Evidence related to reasons for hospital admissions

- Slide 2 – Unable to cope at home: malnutrition
- Slide 3 – Unable to cope at home: dehydration
- Slide 4 – Unable to cope at home: dementia and cognitive impairment
- Slide 5 – Unable to cope at home: poor mental health
- Slide 6 – Unable to cope at home: social isolation and loneliness
- Slide 7 – Unable to cope at home: unsuitable housing
- Slide 8 – Confusion: Urinary Tract Infection
- Slide 9 – Confusion: Delirium
- Slide 10 – Falls and fractures: Falls
- Slide 11 – Fragility fractures
- Slide 12 – At risk: Unable to care for self or others; poor general health; impaired mobility

Reason for admission: Unable to cope at home

Malnutrition	Evidence to support arguments to address malnutrition
Contributing factors: • Disease related – dysphagia, cancer, COPD, dementia • Physical disability • Social isolation • Depression • Lack of access to food • Insufficient protein and fat in diet • Cognitive impairment • Fear of falling	Around 1 in 10 older people are malnourished, or at risk of malnutrition.[1] Being under nourished can have complex health repercussions and seriously affect health and wellbeing. Disease-related malnutrition is associated with several long-term conditions such as dysphagia (swallowing problems), cancer, chronic obstructive pulmonary disease (COPD), dementia and physical disability. But malnutrition can also affect older people without long-term conditions through poor diet, a lifetime of dieting, fear of falling, depression, social isolation, and not having the right equipment to be able to eat easily. Malnutrition can lead to a weaker immune system, increasing the risk of infections, poor wound healing, and muscle weakness, which can result in falls and fractures. For an older person experiencing malnutrition, we know that compared to well-nourished individuals they are: • twice as likely to visit their GP; • have more hospital admissions; • stay in hospital longer; • have more ill health (co-morbidities).[2] For more information, visit the Malnutrition Task Force website: Malnutrition Task Force | Undernutrition | Small Appetite | Malnourished | Charity [1]Russell, C.A. and Elia, M. for BAPEN and collaborators. (2014) Nutrition Screening Surveys in Hospitals in the UK, 2007 – 2011, A report based on the amalgamated data from the four Nutrition Screening Week surveys undertaken by BAPEN in 2007, 2008, 2010 and 2011. Available from: http://www.bapen.org.uk/pdfs/nsw/bapen-nsw-uk.pdf [2]Guest, J. F., Panca, M., Baeyens, J.P., de Man, F., Ljungqvist, O., Pichard, C.,Wait, S and Wilson, L. (2011) Health economic impact of managing patients following a community-based diagnosis of malnutrition in the UK. Clinical Nutrition. 30 (4), 422–429.

Age UK services that could help to prevent contributing factors

Nutrition & hydration support Health Coaching Winter / seasonal health support	Activity groups (social and physical inc. falls prevention)	Day centres 1:1 activity support (e.g., Travelling Companions)
Support at home (e.g., post-discharge support, home care, footcare, shopping and cleaning)	Care co-ordination and navigation Support for Carers Information and advice	Dementia support (e.g. groups, Admiral Nurses) Mental health and wellbeing support
Social support (groups and befriending)	Transport support	Personal Independence Coordinators Social Prescribing

Reason for admission: Unable to cope at home

Dehydration	Evidence to support arguments to address dehydration
Contributing factors: • Fear of falling • Incontinence • Lack of thirst • No access to drinks • Being reliant on others for drinks • Lack of adapted equipment • Cognitive impairment	Older people are vulnerable to dehydration due to physiological changes in the ageing process, but this can be complicated by many diseases, and mental and physical frailty that can further increase risk of dehydration. It is more common in those with cognitive impairment and changes in functional ability. Age-related changes include a reduced sensation of thirst, and this may be more pronounced in those with Alzheimer's disease or in those that have suffered a stroke. This indicates that thirst in older people may not be relied on as an indicator of dehydration. Reduced renal function is also a risk factor. The kidneys play a vital role in fluid regulation but their function deteriorates with age, and the hormonal response to dehydration (which is key to fluid balance) may be impaired. Dehydration is associated with poor health outcomes such as increased hospitalisation and mortality. For example, a two-fold increase in the mortality of stroke patients has been reported. Common complications associated with dehydration also include low blood pressure, weakness, dizziness and increased risk of falls. Poorly hydrated individuals are more likely to develop pressure sores and skin conditions. Many older people are reluctant to drink to avoid the need to go to the toilet, particularly at night, but restriction of overall fluid intake does not reduce urinary incontinence frequency or severity. For people are reluctant to drink, fruit and ice lollies can also provide necessary fluids. For more I information, see the British Nutrition Foundation website: Dehydration in older people - British Nutrition Foundation

Age UK services that could help to prevent factors contributing to situation

Nutrition & hydration support Health Coaching Winter / seasonal health support	Activity groups (social and physical inc. falls prevention)	Day centres 1:1 activity support (e.g., Travelling Companions)
Support at home (e.g., post-discharge support, home care, footcare, shopping and cleaning)	Care co-ordination and navigation Support for Carers Information and advice	Dementia support (e.g. groups, Admiral Nurses) Mental health and wellbeing support
Social support (groups and befriending)	Transport support	Personal Independence Coordinators Social Prescribing

Reason for admission: Unable to cope at home

Dementia Cognitive impairment	Evidence to support arguments to address dementia and cognitive impairment
Contributing factors: • Inadequate support in the community • Carer breakdown • Lack of diagnosis • Social isolation • Poor diet (CI) • Illness or infection (CI)	At any one time 1 in 4 hospital beds are occupied by people living with dementia.[1] People with dementia often experience longer hospital stays, delays in leaving hospital and reduced independent living. People with dementia are more likely to be admitted to hospital due to acute illness,[2] and have increased mortality in hospital and after discharge.[3,4] Contributing factors to mortality include comorbidities, poorer functional and nutritional status,[5,6] more severe cognitive impairment (CI),[7] and increased risk of delirium.[8,9] Patients without a prior diagnosis may be at additional risk from worsening of their condition in hospital, as they may not benefit from care intended to meet the needs of patients with dementia, e.g. close observation of food and fluid intake, avoidance of sedatives and antipsychotics, reduced movement between wards to avoid further confusion and beds near clear signage to toilets.[10,11]

[1]National Audit of Dementia - Round 4 Audit Report – HQIP

[2]Toot S et al. Causes of hospital admission for people with dementia: a systematic review and meta-analysis. *J Am Med Dir Assoc* 2013; 14: 463-70.

[3]Sampson EL et al. Survival of people with dementia after unplanned acute hospital admission: a prospective cohort stud. *Int J Geriatr Psychiatry* 2013; 28: 1015-22.

[4]Borson S et al. Improving dementia care: the role of screening and detection of cognitive impairment. *Alzheimers Dement* 2013; 9: 151-9.

[5]Zekry D et al. Does dementia predict adverse hospitalization outcomes? A prospective study in aged inpatients. *Int J Geriatr Psychiatry* 2009; 24: 283-91.

[6]Stratton RJ et al. 'Malnutrition Universal Screening Tool' predicts mortality and length of hospital stay in acutely ill elderly. *Br J Nutr* 2006; 95: 325-30.

[7]Sampson EL et al. Dementia in the acute hospital: prospective cohort study of prevalence and mortality. *Br J Psychiatry* 2009; 195: 61-6.

[8]Travers C et al. Prospective observational study of dementia in older patients admitted to acute hospitals. *Australas J Ageing* 2014; 33: 55-8.

[9]Ryan DJ et al. Delirium in an adult acute hospital population: predictors, prevalence and detection. *BMJ Open* 2013; 3: e001772. doi:10.1136/bmjopen-2012-001772.

[10]Andrews J & Christie J. Emergency care for people with dementia. *Emerg Nurse* 2009; 17: 12, 4-5.

[11]Archibald C. Meeting the nutritional needs of patients with dementia in hospital. *Nurs Stand* 2006; 20: 41–5

[12]Archibald C. Promoting hydration in patients with dementia in healthcare settings. *Nurs Stand* 2006; 20: 49–52.

Age UK services that could help to prevent factors contributing to situation

Nutrition & hydration support Health Coaching	Activity groups (social and physical inc. falls prevention)	Day centres 1:1 activity support
Support at home (e.g., post-discharge support, home care, footcare, shopping and cleaning)	Care co-ordination and navigation Support for Carers Information and advice	Dementia support (e.g. groups, Admiral Nurses) Mental health and wellbeing support
Social support (groups and befriending)	Transport support	Personal Independence Coordinators Social Prescribing

Reason for admission: Unable to cope at home

Poor mental health	Evidence to support arguments to address the factors
Contributing factors: • Undiagnosed depression and anxiety • Dementia and cognitive decline • Poor physical health • Multiple long-term conditions • Enduring mental health conditions • Financial worries • Unsuitable living conditions • Unmet health and care needs • Social isolation and loneliness • Bereavement • Loss of purpose • Caring for others	As we age, getting the right support for our mental health is crucial. It is widely accepted, however, that the mental health needs of older people are often overlooked and mistreated. Just over 5% of referrals to NHS Talking Therapies are made up of people over 65, despite them making up 19% of the population.[1] There are often the twin challenges of older people themselves not seeing mental health as important or treatable, and health professionals sharing this view. As a result, older people are less likely to seek out help and if they do, health professionals are less likely to refer them for effective treatment. Many of the factors that can lead to depression in later life occur more frequently with advancing age. The longer people live, the more likely they are to lose close friends and family members; become more socially isolated and lonely; lose a sense of purpose and status; have money worries; experience poor health or develop dementia, leading to a loss of independence. Depression is the most common mental health condition in older people, affecting 18% of people aged 65 or over, followed by anxiety at 17%.[2,3] For more information visit Age UK's webpages on mental health and our report Estimating Need in Older People. You can also read our Policy Position Paper (reference 2). Age UK co-produced the NHS Talking Therapies (previously IAPT) Positive Practice Guide for older people and is part of MindEd, which produces mental health resources for older people and their families. [1]NHS Digital (2022), Psychological Therapies, Annual report on the use of IAPT services, 2021-22 [2]Age UK. Mental Health: Policy Position Paper [Internet]. 2019. Available from: https://www.ageuk.org.uk/globalassets/age-uk/documents/policy-positions/health-and-wellbeing/ppp_mental_health_england.pdf [3]Global Burden of Disease (GBD) Study, 2019 Available from: https://ghdx.healthdata.org/gbd-results-tool

Age UK services that could help to prevent factors contributing to situation

Health Coaching Winter / seasonal health support	Activity groups (social and physical inc. falls prevention) Social support (groups and befriending)	Day centres 1:1 activity support (e.g., Travelling Companions)
Support at home (e.g., post-discharge support, home care, footcare, shopping and cleaning)	Care co-ordination and navigation Information and advice	Dementia support (e.g. groups, Admiral Nurses) Mental health and wellbeing support
Support for Carers	Transport support	Personal Independence Coordinators Social Prescribing

Reason for admission: Unable to cope at home

Social isolation and loneliness	Evidence to support arguments to address the factors
Contributing factors: • Living alone • Bereavement • Lack of social contacts • Poor physical health • Poor mental health • Limited mobility • Sensory and cognitive impairments • Loss of independence • Loss of purpose • Inaccessible neighbourhood • Poor transport • Covid worries • Financial worries	Loneliness is a negative feeling people experience when the relationships they have do not match up to those they would like to have. Loneliness is about how meaningful the conversations and interactions that people have are, and not necessarily about the number of people they have contact with. Being lonely is not the same as being isolated. A person can be isolated but not lonely, or can feel lonely yet be surrounded by people. Whilst participating in social activities can help some people to overcome loneliness, many lonely people's needs are more complex. The support needed to cope with or overcome loneliness will depend on the person's circumstances. It may require someone to talk to, to help build confidence, to provide advice to help resolve money issues, to arrange transport or other access to events in the community, or something else. The support needs to be tailored to each individual person (and at times to be creative and imaginative), with the duration of the support needed also varying. See Age UK's Supporting Older People Feeling Lonely Good Practice Guide and our webpages on loneliness for more information, along with the Campaign to End Loneliness website. Age UK's October 2022 polling of older people aged 60+ showed that: • 70% felt lonely to some extent, with 7% saying they often or always felt lonely and didn't have anyone to turn to for help. • 9% of older people rarely have social contact with others in person. • 9% never have any social contact with others over the phone or online. • 28% worried about Covid a moderate amount; 13% a lot; and 4% all the time. • 94% worried about the cost of living to some extent, with 16% worried all the time.

Age UK services that could help to prevent factors contributing to situation

Health Coaching Winter / seasonal health support	Activity groups (social and physical inc. falls prevention)	Day centres 1:1 activity support (e.g., Travelling Companions)
Support at home (e.g., post-discharge support, home care, footcare, shopping and cleaning)	Care co-ordination and navigation Information and advice	Dementia support (e.g. groups, Admiral Nurses) Mental health and wellbeing support
Social support (groups and befriending) Support for Carers	Transport support	Personal Independence Coordinators Social Prescribing

Reason for admission: Unable to cope at home

Unsuitable housing	Evidence to support arguments to address the factors
Contributing factors: • Poor quality housing • Unmet need for aids and adaptations • Disrepair • Fuel poverty • Poverty and cost of living increases • Delays in processing DFG applications	Housing conditions can influence our physical health – people living with respiratory conditions, or arthritis have better health outcomes if they live in a warm and dry house than those living in damp or cold conditions. Many of those impacted the most last winter were older people, living with frailty and Multiple long-term conditions. Polling by Age UK this winter showed that 29% older households in England are in fuel poverty, spending 10% or more of their post-tax income on energy bills to maintain an adequate standard of warmth. An increase from 10% the previous year.[1] Around 9000 people a year die in cold homes and almost 3 in 4 55-64 yr olds reduced their energy use last winter due to cost of living.[2] In 2021, 14% or 3.4 million occupied dwellings failed to meet the Decent Homes Standard. Figures from the English Housing Survey (2021) show that 53% of households (one million) also do not have the adaptations they need – up from 45% (864,000) in 2014-15. 33% of households that need adaptations say their home is unsuitable and they want to move. A House of Commons Library briefing paper from April 2023 examines some of the challenges with accessing Disabled Facilities Grants for aids and adaptations.[3] In England, the maximum amount councils can give each DFG applicant is £30,000 – a cap that has not been raised since 2008.[4] The BIJ found nearly 80% of local authorities in England and Wales are using discretionary powers to top up funding, but the extra money a person can get varies wildly by council. In some areas this is top up is a grant, but in many areas it is a loan.[5] ONS analysis of the impact of the cost of living crisis on people's ability to heat their homes: https://www.ons.gov.uk/peoplepopulationandcommunity/personalandhouseholdfinances/expenditure/articles/impactofincreasedcostofliving onadultsacrossgreatbritain/september2022tojanuary2023 Age UK's webpages on housing options in later life [1] age-uk-energy-public-policy-report-march-2023.pdf (ageuk.org.uk) [2] New data reveals impact of cost-of-living crisis as we brace for coldest December in a decade | Centre for Ageing Better (ageing-better.org.uk) [3] https://researchbriefings.files.parliament.uk/documents/SN03011/SN03011.pdf [4] DLUHC & DHSC (2022). Disabled Facilities Grant (DFG) delivery: Guidance for local authorities in England [5] Gayle, V., Hamada, R. & Boutaud, C. (2022). Disabled people trapped waiting years for vital home adaptations. Bureau of Investigative Journalism

Age UK services that could help to prevent factors contributing to situation

Winter / seasonal health support Support at home (e.g., shopping and cleaning, small repairs)	Care co-ordination and navigation Information and advice	Personal Independence Coordinators Social Prescribing

Reason for admission: Confusion

Urinary Tract Infection (UTI)	Evidence to support arguments to address the factors
Contributing factors: • Bacterial infection from • Poor hygiene • Urinary catheter • Sex • Kidney stones • Enlarged prostate • Dehydration	UTIs are caused by bacteria entering the urinary tract. This is most commonly bacteria from faeces, due to poor hygiene or wiping back to front after going to the toilet, but can also be from urinary catheters or having sex. Older people are more susceptible to UTIs due to a weaker flow of urine, meaning the bladder doesn't empty fully. In men, an enlarged prostate can also make it difficult to empty the bladder completely. This can lead to bacteria building up in the urine and bladder. Women are more likely to develop UTIs than men, as bacteria can reach the bladder more easily in women. UTIs are a significant cause of mortality, especially amongst the elderly population, with UTI related symptoms accounting for between 1-3% of all primary care consultations and being the main reason for 13.7% of community antibiotic prescriptions.[1] UTIs are a common reason for hospital admissions of older people. UTIs can cause severe confusion, which develops quickly over a couple of days. For more information see Age UK's webpages on UTIs. If someone with dementia develops a UTI, they may quickly become more confused or agitated, or you might notice a sudden change in their behaviour. This sudden confusion is also known as delirium (see slide 8). See Alzheimer's UK webpages on UTIs for more information. [1]Bilsen MP et al., Guideline commentary on updated NICE guidelines for urinary tract infections, *Age and Ageing*, Volume 52, Issue 3, March 2023, afad013, https://doi.org/10.1093/ageing/afad013

Age UK services that could help to prevent factors contributing to situation

Nutrition & hydration support Health Coaching	Activity groups (social and physical inc. falls prevention)	Day centres Winter / seasonal health support
Support at home (e.g., post-discharge support, home care, footcare, shopping and cleaning)	Care co-ordination and navigation Information and advice	Dementia support (e.g. groups, Admiral Nurses)
Mental health and wellbeing support	Support for Carers	Personal Independence Coordinators Social Prescribing

Reason for admission: Confusion

Delirium	Evidence to support arguments to address the factors
Contributing factors: • Urinary tract infection (see slide 7) fever • Stroke or TIA • Low blood sugar (diabetes) or dehydration • Head injury • Medication side effects • Alcohol poisoning or withdrawal • Carbon monoxide poisoning • Severe asthma attack • Some seizures	Delirium is the most common acute disorder of cognitive function in older patients.[1] Delirium is a worsening or change in a person's mental state that happens suddenly, over one to two days. The person may become confused, or be more confused than usual. Or they may become sleepy and drowsy. Delirium can be distressing to the person and those around them, especially when they don't know what's causing these changes. Delirium is different from dementia. But they have similar symptoms, such as confusion, agitation and delusions. If a person has these symptoms, it can be hard for healthcare professionals who don't know them to tell whether delirium or dementia is the cause. When a person with dementia also gets delirium they will have symptoms from both conditions at once. For more information see the Alzheimer's Society's webpage on delirium. Prevalence of delirium on admission to hospital ranges between 10% and 31%[2] but estimates vary according to the population measured. Prevalence is highest among those who are frail or patients who are critically unwell, for example patients on intensive care units, following surgery, or at the end of life. Over the age of 80 years, more than one third of those in hospital will experience delirium.[3] Delirium is life threatening, often under-recognised, serious, and costly. It can often be resolved when the underlying cause is identified and treated, but early detection is crucial.[1] [1]Iglseder B, Frühwald T, Jagsch C. Delirium in geriatric patients. Wien Med Wochenschr. 2022 Apr;172(5-6):114-121. doi: 10.1007/s10354-021-00904-z. Epub 2022 Jan 10. PMID: 35006521; PMCID: PMC8744373. [2]Siddiqi N, House AO, Holmes JD. Occurrence and outcome of delirium in medical in-patients: a systematic literature review. Age Ageing 2006;35:350–64. Abstract/FREE Full TextGoogle Scholar [3]Ryan DJ, O'Regan NA, Caoimh RO, et al. Delirium in an adult acute hospital population: predictors, prevalence and detection. BMJ Open 2013;3:e001772. Abstract/FREE Full TextGoogle Scholar

Age UK services that could help to prevent factors contributing to situation

Nutrition & hydration support Health Coaching Winter / seasonal health support	Activity groups (social and physical inc. falls prevention) Social support (groups and befriending)	Day centres Personal Independence Coordinators Social Prescribing
Support at home (e.g., post-discharge support, home care, footcare, shopping and cleaning)	Care co-ordination and navigation Support for Carers Information and advice	Dementia support (e.g. groups, Admiral Nurses) Mental health and wellbeing support

Reason for admission: Falls and fractures

Falls	Evidence to support arguments to address the factors
Contributing factors: • Poor strength and balance ability. • Lack of physical activity • Living with frailty • Unmitigated risk factors in the home (trip hazards) • Postural hypotension • Polypharmacy • Visual impairment • Vestibular disorders (dizziness) • Undiagnosed or untreated osteoporosis • Malnutrition / dehydration • Continence problems	A fall is defined as an event which causes a person to, unintentionally, rest on the ground or lower level, and is not a result of a major intrinsic event (such as a stroke) or overwhelming hazard. Every year, 30% of older people aged 65+ living in the community will fall. Of these, 20% will experience an injury, and 10% result in a fracture. Every year there are over 210,000 falls-related emergency hospital admissions among people aged 65 and older in England).[1] It is estimated that falls cost the NHS around £1 billion a year.[2] A Cochrane evidence review showed that group and home-based exercise programmes, containing some balance and strength training exercises, effectively reduced falls, as does Tai Chi. Overall, exercise programmes aimed at reducing falls appear to reduce fractures. Multifactorial interventions assess an individual's risk of falling, and then carry out treatment or arrange referrals to reduce the identified risks. Overall, current evidence shows that this type of intervention reduces the number of falls in older people living in the community. Interventions to improve home safety appear to be effective, especially in people at higher risk of falling and when carried out by occupational therapists. An anti-slip shoe device worn in icy conditions can also reduce falls. In people with disabling foot pain, the addition of footwear assessment, customised insoles, and foot and ankle exercises to regular podiatry reduced the number of falls but not the number of people falling.[3] Additional resources: Raising the Bar on Strength and Balance – includes commissioning and service design information; National Falls Prevention Coordination Group's resources on Deconditioning – includes commissioning and service design information; Wider Impacts of Covid-19 on physical activity, deconditioning and falls in older adults- includes costings and impact data; Age UK webpages on falls prevention; NICE Guideline [CG161]: Falls in older people: assessing risk and prevention; Royal Osteoporosis Society webpages. [1]Public Health England (2018) 'Falls: applying All Our Health', London: Public Health England [2]Leal J, et al (2016) 'Impact of hip fracture on hospital care costs: a population-based study', Osteoporosis International, Vol. 27(No.2), pp. 549-558. [3]Gillespie LD, Robertson MC, Gillespie WJ, Sherrington C, Gates S, Clemson L, Lamb SE. Interventions for preventing falls in older people living in the community. Cochrane Database of Systematic Reviews 2012, Issue 9. Art. No.: CD007146. DOI: 10.1002/14651858.CD007146.pub3.

Age UK services that could help to prevent factors contributing to situation

Nutrition & hydration support Health Coaching Winter / seasonal health support	Activity groups (social and physical inc. falls prevention) Information and advice	Day centres 1:1 activity support (e.g., Travelling Companions)
Support at home (e.g., post-discharge support, home care, footcare, shopping and cleaning)	Care co-ordination and navigation Support for Carers	Personal Independence Coordinators Social Prescribing

Reason for admission: Falls and fractures

Fragility fractures	Evidence to support arguments to address the factors
Contributing factors: • Undiagnosed or untreated osteoporosis • Some medications • Malnutrition / dehydration • Early menopause • Rheumatoid arthritis • Poor strength and balance ability. • Lack of physical activity	Osteoporosis is a condition where bones lose strength and are more likely to break. It mainly affects older people. One in two women and one in seven men aged 50+ will fracture a bone due to Osteoporosis. As bones lose strength, they can break after a minor bump or fall. These are known as fragility fractures. Fractures are the most common reason for hospital admissions around the world. he total cost of fragility fractures to the UK has been estimated at £4.4bn which includes £1.1bn for social care. Hip fractures represent a large burden on the National Health Service, and are estimated to cost the UK £2bn a year.[1] Unsurprisingly, hip fractures account for the most fracture admissions and by far the most bed days. Hip fractures can have a huge impact on an older person's life, adversely affecting their confidence, independence, mobility and lifespan. Cochrane evidence reviews showed that Vitamin D combined with Calcium can reduce fracture risk,[2] and that exercise slightly improves bone mineral density (BMD) and slightly reduces the risk of having a fracture. Progressive resistance strength training for the lower limbs, has the most effect on BMD at the top of the thigh bone and combined exercise programmes on BMD at the spine.[3] More information: Royal Osteoporosis Society webpages; Age UK's webpages on Osteoporosis; NICE Guideline [CG146]: Osteoporosis: assessing the risk of fragility fracture; National Falls Prevention Coordination Group's Falls and Fractures Consensus Statement. [1]Svedbom A, Helmlund E, Ivergård M, Compston J, Cooper C, Stenmark J, McCloskey EV, et al. Osteoporosis in the European Union: a compendium of country specific reports. Arch Osteoporos [Internet]. 2013 [cited 2016 Nov 24];8(1–2). Available from: www.ncbi.nlm.nih.gov/pmc/articles/PMC3880492/ [2]Avenell A, Mak JCS, O'Connell DL. Vitamin D and vitamin D analogues for preventing fractures in post-menopausal women and older men. Cochrane Database of Systematic Reviews 2014, Issue 4. Art. No.: CD000227. DOI: 10.1002/14651858.CD000227.pub4. [3]Howe TE, Shea B, Dawson LJ, Downie F, Murray A, Ross C, Harbour RT, Caldwell LM, Creed G. Exercise for preventing and treating osteoporosis in postmenopausal women. Cochrane Database of Systematic Reviews 2011, Issue 7. Art. No.: CD000333. DOI: 10.1002/14651858.CD000333.pub2.

Age UK services that could help to prevent factors contributing to situation

Nutrition & hydration support Health Coaching Winter / seasonal health support	Activity groups (social and physical inc. falls prevention) Information and advice	Day centres 1:1 activity support (e.g., Travelling Companions)
Support at home (e.g., post-discharge support, home care, footcare, shopping and cleaning)	Care co-ordination and navigation Support for Carers	Personal Independence Coordinators Social Prescribing

Reason for admission: At risk

Factors contributing to situation	Evidence to support arguments to address the factors
• Unable to care for self or others • Poor general health • Impaired mobility • Malnutrition and dehydration (Slides 1&2) • Dementia and cognitive impairment (Slide 3) • Poor mental health (Slide 4) • Social isolation and loneliness (slide 5)	Access to NHS services is challenging, waiting lists are long, and more older people living in poor health. According to the 2021 Census, there are 2,173,351 people aged 50+ in 'bad' or 'very bad' health in England, which is 10% of that population.[1] These data can be broken down to ICB level, and different age groups, to aid local discussions. Age UK's own research into older people's experiences of accessing health and care services has shown that in October 2022, 45% of older people were concerned about accessing GP appointments; 35% about their ability to access a hospital appointment; 25% about their ability to access a planned operation; and 35% about their ability to access A&E.[2] In addition, 14% said that their ability to look after themselves had deteriorated over the previous 12 months, with one in five 18% finding it more difficult getting into and out of bed; 15% finding it more difficult getting dressed or undressed; 31% finding it more difficult to get up and down stairs; 16% finding it more difficult to shower, wash, or have a bath; and 10% finding it more difficult to get on and off the toilet.[2] Research by Age UK has found that 1.3 million, 61% of older unpaid carers (age 65+) have felt unhappy or depressed. The same research also found that 1.5 million, 70% of older unpaid carers, have felt under strain; 1.1 million, 55% of older unpaid carers live with a long-term illness or disability themselves.[3] More information: Age UK Carers webpages and Carers UK webpages and reports. [1] https://www.ons.gov.uk/datasets/create [2] Age UK Polling, undertaken by Kantar using a self-completion online survey, 4-17th October 2022. Total number of people 60yrs + polled was 1623. Kantar uses robust methods to ensure that their sample is representative of the UK population aged 60+. Full polling results on The Loop. [3] Age UK analysis of wave 12 of Understanding Society, collected 2020-2022

Age UK services that could help to prevent factors contributing to situation

Nutrition & hydration support Health Coaching Winter / seasonal health support	Activity groups (social and physical inc. falls prevention)	Day centres 1:1 activity support (e.g., Travelling Companions)
Support at home (e.g., post-discharge support, home care, footcare, shopping and cleaning)	Care co-ordination and navigation Support for Carers Information and advice	Dementia support (e.g. groups, Admiral Nurses) Mental health and wellbeing support
Social support (groups and befriending)	Transport support	Personal Independence Coordinators Social Prescribing