Discharge Support Volunteers

Evaluation Report

Kingston Hospital NHS Foundation Trust

August 2024

helpforce

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Volunteering
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Executive summary

The project

Discharge support volunteers at Kingston Hospital NHS Foundation Trust supported patients during the transition from hospital to home by providing practical and emotional support between March 2019 and March 2024. These volunteers provided telephone calls support over the six weeks following discharge to address patient needs and provide referrals to local services. The service was offered to patients aged 65 and over who are anxious about returning home or at risk of loneliness.

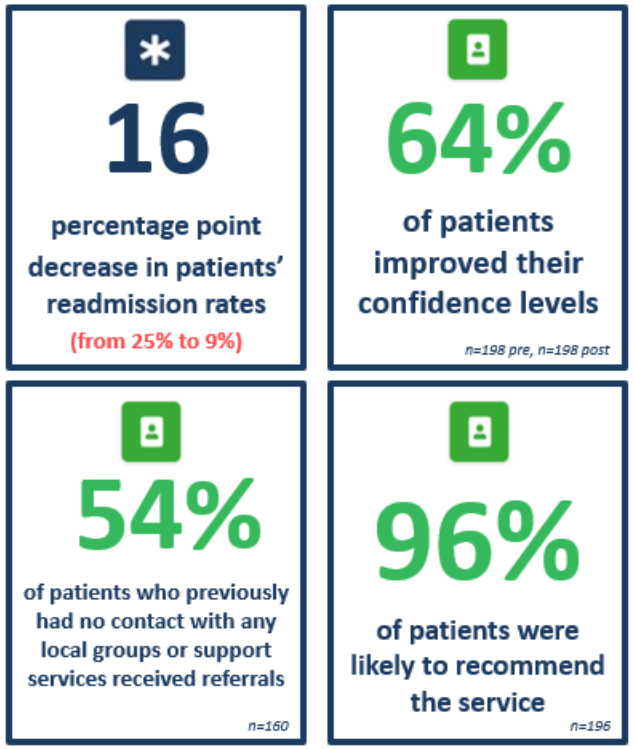
Evaluation approach

Using its established *Insight & Impact* evaluation service, Helpforce follows a consistent methodology to determine the impact of volunteering roles on health outcomes. Target outcomes are identified across a range of beneficiaries representing the people and organisations involved, and then the necessary data is collected to prove and evidence the outcomes.

Key findings

Over the period of project delivery:

- Patients' average **confidence to cope score increased** from 6.8 to 8.0 after receiving support.
- The **readmission rate of patients who received volunteer support was considerably lower** compared to the control group of no intervention (9% compared to 25%, respectively).
- **54% of patients** who previously had no contact with community support **received onward referrals.**
- **96% of patients** reported feeling **likely to recommend** the discharge support volunteer service.



Conclusions

The discharge support volunteer programme has been effective in improving patient outcomes by enhancing confidence, reducing hospital readmissions, and increasing access to community support services, highlighting the success of the programme. Patients also reported a willingness to recommend the service, underscoring their satisfaction with the support they received.

Context: Discharge Support

- Hospital discharge is a critical transition for patients, particularly the elderly, requiring careful coordination between healthcare providers and patients/caregivers (Carroll & Dowling, 2007).[1] Effective discharge involves maintaining a sense of momentum in recovery, providing adequate support, and keeping patients informed (Ellis-Hill et al., 2009).[2]

- Emergency readmissions among elderly patients are a significant concern, with several risk factors identified. These include advanced age, male gender, living alone, and certain medical conditions like cardiorespiratory diseases, diabetes, and cognitive impairment (Cande et al., 2021).[3] Data from year 2020/21 showed that 15.5% of patients discharged from NHS hospitals are readmitted as emergencies within 30 days (Nuffield Trust, 2022).[4]

- A large-scale analysis of NHS data from 2004-2010 found that 8.7% of hospital discharges resulted in 30-day readmissions, with 27.8% categorised as potentially preventable (Clarke et al., 2012).[5]

- Aware of these challenges, the Kingston Hospital volunteering team set to supporting this transition, providing a helping hand to patients after a recent hospital stay.

[1]*Carroll, Á., & Dowling, M. (2007). Discharge planning: Communication, education and patient participation. British Journal of Nursing, 16(14), 882-886.*
[2]*Ellis-Hill, C., Robison, J., Wiles, R., McPherson, K., Hyndman, D., Ashburn, A., & On Behalf Of The Stroke Association Rehabilitation Research Centre Team. (2009). Going home to get on with life: Patients and carers experiences of being discharged from hospital following a stroke. Disability and Rehabilitation, 31(2), 61–72.*
[3]*Cande, C., Sebbane, M., Bobbia, X., Claret, P.G., Guillou, C., Tchalla, A. & Blain, H. (2021). Risk factors of readmission into emergency department in patients aged 75 or older: a systematic review. Gériatrie et Psychologie Neuropsychiatrie du Vieillissement. 19(3):253-260.*
[4]*Nuffield Trust. (2022, June 29). Emergency readmissions. Nuffield Trust.*
[5]*Clarke A, Blunt I, Bardsley M (2012) PS18 Analysis of Emergency 30-Day Readmissions in England Using Routine Hospital Data 2004-2010. Is there Scope for Reduction?, J Epidemiol Community Health, 66:A45.*

Service Overview

- Discharge Support Volunteers at Kingston Hospital NHS Foundation Trust aim to enhance patient experiences during the transition from hospital to home and the community.
- These trained volunteers provide an impartial listening ear, imparting practical and emotional support to patients following a recent hospital stay. Volunteers can carry out up to 6 telephone calls to identify and address patient's needs, referring to local support services to further assist the patient. Volunteers are also tasked with collecting information from patients about their experience of receiving support, to help evaluate the impact and ensure sustainability of the programme.
- The service offers free, confidential support to patients across all boroughs who are 65 years old or over, anxious about returning home, worried about how they will manage once home, or at risk of loneliness and social isolation.
- Patients can access the service via a referral and any healthcare professional or member of the ward staff can refer patients to the service.
- Between March 2019 and March 2024, 17 active volunteers delivered the service. During this time, a large amount of discharge support volunteer activity was reported. In total…

238

patients completed 6-week discharge call support programme

1,284

telephone contacts achieved

Evaluation approach: Outcomes

Helpforce's approach to evaluating...

Using its established *Insight & Impact* evaluation service, Helpforce follows a consistent methodology to determine the impact of volunteering roles on health outcomes.

Evaluation of the discharge support volunteers project at Kingston Hospital NHS Foundation Trust was conducted using data collected from patients by the volunteers. Helpforce's role was to support the evaluation of the programme by analysing this data. We were looking to answer the following questions about the project:

- What difference have discharge support volunteers made to the patients' confidence to cope at home levels?
- Has the support provided resulted in increased use of community services among patients?
- What impact discharge support volunteers had on emergency readmission rates in the hospital?

The project supports both patient and organisational outcomes. These include improved patient confidence to cope at home levels, increased use of community support and reduced emergency readmission rates within the hospital.

Kingston Hospital NHS Foundation Trust set up the data collection mechanisms and collected the data, Helpforce was brought in for analysis and final evaluation reporting only.

Evaluation approach: Outcomes and methodology

Helpforce's approach to evaluating...

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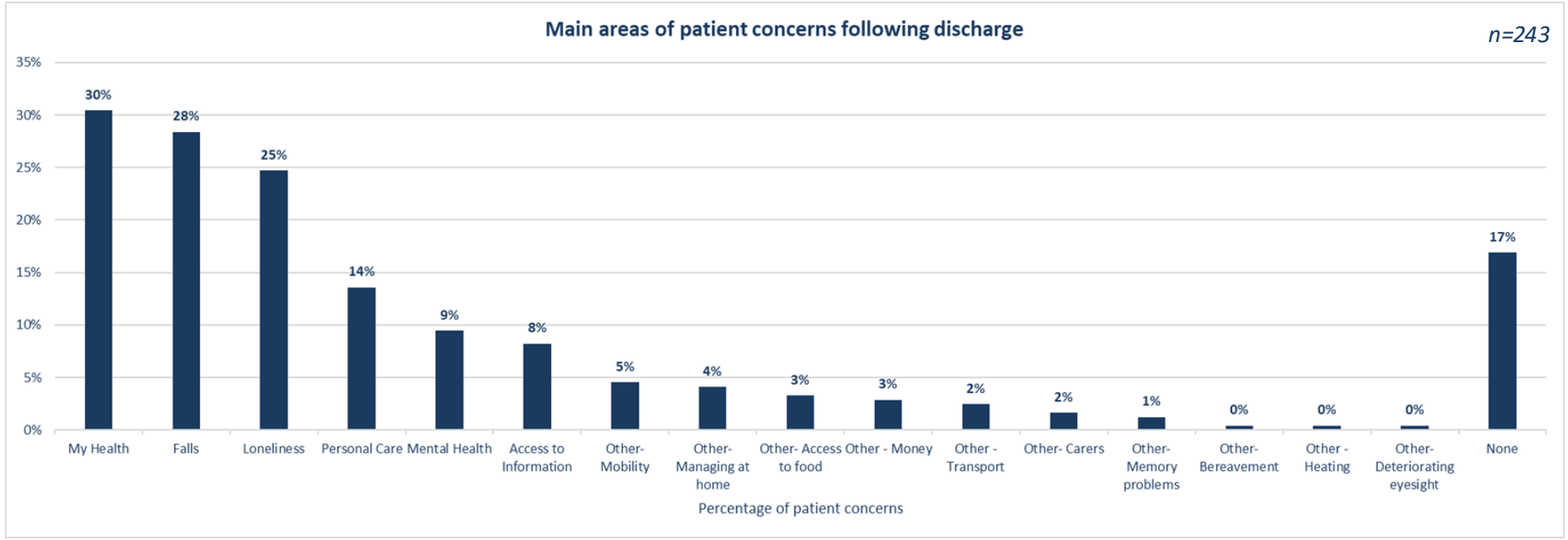
The evaluation involved analysing data collected via the **patient referral form** - the form was used during the first and last telephone calls between 2019 and 2024 to gather data including readmission information and the patients' levels of confidence and satisfaction, demonstrating the impact of the service.

Throughout the report, data findings are linked back to the beneficiary using icons at the top right-hand side of the screen. Evidence strength is also rated using icons. These icons are as follows:

Insight: Patient concerns following discharge

During the initial call with the patients, they were asked about their main areas of concern following discharge. The graph below illustrates the breakdown of these issues.

- The primary concerns were their health (30%), falls (28%), and loneliness (25%), highlighting the areas this patient cohort had concerns regarding following their hospital stay.
- Notably, 17% of patients reported having no concerns, indicating that some felt adequately prepared and/or supported post discharge.



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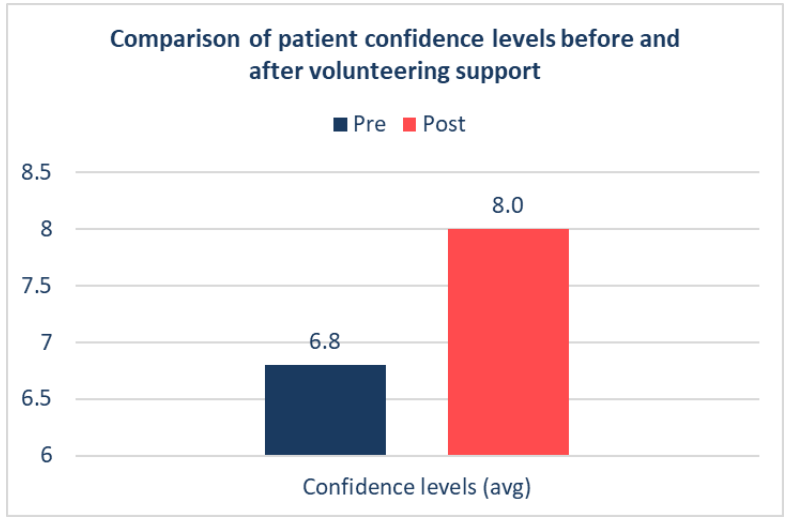
[6] *The percentages do not total 100 as respondents could select multiple concerns. A total of 29 patients did not provide information on their concerns.*

Impact: Patients' confidence levels and community service use

Before and after receiving discharge volunteer support, patients were asked to reflect on their confidence levels.



139 patients were **referred to local support services**

54% of patients with **no prior contact** with local groups or support services **received referrals**

- The data shows that the average confidence level **increased from 6.8 before receiving the support to 8.0.**
- Further, **64% of patients improved their confidence to cope at home levels** after volunteer support.[7]

These improvements suggest that the volunteers' support had a positive impact on individuals' confidence to cope at home following hospital discharge.

Additionally, volunteers referred patients onto several local organisations to provide continued support following their stay in hospital.

- In total, **139 patients were referred on**, and the main referral destinations were: GP, Age UK Befriending Service, Connected Kingston Befriending Service, Kingston Falls Service, Staywell Befriending Service and Silver Line.
- 160 patients reported that before the volunteering support, they were not in contact with any local groups or support services. **Over half of these patients received referrals** to local groups or support services.[8]

Patients provided further feedback on the impact of the support they received to both help build their confidence and gain additional support within the community...

> ***"My confidence has improved and I feel better both physically & mentally, very happy with the service."***
>
> Patient

> ***"Very useful, the volunteer helped get telephone numbers for services required in the community i.e. bank and social services. The support was valuable & nice to have someone to talk to. I would recommend the service."***
>
> Patient

> ***"Really helpful offered information on how to get more help once back at home."***
>
> Patient

[7] *n=198 pre, n=198 post*

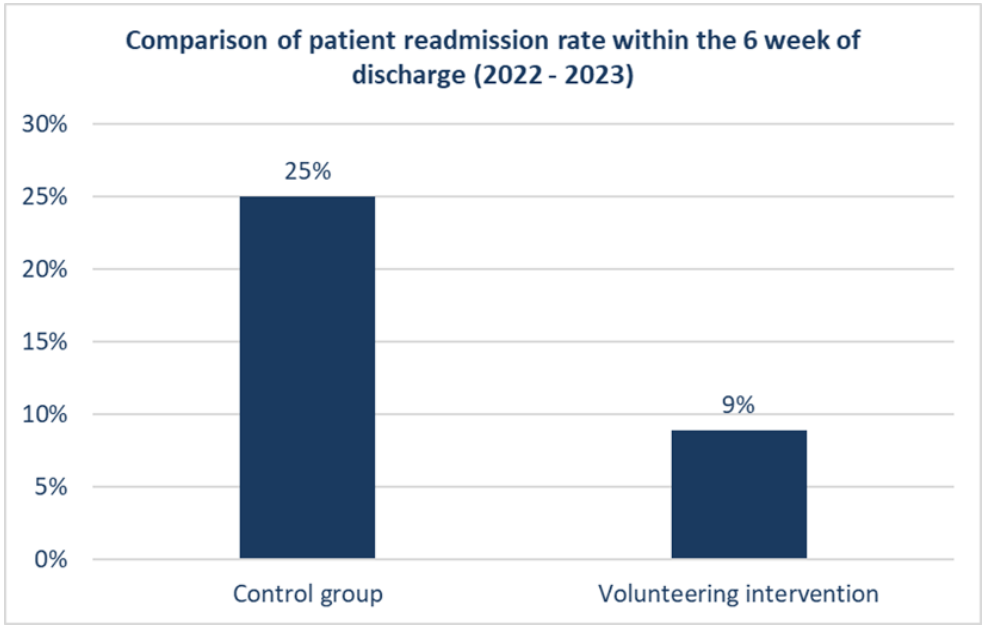
[8] *n=160*

Impact: Readmission rate

After receiving discharge volunteer support, patients were asked if they had been readmitted during the 6-weeks following their initial meeting. The readmission data collected from the patients who received the volunteer support was compared to a matched control group (who did not receive volunteer support), with data provided by the hospital's data team.

- The **readmission rate of patients who received volunteer support was considerably lower** compared to the control group (25% for the control group, 9% for those who received the discharge volunteering calls support).[9]

- Whilst the data is not directly comparable (please see footnote below) these findings do indicate that the support provided to patients via discharge calls, supporting them to better manage their health and access the support they need, may indeed have a positive impact on reducing readmissions within the 6-week period following discharge.



[9] *n=1008 control group, n=79 intervention*

Please note: These results should be taken with caution due to a significant discrepancy between the sample sizes of the two groups. While the total number of patients was over a thousand in the control group for years 2022 and 2023, this was less than 80 in the volunteer intervention group. The control group readmission rate is also based on hospital data records, whereas the readmissions for patients who were supported by a volunteer is based on self-reported readmissions.

Impact: Patient satisfaction

Patients were asked to reflect on their satisfaction with the support they received from the discharge support volunteers.

- **96% of the patients** reported that they were **likely to recommend the service**, of those, **78% were 'extremely likely'.**[10]
- Additional feedback was provided by patients on the support delivered by discharge support volunteers...

96% of patients reported they were **likely or very likely to recommend** the service to others

78% reported they were **extremely likely**

"I liked having advice about who to call in hospital. It's been lovely having a warm friendly voice after being alone."

Patient

"The volunteer was very good, really reassuring, made me feel better when I was feeling down."

Patient

"It was good to be able to discuss medical appointments [with] the volunteer and she was able to give information on how to apply for transport, I don't have many visitors, so it was nice to receive a phone call."

Patient

"I really enjoyed having a supportive but cheerful chat each week, such a pleasure."

Patient

[10] *n=196*

Volunteer feedback

A Kingston volunteer who has been delivering the discharge call volunteering role discussed their experience…

"It has been a rewarding experience. Some of the patients I have met have been remarkable individuals who have kept positive even though they have had serious health issues.

Most have been very happy to share quite detailed information about their lives, and how their ill health has impacted them. Most have said that they have enjoyed having someone to talk to, and some felt that six weeks went by very quickly.

However, a few did not need / want any interaction with me and I quite understand that. After all, a DSV is another link to their hospital experience, and those that were less keen to talk were those for whom the hospital stay was not very pleasant.

I have had good support from the volunteering team.

I think having someone to talk to helped the patients deal with their difficulties. I noticed that patients, who at the start of the interaction period were rather down or despondent, were more positive towards the end of the six week period."

Discharge Support Volunteer – Kingston NHS Hospital Trust

Conclusions and recommendations

- The Discharge Support Volunteer Programme at Kingston Hospital NHS Foundation Trust has shown that 6-week telephone support from skilled volunteers can improve outcomes for individuals transitioning from hospital to home.
- By providing practical and emotional support, findings suggest that the programme positively impacted patient confidence, potentially reduced hospital readmissions, and increased access to community support services for patients aged 65 and older who are at risk of loneliness or anxiety about returning home.
- Average confidence scores increased notably, reflecting improved patient empowerment and ability to self-manage at home.
- The readmission rates appeared to be considerably lower for those who received volunteer support compared to the control group, suggesting the programme's potential impact in addressing key factors that might lead to emergency hospital readmissions following discharge.
- In this evaluation, readmission data for the cohort supported by volunteers was collected through phone calls. However, information could not be obtained from all patients who completed the 6-week support programme. To ensure the findings accurately reflect the impact, it is recommended that future data collection should access the readmission data of the volunteer intervention group through the hospital data team.
- The increase in referrals to community support services highlights the programme's role in bridging the gap between hospital care and ongoing community support.
- A high level of willingness to recommend the service reflects patient satisfaction and the programme's success in improving their overall experience.
- In summary, the evaluation of the Discharge Support Volunteer Programme has highlighted the significant potential impact that volunteer-led telephone support can have on patient health outcomes, including organisational improvement such as reduced readmissions.

Acknowledgements

Helpforce would like to pass on our thanks to Kingston Hospital NHS Foundation Trust, and in particular to Laura Greene, Head of Volunteering & Community Partnerships. We also share our appreciation to the patients and volunteers who participated in providing their feedback.

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Thank you

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