





### How did we involve people?

An informed CLAHRC Public Advisor was essential to the project. Only through direct knowledge and personal experience of the local health care system (in this case as a dementia carer) could the wider context for the analysis be effectively brought into play. This was critical in discussions around the management of the readmission process and in interpreting the available data from a practical and grounded local experience.

### What we found and what does this mean?

Emerging themes and findings:

- Age was by far the dominant variable - with a significant bias in the data towards older people being readmitted to hospital;
- The average age of a readmitted patient was 84. This brought with it a cluster of well-recognised readmission issues from the medical perspective involving multiple comorbidities, polypharmacy and impaired mobility;
- By diagnosis, the most prominent causes for readmission were pneumonia (12.2%) and septicaemia (9.6%). Other conditions with a high incidence were COPD, UTI and heart disease – again consistent with the wider literature;
- A significant feature of the spatial distribution of readmissions was a peak in a single postcode district (FY8) Lytham St

### What next?

The Fylde Sub-Region is an interesting experimental setting for research to inform practice that takes in the complexity of the contextual conditions and their influence on health, well-being and inequalities. Blackpool has the worst Index of Multiple Deprivation in England in (IMD, 2015) and ranks as a one of the country's poorest communities. By complete contrast, Lytham St Anne's ranks among the more affluent. This is a feature replicated for many "Seaside Towns". This tends to map a bi-polar demographic – very old and younger-disadvantaged

Anne's, Lower secondary peaks appeared for the deprived inner suburbs of Blackpool.

- While age was important generally, socio-economic status made for very different patient populations among 30-day returners;
- Among the contextual factors with a potential role on discharge-home was the relationship between income and either local authority-provided or privately purchased social care with issues for those falling in-between (across a system of different jurisdictions);
- The interface between hospital-based and community-based care and its influence on home conditions on discharge was thought to be significant but more work is needed properly to research it;

The themes of age, diagnosis and time to readmission are consistent with the published medical literature. The "return rate" of 15% for the Fylde sample was also consistent with what would be expected from an older demographic across the UK (against a general average of 7%). The "surprise" feature of the project findings was the incidence of the "peak" in the spatial distribution of the 30-day returner population. A more granular analysis of the contextual conditions (not available to us in this project) might be able to reveal some important insights.

across its complex local and jurisdictional geography. An acute hospital and social care system that has to face these challenging circumstances has much to learn and to teach us generally about health inequalities in a *grounded setting*. "Next" – should be a major cross-national study to explore what wealth and income differentials; jurisdictional arrangements for social care; acute hospitals and community care services and the voluntary sector would have to learn to deal with the complexity of the conditions they confront every day.