Understanding the role and impact of discharge support volunteers at Kingston Hospital NHS Foundation Trust, analysis of the data captured by the service

(November 2021)

Contents

Background

Kingston Hospital NHS Foundation Trust deploys volunteers in a variety of roles to help the trust deliver high quality and efficient services. One of these volunteer roles is to provide support to elderly people discharged to home from hospital. The service aims to help patients cope better at home and in their communities.

The role of a Discharge Support Volunteer has four key elements, these are to:

i) Meet the patient at bedside (pre-Pandemic) to establish immediate needs and issues that may prevent them from going home 'Safe, Well and Warm'.
ii) Develop an immediate support plan to ensure the patient has the confidence to go home alone with their core needs met
iii) Support patients for up to 6 weeks via telephone using a coaching and social prescribing model
iv) Collect data that supports the evaluation of the impact and sustainability of the service intervention.

The service is designed for patients over the age of 65 who are discharged back to their home alone and without recourse to a package of care or existing connections to community-based support or services.

During the Pandemic, volunteers were removed from the ward environment. Their activity was replaced by a screening call, led by a member of staff, who screened the patient for their eligibility to take part in the service, then allocated the patient to a volunteer for the 6-week package of follow-up calls. The service is open to referrals across multiple wards and the Emergency Department. During a typical month, the service supports a caseload of approximately 35 patients and an average cohort of 10 volunteers give 3 hours per week of telephone support and social prescribing to an individual caseload of up to 3 patients.

Although a discharge support volunteer role was introduced by the trust as far back as 2016, the data set out in this document largely relates to activity undertaken since the beginning of 2020, a period which has seen considerable growth in the scale and impact of the service.

Key findings

1. The volunteers appear to deliver statistically significant **improvements in confidence levels** amongst the patients who receive their support (up by 19%).

2. Volunteer support also appears to deliver **improvements in links to local groups or support services**. The proportion of patients understood to be in contact with a local group or support service at the point of discharge from the service was 31% higher than the proportion of patients in contact with a local group or support service at the point of first contact with the service.

3. **Patients are overwhelmingly positive about the service** with 72% of those who received volunteer support using the maximum possible rating, ten, to describe their likelihood of recommending the service (the scale used was from 1 to 10)

4. There does not appear to be a relationship between changes in patient confidence levels and the number of contacts that patients have with volunteers. The correlation test shows neither a positive nor a negative trend.

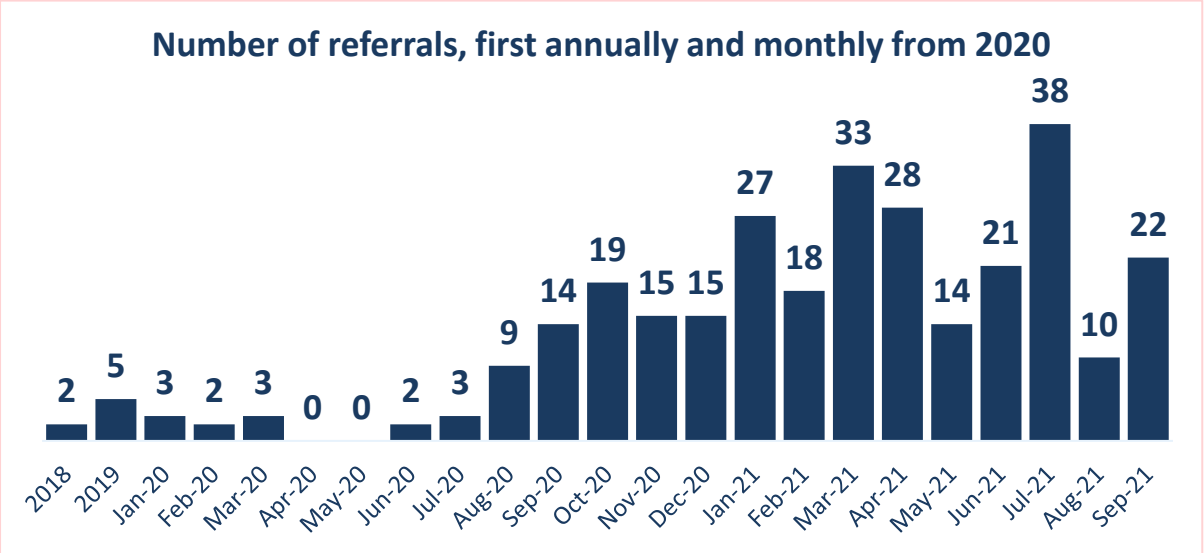
The available data does not make it possible to draw any clear conclusions about the impact of the volunteer service on hospital readmissions. The data captured by the service suggests that 12% of those who received volunteer support were readmitted, which is slightly lower than a similar figure for emergency hospital readmissions published by NHS Digital for Kingston upon Thames of 16.1%, but patient cohort, or timeframe, differences could easily explain this variation.[1]

Referrals to the discharge support service

Since it was introduced, the service has maintained a database to record details of referrals and to track progress. The analysis in this document looks at a snapshot of data extracted on 07/10/2021. It covers the 311 referrals that had been recorded by the service prior to this date. It is worth noting that since the database is updated retrospectively by the volunteers, rather than at the time of activity, some data in the system is always slightly out of date.

As can be seen in the chart below (Chart 1) there have been 308 referrals to the service where a referral date was recorded. The bulk of these referrals have occurred since mid-2020, but some referrals have been recorded from as far back as 2018 when the service was first introduced.[2] On average since July 2020 the service has been receiving around eighteen referrals per month.

Chart 1. Number of referrals to the discharge support service (sample size n = 308)



[1]The percentage of emergency admissions to any hospital in England occurring within 30 days of the most recent discharge from hospital for Kingston upon Thames between 01/04/19 to 31/03/20 3b Emergency readmissions within 30 days of discharge from hospital - NHS Digital

[2] Due to the small number of referrals recorded on the system in 2018 and 2019 there is a risk that the referral dates have been captured incorrectly, however it was agreed with the service that these records were likely to represent genuine referrals and should therefore be included in the analysis

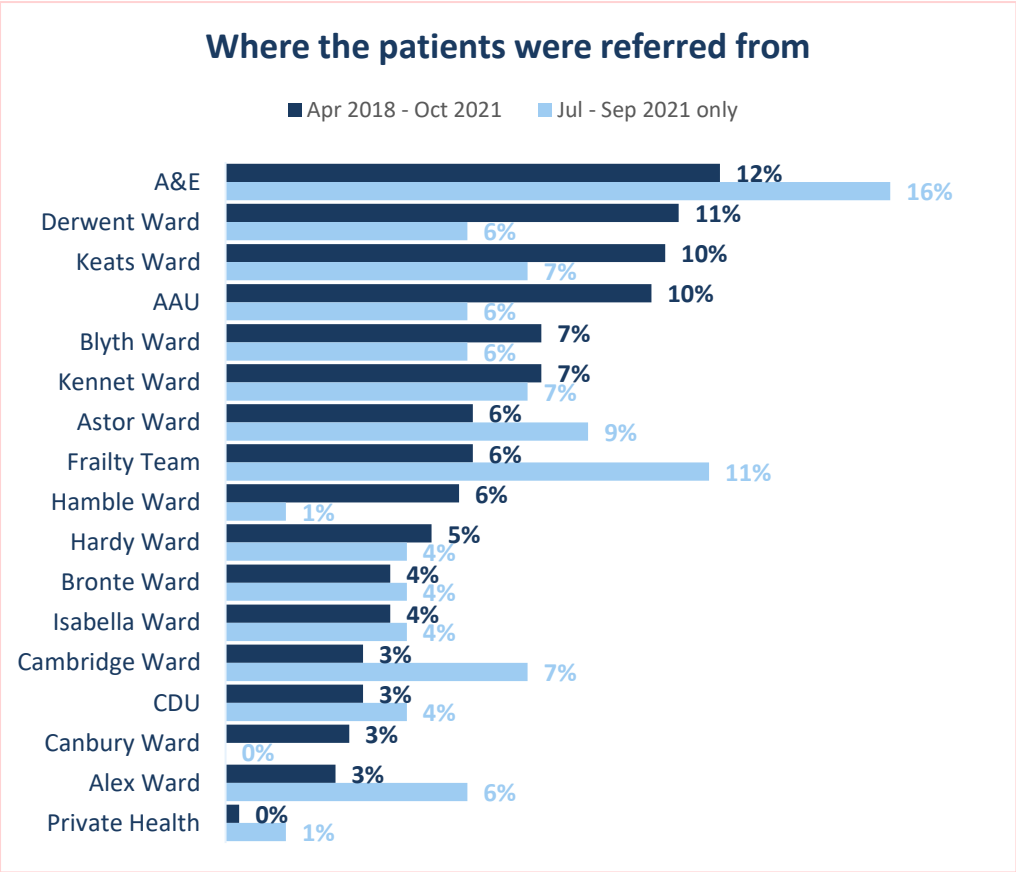
Referrals are received from a wide variety of wards and teams, suggesting a good awareness of the service amongst staff and a spread of eligible patients located across the hospital (Chart 2).

The available referral data suggests that the A&E department has been the largest source of referrals since the service was introduced (12% of all referrals). A comparison with the referral data for the most recent quarter (July – September 2021) indicates that this is still very much the case. During this most recent quarter the A&E department was the source of 16% of referrals.

Comparison between referral data in the latest quarter and since the service was introduced suggests that the variety of referral sources has been maintained over time. However, there do appear to have been some slight shifts in the importance of different referral sources in addition to the growth in relative share seen for the A&E department. The Frailty Team has seen the biggest increase in share of referrals. The team accounted for 11% of referrals in the latest quarter (6% above the proportion of referrals seen since the introduction of service). There were also increases in referral share seen in the latest quarter for Cambridge Ward (up 4%), Astor Ward (up 3%), Alex Ward (up 3%) and CDU (up 1%).

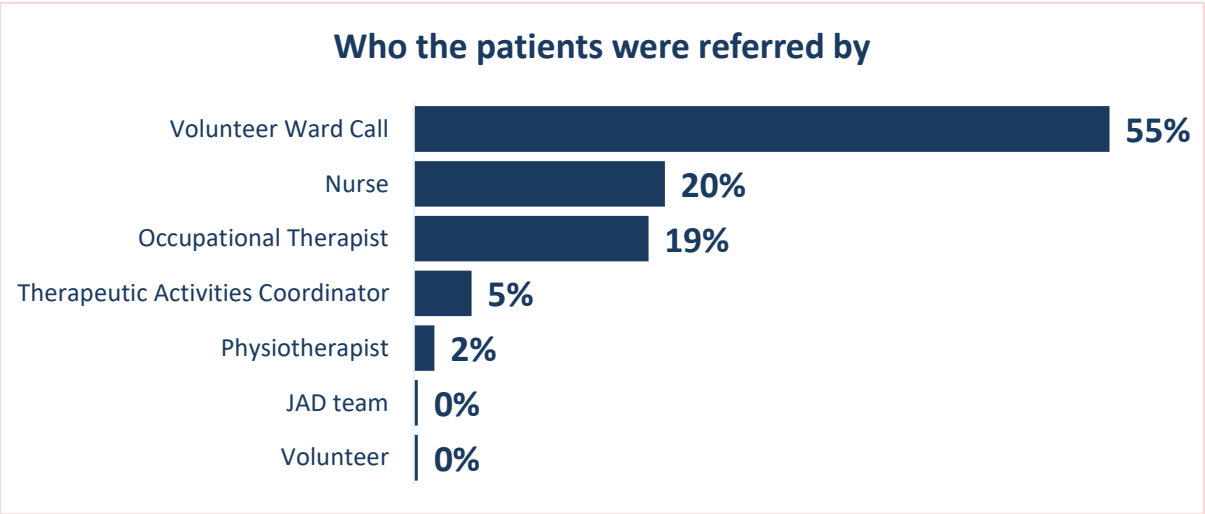
The biggest decrease in referral share was seen in Derwent Ward (down 5%), closely followed by AAU and Hamble Ward (down 4%). Keats Ward and Canbury Ward experienced a decrease in referral share of 3%.

Chart 2. locations and teams within the hospital that refer to the discharge support service (n = 308 for complete data, n = 70 for data from last quarter)



In a significant proportion of cases (55%) referrals are being triggered by the proactive actions taken by the service itself (volunteer ward calls), but nurses (20%) and occupational therapists (19%) are also important sources of referral (Chart 3).

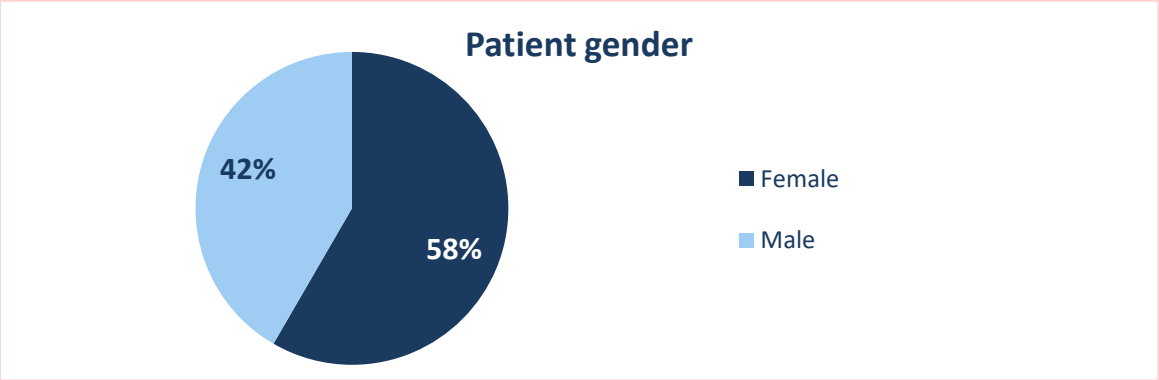
Chart 3. Referrals to the discharge support service by role (n = 308)



Who uses the discharge support service?

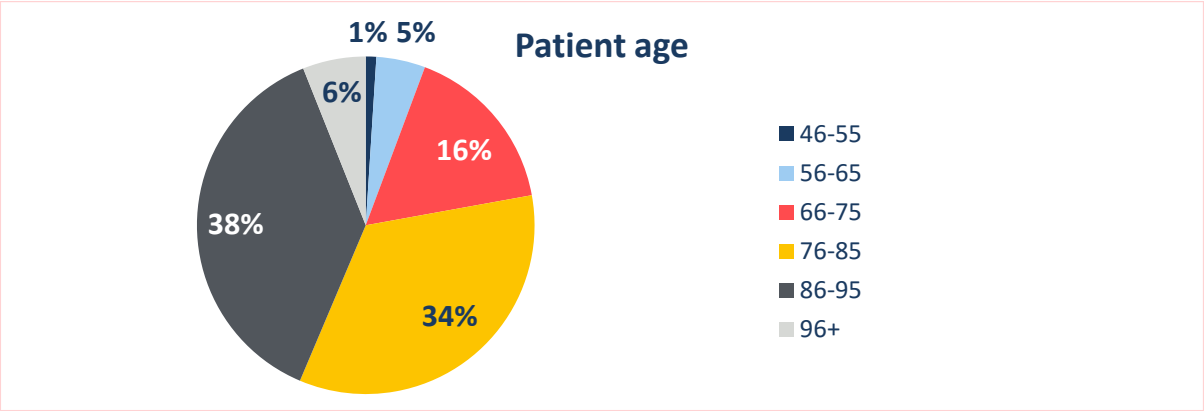
Patients referred to the service are more likely to be female (58%) than male (42%) (Chart 4). These proportions appear to be largely in line with the gender split seen for Finished Consultant Episodes (FCEs) for Kingston Hospital NHS Foundation Trust in 2020/21 (39% Male and 61% Female).[3]

Chart 4. Referrals by gender (n = 305)



Patients referred are overwhelmingly aged sixty-six and over (94%), but it is interesting to note that six percent of referrals are for people aged 65 or under, suggesting some flexibility around eligibility criteria (Chart 5).

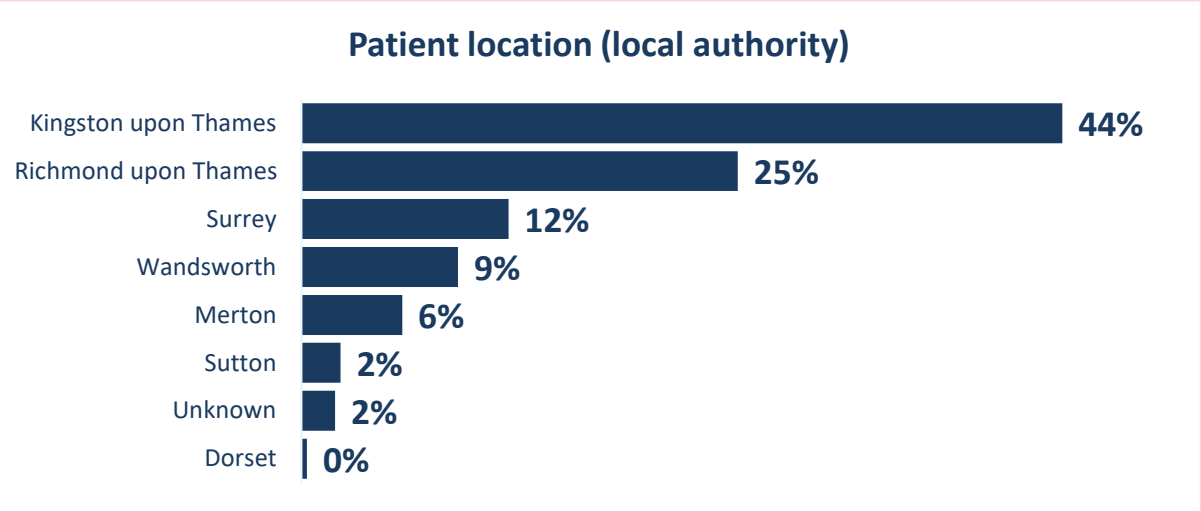
Chart 5. Referrals by age group (n = 298)



Although the discharge support service primarily receives referrals for patients who are from Kingston upon Thames (44%) or Richmond upon Thames (25%), the service has also received referrals for people from as far afield as Dorset (Chart 6).

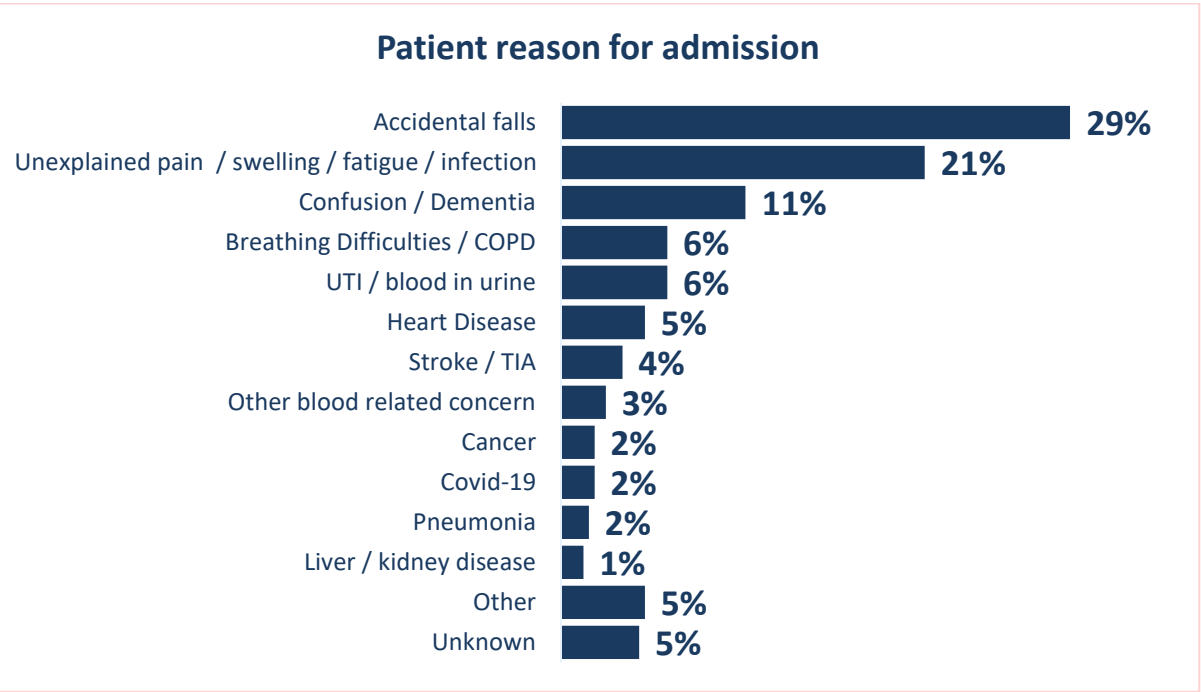
[3] "Hospital Admitted Patient Care Activity, 2020/21: Hospital Providers", The NHS Digital, Hospital Episode Statistics for England. Admitted Patient Care statistics, 2020-21, Copyright © 2021, NHS Digital, Secondary Care Analysis. All Rights Reserved. https://files.digital.nhs.uk/BB/EEDB69/hosp-epis-stat-admi-hosp-prov-2020-21-tab.xlsx

Chart 6. Referrals by local authority of residence (n = 311)



The service receives referrals for patients who have been admitted to hospital for a wide variety of reasons (Chart 7). An accidental fall is the most common reason linked to a referral to the service (29%). The other relatively common reasons for admission linked to a referral are unexplained pain / swelling / fatigue / infection (21%) and confusion / dementia (11%).

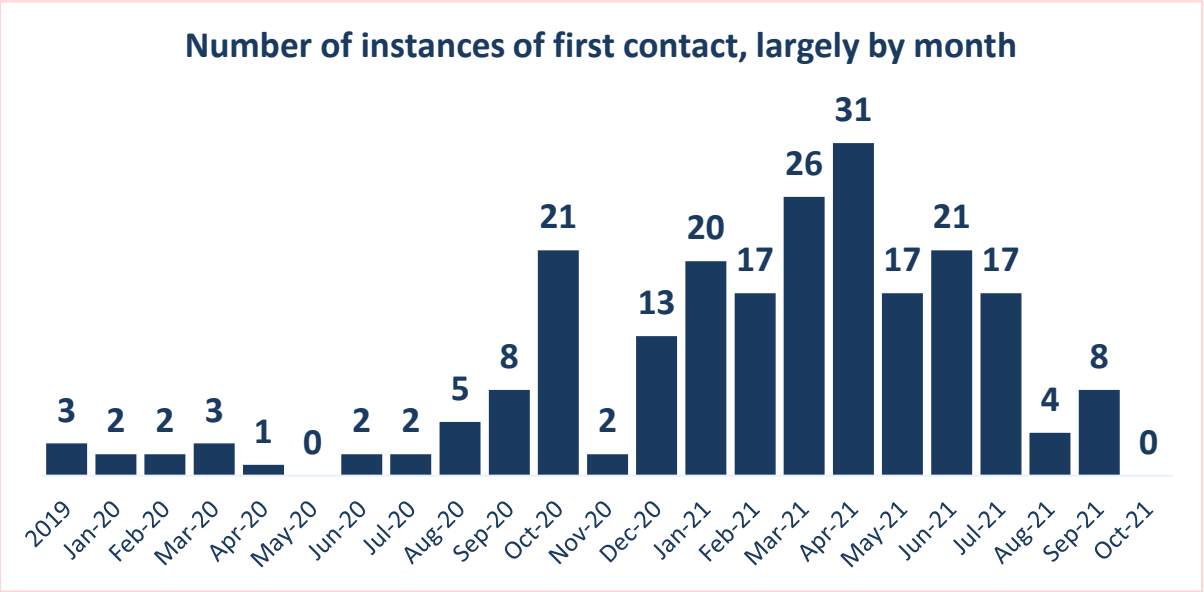
Chart 7. Referrals by reason for hospital admission (n = 311)



Service activity

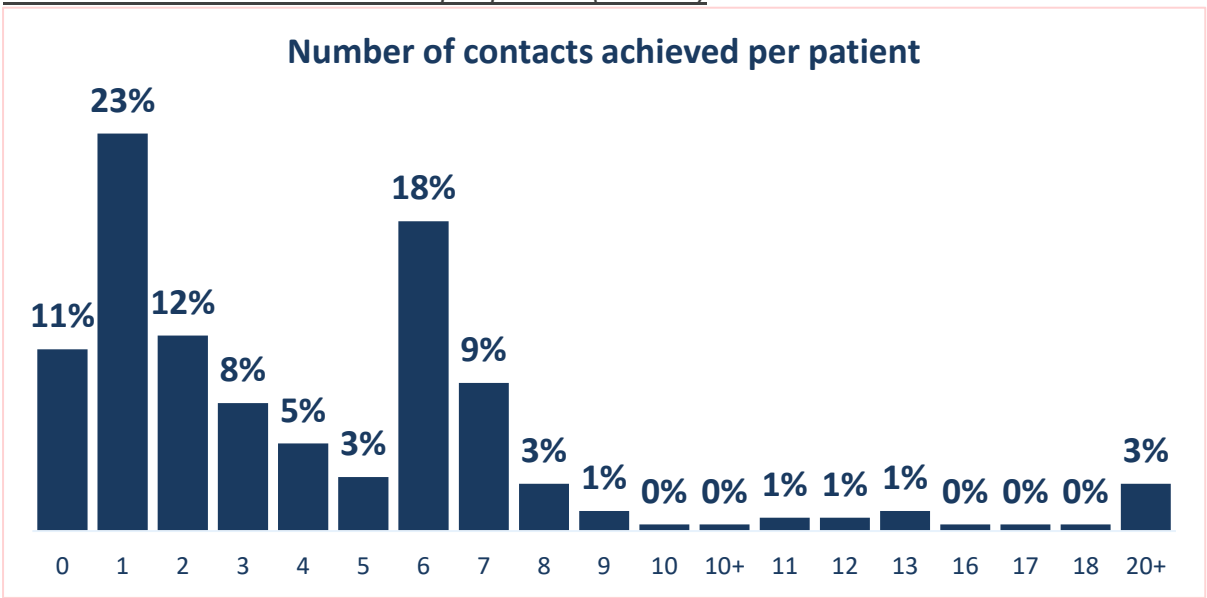
The available data indicates that the referrals to the service resulted in 225 instances of first contact between patients and volunteers. On average since January 2020 the service has been making 10 first contacts per month (Chart 8).

Chart 8. First contacts between patients and volunteers (n = 225)



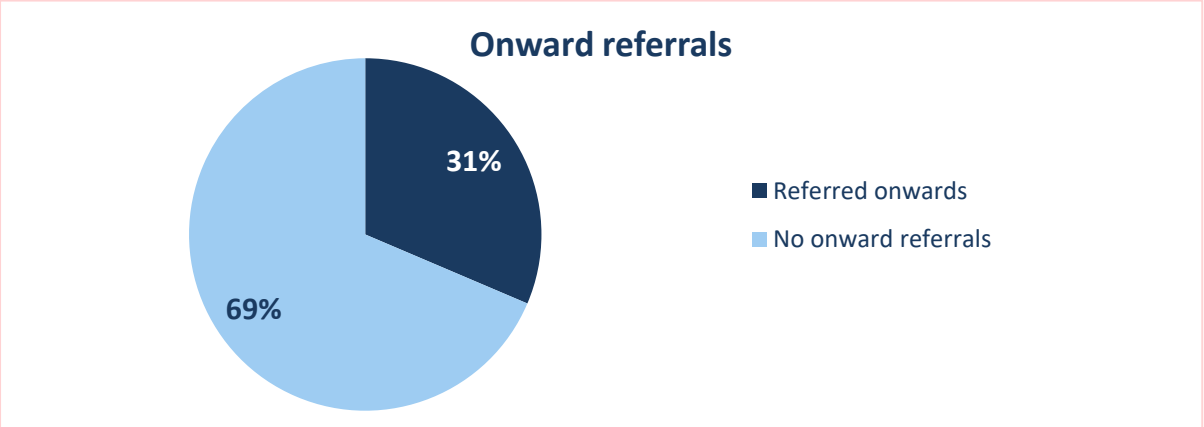
The number of contacts achieved per patient (Chart 9) ranges from 0 to over 20. Although the service aims to achieve six contacts with each patient the actual number of contacts varies considerably based on the needs of the patient. It is interesting to note that the proportion of patients with just one contact (23%) is actually higher than the proportion with six contacts (18%).

Chart 9. Contacts with volunteers per patient (n = 252)



Where appropriate the volunteers will make onward referrals for the patients that they work with. Following contact with the discharge support service 31% of patients were referred onwards and 69% received no onward referrals (Chart 10).[4]

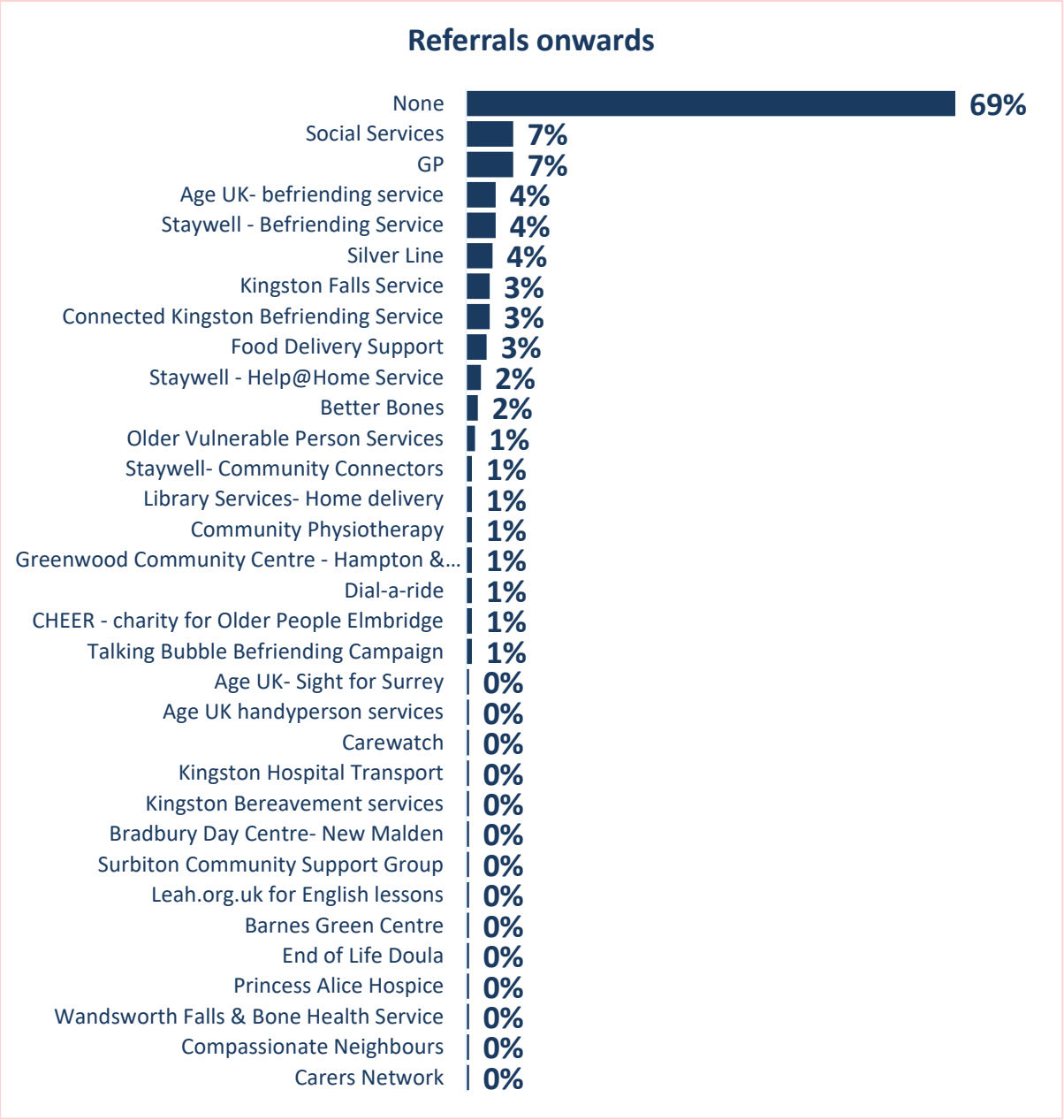
Chart 10. The level of onward referrals (n = 242)



Of the 311 patients referred to the service 242 had an onward referral record. As noted above only 31% of these 242 patients were referred on to somewhere specific. Onward referrals are made to one or multiple places (Chart 11). The most common places to make onward referrals to were Social Services (7% of those with an onward referral record) and GPs (also 7%).

[4] In sixty-nine records the onward referrals field was left blank. These 69 records have been excluded from the calculations presented in charts 10 and 11.

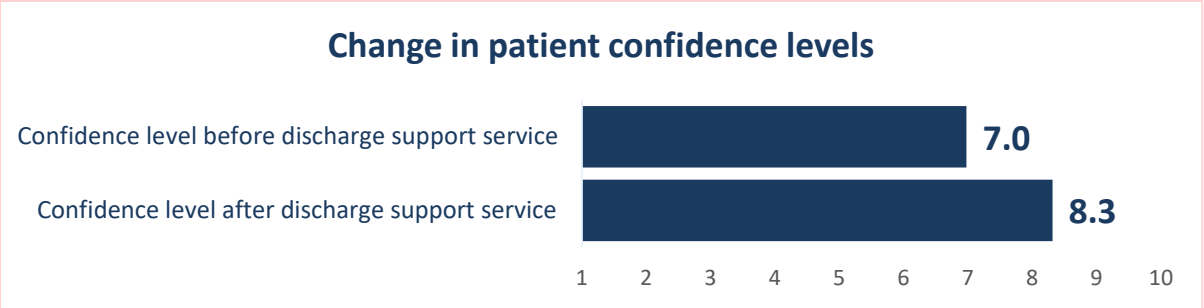
Chart 11. The onward referral breakdown (n = 242)



Service delivery outcome 1: The impact on patient confidence

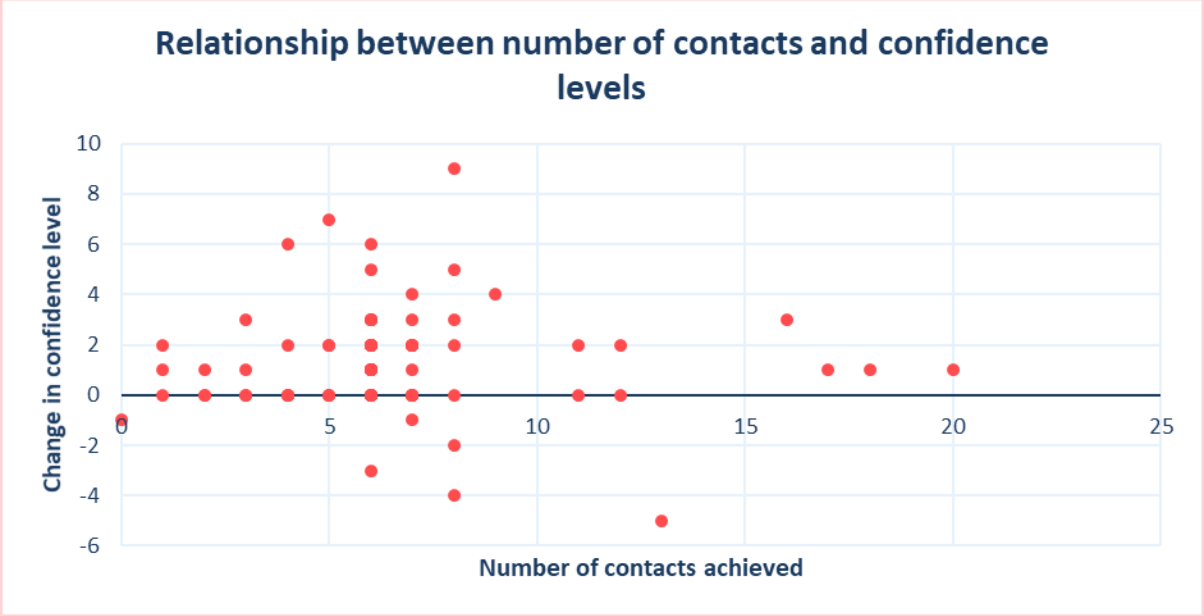
The service records patient confidence levels at the point of first contact and then again at the point when the volunteer support ends. On average across the 104 patients who had confidence levels recorded at both points there was a statistically significant increase in confidence levels of 19% (based on the p-value of paired t-test (2-tailed)). At first contact patients had average confidence levels of 7.0 (on a scale of 1 to 10 where ten is the maximum) and by the point of leaving the service their confidence levels had risen to an average of 8.3 (Chart 12). Although the available data does not make it possible to directly attribute this positive change to the discharge support service, there does appear to be an association between the service and this outcome.

Chart 12. The impact of the service on patient confidence levels (n = 104)



Although the service aims to provide six contacts with patients it is interesting to note that there is no visible or statistically significant correlation between the number of contacts and changes in confidence levels (Chart 13).

Chart 13. The relationship between contacts and confidence levels (n = 99)



Service delivery outcome 2: Links to local groups and support services

Amongst the 107 patients who had records showing whether, or not, they were in contact with any local groups or support services, captured at both first contact and at the point of moving on from the discharge support service there was an increase of 29% in the proportion who said 'yes' when they moved on from the service when compared to the proportion who said 'yes' at first contact (Chart 14).

Chart 14. The proportion of patients in contact with local groups or support services before and after receiving discharge support (n = 107)

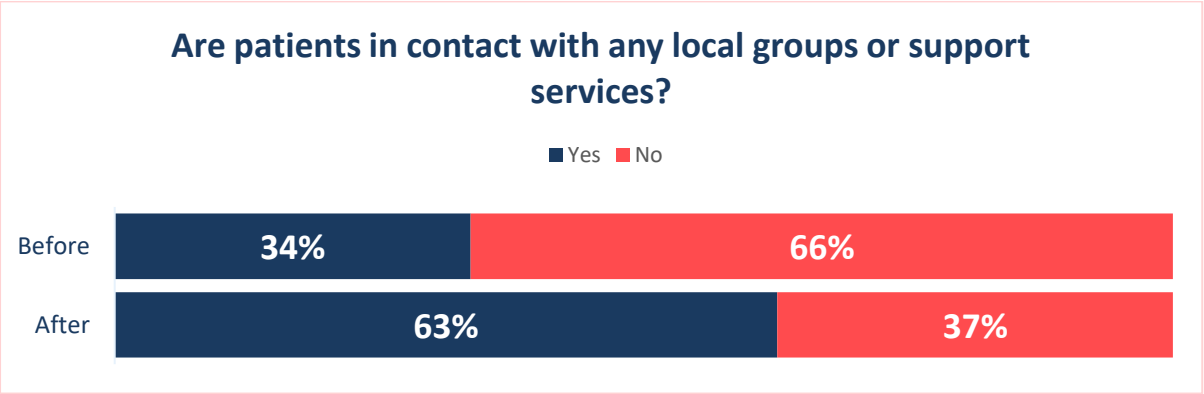
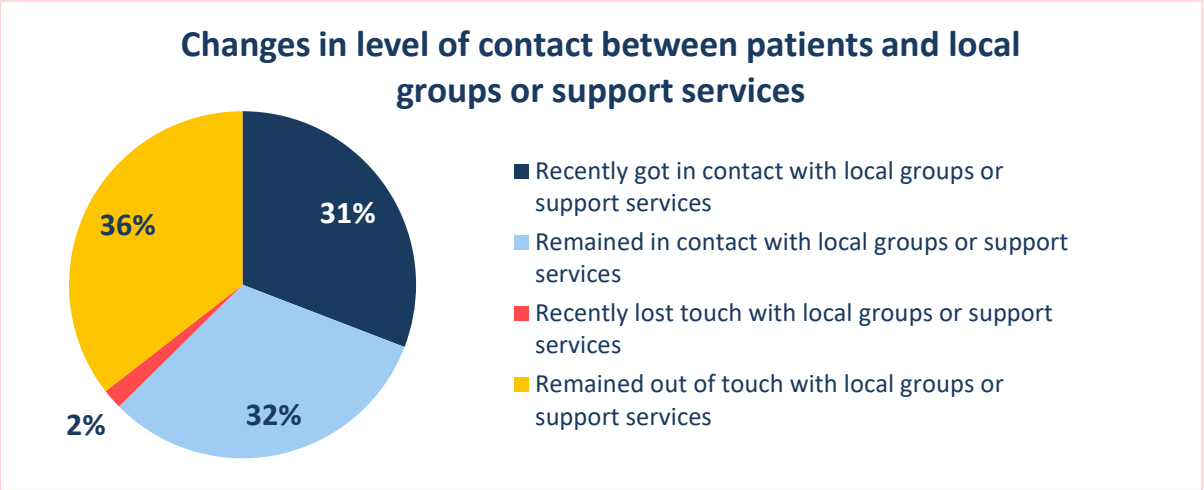


Chart 15 shows how this change was reflected at an individual patient level. Only two percent of patients appear to have lost contact with local groups or support services. This means that 31% of patients were helped to get in contact with local groups or support services after having been assisted by the service.

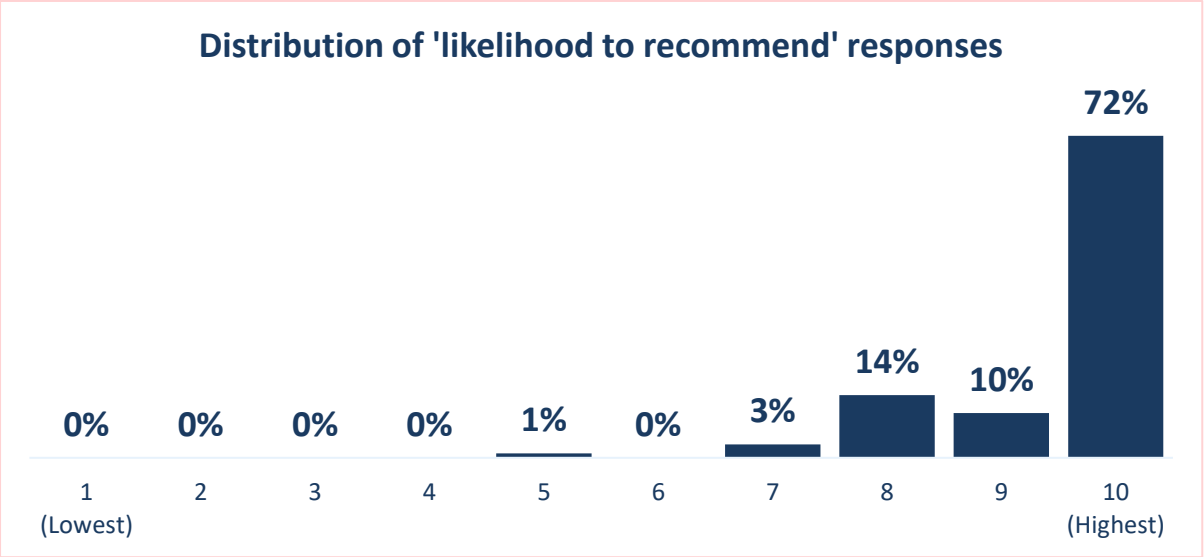
Chart 15. Changes in the level of contact between individual patients and local groups or support services (n = 107)



Patient feedback about the discharge support service

Patients are overwhelmingly positive about the service with 72% of those who received volunteer support using the maximum possible rating 10/10, to describe their likelihood of recommending the service. (Chart 16).

Chart 16. The distribution of 'likelihood to recommend' responses (n = 100)



Does the discharge support service have any impact on hospital readmissions?

The available data does not make it possible to draw any clear conclusions about the impact of the volunteer service on hospital readmissions. The data captured by the service suggests that 12% of those who received volunteer support were readmitted (Chart 17), which is slightly lower than a similar figure for emergency hospital readmissions published by NHS Digital for Kingston upon Thames of 16.1%, but cohort or timeframe differences could easily explain this variation.[5] Although the lack of a clear link between the service and reduced hospital readmission may seem disappointing it is important to note the many and complex reasons that can lead to a readmission which are outside the control of this service, most notably deteriorating health conditions. To fully understand the impact of this service on readmissions a more thorough study which tracks individuals and factors in the number of previous admissions may be required.

[5] The percentage of emergency admissions to any hospital in England occurring within 30 days of the most recent discharge from hospital for Kingston upon Thames between 01/04/19 to 31/03/20 3b Emergency readmissions within 30 days of discharge from hospital - NHS Digital

Chart 17. Hospital readmissions since contact was established with the volunteer service (n = 116)