2023)

DESCRIPTION OF TASK	FREQUENCY
Fitting key safes to enable support services to access the property	141
48-hour post-discharge telephone calls	551
Provision of telecare devices (e.g., alarm pendants and other wearables)	107
Follow up welfare phone calls	617
Home hygiene cleaning services	33
Specialist hoarding cleaning services (for homes deemed to be pose a safety risk)	5
Deliveries of equipment and furniture	17
Rearrangement of furniture (to optimise safety)	69
Handyman services	18
Provision of hot meal services (provided free to the patient for a two-week period)	142
Heating services (to ensure a warm home)	3
Medication collections	11
Patient/carer advice and signposting	173
Shopping (of essential items)	55
Signposting for ongoing support (for patients identified as 'socially isolated')	30
Provision of mobile phones and pre-paid SIM cards to support those living alone to keep connected)	3

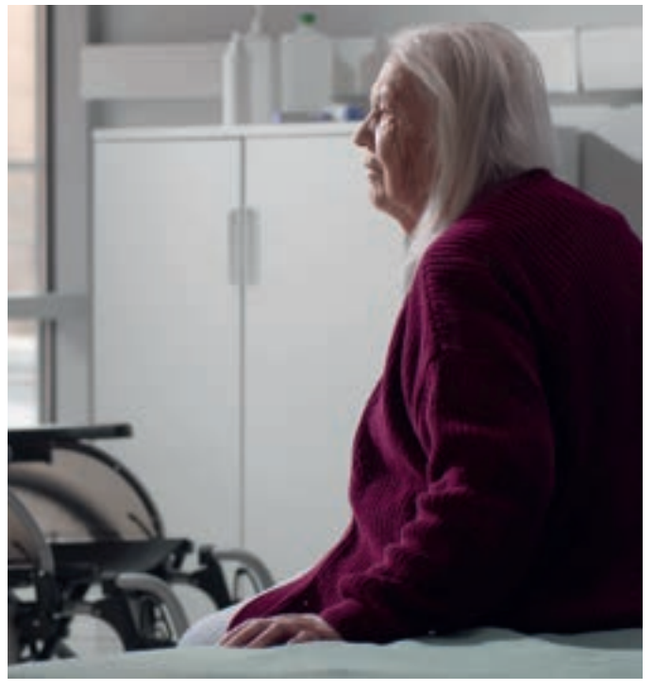
MULTIDISCIPLINARY, INTEGRATED AND PERSON-CENTRED APPROACH

Through discussions with the social prescribers and observations made during shadowing by the ARU researchers, it was evident that the UCAN acute social prescribing team were working well as part of an effective multidisciplinary approach. Referrals to the service were being received formally through the discharge referral processes (including ward staff and discharge coordinators) and informally by word of mouth through the hospital discharge team. The team also had (limited) access to information held on the hospital clinical system which was separate to their own system and could pre-empt patient discharges. In addition to checking information and updating the Ticket Home platform, the team also visited the wards several times during the day to speak to staff members about potential discharges. They observed that these informal interactions of sitting and talking to patients were an effective person-centred approach revealing important information about patients' home circumstances. The acute prescribers were able to build trusting relationships with patients and family members which helped them deal with challenging situations. As one of the acute prescribers acknowledged, "being real with them on a personal level is really important".

MANAGEMENT OF COMPLEX CASES

Whilst the Ticket Home service was originally designed to manage low to medium support it was evident that, as the service grew and became embedded into hospital discharge processes, the UCAN team increasingly received more complex referrals. UCAN's community experience and expertise was particularly valuable in this regard. The team spoke about leveraging existing relationships in the voluntary, housing and local authorities to 'get things done'. Examples included issues relating to safeguarding and homelessness; if someone had no home to go to, they were provided with clothes and food and could also be referred to relevant charities. UCAN's unique position in understanding housing legislation and close working with the housing representative in the discharge hub helped with understanding the 'duty to refer'. This duty requires nurses and other staff to refer patients who are homeless, or at risk of homelessness, to the local authority housing department. It was beneficial that one of the acute prescribers had prior experience in this area; this helped develop working relationships with nurses and other PAH staff involved in discharging patients.

Furthermore, as UCAN supported the Sudanese evacuation and Ukraine refugees with humanitarian support, they had prior understanding of issues pertinent to these groups when admitted to hospital. One team member described a complex case of a homeless refugee admitted to hospital who had no home to go to after they were medically fit for discharge. The team were able to assist by arranging assistance to complete applications to enable the patient obtain housing. Notably, discharge delays due to housing issues are becoming an increasing problem (Maguire, 2023).



UCAN's acute social prescribing team have developed a close working relationship with the hospital discharge team and the Local Authority housing liaison officer. This was facilitated by the team being in the same offices, enabling the sharing of ideas and interdisciplinary learning.

This was particularly valuable when the service was initially being established as it facilitated conversations that were advantageous for team building. The team responded well to complex social issues, such as housing issues relating to patients in council homes, although they did signpost for those requiring private services. The acute social prescribers' expertise and resources for finding housing solutions both gained the team respect and enabled them to work in a more integrated way with PAH discharge staff. However, a few challenges were also reported, including instances of miscommunication with other staff and pressures to discharge patients quickly but not efficiently. For example, a miscommunication was reported concerning an occupational therapy assessment of a patient's need and the Ticket Home team's assessment of a bed-at-home requirement for the patient on discharge. Although this was resolved, it indicated that some communication problems prevailed.

It was evident that the acute social prescribing team not only engaged patients in discharge planning, but that they also facilitated the engagement of patients' family members. On a visit to a care of the elderly ward, an ARU team member observed an interaction between a female patient and her daughter. It was striking that the patient could not adequately anticipate or articulate her needs post discharge which reinforced the need to liaise with family members in some instances. The daughter was appreciative of being included in the conversation about the patient's discharge planning and identified a need for support as she and her siblings lived some distance away, meaning that co-ordination of post-discharge support for their mother would be challenging.

It was particularly interesting to see how the acute social prescribers interacted with information on the clinical systems. On one visit, the ARU team member observed use of a proforma document to gather information. This was a comprehensive and relevant proforma and was useful for collecting and organising information. It enabled the social prescriber to develop their recommendations and respond to requests for support accordingly. It was also noted that requests for support could be made prior to the decision to discharge the patient, suggesting that in some cases, ward staff are anticipating patient needs in advance; for example, in one case a patient had been referred as potentially benefiting from a wrist worn alarm device that could alert agencies in case of emergencies. Furthermore, the social prescriber was able to establish that this patient had two daughters living close by who were able to support him on discharge and that, although the patient himself requested help with cooking a gluten free diet, he had sufficient finances to pay for a catering service himself. The comprehensiveness of the assessment tool was therefore useful and testament to UCAN's efforts to avoid unnecessary costs.

The Ticket Home team work flexibly and quickly, which is particularly important for patients with complex housing and social needs. Services provided by Ticket Home also enabled recovery at home and admission avoidance. Some of the services offered by Ticket Home that enabled timely discharges are also relevant to supporting recovery at home; for example, services that aim to prevent trips and falls and to enable medication collection, which is crucial to avoid adverse medication errors and consequential early readmission (Greysen et al., 2015).

TRANSITIONAL SUPPORT PATIENT WELFARE

It was reported that patients greatly valued receiving welfare phone calls from the acute social prescriber team 48 hours after being discharged. This critical aspect of the service provides an opportunity to discover if the discharge has gone as anticipated and to identify if any further support is required. At this stage, the team ask patients and/or carers a set of standard questions to find out whether patients are eating and drinking, and how they are coping. Patients can, and do, request these welfare phone calls; for many, this was the only service they chose to receive from those on offer by the Ticket Home service, with 551 (84%) of the 653 patients receiving UCAN support choosing to receive the 48-hour post-discharge phone calls only.

The welfare calls evidently provided reassurance and moral support; a listening voice for both patients and their relatives. Importantly, the 48-hour post-discharge telephone call appears to have been particularly valuable in preventing readmissions; likewise, it has been found that a telephone call following discharge can greatly reduce readmissions (Burns et al., 2014). Empirical research with older frail people discharged from hospital highlights that post-discharge contact with the health care system can create frustrations (Andreasen et al., 2015). Moreover, loneliness and social support has been identified as an issue of concern, leading to the advocation of a bio-psycho-social approach to prevent readmission (Ibid.).

Depending on their needs and preferences, patients received follow-up welfare phone calls from Ticket Home on a weekly basis over the subsequent six weeks. These welfare calls were carried out by UCAN volunteers. If problems were identified during these welfare calls, patients' needs were logged and the acute social prescribers were able to intervene and provide what was required, such as signposting and supporting those who were experiencing social isolation. In using the UCAN's information resources, the volunteers can help signpost to other services and refer people for further help as required, such as GP social prescribers, bereavement or befriending services. If not previously made available, care technology, such as pendant alarms and key safes, can also be provided at this stage.

READMISSION AVOIDANCE AND COST SAVING

These findings have shown, the UCAN Ticket Home service contributes to readmission avoidance and significantly better outcomes for the patient overall and may also represent cost savings for the NHS Trust. Notably, the acute trust benefits from maximising bed capacity for new admissions and income/incentives for number of patients treated.

Ticket Home also offers further potential benefits and financial gains in terms of social care provision. The hours of care provided, either voluntarily or through the community responders, represent care that would otherwise have been provided by statutory providers at a significantly greater financial cost. Consider, for example, three hours spent fixing a person's toilet, so they are able to remain at home in a safe and habitable environment, not forgetting the human contact and potential onward referral benefits this provides. This equates to time and money saved within the social care system.

CASE STUDIES

The following six testimonials provided by the Ticket Home acute social prescribers are narrative descriptive accounts of individuals who have been supported by the Ticket Home service. These highlight patients' social circumstances and the impact that service has had on their, and their families', well-being following discharge. These case studies also provide insight into the contribution the service makes to PAH discharge processes, and the value of UCAN's unique position as a bridging service in the community.

To protect patient confidentiality and anonymity, patients' names have been replaced with pseudonyms and in some instances details of the case have been altered.

CASE STUDY A

BACKGROUND

Annie, a woman in her late seventies who suffers from dementia, was admitted to hospital with a severe bout of gastroenteritis. She was referred to the Ticket Home team by the Transfer of Care team at PAH.

TICKET HOME TEAM INTERACTION

On investigating the referral, the Ticket Home team was asked to communicate with the patient's son. On discussing her potential discharge from hospital with her son and the hospital staff, it became evident that she was unable to return home in its current state. Following what her son described as his mum's "mishaps" because of the illness, the carpet was in need of a deep clean and, despite his best efforts, he had been unable to organise this.

On further discussion with her son, it was identified that, although Annie was able to take herself out to the local shop, her GP practice and to the pharmacy to pick up her prescriptions, she sometimes got a little confused about her whereabouts. Her son was very concerned about his mother and how she would cope after being discharged, and he did not know what support was available for her or where to go to get it.

The Ticket Home team organised for a professional deep clean of the woman's home, much to the relief of her son. The Ticket Home team also took time to discuss various options for supporting her, including the offer of a personal pendant alarm that had a GPS facility, which her son was happy to agree to. The Ticket Home team arranged for the fitting of a key safe to the property, and he also accepted the offer of 14 days of meals for his mother on her return home and telephone welfare checks post discharge for a further six weeks.

COMPLETED TASKS AND OUTCOMES

- A professional deep clean of the patient's home to facilitate her discharge from hospital;
- Fitting of a key safe;
- Ordering a pendant alarm with GPS facility;
- Delivery of meals for 14 days post discharge;
- 48-hour post-discharge welfare call;
- Volunteer supported welfare calls for a further six weeks following discharge.

The son expressed his delight with the Ticket Home service that he and his mother had received. He said that the cleaning of the property had been prompt and professional, and that his mother had settled back home and was continuing to feel much better. The meals had greatly reduced stress, ensuring that she received good nutrition, and his mother's confusion seemed greatly improved, so much so that the request for the pendant alarm was "put on hold". The need for a pendant alarm was kept an eye on during the welfare calls and, at the point of discharge from the Ticket Home Programme, her son was given all the information he needed should he decide that his mother needed any care technology in the future.

Annie's son said that he thought that the Ticket Home Service had been "brilliant" and had been very pleased and relieved to have someone support him and his mum.

CASE STUDY B

BACKGROUND

Barbara is in her nineties and had a non-elective stay in PAH for ulcerated legs. The Ticket Home team identified that she lives alone in a two-storey house and although she was not able to use the stairs, she did have a working stair lift that enabled her to get upstairs to her bedroom. It was further identified that although she had adult children, they both lived abroad and were therefore unable to provide support.

TICKET HOME TEAM INTERACTION

The Ticket Home team interacted with Barbara on the ward. Having identified her living arrangements, support network and ability to undertake practical tasks such as shopping, the Ticket Home team took time to discuss with Barbara how she would cope after discharge from hospital. Barbara confessed that while she tried to remain independent in her own home, she was concerned about her ability to cope when she went home.

The Ticket Home team spoke to her about practical solutions that they could help with, including providing hot meals for the first two weeks of recuperation and assistance with shopping thereafter. The team also offered to refer her to some befriending services, as it had been identified that family and friends had all moved away. Barbara did not want to be referred to these services, instead asking to receive follow-up welfare calls from the Ticket Home volunteers. She also accepted that the offer of hot meals for two weeks after discharge, which the Ticket Home staff arranged. Barbara turned down the offer of support with shopping as she said she was able to get to her local store on her own and she would be able to continue to do this on discharge.

Within 48 hours of discharge, the Ticket Home team called Barbara to ensure that she was coping at home and that she had been receiving the meals arranged for her. She asked if it was possible for the meals to be adjusted so that instead of providing a pudding, which she would not eat, she could be provided with a piece of fruit. This request was passed onto the meal provider and the change was made. It was agreed that Ticket Home volunteer welfare calls would continue.

During future welfare calls, it was noted that Barbara's family had stayed with her for a little while. Furthermore, they had raised concerns about their mother and had asked for some help in ensuring that she received more care support. The Ticket Home team discussed her practical needs with her family, and it was agreed that support with shopping was required. The Ticket Home team were able to signpost to other volunteer and support services within the area to assist Barbara, especially after her family had returned home. A referral to Barbara's GP Social Prescribing team was also made to look into her ongoing support needs.

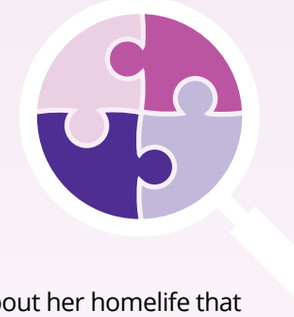
Welfare calls continued for Barbara beyond the six-week period to ensure that referrals to supporting organisations were appropriately taken up.

COMPLETED TASKS AND OUTCOMES

- 48-hour post-discharge call;
- Volunteer supported welfare calls;
- Two weeks of hot meal support;
- Referral for social prescribing support;
- Signposting for support with shopping and transport.

Barbara's expectations of what she would be able to cope with on discharge from hospital did not fall in line with the reality she faced on going home. The continued support of Ticket Home post discharge meant that her unrecognised needs were supported. Communication with her family members meant that they were happy that their mother was receiving the support she needed once they had to return to their own homes in other countries. Because of the ongoing support that she required for her medical condition, the support provided by Ticket Home extended beyond the six-week period as it was necessary to ensure that referrals were properly followed up to ensure her continued care.

CASE STUDY C



BACKGROUND

Catherine is 69 years old and was admitted to PAH for elective surgery on her arm. The Ticket Home team received a referral from the ward asking them to speak to her about her discharge.

TICKET HOME TEAM INTERACTION

The Ticket Home team visited Catherine on the ward. They took time to talk to her about her homelife that she would shortly be returning to. The Team learned that she was a carer to her husband who was blind. It was noted that one of her arms was already immobile and that the other was still in recovery from surgery, so her ability to undertake everyday tasks was severely challenged. It was agreed that Ticket Home would provide hot meals for both her and her husband for a two-week period.

During conversations with Catherine, it was recognised that she and her husband were probably entitled to more support than they were currently receiving, and it was agreed that the Ticket Home team would initialise a referral for Catherine to receive social prescriber support from her local GP practice that would enable her and her husband to seek all the support they needed.

A 48-hour post-discharge call was made to ensure meals were being received and that all needs were being met. During this conversation, Catherine asked for some home help with tasks such as laundry, which the Ticket Home team made a referral for.

Further welfare calls ensured that she continued her journey back to wellbeing and that referrals had been successful and all support requested had been received.

COMPLETED TASKS AND OUTCOMES

- 48-hour post-discharge call;
- Volunteer supported welfare calls, identifying ongoing support needs for home-help;
- Referral to social prescriber to ensure Catherine received appropriate financial support;
- Two weeks of hot meals provided for both Catherine and her husband.

At the end of her care under the Ticket Home programme, Catherine expressed her thanks to the team. She stated that it had made things much simpler for her and she was very grateful for the support for both her and her husband.

CASE STUDY D

BACKGROUND

Dorothy is an 85-year-old woman who had been brought into PAH by paramedics. The paramedics had flagged up a few concerns to the ward team that would need to be addressed prior to her returning home. The Transfer of Care team asked the Ticket Home team to assist in assessing the practical needs of the patient for discharge.

TICKET HOME TEAM INTERACTION

A member of the Ticket Home team accompanied a member of the Transfer of Care team to meet Dorothy on the ward. She presented as a frail lady who was very personable. She advised that she had lived alone in a farmhouse for many decades. She described herself as “an old farmer’s daughter”, and stated that she was not bothered by a lack of central heating and the occasional rat around the place. She was very happy for the Ticket Home team to contact her next of kin and to work with her in gaining access to the property and identifying necessary tasks.

Through the paramedics’ report and interaction with the patient, her needs at this time were identified as fitting a key safe, cleaning, arranging for pest control to visit the property and checking the heating in the house, as there seemed to be nothing other than individual electric fires.

The family member who was contacted was very relieved to speak to someone as she had grave concerns about Dorothy returning to her home.

She described the house as being far worse than Dorothy had said, and that, because Dorothy was a proud and independent woman, she had not been able to see the condition of the house other than the living room until Dorothy had been admitted to hospital. In discussion with the family member, key areas of concern were identified:

- General decrepit state of the crumbling farmhouse;
- Fire safety, which had been flagged by the paramedics to the fire service;
- Rodent infestation, including faeces in the patient's clothing and a strong smell of ammonia from rat urine throughout the property;
- No cooker;
- No washing machine;
- Cupboard doors hanging off;
- Kitchen floor covered in junk mail;
- Safe navigation through the property would be difficult for the patient, with the stairs being particularly troublesome, if not impossible.

The next of kin felt that, given the state of the property and Dorothy's health conditions, she would not be able to return to the property on discharge.

The Ticket Home team advised the Discharge team of this evolving situation, and it was agreed that this was a complex case and that it would be inappropriate to discharge the patient back to the property. It was agreed that she would be transferred to St Margaret's Hospital and then onto interim accommodation whilst her needs were being assessed for her future living arrangements.

COMPLETED TASKS AND OUTCOMES

- Discussion with the patient about her living conditions and appropriate family members to contact regarding her home situation.
- Detailed discussions with next of kin to discuss the patient's home situation and the options for discharging the patient from PAH.
- Detailed discussions with Transfer of Care team about the evolving situation.

Through discussion, it became apparent that the patient's needs were beyond the scope of the Ticket Home project. However, as it is part of the remit to flag any complex safeguarding and care discharge issues or concerns to the relevant hospital staff or external agencies, Ticket Homes' involvement in this case assisted in the appropriate and timely transfer of Dorothy from an acute bed to a more appropriate bed at St Margaret's hospital. Further to the Ticket Home's investigations and signposting, Dorothy's needs were reassessed and a care home placement was found for her.

CASE STUDY E

BACKGROUND

An Occupational Therapist referred a patient called Ellen to the Ticket Home team. In her mid-seventies, Ellen was admitted to PAH a few days prior to the referral.

TICKET HOME TEAM INTERACTION

The Ticket Home team spoke to Ellen about her needs. She was hoping to be discharged from hospital soon with a package of care in place. However, her mobility was compromised and she was going to have difficulty getting to the front door to give carers access to the property. It was agreed that Ticket Home would arrange for an urgent key safe to be installed at her property.

COMPLETED TASKS AND OUTCOMES

- A key safe was fitted to the patient's property within the same day that the referral was received.
- A 48-hour post-discharge welfare call ensured the patient's safe return to the property and that the key safe was working well for her and her carers.

Ellen declined Ticket Home's offer of meal provision and ongoing welfare support calls. However, because of the speed with which the key safe had been installed, there was no barrier to her discharge from hospital once the package of care had been put in place and her discharge, which had been estimated to take place at 5pm, actually happened at 12.15pm. This freed up the bed much earlier and assisted in the improved flow of patients through the hospital journey.

CASE STUDY F

BACKGROUND

The Ticket Home team was asked by the head of the Discharge team to help with a complex discharge. Frank is an 81-year-old male who, at the time of his stay in hospital, was homeless. There had been two previously failed attempts at discharge, neither of which involved the Ticket Home team.

TICKET HOME TEAM INTERACTION

On being asked to help with the discharge, the Ticket Home team interacted with staff at PAH and St Margaret's hospital, both of whom had been involved in Frank's care. It was identified that the patient was potentially going to be re-homed, but that help was needed to make sure this would happen. Coordination between the local housing department, removers, hospital and patient was intricate and complex.

As well as their interaction with the hospital staff, the Ticket Home team spoke to the Independent Living team at Epping Forest District Council.

Through discussions with the patient and partner organisations, it became apparent to the Ticket Home team that the patient had been very frustrated with two previous failed discharges and that the support worker from The Housing Association organisation who had been assigned to him to assist in the move was not able to progress the matter to its desired conclusion within the necessary timeframe.

A member of the Ticket Home team visited the property and liaised with the Housing Department, the patient and the removal company to coordinate the operation.

It was noted that Frank lacked some very basic items and the Ticket Home team sought to provide essentials such as clothing, bedding, furniture, a microwave and other kitchen items. It was also agreed that two weeks of hot meals would be provided.

COMPLETED TASKS AND OUTCOMES

- Complex communications with PAH, St Margaret's Hospital, Epping Forest District Council and Peabody;
- Visiting the prospective property;
- Contracting the removal of items with Happy Moves;
- Providing furniture, bedding and clothing for the patient and ensuring the delivery of these items to the property;
- Arranging for two-weeks' provision of hot meals on discharge;
- Continuing to support the patient throughout the discharge journey and, once discharged, continuing communication with other support organisations to ensure that the patient's ongoing needs were met and adequately signposted.

Despite the complexities of this case, and two previously failed discharge attempts, Frank was successfully discharged ahead of the anticipated discharge date. Ticket Home involvement was integral in this achievement.

SUMMARY AND DISCUSSION

A major advantage of the Ticket Home service was that it provided flexibility and, with community-based expertise at its disposal, the services that really supported patient's basic but essential needs. However, to deliver this service, the Ticket Home team had to overcome challenges in making the service known and in collaborating with staff at PAH.

A major challenge initially experienced by the Ticket Home team was to embed the service and work in an integrated manner with existing PAH staff involved in discharging patients. To do this, they had first to ensure that ward matrons, discharge co-ordinators and patients were made aware of the Ticket Home service and could see its value. The team worked hard to raise awareness, ensuring that posters, stickers and leaflets were placed in all areas of the ward to ensure visibility of the service. They also drew attention to the services by setting up pop up stands around the hospital and making regular ward visits. The Ticket Home team felt that progress was slow but working. Notably, stickers and barcodes on patients' bedside tables had been introduced to facilitate easier access by patients and their relatives, as well as staff.

During the year, normal hospital routine was disrupted by national NHS staff strike days. This had the unintended consequence of better integrating the Ticket Home team. During this time, they were invited to attend the bed meetings where patient discharge was being discussed. Nevertheless, some challenges regarding the integration of the service and working effectively and efficiently to manage patient discharge in a timely manner continued to be reported by the UCAN acute social prescribers.

Another persistent challenge experienced by the team was to start planning discharge as early as possible. Despite efforts by the Ticket Home team to instigate planning the discharge soon after admission, it was reported that hospital staff mostly resisted doing so until discharge was imminent. The Health and Care Act 2022 introduced a new duty for NHS trusts and foundation trusts to involve patients and carers in discharge planning. This applies in situations where an adult patient is likely to need care and support after their hospital discharge, and the trust considers it appropriate to involve them or their carers in planning their hospital discharge. The new duty states that this should be done as soon as is feasible after the trust begins making plans relating to the patient's discharge. Nevertheless, adopting and applying this instruction might be culturally challenging as hospital ward and discharge staff were often seen as more reactive than proactive in their actions.

Other challenges that the Ticket Home team encountered included a 'slight mission creep' insofar as while the team worked flexibly and pragmatically to facilitate a patient discharge, they sometimes had to tackle difficult issues such as people who hoard or whose homes required deep cleaning. Hoarding results in living spaces that are cluttered and likely to be unhygienic, raising health and safety concerns for occupants and for any visiting service providers (Porter & Hanson, 2022). The team took on tasks to organise an external team to clear cluttered spaces and provide a deep cleaning service to assist with patient discharge. As this work went beyond the bounds of their initial remit and with constraints on funding, the Ticket Home team found this provision challenging and had to limit the extent to which they provided this service. They have, however, continued to act as a conduit with the local authority housing department.

IMPLICATIONS

It should be noted that whilst quantifying the potential financial and qualitative impact of the Ticket Home project is possible in crude terms, what is most difficult to estimate is the potential future financial and qualitative opportunity. Ticket Home not only supports patients following a hospital stay, but also acts as a door opening onto a wealth of other opportunities which are all proven to tackle and improve the wider determinants of health.

With respect to the future adoption of the Ticket Home Discharge model, learning from the pilot at PAH will be used to enhance the model. The Ticket Home demonstrated significant impact upon hospital flow and improvements in the resilience of discharges and subsequent reductions in readmissions. It would be relevant to any acute hospital setting who could deploy it in three forms:

- digital platform and associated apps,
- initial implementation of the model over a fixed period,
- delivery of the whole model.

It could be easily integrated into a Transfer of Care team. This would bring a range of benefits to the acute hospital, providing solutions to the challenges, costs and risks of discharge and the related concerns that patients and their carers may have. It also strongly links into Step Down settings and the Virtual Hospital approach, as well as complementing the Primary Care Network Integrated Neighbourhood models.

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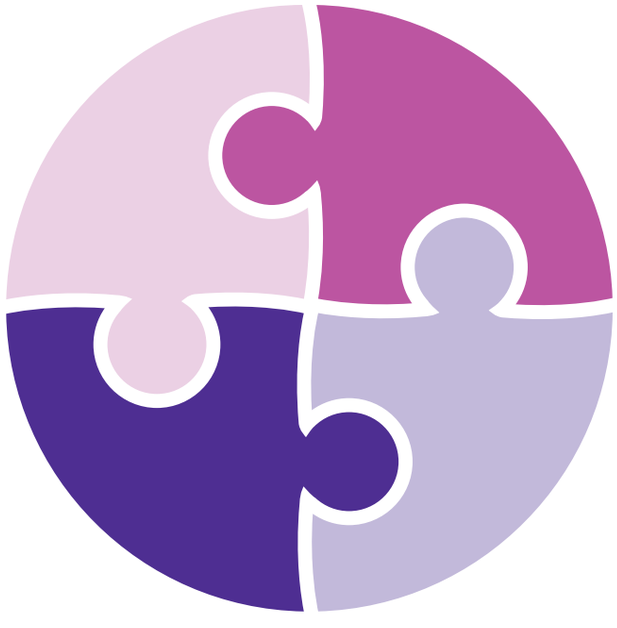

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NHS
The Princess Alexandra Hospital
NHS Trust

UCAN
Uttlesford Community Action Network