



# Life beyond the ward

**Recommendations** for  
improving hospital discharge in  
**Northern Ireland**

# Introduction

This discussion paper outlines the findings of research conducted in Northern Ireland to explore the experiences of people being discharged from hospital. This research was conducted as part of a UK-wide study, the breadth of which is explored in the British Red Cross report, *Home to the unknown: Getting hospital discharge right*.<sup>1</sup>

The British Red Cross has a proud history of working in partnership with the NHS and Health and Social Care Trusts, and plays a unique role in providing health and social care services in Northern Ireland and across the UK.

Our volunteers and staff work in hospitals, people's homes and the gaps in between, providing person-centred support, simple acts of kindness and non-clinical interventions that make all the difference to patient care, recovery and outcomes. They support patients in hospital emergency departments, provide ambulance support, help people get home from hospital, carry out home assessments, and support older and vulnerable people to live independently at home. Our work addresses some of the immediate operational

challenges facing the NHS and Health and Social Care Trusts today, such as how to put the patient at the centre of decision-making, how to shift the emphasis to prevention and how to join up services to improve patient experience and outcomes.

Through this work we witness the strain the NHS and the Health and Social Care Trusts are under and the impact this can have on vulnerable individuals. We believe that safe, well-planned discharge can make all the difference to an individual's recovery – as well as improving the flow of patients through the system, and reducing costs to the health and social care system.

Through British Red Cross operations and from our research, we also see many examples of good practice initiatives including; discharge to assess, multi-disciplinary discharge teams, transition wards, assisted discharge and acute care at home - and we see the impact this is having on the ground. Many are working in successful partnership with the community and voluntary sector, particularly through the Integrated Care Partnerships (ICPs) and new initiatives such as Pathfinder.

## British Red Cross recommendations

To improve the experience and outcomes of people as they are discharged from hospital in Northern Ireland



**Harness non-clinical support** from volunteers and the community to improve patient flow and outcomes



**Check** people's **ability to live independently** as part of the discharging process



**Increase resources** for community services to help people recover successfully following discharge from hospital

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<sup>1</sup> – British Red Cross (2018). Home to the unknown: Getting hospital discharge right. London: British Red Cross. [redcross.org.uk/hospital-discharge](https://www.redcross.org.uk/hospital-discharge).

This paper explores experiences of hospital discharge and makes recommendations to help prevent unnecessary hospital admission and re-admission. This report focuses on research conducted in Northern Ireland, and should be read in conjunction with our earlier report drawing on UK-wide findings, *Home to the unknown*. In discussing our findings, we draw on other evidence and the current policy and practice landscape in Northern Ireland.

## The health and social care landscape

In recent years, the Department of Health in Northern Ireland has initiated a number of changes to local health and social care structures, with the aim of delivering high-quality and sustainable services that address changing societal needs. Shortly before the Northern Ireland Executive collapsed in 2017, the Department of Health published *Health and wellbeing 2026: Delivering together*, a ten-year approach to transforming health and social care.<sup>2</sup> This plan was a response to the report produced by Professor Rafael Bengoa, who was tasked with considering the best configuration of health and social care services in Northern Ireland.<sup>3</sup> The Bengoa report found that a new service model was required and, in response, the Department of Health report identified four key areas for improvement:

1. Building capacity in communities and in prevention to reduce inequalities and ensure the next generation is healthy and well.
2. Providing more support in primary care to enable more preventive and proactive care, and earlier detection and treatment of physical and mental health problems.
3. Reforming community and hospital services so that they are organised to provide care when and where it is needed.
4. Ensuring that the administrative and management structures make it easier for staff to look after the public, patients and clients.

However, despite this strategic change, the health and social care system in Northern Ireland has struggled to keep pace with changing population needs.<sup>4</sup> The growing pressure of an ageing population and the increasing incidence of long-term conditions and co-morbidities are putting the sector under significant strain. While significant progress has been made by the Department of Health, the absence of an Executive and Assembly since 2017 has arguably impeded key transformation initiatives.

## Changing health needs and an ageing population

There is growing demand for health and social care services in Northern Ireland. From 2012/13 to 2017/18, the overall number of Emergency Department attendances in Northern Ireland increased by 24 per cent.<sup>5</sup> It is forecast that there will be 187,348 emergency admissions to hospital during 2025/26, almost 13,000 more than during 2016/17.<sup>6</sup>

This growth in demand is in part due to the rise in people living with long-term conditions and complex multi-morbidities. People are living for longer, but the increase in life expectancy is not matched by an increase in 'healthy life expectancy' (the number of years someone lives in good health), particularly in the most disadvantaged areas. For instance, female healthy life expectancy in the most deprived areas is 14.2 years shorter than in the least deprived areas; male healthy life expectancy is 11.8 years shorter in the most deprived areas than the least deprived.<sup>7</sup>

Reliance on health and care services is similarly inequitable. For example, the Bengoa report found that there are 9 admissions to hospital for every 20 people in the most deprived areas, compared with 6 admissions for every 20 people in the least deprived areas, while emergency admissions to hospital are 74 per cent higher in the most deprived communities than in the least deprived.<sup>8</sup>

<sup>2</sup> – Department of Health (2016). *Health and wellbeing 2026: Delivering together*. Belfast: Department of Health.

<sup>3</sup> – Expert Panel (n.d.). *Systems, not structures: Changing health & social care*.

<sup>4</sup> – Dayan M and Heenan D (2019). *Change or collapse: Lessons from the drive to reform health and social care in Northern Ireland*. London: Nuffield Trust.

<sup>5</sup> – Health and Social Care Board (2018). *Annual report and accounts for the year ended 31 March 2018*. Belfast: Health and Social Care Board.

<sup>6</sup> – Department of Health (n.d.). *Urgent and emergency care in Northern Ireland – Population health needs assessment*. [Belfast]: Department of Health, pp. 69-70.

<sup>7</sup> – Expert Panel (n.d.). *Systems, not structures: Changing health & social care*, p. 14.

<sup>8</sup> – Expert Panel (n.d.). *Systems, not structures: Changing health & social care*, p. 15.



This means that discharge processes are more important than ever in promoting a person's ability to recover successfully following an admission to hospital and avoid unnecessary re-admission. Extended stays in hospital impact negatively on physical and mental well-being; some studies have found that older people can lose 5 per cent of muscle strength per day of treatment in a hospital bed.<sup>9</sup>

Despite such evidence, too often people are staying longer in hospital than they need to. In 2017/18, there were 46,000 delayed bed days across the Northern

Ireland Health Service.<sup>10</sup> Some 12,900 of those were caused by a lack of domiciliary care packages, 10,100 by hospital care planning issues or delays, and 7,775 by a shortage of care-home beds.<sup>11</sup> Most shockingly, data collected by Marie Curie in 2017/18 revealed that patients in Northern Ireland were dying while waiting to be discharged.<sup>12</sup>

These conditions illustrate the urgency of getting hospital discharge right, with a focus on prevention and support, tackling unnecessary hospital admissions and the cycle of re-admission.

<sup>9</sup> Morse A (2016). Discharging older patients from hospital. Report of the Comptroller and Auditor General. National Audit Office.

<sup>10</sup> Marie Curie [2019]. Every minute matters: The impact of delayed discharges from hospital on terminally ill people in Northern Ireland. London: Marie Curie, p. 3.

<sup>11</sup> Marie Curie [2019]. Every minute matters: The impact of delayed discharges from hospital on terminally ill people in Northern Ireland, p. 3.

<sup>12</sup> Marie Curie [2019]. Every minute matters: The impact of delayed discharges from hospital on terminally ill people in Northern Ireland, p. 3.



# Research method

The findings and recommendations in this report are based on evidence gathered through two research projects commissioned by the British Red Cross.

- **The Red Cross UK-wide 'patient journey focused' research project *Home to the unknown***, conducted by Revealing Reality, an award-winning social research agency commissioned by the British Red Cross to undertake in-depth research into the transition from hospital to home, explored patient experiences of unplanned stays in hospital, their return home from hospital, and their recovery journey. This discussion paper draws upon the Northern Ireland-specific research within this project, which included interviews with:
  - hospital front-line emergency and discharge staff (including a site visit)
  - Red Cross volunteers and staff (Red Cross Assisted Discharge service based in A&E wards)
  - eight people in Northern Ireland recently discharged from hospital and living back at home.

This discussion paper provides a summary of the findings. The full UK-wide report, *Home to the unknown*, provides more detailed results of the qualitative research.

- **A Northern Ireland 'systems focused' research project** was conducted by RF Associates on behalf of the Red Cross, to gain further analysis on the role of the community and voluntary sector in

tackling avoidable admissions and re-admissions to hospital.

This involved:

- a literature review
- a focused mapping exercise of key stakeholders and non-clinical interventions and support delivered in communities
- seven in-depth qualitative interviews via telephone with key experts – four in the Hospital Trusts, two in health bodies outside the Trusts and one external stakeholder from the community and voluntary sector
- additional insights and input from front-line Red Cross staff in Northern Ireland.

We discuss the findings of these two research studies, making reference to recent policy and practice initiatives in Northern Ireland, and drawing broader evidence from health and social care.

We hope that this will fill a gap in existing data about how often patient discharge ideals are delivered, what the outcomes are for patients when they are, and what outcomes patients experience when they are not.

These insights have been used to develop recommendations to improve policy and practice in both acute and community health settings; these are aimed at Health and Social Care Trusts, other providers, and community and voluntary organisations, including the British Red Cross.

# Key insights from the research in Northern Ireland

Our research found that a person's experience in hospital and their preparation for discharge impacted on their short-term and longer-term recovery, rehabilitation and well-being. A number of key factors in this experience were identified:

- variation in discharge practices across hospitals
- challenges in accessing social care packages and wider support
- transfers between hospital teams and into community settings
- returning to unsuitable housing.

## Variation in discharge practices across hospitals

Our research highlighted that the decision to discharge a patient is dependent on individual clinical practice. This can lead to a variation in discharge decisions. For example, while one consultant may be willing to discharge a patient to receive IV antibiotics in the community or at home, another consultant may prefer this to be administered in a hospital setting.

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***There shouldn't be too much regional difference [in discharge policies]. The only thing is that when we would declare medically fit ... it's down to the individual consultant – some are more risk averse than others. Some people are prepared to do stuff like IV antibiotics in the community whereas others want to monitor that in the hospital. We are trying to standardise that as well.***

” (Trust interviewee)

Our research found that professional decisions about discharge take place in the context of hospital-wide patient flow or are based on purely clinical assessments, rather than on holistic assessments including the non-clinical needs essential to prepare patients for leaving hospital.

## Challenges in accessing social care packages and wider support

A barrier for people leaving hospital when they are ready is ensuring the appropriate package of care and support is in place. In Northern Ireland, data show that in 2017/18, of the 46,000 delayed bed days across the Northern Ireland Health Service, 12,900 were caused by a lack of domiciliary care packages.<sup>13</sup>

Interviewees<sup>14</sup> highlighted that there are not enough care-home places in Northern Ireland. They identified Trusts having difficulties with procurement as a result of care homes deregistering and changing status, which has reduced the number of available beds for patients with more complex needs.

Interviewees also mentioned workforce issues, such as the issue in Northern Ireland of large rural areas where insufficient domiciliary care is available because there are simply not enough care workers.

<sup>13</sup> Marie Curie [2019]. Every minute matters: The impact of delayed discharges from hospital on terminally ill people in Northern Ireland, p. 3.  
<sup>14</sup> – Seven in-depth qualitative interviews with key external stakeholders were conducted via telephone by RF Associates on behalf of the Red Cross in Northern Ireland. Four of these interviews were conducted with stakeholders in the Trusts, two in health bodies outside the Trusts and one external stakeholder from the community and voluntary sector. See 'Research method' for further information.

“  
***We have large pockets of rurality where there are just no services that people can avail of – such as home care, domiciliary care. There are no domiciliary care workers in parts of our Trust, so that’s a reason why ... packages of care break down. And then if you combine that with a physical problem they may end up in the emergency department.***

” (Trust interviewee)

Interviewees were also conscious of the challenge facing clinicians when the patient is older, frail and living with multiple health conditions. In such cases, a person may be assessed as fit to be discharged but then the lack of appropriate care outside hospital may lead to a delay in discharge, during which time a person slides into being medically unfit again and unable to leave hospital.

“  
***The threshold now between medically fit and intervention is so fragile that someone could be declared medically fit at 4 p.m. today but if they don’t discharge by tomorrow – given that these are predominantly frail older people – one or other blood will go off again and they are technically medically unfit again.***

” (Trust interviewee)

Those who are deemed clinically fit to leave hospital and are sent home, but still require some support after discharge, yet are ineligible for a social care package, may be overlooked. To give patients the greatest chance of returning to an independent life after hospital those who require additional support at home and in their community must receive it – to break the cycle of re-admission and improve their recovery

trajectory.<sup>15</sup> This was reflected in interviews with Trusts, and echoes the findings of previous British Red Cross research.<sup>16</sup>

“  
***If there was something that we could do that would augment domiciliary care ... there were things that we could do on a voluntary basis such as through befriending, whether that’s pick up the phone and helping, you know checking that somebody’s taking their medication, those sorts of things, because we would put a 15-minute call in for that at the minute ... we need to realign how we spend the money in the community.***

” (Trust interviewee)

### **Transfers between hospital teams and into community settings**

Our research found that challenges can stem from coordination between teams at the clinical handoff in hospital. Sometimes the communication of patient needs breaks down between ward staff and those working in discharge lounges. As a result, patients often lack clarity about what was driving their discharge decisions. One person told us that they were unclear about their diagnosis during their entire stay in hospital as well the decision for them to be discharged. This lack of understanding meant that people were often unsure what the next steps were, how to best contribute to their own recovery, or why decisions were being made.

These experiences highlight the need to facilitate more frequent in-person discussions with patients, and their families and carers, about their holistic clinical and non-clinical needs. These discussions need to take place prior to discharge to improve patient experience and communication, and need to include decision-making on care options, needs and support prior to discharge.

<sup>15</sup> – British Red Cross (2019). Home to the unknown: Getting hospital discharge right.

<sup>16</sup> – British Red Cross (2018). In and out of hospital. London: British Red Cross.

**Cat (84)** was confused about the cause of her stomach ulcers that had necessitated her hospital visit. Jill, her daughter, only realised during the interview with the researchers that her mother's ulcers had been caused by an allergic reaction to her medication. Not understanding the cause of her illness when she was in hospital meant Cat was unable to be instrumental in her own recovery.

Reflecting on the move from hospital to community setting, the stakeholder interviews suggest that while the direction of transformation of services in Northern Ireland is clearly articulated at a strategic policy level, at an operational level, for some, the shift in culture to greater integration across system partners is still developing. It will require further trust and confidence building to embed real and sustainable partnerships, working with the community and voluntary sector.

This is reflected in the Nuffield Trust's recent assessment of Northern Ireland's health and social care transformation. The Nuffield Trust concluded that: "there is little sign so far of the intended shift of care and resources into care outside hospital. Despite notional integration of health and social care, there are signs that the latter remains overlooked."<sup>17</sup>

This was also reflected in our research,<sup>18</sup> as interviewees said that Trusts can struggle with the transfer from hospital to community setting as it requires the consideration of issues beyond the clinical setting and taking into account the wider social determinants and influences on health.

They spoke about the dominance of the clinical model of care in health services, with an emphasis on purely physical healthcare needs, rather than the whole person, including mental health, emotional and social needs.<sup>19</sup> For example, tackling loneliness

and isolation was raised as an area of concern which needs new ways of working to address. The Trusts perceived that more flexible, person-centred services are required to treat the person holistically, but the way in which healthcare services are managed can make this difficult to achieve in practice.

### **Returning to unsuitable housing**

Our research found that, for some people, returning home from hospital resulted in quicker recovery after illness or injury. For others, however, returning home was a complex and difficult process. These people, in particular, became vulnerable to hospital re-admission upon returning home.<sup>20</sup>

For example, some people who were deemed clinically fit to leave hospital were sent home to a house that was inappropriate for their recovery and changing needs. Some people told us that they simply did not have enough practical and emotional support to enable their recovery.

Some people went home to houses that had not been prepared for their return, with no hot water or heating on. Others returned to homes that were unsuitable for their changed or changing needs. This ranged from struggling with a single step up to a front door, to feeling unable to get upstairs to the toilet.

We know that being sent home to conditions inappropriate for recovery means that people face increased risk of falling, as well as other hazards. This has a significant impact on a person's recovery trajectory.<sup>21</sup>

The Royal College of Occupational Therapists has also highlighted that there has been a significant increase in the number of people needing rehabilitation.<sup>22</sup> Rehabilitation must be adequately resourced to respond to demand both at primary care level and from hospital discharge.

<sup>17</sup> – Dayan M and Heenan D (2019). Change or collapse: Lessons from the drive to reform health and social care in Northern Ireland.

<sup>18</sup> – Research conducted by RF Associates (see 'Research method').

<sup>19</sup> – Research conducted by RF Associates (see 'Research method').

<sup>20</sup> – British Red Cross (2019). Home to the unknown: Getting hospital discharge right.

<sup>21</sup> – British Red Cross (2019). Home to the unknown: Getting hospital discharge right.

<sup>22</sup> – College of Occupational Therapists (n.d.). Reducing the pressure on hospitals: A report on the value of occupational therapy in Northern Ireland. London: College of Occupational Therapists.





Interviewees identified the risk that some older people who experience a longer stay in hospital become less mobile and increasingly frail during their stay. This negatively impacts their longer-term recovery and increases the likelihood of delayed discharge or re-admission.

Trusts have developed fall prevention schemes to support people, and interviewees referenced the work of the Public Health Agency (PHA) and Integrated Care Partnerships (ICPs) to further progress prevention work at pre-frailty stage. Reflecting on the causes and opportunities to prevent falls, one interviewee said:

“**Unnecessary re-admissions [can be caused by falls] where maybe things haven't been adjusted in the home to make life easier for the person ... it could be simple handyman type stuff ... a path needs clearing, large cumbersome furniture needs moving ... you know some of those very practical things, that [cause a person to] fall again.**”

” (Trust interviewee)

For people recovering from a fall, it was often difficult to move about their home before their hospital stay, and when they returned they found their homes even less suitable. However, Theresa's example below illustrates the need for person-centred interventions that address whether someone's home is appropriate for their recovery.

**Theresa** (65) had been admitted to hospital several times over the previous three years following falls at home. She had been referred to an occupational therapist who explored options to establish safer mobility around her house. But Theresa had turned down the recommended construction of a lift in her house as the lift shaft would have “been right in the middle of my living room”.

Following her most recent visit to hospital with bronchitis, Theresa had been struggling even more with the stairs in her house and had resorted to sleeping downstairs in her chair on nights she felt unable to make it up to her bedroom. She had also begun to restrict her intake of food and drink to limit the number of times she had to visit the upstairs toilet.



## **Sharon, 77**

### **Sharon was discharged without understanding her diagnosis or medication**

Sharon waited 12 hours in A&E before she was told she had suffered a minor heart attack and had underlying pneumonia.

When she left hospital 12 days later, she was told there was a “query” about whether she really had had a heart attack because her angiogram showed clear arteries.

Sharon was given new medication but wasn’t sure whether to continue with her old medication too – she had to ring a pharmacist to find out.

Arriving back home, Sharon felt cold and deflated and didn’t leave the house for a week.

Sharon didn’t know whether to expect a follow-up appointment from the cardiologist in hospital. She was referred to cardiac rehabilitation, but she could not get there without a car.

Since being home, she has been cautious about going out in cold or windy weather and about doing exercise.

Sharon had not been to hospital since the birth of her now grown-up children. Normally she lives alone but since she came home from hospital last year, one of her sons has been staying in the spare room.

Sharon had been having pain in her back and a cough, which she described as “nothing exciting”, but her son was worried and took her to A&E. She was shocked to be told when she was admitted to hospital that she had suffered a minor heart attack and that she had pneumonia.

After 12 days in hospital, Sharon was sent for an angiogram to determine whether she could be discharged. When he got the results, the consultant told Sharon he couldn’t be sure she had definitely had a heart attack but that, either way, she was ready to go home.

Sharon was given new medication to take at home and her son came to pick her up. She found the hustle and bustle outside the hospital disorienting and was relieved to be back in her house.

For the next week she had lots of visitors, but she didn’t go outside. She realised she wasn’t sure whether she should continue taking her medication for high blood pressure as well as her new tablets from the hospital. She rang the pharmacist who told her just to take her new medication.

Since returning home, Sharon has felt confused about what exactly happened to her and how she might need to change her habits or the way she looks after herself. She spends more time indoors, knitting for the homeless, and hasn’t been to her arts and crafts class for a while. She has stopped using her exercise bike because that was what she was doing when she fell ill.



“  
 I didn't want to be on my own. I'm  
 lucky to have the support I have from  
 family and friends. There was no other  
 support offered.”

” Sharon

## Sharon's journey

### No longer goes out in the cold, or the evenings

Though she still sees her friends, Sharon now spends more time at home in the evening knitting for the homeless

### Never been in hospital before

Sharon manages her asthma and blood pressure with the support of her GP

### Worried about her long-term health

Sharon is very shocked to discover she had a heart attack and pneumonia

### Unclear expectations

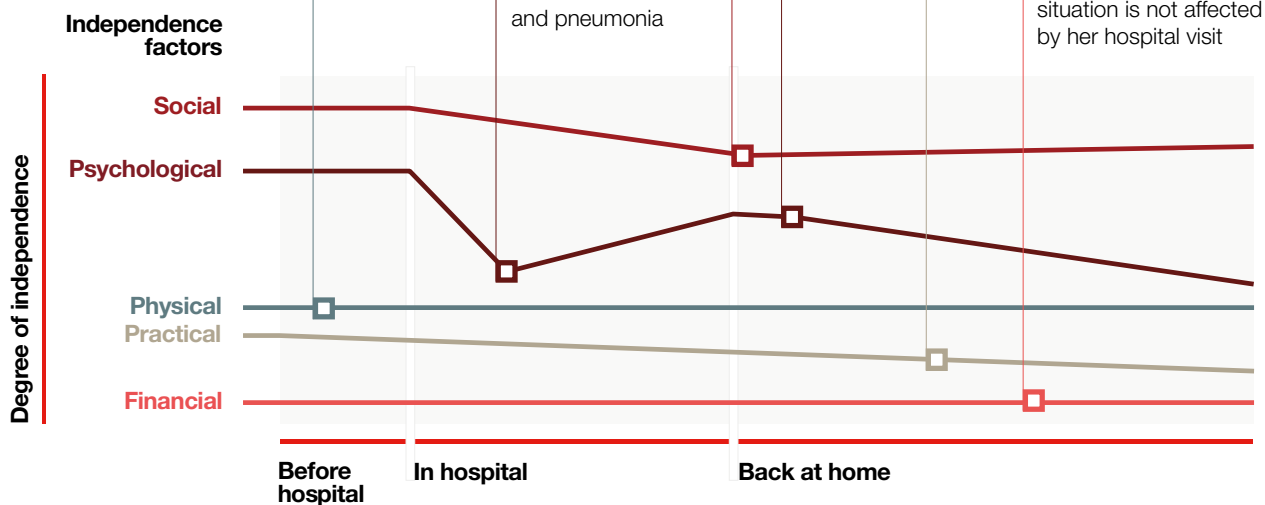
She is anxious she has not been offered a follow-up cardiology appointment

### Services located far away

Sharon cannot attend cardiac rehabilitation clinic without a car

### Comfortable on a state pension

Sharon's financial situation is not affected by her hospital visit



# Key recommendations

## 1

### **There is a substantial opportunity for commissioners and providers to harness the power of non-clinical support, including the voluntary and community sector (VCS).**

This will relieve pressure on Health and Social Care Trusts, create better outcomes for people and improve patient flow between health and social care providers.

The British Red Cross recommends the following options should be explored.

- Supporting change and recovery by having a named non-clinical person to provide support throughout a person's journey through hospital and the return home again, including having them as the critical link with community teams.
- Facilitating more frequent in-person discussions with patients, their families and carers, about their holistic clinical and non-clinical needs, in order to improve patient experience and outcomes.

## 2

### **Checking people's ability to live independently as part of the discharging process.**

In our report *Home to the unknown: Getting hospital discharge right*, the British Red Cross sets out five independence factors that illustrate the importance of considering how the wider context of a person's life – beyond their immediate clinical needs – should be accounted for in planning for their discharge. We recommend that a five-part independence check should be completed as part of an improved approach to patient discharge – either prior to discharge or within 72 hours of going home. This would help inform the setting of a realistic discharge date and would include assessing:

1. practical independence (e.g. suitable home environment and adaptations)
2. social independence (e.g. risk of loneliness and social isolation; whether they have meaningful connections and support networks)
3. psychological independence (e.g. how they are feeling about going home; dealing with stress associated with injury)
4. physical independence (e.g. washing, getting dressed, making tea) and mobility (e.g. need for a short-term wheelchair loan)
5. financial independence (e.g. ability to cope with financial burdens).

### 3

#### Fulfilling the shift to community based services.

To better meet the changing health needs of society and fulfil the vision of Bengoa, momentum is required to shift resources and build capacity at a community level, which helps people to maintain their independence for longer.

- Improved funding of community based services, including the community and

voluntary sector, to more successfully bridge the gaps between traditional acute and primary care services.

- Greater flexibility in commissioning and budgeting processes to facilitate the required shift to and scaling of community based services.
- Sustain and deepen structures for collaboration with the community and voluntary sector.

#### Leaving hospital: Can this person live independently?

British Red Cross recommends a **five-part independence check** as part of the discharge process – before or within 72 hours of discharge.



**Practical independence** – Can they manage at home? Are there any unmanageable physical obstacles?



**Social independence** – Are they at risk of loneliness? Do they have good social connections and support?



**Psychological independence** – How do they feel about returning home? Are they stressed about living with their illness or injury?



**Physical independence** – Can they look after themselves and their home?



**Financial independence** – Do they have any financial issues as a result of their injury or illness?

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# Conclusion

Unplanned hospital stays are inevitably disruptive to a person's well-being. But the experience someone has during their stay in hospital, the ways they are prepared for discharge, and the extent to which the trajectory of their long-term recovery is actively considered in hospital all affect their ability to thrive once they return home.

The strategic intent of transformation of health and social care in Northern Ireland is clear and the Department of Health in Northern Ireland has taken key steps to transform local health and social care structures to respond to changing societal needs. However, the insights from this research highlight the necessity of greater collaboration across system partners, including sharing

responsibility for successful transition between acute and community services.

To improve the experiences and outcomes of people being discharged from hospital, we need to ensure that primary and community services are well resourced to support people as they begin their recovery at home.

Most importantly, all system partners have a role in ensuring that every decision made with patients and their families about discharge and support following a stay in hospital considers not only clinical needs, but the broader, varied factors that impact on a person's ability to recover and live as independently as possible following a stay in hospital.







The British Red Cross has been working between home and hospital since before the NHS was established. Today our health and social care services help over 200,000 people across the country continue to live safely and independently. Our services have a simple idea at their heart: preventing health problems from escalating into personal crises.

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