BritishRedCross

Evaluation of the 2017/18 Winter Pressures Services Funded by NHS England

Final Report

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The power of kindness

Contents

1. **Summary of findings** ... 3
2. **Conclusion and recommendations** ... 5
3. **Introduction** ... 7
4. **Service user feedback** ... 9
4. **Service user interviews** ... 14
5. **Hospital trust feedback** ... 17
6. **Hospital trust interviews** ... 22
7. **Service activity** ... 26
8. **Context of Winter Pressures 2018** ... 32
9. **Internal lessons learnt workshop and feedback** ... 34

Appendix 1: Theory of Change with Winter Pressures Evidence ... 38
Appendix 2: Winter Pressures Data Capture Recommendations ... 39

1. Summary of findings

Introduction

This report presents the findings from the evaluation of our 2017/18 Winter Pressures services, delivered in 13 hospitals between January and March 2018. This report draws upon the following sources of evidence:

320 service user feedback responses, 16% of all people supported.

Interviews with three service users.

118 feedback responses from staff in 10 hospitals supported.

Interviews with five healthcare professionals from 4 hospitals supported.

Analysis of operational data taken from BRM.

Findings from an internal lessons learnt workshop and related feedback.

Key findings

Satisfaction with the service was almost unanimous; nine out of ten people providing feedback identified the highest level of satisfaction, and interviews with service users and hospital staff confirmed this. It is clear that the Red Cross service was perceived to be of high quality.

Our workforce was universally praised by both service users and hospital staff in their interviews and their feedback form written comments. They were praised for being friendly and polite, helpful and proactive in providing support to service users and to the departments and wards they worked in.

The people we supported and hospital staff both identified our service as being quick and efficient, getting people home from hospital quicker than expected or when compared to other services. 97% (1,984) of the people we supported were first seen by our service on the day they were referred to us.

"We had an elderly gentleman who lived alone and would have waited hours to get home (and likely it would have been evening by then). The Red Cross team collected this gentleman within 30 minutes and had him home within the hour. A fantastic service for all."
Simon Doble, Charge Nurse, Royal Cornwall Hospitals NHS Trust

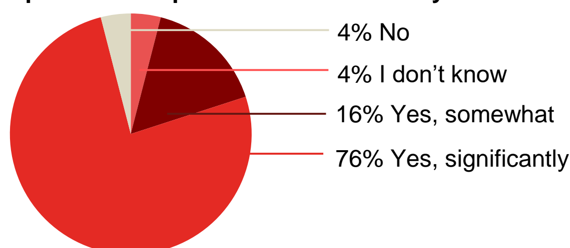
"On my day of discharge I received final clearance at 3pm in the afternoon, your driver was waiting in reception and I was on my way home about 15-20 minutes later."
Service user

"The wait was non-existent and staff (driver) very understanding."
Service user

Service users also appreciated the kindness and compassion shown to them. All services users providing feedback told us they were treated with dignity and respect.

Hospital staff felt Red Cross services were helping to relieve pressure on the NHS, particularly with regards to supporting timely patient discharges and preventing any delays patients may experience in getting home from hospital through other provision.

Figure 1 perceived impact of service on delayed transfers of care



Base: 101 hospital staff responding

"As Red Cross have been able to get patients home quicker than hospital transport, this has prevented delays in discharges to home in time for package of care to start."
Alison Breakwell, Nurse Specialist, Portsmouth Hospitals NHS Trust

As illustrated in figure 1 92% of hospital staff responding to our feedback believed that our service had helped reduce delayed transfers of care or delayed discharges, with 76% suggesting the impact had been significant in this area. Our ability to provide transport was identified as being key in enabling this impact. A number of hospital staff identified this as being important given the care packages already in place at the patients' home.

Our support helped patients to feel confident recovering in their own home and reduced the anxiety that could be felt around being discharged from a stay in hospital. It helped to reassure hospital staff that they were delivering a safe discharge.

79% of service users responding to our feedback stated the service had helped them feel confident continuing their recovery at home, the majority (59%) identifying that it had helped a lot.

> *"I was very anxious and overwhelmed about going home. I was worried I was not going to manage. It really helped having the transport and calmed me down."*
> **Service user**

> *"When we were going home, [the Red Cross worker] and I talked about the local area and that was really nice and comforting…* [Red Cross worker] *was really, really sweet, and I felt safe with her."*
> **Service user**

Although staff responding to feedback were less certain about the impact of our services on reducing unnecessary hospital admissions and unplanned emergency re-admissions, the resettlement element of our service was recognised by some hospital staff as helping to:

- reduce distress and anxiety felt by patients and their families during the discharge;
- reassure staff that patients would be safe at home;
- reduce the likelihood of re-admission for those patients receiving our follow on support.

> *"The Red Cross absolutely had an impact on delayed transfers of care. Hospital readmissions too. Patients felt more confident going home and staying at home. If the Red Cross had not been there, some of these discharges would have failed. They helped prevent discharges from failing."*
> **Clare Cherrington, Duty Manager, Queen Alexandra Hospital, Portsmouth Hospital University Trust**

> *"The service you offered ensured I could take appropriate risk to DIC a patient without worry that it would fail - by ensuring a patient is settled and has the appropriate things at home DIC decisions were much easier to make."*
> **Lucy Elloway, Senior Team Lead Physiotherapist, Portsmouth Hospitals NHS Trust**

Our service delivery was varied across services, with the flexibility in and responsiveness of our service offer being praised by hospital staff for ensuring we could meet their needs and those of their patients'. 98% of people providing feedback agreed that they got the support they needed at the right time.

Hospital staff interviewed commented on how the service often *'went the extra mile'* to support patients being discharged from hospital, going beyond what traditional partners are often able to do. Our operational data demonstrated the range of different tasks undertaken to facilitate a discharge, including collecting and delivering medication, undertaking or overseeing minor home adaptations, undertaking or collecting shopping with or on behalf of the people we supported and liaising with people's next of kin to ensure a discharge could take place.

We spent over 3,500 hours in direct contact with the people we supported. The average time spent with people supported was 1 hour 42 minutes, but ranged from 48 minutes in one service to 3 hours and 18 minutes in another. All services delivered each activity type but the proportion of time spent on each activity type differed, overall we supported the following number of people through each type of activity:

1,299 (63%) people were supported whilst in hospital

1,505 (73%) people taken or escorted home from hospital

958 (47%) people were supported in their own home

878 (43%) people were supported through at least one phone call

98 (5%) people had a signposting action recorded

There could be potential cost savings for the NHS Hospital Trusts our services supported. Although additional data is needed to confirm whether savings have been realised and it was recognised by hospital staff interviewed that it would be difficult to attribute any preventative benefits to our service alone.

Suggestions gathered through feedback and interviews with hospital staff for how we could do anything differently or better were dominated by requests for additional Red Cross resource. Service user feedback and interviews also indicated a desire for more support and suggested greater marketing of our services. Several of the hospital staff interviewed identified that they would, with experience, deploy the resource a bit differently, focussing on different wards/departments and/or types of patients e.g. 'frequent flyers'. 100% of the hospital staff providing feedback identified that the service would be beneficial next winter.

2. Conclusion and recommendations

Conclusion

"The [Winters Pressures] *service complemented our stretched NHS and social care resource. They were responsive and professional. On a number of days they made the difference to patients getting home and the hospital having another bed for the night.* [The Red Cross] *were a key partner in our ability to get through winter and beyond. Working with the third sector like this complements the work of the NHS and we need to build on experiences like this."*
Mary Tunbridge, Managing Director, William Harvey Hospital, East Kent Hospitals University Trust

This evaluation has presented evidence that demonstrates the value of our Winter Pressures support services to both the individual people and the hospital trusts supported**.** People who had been in hospital received a compassionate and responsive service getting them home from hospital quickly. The emotional and practical support provided within people's homes helped them settle, and was perceived as helping them to recover and feel more confident in their ability to cope on their own.

Knowing that their patients were receiving a high quality service based on their holistic needs was also reassuring to hospital staff. There was a very strong and clear perception that our service had helped to increase patient flow by reducing delayed transfers of care, and to a lesser extent, had potentially reduced hospital readmissions by ensuring safer more successful discharges. Given that the hospital trusts we supported experienced higher than average ambulance handover delays and bed occupancy rates it provides evidence that we were not only there for the people supported when they needed it, but that we were also there for the hospital trusts at a time of increased pressure.

To maximise the financial benefits our service requires a partnership approach, and we must build on the willingness of hospital trusts to support us in objectively evidencing this in the future. We must also improve the quality of the data we collect and the consistency with which this is recorded to support a more robust economic and process evaluation of the support we deliver. Although our services must retain the flexibility that was so valued, the evaluation has identified that our service model theory of change wasn't delivered consistently through these services, as illustrated in appendix 1. This reinforces the need identified in our internal lessons learnt exercise to develop a clear service model and ensure this is communicated across services to deliver the consistency needed to realise and maximise the financial value of our service.

Recommendations for service delivery

Recommendation 1: In planning for next year's Winter Pressures work explore opportunities to work with our Ambulance Support service. Our ability to provide transport was identified by staff and service users as being key in enabling our impact this winter, but analysis of our operational data revealed considerable variation in the proportion of people supported with journeys by service. Ensuring all services have access to vehicles that may be being under-utilised in other services, including having access to vehicles that can accommodate wheelchairs, could help to further increase our impact on patient flow by improving our capacity to take more people home from hospital in the timely and efficient manner reported in this evaluation.

Recommendation 2: Consider whether a frequent attender's service model could be built into or aligned to our Winter Pressures support next year as an early intervention to prevent unnecessary A&E attendances during the Winter Pressures period. Our economic analysis indicates preventing people from attending and being admitted through A&E departments offers the biggest potential cost saving to the NHS Hospital Trusts, and although a frequent attender service would incur more costs on our side, previous evaluations indicate that this model can deliver additional savings to other services in the health and care system and help sustain reductions in inappropriate service use for at least three months after intervention. Delivering support to people identified as frequent attenders in the months leading up to Winter Pressures may therefore be useful in helping to reduce their A&E attendances during this period.

Recommendation 3: Ensure all services are delivering against the service model's intention to signpost and connect people supported into other community based services. The healthcare professionals interviewed clearly valued the resettlement element of our service model and our efforts to enhance the success of discharges. However, the low volume of signposting activity reported through this evaluation is a concern. Even considering the possibility that this activity is under-reported, signposting is key to supporting people to feel safe and confident recovering in their own home and achieving our identified outcome of preventing unplanned readmissions.

Recommendations for data monitoring and evaluation

Recommendation 4: Action the recommendations in the data capture report in appendix 2 to improve the reliability and validity of findings reported for subsequent Winter Pressures and business as usual services delivering against the Assisted Discharge service model. This report outlines the issues faced in the analysis of our operational data this year, particularly with regards to identifying the number of people supported and the frequency with which we are supporting people still in hospital with non-clinical tasks which can facilitate quicker and safer discharges. Recommendations to provide a remedy to these issues are included. If the recommendations are not possible within the current data system compromise solutions must be found to reduce the incidence of these issues in the future.

Recommendation 5: Start capturing data to identify the productivity gains provided to hospitals by freeing up the time clinical staff would otherwise spend on undertaking non-clinical tasks. Including this as an indicator of the economic efficiencies provided by our service would be a valuable addition. To do this we should work with a small number of hospital staff to estimate the time taken for them to carry out the non-clinical tasks we can complete. A total time saving can then be estimated and NHS salary band data used to calculate a monetised productivity gain.

3. Introduction

In December 2017 the British Red Cross received over £420,000 of funding from the NHS to provide support in 13 NHS Hospital Trusts across England during a period of time commonly known as 'Winter Pressures'. The aim of this support was to aid patient flow and help to ensure that nursing and medical staff are free to deal with the clinical needs of patients. Our services worked in the following ways:

- Supporting Accident and Emergency departments to avoid unnecessary admissions and speed up the discharge of vulnerable patients who do not need ongoing medical treatment.
- Supporting patients who are medically fit to go home following treatment on other hospital wards/departments.

The services offer practical and emotional support outside of a patients' medical needs; providing transport to and resettlement at home. Our Winter Pressures offer was a combination of new services set up where there was no existing hospital support service and up scaling of existing services to enhance their capacity during this period.

Our engagement with NHS England about our response to Winter Pressures began in October 2017 and final confirmation of our funding and the hospital sites to be supported were confirmed in mid-December. Services were operational from the 2nd January 2018 and ran up to the end of March 2018, supporting people through our Assisted Discharge, and where required and available, Home from Hospital service models.

Red Cross run Assisted Discharge and Home from Hospital services in many NHS Hospital Trusts across England. These services may run throughout the winter period and some may have received additional funding directly from their commissioning Trusts to improve their capacity during this period. These services are not the subject of this evaluation, which focuses only on those 13 services which were funded by the central NHS England funding.

Evaluation approach

Initial indications were that NHS England would be providing an evaluation of all their centrally funded Winter Pressures support services but it was later identified, after the services had been initiated, that this would only involve a very 'light touch' evaluation. A small amount of funding was found to commission an independent consultant, Shelley Dorrans, to undertake the following:

- **A small tracking study of no more than six people we supported** with the aim of understanding their experience of our support, their health and social care service use before and after their discharge from hospital, including whether there had been any related unplanned readmissions, take up of any support services they were signposted to by our service and the sustainability of outputs and outcomes reported after their initial experience of the Red Cross.
- **In depth interviews with three staff working in hospitals supported** by one of our services to explore and identify their experience of working with the Red Cross, the contribution of our services to patient flow within the hospital and any other unplanned benefits of working with us through the Winter Pressures period.

Although four service users were recruited by services to participate in the research, the three who undertook an initial interview had received a brief intervention and had difficulty in remembering our service and their previous health and care service use. Therefore, it was agreed that more resource should be focussed on interviewing hospital staff, and that any further contact with the three service users would be limited to a follow up phone call. For the in depth interviews with hospital staff Red Cross service teams were only able to identify five people for interview, representing four different NHS Hospital Trusts.

To provide further insight into the delivery and outcomes of our services the Innovation and Insight Evaluation Team undertook the following:

- **An analysis of service user feedback collected from our Winter Pressures services.** 320 people (16% of all people supported) provided their feedback through returning a paper form left with them after our support or by completing their feedback through a telephone call with a member of service staff as part of their follow up safe and well call. This sample ensures we can be 95% certain that people supported would answer somewhere between 5% above or 5% below the responses reported in this evaluation. A thematic analysis was undertaken of all written comments provided through the feedback.
- **A descriptive analysis of the operational data routinely collected by our services.** This includes details on the date and source of referrals, some basic demographic characteristics of the people we supported, and the activities we delivered as part of their support.
- **A feedback survey for hospital staff** to gather their experience of working with the Red Cross, the contribution of our services to patient flow within the hospital and suggestions for how our service could be improved in subsequent years. Staff were provided with both hard copy feedback forms and a link to an online feedback

form; 118 responses were received from staff within at least 10 of the hospitals supported. A descriptive analysis of the quantitative data and a thematic analysis of written comments provided were undertaken.

> **A thematic analysis of feedback gathered through a range of internal sources, including a lessons learnt workshop.** This presents a summary of the key operational lessons learnt and recommendations for action which arise from them.

The Data Scientist in the Innovation and Insight Directorate was also engaged to undertake analysis of the NHS Situation Reports and other associated data to identify the key contexts and trends in data for the 2017/18 Winter Pressures period.

4. Service user feedback

Introduction

The Winter Pressures services were asked to gather feedback about the service from the people they supported. Services adopted different approaches to gathering this feedback:

- Paper feedback forms and prepaid return envelopes were given to service users at the end of their support;
- Service staff and volunteers asked feedback questions as part of their routine welfare check/follow up phone calls;
- Service staff and volunteers made phone calls to people supported to specifically gather their feedback on the service.

All feedback responses have been included in this analysis. All written comments received were transcribed and coded to enable a thematic analysis to be undertaken.

Profile of respondents

A total of 320 people supported provided their feedback; table 1 shows the breakdown of responses by service. This represents 16% of people supported and ensures that we can be confident findings would represent those of all people supported within ± 5% of the national score reported (this does not apply to service specific scores).

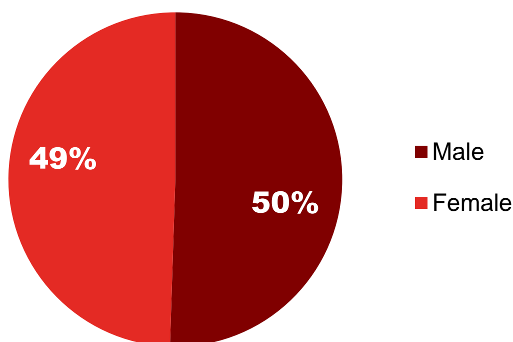
Table 1 Feedback responses by service

Service	No. feedback responses	Total people supported	% of people supported
Lewisham Home from Hospital	1	185	<1%
East Kent Home from Hospital	27	142	19%
Oxford Assisted Discharge	8	121	7%
Worcestershire Assisted Discharge	52	142	37%
Hull and East Riding Assisted Discharge	112	264	42%
Kings College, London Home from Hospital	2	38	5%
Lincoln Assisted Discharge	57	242	24%
York Assisted Discharge	0	356	0%
Portsmouth Assisted Discharge	9	122	7%
Shrewsbury Assisted Discharge	39	209	19%
Chester Assisted Discharge	1	178	<1%
Cornwall Assisted Discharge	12	58	21%
All services	**320**	**2,057**	**16%**

Source: Winter Pressures feedback report 18/04/2018; Final Winter Pressures BRM report.

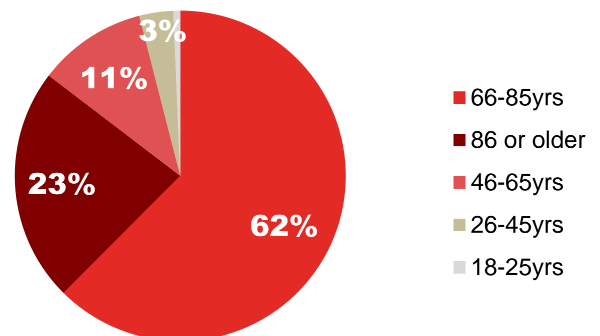
Two demographic questions were asked of respondents, age and gender; breakdowns of responses by characteristic can be seen in figure 2 and 3.

Figure 2 Feedback responses by gender



Source: 320 responses from feedback report 18/04/2018
Note: Does not sum due to rounding

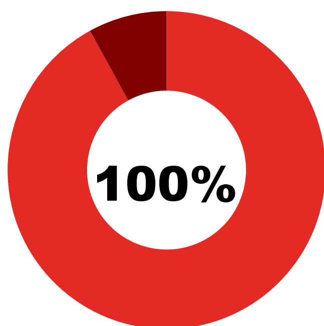
Figure 3 Feedback responses by age



Source: 320 responses from feedback report 18/04/2018

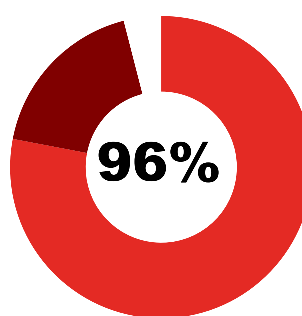
Satisfaction with service

Figure 4 Satisfaction with service provided



Source: 317 responses from feedback report 18/04/2018. 3 people provided no response

Figure 5 Friends and Family Test responses



Source: 320 responses from feedback report 18/04/2018

Figures 4 and 5 demonstrate high levels of satisfaction with their experience of our service and high levels of recommendation in the Friends and Family Test. It should be noted that the satisfaction result includes 35 people who indicated 'very dissatisfied' to this question. These responses were validated as mistaken given the ordering of the scale responses by: using the other quantitative scores, which were all very positive, and analysis of their written comments which indicated their high levels of satisfaction with the service. These scores were therefore transformed to very satisfied responses.

Table 2 Satisfaction by service*

Service	No. responses	Satisfied	Very satisfied
Hull and East Riding Assisted Discharge	112	4%	96%
Lincoln Assisted Discharge	57	11%	89%
Worcestershire Assisted Discharge	52	10%	90%
Shrewsbury Assisted Discharge	39	10%	90%
East Kent Home from Hospital	27	7%	93%
All services	**320**	**8%**	**92%**

Source: 320 responses from feedback report 18/04/2018. *Services with more than 20 people providing feedback

Table 3 Likely to recommend by service*

Service	No. responses	Extremely likely	Likely	Neither	Extremely unlikely
Hull and East Riding Assisted Discharge	112	85%	12%	1%	2%
Lincoln Assisted Discharge	57	82%	16%	0%	2%
Worcestershire Assisted Discharge	52	66%	32%	0%	2%
Shrewsbury Assisted Discharge	39	76%	21%	0%	3%
East Kent Home from Hospital	27	77%	19%	0%	4%
All services	**320**	**78%**	**18%**	**0%**	**4%**

Source: 320 responses from feedback report 18/04/2018. * Services with more than 20 people providing feedback

People were asked to provide comments to explain their satisfaction and recommendation scores. Only one person provided a comment with a negative sentiment, and this identified that they felt they needed more support than was provided. This person still identified that they were satisfied with their service and would be likely to recommend it to others. The top five most frequent themes of the positive comments were as follows:

> **People were very thankful for and appreciative of the service they received.** Almost a quarter (23%; 55 people) of people providing comments referenced thanks and appreciation; for two thirds of these people it was the only comment they made. The other third were most likely to talk about this with or in connection to comments about our workforce.

"Thank you so much for taking me home"

"Thank you so much - really pleased to be home!"

"A much needed service and I am grateful to have been able to use it at a time when I was in need. Very kind, courteous, empathetic drivers."

- **Our workforce were recognised for being friendly and polite.** 45 people (18% leaving comments) made reference to this as a factor in their positive experience of our service.

  "So very helpful, pleasant and approachable."

  "Lady very polite, efficient and friendly."

  "It is such a boon when a difficult situation arises to have such friendly and helpful service and I am so grateful for it."

- **People appreciated and recognised the kindness and compassion shown to them by our workforce providing the service. (**44 people, 20%). This includes people who specifically identified that the service treated them with dignity and respect. These comments were often linked to other comments about our workforce being helpful and friendly.

  "The consideration given by the Red Cross was impeccable and kind"

  "Very kind and patient"

  "Everyone so kind and friendly."

- **People identified our service as being high quality.** (41 people; 17%) People most frequently used words such good, great, amazing, excellent or brilliant as a way of explaining their satisfaction with our service. For example,

  "Absolutely marvellous service"

  "Very satisfied, it was excellent"

  "It's a great service."

- **Our service was delivered efficiently, getting people home from hospital quickly.** 32 people (13% of comments) described our service as prompt, efficient and commented on how they got home quicker than expected with minimal waiting time if any.

  "On my day of discharge I received final clearance at 3pm in the afternoon, your driver was waiting in reception and I was on my way home about 15-20 minutes later."

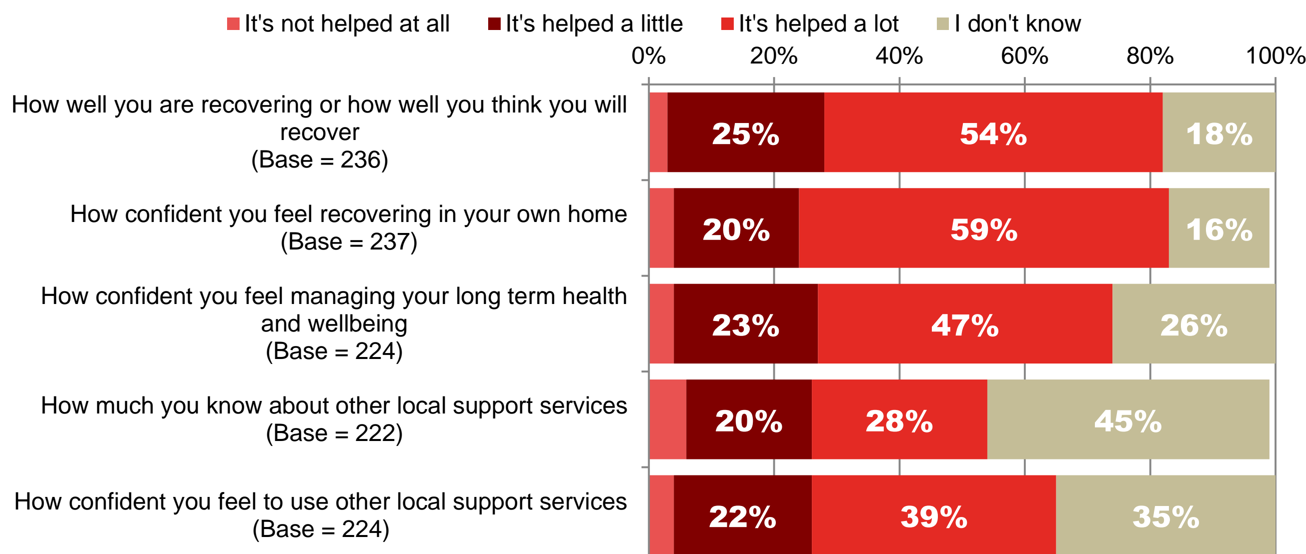
  "Took me home from hospital very efficiently."

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

How our service helped

People were asked to identify if our service had helped with a number of identified aspects related to their health and wellbeing, the findings from this are summarised in figure 6.

Figure 6 How our service helped



Source: 320 responses from feedback report 18/04/2018. Base variable due to no response to the question.

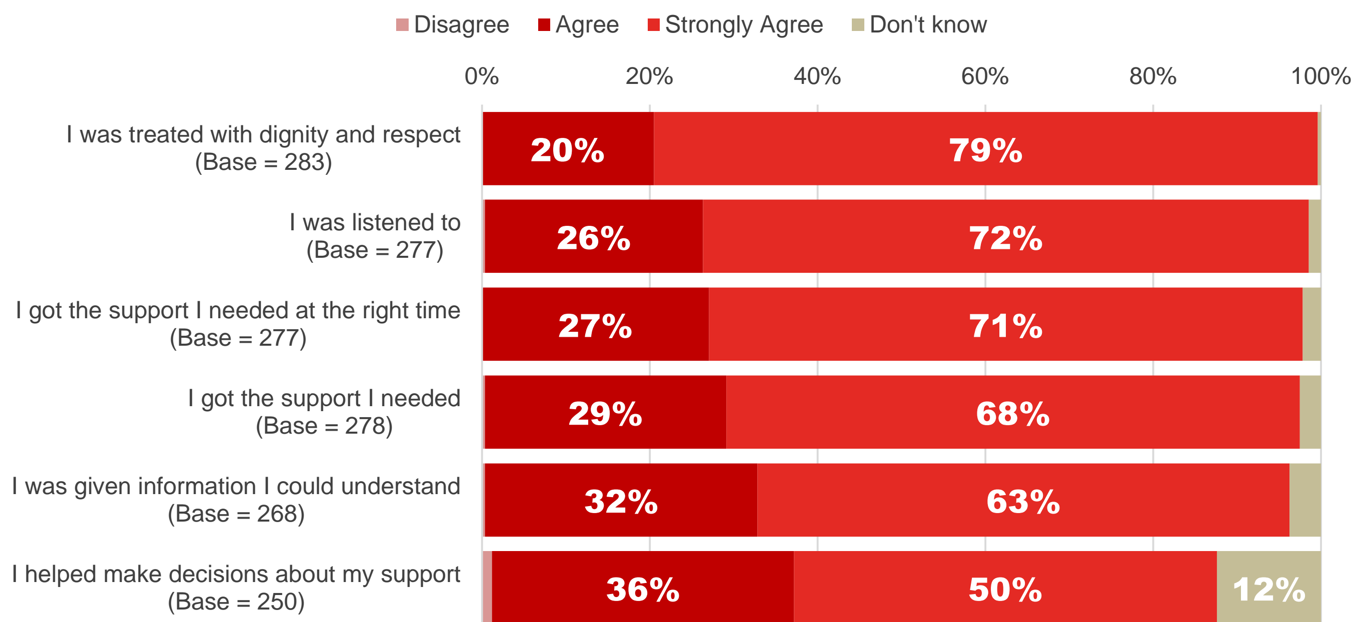
Almost 8 out of 10 people responding to these questions identified that our service has helped them to recover well and feel confident in continuing their recovery in their own home. The majority identified our service had helped a lot. 70% of people also identified that our service had helped them feel confident in managing their health and wellbeing in the future.

Less than half of people responding identified that our service had helped them to know more about other local support services.

Experience of our service

We asked people how much they agreed or disagreed with statements regarding the quality and experience of our service. Figure 7 shows that the majority of people responding to the question strongly agreed with these statements.

Figure 7 Agreement with statements regarding their experience of our service



Source: 320 responses from feedback report 18/04/2018. Base variable due to no response to the question.

Almost all people responding identified that we had treated them with dignity and respect and had listened to them, that they had got the support they needed, and had got this at the right time.

Only three people disagreed with any of these statements, and all three disagreed that they had been involved in making decisions about the support we provided to them. All three of these people received support from the Hull and East Riding Assisted Discharge. This score didn't impact on their overall experience of the service, they were still very satisfied and were extremely likely to recommend the service to their family and friends. There were 31 people who identified that they didn't know how much they agreed or disagreed with this statement. These people came from 7 of the services, but they had all received an Assisted Discharge service. Again, they still indicated they had a positive experience and were likely to recommend the service to their family and friends.

How could we improve our service?

162 people wrote a comment when asked how we could improve our service, but half of these comments (49%; 80 people) identified that no improvement was necessary and a further 26 made comments which identified their experience as positive either generally by referencing the quality of their experience or their gratitude and appreciation for the service.

18 people did make a suggestion for how the service could be improved. People were most likely to make recommendations related to the future of the service, these nine comments referenced ensuring the service could continue, how the service should support more people and that there should be greater promotion of the service. For example,

"Getting more information out about who you are and what you do."
"More help and funding would not go amiss."

“Help more people like me.”

Six people’s recommended doing something different; three people wanted more of the support provided, two comments were around better supporting or considering the needs of people who were less mobile or ambulant. Another two suggested doing something different: delivering personal care and a service that takes people from home to hospital.

Three people wanted a shorter waiting time. For example, *“Improve waiting time, shouldn't be waiting so long.”*

4. Service user interviews

Introduction

An independent consultant, Shelley Dorrans, was commissioned by the Red Cross to undertake interviews with service users about their experience and impact of using a Red Cross Winter Pressures service. This section of the report has been written by Shelley.

The Red Cross recruited four service users to participate in the research. The original intention was to interview each service user at three points in time: (i) as soon as possible following their discharge (ii) one month after their discharge, and (iii) 3 months after their discharge. Three of the four service users could be contacted and agreed to participate in the research. All requested telephone interviews for their initial interview.

The three service users participated in their initial interview in April 2018. The interviews explored their experience of the Red Cross service and any impact that this had. The interviews also trialled the use of a simplified version of the client services receipt inventory (CSRI) designed to collect quantitative data on service users' use of health and social care services in the three months prior to their contact with the Red Cross, and three months afterwards.

All three service users received relatively brief interventions from the Red Cross and had varying degrees of difficulty accurately remembering their use of health and social care services in the period leading up to their contact with the Red Cross. For these reasons, it was agreed with the Red Cross that more resource should be focussed on interviewing hospital staff, and that any further contact with the three service users would be limited to a follow up phone call to check how their recovery was going, whether they had contacted any local services that they had been signposted to, and whether they had been readmitted to hospital for reasons related to their previous admission. One service user participated in a follow up phone call; one could not be reached despite multiple attempts, and one had been re-admitted to hospital at the time of the call and was too unwell to participate.

This section of the report therefore sets out the findings from interviews with three service users. It includes two vignettes designed to give a more detailed insight into the kinds of support provided by the Red Cross and the impact that this had.

About the interviewees

- All three interviewees had been admitted to hospital for falls and came into contact with the Red Cross at the point of discharge. Two interviewees were accompanied home by a Red Cross worker, the other was not.
- Interviewees were female, aged 55, 68 and 88, and lived alone.
- Two interviewees had been staying at University Hospital Lewisham, and one had been staying at Queen Alexandra Hospital in Portsmouth.

Experience of the Red Cross service

All three service users were happy to have been approached by the Red Cross and were grateful for the support they received. They all commented on how comforting it was to have someone to talk to whilst waiting to be discharged. The two service users who were accompanied home by the Red Cross described the practical and emotional support they received on the journey home and after they had arrived home.

The service users were unanimous in their praise for the Red Cross staff who supported them, using terms such as *'sweet', 'friendly'* and *'an angel'* to describe them. The support provided to each service user differed, but all felt that they received the kinds of support that they needed or wanted.

Given the range of health and social care professionals that service users come into contact with, it was not always immediately clear to service users that it was the Red Cross that was supporting them. For one service user, this only became apparent once she was home and had a chance to relax and talk things over with the worker.

Impact of the Red Cross service

Service users found it quite difficult to articulate the impact of the Red Cross service. They tended to comment on the helpfulness and/or empathy of their Red Cross worker, rather than specific impacts. It was clear from listening to the service users that the Red Cross support had helped them in a number of ways, although the impact varied from service user to service user. Across interviewees, the following impacts emerged:

- feeling comforted by having someone to talk to within the hospital setting;
- improved mood as a result of talking to a Red Cross worker;
- feeling more confident about returning home;
- feeling more confident about coping at home;
- feeling safer at home.

Two of the three service users reported receiving information about local services which was tailored to their needs. One service user learned about the Taxicard service (a scheme for London residents with serious mobility and/or sight impairments) and later received an application form in the post from their Red Cross worker. Another service user was given a list of local services which could support her in a range of different ways. Neither service user had followed up on these services at the time of interview however nor were they sure if they would in future.

Service user vignettes

The following vignettes have been developed from the interviews conducted with the two service users in question.

Vignette 1: Jeanette

Introduction

Jeanette, 68, lives on her own in Sidcup. She enjoys getting out of the house to see friends and go to church, although persistent light headedness over the last year or so has limited her ability to do so. She has been admitted to hospital *'quite a few times'* over the last year as a result of falls. Jeanette has regular support from neighbours, her son and his family, and a friend.

Red Cross support

Jeanette came into contact with the Red Cross at University Hospital Lewisham. She'd been admitted to hospital following a fall at home. Whilst not badly injured in the fall, medical staff wanted to investigate the possible reasons for Jeanette's loss of consciousness and persistent light headedness.

On the day of her discharge, Jeanette felt ready to return home but was feeling upset as a fellow patient she had made friends with on the ward had passed away the previous night. The Red Cross worker met Jeanette in the discharge lounge. She came over and introduced herself and offered Jeanette a cup of tea.

> *"I was coming out of hospital and I felt disorientated and a bit alone, as there was no-one there to meet me. [The Red Cross worker] came up and said 'hello'… It was unexpected and it was very, very welcome and it had never happened to me before in other hospitals."*

As Jeanette was being discharged at meal time, the Red Cross worker arranged for some food to be packaged up for her to eat at home, something that Jeanette was particularly appreciative of. The Red Cross worker accompanied Jeanette home, checked that she had sufficient food in the house and chatted to her for *'about an hour'* until she felt settled and was happy for the Red Cross worker to leave her on her own.

Impact

Jeanette was extremely appreciative of the Red Cross worker's support within the hospital, on the journey home and in her house. The Red Cross worker '*lifted her mood'* at a time when she was feeling quite low. Having someone accompany her home meant that Jeanette's experience of returning and settling back at home was easier than she thought it would be. Jeanette commented on the warm and friendly communication style of the worker and said she felt *'safe'* in her presence.

> *"When we were going home, [the Red Cross worker] and I talked about the local area and that was really nice and comforting…[the Red Cross worker] was really, really sweet, and I felt safe with her."*

Recovery at home and further support

Jeanette was unsure about whether she had received any information about local support services from the Red Cross worker but felt that such information would be useful, particularly as she is *'not getting out much at the moment'* and would appreciate some help in this respect. Jeanette did not have any further contact with the Red Cross following her return from hospital and did not feel she needed any, as a carer visits her twice a day to help her wash and provide support with practical tasks.

When re-interviewed in May 2018, Jeanette had not been readmitted to hospital for any reason in the five weeks since her contact with the Red Cross, although her light headedness persists.

Vignette 2: Karen

Introduction

Karen, 55, lives in Fareham, with a cat that she is very fond of. Karen has a number of long-term health conditions, including anorexia, low blood pressure and low mood, which means that she doesn't leave the house often. Karen wears a 'panic alarm' and has been admitted to hospital *'six or seven times'* in the last year as a result of falls. Karen has no regular support at home from family or friends. Her GP calls her every 2-4 weeks to check how she's doing. Karen has had home visits from an occupational therapist in the past, as well as discussions with social workers, physiotherapists and occupational therapists whilst in hospital. Karen's local authority has undertaken a care needs assessment, although Karen is unsure of the outcome of this.

Red Cross support

Karen came into contact with the Red Cross whilst being discharged from Portsmouth's Queen Alexandra Hospital. She'd been admitted to hospital following a fall. On the day of her discharge, Karen was still feeling unwell and wasn't sure that she would cope at home, but she wanted to check that her cat was okay. The Red Cross worker accompanied Karen home and helped her to settle in. The Red Cross worker cleared out old food from Karen's kitchen, checked she had enough to eat, and then drove to Portsmouth to collect a commode as Karen didn't think she could climb her stairs to use the bathroom. Karen was particularly appreciative of the care that the Red Cross worker showed to her cat, which had been fending for itself for whilst Karen was in hospital. The worker fed the cat and changed its litter tray, which "*meant so much*" to Karen.

"It was very valuable to have the Red Cross help me home. [The Red Cross worker] was an angel, I was so glad to have him there."

To support Karen's ongoing recovery at home, the Red Cross worker provided her with a list of local support services and their contact details, including mental health support, the local Red Cross branch and *'loads of other services'*. Whilst she felt this was really useful, she was unsure whether she would contact any of them.

Impact

The support from the Red Cross meant a great deal to Karen. The simple fact of having someone to talk to and accompany her home meant that her discharge from hospital was less stressful that it might otherwise have been. Having access to a commode meant that Karen felt safer in her home as she wouldn't have to climb her stairs as often as usual. Karen also felt that she now has a better understanding of the kinds of support that the Red Cross can offer, both in the hospital and local community, and has been left with a very positive impression of the charity.

Recovery at home and further support

Following her discharge from hospital, Karen received a further phone call from the Red Cross to check how she was doing. She felt that she would have liked some ongoing companionship but noted that this didn't have to be from the Red Cross.

"I would feel more confident [recovering at home] having someone pop round regularly, maybe once or twice a week."

Although Karen was concerned about her ability to recover at home on her own, she felt that the Red Cross worker did everything he could to help her. Unfortunately, Karen was readmitted to hospital two weeks later following another fall.

5. Hospital trust feedback

Introduction

The Red Cross Winter Pressures services were asked to gather feedback about the service from the staff at the hospital(s) being supported through a survey. Through this survey we wanted to gather feedback on if and how our services had impacted on 'patient flow' through the hospital and their satisfaction with and experience of our service and workforce.

The survey was available in paper format and as an online survey. Paper copies were provided with prepaid envelopes to return completed responses directly to the Innovation and Insight Directorate.

112 people (95%) completed a paper survey

6 people (5%) completed the survey online

All 118 responses have been included in this analysis. All written comments received were transcribed and coded to enable a thematic analysis to be undertaken.

Profile of respondents

People were given the opportunity to tell us the hospital they worked in at the end of the survey, but they were also informed they could answer anonymously.

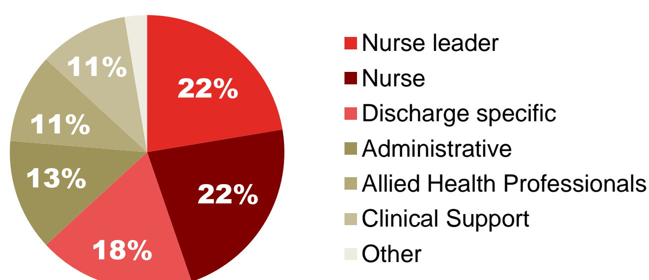
Table 4 Responses by service

NHS Hospital or Trust	Red Cross Service	Number	%
Lewisham & Green NHS Trust	Lewisham Home from Hospital	5	4%
East Kent Hospitals University Trust	East Kent Home from Hospital	4	3%
Oxford University NHS Trust	Oxford Assisted Discharge	9	8%
Worcestershire Acute Hospital	Worcestershire Assisted Discharge	2	2%
Hull Royal Infirmary	Hull and East Riding Assisted Discharge	16	14%
King's College Hospital NHS Foundation Trust	Kings College, London Home from Hospital	0	
United Lincolnshire Trust	Lincoln Assisted Discharge	22	19%
York Teaching Hospital Trust	York Assisted Discharge	4	3%
Portsmouth Hospital NHS Trust	Portsmouth Assisted Discharge	31	26%
Shrewsbury and Telford Hospitals	Shrewsbury Assisted Discharge	8	7%
Countess of Chester Hospital NHS Foundation Trust	Chester Assisted Discharge	0	
Royal Cornwall Hospitals	Cornwall Assisted Discharge	13	11%
Another hospital / trust	Unknown	4	3%
All NHS Hospitals or Trusts		**118**	**100%**

Source: 118 responses to feedback request 26/04/2018

There were 76 people (64% of respondents) who were happy to provide their name and job role. Job roles were categorised, and the breakdown of responses by category can be seen in figure 8. Almost half all people (44%; 34 people) providing details of their role could be classed as clinical, including nurses and nurse leaders such as sisters and charge nurses. A further 14 people (18%) identified a role specifically related to discharge, some of these also explicitly identified their role as clinical but this could not be determined for all cases.

Figure 8 Responses by staff role where identified

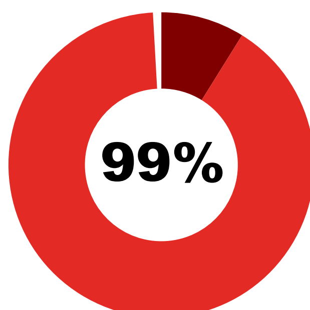


Base: 76 people who identified their role; 64% of all respondents

Satisfaction with the service

People were asked to rate their overall satisfaction with the Red Cross service, and all but one person who answered this question identified that they were either satisfied or very satisfied, as illustrated in figure 9.

Figure 9 Overall satisfaction with Red Cross service



Base: 113 people; 5 people provided no response to this question.
1 person (1%) responded 'I don't know'.

People were asked to provide written comments to explain the reason for their rating, and 94 people (80%) did this. The top five most frequent themes of comments were as follows:

1. **We delivered a quick and efficient service** – 25 people (27% leaving comments) commented on our services being prompt and punctual in collecting patients. Some people also linked this to being responsive to phone calls and enquiries.

   "We had an elderly gentleman who lived alone and would have waited hours to get home (and likely it would have been evening by then). The Red Cross team collected this gentleman within 30 minutes and had him home within the hour. A fantastic service for all."
   Simon Doble, Charge Nurse, Royal Cornwall Hospitals NHS Trust

2. **Our friendly and polite workforce** was praised by 23 people (24%). Within these comments our workforce were often identified as being approachable. For example,

   "Friendly, wonderful team. Happy to help on any task we asked of them."
   Lucy Elloway, Senior Team Lead Physiotherapist, Portsmouth Hospitals NHS Trust

3. 16 people (17%) commented on how **we provided a high quality service,** using words such as '*excellent*' ,'*brilliant'*, and *'very good'*. For example,

   "The patient discharge lounge relies greatly on the Red Cross, with often over 15 plus discharges a day. They offer an excellent service."
   Maria Jones, Staff Nurse, Hull Royal Infirmary

   "The service has been excellent. The staff have been "going the extra mile" for our patients. I highly recommend this service to all hospitals…"
   Diana Mills, Staff Nurse Discharge Lounge, Shrewsbury and Telford Hospitals NHS Trust

4. **Our workforce or services were helpful** to both patients and the hospital staff being supported. This was identified by 16 people; 17% of those leaving comments.

   "The team recently based at The William Harvey Hospital were always very eager to help, they were always very enthusiastic and no job was too small. They provided an excellent service which facilitated people being discharged from the hospital."
   Elizabeth Tidy, Case Officer - Social Services Integrated Discharge Team, East Kent Hospitals University NHS Foundation Trust

   "Very helpful and always willing to do what they can to help patients."

5. **Our service helped to facilitate faster discharges from hospital.** 16 people (17%) explicitly identified that our service had helped them to get patients out of hospital earlier and back home quicker; reducing the time patients would have had to wait for alternative transport home. For example,

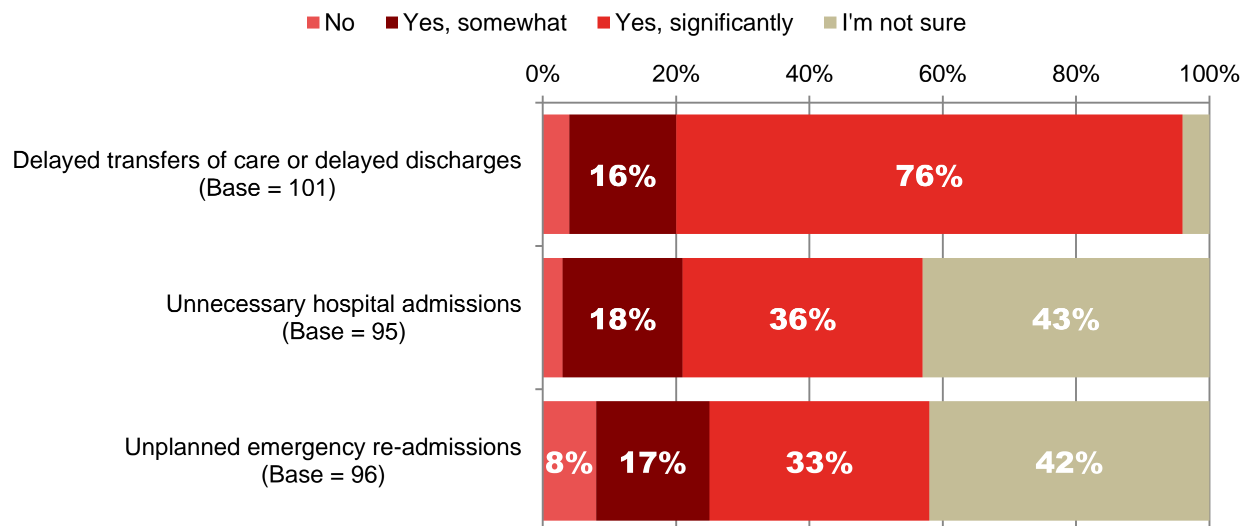
"The service has been invaluable assisting with the effectiveness of timely discharging of patients from hospital."
Roberta Chapman, Ward Sister - Elderly Assessment Unit, Hull Royal Infirmary

"Excellent patient service, ensuring timely discharge for ambulatory patients, meaning less delays + assurance that patient settled in."

How our service helped

People were asked to identify the impact of our services on factors affecting the performance of the hospital.

Figure 10 Impact of Red Cross service



Base: Varies due to people providing no response

Figure 10 shows the majority of the respondents felt the services made a significant impact on reducing delayed transfers of care or discharges. Over nine in ten (92%) people responding felt the services reduced delayed transfers of care or delayed discharges, with 76% believing this impact had been 'significant'.

This positive rating was reinforced by the comments; when asked why they had provided these ratings 42% (29 people) identified that our service had helped to facilitate more timely discharges which ensured patients got home quicker. A number of people identified this as being important given the care packages already in place at the patients' home. For example,

"As Red Cross have been able to get patients home quicker than hospital transport, this has prevented delays in discharges to home in time for package of care to start."
Alison Breakwell, Nurse Specialist, Portsmouth Hospitals NHS Trust

Being able to transport people home was identified as central to this impact by 17 people, 25% of those people leaving comments. People commented on how our provision meant people did not have to wait for patient transport services. The resettlement activity was also identified in the comments of 10 people, with many acknowledging that this had helped to reduce distress and anxiety felt by patients and their families during the discharge, and reassured staff that patients would be safe.

"I believe when a patient is finding it difficult to return, when they are alone the Red Cross take the patient home, interaction re care needs and help collecting food, medication. Hospital Transport do not have patient needs, they just drop the patient home which can cause re-admissions by family or a patient if they have anxiety."

"Helped tremendously with delayed transfers of care and hospital readmissions. Due to the fact of transporting vulnerable people home; settling them in their home environment after an extended hospital admission and assisting/signposting them with domestic support."
***Katy Moat, Case Manager for Integrated Discharge Team,* East Kent Hospitals University NHS Foundation Trust**

"The service you offered ensured I could take appropriate risk to DIC a patient without worry that it would fail - by ensuring a patient is settled and has the appropriate things at home DIC decisions were much easier to make"
Lucy Elloway, Senior Team Lead Physiotherapist, Portsmouth Hospitals NHS Trust

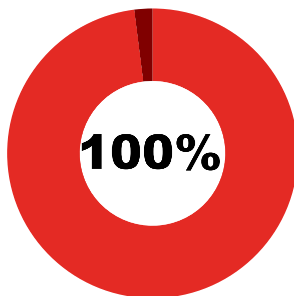
Staff responding to the questions about impact were less certain about the impact of our services on reducing unnecessary hospital admissions and unplanned emergency re-admissions; just over four in ten felt unable to say whether or not the services had impacted on these areas. However, around half of people felt our services did have an impact on these areas, with a third (36% and 33% respectively) feeling that the impact was 'significant'. Through their comments seven people specifically referenced how our service had helped avoid re-admissions, prevent unnecessary admissions and/or reduced the length of inpatient stays. For example,

"These professionals have been able to take patients home and ensure their safety, settling them into their home, ensuring food, heating and drinks available. Most of these patients would have remained in hospital overnight."
Ann Readhead, Sister Transfer Lounge, Oxford University Hospitals NHS Foundation Trust

Seven people also referenced how they were only involved in the discharge of patients, and therefore felt they could not comment on the questions related to unnecessary admissions or unplanned readmissions.

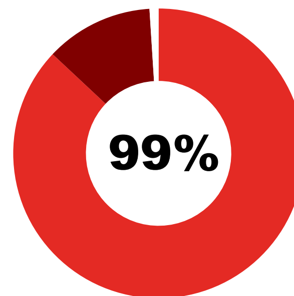
These positive findings related to service impact were reinforced when asked if the service would be beneficial in the future. As can be seen in figures 11 and 12 all people felt a repeat service next year would be beneficial and all but one person felt that the service would be beneficial throughout the year.

Figure 11 Would the service be beneficial next winter?



Base: 94 people providing a response.

Figure 12 Would the service be beneficial throughout the year?

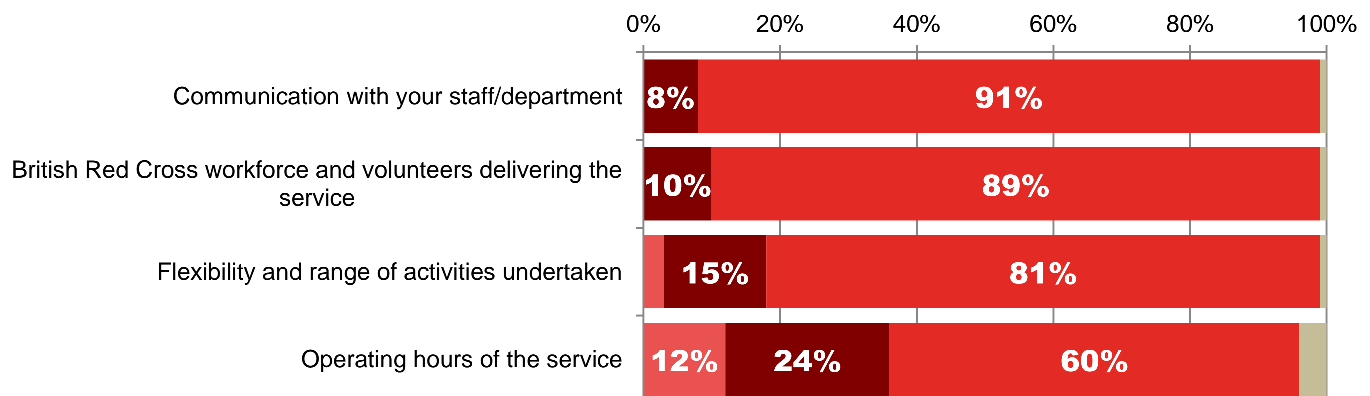


Base: 99 people providing a response.

Experience of our service

Overall, the hospital staff members were very positive about the communication and flexibility of the services, and the staff and volunteers working with them. As illustrated in figure 13 almost all respondents felt the services' communication with their departments was 'good' or 'very good' (99% combined), and the same proportion felt the same about the staff and volunteers working in the services (99%). Over nine in ten thought the flexibility and range of activities undertaken by the services was good or very good (96%).

Figure 13 Measures related to experience of working with Red Cross services



Base: 100 people; 18 people provided no response to these questions

The positive scores for our workforce reinforce the findings from the written comments, which identified our workforce as a central success factor in the service.

The flexibility of our service offer was also referenced by 12 people leaving comments related to their satisfaction with the service; these comments identified flexibility in what was delivered and when it was delivered. The following comments were illustrative of many,

"Flexible service who understand the pressure on the hospital teams."

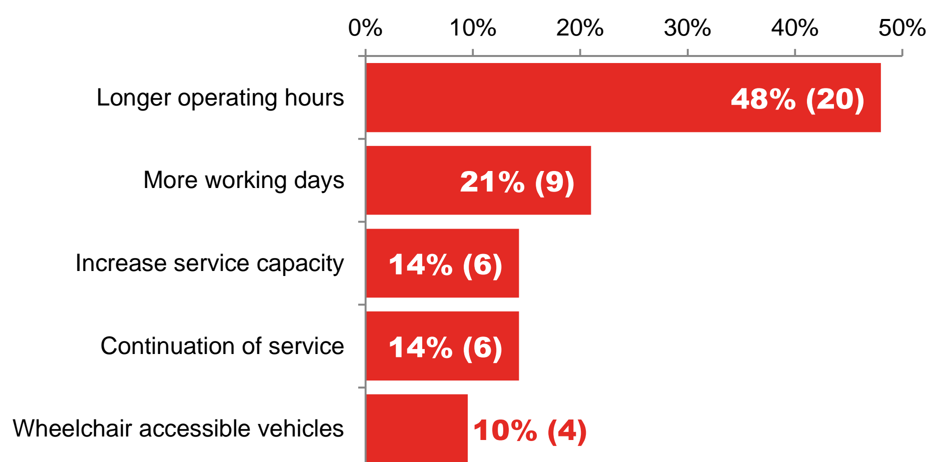
"Willing to go the extra mile to expedite a discharge."

"Working hours very flexible when needed."

How we could improve our service

42 people provided suggestions as to how the service could improve, and in line with the less positive findings related to operating hours, the most frequently identified improvement for services was to extend them. The top five most frequent suggestions for improvement are identified in figure 14.

Figure 14 Top 5 most frequently identified areas for improvement



Base: 42 people providing suggestions for areas of improvement. Number in brackets is number of people

With regards to longer operating hours seven people specifically requested later finishes and six people requested earlier starts. These comments came from people working across four different hospital trusts.

Six of the nine people suggesting more working days, specifically identifying that the service should consider working weekends. These comments came from at least three different hospital trusts.

6. Hospital trust interviews

Introduction

This chapter sets out the findings from five healthcare professional interviews. An independent researcher, Shelley Dorrans, was commissioned by the Red Cross to undertake these interviews, and this section of the report has been written by her.

The five interviewees represented four different Trusts supported by a Red Cross Winter Pressures service, these were:

- East Kent Hospitals University Trust
- United Lincolnshire Trust
- Lewisham & Green NHS Trust
- Portsmouth Hospital NHS Trust

Trusts' experience of Winter Pressures in 2017/18

All interviewees reported that their Trust had experienced significant pressures over the winter season, with one interviewee describing it as the *'worst winter I've ever known'* in the 20 years that she had been working in the NHS. Several interviewees made the point that pressures extended beyond the traditional 3-month winter period, with one interviewee describing it as '*year-round pressures'*.

"There's not much difference across the year in terms of the pressures we face with patient flow. It's just relentless. Easter was worse than Christmas this year."
Alison Berti, Team Manager, Integrated Discharge Team, East Kent Hospitals University Trust

The winter season brings specific challenges, although these are experienced differently by different hospitals depending on their patient profile and existing resources. Interviewees pointed to a greater volume of patients with flu and norovirus; difficulties discharging patients who have no heating and/or food at home; more elderly and sicker patients needing medical help; more patients coming into hospital via blue light ambulances; and, for one hospital, more out-of-borough patients. Patient demographics and related social issues can delay patients being discharged from hospital in winter, as illustrated in the following quotation:

"Winter means sicker and older patients turning up at ED and increased bed occupancy. We have complex cohorts of patients with many social needs, for example, a family member has the spare keys to their house and they need to get these before they go home, patients with no or little food in the house, patients with no heating, and lots of house-keeping issues that hold up discharge."
Meredith Deane, Deputy Chief Operating Officer, Lewisham and Green NHS Trust

All interviewees were extremely grateful to have had Red Cross support over the winter period and all agreed that the service had played an important role in helping them to manage these pressures.

The value of our service

Interviewees were asked to comment on the value of the Red Cross Winter Pressures service. Their responses are summarised below.

> Enhancing the support available to patients in the hospital setting

Interviewees felt that Red Cross staff and volunteers provided emotional and practical support to patients within the hospital that medical staff and/or other statutory services often aren't able to as they are so pressed for time. Interviewees cited examples such as a Red Cross worker taking an elderly patient to visit their spouse on a different ward, before they were discharged home; spending time with patients to help reduce any anxieties about returning home; and communicating with family members and/or carers to help organise other support once the patient gets home.

> Accompanying patients and helping them settle at home

All interviewees stressed the value of having of having Red Cross staff accompanying patients home (in Red Cross transport or otherwise) and ensuring that they had their medication, sufficient food and heating, and relevant equipment in place. They felt that this helped patients feel more confident about recovering at home, which in turn enhanced the success of their discharge.

"If a patient needed some shopping done or they had a care plan that needed to start at a certain time, the Red Cross was good at accommodating this. It wasn't just the transport that was important, it was the transition services that were key to us."
David Rimmington, Ward Clerk, Digby Ward, United Lincolnshire Trust

> Going 'the extra mile' to facilitate discharges

Interviewees commented on how the service often *'went the extra mile'* to support patients being discharged from hospital, going beyond what traditional partners are often able to do. Interviewees provided specific examples of this, including the following:

"What was really great is that they would also take a patient's medication home for them. If it was getting late and dark outside, the Red Cross would take the patient home, ensuring they got home in a timely manner, and they would come back to collect their medication and take it to them."
Meredith Deane, Deputy Chief Operating Officer, Lewisham and Green NHS Trust

"The most fantastic part of what they [the Red Cross] did was the meet and greet for equipment in a patient's home. For example, they would travel to collect house keys from a family member, wait at a patient's house for a new bed to be delivered, collect the patient and then take them home."
Alison Berti, Team Manager, Integrated Discharge Team, East Kent Hospitals University Trust

> An inclusive and responsive service

Several interviewees talked about the inclusiveness of the Red Cross service, which was not bound by narrow age or geographical criteria, as is the case for some local services.

"The challenge is that certain team's only deal with 50+ age groups of patients, and some only work in certain geographical areas. There is no blanket cover – this came from the Red Cross. They worked in all geographical areas and were happy to help anyone over 18."
Alison Berti, Team Manager, Integrated Discharge Team, East Kent Hospitals University Trust

Others pointed to the responsiveness of the Red Cross service, particularly when compared to their existing hospital transport scheme, which was important when a patient had a package of care due to start on the day of discharge.

"The Red Cross was really good at responding quickly. We need to get someone out of hospital to be able to get someone else in. The speed with which the Red Cross responded helped enormously with our discharge planning."
David Rimmington, Ward Clerk, Digby Ward, United Lincolnshire Trust

> A 'known brand'

The Red Cross is a well-known and respected charity, and interviewees felt that patients and family members therefore had trust in Red Cross staff and volunteers. Hospital staff also reportedly felt that their patients were in 'safe hands' with the Red Cross and were happy to refer patients into the care of the charity.

> Positive messaging

One interviewee felt that close partnership working with the Red Cross had sent a positive message to staff and patients about the value of community sector providers' skills and experience, which can complement and add value to those within a medical setting. This interviewee went on to note that their hospital is keen to expand its partnerships with the third sector based on its positive experience of working with the Red Cross and other charities over the winter period this year.

Impact of our service

Interviewees were asked to comment on whether the Red Cross service had impacted on delayed discharges and delayed transfers of care, unnecessary hospital readmissions and/or unplanned emergency readmissions. Interviewees were most confident about the Red Cross's impact on delayed transfers of care or delayed discharges as the following comments illustrate:

"Anecdotally, we know we would have had delays [in discharges] without them."
Alison Berti, Team Manager, Integrated Discharge Team, William Harvey Hospital, East Kent Hospitals University Trust
"Had the BRC not been there, some discharges would have been a lot slower."
David Rimmington, Ward Clerk, Digby Ward, United Lincolnshire Trust

Central to this finding was the availability of Red Cross transport, which some interviewees described as quicker than their existing hospital transport scheme, the speed of the Red Cross's response, and a practical 'can do' attitude.

One interviewee indicated that the Red Cross helped reduced the length of hospital stay for some patients but went on to note the challenge of definitively demonstrating the Red Cross's impact on delayed transfers of care due to other activity (by hospital teams and/or other third sector providers) that was happening at the time.

"I would say the Red Cross service definitely helped in reducing the length of stay for patients in hospital. With DTOC, I'm not sure I would be able to unpick whether it was the Red Cross or some other kind of activity that we were involved in".
Meredith Deane, Deputy Chief Operating Officer, Lewisham and Green NHS Trust

One interviewee commented on the Red Cross's impact in reducing unnecessary hospital admissions, as a result of staff and volunteers supporting patients in the Emergency Department and being able to transport them home. Another interviewee felt that the Red Cross's focus on helping people feel settled and comfortable at home meant that some discharges were more likely to be successful.

"The Red Cross absolutely had an impact on delayed transfers of care. Hospital readmissions too. Patients felt more confident going home and staying at home. If the Red Cross had not been there, some of these discharges would have failed. They helped prevent discharges from failing."
Clare Cherrington, Duty Manager, Queen Alexandra Hospital, Portsmouth Hospital University Trust

All interviewees agreed that the service's impact on delayed transfers of care and hospital readmissions would be hard to prove definitively at the time of the research, either because they were unsure whether any hard data existed (or they hadn't seen any) or because it would be difficult to distinguish the Red Cross' contribution from that of other third sector organisations and/or efforts by hospital teams. All interviewees were open to exploring if and how relevant quantitative data could be collected should they receive the service in future and would welcome early discussions with the Red Cross about this.

Beyond these three indicators, interviewees highlighted a range of other impacts as follows:

- One interviewee highlighted that the Red Cross helped them discharge a higher volume of patients than would otherwise be the case.
- One interviewee pointed to productivity gains for medical staff when Red Cross staff and volunteers relieved them to having to sort out the (non-medical) practicalities of getting patients home.
- One interviewee reported that the Red Cross, by being present in the Emergency Department, was able to support 'frequent flyer' patients (patients who regularly attend with no medical emergency) to return home more quickly than might otherwise be the case.
- One interviewee talked about how helpful it was to have the Red Cross take patients home in the evening which *'gave staff comfort'* that they would have one or two extra beds going into the night, reducing the risk of patients having to be placed in corridors.
- One interviewee reported that some hospital staff have increased their use of Red Cross community services following the end of Winter Pressures due to staff being more familiar with the Red Cross, its services and the way that they are delivered.

Experience of working with our teams

Interviewees were united in their praise of Red Cross staff and volunteers and their experience of working alongside them. In particular, they commented on:

- The positive attitude of Red Cross staff, their 'approachability' and their willingness to help when they could.
- Effective communication with hospital staff in terms of receiving referrals, seeking clarification when needed, and keeping hospital staff informed of progress. This helped build trust and cement relationships.
- The connection that Red Cross staff had with patients and their families, which provided reassurance at a stressful time.

"If you called them [the Red Cross] and they couldn't attend when you needed them to, you knew it was because they were busy and that they would do their best to help when they could. They were very approachable. Because they came onto the ward and had face-to-face conversations with us [at the point of discharge], we built up a good relationship with them."
David Rimmington, Ward Clerk, Digby Ward, United Lincolnshire Trust

Several interviewees made a point of emphasising the Red Cross's willingness to problem solve when difficult issues came up and more traditional partners were unable to help due to capacity issues or restrictions on the types of patients they support.

[Working with the Red Cross team] was such a positive experience. It's the 'can do' attitude. Nothing phased them. They listened to every quandary that we had and they problem solved it if they could."
Alison Berti, Team Manager, Integrated Discharge Team, William Harvey Hospital, East Kent university Hospitals NHS Trust

Future improvements

When asked about improvements to the Red Cross Winter Pressures service, should it be re-commissioned in future, interviewees put forward a number of suggestions, although it's not clear how feasible or realistic these are. For the most part, interviewee's suggestions centred on having increased Red Cross resource in future (some interviewees wanted 'more of the same' during the winter months and others wanted the service to be offered year-round) and/or extended hours. In some cases, this related to the practical realities of how a hospital operates, as illustrated in the following quotation:

"The Red Cross started at, I think, 11am and finished at 7pm. It meant they were inundated with referrals at 11am. We knew who we were going to have a problem with at 8am. Extended hours would have been better."
Alison Berti, Team Manager, Integrated Discharge Team, William Harvey Hospital, East Kent university Hospitals NHS Trust

Other suggestions put forward were:

- Red Cross staff and volunteers being trusted assessors for equipment to be installed in people's homes.
- A transport service which can manage people in wheelchairs and on stretchers.

When asked to reflect on whether their hospital would do anything differently should they receive the service again, several interviewees felt that they would, with experience, deploy the resource a bit differently, focussing on different wards/departments and/or types of patients e.g. 'frequent flyers'. One interviewee felt that earlier and more proactive communications with relevant hospital staff would be helpful, prior to the Red Cross service starting.

"As this was a new service, perhaps we didn't utilise it to its full potential. We could have focussed a little more on admission avoidance in our emergency departments. We should have had the support team [Red Cross staff and volunteers] walking around the site, being very visible to patients. We should have been more innovative, for example, Red Cross staff being buddied with specific wards, departments or matrons. We could have linked them to our 'frequent flyers', regular attenders at ED, to help align better with community support for these patients, and maybe prevent them from requiring a hospital attendance."
Mary Tunbridge, Managing Director, William Harvey Hospital, East Kent Hospitals University Trust

7. Service activity

Introduction

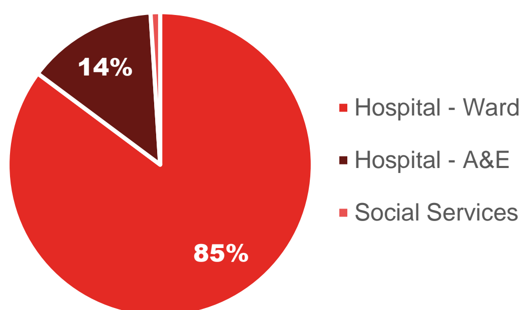
Case records in BRM, the internal Red Cross database, were analysed to identify the activities undertaken and the support that was provided to the people we supported. Table 5 identifies the hospitals that provided referrals into our service, and the Trust they are operated by. The majority of our services received referrals from more than one hospital.

Table 5 NHS Hospitals supported by Red Cross service

British Red Cross Service	NHS Hospitals supported	NHS Trust
Chester Assisted Discharge	Countess of Chester Hospital	Countess of Chester Hospital NHS Foundation Trust
East Riding Assisted Discharge Hull Assisted Discharge	Castle Hill Hospital Hull Royal Infirmary	Hull and East Yorkshire Hospitals NHS Trust
York Assisted Discharge	York Teaching Hospital	York Teaching Hospital NHS Foundation Trust
Lincolnshire Assisted Discharge	Lincoln County Hospital Pilgrim Hospital Boston	United Lincolnshire Hospitals NHS Trust
Shropshire Assisted Discharge	Royal Shrewsbury Hospital	Shrewsbury and Telford Hospital NHS Trust
Worcestershire Assisted Discharge	Alexandra Hospital Redditch Evesham Community Hospital Malvern Community Hospital Worcestershire Royal Hospital Kidderminster Hospital and Treatment Centre	Worcestershire Acute Hospitals NHS Trust
King's College	King's College Hospital	King's College Hospital NHS Foundation Trust
Lewisham Home from Hospital	University Hospital Lewisham	Lewisham & Green NHS Trust
East Kent Home from Hospital	William Harvey Hospital Queen Elizabeth The Queen Mother Hospital	East Kent Hospitals University Trust
QA Assisted Discharge	Queen Alexandra Hospital	Portsmouth Hospitals NHS Trust
Cornwall Home from Hospital	Royal Cornwall Hospital	Royal Cornwall Hospitals NHS Trust
Oxford Home from Hospital	John Radcliffe Hospital Horton General Hospital	Oxford University NHS Trust

Base: Case records in BRM and referring organisations

Figure 15 Source of referrals



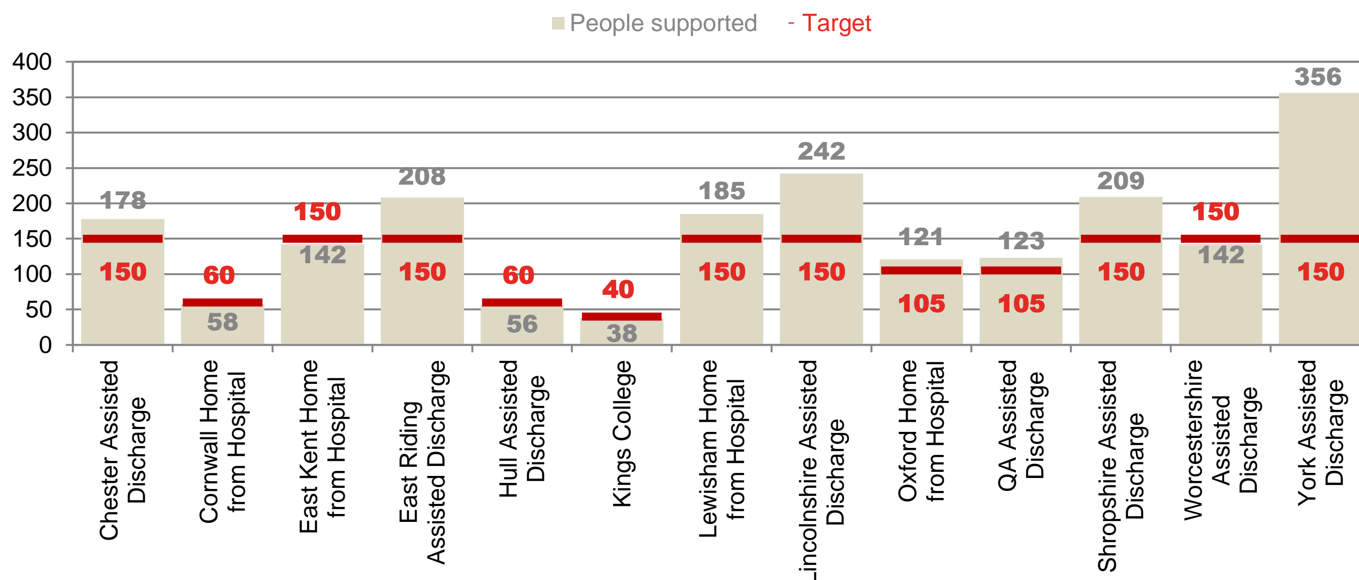
Base: 2,057 people supported between 1st January and 31st March with activity data

Figure 15 shows that the majority of people supported (85%, 1,738) were referred through hospital wards, including dedicated Discharge Lounges and Acute Medical Units. There were four people who self-referred, five people were referred through a GP, one person was referred by a charity and one person had an unknown referrer; these represent less than 1% of all referrals and are therefore not displayed in figure 15.

People we supported

Between 1st January 2018 and 31st March 2018 we supported 2,057 people across 13 NHS Hospitals in England, the breakdown and delivery against targets is identified in figure 16.

Figure 16 Number of people supported by NHS Hospital



Base: 2,057 people supported between 1st January and 31st March with activity data

Eight of our 13 services reached or exceeded their target for numbers of people supported. Five services supported slightly fewer people than their target; performance was still no less than 93% of the total target for each of these services. They were only 24 referrals short of target across all of these five services in total, and all five of these services had to decline support due to the referral not meeting service criteria, had support declined by the service user or were unable to provide support for another reason. Table 6 shows that the number of referrals received increased every month, by March the number of referrals received across all services had increased 44% compared to referrals in January.

Table 6 People support by month

People supported	January	February	March	Total
Chester Assisted Discharge	45	66	67	178
East Riding Assisted Discharge	49	59	100	208
Hull Assisted Discharge	13	17	26	56
York Assisted Discharge	91	137	128	356
Lincolnshire Assisted Discharge	64	82	96	242
Shropshire Assisted Discharge	56	72	81	209
Worcestershire Assisted Discharge	36	64	42	142
Kings College	23	9	6	38
Lewisham Home from Hospital	41	68	76	185
East Kent Home from Hospital	44	32	66	142
QA Assisted Discharge	35	48	39	122
Cornwall Home from Hospital	23	20	15	58
Oxford Home from Hospital	34	29	58	121
Total	**554**	**703**	**800**	**2057**

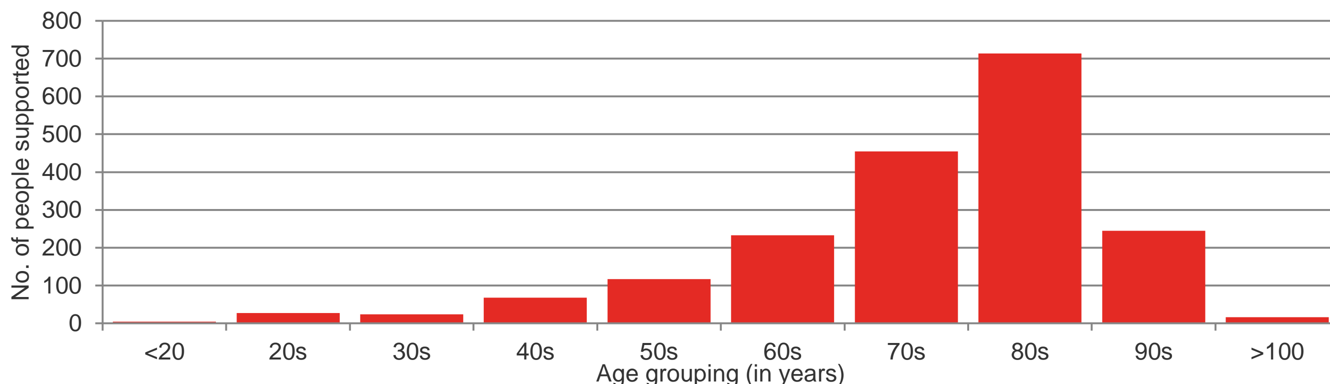
Base: 2,057 people supported between 1st January and 31st March with activity data

98% (1,984) of the people we supported were seen by our service for the first time on the day they were referred, a further 1% were seen the following day. The remaining 1% were seen up to eight days later. There were 30 records which had to be removed from this analysis as the first activity on their case record took place before the identified date of referral.

49% of the people we supported were female, and 45% were male; we have no recorded gender details for 6% of cases.

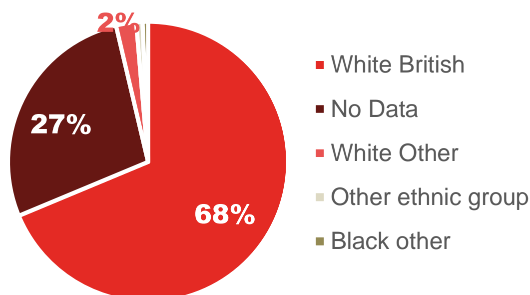
Figure 17 shows the number of people by age and clearly shows we were largely supporting an aging group of people, Over half (59%; 1,243) of the people we supported with valid age data were aged 75yrs or above; 17 of these were 100 years or older, three were 105 years old. At the younger end of the scale we supported 14 people who were 25yrs of age or younger, the youngest being 17 years old.

Figure 17 People supported by age



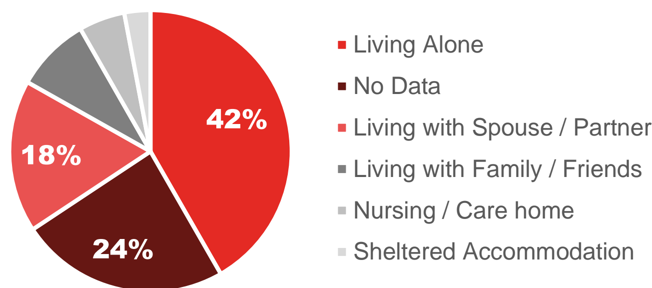
Base: 1,903 people supported with completed age data

Figure 18 Ethnic background of people supported



Base: 2,057 people supported; 561 people supported had no ethnic background data. Ethnic groups with less than <1% are not shown.

Figure 19 Living arrangements of people supported



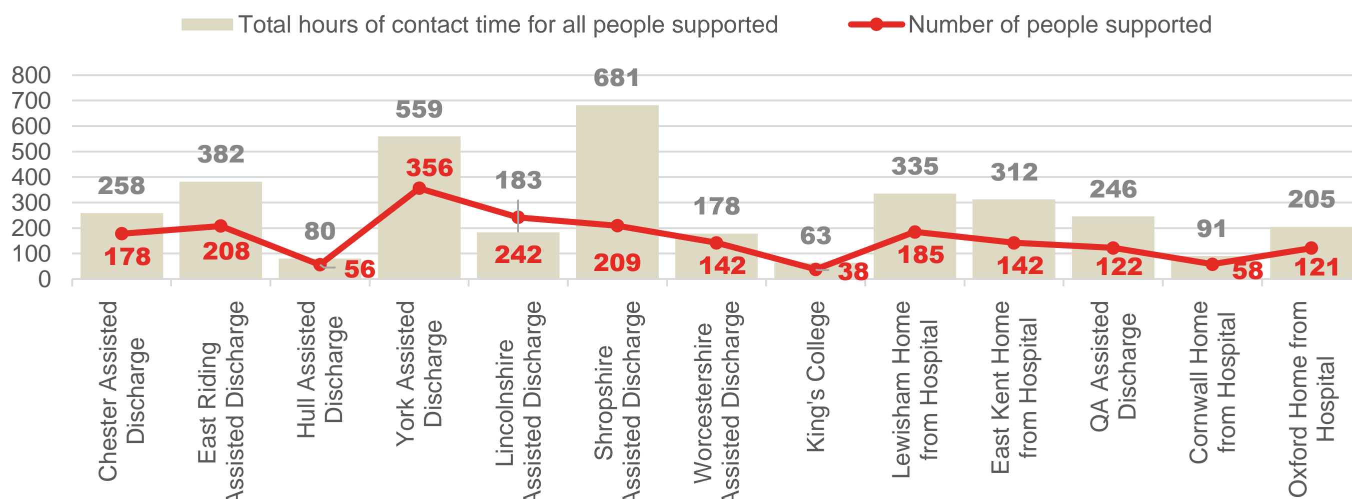
Base: 2,057 people supported; 503 people supported had no data on their living arrangements.

Figure 18 shows that over two thirds of the people we supported (68%; 1,391) were from a White British background; only 103 people were identified as coming from a minority ethnic background.

The support we provided

We spent at least 3,572 hours in direct contact with the people we supported through our Winter Pressures services; direct contact includes supporting people whilst they are still in hospital, taking or escorting people home after a hospital episode, supporting people in their home once back from hospital and providing support through telephone calls.

Figure 20 Total hours contact time and people supported by service

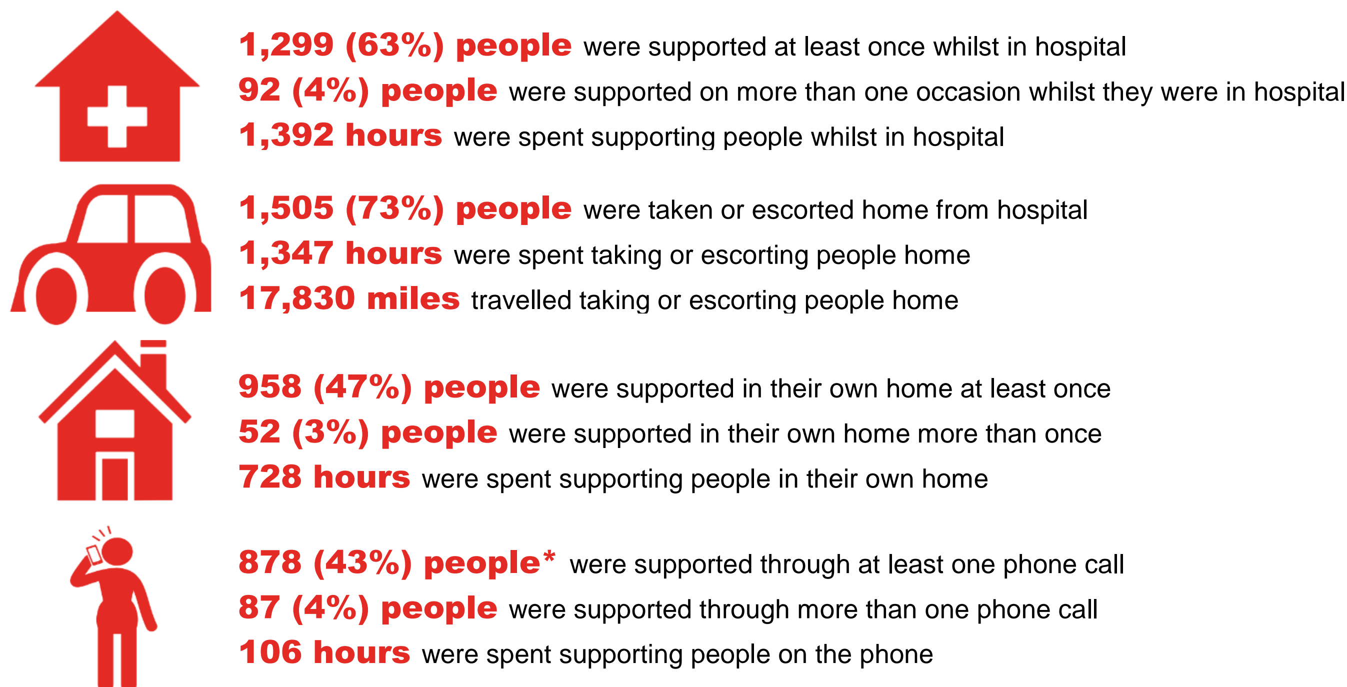


Base: 2,057 people supported.

Across all services we spent an average of 1 hour and 42 minutes with each person we supported, with support time ranging from less than an hour up to just under 170 hours. Figure 20 shows the total hours of contact time and the number of people supported for each service. The service in Lincolnshire spent the least amount of time with the people they supported, spending an average of 48 minutes with each person. The service in Shropshire spent the most amount of time in contact with the people they supported, with an average 3 hours and 18 minutes with each person.

Figure 21 provides some key statistics about how and where the direct contact time with people we supported was spent.

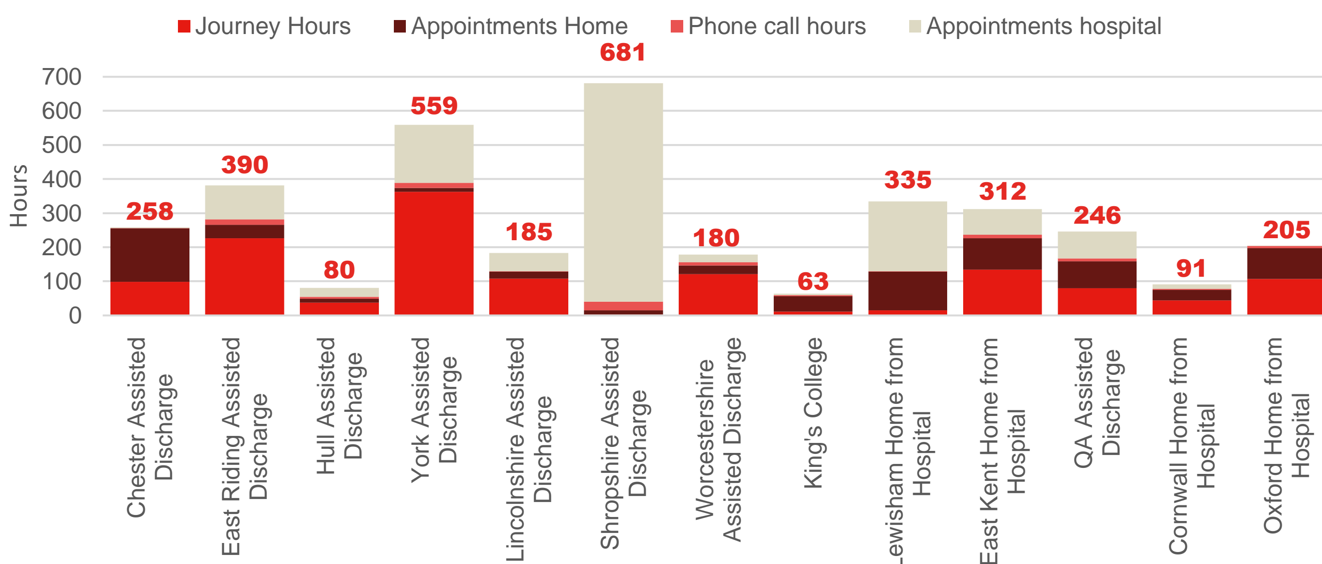
Figure 21 Key statistics by the type of direct contact activity



Note: Due to inconsistencies in data capture there are 10 journeys, 31 appointments and 22 phone calls which had no durations included in the activity record. Although every effort has been taken to clean the data, the inconsistencies in data capture may also mean that some activities have been included or excluded inappropriately. * Phone calls where there was no response from the person supported, or where messages were left for people supported were not included in these figures and so the figure for phone calls above only includes those calls where direct contact was made.

There was variability in the type of support provided by service, as illustrated in figure 22. All services delivered each activity type but the proportion of time spent on each activity type differed.

Figure 22 Total hours of support provided by service with activity type



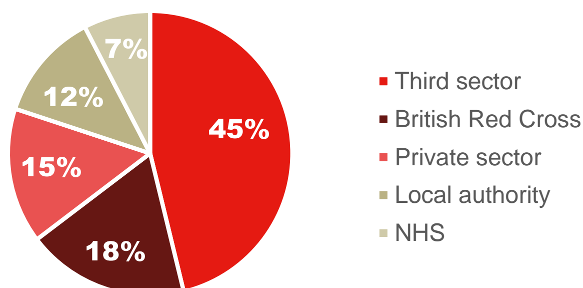
Base: 2,057 people supported. Due to inconsistencies in data capture there are 10 journeys, 31 appointments and 12 phone calls which had no durations included in the activity record. Although every effort has been taken to clean the data, the inconsistencies in data capture may also mean that some activities have been included or excluded inappropriately.

Services are also able to identify different tasks that they undertake with the people they support, many of which directly support and facilitate the discharge of patients from hospital. There is considerable variation in how these tasks are captured in BRM which means providing accurate numbers of people supported in this way is not possible, but we can identify the range of tasks undertaken:

- **Collecting and delivering medication** from the hospital pharmacy and delivering these to the people we supported whilst they were still in hospital or delivering them to people's homes if they had already been discharged.
- **Collecting and delivering equipment** to people in their own homes or in hospital, overseeing the delivery of equipment by a third party at peoples' homes to facilitate their discharge from hospital, and transferring equipment between hospitals.
- **Undertaking or overseeing minor adaptations or modifications in peoples' homes** such as moving furniture, overseeing the installation of pendant alarm systems and undertaking home safety checks to help ensure the patient can return to a safe home environment.
- **Transferring medical records and notes** within or between hospitals.
- **Doing or collecting shopping on behalf of or with the person supported** to ensure they had food to eat immediately upon their return home from hospital.
- **Liaising with people's next of kin** in order to facilitate their discharge from hospital.

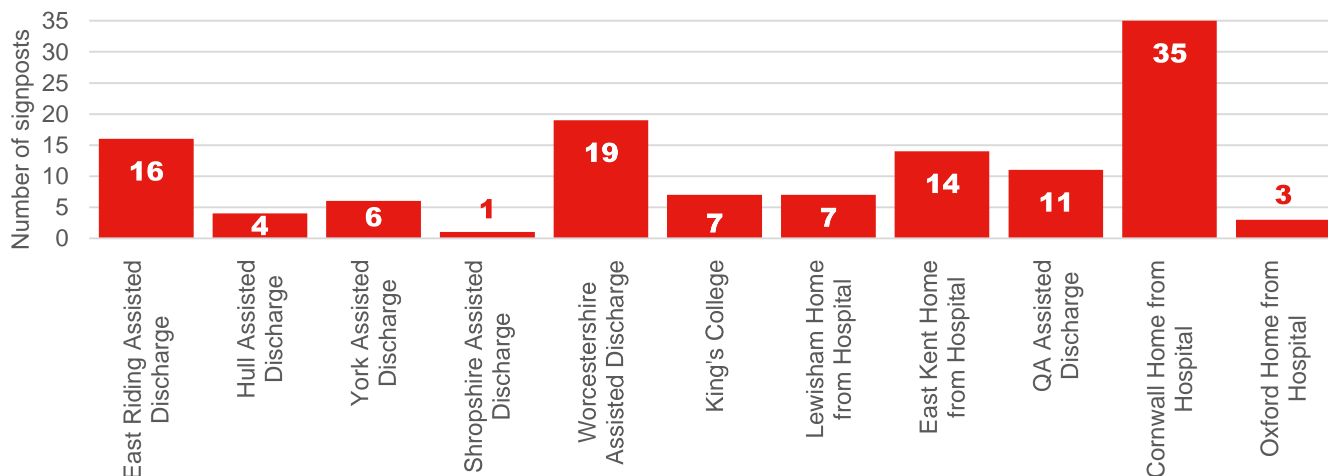
Services also supported people through signposting them to other organisations who may be able to provide support for them. Overall, a total of 123 signposts or referrals were recorded for 98 people we supported (5% of people supported). The types of organisations people were signposted to can be seen in figure 23. The majority (45%; 58) of signposts were to third sector organisations, and within this almost half were made to Age UK. For seven people a signpost was the only activity attached to their case record. As with the other types of support provided, there is inconsistency in how signposting activity is captured and although every attempt has been made to clean this data and identify signposting actions which may not have been recorded correctly it is still likely that this the following figures underestimate the true extent of our signposting activity.

Figure 23 Signposts by type of organisation



Base: 123 signposts recorded in case files

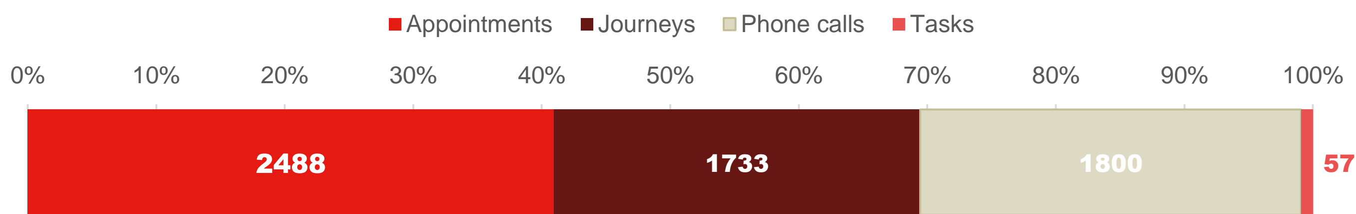
Figure 24 Signposts by service



Base: 123 signposts recorded on case records. Includes explicit signposting actions. Although every attempt has been made to clean this data and identify signposting actions which may not have been recorded correctly inconsistencies in data capture mean it is still likely that these figures underestimate the true extent of our signposting activity.

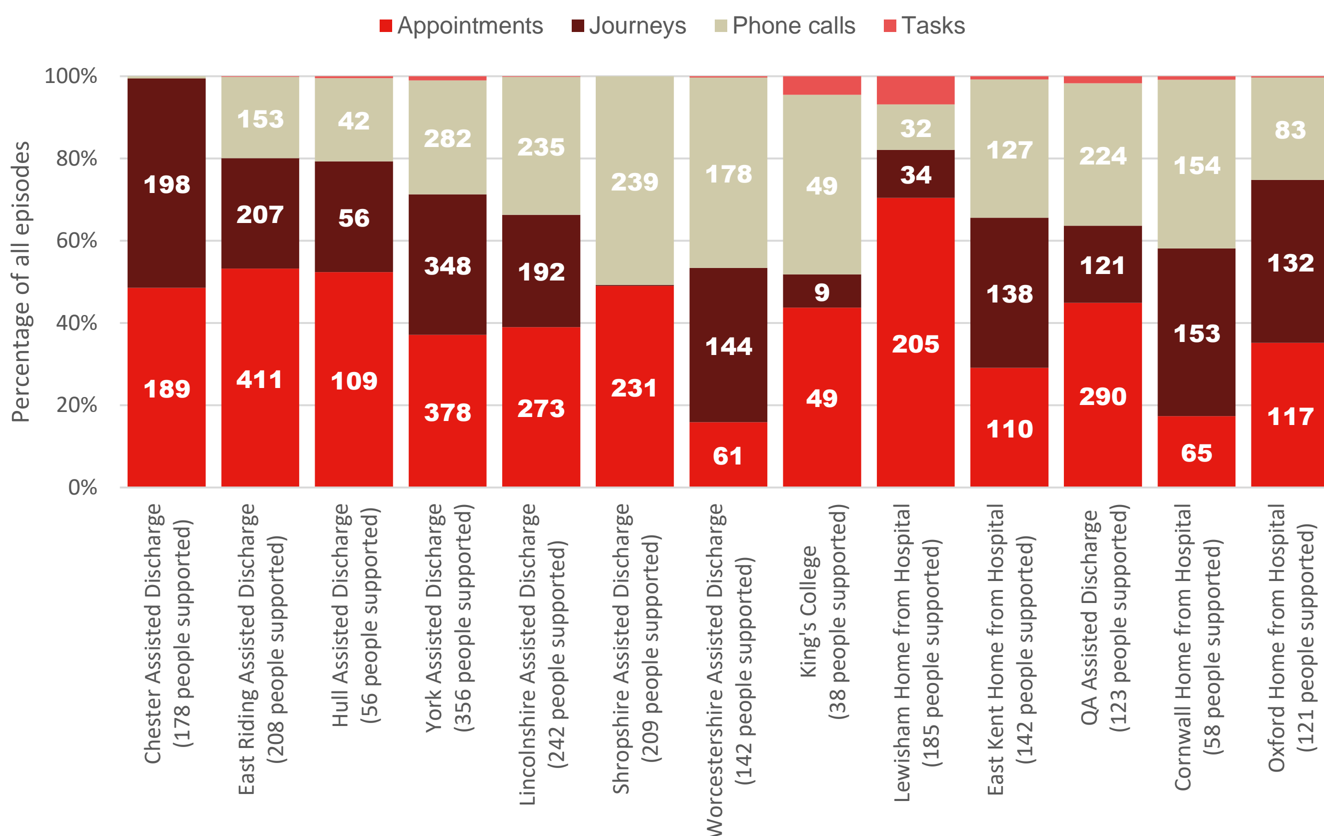
Each of these different types of activity i.e. appointments in hospital, journeys home, appointments at home, telephone calls and tasks can be identified as an episode of support. Signposts are excluded from this as they should be delivered through or during one of the other activity types hence including them would double count them as episodes. Overall, we delivered 6,078 episodes of support, the breakdown of these episodes by activity type is illustrated in figure 25, with the breakdown of these by scheme show in figure 26.

Figure 25 Episodes of support by activity type



Base: 2,057 people supported. Although every effort has been taken to clean the data, inconsistencies in data capture may mean that some activities have been included or excluded inappropriately.

Figure 26 Breakdown of episodes of support by scheme



Base: 2,057 people supported. Although every effort has been taken to clean the data, inconsistencies in data capture may mean that some activities have been included or excluded inappropriately. Appointments includes appointments in hospital and in the service users' home.

8. Context of Winter Pressures 2018

Introduction

During winter the NHS collect and publish daily situation reports from acute Hospital Trusts. These reports indicate where there are pressures on the NHS around the country in areas such as breaches of the four-hour waiting time, ambulance handover delays and general and acute bed capacity. These reports have been analysed to identify trends in those Trusts where a Red Cross Winter Pressures service was operating compared to other Trusts where there was no dedicated Red Cross Winter Pressures service.

Accident and Emergency closures and diverts

Accident and Emergency departments might be closed temporarily when patient safety is compromised due to overwhelming demand or an incident at the Trust. At times of peak demand or in response to an incident, new arrivals to Accident and Emergency (either ambulance or walk in) might be diverted to another department. Diverts occur for short periods of time so one Trust might report multiple diverts on any given day. While reducing pressure on the diverting hospital, diverts increase pressure on the receiving hospital and so they are a good indicator of overall pressures on the system.

As identified in table 8 the majority of Trusts experienced no Accident and Emergency diverts or closures in winter 2017/18. There were slightly fewer diverts and no closures in Trusts where our services were present.

Table 7 Accident and Emergency diverts and closures during winter 2017/18 by Trusts in which Red Cross operated services or not

Red Cross present?	Diverts			Closures		
	Median	Max.	Standard deviation	Median	Max.	Standard deviation
No	0	9	0.19	0	1	0.01
Yes	0	5	0.52	0	0	0.00

This pattern was reversed over the winter of 2015/16, where there were more diverts in the Trusts where a Red Cross service was present.

Table 8 Accident and Emergency diverts and closures during winter 2015/16, split by Trusts in which Red Cross operated services or not

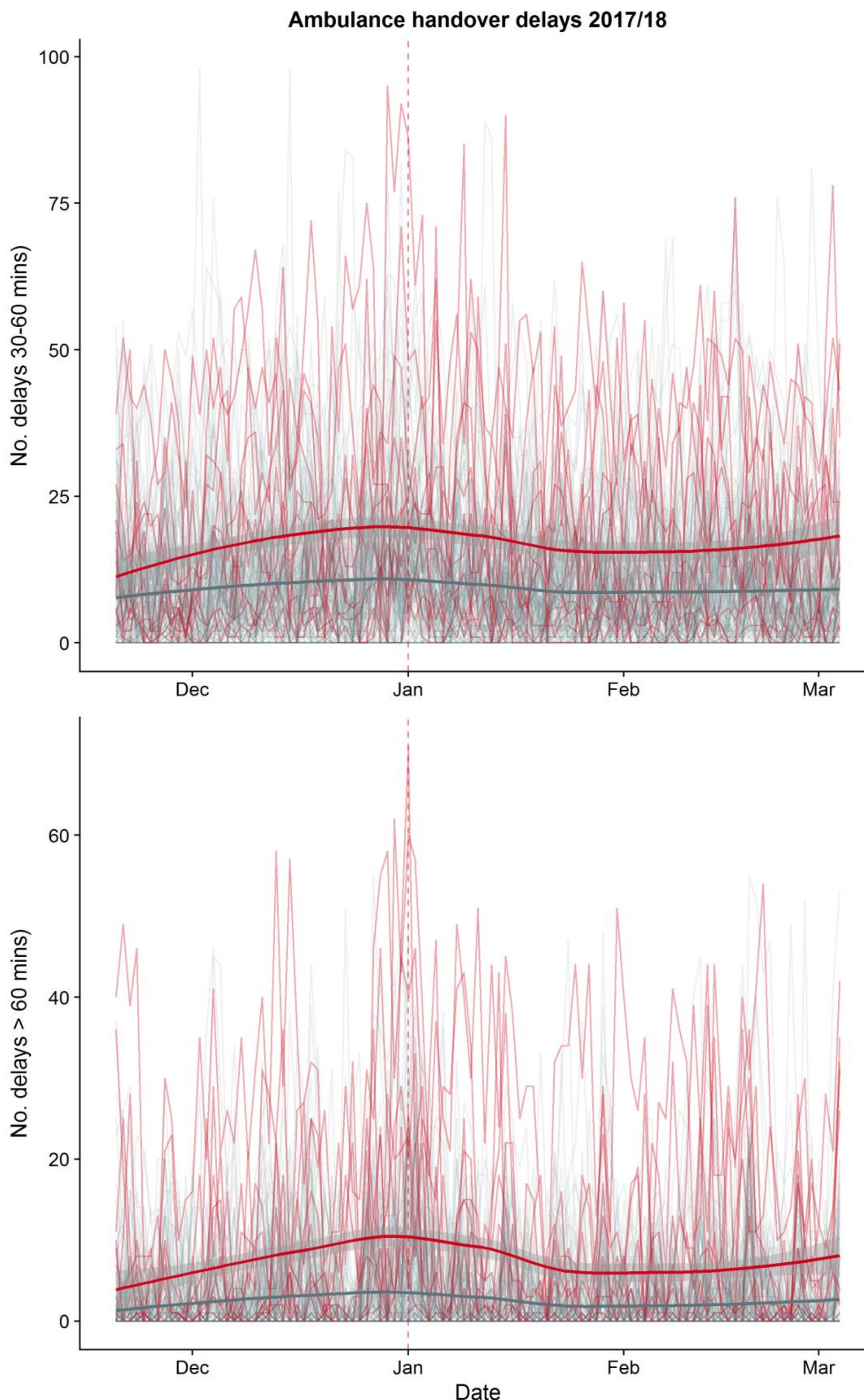
Red Cross present?	Diverts			Closures		
	Median	Max.	Standard deviation	Median	Max.	Standard deviation
No	0	9	0.19	0	1	0.01
Yes	0	5	0.52	0	0	0.00

Ambulance handover delays

Transferring a patient from the care of ambulance staff to the care of Accident and Emergency staff should take no more than 15 minutes. Over winter, there are frequent handover delays of more than 30 minutes or more than an hour. These delays do not necessarily mean that people were waiting in ambulances; they may have been moved into the Accident and Emergency department but the handover to department staff might not have been completed. This is considered a significant indicator of Winter Pressures as it shows not only how stretched Accident and Emergency departments are but also reduced availability of ambulances to respond to other calls.

Figure 27 shows ambulance handover delays through the Winter Pressures period in Trusts where there was a Red Cross Winter Pressures service and all other Trusts. This shows that although on average the number of handover delays was reasonably low, there was a lot of peaks during the course of winter meaning large numbers of people experienced delays on a regular basis. There was a swell in delays on New Year's Eve and generally around late December/early January. Overall, the Trusts in which our services operated featured higher numbers of handover delays compared to the England average. When it comes to bed occupancy, figure 27 also shows that the Trusts in which our services operated had higher bed occupancy rates compared to other Trusts.

Figure 27 Ambulance handover delays of greater than 30 minutes (top panel) and longer than an hour (bottom panel). Thin red lines show Trusts in which a Red Cross service was present. Faint grey lines show all other Trusts. The thick red and grey lines show average bed occupancy rates in Trusts where Red Cross services were operating and all other Trusts, respectively.



Note: The dashed line shows 1st January 2018.

9. Internal lessons learnt workshop and feedback

Introduction

In winter 2017 Red Cross submitted a proposal to NHS England and secured funding to provide Winter Pressures support in 13 hospitals in England between January and March 2018. This included up scaling some existing services and creating new services where there was no current provision. Services facilitated the discharge of people from hospital through an Assisted Discharge and/or Home from Hospital service model.

This paper draws together findings from a range of sources:

- A lessons learnt workshop attended by operations colleagues from five of the 13 services and a range of colleagues from supporting functions.
- Conversations with other Red Cross colleagues, teams and services.
- Requests from and conversations with NHS England stakeholders.
- Feedback from operational teams gathered through the wash up phone calls.
- Desktop review of key operational documents.

What follows is a summary of the key operational lessons learnt and recommendations for action which arise from them, identifying timeframes, action owners, independent functions/teams and links to other recommendations.

A key recommendation of this report is to continue the working group throughout 2018 in order to support and implement the recommendations detailed throughout.

Commissioning and Operational Planning

Lessons learnt:

- A requirement to maintain and update the contracts database to ensure consistency of information regarding current contracts to inform decision making.
- To develop clear one page service models with a core offer to support consistent messaging around service models, a national financial model, and sharing with operational teams to ensure consistency of approach.
- To retain flexibility in the delivery of models, to ensure operational delivery is based on the needs of the hospitals supported.
- Undertake competitor analysis to ensure the 'added value' and flexibility of Red Cross offer; identify where other voluntary sector or commercial organisations are engaged or preferred.
- To identify in advance of future responses , where possible, where NHS England have existing Winter Pressures funding and where this may overlap/compete with Red Cross offer.
- Identify possibilities for continuation funding delivered to schemes at the commencement of any winter response.
- Continue to support 'winter' planning throughout 2018/19 via a Winter Working Group.
- To develop action planning based on 2018/19 delivery, to inform the development of a comprehensive improved plan for 2018/19, continuing the Winter Working Group to inform and drive developments for winter 2018/19.

Table 9 Commissioning and operational planning recommendations

Recommendation	Timeframe	Owner	Dependencies	Links
#1 Develop suite of materials defining our services and key messages.	May	Working group	Operations / I&I / Finance / Comms	#7
#2 Scope and develop a national proposal for NHSE to support Winter Pressures 2018/19 and present to NHS England in advance (to include area /regional proposals).	June – August	Working group	Operations / I&I / Finance	#8 #10
#3 Continue the Winter Working Group throughout 2018, and assign ownership of lessons and next steps.	May	Alison Kaye	Working group	
#4 Develop a national action plan to describe and define our approach for winter 2018/19 including the implementation of the lessons and recommendations of this report.	August	Working group	Operations / P&A / Comms / I&I	#6 #10

Implementation and Delivery

Lessons learnt:

- A consistent approach via weekly implementation calls was successful, practical questions could be answered; documents provided and facilitated sharing practice between services.
- A flexible operational model adapted to meet demand for referrals and needs of service users was well received by hospitals.
- To ensure we are matching the capacity of our model to demand across all services.
- Greater guidance and communication of the service model for services by providing clarity of referral criteria and referral source.
- Provide clarity regarding under achievement of targets in relation to any impact on receipt of finance and impact of over achievement of targets i.e. financially and internal and external messaging.
- Clarifying GDPR implications for use of phones, and personal devices, to communicate referrals and issues between team members, is needed for subsequent delivery.
- A requirement to review connectivity in hospitals and remote working accessibility.
- Improve joined up working between Independent Living and Crisis Response/Emergency Response, including mapping where Emergency Response teams are supporting Winter Pressures teams and aligning working practices to maximise resources.
- Prepare hospitals for service closure at the end of Winter Pressures to reduce disappointment and manage reputational risk. Of particular importance for upscale services which need to reduce capacity and manage additional demand after closure.

Table 10 Recommendations for implementation and delivery

Recommendation	Timeframe	Owner	Dependencies	Links
#5 Develop mechanisms for sharing good practice and lessons learnt internally across the UK	May	Working group	Operations / I&I / Comms / I&PS	#4

Recruitment and Resourcing

Lessons learnt:

- A longer lead in time would ensure usual practices for recruitment could be followed and reduce the additional pressure felt by services during peak times.
- To centralise the recruitment of agency staff and provide dedicated additional capacity to area teams to help achieve consistency of processes and quality of people recruited.
- Contingency planning for additional capacity to support services operationally.
- To cover staff absence through illness or annual leave throughout implementation.
- Clarity on processes for recruiting volunteers as casual staff and terms of reference for staff taking on additional hours to minimise the impact on teams.
- Identifying key activities for staff and volunteer induction and training in order to provide consistency. Suggestions include BRM training for new starters, a national ‘orientation’ to Winter Pressures services and the inclusion of Crisis/Emergency Response.

Operational Data and Reporting

Lessons learnt:

- Weekly reporting was successful in helping teams to manage service performance against targets and identify gaps in data so they could be resolved quickly.
- Data lag was reduced as teams could see when and how their data was being used, people could see the value in BRM and their confidence in it increased. Towards the end of the project the reported data on the implementation calls was lower than BRM indicating a shift in the speed with which data was being input.
- BRM guidance was seen as helpful - upscale services required clearer guidance on how to differentiate referrals between their business as usual and Winter Pressures services to avoid confusion and data discrepancies.
- Enabling on site data input to BRM system to improve the speed of input and reduce retrospective data entry burden.

Evaluation and feedback

Lessons learnt:

- Releasing evaluation data throughout the period of operational delivery to support local teams to have informed discussions with commissioners.
- Identify the impact of upscale services from their business as usual performance. To be used by new schemes to understand how they can become business as usual and prepare for surge in readiness for next winter.
- Develop a consistent set of evaluation tools that enable presentation of successes, key impact and learning to a wider audience.
- Share tools across all directorates; operations, communication and marketing, policy and advocacy and business development.
- Undertake a thematic analysis of case studies, aligned to findings from the In and Out of Hospital report recommendations, to support development of policy and advocacy messaging.
- To publish the evaluation report widely and raise the profile of evaluation for winter 2018/19 via a range of media and key stakeholders.

Table 11 Recommendations for evaluation and feedback

Recommendation	Timeframe	Owner	Dependencies	Links
#6 Develop evidence based tools, including potential financial savings/return, to support key external messaging e.g. WebEx.	May – September	Donna Clarke Alison Kaye	I&I / Comms / Operations	#9 #2
#7 Include thematic analysis of case studies, service user feedback and service provider feedback as part of evaluation.	April – June	Donna Clarke	I&I / P&A / Comms	#11
#8 Undertake evidence planning alongside development of proposal for 2018/19.	June – August	Donna Clarke	P&A / Comms	#2 #4 #9
#9 Review the evaluation timeframe to ensure published data is timely.	June - August	Donna Clarke	I&I	#8

External Relationships and Communications

Lessons learnt:

- Top down national/regional communication from NHS England winter director or a Hospital-based Director helped boost referrals. Ensuring this happens before implementation clarifies Red Cross service presence and ensures referrals from the outset and would avoid difficult early conversations with hospital staff.
- Greater clarity and awareness of communication and advocacy messages around Winter Pressures, particularly amongst front line staff, to ensure consistency between local and national messaging.
- Communications team needed to understand the impact of the change we wanted to make, and then have the data collected to provide evidence of this in their work. Using advocacy calls and evaluation data together will create a stronger communication message.
- Move away from 'Winter Pressures' messaging and identify how we can better message that we are there to support year round, and can upscale and surge our services as needed.
- Conversations at local and national level require the same message to ensure consistency.
- Clarity about how we message work with Emergency Response teams as we already provide support in winter.
- There is a political context to Winter Pressures which affects how our services are received; this can be difficult to predict in advance. We need to be aware of how we can be portrayed when supporting the NHS.
- Ensuring we make link to local Winter Pressures services to local MPs and other relevant stakeholders.

Table 12 Recommendations for external relationships and communications

Recommendations for action	Timeframe	Owner	Dependencies	Links
#10 Develop a joint plan for external messaging nationally and locally. To include: full stakeholder mapping, advocacy and communication messages, review of existing external communication mechanisms and development of data framework to evidence. (includes fundraising).	June onwards	Working group	Comms / P&A / Operations / Fundraising / I&I	#8

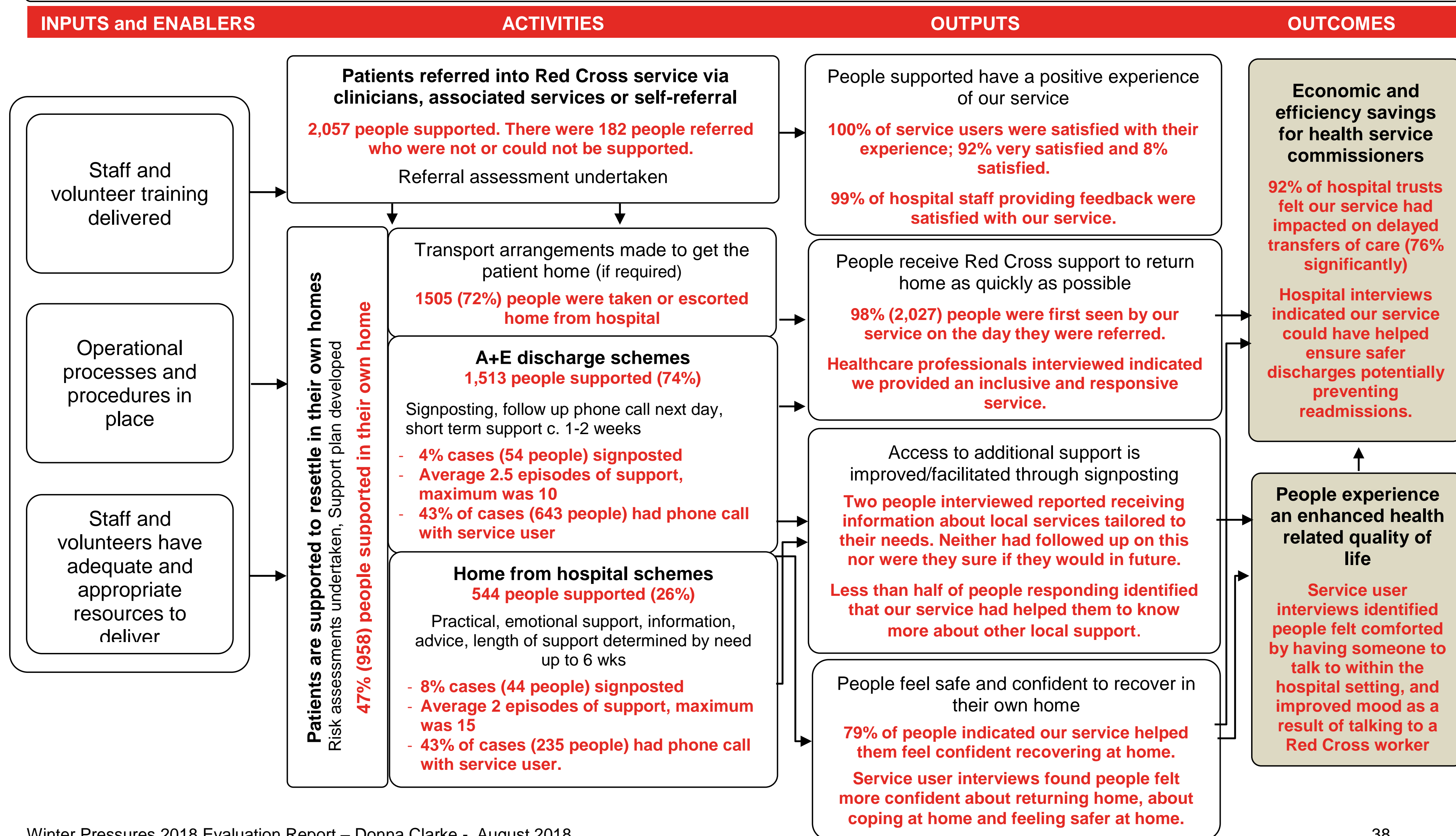
#11 Consider scoping and developing a new or improved shared system/processes to map external conversations with providers, commissioners and other stakeholders.	June onwards	BDPM Network	BDPM Network	**#2** **#4**

Appendix 1: Independent Living Assisted Discharge/Home from Hospital - Theory of Change with Winter Pressures Evidence

Identified need: Red Cross is working alongside health commissioners and local authorities in the health and social care sector which is increasingly under pressure due to funding cuts and increased demand for services.

Our goal: To support people to recover from a health crisis in their own homes and regain their independence, whilst consequently reducing the burden on the health and care services within which British Red Cross services are operating.

INPUTS and ENABLERS | ACTIVITIES | OUTPUTS | OUTCOMES



Appendix 2: Winter Pressures Data Capture Recommendations

Introduction

This report has been written following analysis of operational data for the evaluation of the 2018 Winter Pressures services. It identifies issues related to our data capture and reporting and the implications of the issue. It also provides some recommendations in response to the issue which are aimed at improving the validity and reliability of our monitoring and evaluation of these services by:

- Suggesting new data that we need to collect to provide evidence against the service theories of change.
- Providing suggested definitions and guidance to improve the consistency of data capture.

These recommendations need to be considered as a priority and responses provided as to the feasibility of implementation. A timetable for implementation should be developed, along with a series of guidance tools and resources to support implementation both of which are tested thoroughly in a small number of services before national roll-out. Service managers should routinely monitor compliance to the new guidelines. New reports can then be developed that align to the service model theories of change and provide regular feedback for teams on their service delivery.

1. Process of data capture

<table>
<tr><th>Issue no.</th><th>Issue summary</th><th>Implications</th><th>Relevant BRM fields</th></tr>
<tr><td>1.1.</td><td>People are required to or are recording activities or elements thereof in multiple areas of BRM.</td><td>Inefficient data capture requires more time and increases the chance of inconsistent unreliable data being recorded, affecting the reliability of the monitoring and evaluation of services.</td><td>Case record and Activities tables</td></tr>
<tr><td colspan="4">Recommendation(s) for data capture
- A data capture form should be developed that enables all necessary reporting from an episode of support to be entered in one place, but stores the data within the relevant activity data table (i.e. appointments, journeys, phone calls, signposts, tasks)
- If possible the form should be dynamic and provide the fields to be recorded based on responses to filter questions. For example, is someone selects to record a journey, they enter the required information and are then asked if this journey includes resettlement. If they respond with yes, the fields required to enter an appointment are then displayed on the form. The following interdependences have been identified but may not be limited to:
1. Journeys with resettlement, tasks and signposting
2. Appointments with tasks, journeys and signposting
3. Phone calls with tasks and signposting
- Stand-alone inputting should be retained for tasks.
- Signposting should not be permitted as a stand-alone data entry form, this should also be linked to some form of direct contact with service users.</td></tr>
</table>

2. Referral forms

Issue no.	Issue summary	Implications	Relevant BRM fields
2.1.	Inconsistent or lack of reporting on preventative outcomes of Red Cross support. No fields within BRM to enable this to be captured where it is recorded.	Economic assessment can only be made on national assumptions with no input from NHS partners.	Case record

Recommendation(s) for data capture

- All services should capture information from the NHS provider making the referral to help support us in reporting against our identified outcome of delivering efficiency savings for our NHS partners. It is proposed that this includes the following questions: (All response options: Yes definitely; Yes maybe; No; I don't know)
  1. Will referral to this service help to reduce the length of this persons hospital stay? (Only to be asked for referrals from inpatient/discharge wards)
  2. Will referral to this service help to prevent an inpatient admission for this person? (Only to be asked for referrals from Accident and Emergency)
  3. Will referral to this service help to prevent a delayed transfer of care for this person?
  4. Will referral to this service help to ensure a safer discharge for this person?
- New fields should be created to enable responses to be captured in BRM.

3. People supported

Issue no.	Issue summary	Implications	Relevant BRM fields
3.1.	Referrals being flagged as accepted when no support was provided. The reasons for no support were varied and captured in a variety of different free text fields. There was no consistency in how this was recorded	People are being incorrectly included in reach figures leading to unreliable and inaccurate reporting on the number of people supported.	Assessment result; Case status; Case closure reason

Recommendation(s) for data capture

- We need to distinguish between referrals accepted but no support was provided. The options on the Assessment result field could include the following categories to:
  1. Declined - by service user
  2. Declined - does not fit service criteria
  3. Declined - for identified risk
  4. Declined - due to service capacity
  5. Pending - due to service capacity
  6. Pending - due to service user needs
  7. Accepted for support
  8. Failed referral – no contact (to be used where contact with service user could not be established to provide or plan support)
  9. Failed referral – no longer required (to be used where not receiving support from Red Cross was a choice of the service user)

10. Failed referral – no discharge (to be used when supporting people out of hospital and discharge was delayed by hospital)

- Assessment result field should be updated when required, so for example, if a referral has been accepted the Assessment result should be set to Accepted for support, if the service user referred could not be contacted this should then be set to Failed referral – no contact.
- Case status would default to Closed for those referrals where the Assessment result is declined, failed and pending, and default to Open where a case Assessment result is Accepted for support.
- Case closure reason would only apply to people who have been flagged as Accepted for support. The case closure reason categories could include the following:
  1. End of agreed provision (to be used where people have completed their planned period of support from the Red Cross regardless of duration);
  2. Early termination – service user need intensified (to be used need exceeded what the service could provide before end of planned provision);
  3. Early termination – service user admitted to hospital;
  4. Early termination – death of service user;
  5. Early termination – service user choice (to be used where service user chooses to end support before initially agreed date);
  6. Early termination – lost contact (where the agreed support has not been completed but the service user cannot be contacted to arrange support. To be used after and agreed period of time has elapsed or a set number or process of actions have been attempted to establish contact).

4. Appointments

<table>
<tr><th>Issue no.</th><th>Issue summary</th><th>Implications</th><th>Relevant BRM fields</th></tr>
<tr><td>4.1.</td><td>Service are inconsistently recording resettlement when taking or escorting people home from hospital.</td><td>Under-reporting of support provided, this consequently impacts confidence in assumptions for economic assessment.</td><td>Appointments: Appointment Subject, Appointment location</td></tr>
<tr><td colspan="4">Recommendation(s) for data capture
> When taking or escorting service users home from hospital and accompany the service user into their home and undertake related tasks this must be recorded as a separate appointment with the Appointment location field set to Service user home.
> The Appointment subject field should include the following options:
1. Assessment or support planning (to be used for the first session with service users where assessments and support planning take place)
2. Resettlement (to be used when taking or escorting the service user home from hospital and service user is accompanied into their home, should also be used where we meet service user at home upon their discharge where we are not involved in the journey)
3. Review (to be used for the last session of the agreed provision where goals are reviewed and end of intervention measure)
4. Ongoing support (to be used for sessions which form part of the follow on practical and emotional support required and planned)
5. Other, with free text description field when this option is selected to provide further details.
> Where a service user does not want to be accompanied into their home then no resettlement appointment should be recorded.
> No appointment should be logged when collecting someone from hospital as part of their journey home.</td></tr>
<tr><td>4.2.</td><td>Appointment end dates being set before a start date, or end dates being incorrectly identified.</td><td>The hours spent supporting service users is over or underestimated.</td><td>Appointments: Start date, End date</td></tr>
</table>

Recommendation(s) for data capture > Data validation is applied to the date fields to identify the following: 1. Start dates are within the same calendar year as the date of entry. 2. End dates are on the same day as the start date.			
4.3.	Appointments are being used to record activities which involve no face to face contact time with service users.		Appointments: All fields
Recommendation(s) for data capture > Appointments are only used to record the face to face contact time with service users. Any other activities should be recorded as either phone calls, journeys or tasks.			
4.4.	Potential inconsistent recording of contact time with service users where they are supported in locations other than hospital or home, other field with free text used to specify location.	Difficult to identify when we are supporting service users into community activities/groups.	Appointments: Appointment location
Recommendation(s) for data capture > Appointment location field could have the following response options: 1. Service user home 2. Hospital 3. Community activity/group (to be used when we have accompanied service user to a purposeful group/activity for them to engage in/with, even if contact episode started at service user home) 4. Community venue (to be used when attending community venues but with no specific engagement opportunity e.g. coffee shops, walks, even if contact episode started at service user home) 5. Red Cross office 6. Statutory care service (to be used when we escort people to subsequent medical or social care appointments, e.g. GP, dentists, hospital outpatients, social care meetings, care home visits) 7. Other, with a free text box to specify other location. > Remove requirement to report on travel time as part of this activity. Travel time should be mapped as a journey. See subsequent issues and recommendations.			

5. Journeys

Issue no.	Issue summary	Implications	Relevant BRM fields
5.1.	Some journeys were entered as tasks when transport was provided home from hospital and some journeys which did not involve a service user directly were mapped as a journey.	Number of journeys and time spent in contact with services users is underestimated; inclusion of inappropriate journeys means contact time is overestimated.	Journeys: Journey subject, Journey from, Journey to, Duration
Recommendation(s) for data capture			

- Where we have transported or escorted someone as part of their support provision this must be recorded as a journey. Return journeys back from taking or escorting someone home from hospital or another location should not be recorded if there was no service user in the vehicle.
- Include a new field which identifies the vehicle used to undertake the journey, this will help identify where we are using Red Cross vehicles, volunteer/staff vehicles or taxis. The response options could include:
  1. Red Cross owned/leased vehicle
  2. Staff/volunteer owned vehicle
  3. Taxi
  4. Other, with free text field to specify details
- Journey subject should help identify the rationale for the journey, this will help identify whether this is transport provided as an element of service delivery, or transport which facilitates other elements of support to be provided. The response options could therefore be:
  1. Facilitate discharge (to be used to identify where we have transported or escorted someone home from a hospital episode and this facilitates their discharge from hospital)
  2. Attendance at health/care provider (to be used where we are transporting people to and from other health appointments, hospital outpatients, GP appointments, social care or social services appointments)
  3. Facilitates community engagement (to be used where we are transporting people to facilitate their engagement in community activities/groups or support from other community based non-statutory providers)
  4. Other, with free text field to specify details.
- Consider enforcing completion of the mileage field. If mileage is recorded for vehicle logs this could be usefully included in BRM, this would allow an accurate reporting of mileage covered. This can only be reported currently for journeys home from hospital to service user home using postcodes for hospital and service users' home address. This can lead to inaccurate reporting where people are transported to temporary living accommodation or train stations etc.

6. Phone calls

Issue no.	Issue summary	Implications	Relevant BRM fields
6.1.	Difficult to identify the purpose of the phone call and distinguish those made as part of safe and well follow up from those which form part of ongoing support provision.	Cannot specifically identify how many safe and well phone calls are being made or ongoing support provided through phone calls which affects evaluation of service model effectiveness.	Phone calls: Phone call subject

Recommendation(s) for data capture

- Phone call subject needs to identify type of provision against service model, response options should be amended to include the following:
  1. Safe and well follow up call (to be used for Assisted discharge services where a safe and well follow up phone call should be undertaken the day after discharge)
  2. Assessment or support planning (to be used when the assessment or support planning is undertaken over the phone)
  3. Ongoing practical and emotional support (to be used when the phone call forms part of the support provision and provides emotional and practical support, including signposting and providing information on other support services. Only to be used for phone calls with service user)

<table>
<tr><td colspan="4">4. Administrative (to be used when the call is to arrange/confirm subsequent support provision but is not an assessment or support planning call)
5. Review (to be used for the last contact of the agreed support provision where goals are reviewed and end of intervention measures collected)
6. Other, with free text field to specify details.
> Phone calls to receive referrals into our services should not be recorded.</td></tr>
<tr><td>6.2.</td><td>Phone calls are being recorded as complete when no contact has been established.</td><td>Inaccurate reporting of support provided via phone calls.</td><td>Phone calls: Phone call subject</td></tr>
<tr><td colspan="4">Recommendation(s) for data capture
> Phone calls should only be recorded when contact has been successfully established. Phone calls where there was no reply from the intended recipient should not recorded. Phone calls should not be recorded where voicemail messages have been left.</td></tr>
</table>

7. Signposting

<table>
<tr><th>Issue no.</th><th>Issue summary</th><th>Implications</th><th>Relevant BRM fields</th></tr>
<tr><td>7.1.</td><td>Evaluations indicate that signposting is being under-reported in BRM.</td><td>Affects the evaluation of our service model, by creating false findings.</td><td>Signposting</td></tr>
<tr><td colspan="4">Recommendation(s) for data capture
> A clear definition of signposting needs to be developed and circulated to identify what can be validly reported as a signpost, for example, does simply telling someone about a service/activity/group count as signposting? Does a signposting need to include the provision of some sort of documented information (hard copy or e-format) which can be left in the possession of service user for later reference?
> All signposting as per agreed definition must be recorded.
> One signposting activity should be recorded for each individual organisation/group/activity that the service user is given information about.</td></tr>
<tr><td>7.2.</td><td>Difficult to identify the types of organisations/groups/activities we are signposting people to.</td><td>Not easy to understand the needs of our service users, improving this will support our advocacy work, identify gaps in support where Red Cross could develop an offer and inform development of existing services.</td><td>Signposting</td></tr>
<tr><td colspan="4">Recommendation(s) for data capture
> Include a new mandatory field to identify the type of organisation the person is being signposted to. This should include the following categories:
1. British Red Cross
2. NHS
3. Local authority
4. National government
5. Third sector</td></tr>
</table>

<table>
<tr><td>
6. Community group
7. Private sector
8. Other, with free text field to specify details
> Include a new mandatory field to identify the secondary category of the organisation and the more specific details about the population they serve or other related factors. The full list of these is included as an appendix.
> Review the other categories on an annual basis to identify trends which would indicate creating a new primary or secondary category would be beneficial.
</td></tr>
</table>

8. Tasks

<table>
<tr><th>Issue no.</th><th>Issue summary</th><th>Implications</th><th>Relevant BRM fields</th></tr>
<tr><td>8.1.</td><td>Tasks are being inconsistently reported within BRM; some people use free text fields in other activities to identify these, other people are reporting these specifically as tasks.</td><td>Under reporting of the non-clinical support that we provide, in terms of range and frequency of support.</td><td>Tasks</td></tr>
<tr><td colspan="4">Recommendation(s) for data capture
> Tasks are specific actions undertaken that facilitate a service users discharge from hospital by ensuring they can be discharged quicker and potentially safer than without our support. Only actions that fall within this definition should be recorded as a task.
> A new mandatory field called Task category should be included, and all tasks should be identified against one of the following:
1. Risk assessment undertaken
2. Collecting and/or delivering medication
3. Collecting and/or delivering equipment
4. Undertaking and/or overseeing minor home adaptations (possibly with a free text field to specify details)
5. Transferring medical records or notes
6. Doing or collecting shopping
7. Liaising with next of kin (possibly with a free text field to specify details)
8. Other, with accompanying free text field to specify details
> Tasks can be undertaken as part of other activity types, such as appointments or phone calls, but any actions which fall within the definition of a task should also be specifically recorded as such.</td></tr>
<tr><td>8.2.</td><td>Unclear whether service users are present when tasks are being undertaken. Where tasks are undertaken as part of another activity the time spent with service users is being captured twice once in the master activity e.g. appointment and then again as a separate task.</td><td>Time spent with service users may be being double counted or underestimated.</td><td>Tasks</td></tr>
<tr><td colspan="4">Recommendation(s) for data capture</td></tr>
</table>

- A new field should be created to identify where tasks are linked to a master activity and where they are completed independently. This should be a mandatory field to ensure that a response is provided and include two response options:
  1. Completed as part of another activity
  2. Completed as a stand-alone action
- Where tasks are completed as part of another activity, the time spent with the service user should not be included in any reporting on the time spent on support provision.
- Tasks identified as stand-alone actions are by default tasks which are undertaken without being in direct contact with the service user. The duration of these task should not therefore be included in reporting on contact time with service users.