British Red Cross

Support at Home services provided by the British Red Cross

Overview

In 2017 the British Red Cross helped over 187,000 people live independently, and as a result avoid unnecessary hospital admissions and delayed discharges.

We have been delivering health and social care services for over 70 years, working closely with our partners to help people move more swiftly and safely though the care system.

Our range of services provide a person-centred approach to ensure all the practical and emotional needs of a person are met, to help them get back on their feet and live independently.

The British Red Cross is working with more than 60 hospitals in the UK, including over 15 A&E departments. We work in partnership with local services and support; utilising existing community assets first. Our services build resilience not reliance; providing support only where needed, and reducing this over time.

We deliver four Support at Home models, which can be commissioned individually as stand-alone services, or linked together to provide a simple and effective care pathway. Each of the services has additional support options, enabling us to create a bespoke service to meet your local needs.

All of our services support at least two of the following outcomes:

1. **Preventing admission from home**
2. **Preventing admission from A&E**
3. **Preventing delayed discharge**

Our services also provide a range of benefits for the people we support, including;

- **Improvements to health and well-being**
- **Increased and retained independence**
- **Enhanced quality of life**
- **Greater choice and control over health, well-being and support**
- **Increased information and access to appropriate services**

For more information on the services we offer visit:
redcross.org.uk/commissioners

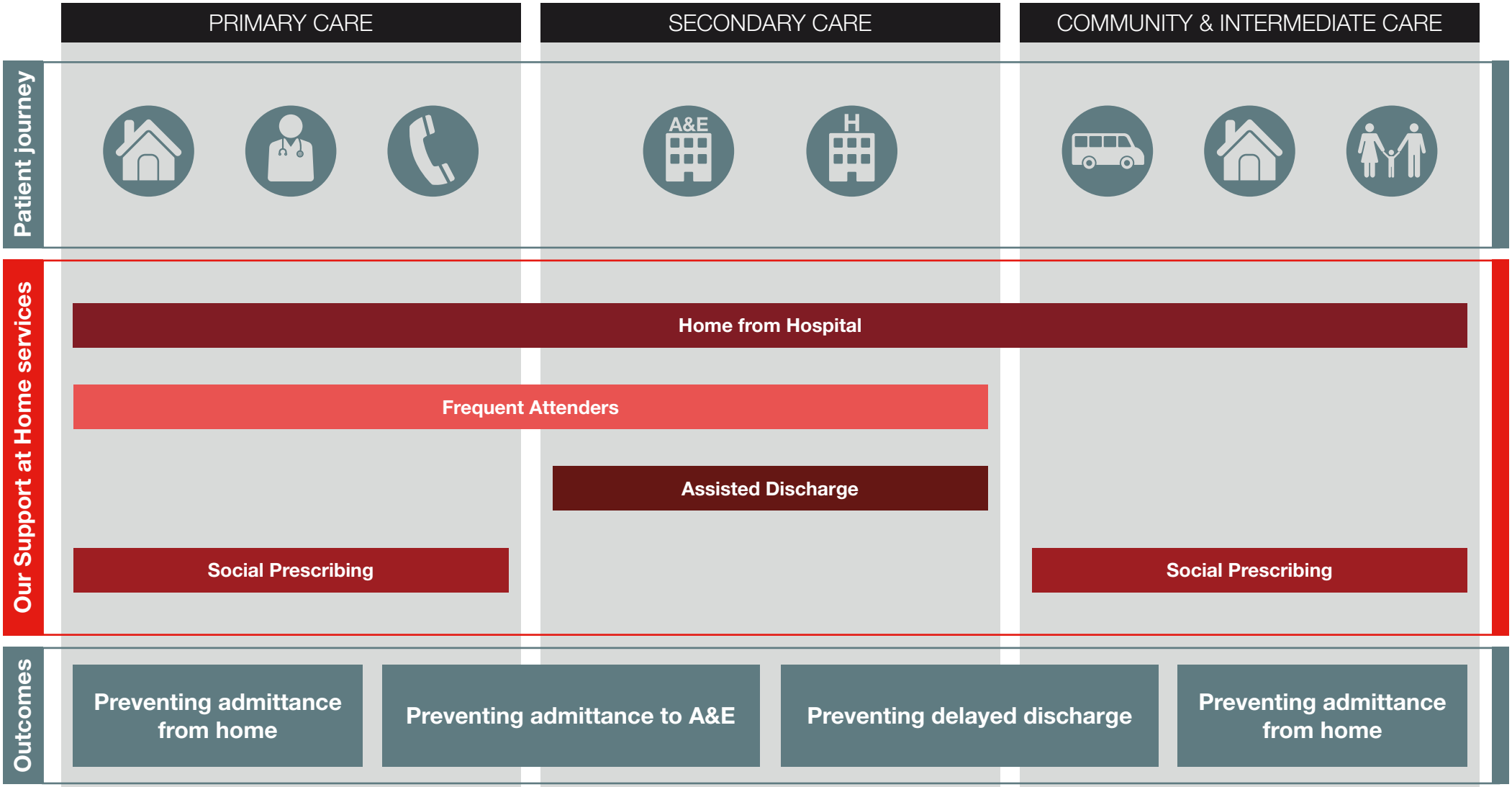
"We've developed a successful working partnership with them and they provide great support to patients when they are discharged from A&E. It is reassuring to know that when our patients leave our care they have someone with them to ensure they are settled in at home safely. They really do provide a great service and it is very much appreciated by us all at the Countess."

Tony Chambers, Chief Executive at Countess of Chester Hospital

BritishRedCross

Support at Home services provided by the British Red Cross

How our services fit with the patient journey



British Red Cross

Key elements of our Support at Home Services

	1: Referral			2: Engagement			3: Support								4: Outcomes		
	Primary care	Secondary care	The community	Referral assessment	Building a profile	Partnership working	Transport home from hospital	'What Matters To Me'	Resettlement	Time limited practical & emotional support	Transport to attend appointments	Personal care	Follow up call	Supported referrals	Preventing admission from home	Preventing admission from A&E	Preventing delayed discharge
Social Prescribing	✓		✓	✓		✓		✓		✓	Optional		✓	✓	✓	✓	
Assisted Discharge		✓		✓		✓	✓		✓	✓			✓	✓		✓	✓
Home from Hospital	✓	✓	✓	✓		✓	Optional	✓	✓	✓	Optional	Optional	✓	✓	✓	✓	✓
Frequent Attenders	✓	✓		✓	✓	✓		✓	✓	✓	Optional		✓	✓	✓	✓	✓

BritishRedCross

Social Prescribing

Referrals from:
GPs, other Primary Care medical professionals, Social Care

British Red Cross Social Prescribing

If further support is required:
Supported referral to local provision

The objective of the service is to enable people to take greater control of their health and well-being and reduce their need for NHS services and clinical input. The service provides one-to-one short-term support for up to 12 weeks, helping people who are accessing primary care and social care connect with non-clinical support within the community. We provide emotional support, confidence building, signposting and supported referrals to other organisations to achieve the goals outlined in a personalised support plan. Support is provided face to face and via telephone.

CRITERIA:

- Must be aged 18 or over
- Must have a social, emotional or practical need that can be met by a non-clinical service

ENSURING QUALITY:

- Our internal Quality Standards Framework sets standards based on best practice, sector evidence, and national legal requirements.
- Outcomes are measured using our 'What Matters To Me' approach – we use a person-centred method to support people to develop their support plan which informs the goals they set and how to achieve them. We monitor progress closely to ensure quality.
- British Red Cross Independent Living Learning and Development has the externally awarded Skills for Care Quality Mark for quality of learning and development in adult social care.

OPTIONAL EXTRAS:

- 7 days a week service and out of hours support
- A transport element – to help people attend appointments and engage with community services and support
- Health coaching

THE DIFFERENCE WE MAKE:

For the people we support:

- **Reduced loneliness** – Our Connecting Communities programme is helping 8 out of 10 people we support to achieve a positive change in their loneliness, as measured through the University of California, Los Angeles (UCLA) loneliness scale.
- **Improved wellbeing** – One evaluation found improvements in wellbeing, which were maintained in 10 of the 11 people engaged in a follow up review three months later.
- **Improved independence** – Feedback from people supported said our service gave significant/excellent help in managing their day to day life.

For local health and social care services:

- More appropriate use of health services
- More appropriate and delayed use of social care services
- Holistic flexible support option to address unmet social and health needs

Social Prescribing: our service model

WHAT WE DO:

- Referrals are received and eligibility assessed by the British Red Cross social prescribing link worker.
- Cases are allocated to a Red Cross social prescribing link worker or volunteer (depending on the support needs of the individual) and tailored one to one support commences.
- The Red Cross social prescribing link worker meets with the person to identify achievable goals to help them better manage their health and well-being.
- Support can include practical and emotional support, such as, confidence building, signposting and supported referrals to enable increased personal resilience and greater access to support in the community.
- Transport can be provided if required to help individuals achieve their goals, for example, attending important appointments and facilitating initial access to support services or community activities.
- Support can be provided for up to 12 weeks, with support tapering as the individual's resilience increases and they are able to put solutions in place to better manage their health and well-being.

* Optional elements of the service model are highlighted in grey

WHAT PEOPLE SAY ABOUT OUR SOCIAL PRESCRIBING SERVICE:

100% of people providing feedback said they would recommend our social prescribing service to family and friends.

100% of people providing feedback agreed they were treated with dignity and respect.

"…could not be more pleased with this service…Felt reassured someone could give information on services so they could make an informed decision."

"All useful and helpful information."

"Can't thank Tom [volunteer] enough for getting my Dad into a group which he thoroughly enjoys and still goes to every week. Unfortunately, with my Dad's condition he can't remember Tom, but we as his family will be sure to tell others about how amazing the Red Cross are and how they have helped us."

British Red Cross

Assisted Discharge Service

Referrals from: **Discharge Teams**

British Red Cross Assisted Discharge Service

If further support is required: **Home from Hospital**

The objective of the service is to ensure people are not unnecessarily admitted to, or delayed in leaving, hospital to the detriment of their wellbeing and independence. This service helps assist frail older people and vulnerable people home from hospital, whether they were inpatients or attended A&E. We can provide initial support for up to 72 hours, to help them settle back in and ensure their safety. In doing so, the service seeks to improve patient flow, reduce delayed transfers of care (DTOC) and avoid unnecessary readmissions.

CRITERIA:

- Must be inpatients or attending A&E
- Must be medically fit for discharge and mobile
- Must be aged 18 or over

ENSURING QUALITY:

- Our internal Quality Standards Framework sets standards based on best practice, sector evidence, and national legal requirements.
- British Red Cross Independent Living Learning and Development has the externally awarded Skills for Care Quality Mark for quality of learning and development in adult social care.

OPTIONAL EXTRAS:

- Surge capacity at peak times, for example winter pressures
- Trusted Assessor / Discharge to Assess
- 7 days a week service and out of hours support

THE DIFFERENCE WE MAKE:

Findings from the evaluation of our 2018 winter pressures work show:

- **96% of people feel safe and confident recovering at home** – people told us our staff and volunteers made a significant contribution to this.
- **95% feel confident to manage their health and wellbeing in the future** – including two thirds who felt we had helped a lot.
- **99% of people know more about local community services** as a result of our service.

We help hospital services by contributing to:

- **Reducing delayed discharges by getting people home quickly** – 76% of hospital staff giving their feedback told us our service had significantly helped with this.
- **Improving people's experience of hospital discharge**
- **Avoiding unnecessary admissions from Accident and Emergency Departments**

"These professionals [from BRC] have been able to take people home and ensure their safety, settling them into their home, ensuring food, heating and drinks are available. Most of these patients would have remained in hospital overnight."

Assisted Discharge: our service model

WHAT WE DO:

- Referrals are received from discharge teams based either on wards or within A&E departments and eligibility is checked by a service co-ordinator.
- We meet with the person prior to discharge to discuss and plan how we can best help them home.
- If required, a support worker or volunteer transports the person home (with their carer if appropriate).
- The support worker resettles the person back into their home; e.g. helping to switch the heating on, tidy up, carrying out essential food shopping and ensuring the home is safe and secure.
- We carry out a safe and well call within 72 hours of resettlement.
- Support workers signpost people to other organisations or other British Red Cross services depending on need.

WHAT PEOPLE SAY ABOUT OUR ASSISTED DISCHARGE SERVICE:

98% of people providing feedback said they would recommend our Assisted Discharge service to family and friends.

99% of people giving feedback agreed they were treated with dignity and respect.

"A big big thank you to your two staff members not only for the lift home but for the care, help and advice given for me to feel safe at home."

"The wait was non-existent and staff very understanding. "

"I was very nervous about returning to my home but the help from the lady who brought me was admirable and gave me confidence."

"The lady who helped me home couldn't do enough for me…She made sure I left with all my possessions, made sure my sick note was adequate, and all my follow up appointments were clear."

"I could not have managed without you and just knowing you were there gave me confidence and helped me feel better!"

British Red Cross

Home From Hospital

Referrals from:
Social Services, Discharge Teams

British Red Cross Home From Hospital

If further support is required:
community services, Social Care

The objective of the service is to enable people to continue living at home without acute care and with reduced on-going support needs. We provide one to one short term support for up to 12 weeks, to increase a person's resilience and independence following an illness, injury, hospital admission or other crisis. We use a person-centred approach and tailored support plans to provide emotional support, confidence building, signposting and supported referrals to other organisations. We use community based services to avoid or delay a requirement for adult social care. It also helps hospitals to discharge patients more quickly by managing the risks of an immediate re-admission through delivering non-clinical activities.

CRITERIA:

- Must be aged 18 or over
- Must have a social, emotional or practical need for the service

ENSURING QUALITY:

- Our internal Quality Standards Framework sets standards based on best practice, sector evidence, and national legal requirements.
- Outcomes are measured using our 'What Matters To Me' approach – we use a person-centred method to support people to develop their support plan which informs the goals they set and how to achieve them. We monitor progress closely to ensure quality.
- British Red Cross Independent Living Learning and Development has the externally awarded Skills for Care Quality Mark for quality of learning and development in adult social care.

OPTIONAL EXTRAS:

- Transport home from hospital and/or to support people to attend appointments or engage with community services and support
- Personal Care (requires CQC registration)
- Trusted Assessor / Discharge to Assess
- Health Coaching
- 7 days a week service and out of hours support

THE DIFFERENCE WE MAKE:

We help the people we support to:

- **Reduce loneliness** – In one service 85% of people recorded a positive change, as measured through the University of California, Los Angeles (UCLA) loneliness scale.
- **Feel confident to manage their health and wellbeing in the future** – 85% of people completing an outcome survey agreed we'd helped them to manage their day to day activities better.
- **Know more about local community services and feel confident to use them** – 99% of people giving feedback knew more and 94% felt more confident to use local services after our winter pressures services in 2018.

We help health and social care services by:

- **Avoiding / delaying the requirement for long-term adult social care services**
- **Reducing delayed discharges and transfers of care** – 8 out of 9 hospital staff providing feedback stated our winter pressures services had helped.
- **Supporting safe discharges** – one evaluation identified that staff felt confident our service supported patient safety.
- **Contributing to potential cost savings** – generated by saving bed days, avoiding admissions and reducing use of taxi's to get people home.
- **Improving people's experience of hospital discharge**
- **More appropriate use of primary care services**

Home from Hospital: our service model

WHAT WE DO:

- Staff promote and advertise the service to referral partners in the community and in hospitals.
- Referrals are received from the community, primary and secondary care. Eligibility is checked by a Service Co-ordinator.
- For referrals from hospitals, if possible and appropriate we meet with the person prior to discharge to discuss how we can best help them.
- A service co-ordinator, support worker or volunteer may escort the person home from hospital or meet them at home.
- During our first visit with the person in their home we conduct a home assessment and set out goals they would like to achieve over the next few weeks.
- We schedule weekly calls and visits with staff or volunteers to support people to achieve their goals, recover quicker and build resilience and independence.
- Short-term personal care, with a reablement focus, can be provided if required.
- At the end of our support period we assess how successful people have been in achieving their goals and may signpost to other organisations or other British Red Cross services to aid even greater independence and resilience building.

* Optional elements of the service model are highlighted in grey

WHAT PEOPLE SAY ABOUT OUR HOME FROM HOSPITAL SERVICE:

98% of people giving feedback said they would recommend our Home from Hospital service to family and friends.

99% of people giving feedback agreed that they were treated with dignity and respect.

"Wonderful service, was just what I needed to help in my recovery."

"I had a lovely young lady visit me once a week for 6 weeks to take me for walks and shopping. She was brilliant and helped me enormously to regain my balance and confidence."

"First class treatment from the off. Achievable aims and objectives with a good base knowledge of subjects and activities. I do believe that I have turned a corner thanks to my mentor."

"Without your help I would not have got better so fast."

British Red Cross

Frequent Attenders Service

Referrals from: **GPs, Hospitals (A&E), Ambulance Trusts, Police, Fire & Rescue**

British Red Cross Frequent Attenders Service

If further support is required: **Community Mental Health**

The objective of the service is to enable service users to better manage their long-term conditions and to support them to access the right care and support at the right time. We provide one to one short-term intensive support for up to 12 weeks to uncover the root causes of a person's frequent GP or A&E attendance and to support them to develop appropriate coping strategies, often in conjunction with other statutory agencies. The service seeks to reduce the number of inappropriate visits to GPs, Social Care, A&E and calls to emergency services.

CRITERIA:

- Must be a "Frequent Attender" (an individual who is visiting or calling emergency services 12+ times a year)
- Must be aged 18 or over
- Must have a social, emotional or practical need for the service, and currently using emergency services inappropriately

ENSURING QUALITY:

- Our internal Quality Standards Framework sets standards based on best practice, sector evidence, and national legal requirements.
- Outcomes are measured using our 'What Matters To Me' approach – we use a person-centred method to support people to develop their support plan which informs the goals they set and how to achieve them. We monitor progress closely to ensure quality.
- British Red Cross Independent Living Learning and Development has the externally awarded Skills for Care Quality Mark for quality of learning and development in adult social care.

OPTIONAL EXTRAS:

- 7 days a week service and out of hours support
- Team to include Community Psychiatric Nurse

THE DIFFERENCE WE MAKE:

We help the people we support to:

- **Improve their physical and emotional health** – a small evaluation identified significant improvements after our support.
- **Reduce feelings of loneliness and social isolation** – supporting people to engage in social and community activities helped achieve a positive change.
- **Have a better understanding of their own issues** – all people completing feedback for one service identified our support had helped.
- **Know more about services available and when it's appropriate to use them** – our evaluations shows education helps improve decision making, leading to more appropriate use of services.

We help local services by:

- **Reducing attendances at A&E and Urgent Care services** – there was a 62% reduction in attendance after our support in one service, and a follow up evaluation of another showed 37% had avoided using their Urgent Care Centre.
- **Reducing inappropriate use of ambulance services** – an 85% reduction in ambulance use was seen after our support in one service.
- **Reducing inappropriate use of GP services** – one evaluation showed 98% of people asked had opted for alternatives to manage minor ailments instead of going to their GP since our support.
- **Achieving cost savings** – our evaluation demonstrates strong proof of concept for short term cost savings as a result of reduced service use.

Frequent Attenders: our service model

WHAT WE DO:

- Referrals are received either from GPs or A&E, depending on the service requirement.
- Support workers work in partnership with health and care professionals to build a profile of the individual and the issues resulting in their frequent attendance. This may include housing issues, issues relating to substance abuse and/or mental health issues.
- Support workers work with people to identify achievable goals which will reduce their inappropriate use of health services.
- People are assisted for up to 12 weeks through emotional support, confidence building, signposting and supported referral to achieve the goals outlined in their support plan.
- Partnership working with other agencies is key in ensuring a holistic approach and sustainable result.
- Transport can be provided if required, for example to accompany a person to an appointment or to access appropriate support and advice.
- Service support tapers as individual's resilience increases and they are able to put alternative coping strategies in place.

* Optional elements of the service model are highlighted in grey

WHAT PEOPLE SAY ABOUT OUR FREQUENT ATTENDERS SERVICE:

"The service has truly saved my life. I was rock bottom when you first came on the scene and have turned full circle to now enjoy life and understand my problems."

"I was supported emotionally, physically and mentally."

WHAT SERVICES SAY ABOUT OUR FREQUENT ATTENDERS SERVICE:

"The British Red Cross Frequent Caller Support Service has played an invaluable part in the management and reduction of a number of frequent service users to the emergency services by way of call reduction and emergency department attendances."
Frequent Attenders Strategy Group, Wales