British Red Cross

EXPLORING THE DIFFERENCE MADE BY SUPPORT AT HOME

Sarah Joy, Susana Corral and Femi Nzegwu

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Acknowledgements

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Executive Summary

> “She took the time to sit and talk to me and it made me feel like I was a human being again.”
> **Red Cross service user**

Background

Support at home provides time-limited care and support to people at a time of crisis who are finding it difficult to cope at home. In 2012, the research, evaluation and impact team undertook an evaluation of the British Red Cross Support at home services. The main aim was to gain a better understanding of the difference made by the service for our service users, and to grow our evidence base.

Overall the research was designed to provide the organisation with a comprehensive overview of the impacts of Support at Home, from which it can make strategic for the next strategy and beyond.

Findings

What difference do we make?

Our findings showed that four service user outcomes were significantly improved or increased following receipt of Support at home:

1. **Improved wellbeing:** We support people to feel in good spirits; we provide reassurance and alleviate worries.

2. **Increased ability to manage daily activities:** We support people to rebuild/regain their confidence and to get back on their feet again after a stay in hospital.

3. **Increase in leisure activities:** We support people to build their social confidence, as well as the physical confidence to go out and they have more things they enjoy doing with their time.

4. **Improved coping skills:** We support people to keep on top of things and make decisions on a range of issues they are dealing with and help to reduce the struggles people face.

Other positive changes were also reported related to the wider benefits of the service beyond the service user outcomes alone:

1. **Enabling safe discharge:** We provide reassurance (to both service users and referrers) that they will be checked up on, and that there will be someone to turn to when they get home from hospital.

2. **Supporting carers:** We alleviate some of the stress, providing reassurance and giving valuable information on local sources of support.

3. **Enabling patient advocacy – developing advocates for our service users:** We support service users to get help and ensure their needs are met.

Conclusion

Overall the research highlighted that the common area of major impact of Support at home is the enhancement of service users' quality of life. The support provided is characterised by a strong sense of trust by service users in the Red Cross brand (and, therefore, in its staff and volunteers), alongside a compassionate, caring, non-judgemental, time-flexible and person-enabling approach. Service users in the study attest to the impact of this approach on their own wellbeing. These are the Red Cross' strengths and should be central in any national shaping and marketing of the Support at home service.

Recommendations

The findings from this research have led us to develop seven recommendations to make to the organisation, drawn from the impacts and challenges found in the study.

1. **Champion our strengths:** The Red Cross would benefit from carefully marketing its offer by selling its strongest points – e.g. improving the wellbeing and quality of life of the people it supports.

2. **Respond to the changing profile of our service users:** The Red Cross would benefit from making a strategic decision about how we best support our service users, given the observed shift in the profile of our service users (now including people with more complex needs).

3. **Develop active partnerships to extend our reach and maximise impact:** The Red Cross would benefit from expanding and intensifying our partnerships in order to reach greater numbers of people in need.

4. **Clarify the Red Cross' position for people in need who fall outside of our commissioned contracts:** The Red Cross would benefit from devoting resources to understanding the experiences of frontline staff and acknowledge the reality of delivering Support at home as a contracted service in a humanitarian organisation.

5. **Collect consistent and routine local and national data to inform service learning and development:** The Red Cross would benefit from a better understanding of the profile of its service users, to develop more comprehensive knowledge of our service

users' contexts and needs.

6. **Develop signposting to ensure long-term impact:** The Red Cross should ensure people are transitioned from our care appropriately through good signposting.

7. **Grow our skills in order to advocate on behalf of our service users:** The research suggests that we embed and enhance this vital component of our work by encouraging the development of advocacy skills through clear organisational guidance and training for staff and volunteers.

1 Policy context

The UK's population is ageing and people are living longer. The number of people aged 65+ years old is expected to rise by nearly 50% in the next 20 years, reaching over 16 million.[1] This is a human success story and should be celebrated. Older people are assets to society and the economy, with much to contribute. But equally, as a consequence of this ageing population, more people have long-term health conditions putting more pressure on our health and social care services. Within the context of increasingly limited public funds and rising health/social care needs in the population, these services are already struggling to cope.

In 2007, the Department of Health published *Putting People First*, a shared vision and commitment to the transformation of adult social care aiming to ensure that people who need care and support have choice, flexibility and control to live their lives the way they wish. The report set out plans to reform public services with a focus on personalisation, enabling people to plan their care tailored to their own needs for independence, wellbeing and dignity.

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[1] National population projections, 2010-based, Office for National Statistics, 2011

Still recognising the role of personalisation, the publication of the draft Care Bill in February 2013 put forward new duties for local authorities to promote wellbeing, prevention services, information and advice, a stronger framework for eligibility and assessment, new rights for carers and an approach that recognises and builds on the strengths of people and communities. Yet the reality is that, at the same time, local councils are facing cuts to their social care budgets[2], leading many of them to raise their eligibility thresholds for the receipt of social care and support, and making it increasingly difficult for people to access these services.[3]

The NHS is entering into a period of major structural reform in the way its services are provided and funded. There is a focus on reducing hospital stays by shifting care and treatment from acute hospital-based care to the community delivered by community-based, multi-agency teams. The discharge process inevitably works to extremely tight timescales and is often described as fraught with communication issues between the Acute Trusts and Community Care. Ellins et al. (2012) explored older people's experiences of care transitions and highlighted that how people are treated, interactions and interpersonal relationships have the biggest impact on patient experiences. Lack of communication, clarity and involvement in their discharge arrangements was often cited as the most frustrating thing. They found that people with moderate levels of need, hence those who are not usually eligible for a care package, can end up feeling isolated and unsupported.

Commissioning priorities

Alongside structural reform, the NHS commissioning process is changing. In England, NHS decision-making has shifted from Primary Care Trusts to GP consortia, and in Scotland new commissioning models are being explored which could change the way services are delivered. Reducing unnecessary emergency hospital admissions is a clear priority for everyone. This outcome carries the largest financial incentive for the newly formed Clinical Commissioning Groups in their Quality Premium targets.[4]

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[2] Following funding cuts of 28% in the Spending Review, Local Authorities have reduced their budgets by £2.68 billion over the past 3 years, reported in the ADASS Budget Survey, May 2013

[3] The number of people receiving publicly funded social care has fallen by 17% since 2006/7, while the population aged 85 years and over has risen by more than 20% over the same period, reported in The King's Fund Briefing (2013), The Care Bill: Second Reading in the House of Lords.

[4] Of the Quality Premium targets, avoiding unnecessary emergency admissions is the largest portion worth 25%. There are 4 national targets applicable to all CCGs and 3 local ones allowing them to respond to the needs of their local population. See Quality Premium: 2013/14 guidance for CCGs, NHS England, March 2013.

In 2011, three pieces of research (two in England and one covering Scotland) were carried out on behalf of the British Red Cross to capture commissioners' experiences, views and current commissioning practices for services offering low-level support at home.[5] In line with the policy priorities set out above, three specific commissioner objectives were evident across the board:

- *Developing prevention strategies and avoidance of unnecessary admissions into hospital.* Initiatives supporting this are a major priority. For example, exploring better options for falls response and prevention.

- *Expanding the provision of time-limited re-ablement services.* This is viewed as critical to help people "get back on their feet again", either when they have been discharged from hospital or when there is a risk of them needing to be admitted to hospital. However, a pressure on resources was also acknowledged as a barrier to expanding this provision.

- *Ensuring flexible, personalised care.* The personalisation agenda is a big influence on commissioners and is driving a shift in the emphasis of care from fixed, condition-centred care to flexible, person-centred care.

Further priority areas mentioned by commissioners included: minimising delayed discharges; dementia care provision; relief support for carers; re-ablement services for people with chronic conditions; and emphasising choice and control in social care support, including more people using personalised budgets.

The role of the voluntary sector in delivering social care

Voluntary sector organisations have been involved in the delivery of social care for a very long time. In a recent King's Fund report, Naylor et al. (2013) highlighted that around 3 million people volunteer in health and social care, making an important contribution to people's experience of care.

In 2007, the National Strategic Partnerships Forum highlighted that the voluntary sector's role in health and social care is distinct from other providers in the commercial or statutory sector. The "added value" that voluntary organisations can offer is suggested to include community engagement, access to "hard-to-reach" groups, innovation, cost-efficiency, strong user and carer involvement, volunteers and absence of stigma and threat. However, a review carried out by Dickinson et al. (2013) for the National Institute for Health Research (NIHR) School for Social Care Research suggests caution in attributing these common values across all voluntary sector organisations delivering social care. They highlighted that the nature of the relationship between state commissioners and voluntary organisations is critical in achieving the greatest impacts. While there is evidence of strong partnerships between trusts and voluntary sector providers in achieving high-quality, patient-centred care, there remain some barriers to effective partnership working, including a lack of mutual understanding and clarity of roles and responsibilities.

In addition, the current economic context of restricted financial resources presents a challenging environment for volunteering. Naylor et al. (2013) highlight the importance of having a strategic approach, a clear vision and a focus on volunteering as a means of improving quality rather than cutting costs. These factors are described as key enablers for seizing the opportunities that exist in health and social care now and in the future.

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[5] A survey was carried out with 169 Local Authority and NHS commissioners in England and 3 in-depth interviews with GP Consortia commissioners (in Care in the Home Commissioners, IFF Research, 2011); 14 in-depth interviews with LA and NHS commissioners were also carried out in England (in the Study of Care in the Home Commissioning, IFF Research 2011); In Scotland 8 interviews were carried out with Red Cross staff and 11 interviews with LA and NHS commissioners (in Care in the Home Commissioning Environment Scotland, Emma Naismith 2011). All studies included commissioners who do currently commission Red Cross services and those who don't.

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2 Research aims

The Support at home programme[6] at the British Red Cross offers short-term, practical and emotional support to help people build their confidence and regain their independence. Support at home services are varied in focus and approach across the organisation, allowing local teams to respond to local needs and to reflect commissioner priorities. For example, some services focus on supporting people after a stay in hospital, and others work specifically alongside A&E teams to prevent people being admitted into hospital from A&E. Many of our services provide support for people at home, to prevent them from having to rely on higher-intensity and costly social care.

In 2012, the research, evaluation and impact (RE&I) team undertook an evaluation of the Support at home service. There were three main aims of the study:

> To understand better the difference made by Support at home for our service users

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[6] The service has recently undergone a name change to *Support at Home,* it used to be called Care in the Home (CITH).

- To gain increased knowledge of the health and wellbeing outcomes derived by service users and the factors influencing these individual outcomes
- To grow our evidence base and feed directly into the strategic development of the service

Alongside this study, two additional projects were carried out. The first, conducted in partnership with the LSE[7], looked at the economic impact of our services. The second, in partnership with the Nuffield Trust, aimed to better understand how selected services affect hospital utilisation patterns.

These reports are available separately from
www.pssru.ac.uk/acrchive/pdf/dp2869.pdf
and www.nuffield.org.uk

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[7] The findings of these 2 additional analyses are summarised in sections 4 and 5 and individual reports have been produced by Nuffield and LSE providing further detail on these analyses.


British Red Cross Referral Form
Service User ID
Referral No.
User Name
Address
Referral By
Post Code
Telephone
Date of Birth
Age
Next of Kin
Risk Assessment
Reason for referral
YES NO
FEEDBACK 1
FEEDBACK 2
FEEDBACK 3
FEEDBACK 4

3 Evaluation methodology

3.1 Design

A mixed-methods approach was taken, incorporating quantitative and qualitative data collected from service users, Red Cross staff and volunteers, and referrers to the Support at home service. Face-to-face interviews were conducted with service users in their own homes, before and after receiving the service. In the interviews we asked them how confident they were that they could do certain things, such as carrying out daily activities (looking after themselves, doing tasks around the home, or getting out and about), and managing their finances. We also asked service users about their coping skills (whether they were able to take their mind off their worries, make their own decisions, keep on top of things and cope with life at home). Emotional wellbeing, perceived social connectedness, and satisfaction with life were also key measures of interest.

The questionnaire was designed following a review of validated scales that measure older people's health and wellbeing, alongside a wider consultation exercise, both internal and external. The questions were then cognitively tested and piloted. The post-service questionnaire had the same questions as the pre-service interview, to assess change, and also included a section on the service users' experiences of the service (see Appendix D for a copy of the questionnaires).[8]

Semi-structured telephone interviews were conducted with Red Cross staff, volunteers and referrers to gather their views on and perceptions of the service (see Appendices E and F for a copy of the interview schedules used).

Data analysis incorporated summary descriptives, cross-tabulations and significance tests to look for differences before and after the intervention, as well as thematic analysis of the qualitative data gathered across all the interviews.

3.2 Sample

3.2.1 Site selection

A case study approach was adopted, due to distinct local contexts, varied needs for service provision and the different local commissioning priorities, which lead to a varied service offer across the country.

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[8] All research fieldwork documentation is available from the research team at the British Red Cross, i.e. information sheets, advance letters, consent forms, interviewer instructions etc.

Red Cross services in five locations across the UK were selected to take part in the study. This selection was based on a number of essential variables of interest, including geography – to ensure coverage in the four countries of the UK; continuation of contract funding past March 2012; size of service; and type/aims of service – to try to reflect the range of different Support at home services on offer.[9] The five locations selected as our case study sites to be explored in the evaluation were:

- London: Next Steps service at King's College Hospital
- Yorkshire: Care in the Home service in East Yorkshire
- Wales: Swansea Floating Tenancy Support Service
- Northern Ireland: Care in the Home service in the Southern H&SC Trust
- Scotland: Neighbourhood Links & Red Cross Buddies in the Scottish Borders.

See Appendix B for further details of these individual services.

3.2.2 Participant sample

After the service users' initial service assessment, the service teams sought consent for the research to be conducted. Service users were fully briefed on the purpose of the study in order for them to decide whether they would like to participate.

We interviewed 90 people before their service had begun. The needs and demographic profile of our evaluation participants are described in section 4. Sixty one interviews were achieved with these service users after their receiving the service (following attrition). In an attempt to boost the number of interviews, some one-off retrospective interviews were conducted in evaluation locations where the 'before' cohort numbers were originally low. Table 1 illustrates the interviews conducted in this study.

In addition, 58 semi-structured telephone interviews were conducted with stakeholders across the five locations, including Red Cross staff (22), Red Cross volunteers (24) and referrers (12).

TABLE 1 NUMBER OF SERVICE USER INTERVIEWS BY SITE LOCATION[11]

	London	Yorkshire	Wales	N. Ireland	Scotland	Total
Pre	32	32	14	9	3	90
Post	20	25	9	5	2	61
Retrospective	–	–	21	5	9	35

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[9] The sites were chosen for their differences and so will reflect many but not all of our services across the country. Services providing personal care were excluded and no A&E based services are represented in the 5 sites in this study.

[10] The length of the fieldwork period differed across the sites according to capacity and other factors, hence, more interviews were achieved in some locations than others. In general, the pre-service interviews were conducted by the service team and the post and retrospective interviews were conducted by the research team. However, in London, the pre-interviews were also conducted by the research team.

4 Evaluation findings: The difference made by Support at home

4.1 Who do we support?

4.1.1 Demographics[11]

Overall, the service user profile across four of the five sites evaluated does not differ significantly in terms of ***age and gender***. Just over half (57%) are between the ages of 65 and 80, with the average age being 76 years. Thirty-five per cent are 80+ and 9% under 65. There are many more women (75%) than men (25%). However, in Wales, the service has a much younger population – 67% are under the age of 65 years, with a mean age of 62 years. As in the other sites, the majority (67%) of service users are women.[12]

The ***ethnic profile*** differs markedly across sites. Only in London and Wales are ethnic minority populations seen among service users. This is most prevalent in London at 42% and largely made up of people of African Caribbean background, due to the characteristics of the local population in the surrounding London boroughs.

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[11] The demographic questions were asked in the POST interview hence, the data in this section is largely based on the 61 service users interviewed both at the beginning and end of their service intervention, unless stated otherwise.

[12] It is worth noting that many commissioned contracts do specify age related criteria for the services to target.

Regarding ***housing***, London and Wales service users in the study also differed by ***tenure*** to those in Yorkshire, Scotland and Northern Ireland. The majority in London (79%) and Wales (89%) rent from a social landlord (local authority or housing association tenants). By contrast, service users in the other three sites predominantly owned their own homes (over 80% were owner occupiers).

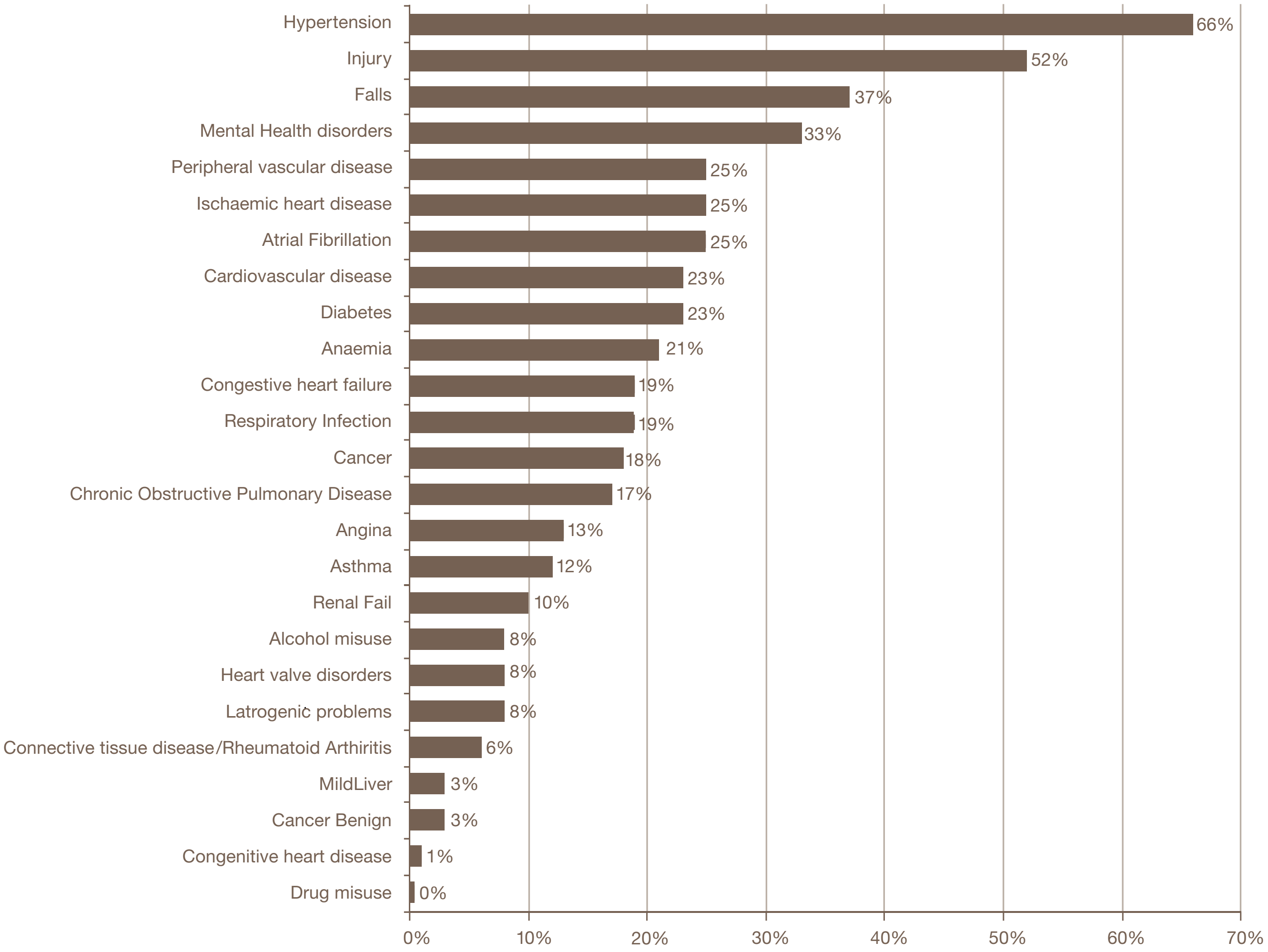
The majority of our sample of service users ***live alone*** – almost seven in 10 in four sites, and a higher nine in 10, in Wales. This is significantly higher than the general population estimate – the proportion living alone is 37% for people aged 65 and over, and 49% for people aged 75 and over (Age UK, 2013).

Appendix C provides more data on the demographic profile of the service users we interviewed. This overall profile broadly aligns with the findings from a 2010 internal review of service user feedback forms. In this review of over 5,000 service users, the majority were over 75 years (67%), women (61%) and classified themselves as white (93%).

4.2.2 Health

Not unexpectedly, many individuals (74%) reported having significant health issues that affect their day-to-day lives. People most commonly expressed a difficulty with mobility (60%). Fifty-five per cent considered themselves as having a disability. Some of the main health conditions

FIGURE 1 DIAGNOSTIC HISTORIES OF BRITISH RED CROSS SERVICE USERS – CO-MORBIDITIES OBSERVED IN THE TWO YEARS PRIOR TO REFERRAL TO SUPPORT AT HOME



Source: NHS HES data – (n=1573) Note: Dementia and Alzheimer's are coded in the Mental Health category.

that participants talked about in the interviews included arthritis, poor memory, poor vision, lupus, diabetes, high blood pressure, mental health (depression, schizophrenia and addiction), stroke, cancer, fractures and hip replacements.

Further insights into the types of medical/health conditions experienced by service users were highlighted in the NHS data collated by the Nuffield Trust for a separate analysis of hospital utilisation patterns. Figure 1 shows the diagnostic histories of 1,573 service users upon discharge from hospital (records taken from Support at home schemes in seven hospitals across London). The most common health conditions largely align with those directly reported by respondents themselves in our study.

A heavily medically-reliant population with complex health care and social needs, 99% of respondents had accessed their GP, nurse or hospital in the three months before referral to the service, 21% had accessed a social service carer, and 27% had other help/support services such as cleaning, gardening, shopping or a meals-on-wheels service.[13]

Clearly, Support at home sees a population that is older, largely female, often living on their own, and with significant chronic health conditions. In some areas, our service users also appear to be quite homogenous, with limited diversity within the group.

4.2 What are their needs (before receiving Support at home)?

We asked participants about their state of health and state of mind prior to receiving support from the Red Cross.[14] People were asked to score themselves on a number of questions using a five-point scale. Our focus when reporting these findings is to explore the needs of our services users, those who felt less than able to cope with their lives, on the range of dimensions we measured. Participant scores of one and two were taken as a self-rating of having "poor" ability to carry out the task in question.

Table 2 shows some of the key measures we will report on in the sections to follow, with the items (or individual questions) that make up each of the dimensions explored. See the questionnaire in Appendix D for the specific question wording.

TABLE 2 DIMENSIONS MEASURED IN THE SURVEY

Section	Dimensions	Items
Physical & Practical capabilities (4.2.1)	Daily activities	Ability to look after yourself Ability to do daily tasks around the home Ability to get out and about
	Manage finances	Ability to manage your finances (e.g. organise payments and bills)
	Control	Control over daily life
Psychological capabilities/ State of mind (4.2.2)	Coping skills	Ability to take your mind off your worries Ability to make your own decisions Ability to keep on top of things Ability to cope with life at home
	Wellbeing	Feeling good about yourself Feeling in good spirits
	Safe at home	Feeling safe and secure in your home
	Satisfaction with life	Satisfaction with life as a whole
Social support, emotional support & leisure (4.2.3)	Social contact	Contact with family, friends and neighbours
	Someone to talk to	Can find someone who will really listen to me if I need to talk
	Leisure activities	Have activities that I enjoy doing with my time

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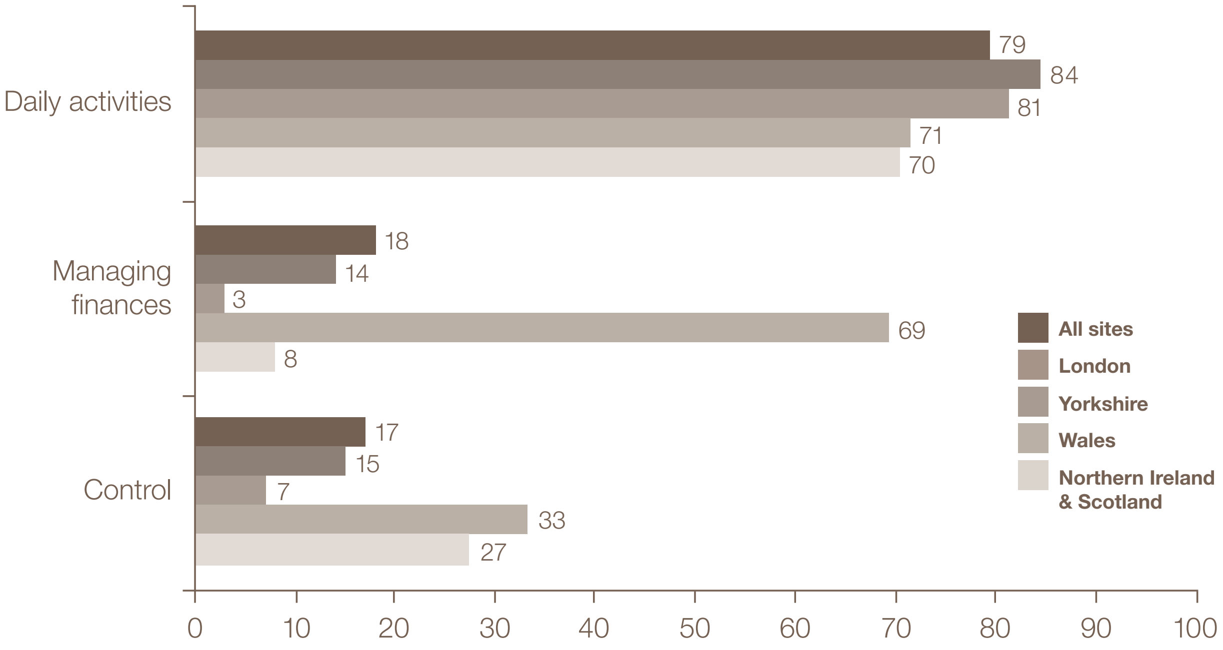
[13] Based on all 90 PRE-service interviews

[14] Based on all 90 PRE-service interviews

FIGURE 2 PHYSICAL & PRACTICAL CAPABILITIES – PERCENTAGE REPORTING A POOR SCORE BY SITE



There were differences across sites,[15] seemingly related to the type of service delivered. For example, where the service focused on a particular aspect of support – e.g. daily living activities – there was a tendency for those service users to report poor capacity in these aspects prior to the service. This is a good indicator that the service is need-responsive.

In this section we examine the service users' reported physical and psychological states, and the associated needs of service users prior to receiving Support at home.

4.2.1 Physical and practical capabilities

We looked at how able people felt they were to carry out their daily activities and manage their finances, and the amount of control people felt they currently had over their life.

Overall, 79% of all participants rated themselves as poor in carrying out daily living activities in *at least one* of the three activities measured (Figure 2). Within this dimension, people most commonly rated themselves as poor at "getting out and about" (64%), followed by "doing daily tasks around the home" (59%), then "looking after themselves" (26%).

While 18% of the overall population rated themselves as poor in managing their finances, the variation across service sites is noteworthy. It is understandable that a significantly higher proportion (69%) in the Wales tenancy support project (with a strong financial support component) would rate their capacity as poor in this area (Figure 2).

Seventeen per cent of all respondents said they had no control at all over their daily lives, again highest in Wales at one in three (Figure 2). Physical health was mentioned as one of the main factors restricting people's ability to feel in control of their daily lives.

Overall, significant numbers of service users before receiving the service reported that:

> **Going out is stressful** and causes anxiety. Fear of falling and stumbling – outside as well as inside the home – is very real (e.g. going upstairs is not possible for some people). Having someone there is very important to enable them to try and slowly regain their confidence.

> **Transport issues are common** in both urban and rural settings. This relates to adjusting to

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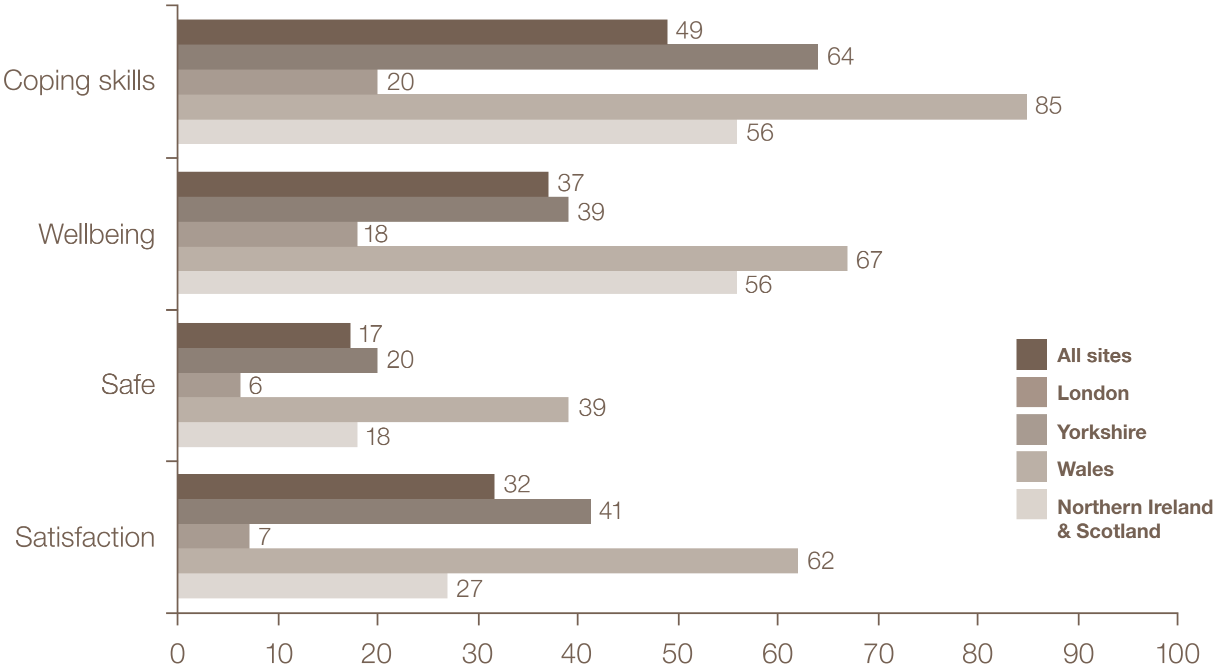
[15] Due to the low numbers of interviews achieved in Scotland and Northern Ireland we have not been able to include them when reporting variation figures across sites. However, we have combined them together to include in the graphs.

FIGURE 3 PSYCHOLOGICAL CAPABILITIES – PERCENTAGE REPORTING A POOR SCORE BY SITE



not being able to drive anymore, as well as not being able go out alone. Having to completely rely on other people and trying to find other ways of getting to places (taxis, public transport routes etc.) are issues confronting this population group.

- **Doing heavy, physical things is difficult or not possible** for some people – e.g. carrying shopping bags, vacuuming, lifting, and having the strength to do certain things around the home.
- **Capability varies on a day-by-day basis** – people have good days and bad days, with needs changing accordingly.
- **"Not being able to do what one used to be able to do" and "everything taking more time than usual"** – e.g. washing, dressing, tidying – are adjustments people deal with regularly. These constitute a source of frustration and upset for many.

4.2.2 Psychological capabilities

We looked at coping skills, wellbeing, feeling safe and secure in one's home, and overall satisfaction with life to assess the state of mind of our participants. Figure 3 shows the proportions who rated their capacities as 'poor' in at least one of the questions under each of these dimensions.

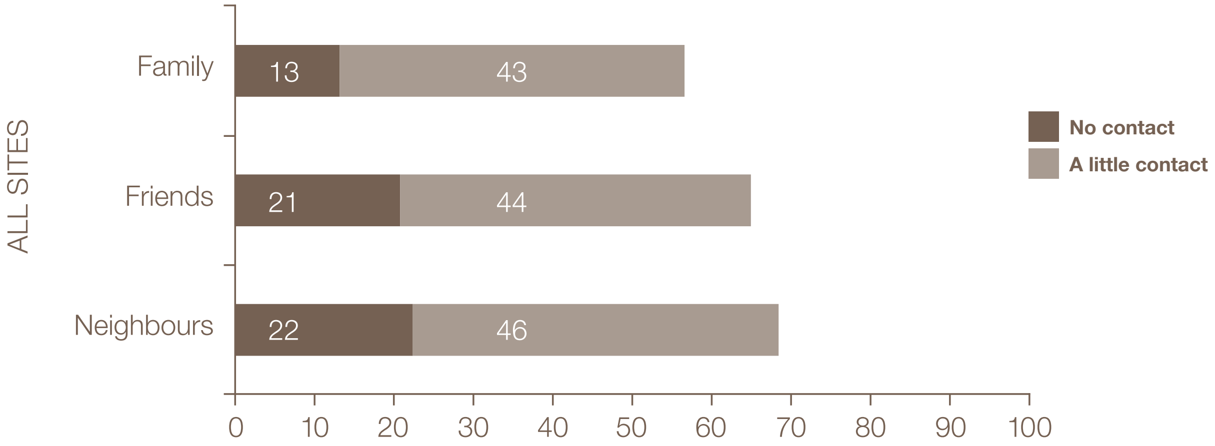
Across all sites, nearly half of our participants (49%) rated themselves as 'poor' for at least one item under coping skills. However, the variation across sites is important to note – higher in London (64%) and Wales (85%) (Figure 3).

Thirty-two per cent reported their satisfaction with life as 'poor' across all sites, ranging from 7% in Yorkshire to 62% in Wales (Figure 3).

Many respondents expressed worry and anxiety in their feedback. Reasons why people did not feel good, or found it difficult to take their mind off their worries, varied according to individual circumstances. Four factors emerged as feeding into this anxiety:

- **Feeling limited and frustrated:** Being unable to look after your home was a source of frustration, coupled with a lack of confidence and self-esteem and/or a fear of falling for some, particularly when no one is around to help.
- **Feeling lonely and alone:** Some people reflected on having too much time to sit and think, reporting it is difficult being on your own a lot, and that they do not have much to look forward to.

FIGURE 4 SOCIAL CONTACT – PERCENTAGE REPORTING ‘NO’ CONTACT AT ALL OR ‘A LITTLE’ CONTACT WITH FAMILY, FRIENDS OR NEIGHBOURS



- **Feeling like a burden on other people:** Some people recognised that the only reason they were able to cope was that they had help from others. This help was hugely influential, but also left some people feeling like a burden, particularly on family members.

- **Financial worries about not having enough money to pay bills:** This was the cause of a lot of stress and worry for some people.

The consequences of not being able to cope at home loom large. People really feared losing their independence. They saw it as possibly resulting in having to go back into hospital or having to move into a nursing home.

4.2.3 Having a social support network and emotional support

We asked participants how much contact they have with family, friends and neighbours. Thirteen per cent had no contact at all with family (highest in London at 19%), 21% had no contact with friends (again highest in London at 29%), and 22% had no contact with neighbours (highest in Wales at 33%)(Figure 4).[16]

We explored people’s social contact in more detail:

- Forty-three per cent of all the service users we interviewed stated that they would like more contact with other people than they currently have.

- Four out of 10 service users have only a little contact or no contact at all with family, friends or neighbours. Out of this group, nearly two-thirds (62%) said they wanted more contact with people.

People reflected on the stark reality of not having as many people around you as you get older as family and friends pass away. Some recognise that they spend a lot of time on their own. Some admit that they feel quite lonely, that they like having company, but do not have as much contact with other people as they would like to.

We also asked about people’s access to *a listening ear* – someone who will really listen to them if they need to talk.

- One in four did not have access to someone to talk to. Here, as with the other variables examined, responses differed across sites (Figure 5).

Finally, we asked people whether they have things they enjoy doing with their time.

- A significant number of people (46%) reported that they did not have any activities that they enjoyed doing with their time. This ranged from 19% in Yorkshire to 75% in

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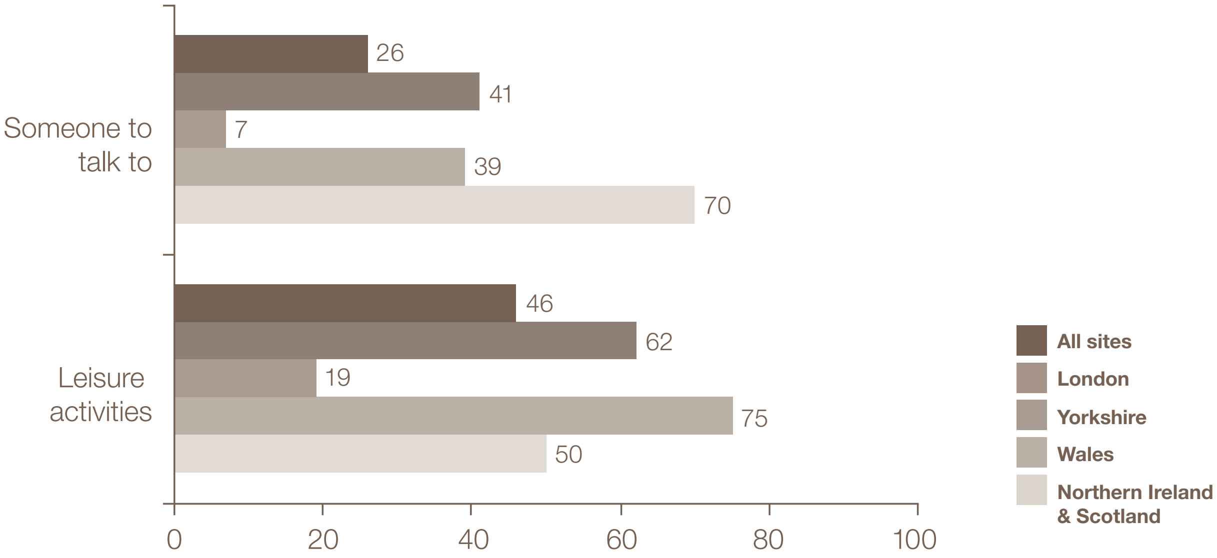
[16] 5% had no contact with family or friends and 3% had no contact with any of the all three groups – that is, neither family nor friends nor neighbours.

FIGURE 5 EMOTIONAL SUPPORT AND LEISURE ACTIVITIES – PERCENTAGE REPORTING A POOR SCORE BY SITE



Wales (Figure 5). Over half of them (61%) indicated that they would like to take part in more leisure activities – ranging from 33% in Yorkshire, to 44% in Wales, to 75% in London.

4.2.4 Access to help at home

Having help at home was essential for many and the only way they were able to cope with life at home. As noted previously, 79% of the sample population reported needing help with daily activities (Section 4.2.1). For this group of people, individual circumstances varied and help came from different sources:

- 20% had access to a formal carer of some sort, for example, a social services carer coming in to support them a few times every day, or social services support of another kind (e.g. intermediate care).
- 32% accessed another sort of formal help, for example, a cleaner, gardener, shopper, meals on wheels service etc.
- 69% got informal support from family, friends and neighbours.
- However, 14% of those that reported needing help had no access to people or places providing help around the home.

There were mixed views about council services, primarily around insufficient time being allocated to support them (service users) in the ways they want. There were also mixed feelings about calling upon family for help, linked to not wanting to be a burden on other people with busy lives. Some people reported experiencing difficulty finding someone to give that bit of extra paid help with the housework.

4.2.5 Summarising the needs of service users prior to Support at home

The findings show that a significant proportion of Support at home service users (89%) have a need in at least one of the areas explored in the study.[17] There is some variation by site, ranging from 81% in Yorkshire to 100% in Wales and London.

Need appears to vary by the type of service provided. In London's hospital-based "Next Steps" service the main areas of need identified are help with daily activities (84%), need for improving capacity to cope (64%) and need for leisure activities (62%). For the service users of Wales' "Tenancy Support" programme[18], high levels of need revolved around the capacity to cope (85%), the need for leisure activities (75%),

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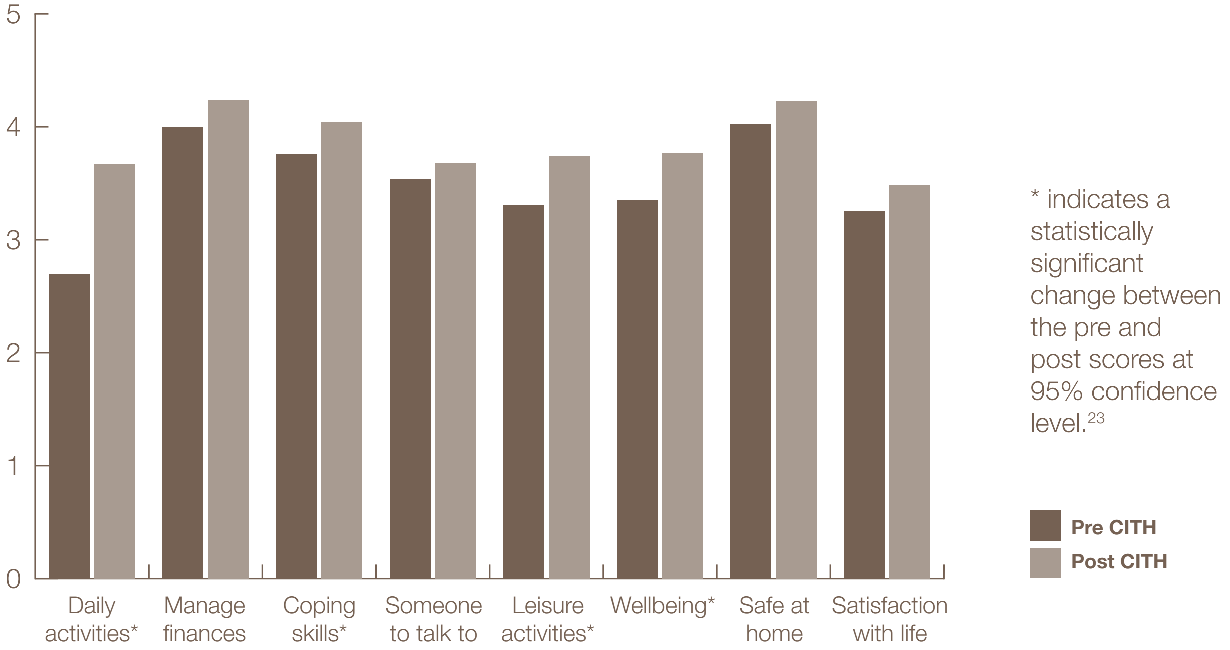
[17] We define the population in need as those who rated their physical, psychological or social capacities and resources as poor, a self-rating of 1 or 2 on a scale from 1 to 5.

[18] Many service users in this service have housing difficulties and some have associated alcohol or drug misuse issues where the Red Cross is one of the last lines of support.

FIGURE 6 THE DIFFERENCE MADE BY SUPPORT AT HOME: AVERAGE SERVICE USER SCORES (FROM 1 TO 5) REPORTED BEFORE AND AFTER THE SERVICE



* indicates a statistically significant change between the pre and post scores at 95% confidence level.[23]

and help with daily activities (71%). East Yorkshire's service[19], on the other hand, identified the most prominent need for 81% of their service users as the ability to carry out daily activities.

Significant proportions of the population seen by our service have complex health care needs alongside social and emotional needs. These needs are not always picked up by other people or organisations, formal or informal, of any kind.

Many service users worry about the present and their capacity to cope in their day-to-day lives. They have limited social support and life is often felt to be a struggle. They also have worries about the future, and do not always see an easy way forward.

For those who define their capacity as 'poor' in any of the key areas explored in this study, there is little doubt as to the need for extra support. This support needs to aim at alleviating some of their struggles and making life that bit more comfortable, indeed bearable, at a time of crisis.

4.3 What difference do we make?

Overall, the greatest impacts of Support at home are seen in seven key areas. The first four areas of impact are service user outcomes (observed as statistically significant from the interviews with service users pre- and post-intervention).[20] Other positive changes were also observed and reported around the wider benefits of the service beyond the service user outcomes alone. These form the final three areas of impact.

4.3.1 Service user outcomes

Figure 6 shows the degree of change (before and after Red Cross support) in the self-reported capabilities of our service users on the different dimensions measured.

As indicated in figure 6, Support at home contributes to the following service user outcomes:

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[19] Many service users in this service need support to change their anti-embolism stockings following being discharged from hospital after an operation.

[20] There was no control group for this study due to ethical and logistical constraints. Hence, while attribution is always a challenge in studies of this kind we are confident, in analysing the qualitative data alongside the quantitative outcomes, that Support at home makes a strong contribution to the differences observed.

[21] Further analysis into those who reported "poor capacity" shows statistically significant improvements in their capacity after the service in all the dimensions measured except managing finance. This reinforces the importance of correctly targeting those most in need – for whom the impact of the service is greatest.

1. Improved wellbeing

> "I'm old, I'm not in good health and I live on my own, so for them to take an interest that's an awful lot and I'm very grateful." (Red Cross service user)

- Data from this study shows wellbeing as a significant area of impact of the service. Service users' narratives confirm this. Repeatedly across the five sites, when asked for their thoughts on the "best aspects of Support at home" service users spoke about *the company* – having someone to talk to and seeing a friendly face to have a chat with; and *reassurance* – knowing someone is thinking about them, helping to alleviate their worries, their sense of isolation and knowing there is someone to turn to when needed.

- We asked respondents in this study to reflect on what helped them to feel good about themselves and their lives. Four factors were most prominent:
  - Having people around and support (feeling well looked after)
  - Looking forward to getting better/being mobile again
  - Having a positive outlook and feeling able to take an interest in things
  - Taking care of their appearance

- These factors capture the greatest strengths of the service. Support at home is grounded in a philosophy and practice that supports the wellbeing of people made vulnerable by ill-health, age and poverty. The service works by helping to make their lives *easier* to manage. It supports people to rebuild their levels of self-worth and confidence in themselves, by appreciating and *being there* for them. This ultimately enables people to rediscover some enjoyment in their lives once again.

- Many of the strengths of the service are noted in the way service users describe how staff/volunteers do things. Some of the words capturing the Red Cross's approach include: *Responsive* (to individual's needs); *Committed*; *Trustworthy* (linked to people's trust in the Red Cross generally); *Non-judgemental*; *Time-flexible* (due to it being volunteer delivered); *Supportive*; *Understanding* and *Interested*; and *Kind* and *Caring*.

- Clearly, an improvement in service users' overall quality of life, especially through the provision of a *listening ear*, and a *sensitive and encouraging voice* is a significantly valued aspect of Support at home from all perspectives. In addition, the practical support and advice provided make a real difference to the lives of those most in need. The impact may not necessarily occur for a prolonged period, but for the period in which the service is provided to service users, at a low point in their lives, the service appears to make a real difference to how people experience the quality of their lives.

2. Increased ability to manage their daily activities

> "The aftercare coming out of hospital, it's been a God send because I wouldn't have improved really.... I was down, I couldn't; I didn't have the confidence at all to go out, no." (Red Cross service user)

- Another key area of impact supported by the data is service users' "ability to carry out daily activities". Specifically, this relates to supporting people to regain/rebuild their confidence in their own abilities to manage their lives, by helping them do much-needed practical tasks. For example, enabling them to get out and about to shop, or to shop on their behalf, or generally to get back on their feet following a hospital discharge. Of of the three components measured (whether people felt able to look after themselves, to do daily tasks around the home, and to get out and about), people experienced the biggest increase in their ability to get out and about.

- Staff perspectives on this key area of Support at home's impact were similar to service users'. Amongst the main areas mentioned by staff were building confidence to support people "to get back on their feet again", helping them to regain their independence and, consequently, increased health and wellbeing because of being at home instead of in the hospital environment.

- In all sites, people's capacity to manage their daily activities increased following the intervention, although the change was highly significant in all but Wales.

3. Increase in leisure activities

> "Red Cross introduced me to the group, which has raised my confidence level a hell of a lot." (Red Cross service user)

- People were more likely to have things they enjoyed doing with their time at the end of the service. People spoke about the service introducing them to places they could go, building their social confidence as well as giving them physical confidence to get out and about again.

4. Improved coping skills

> "Honestly, I just like to appreciate everything they have done for me.... I don't know how to thank him; he's a gentleman. He gave me a lot of support…. They listen and, as well, they feel how you feel and they understand your situation…." (Red Cross service user)

- An improvement in coping skills was found to be significant in one site only – our Wales service, which provides a longer-term source of support for individuals in crisis. Service users spoke about the service playing a big part in their lives by reducing the struggles they were facing, being there to listen to them, discussing issues and offering support in finding solutions to a wide range of problems, from debt, to housing applications, to accessing local services and other practical and health related needs.

The data reveals that Support at home does impact health and wellbeing outcomes for its service users to varying degrees. Although there is evidence of some consistency across the services, some outcomes are clearly influenced by the components of the programme on offer.[22]

4.3.2 Wider benefits of Support at home

Wider benefits of the service were also observed in the study, particularly in the interviews with staff, volunteers and referrers. These are:

1. Enabling safe discharge

> "It's a nice way of getting rid of people's anxiety and if there's any problems upon discharge, sometimes the hospital can sort of make ... assessment, but then when they get home it's a different story. So, the Red Cross can also sort of highlight any risks as well there." (Referrer)

- The NHS stipulates, as a fundamental requirement of the discharge process and good practice, that hospitals identify *at discharge*, what patients need to enable a smooth transition from the hospital level of care to another. Part of this information is obtained through discussion with patients or their families about what is needed to support the patient, including who will prepare meals, provide transportation and undertake chores; what activities they need help with; as well as information on medication and diet. This discharge process does not often take place as effectively and efficiently as it should (Glasby, 2003).

- Staff and referrers in this study talked about how the service supports and impacts the health and social care sector by enabling safer discharge. They reported how it does this in a number of ways:
    - Addressing potential unmet need – referrers mentioned how volunteers, through their home visits, are well placed to flag up risks in the home environment that may impact the person's immediate and long-term health and wellbeing.

    - Providing referrers with reassurance and peace of mind that their patients are being checked up on after discharge.

    - Allowing social services and hospital staff to focus on more complex cases – that is, supporting people with a higher level of need.

    - Relieving some of the pressure on hospital staff by doing some of the smaller tasks associated with discharge (e.g. getting keys cut, chasing up family members).

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[22] Differences were observed between the five services, with the most significant outcomes (by site) reflecting the key components of the service on offer. In Wales – coping skills significantly improved following support. London's hospital based "Next Steps" service saw a significant increase in ability to carry out daily activities, improved psychological wellbeing and a greater engagement with leisure activities, while for Yorkshire's service which commonly supports people to change their anti-embolic stockings, daily activities emerged as the key significant outcome for participants.

2. Supporting carers

> "It provides enormous relief and support to families and carers of the individuals that we are actually supporting because [they may not] have the knowledge of the local community nor the knowledge of the welfare system in order to know what can be done in order to help them out." (Red Cross staff member)

- One of the consistent research findings about the failure of many hospital discharge processes is the lack of attention paid to the needs of carers. Not only is inadequate information available to carers, they are often not provided with sufficient discharge notice for their family member (Glasby, 2003).

- Amongst the vast majority of staff and volunteers consulted for this study, there was a consensus that Support at home has, as one of its by-products, strong support for the service users' carers or families. This is achieved in a number of ways:
  - Enabling families to have a few hours a week to themselves when the staff member or volunteer is present in the home – thereby alleviating some of their stress.
  - Helping carers to identify longer-term local services, options for respite care (e.g. day centres) and local carers' support organisations – providing both the information/advice and support to access these.
  - Providing reassurance to families who do not reside close to their relative that an eye is being kept on them.

3. Enabling patient advocacy – developing advocates for our service users

> "Everything from helping me move in to helping me get a GP, change my address with everybody that I have to, [negotiating with] all the agencies...." (Red Cross service user)

- Another clear outcome of Support at home is the development of a group of skilled negotiators, knowledgeable about where and how to access a range of local services on behalf of their service users. The development of this skill has been occurring over the life of the service. This has significant implications for supporting service users to get the best services for their particular needs in the longer term.

- The clear need for staff and volunteers to ensure service users have information about and access to the services they need has been the catalyst for the development of this role locally. Advocating on behalf of individual service users varies in its depth across Support at home services and, critical as it is in strengthening health and wellbeing outcomes for service users, currently it is not supported by any organisational training/development.

4.4 What service challenges do we face?

The research also found a number of challenges to our services working to deliver a quality service, and responding to people's needs and the changing external environment. Challenges were highlighted in the following areas:

- Supporting more people with long-term health conditions
- Transitioning people off our service appropriately through effective signposting
- Recruiting volunteers and running a volunteer-delivered service
- Targeting our resources most efficiently to achieve greatest impact
- Service visibility and outreach work
- Pressures to meet internal and external targets and grow services in an uncertain external environment
- Collecting systematic data and information on our service users' contexts and needs

The learning from these challenges are reflected and incorporated into the Implications and Recommendations in section 7 of this report.

5 Implications

5.1 Conclusions

The research study highlighted that the major area of impact of the British Red Cross support at home service is the enhancement of service users' quality of life. The impact of the service is greatest for those who report need – that is, a lack of capacity in the areas supported by the service – highlighting that we should clearly target our resources to people and places where need is indicated.

The support provided is characterised by a strong sense of trust by service users in the Red Cross name (and, therefore, in its staff and volunteers), alongside a compassionate, caring, non-judgemental, time-flexible and "person-enabling" approach. Service users in the study attest to the impact of this approach on their own wellbeing. These are the Red Cross' strengths and should be central in any national shaping and marketing of the service.

5.2 Recommendations

The findings from this research have led us to develop a number of recommendations to make to the organisation, drawn from the impacts and challenges found in the study. The recommendations are a result of both the research findings and subsequent discussions with staff focused on drawing out the implications for the organisation.[23]

The following seven recommendations emerge from this study:

1. Champion our strengths

The findings from this study confirm that our greatest impact is observed in improved wellbeing and related quality of life, which directly supports the NHS outcome "Enhancing quality of life for people with long term conditions" (Dept of Health, 2012). Furthermore, these positive changes are more marked for those who rate their capacity in these areas as 'poor' before they receive the intervention. In other words, the greatest change can be seen in those with the greatest need.

Our evidence also suggests the service supports both safe hospital discharge and carers, where present. These are the strongest qualities of Support at home, and they need championing over areas where the evidence is weaker.

Implications for the organisation to consider:

> **Use the evidence available to promote what we're good at.** Look at what the data is telling us (from this study and other sources) about the outcomes we achieve. In addition, we should **continue to gather further evidence,** where needed, to support our work. Support at home is not a "one size fits all". There is a variety of services that sit under the umbrella of Support at home, with different strengths and selling points. Consistent evidence gathered on these and other services will highlight the specific strengths of each.

> **Ensure quality of life is high on everyone's agenda.** The importance of the quality of life of our population needs to come to the fore of our discourse on Support at home. The research suggests that the Red Cross is very well placed to advocate and ensure that quality of life is given a prominent place on the agenda within the wider health and social care sector. For example, as the clinical commissioning groups start to choose the local indicators that will be matched to their Quality Premium Targets, the Red Cross is well positioned to try to influence them to consider quality of life related indicators.

2. Respond to the changing profile of our service users

The findings suggest that, as social services tighten their eligibility criteria, Support at home staff and volunteers are seeing greater numbers of people with complex needs – especially mental health needs. The Red Cross would benefit from making a strategic decision about how we best support our service users and, indeed, whether this observed shift is acceptable and desirable to us.

If it is Red Cross policy to respond increasingly to this new group of service users with increased needs, then there are key activities that could occur to support this proactively. These include sharing learning from existing services[24], providing necessary training for staff and volunteers, and ensuring referral criteria reflect this shift towards those with increased needs.

If it is not desirable that this group form part of Support at home's core support group, then the Red Cross will actively have to turn down these higher-level referrals, possibly with humanitarian and contractual implications.

Implications for the organisation to consider:

> **Acknowledge the implications of supporting people with more complex needs and the internal and external consequences of this.** Internally, the Red Cross would benefit from exploring its role in this new "care framework", where limited resources are increasingly deployed to address greater numbers of individuals with more complex needs. By doing so, it would be necessary to reflect upon the implications to existing service delivery models – most notably whether this reduces the time afforded to service users with lower-level needs. There are also resource implications for taking on this additional level of need – in terms of staff/volunteer training, time and patient outcomes. Externally, our commissioners should be kept fully aware of the implications of this changing landscape, as well as any potential risks and other general

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[23] Discussions of the findings were held across the country with staff from the services that participated in the research.

[24] Some services have specific experience in supporting people with more complex needs and are well placed to share their learning, e.g. the Tenancy Support Programme in Wales.

impacts on the desired outcomes for older people in the population.

- **Consider the creation of a different service delivery model.** Time spent working with people with more complex needs often demands more staff input. This can be a challenge to the way some of our services currently operate and the Red Cross principle of being a volunteer-run organisation. This indicates a need to consider creating a different, higher-spec service for this group of people with more complex needs, with a clear focus and approach distinguished from our "traditional" role supporting people with lower-level needs.

- **Clarify our current role and aims for people with increased needs and longer-term issues.** There is an immediate need to acknowledge explicitly the changing needs of our service users with front-line staff and volunteers, and to clarify what this means for them and their roles. They need to understand what we are seeking to achieve for people with increased needs and/or longer-term health issues, and what elements of these needs can realistically be met.

- **Collate evidence on the needs of our service users.** The Red Cross would benefit from accurately and routinely collected information on the needs of service users, in order to develop a service that is responsive to these changing needs. This will also enable us to play a critical role with our commissioners, informing them on the changing needs landscape as well as provide essential evidence for our work. (See direct link with recommendation 5)

- **Provide training for staff and volunteers to meet the rising needs of our service users.** Staff and volunteers would benefit from consistently acquiring the correct type of training to meet the needs of service users with more complex needs. From the research, the observed skills that would be particularly useful include: psychosocial skills to learn how best to work with our service users who have mental health issues and sometimes people with suicidal thoughts; specific health knowledge to support service users to manage the common health conditions we see[25]; and advocacy skills to ensure service users get the support they need. (See direct link with recommendation 7)

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[25] See section 4.2.2 of this report for a discussion of Red Cross service user's health conditions highlighted in this study.

3. Develop active partnerships to extend our reach and maximise impact

The Red Cross aspires to reach greater numbers of people in need across a wide spectrum of communities. The most effective ways of doing this are by expanding and intensifying our partnerships with those organisations that already work with, and are well connected to, these communities,[26] and increasing awareness of our services amongst those who would refer to us. This also enables us to play to our own strengths and consider how to fill gaps where need is highlighted, as well as looking outside for innovations and new ideas to offer a support role to smaller organisations where appropriate[27] (Jarvis and Marvel, 2013). Such a strategy of actively partnering in this way will also allow us to explore solutions for the challenges raised in recommendation six around signposting – that there are fewer places/community resources to signpost people on to.

Implications for the organisation to consider:

- **Intensify the degree to which the Red Cross promotes and supports the capacity of local organisations and community groups.** Partnering with groups delivering similar or specialist support in their communities could enable a growth in the Red Cross's reach, and also identify critical gaps in the current support available to meet the often longer-term, unmet needs of our service users. (See direct link with recommendation 6). It also contributes to strengthening local, "under the radar" and other potentially innovative grass roots community groups, as well as the community's resilience. Community links are vital in times of crisis. The research highlighted that the Red Cross is well placed to contribute to the building of these links and bringing people together.[28]
- **Make our services more visible.** Life on hospital wards can be dynamic and busy. Without making the services offered more visible to all referrers (including agency staff who may not be familiar with the ward or the Red Cross offer) the degree to which we are automatically called upon, as an immediate choice for referrers looking for this type of support, becomes limited. Similarly, in non-hospital-based schemes, Red Cross offices are often out of town and out of sight. Staff and volunteers acknowledged that more linking in with hospital and community health and social care settings is necessary to provide that vital safety net and ensure we reach more people in need. A strategic and deliberate choice of where staff are located was also considered critical to visibility and outreach.

4. Clarify the Red Cross' position for people in need who fall outside of our commissioned contracts

The Red Cross delivers Support at home as a contracted service within a humanitarian organisation. Ensuring clarity on whether we can provide support to people in need who fall outside of the existing commissioned criteria or catchment area (contract obligations and restrictions) would be of benefit to the Red Cross.

Implications for the organisation to consider:

- **Capture and understand the experiences of frontline staff.** The research highlighted that frontline staff are left dealing with the question of how our contract-driven model fits with the Red Cross vision that "everyone gets the help they need in a crisis". The study suggests that further exploration of the scale of this issue, and consideration of the options for our ways of working, is desirable.

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[26] The evaluation of the TESCO funded Care in the home projects indicated a growing understanding of partnership working and its strategic importance in the development of the service.

[27] Some of our services have specific experience in partnership development and are well placed to share learning, e.g. the Neighbourhood Links service in Scotland.

[28] For example, one Red Cross service in the study identified a need and supported a group of service users to set up an exercise class in the local village hall – contributing to potential health outcomes and the building of social networks.

> **Provide guidance on our position to frontline staff and volunteers.** A clear communication to staff on the way forward is needed.

5. Collect consistent, routine local and national data to inform service learning and development

The Red Cross would benefit from a better understanding of the profile of its service users, to track trends and develop a more comprehensive knowledge of our service users' needs.

Large organisations do face challenges in collecting data, but it is integral that the data collected is of a high quality and as complete as possible, and that systems in place are robust enough to ensure record keeping is thorough.

Implications for the organisation to consider:

> **Ensure essential information is captured in existing data collection systems to enable services to learn and develop.** We need to ensure that data collection systems and governance are designed to collect key national and local data. This includes basic demographic data, as well as information on the needs and contexts of our service users e.g. does the person live alone? Are they are in receipt of social services support?).[29] This would enable the evidence we need for recommendation 2.

> **Prioritise the importance of data collection for our service delivery and credibility.** A positive cultural shift is recommended in the way the organisation collects and uses data. We need to ensure staff and volunteers see the tangible uses of the data they collect and input into the system. Real examples of this should be incorporated into training and be an on-going part of the information fed back by managers at a local level to frontline staff and volunteers.

6. Develop signposting to ensure long-term impact

The Red Cross would benefit from ensuring that our staff and volunteers know how to signpost well, with the aim of transitioning people from our services gently. This may require follow-up where appropriate.

The nature of our service users and the services we offer (short-term interventions for a largely older population with considerable health problems) often means that being able to signpost people onto more long-term support is a challenging, but essential part of our work.

Implications for the organisation to consider:

> **Make signposting a priority and acknowledge the time needed to do it well.** Good signposting and making professional referrals

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[29] Key service user data this study suggests we should be collecting include: Health conditions; Social isolation (living alone, contact with family, friends and neighbours); Access/ use of services (health services, social services, private services, other voluntary services); Family carer support.

to other, sometimes stretched, services is very labour intensive. It requires a significant time investment with outcomes that may not immediately materialise. The very short nature of some of our services can restrict the follow-up necessary for good signposting. However, good signposting provides continuity of support (where needed) to the service user and can mitigate the impact of our service ending. We need to ensure that we build into our service delivery models the capacity and time necessary for good signposting to take place. For example, the need for signposting onto a longer-term service should be assessed and identified at the start of the service, giving staff/volunteers the maximum possible lead time to put the service in place.

> **Support the development and sustainability of local community resources.** The study highlighted the added complication that there are sometimes no other organisations where people can be signposted on to. The Red Cross is well placed to support the capacity of locally based community organisations to provide additional community support to those people who have lower levels of social need. This would also feed into enabling recommendation 3 – extending our reach through partnership working.

> **Provide training for staff and volunteers on signposting.** Guidelines are needed for new and existing staff and volunteers. The study highlighted that the quality and depth of signposting across the UK varies from simply handing someone a leaflet, to accompanying them to the new organisation and fully supporting the transition. Examples of very good signposting practice can be found in the Red Cross's services – including identifying service users' needs and potential need for signposting upfront – but the research also found that this does not occur consistently across the service.

7. Grow our skills in order to advocate on behalf of our service users

"When they say we're from the British Red Cross, I'm a supporter on behalf of so and so… I feel the other side, they [start] listening." (British Red Cross service user)

Enabling service users get what they need, through the resource of time, attention and persistence is a core part of the service. The research highlighted the value that our service users place on this.

The Red Cross is in a unique position of being able to support people to access other services as a respected and impartial organisation. This is a core part of our work and requires a certain understanding and skills set which people can be developed to achieve. Although we may describe this as advocating for our service users it should not be confused with independent advocates, professionally trained roles focussing on supporting people to have a stronger voice.

The research found many good examples of where Support at home staff and volunteers were advocating on behalf of service users in varied situations, and to varying degrees. This ranged from cancelling a mis-sold life insurance policy, to supporting a service user refused food by a food bank, to chasing up and ensuring service users get the appropriate support or assessments they need from mental health or other social service teams. Exercising these advocacy skills can often occur as our service is coming to an end, and as such contributes to ensuring a continuity of support for the service user.

Implications for the organisation to consider:

> **Provide training for staff and volunteers to use advocacy skills when appropriate.** The research suggests we enhance and embed this vital component of our work and encourage the development of advocacy skills through clear organisational guidance and training for staff and volunteers. In order to ensure a consistent approach across the organisation training sessions should cover when and how it is appropriate to advocate, as well as for how long. Information could be shared on, for example, what rights people have regarding access to community care services, the assessment processes and common issues people encounter. In addition, an understanding of the difference between the work we do and the work of professional independent advocates would serve to ensure that it is clear when we should act and when we should refer onto specialist services.

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Appendix B Descriptions of services selected for the evaluation

Next Steps service in London

The service is based in King's College Hospital and supports the hospital discharge teams. It provides up to four volunteer home visits over a four-week period, as well as telephone calls to check the person is coping at home after discharge.

The service provides support to meet the needs of the individual. For example, accompany them to and from GP appointments, prescription collection, collecting or assisting with shopping, help to access social services and/or other community support, and friendly chats and company.

The service aims to provide time-limited care and support in the home for people after an accident or illness, giving people the confidence to continue with their daily lives.

Care in the Home service in East Yorkshire

The service is provided for up to six weeks and delivered by a mix of trained staff and volunteers. The service can offer social visits and support for rebuilding confidence, help with essential light household chores, shopping, prescription collection, and information about other support services in the local area. Trained staff and volunteers also provide help with changing anti-embolic stockings, a specialist component of this service, following discharge from hospital after an operation.

The service aims to enable individuals to be promptly discharged from hospital or prevent admission/ readmission for others by facilitating independence and ongoing self-care.

Floating Tenancy Support Service in Swansea

The service supports older people (aged 55+), refugees and patients being discharged from hospital (aged 18-65). It is a time-limited, currently largely staff delivered 12-week service[30] offering advice and practical support on a range of issues including:

> Money advice, e.g. benefit checks, debt advice, reducing household bills

> Help with moving home, e.g. assessments, sourcing appropriate housing, practical needs e.g. furniture needs, accessing local services, education

> Practical help and advocacy, e.g. paperwork and form filling, arranging meals on wheels or shopping services, liaising with social services, housing or health professionals on person's behalf

> Emotional support, e.g. talking through problems, identifying information needs, accessing befriending services

> Signposting to local groups and specialist support (e.g. mental health, substance mis-use support groups) and accompanying people to these groups

The service aims to ensure vulnerable people are supported through crises and are made to feel safer, more secure and more able to live independently within their community; and to enable vulnerable tenants to manage their tenancies successfully, and have appropriate support to maintain and develop their independence.

Care in the Home service in the Southern H&SC Trust, Northern Ireland

The service consists of an eight-week programme[31] for clients whose needs have been assessed by Southern Health and Social Care Trust staff and referred to the Red Cross. Each service user is matched with a volunteer and receives an average of one visit per week, which will vary in duration

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[30] However, the nature of some of the work involved and the outcomes the service is measuring itself against are, in reality, much longer term. This can result in the service supporting people for up to a year and longer.

[31] Note the service length has recently been increased to 12 weeks in line with service user & volunteer feedback.

depending on the activity undertaken. The service provides home support, transportation, access to wheelchairs, accompanied shopping, therapeutic care massage, and accompanying clients to local clubs/groups in order to promote the physical, mental, social and emotional health and wellbeing of older people.

The service aims to improve the quality of life for vulnerable clients by providing a range of services and activities to support independent living at home.

Neighbourhood Links and Red Cross Buddies in the Scottish Borders

The service provides support to people with low-level social needs by assisting them to re-engage with their community, and providing information to enable them to manage their day-to-day activities better. It consists of two distinct elements:

- **Neighbourhood Links.** An extensive information, advice and signposting programme in the local communities of the Scottish Borders. This is delivered by Red Cross staff.

- **Red Cross Buddies.** A 12-week service offering social support in the form of weekly visits from a volunteer. Not everyone requires a buddy, but for those that do a support plan is drawn up to cover the individual's specific wishes and needs from these visits.

The service aims to support people with low-level needs to live at home, and to promote and develop the capacity of locally based voluntary and community organisations to provide additional community support to those people who have lower levels of social need.

Appendix C Demographic profile of service users interviewed in the study

The demographic questions were asked in the post interview. Therefore, these are based on our 61 service users interviewed both before and after the service. The symbol '–' denotes no service users reported in this demographic. Please note some of the sample sizes are very small, in particular in Scotland and NI, hence percentages are not recorded for these sites.

		ALL		LONDON		WALES		YORKSHIRE		NI	SCOT
		count	**%**	**count**	**%**	**count**	**%**	**count**	**%**	**count**	**count**
Gender	Male	16	26.2	4	20	3	33.3	6	24	2	1
	Female	45	73.8	16	80	6	66.7	19	76	3	1
	Total	**61**	**100**	**20**	**100**	**9**	**100**	**25**	**100**	**5**	**2**
Ethnicity	White	49	81.7	9	47.4	8	88.9	25	100	5	2
	Mixed	2	3.3	2	10.5	–	–	–	–	–	–
	Asian	–	–	–	–	–	–	–	–	–	–
	Black	9	15	8	42.1	1	11.1	–	–	–	–
	Chinese	–	–	–	–	–	–	–	–	–	–
	Total	**60**	**100**	**19**	**100**	**9**	**100**	**25**	**100**	**5**	**2**
Age	Min-Max	32-93	n/a	52-93	n/a	32-82	n/a	56-86	n/a	72-81	74-84
	Mean	73.8	n/a	74.5	n/a	61.6	n/a	77.2	n/a	76.0	79.0
	Std.Dev.	11.2	n/a	11.3	n/a	15.4	n/a	7.1	n/a	4.7	7.1
	Total	**55**	**n/a**	**16**	**n/a**	**9**	**n/a**	**24**	**n/a**	**4**	**2**
Age bands	Under 65	10	18.2	3	18.8	6	66.7	1	4.2	–	–
	65-80	28	50.9	8	50	2	22.2	14	58.3	3	1
	Over 80	17	30.9	5	31.3	1	11.1	9	37.5	1	1
	Total	**55**	**100**	**16**	**100**	**9**	**100**	**24**	**100**	**4**	**2**
Live alone[1]	Yes	54	68.4	18	69.2	10	90.9	18	60	7	1
	No	25	31.6	8	30.8	1	9.1	12	40	2	2
	Total	**79**	**100**	**26**	**100**	**11**	**100**	**30**	**100**	**9**	**3**
Tenure	Owner	31	52.5	4	22.2	–	–	22	88	4	1
	Renting	26	44.1	14	77.8	8	100	3	12	1	–
	Total	**57**	**100**	**18**	**100**	**8**	**100**	**25**	**100**	**5**	**1**
Rent	Social	26	100	14	100	8	100	3	100	1	–
	Private	–	–	–	–	–	–	–	–	–	–
	Total	**26**	**100**	**14**	**100**	**8**	**100**	**3**	**100**	**1**	**–**
Health condition	Yes	42	73.7	17	89.5	6	75	15	62.5	3	1
	No	15	26.3	2	10.5	2	25	9	37.5	2	–
	Total	**57**	**100**	**19**	**100**	**8**	**100**	**24**	**100**	**5**	**1**
	Mobility	29	60.4	11	55	6	85.7	8	50	2	2
	Sight	10	21.3	4	21.1	1	14.3	4	25	–	1
	Hearing	6	12.5	3	15	1	14.3	2	12.5	–	–
	Speech	4	8.3	–	–	2	28.6	1	6.3	–	1
	Read/Write	4	8.3	–	–	2	28.6	2	12.5	–	–
	Other	19	39.6	9	45	2	28.6	7	43.8	1	–
	Total	**48**	**100**	**20**	**100**	**7**	**100**	**16**	**100**	**3**	**2**
Consider disabled	Yes	26	55.3	8	72.7	4	44.4	11	47.8	3	–
	No	21	44.7	3	27.3	5	55.6	12	52.2	–	1
	Total	**47**	**100**	**11**	**100**	**9**	**100**	**23**	**100**	**3**	**1**

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[1] This question was asked in the PRE interview. Therefore, based on the service users interviewed *before* the service started

Appendix D Pre- and post-service questionnaires

Date & time of interview	
BRC number	
Postcode	
Name of interviewer	

PRE- service Questionnaire

Remember to gain consent! Please reassure the service user that it is their views and experiences that are important to us. There are no right or wrong answers!

I would like you to think about your daily life, carrying out your day to day activities. I'm going to ask you some general questions, could you indicate for me using the scoring system on this card **how confident you currently are that you can do certain things** (SHOW CARD 1). One means you feel you cannot do it at all, 5 means you feel certain that you can do it. And the middle of the scale is 3.

Thinking about your daily activities, **how able are you** to do the following:	**Cannot do at all**				**Certain can do**	Depends/ DK/NA/ Refuse
	1	**2**	**3**	**4**	**5**	**Write in**
1. To look after yourself, for example, to wash, get dressed...	1	2	3	4	5	
Comments						
2. To do daily tasks around the home, for example tidying, cleaning…	1	2	3	4	5	
Comments						
3. To get out & about, for example, go shopping, do your errands…	1	2	3	4	5	
Comments						
4. Do you have someone to help you do any of these things?	Yes / Sometimes / No / DK					
If so, **Who?** *Circle all that apply*	1. Family 2. Friends 3. Neighbours 4. Homecare 5. Other *Please specify:*					
5. Can I just check who you live with? *If already mentioned, write in…*						
6. Are you currently taking any medication?	Yes / No / DK (if No → Q8)					
And how able are you to...	**Cannot do at all**				**Certain can do**	Depends/ DK/NA/ Refuse
7. To take your medication when you need to	1	2	3	4	5	

Comments						
8. To manage your finances well, for example organising bills & payments	1	2	3	4	5	
Comments						
9. To take your mind off your worries	1	2	3	4	5	
Comments						
10. To make your own decisions	1	2	3	4	5	
Comments						
How able are you to…	**Cannot do at all**				**Certain can do**	
11. To keep on top of things	1	2	3	4	5	
Comments						
12. To cope with life at home	1	2	3	4	5	
Comments						
13. Do you know how to get equipment to support you around the house if you needed it, for example an alarm, a shower seat…?	Yes / No / Depends					
Comments						
14. I'd now like to ask you about any health related services you've had recently. In the last 3 months, have you…read out..				Further details (*please circle /write in)*		
14a. Seen your GP?	Yes / No / DK			If YES: At home / At surgery / Both		
14b. Seen a nurse?	Yes / No / DK			If YES: At home / At surgery / Both		
14c. Had any hospital appointments in the daytime?	Yes / No / DK					
14d. Had to stay in hospital overnight?	Yes / No / DK					
14e. Had any health appts elsewhere (e.g. physio)?	Yes / No / DK			If YES: Where?		
14f. Had a carer support you at home?	Yes / No / DK					
14g. Had a meals service at home?	Yes / No / DK					
14h. Had any other services or support?	Yes / No / DK					
Comments						

Please use this scoring card to answer the following questions... SHOWCARD 2…					
	None at all	**A little**	**A lot**	Depends/ DK/NA/ Refuse	
15. How much do you know about what help is available to you from local organisations in your area? Would you say you know...*read out*	1	2	3		
Comments					
	None at all	**A little**	**A lot**	Depends/ DK/NA/ Refuse	Further details, e.g. who?
16. How much contact do you have with other people, firstly, with:					
16a. Family… *read out…*	1	2	3		
16b. Friends…*read out…*	1	2	3		
16c. Neighbours…*read out…*	1	2	3		
16d. Anyone else? e.g. local people or groups in your area	1	2	3		
17. Can I just check would you like more contact with others?	Yes / No / DK				
Comments					
	None at all	**A little**	**A lot**	Depends/ DK/NA/ Refuse	
18. How much control do you have over your daily life at the moment	1	2	3		
Comments					

Now, I'm going to read you a few statements, could you indicate for me using the scoring system on this card **how much you agree or disagree with each one** (SHOW CARD 3). One means you strongly disagree, 5 means you strongly agree. And the middle of the scale is 3.						
	Strongly disagree				**Strongly agree**	Depends/ NA/ Refuse
	1	**2**	**3**	**4**	**5**	**Write in**
19. It's easy for me to find someone who will *really* listen to me if I need to talk	1	2	3	4	5	
Comments						
20. I have activities that I enjoy doing with my time	1	2	3	4	5	
Comments						

21. Can I check would you like to take part in more activities?	Yes / No / DK					
Comments						
And I have a few statements about how you feel….						
22. I feel safe & secure in my home	1	2	3	4	5	
Comments						
23. I feel in good spirits	1	2	3	4	5	
Comments						
24. I feel good about myself	1	2	3	4	5	
Comments						

25. Finally, I'd like to ask a question about how satisfied you feel. (SHOWCARD 4). **Thinking about your own life & personal circumstances, how satisfied are you currently with life as a whole?**					
Completely dissatisfied				**Completely satisfied**	Depends/ DK/ NA/ Refuse
1	2	3	4	5	
Comments					

26. Is there anything else you'd like to tell me about how you're coping with life in general?	
CHECK Is it ok for me to pass on some of the things you've mentioned to the Red Cross service team to inform any support they might be able to offer you?	Yes / No

END OF PRE-SERVICE INTERVIEW

The POST service interview asked all of the questions in the PRE interview above (except 14, 17, 21 and 26) plus an additional section (below) asking for views and experiences of the service and some demographic data.

POST- service Questionnaire (Section 2)

Now I'd like to ask you about the support that the Red Cross provided over the past few weeks, for your experiences and views of this support. Your answers will help us improve our service.

23. First of all, can you tell me a bit about the support you got from the Red Cross. What did they help you with over the last few weeks? **INTERVIEWER: We need as much detail as possible at this question.** **PROBES:** How many visits did you get? Who visited you and what did they do? What happened on visit 1, visit 2, visit 3… etc.? Did you get any telephone calls? Did you get any practical support? **Anything else?**	
24. Can I just check, were you visited by the same person each time or did you see different people?	Same / Different / DK / only had 1 visit
Details	
25. Do you know if they were staff or a volunteer?	Staff / Volunteer / Both / DK
26. What was the best thing about the Red Cross support for you? What was most helpful?	
27. Was there anything you didn't find helpful?	
28. Was there anything you needed that the Red Cross didn't provide?	
29. And how did you find the way you were treated by Red Cross staff and volunteers? *PROBES: Were they helpful or unhelpful? Were they easy to talk to or not always?*	
30. Was the Red Cross service explained clearly to you? Were you clear what support they could offer you?	Yes / No / DK
Comments	
31. I'd like you to think about whether the Red Cross helped you to get support from any other services – either by referring you to other places or by telling you about them? First of all, did they help you get support from:	
31a. any health services	Yes / No / DK / Not needed

31b. any local organisations or groups	Yes / No / DK / Not needed
31c. any other services providing practical support at home	Yes / No / DK / Not needed
If YES: Where/ which service(s)? How did that happen?	
If NO: Would you have liked this?	Yes / No / Not needed / DK
Comments	

I'd like to ask you how satisfied you were with certain things about the service. Please be honest in your responses as we'd like to understand how we can improve things. Your answers are confidential. Using the same scale as before... SHOWCARD 4... First of all how satisfied were you with...

	Completely dissatisfied		**Neutral**		**Completely dissatisfied**	**Depends/ DK/ NA/ Refuse**
32. The time of day you were visited	1	2	3	4	5	
Comments						
33. The number of visits you had each week	1	2	3	4	5	
Comments						

Thinking about the overall length of the service from the first visit to the last. How satisfied were you with

34. How long the service lasted for	1	2	3	4	5	
Comments						

35. Can I just check, has the service ended?	Yes / No / DK
Comments	
If YES: How were you informed?	
If NO/ DK: Are you aware when the service will be ending?	
36. Did you have any choice over the type of support you got from the Red Cross? Would you say...*READ OUT*..	None at all / A little / A lot / *Other*

I'd now like you to think a little bit more about how you were treated and supported by Red Cross staff and volunteers. Did you feel that they... SHOWCARD 5…

	Not at all	**A little**	**A lot**	Depends/ DK/NA/ Refuse
37. Were friendly & compassionate	1	2	3	
Comments				
38. Treated you with dignity & respect	1	2	3	
Comments				
39. Listened to your needs	1	2	3	
Comments				
40. Supported you in the way you wanted	1	2	3	
Comments				
41. Understood your situation	1	2	3	
Comments				
42. Helped you to cope better	1	2	3	
Comments				
43. Helped you to increase your independence	1	2	3	
Comments				

44. Check - have you ever had this service from the Red Cross before?	Yes / No / DK
45. Finally, would you recommend the service to a friend?	Yes / No / DK
Why?	

I just have a few final demographic questions to ask you. This is so that we can build a better picture and profile of the people we support

46. Do you mind me asking how old you are? *(write in)*	
47. Gender *(interviewer to simply make a note)*	☐ Male ☐ Female

48. How would you describe your ethnicity?	☐ White:
	  ☐ White British
	  ☐ White Irish
	  ☐ Other White
	☐ Mixed:
	  ☐ White and Black Caribbean
	  ☐ White and Black African
	  ☐ White and Asian
	  ☐ Other Mixed
	☐ Asian or Asian British:
	  ☐ Indian
	  ☐ Pakistani
	  ☐ Bangladeshi
	  ☐ Other Asian
	☐ Black or Black British:
	  ☐ Black Caribbean
	  ☐ Black African
	  ☐ Other Black
	☐ Chinese
	☐ Other group (specify):
	☐ Prefer not to say

49. Do you own your own home or are you renting?	☐ Own ☐ Rent ☐ Other (specify):
If RENT: Are you renting from the council, a housing association or a private landlord?	☐ Council / Local Authority ☐ Housing Association ☐ Private landlord ☐ Other (specify):
50. Do you have any long term health conditions that affect your day to day life?	☐ Yes ☐ No ☐ DK
If YES: How does this affect you?	☐ Mobility ☐ Sight ☐ Hearing ☐ Speech ☐ Reading/ writing ☐ Other (specify):
51. And can I just check, do you consider yourself as having a disability?	☐ Yes ☐ No ☐ DK
52. We may like to contact you again. Would you be happy for us to contact you again in the future for a short conversation to see how you are?	☐ Yes ☐ No ☐ DK

QUALITATIVE PROMPTS if person unable to complete questionnaire

1. How able are you to carry out daily activities (e.g's Q1-3)?
2. Do you get any support from other people or services (see list at Q.14)?
3. How much contact do you have with other people? And who do you live with?
4. How do you currently feel – e.g. in control of daily life? Safe at home? Satisfied with life?
5. Can you tell me about the support you got from the Red Cross? What did they help you with?
6. Did the Red Cross help you to get support from any other services (such as any health services or local organisations)?
7. How did you feel you were treated and supported by Red Cross staff and volunteers? *PROBES: Were they friendly and compassionate? Did they understand your needs? Did you feel they helped you cope better? Helped you to increase your independence?*
8. How satisfied were you with the service, in terms of the number of visits you got, the time of day they came? Were you clear when the service was coming to an end?
9. Would you recommend the service to a friend?

INTERVIEWER Questions *(to be completed after the interview)*

A. How long did the questionnaire take to complete?	
B. How long did you spend with the service user?	
C. Was anyone else present during the interview?	No / Yes Who? ____________________
D. We'd like to get the perspectives of family members to ask for their views on how/ whether BRC service & support addresses needs. **Did the service user talk about any family members that may be appropriate to interview?**	No / Yes Who? ____________________

E. How easy or difficult was it to complete this questionnaire? *(please circle)*

Very difficult	Fairly difficult	OK – neither easy nor difficult	Fairly easy	Very easy	Other *(explain below)*

Please explain: *e.g. how much guidance/interpretation did you need to give?*

F. Were there any particularly difficult questions or contradictory responses? *Please note the question number & issue below*	Yes / No / DK

G. Summary of ongoing support needs that the service user reported during the interview

H. Is there anything we need to follow up for this service user? If so, please state who needs to do this follow up activity and alert/log appropriately

I. Any other comments or observations?

Appendix E Interview template – Red Cross staff & volunteers

You & your role

1. When did you start working/ volunteering in your current role for the Red Cross?
2. What attracted you to the role?
3. What was your background?
4. Could you briefly summarise what you do – what does your role involve?
5. Thinking back to when you started this role, did you get any specific training to prepare you for the job?
6. And what, if any, ongoing training and support do you get in your role?
   PROBE TO CHECK: Any training sessions, workshops, briefings or information sessions, debriefing, one to ones/ supervisions, peer support etc.

The service

7. What would you say the aim of the service is? How would you describe that?
8. Imagine I am completely new to the service – could you tell me about the key things you provide?
9. Thinking about your past week, have you had any direct contact with service users – either home visits or telephone calls?
   If yes – could you tell me a little more detail about those?
10. *Check if not already mentioned* – Do you provide befriending?
    If yes, could you tell me how this is done? i.e. Who provides this? How often? For how long? What does it involve?
11. Check if not already mentioned – Do you provide signposting?
    If yes, could you tell me how you do this? i.e. Who provides this? What does it involve?
12. In your view, what's the best thing about the service?
13. Is there anything you might like to change about the service?

Your service users

14. Who is the service targeted at?
15. Can you tell me a little bit about how referrals are assessed and accepted as service users?
    INTERVIEWER: If the volunteer is not involved in this / doesn't know anything about it then please reassure them that's fine & go to Q21.
16. Are there any specific criteria for referrals, for example, regarding the needs or current situation of potential service users? What are these?
17. Do many people get turned down, because they don't fit our criteria? Why would that be?
18. And do many people refuse the service themselves or decide they don't need it? Why would that be?
19. Does the service have any targets to meet regarding the number of service users? What effect, if any, does this have on the service?
20. Do you think the commissioning environment influences the work we do? For example our service priorities, developments or otherwise? How is that?
21. In your view, do you feel we are reaching people in the greatest need (who fit our criteria), and who have nowhere else to turn? Why is that?

Value & impact

22. Thinking about the impact the service has on people's lives. What difference do you think it makes to service users? Can you give me an example? *Please probe fully…* To what extent do you feel the service users value the service?
23. What do you think people would do otherwise, if the service didn't exist?
24. Do you think the service prevents people from being admitted or readmitted into hospital? What makes you say that? Can you give me an example?
25. Can you describe any specific things in place that enable the service to prevent readmissions? How are staff & volunteers equipped to do this through the information or support they offer?
26. *Check if not already mentioned* – Does the service support people who have just been discharged from hospital?
    If yes, go to 27
    If no, go to 28
27. Do you think the service enables patients to be discharged quicker who might have otherwise had to stay in hospital longer? What makes you say that?

Finally…

28. Do you think our service impacts other people? For example the NHS hospital or social services staff or the families & carers of our service users? Anyone else? And how is that?
29. So summing up, what would you say are the main successes of the service?
30. And what would you say are the main challenges of the service?
31. *(Volunteers only)* Finally, what does volunteering for the service mean or bring to you?
32. Is there anything else you would like to add? Any further comments?

Appendix F Interview template – Referrers

You & your role

1. Which organisation or department do you work in? What is your role?
2. Could you briefly summarise what you do – what does your job involve?
3. How did you learn about the Red Cross service? When was that?
4. And can I check, do you personally refer people to the Red Cross? How often?

The Red Cross service & your referrals

5. How would you describe the Red Cross service, it's aims and what it provides? Anything else? *CHECK: if they feel clear what the BRC service offer is.*
6. Can you tell me how you would assess someone and decide to refer them to the Red Cross. What characteristics or criteria would you use? For example, regarding their needs or current situation? Anything else? *CHECK: if they are aware of any specific criteria that the Red Cross Service has and what they are.*
7. What would you do otherwise, if the Red Cross service didn't exist? Are there any other services to refer to? Or any other options?
8. I'd like you to think about the last person you referred to the Red Cross. Could you tell me a little bit about them, why you referred them and what you wanted the service to provide?
9. Are there people you would like to refer but don't fit our service or our criteria for referrals? If yes, who are they/ why is that?
10. And can I just check, how do you refer people to the service? Does the referral process work ok for you? Are there any ways it could be improved?

Value & impact

11. Thinking about the impact the service has on people's lives. What difference do you think the Red Cross service makes to people?
12. How does the Red Cross service impact your work? What difference does it make for you to be able to refer people to the Red Cross?
13. In your view, what's the best thing about the service? Is there anything unique about the Red Cross service that makes it stand out? *Please probe fully…* What are it's main strengths? Anything else?
14. Is there anything you would like to change about the service? Anything that doesn't work as well as it should? Anything that could be improved?
15. Do you think the service prevents people from being admitted or readmitted into hospital? What makes you say that? Can you give me an example?
16. *Check if not already mentioned* – Do you work in hospital discharge?
    If yes, go to 17
    If no, go to 18
17. Do you think the service enables patients to be discharged quicker who might have otherwise had to stay in hospital longer? What makes you say that?
18. Do you have any ideas for the future development of the service? How we can build on our strengths? Are there any specific gaps that the service could fill?
19. Is there anything else you would like to add? Any further comments?

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**REFUSING
TO IGNORE
PEOPLE
IN CRISIS**

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