Interim Evaluation of the Nightingale Service

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Healthwatch Richmond: Evaluation of the Nightingale Service

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Introduction

Healthwatch Richmond has been commissioned to provide Age UK Richmond with an independent evaluation of the Nightingale Service. The aim of this interim report is to provide Age UK Richmond with some initial findings to support the development of the service and their own internal and external reporting needs.

The Nightingale Service was established on 1st September 2015 as a result of an identified need to provide support to older residents in the Borough of Richmond upon Thames, prior to admission and following their discharge from hospital. It is initially funded as a pilot to run for one year.

This evaluation aims to provide a transparent and clear framework for measuring the outcomes and outputs of the Nightingale Service and, where possible and reasonable to do so, ascribe a financial value. It will take into account the views of stakeholders and the value they place on the outcomes achieved by the service.

Getting services right for older people being transferred home from hospital has become the 'must do' delivery objective for health and social care communities. Therefore, ensuring people do not stay in hospital for longer than is necessary, and receive a safer more dignified transfer of care, is essential. The Department of Health's *High Impact Changes for Transfers of Care* recognises these priorities.

Within this initiative, service providers aspire to achieve an exemplary level. Focus on choice and early engagement with families and carers is key to reducing delayed transfers of care and the associated costs. Ensuring a coordinated multi-disciplinary, multi-agency (which includes the voluntary sector) discharge planning process is identified as crucial to ensuring effective discharge and positive outcomes for patients.

At the time of writing the interim evaluation, (6 months into the pilot), the Nightingale Service has already exceeded its 12-month target of supporting 115 people. The majority of referrals have been from the acute sector service providers.

Background to Nightingale Service

In 2013 Age UK national launched a programme in Cornwall to ensure older people being discharged from hospital received personalised integrated care. It was evident that many older people were being discharged from hospital without a sustainable plan in place to keep them safe, well and free from risk of readmission. Age UK recognised the need for a person-centred approach to improve older people's health and wellbeing, and thereby reduce unplanned hospital admissions. By working in partnership with health and social care, the intention was to bring a transformational change to the process of discharging people home from hospital.

With this aim in mind, the Personal Integrated Care Programme was launched. As well as improving the health and well-being of older people, the programme aimed to deliver cost savings based on evidence from international best practice, with the intention of helping to alleviate the financial pressures within the local health and social care economy.

The programme was so successful that in 2015 it was expanded to nine other geographical areas, each one supporting 500-1000 older people each year. Interim results from the Personalised Integrated Care programme in Cornwall were highly promising and lived up to the aspirations of the project. Looking at the first 325 older people who went through the programme, the following was observed:

- 31% reduction in all hospital admissions
- 26% reduction in non-elective hospital admissions
- 20% average improvement in well-being
- 20% of people supported go on to become volunteers themselves
- 8% reduction in social care costs

The statistics highlighted above were all locally commissioned. The Nuffield Trust has been commissioned to evaluate the service over a one-year period in Cornwall. It is expected the report will be published in 2016.

Through the work of Age UK centres across the country, it has been identified that the biggest obstacle facing older people coming out of hospital, or needing extra support, is the smooth transition back into the community and co-ordination of their care and well-being. The needs of older people are often complex and require multi agency support. At the same time, there are also those who require minimal intervention to enable them to go home with confidence. A simple example of this is having someone available who can switch on their central heating so that they can return to a warm home.

During interviews as part of this review, several stakeholders have told us that communication between agencies is well intentioned, but often very poor, leading to delays in transfers of care. Pathways are often complex and as a consequence, take too long.

With communication seemingly becoming an obstacle to personalised care in Richmond, Age UK Richmond recognised the need for a service 'wrapped around the individual', which ensured a single point of contact for older people who were being discharged from hospital. Equally, it was essential that the views of those individuals were respected, and unnecessary obstacles to their living at home independently were addressed.

Aim of the Nightingale Service

The Nightingale Service began in September 2015 and aimed to improve outcomes for older residents of Richmond upon Thames. The focus is to assist people to be discharged from hospital in a prompt and smooth manner, whilst simultaneously providing support for them to reside at home safely and independently. The Nightingale Service identified one central point of contact as essential to overcome communication barriers between providers, and this point of contact is the Nightingale Service Manager.

Desired outputs for individuals were agreed, focusing on maintaining independence and well-being, so that vastly improved outcomes were delivered. Establishing relationships with prominent stakeholders, together with local health and social care service providers, is key to success of the service.

The pilot was funded to run for a twelve-month period from 1st September 2015 with the intention to support 115 older people during the period of the pilot.

The criteria for referral to the Nightingale Service are as follows:

- Over 65 years of age
- Living alone
- Resident in the Borough of Richmond upon Thames

The criteria for exclusion from the service were:

- Life limiting diagnosis
- End of life Care
- Cancer patients
- Residing in a residential home
- Residing in a nursing home
- Diagnosis of dementia

Scope of the evaluation of the pilot

Age UK Richmond has commissioned Healthwatch Richmond to carry out an independent review of the service. The aim is to provide evidence as to whether the service has improved outcomes for clients, as well as whether it is value for money and, through this, if it has reduced the cost to acute, community and social service providers. Because of its rigorous methodology, *'Social Return On Investment'* (SROI) was considered to be the best tool to demonstrate this.

Client entry and exit assessments were to be undertaken by the service to measure the outcomes for service users. Interviews with services users and stakeholder were to be used to establish a link between the service and savings in health and social care. It was essential to establish what had changed for clients and providers and whether this was the result of the Nightingale Service.

Unfortunately, due to administrative challenges, the entry and exit assessment for each client was unavailable for Healthwatch Richmond to analyse during the interim evaluation of the Nightingale Project.

Healthwatch Richmond revised the methodology accordingly, and alternative sources of data were agreed with Age UK Richmond, which would measure the outputs of the service both in social and financial terms. The outputs used in the review are those which stakeholders have identified as crucial to the smooth discharge of older people, together with those which impact greatly on the capacity of staff time in acute and community service providers. The most important of these appears to be the fitting of key safes at older persons residences, for if this simple task is not delivered in a timely fashion, it can lead to delays in discharge of up to seven days.

It is noted that access to records of output data has not been ideal and Healthwatch will make recommendations for improving this as part of the report.

Findings

Stakeholder interviews

Successful collaboration between Age UK Richmond and local health and social care providers is reliant on establishing trust, strong relationships and developing consistent and reliable communication pathways. The shared goal between Age UK Richmond and stakeholders, for patient centred care and integration of services, is to ensure smooth/safe discharge as the crucial success factor for the Nightingale Service.

Stakeholder involvement at all stages of the project has been critical. Engagement with the following stakeholders was identified as essential, in order to establish their objective views and experiences of the service:

- West Middlesex University Hospital
- Kingston Hospital
- Hounslow and Richmond Community Healthcare
- Richmond Response and Rehabilitation Team
- GP Alliance

In total, six stakeholders were interviewed for the evaluation, in order to establish their feedback regarding the Nightingale Service, through semi-structured discussion. Those stakeholders included Directors, who are in a position to influence strategic decisions, and frontline professionals. Stakeholders who were unable to commit time to semi-structured interviews have been invited to comment on the draft report.

Findings of stakeholder interviews

The Nightingale Service's involvement of stakeholders at an early stage of the pilot has clearly contributed to the significant 'buy in' demonstrated through support for, and a dependence on, the service from the stakeholders.

Key positive messages from stakeholder feedback:

- It is evident from qualitative data and statements, that the Nightingale Service has positively impacted on both acute and community health care providers.
- All stakeholders are very supportive of the service, and it has been integral to planning discharges from hospital, as demonstrated by this quote from one:

"Nightingale Services are on hand and specific to discharge needs, particularly around key safes, access to shopping and environmental changes, to enable timely discharge home from hospital."
- Jennifer Cole, Occupational Therapist, RRRT and In-Reach Hospital Project

- All those interviewed expressed a strong desire for the service to continue and many stated they would be unable to fulfil their roles in a timely manner without the Nightingale Service.
- The greatest impact from the presence of the Nightingale Service is felt within the acute sector.

- The Nightingale Service has made the transition from hospital to home much smoother for clients, their families and staff.

- The presence of the Nightingale Service Manager has been vital and integral in establishing excellent working relationships and communication between service providers:

"The discharge process is now slicker, it causes less stress and anxiety to families and less professional tension between service providers." Anne Stratton, Associate Director, Adult Acute Services and Operations Lead for NWL, HRCH

- There has been a significant improvement in staff and service productivity. The greatest is in respect of the number of hours it takes staff to perform administrative tasks, such as ringing around other providers. From a management point of view, service providers state it allows them to concentrate staff resources where they are most productive.

- It has improved professional relationships between agencies, reducing tensions and friction during the discharge process. One stakeholder said -

"It is a really good service and has definitely helped with difficult discharge situations." Christina Richards, Clinical Services Manager for Older People and Head of Therapies, WMUH.

- The Nightingale Service supports providers of care to achieve exemplary status in the Department of Health High Impact Change Model.

- Referrals to Richmond Response and Rehabilitation Team (RRRT) have increased by 240% on the same time last year, which signals that numbers of early interventions are increasing, aiding prevention. The Nightingale Service is considered to have made a significant impact on this rise:

"The Nightingale Service helps with really early prevention of admission and readmission." Anne Stratton, Associate Director, Adult Acute services and Operations Lead for NWL, HRCH

- All acute stakeholders agree that the presence of the Nightingale Service can expedite discharge by between 4 and 7 days.

- The greatest contributory factor is considered to have been the fitting of key safes at client's homes. London Borough of Richmond upon Thames does not cover the cost of key safes or fund their fitting. This often leads to delays, as many older people cannot be discharged without a key safe, which is vital to permitting carers access to their home. This simple task often relied on family members, which delayed discharges quite significantly. There is evidence that the Nightingale Service can expedite the fitting of a key safe by several days, with several being fitted within one day of referral and a key safe even being fitted in an older person's home on Christmas day 2015:

"Discharge would not have happened without the Nightingale Service." Jenny Thomas, Interim Programme Director, Kingston Hospital.

- The handyman service has also contributed to the prompt discharge of older people. According to several stakeholders, not having to wait for other agencies to fit items such as

grab rails as an example has made a significant difference. Rails and adjustments to an older person's home are usually carried out within 2- 3 days of referral to the Nightingale Service:

"The Nightingale Service is reliable and offers more flexibility in the type of tradesmen" Wilsun Dodson, Manager, RRT.

- Unfortunately specific details of the types of task carried out for each individual by the handyman service were not available to inform the production of this interim report. This has made it difficult to measure the impact on discharges or the cost savings involved.

- Providing a Nightingale Service volunteer to wait at a client's home for equipment delivery was identified by stakeholders as contributing to a reduction in delayed discharges. A band 5 therapy assistant, taking up approximately half their working day, would normally have fulfilled this role. Anecdotal stakeholder feedback indicated this was a significant factor in staff time saving; however it was only possible to identify one discharge where this occurred from the available data.

- Not having someone to buy a pint of milk and basic essentials can delay discharge. Shopping services are not available via social services support; however a number of voluntary sector agencies, including the Nightingale Service do provide this. It became apparent during stakeholder interviews that the single point of contact offered by the Nightingale Service was beneficial to both service users and staff:

"The Nightingale Service has become the go-to service, bringing everything under one umbrella." Christina Richards, Clinical Services Manager for Older People and Head of Therapies, WMUH.

- The prompt discharge processes in place when the Nightingale Service is involved allows for other patients requiring admission to be treated without delay:

"The presence of the Nightingale Service results in bed days saved, making beds available to new patients, allowing us to treat more people and prevent harm." Jenny Thomas, Interim Programme Director, Kingston Hospital

- One stakeholder commented that the Nightingale Service has reduced a delay in discharge for people waiting for a bed at Teddington Memorial Hospital or a care home.

- Therapists in Accident and Emergency at West Middlesex Hospital are accessing the service to prevent admissions by enabling people to return home:

"The presence of the Nightingale Service prevents admission, stopping some clients going further than Accident and Emergency. " Christina Richards, Clinical Services Manager for Older People and Head of Therapies, WMUH.

- All stakeholders and clients referred to the enthusiasm, commitment, drive and energy of the Nightingale Service manager as being a significant factor in the success of the pilot:

"Allan is a life saver."
"Without Allan I could not do my job."
"Allan's presence at all the meetings and his communication skills make everything easier."

Key negative messages from stakeholder feedback

- The Nightingale Service has become so intrinsically embedded within the older peoples discharge process that many health professionals are convinced it is the reason for the improvement in discharge. However, when asked to provide detailed evidence to support this claim, stakeholders have been unable to do so. The introduction of the Nightingale Service, coinciding with that of the Department of Health requirement for significant improvements in transfers of care, means it is difficult to attribute improvements in the discharge process to the Nightingale Service alone.

- Stakeholder comments and feedback suggest that a reliance on the Nightingale Service has created a dependency. Should a decision be made no longer to fund the service, it is likely there would be a significant negative impact on the discharge process:

"The Nightingale Service provides reassurance in the discharge of older people from hospital to home."

- Whilst the feedback about the Nightingale Service Manager is highly commendable and should be recognised, some stakeholders have expressed concern over the long-term sustainability of the service due to the over-reliance on a single professional. This presents a specific risk to the service should staffing arrangements change.

- The success of the service is evidenced by the fact that within the first six months of the pilot, demand has already exceeded the original plan of 115 service users per annum. It seems almost certain that demand will continue to rise and it is unclear how capacity can be increased to meet this.

- Due to the nature and ethos of the service, combined with the increase in older people with dementia, there is a desire for the Nightingale Service to be extended to those with memory problems. However, this would lead to a requirement for additional training and recruitment of specialist staff.

Analysis of Outputs

Output Data

The lack of availability of the data originally agreed to support the evaluation, has inhibited Healthwatch Richmond's ability to validate the benefits from the Nightingale pilot. This is particularly significant if Healthwatch Richmond is to be able to calculate any financial values for the pilot. This data must be made available for the drafting of the final report, which is to be published in September 2016.

To identify where outputs have been delivered, a manual examination of the database used to record activity by the Nightingale Service was undertaken. This approach required a subjective judgement to be made as to whether the narrative recorded for each of the several hundred lines of data evidenced a positive output having been delivered.

As a consequence there is an unacceptably low level of confidence regarding the figures created from this form of data collection, and any conclusions based on these are for illustrative purposes only. It should also be noted that at present, although it is possible for the reviewers to state the value of outputs, it is not possible to quantify the number of outputs that the service has delivered.

We strongly encourage Age UK Richmond to provide counts of actual outputs delivered, or if this is not possible, to improve its monitoring of service outputs so that calculations can be included in the final report.

Financial comparisons

Although there is insufficient quantitative data to evidence precisely how many outputs have been delivered, a wealth of subjective evidence has been collected to demonstrate that the Nightingale Service is saving costs in the health and social care sectors, hours of professionals' time and bed days.

Going forward, it would be beneficial for the service providers to supply statistics for each patient discharged into the care of the Nightingale Service.

- All stakeholders estimated that the Nightingale Service was saving an average of 3.5 hours per patient at a band 6 level nurse or occupational therapist. Utilising an average band 6 salary to illustrate, this equates to a saving of approximately £54 for every client referred to the Nightingale Service.

- Reviewing the feedback from stakeholders provided an estimate of the number of bed days saved per key safe fitted is an average of approximately 3 days and the average cost per bed day is approximately £300. This then indicates that the estimated cost saving of bed days equates to £1500, per referral to the Nightingale Service. Subjective feedback from stakeholders indicates the fitting of key safes has had a significant impact on discharge times and bed days saved.

- Feedback from stakeholder interviews indicates the requirement for therapy assistants to support the delivery of equipment to clients' homes has been reduced for older people living in Richmond Borough. The average salary of a band 5 therapy assistant is £12.31 per

hour. This equates to an average saving of £50 per visit to wait in a client's home for equipment delivery.

- The Nightingale Service's Handy Person service carried out a number of visits. It was often unclear from the records what was delivered on these visits, but it is not unreasonable to assume that these would have achieved similar savings.
- There may be additional bed days saved from these activities, but it is not possible to estimate or infer this from the available data.
- Several of the people referred to the Nightingale Service received a welfare and benefits review. The total additional income for all individuals from this activity was reported to be approximately £7,500.
- Some of those older people returning home prior to the Nightingale Service may have previously required a one day package of care from a re-enablement service, in order to settle them back home. The cost of this is estimated to be £23 per hour. From the limited data available, it is difficult to quantify how many clients this would have applied to.

Illustration of financial value

The following illustration is based on the data provided to Healthwatch Richmond covering the period September 2015 - January 2016.

KEY OUTPUTS	#	IMPACT	Total
Time saved per person discharged	59	£54	£3,186
Bed days saved from fitting key safes	12	£1,500	£18,000
Time saved being home to take deliveries/acting as a carer	1	£50	£50
Time saved from other Handy Person visits	24	£50	£1,200
Value of Welfare/benefits received as a result of intervention			£7,500
		Illustrative Total	**£29,936**

Total direct financial value is estimated to be £30,000 over the 5 months for which data was provided. This does not include the intangible benefits, which are clearly significant for service users and described in the following section.

It is also important to note that the confidence with which this financial value can be reported is low, and that there may be savings made that we have been unable to measure.

The cost of providing the service for the period is estimated to be £29,166, based on a total income of £70,000 per annum.

Social outcomes for older people

The cost to both service providers and clients cannot be measured in financial savings alone.

The social outcomes for older people returning home to live independent lives are largely intangible. The case studies included in this report demonstrate very clearly the positive impact the Nightingale Service has had on the lives of the older people. All those who were interviewed for this report spoke of their gratitude to the service. The common messages taken from the interviews were:

- Worry and feelings of isolation were key concerns which had been alleviated by the Nightingale Service.
- The Nightingale Service made clients feel valued and their opinions and wishes respected.
- The ability to maintain independence in their own homes was of paramount importance to all clients who contributed to this report.
- The reassurance clients received from the Nightingale team was a key factor in their smooth transition from hospital to home.
- The knowledge that clients' shopping and practical needs would be dealt with by the Nightingale Service speeded their recovery, mental health and well-being.
- Knowing the Nightingale Service was coordinating discharge from hospital was a key cause of relief to the older people interviewed.
- The single point of contact for all those interviewed was a key factor in their health and well-being.
- The Nightingale Service has impacted so positively on the lives of older people that several of those interviewed became emotional when they expressed their gratitude to the Nightingale Service Manager and the team of volunteers.
- The impact on relatives and friends of the older people can be summed up by the comment made by one granddaughter who lives some distance from her grandfather:

> *"As a family we are fully reassured knowing that the Nightingale Service is there for my grandpa. I have been seriously ill myself, so having the service take care of him and making sure he is happy and comfortable has benefited us extremely well."*

The key positive factors are demonstrated in more depth in the case studies at the end of this report.

Conclusions

- The Nightingale Service has positively impacted on the effectiveness and efficiency of the discharge of older people.
- It has improved professional relationships between providers of health and social care and appears to have delivered considerable cost savings. However, much of this is based on subjective anecdotal evidence and not supportive data (which Age UK Richmond must address for the final report).
- Record keeping and data collection needs to be specific and measurable to gain meaningful financial analysis of the Nightingale Service. Going forward it would be sensible to agree with stakeholders a format for future statistical data collection and performance metrics.
- Referrals to the Nightingale Service by General Practitioners are very low, with only one referral made at the time of writing this report. Early intervention, as a consequence of GP referrals, has the potential to reduce hospital admissions.
- Importantly, the Nightingale Service appears to have significantly improved the quality of life and well-being of over 100 older people in the Borough of Richmond upon Thames.
- In delivering these achievements, the Nightingale Service has become indispensable in the view of the stakeholders interviewed and the older people who have been the recipients of the service.

In summary, the Nightingale Service appears to be an excellent initiative, but to demonstrate its activity and become sustainable it will also need to record its activities and outputs better. This will be particularly important as inevitably demand will almost certainly exceed resource.

Case study 1 - Mr P.

Mr P is an 84-year-old gentleman who lives alone in a third floor flat. He came to England from Ghana in 1957 and has lived in the flat since 1981. Mr P's only relative in the UK is his granddaughter, who resides in Kent.

Mr P describes himself as being very independent, fit and healthy prior to his recent illness. His flat is immaculate and he takes great pride in his home. Mr P managed to shop for himself and kept himself active by walking daily. He noticed his ability to walk and do household chores was reducing gradually due to shortness of breath and an inability to eat his normal diet.

In December 2015 Mr P was admitted to Kingston Hospital as an emergency admission. He underwent extensive surgery for a blockage in his stomach. The outcome of the surgery was that Mr P required a stoma. This was a massive shock to him and frightened him.

Mr P remained in Kingston Hospital recovering for over two weeks. He stated that he became very anxious about returning home, as he had no local support networks. He was very worried that he would not be discharged to his own home.

Mr P was introduced to the Nightingale Service Manager prior to his discharge, which he says helped him greatly. He was concerned that if he went to stay with his granddaughter in Kent he would not be able to eat his own food, as having a stoma meant a change in his diet. He was also very nervous about self-managing the stoma, but meeting the Nightingale Service Manager very early on alleviated his fears about recovery and gave him confidence in being able to return home with support.

The Nightingale Service supported Mr P with shopping, cleaning and accompanying him to hospital appointments, which gave him great peace of mind, as he did not feel alone. The shopping support meant that Mr P could buy the food he wanted, and having someone to keep his flat clean and tidy was extremely important to him. Mr P described how the support with shopping and collection of his medication took enormous pressure off him. Mr P said the Nightingale Service Manager *"knitted everything together for me."* He also said that he was very keen to return home, *"fed up of being in hospital"* and once the Nightingale Service was part of his discharge plan, things moved faster

The Nightingale Service Manager liaised with the GP who had been unaware of Mr P's admission to hospital. He also liaised with the stoma nurse ensuring Mr P had easy access to the service and felt confident to contact them when he was worried. Mr P was also accompanied to a day centre to rebuild his confidence and provided access to talks and activities of interest to him.

The Nightingale Service Manager ensured Mr P's granddaughter was kept fully informed of his progress. This has given her great reassurance following his recovery.

Two months after discharge, a relatively short period of time following life changing surgery, Mr P is gaining his confidence and walking outside unaided, for short spells. He has been referred to a local charity, encouraging him to use public transport with confidence again.

Mr P said the Nightingale Service has helped him keep his independence, dignity and helped him to feel safe. *"Without the Nightingale Service I would not have survived."*

Case study 2 - Ms W

Ms W is a 93-year-old lady who lives in the family home she has resided in for over 40 years. She is an ex-teacher, loves to read, but has poor vision. Ms W has a friend who stays with her regularly and a granddaughter who visits, so there is activity in the house.

Following a fall at home, Ms W required hip replacement surgery. She remained in hospital for 10 days, but was told due to low blood pressure, she must not bend forward or go upstairs. Ms W describes becoming very frustrated in hospital, as the discharge plan included moving her bed into her front downstairs room. She became very anxious about this idea, as she wanted to see her garden and not be isolated from people coming in and out of the house. There was also the very distressing concern that she would need a commode, if she was in the front room.

Ms W felt *"too poorly"* to raise her disagreement with the plan and said, *"Nobody was listening to me."* She was referred to the Nightingale Service for her bed to be moved prior to her discharge. The Nightingale Service Manager met with Ms W whilst she was on the ward to discuss the plan. Ms W explained that she would feel very isolated with her bed in the front room. In her words *"Nobody was listening to me, all different people kept coming to see me, there was never the same person"*. She then said *"The Nightingale Service Manager was the only person in the hospital who talked normally. He came to my rescue, gave me peace of mind and helped me to think straight"*, *"I couldn't sleep in hospital, was anxious and worried about what to do"*.

The Nightingale Service Manager supported Ms W's desire to return home, before a decision was made regarding her bed. Prior to discharge from hospital a key safe was fitted by the Nightingale Service, allowing the carers to gain access to the property.

Following discharge, Ms W was met on her return home and it was agreed that her recliner chair would be suitable for her to sleep in for the first night. It was in her favourite room in the house, next to the kitchen and downstairs bathroom, and overlooked the garden; however the room was very congested.

Ms W was happier in the back room and expressed a desire to have her bed moved there, so the Nightingale Service handyman service moved Ms W's bed into the back room for her. They cleared the room and raised some furniture to ensure she did not have to bend. This also meant she was near to the bathroom, and grab rails were fitted at the same time. With the aid of a walking frame, Ms W was able to access the bathroom easily and no longer required a commode.

Six weeks since returning home, Ms W is walking confidently with the aid of her frame. She is now keen to go outside the house and a Nightingale Service volunteer is supporting her to slowly build her confidence. She is also keen to attend a day centre and increase her independence.

Ms W's concerns were acknowledged and what was important to her was recognised and accommodated. Of great significance to her is that her privacy and dignity have been respected, as she no longer requires a commode. Ms W also feels very strongly that the Nightingale Service has helped her to maintain independence. By moving her bed to the back room, she is part of the normal activities in the house. This has prevented her feeling isolated, and improved her mental health and well-being. The bed is next to a large window, giving a clear view of her garden and gives her extra natural light to read her books, something that gives her great pleasure.

Case Study 3 - Mrs P

Mrs P is a 77 year-old lady who lives alone in a second floor apartment of a large Victorian House. There are two other residents occupying other flats in the house. As it is a Victorian property, and not purpose built flats, there are no lifts or stair lifts. The stairs are steep and difficult to negotiate. Mrs P is an ex-publican and enjoys the company of others.

Over the Christmas period Mrs P became very unwell with a virus. She remained in hospital for a short period and despite informing the ward staff that she lived alone and her flat was difficult to access when unwell, she was discharged home without any support or package of care.

On the day of discharge, Mrs P was told that transport would take her home, but she was to contact Richmond Social Services herself to arrange that support.

The transport to take Mrs P home did not arrive until 9pm and on arrival home, Mrs P had to negotiate two flights of stairs. Feeling very weak and unwell, together with the flat being cold, it exacerbated her shortness of breath.

Mrs P remained bed bound for three weeks following discharge from hospital. She relied on neighbours to bring her drinks and sandwiches, which made her feel like a burden to others. At the end of the third week, Mrs P contacted Richmond Borough Adult Social Services Team. She stated she felt messed around, unable to move, confined to bed and having to ring around different people to get help. The Access Team referred Mrs P to the Nightingale Service; but she was described as 'not vulnerable'.

The Nightingale Service Manager was very concerned when he saw how unwell Mrs P was and made an urgent referral to the Richmond Response and Rehabilitation Team (RRRT).

In order for RRRT carers to enter the property, the Nightingale Service provided and fitted a key safe. This was subsequently re-fitted, as one of the occupants in the ground floor flat complained about the noise it made when the carers opened it. The flat door was also unsafe and could not be closed properly, leaving Mrs P very vulnerable. The Nightingale Service liaised with Richmond Housing Partnership for a new door to be fitted, making the flat secure.

Mrs P received support from the handyman, housekeeping and shopping services. She describes these services as a "lifeline". The Nightingale Service now coordinates the transport to hospital appointments by another provider. A Nightingale Service volunteer accompanies Mrs P to her hospital appointments, providing her with reassurance and confidence.

Mrs P expressed her gratitude to the Nightingale Service, she said:

"The Nightingale Service Manager coordinated everything so quickly, and what he said he was going to do, he did. How long would it have taken me, and how many phone calls would I have had to make, to get some help?

"If it wasn't for the Nightingale Service, nothing would have been done. It appears that some people don't communicate with people in their own office. The Nightingale Service Manager co-ordinated all my care and even went to see my GP who was unaware of my ill health. I cannot thank them enough."