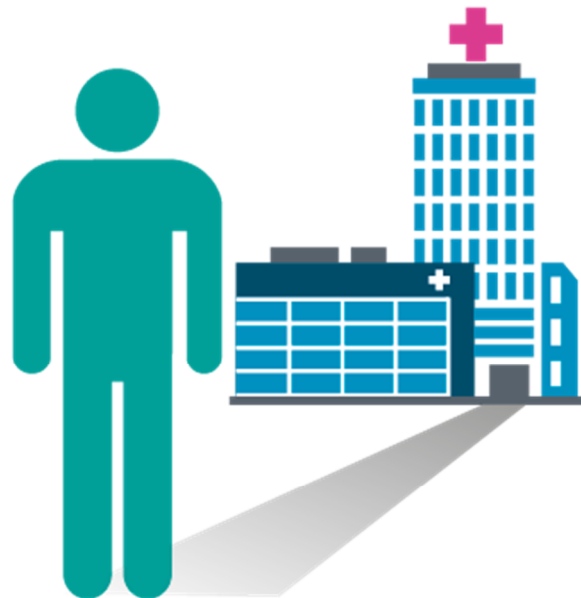# What do the numbers say about emergency readmissions to hospital?

October 2017

Admissions to hospital and delayed transfers of care (DTOCs) are well-monitored and understood, but information about the number of people being readmitted to hospital for unplanned follow-up treatment is less widely available.

Indeed, nothing has been published at a national level regarding these figures since December 2013. NHS Digital says on its website that this is because the methodology is being reviewed.

In October 2017 we published our report _"What happens when people leave hospital and other care settings?"_. This briefing set out what we have heard about people's experiences of leaving hospital over the last two years. It recommended that health and social care organisations improve their use of data to understand where the discharge process is going wrong.

Following this work, we have taken a more detailed look specifically at the data around emergency readmissions. Our work follows a _2016 report by the House of Commons Public_ Administration and Constitutional Affairs Committee which said the Government and NHS need to improve their understanding of this particular dataset.

Our analysis is not meant to suggest to clinicians that they should keep people in hospital for longer. We know that lengthy stays in hospital can put people at risk, for reasons including muscle wastage and exposure to infection. It is also worth noting that the current understanding of the data makes it impossible to distinguish between genuinely unforeseeable emergency readmissions and readmissions that would not be surprising to clinicians, and those where the system could put measures in place to avoid similar circumstances in the future.

We also acknowledge that emergency readmissions are not just the responsibility of the NHS. All organisations involved in caring for people and keeping them out of hospital can benefit from a greater understanding of this issue to help improve people's experiences.

The purpose of this work is to highlight how current emergency readmissions data can help hospital trusts' boards, managers and clinicians identify risk and learn from occasions when things do go wrong. It also outlines how the data collection could be improved.

What we did

We contacted 125 NHS hospital trusts in England and asked for their data on emergency readmissions for each financial year since 2012/13.

We asked for a day-by-day breakdown of the number of people readmitted within the 30-day period after discharge, as well as information about why they were readmitted.

Of the trusts we contacted, 92 (73%) responded either in full or in part to our information request. Of these, 72 provided the full day-by-day breakdown of their data for each of the five years.

What we found

The data shows that for 2016/17 there were a total 529,318 emergency readmissions reported by 84 hospital trusts.

The top line figures from trusts that gave us data for all years between 2012/13 and 2016/17 (72 respondents) show that:

- The number of emergency readmissions has risen over the last five years by 22.8%, from 372,805 to 457,880.

- The number of emergency readmissions within 24 hours of discharge has risen by 29.2%, from 49,529 to 63,964.

- The number of readmissions within 48 hours has risen by 27%, from 77,927 to 98,955.

- Readmissions within 48 hours account for more than 1 in 5 (21.61%) of the total.
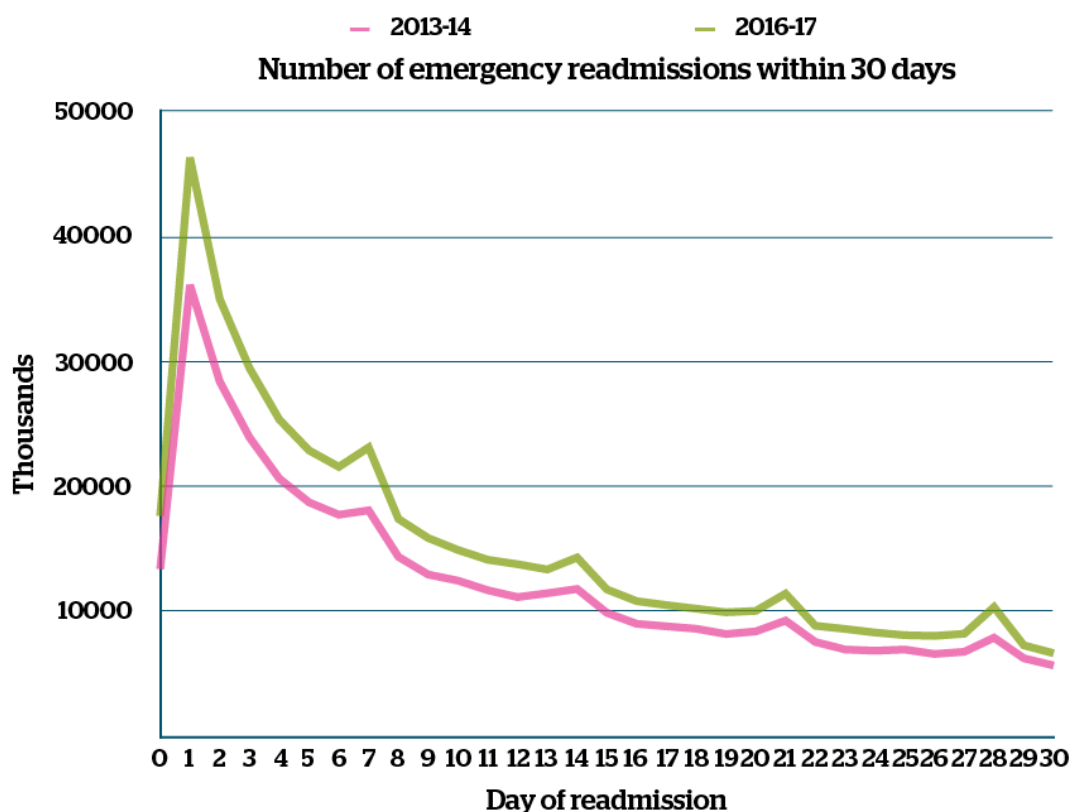
It is important to note that not every emergency readmission is the result of a poorly managed discharge. It is also possible that changes in the way that hospitals treat some patients, for example through increased use of frailty units and ambulatory care units, may have contributed to the rise in readmission figures.

The dataset also comes with some caveats because trusts have not all shared the same data, nor have they shared it in the same way. For example, some have included information about readmissions from departments such as maternity and oncology, and others haven't.

We also do not have a shared definition of an emergency readmission. For example, it is not clear whether someone treated for pneumonia but then having to go back to hospital with a broken hip following a fall should be recorded as an emergency readmission.

However, the rate of growth and the fact that such a high volume of people are returning to hospital within such a short period raises questions about the appropriateness of some decisions to discharge and/or the support provided to help people recuperate.

The data also shows that the proportion of emergency readmissions in the first 48 hours is consistently around 20% of the total number of emergency readmissions across the five years our data covers. This suggests that the situation has existed for some time, and highlights the importance of establishing exactly why the proportion of emergency readmissions is so high.

To get a more accurate understanding of the issue, an agreed and consistent methodology needs to be developed and applied across all trusts.

Data held on the reasons for readmission

Only four of the trusts who responded to us provided any information outlining the reasons for emergency readmission.

In some cases, trusts said that this information was exempt under section 12 of the Freedom of Information Act, based on excessive time or cost. However, many trusts told us that the information was not kept electronically, or was stored on the patient's paper records, making it too difficult to analyse.

Efforts are being made through the National Information Board to make it easier for trusts to capture and use data. However, trusts need to seize this opportunity to help them identify how to improve people's experiences of being transferred between hospital and their home.

Case study: How one trust is reducing readmission rates

We asked Northern Devon Healthcare NHS Trust how they were working to improve people's experiences of discharge and prevent readmissions. This is what they told us:

"We looked at our emergency readmissions data and asked what it could tell us about why people were re-attending. Were there any patterns, and were there any readmissions that could have been prevented?

We realised there was more we could do to make sure people had the right support in place upon discharge to support them to remain independent at home. We needed to look more closely at why people were re-attending and see what we could do to put that right. Discharge planning needed to start earlier and support could be in place sooner to prevent delays in discharge and reduce avoidable admissions.

We put together a multidisciplinary 'Pathfinder' team of social workers, social care assessors, nurses, occupational therapists and physiotherapists. The team works across both the Trust and the local authority, Devon County Council.

The team sees patients in the emergency department and medical assessment unit within an hour of admission and can start discharge planning immediately. There is also a complex discharge team, who manage patients who have more complex discharge needs.

Together their work has led to:

* *A reduction in readmissions within 28 days from 18% in winter 2015 (January to March) to 9.3% in winter 2017*

- *1,098 acute bed days saved through admission avoidance and discharges within 48 hours from April 2016 to March 2017*

- *Improved patient experience – 98% of people seen by the team would recommend their care (Friends and Family Test – January to September 2017)*

The success of the team comes through looking at the person behind the admission, asking whether there is any support they need to keep them well at home. This contributes to the Trust's overall vision, which is to support people to remain independent at home wherever possible, with hospital only when it is needed.

An example of this is an 85-year-old lady who recently attended the emergency department at North Devon District Hospital after repeated falls at home. Her family was worried about her, but she was very clear that she wanted to remain living at home, so the Pathfinder team looked at what they could do to help.

The team arranged for urgent support to be put in place so she could be discharged home from the emergency department, including a night sit and twice-daily visits from a support worker. They also referred her to a community-based associate specialist for elderly care to review her medication and further investigate her falls. The team assessed her home environment and discussed what was needed with the lady and her family. This resulted in her wheeled commode being replaced with a static commode. The team also arranged for pressure pads to be added to the lady's bed and chair to alert her family if she didn't return within a set amount of time, suggesting that she may have fallen. The team carried out further follow-up home visits to make sure she had the support she needed to remain independent at home."

Where next?

The number of people being urgently readmitted to hospital is comparatively small when we consider the huge numbers of hospital inpatients treated each year.

However, it is important to remember the impact it has on people when discharge processes don't go according to plan. In our 2015 report '*Safely home'* and our *updated 2017 briefing* we heard from thousands of people who told us how incredibly distressing it had been for them and their families when they didn't get the support they needed to help them after leaving hospital.

Emergency readmissions are also adding additional burden to a health and social care system which is already struggling to free up beds.

It is vital that the NHS and social care services work with each other, and the wider voluntary sector, to ensure that as many people as possible who are discharged stay out of hospital.

To understand what is going on in more detail and put effective measures in place to make improvements, we suggest that trusts improve current data collection on emergency readmissions by:

- Applying a standard definition for what constitutes an emergency readmission, and which categories are excluded;

- Electronically recording and analysing the reasons people are readmitted;

- Including the breakdown of the demographics for emergency readmissions, identifying groups that are more at risk of an unplanned return to hospital;

- Undertaking further analysis to identify any correlation between emergency readmissions and delayed transfers of care data at a hospital trust level.

At the very least, we would suggest that NHS Digital starts to publish emergency readmissions data again, breaking it down by day as we have done. This data could help ensure that the increasing focus on reducing delayed transfers does not result in a spike in emergency readmissions.

We have also long argued that discharge, and particularly people's experiences of the process, should be used to track how well services are working together.

There has been some encouraging work done on this already as part of the CQC's local system reviews and the Department of Health's NHS-social care interface dashboard.

We would like to see the following combined to create a single metric used across the 44 Sustainability and Transformation Partnerships / Accountable Care Systems:

- Overall hospital admissions

- Delayed transfers of care

- Emergency readmissions

- Social care waiting times for assessments and implementation

Used alongside a qualitative measure of people's experiences, this new metric could help to track how well integrated services are and how well they are fully meeting the needs of the people they are caring for.

About us

We are the independent consumer champion for health and care. Our job is to make sure that those who run local health and care services understand and act on what really matters to people.

A local Healthwatch exists in every area of England. We support them to find out what people want from health and care services and to advocate for services that work for local communities. Local Healthwatch also act as our eyes and ears on the ground, telling us what people think about local health and social care services. We use the information the network shares with us and our statutory powers to ensure the voice of the public is strengthened and heard by those who design, commission, deliver and regulate health and care services.

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