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British Red Cross

# The economic impact of care in the home services

## A report commissioned by the British Red Cross

**November 2012**

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# Contents

# Executive summary

The health and social care reforms across the UK aim to promote greater integration between health and social care, with an increased focus on delivering improved outcomes. These reforms are being conducted in an environment where the system is experiencing increased cost pressure. In this context, preventative care and early intervention schemes are gaining greater prominence.

The British Red Cross ('BRC') has provided healthcare and social care services in the UK for over 30 years, delivering support to over 45,500 service users in current projects. Services range from providing support to people to facilitate early hospital discharge to reducing domiciliary and residential care by delivering personal care, additional support and reablement. Working with individuals following a crisis, the BRC schemes provide practical and emotional support to give reassurance, improve wellbeing and increase resilience. This support reduces the likelihood of avoidable readmissions and supports people to live safely, with dignity and increased confidence in their homes.

This study seeks to contribute to the growing body of empirical literature estimating the economic impact of such schemes. The study estimates the economic benefits to commissioners of both health and social care across six BRC schemes, two covering A&E hospital schemes, and four focussed on community and individual resilience. The economic benefits are estimated by comparing the cost to commissioners of delivering the scheme to the alternative care cost. The cost of alternative care is estimated based on patient information, commissioner assumptions and with independent clinical input around alternative treatments.

Based on analysing these six schemes, BRC is found to be delivering substantial savings to health and social care commissioners. Savings per user from these schemes are estimated to range from £168 to £704 relating to a rate of return between 40% to 280%. Savings are realised through:

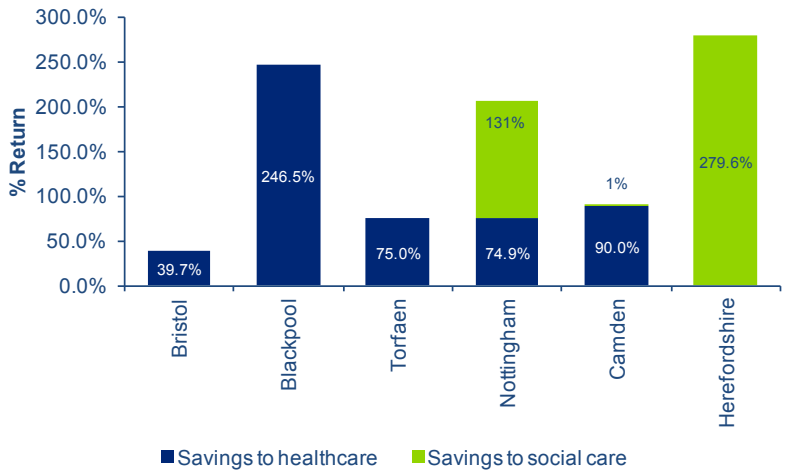
- The prevention of hospital admission or reduced length of stay in hospital, as data indicates that service users can avoid staying up to three days in hospital;
- Reduced levels of hospital readmission, as reported readmission rates for service users are on average estimated to be lower than those found in local hospitals' A&E; and
- Preventing or minimising the use of expensive domiciliary and residential care.

**Savings across BRC schemes**

| Scheme | Type | Savings to health care commissioner | Social care savings | Savings per service user |
|---|---|---|---|---|
| Camden | Community | £76,502 | £707 | £246 |
| Herefordshire | Community | £0 | £218,118 | £347 |
| Bristol[(1)] | A&E Discharge | £46,442 | £0 | £168 |
| Blackpool | A&E Discharge | £191,407 | £0 | £264 |
| Torfaen | Community | £140,869 | £0 | £704 |
| Nottingham | Community | £315,897 | £56,493 | £633 |

(1) Prospective evaluation

**Breakdown of returns in health and social care**



# Executive summary

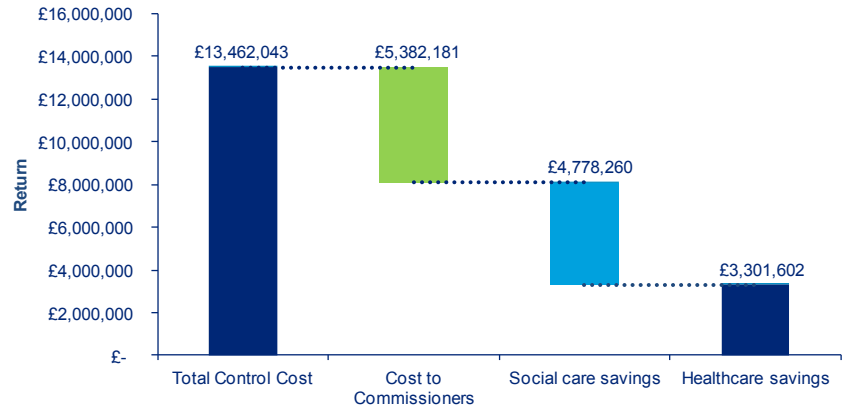
BRC currently delivers over a hundred social support schemes across the UK. Many of these are similar to the six case studies considered in this report. By matching the schemes to the six case studies, BRC schemes are estimated to have the potential to save commissioners £8m. This saving implies an overall return of 149% on commissioner expenditure, suggesting that these schemes deliver material benefits and form a crucial element of care in the UK. The estimated impacts are consistent to other research conducted by the New Economics Foundation (2012) and Arksey et al. (2010).

In addition to savings there are a number of further benefits the schemes deliver.

- Service user benefits. From the six case studies considered over 70% of users reported that the service was excellent indicating that the schemes are highly valued.
- Signposting. BRC regularly provides information and referrals to a wide range of independent and statutory sector organisations facilitating efficient access to additional services for service users.
- Benefits from the use of volunteers. Services are typically delivered by both employed staff and BRC volunteers. The use of volunteers has been found, for example by CSV (2006), to provide additional benefits in terms of reducing social isolation and contributing to independence and well being.

This study has considered the short run savings from the schemes delivered, focusing on savings primarily to the NHS rather than longer run benefits potentially accruing to care commissioners. Future research could helpfully seek to understand the longer term impact.

**Distribution of net savings across BRC schemes**



# Background to this study

### The British Red Cross social support services

The British Red Cross ('BRC') has provided health and social care services for over thirty years, currently delivering £5.4m worth of schemes in the UK. These services range from reablement to domestic and personal care and aim to empower service users to achieve greater independence while reducing the burden on health and social care. Services are primarily funded by health care commissioners and local authorities. In some circumstances, BRC has also contributed to the set-up costs or matched the funding for the services.

Trained and skilled volunteers deliver the majority of services with paid staff coordinating the work and delivering care where the regularity and the intensity of requires. BRC has a network of offices across the UK, providing services across the UK including in major cities and smaller communities.

The services provided form a crucial part of health and social care and they ensure that people with less severe needs receive appropriate care and enabling more expensive resources to be concentrated on those who most need them. They are also increasingly aligned to the policy changes in health and social care across the UK.

### Scope of this study

The BRC has commissioned Deloitte to estimate the economic impact to commissioners of six BRC schemes covering both community and individual resilience and hospital facing schemes.

The economic impact is estimated as savings for health and social care commissioners through a number of channels, including reduced length of stay, prevention of admission, improved hospital readmissions and reduced input from social services.

In addition to estimating the overall economic impact of the six schemes, the overall economic impact delivered across all schemes running between 2011 and 2012 is also considered. BRC has matched each scheme to its closest case study (as shown in the appendix). The corresponding return of the case study is then applied to the scheme.

This report is structured as follows:

- Section 1 provides a summary of the methodology employed in the study;
- Section 2 presents the results of the six case studies; and
- Section 3 estimates the total economic impact across all BRC schemes.

**Case studies considered in this report**

# Changes to health and social care in the UK

Health and social care policy is currently experiencing significant changes across the UK, increasing the importance of the services BRC delivers at the intersection of health and social care. Further, expansion of BRC's services is consistent to the increasing budgetary constraints across the system reducing the burden on more costly services. In England, for example, the Quality, Innovation, Productivity and Prevention Programme (QIPP) is seeking to achieve savings of £20bn by 2014/2015.

**Health and Social Care reform in England**

The coalition government has brought a significant programme of reform to both health and social care in England with the Health and Social Care Act 2012, the publication of the Caring for our Future White Paper in July 2012 and a draft Care and Support Bill. The focus of reforms has been to maximise choice and embed a personalised approach to promote individual's independence and wellbeing. Included in this ambition is a renewed focus on reablement, preventing avoidable readmissions and supporting better integration between services. This is reflected by the transfer of funds from NHS to social care and across the three Outcomes Frameworks for the NHS, Public Health and Social Care. In particular, the Outcomes Frameworks include indicators covering:

- Emergency readmissions to hospital 30 days post discharge (NHS and Adult Social Care);
- The proportion of people still at home 91 days after discharge into reablement or rehabilitation services (NHS and Adult Social Care); and
- Forthcoming measure of local wellbeing, with a focus on social isolation (shared between Public Health and Adult Social Care).

These indicators align to a number of the BRC schemes focussed on reablement and reducing hospital readmissions or admissions.

The White Paper also establishes a minimum eligibility threshold for social care, which could imply increased need from commissioners to establish early intervention services. The White Paper also highlights the need of further development of voluntary services, as well as promoting support from community groups and networks, improving community resilience.

**Health and Social Care reform in Scotland**

The Scottish government recently closed a consultation on the integration of health and social care, which will lead to new legislation. The aim of the reform is to address a lack of consistency in quality of care for disabled adults and older people, delays in discharge from hospital, delays in the provision of preventative care which can enable people to stay at home and avoid hospital admissions. The proposals for reform include the establishment of integrated budgets for joint strategic commissioning that will apply across adult health and social care and the creation of a National Performance Framework, including a set of Quality Outcome Indicators.

**Social Care reform in Wales**

Following the Sustainable Social Services White Paper, the Welsh Government has recently published a draft Social Services Bill. The reform is aimed at integrating the delivery of services on the basis of need, not of age (a definition of "children in need" is currently in the law, but there is no similar one for adults). The Government has proposed the introduction of national eligibility criteria for social care including 'portable assessments' if people move from one part of Wales to another. There is also particular emphasis in the rights of carers and the support they are entitled to receive.

**Health and Social Care reform Northern Ireland**

Northern Ireland is the only nation in the UK where health and personal social care services are integrated in the Regional Department of Health, Social Services and Public Safety. Following a review of health and social care services undertaken in 2011, 99 proposals were presented. Relevant proposals include :

- Increased focus on health promotion and prevention to reduce demand for acute health services;
- Reduction in residential accommodation for older people, with a coordinated increase in services delivered at home and in the community; and
- Introduction of reablement services to encourage independence and help avoid unnecessary admissions of older people into hospital.

# Methodology

# Impact analysis methodology

## Overall methodology

The economic impact of the service to commissioners is estimated in three steps.

- **Step 1 – service costs.** The prices charged for BRC services are identified by considering service level agreements, contracts or financial flows between service commissioners. The contracts fall with a number of different parties depending on the scheme including Primary Care Trusts, Local Authorities or Clinical Commissioning Groups (CCGs). The contract value in some instances is annualised to provide an annual estimate of the service cost.
- **Step 2 - control costs.** This is the cost that would have prevailed had the BRC scheme not occurred (counterfactual/control). Defining a robust control is often challenging. Throughout this study, the alternative service user pathway is developed based on primary and secondary evidence. This research was used to construct a tree diagram of the possible pathways service users could have taken without BRC support.
- **Step3 - economic impact.** The calculation of the economic impact to commissioners is estimated as the change in cost to commissioners between Step 1 and Step 2.

## Data collection

Data for the study has been obtained from various sources including:

- Publicly available information, for example the NHS Information Centre and the Personal Social Services Research Unit;
- Discussions with BRC service managers, as well as other data collected by the BRC;
- Deloitte independent clinicians;
- Discussions with commissioners; and
- Service user feedback collated by BRC.

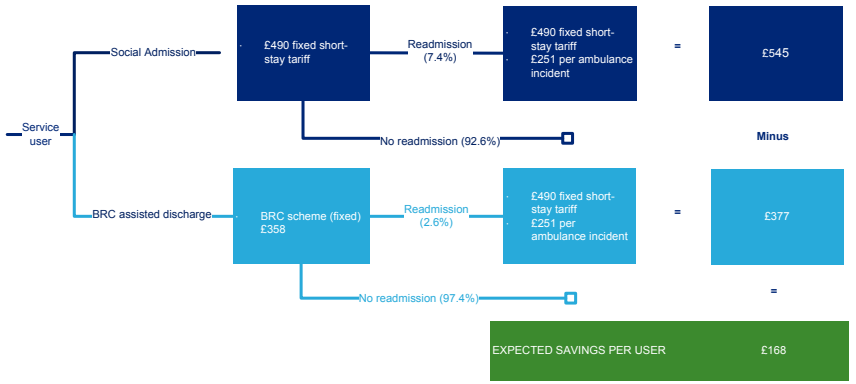
A full description of the data underlying each case study is included in the appendix.

## Scope of methodology

The approach used in this report is focussed on the short-term benefits of the scheme. Future research could consider extending the analysis to consider other impacts such as:

- Not all alternative pathways in the alternative scenario costing are identified. This is particularly relevant when estimating costs to social care where lower level support is difficult to determine.
- Long term impacts are not considered, for example do the schemes continue to have a prolonged impact on people reducing their usage of health and social care.

## Illustrative tree diagram




The indicative tree diagram above provides a simple example of a service user of BRC's A&E assisted discharge scheme.

The dark blue branches of the tree represent the control, or alternative pathway of the service user, if BRC's assisted discharge scheme had not been in place. A social admission would have occurred, incurring a specific cost to the commissioner (in this case, a fixed cost per stay). Readmission data indicates that up to 7.4% of patients re-attend A&E. In this example, this generates an additional admission and an additional ambulance charge.

The light blue branches indicate the BRC service user pathway. Due to the BRC's intervention, the commissioner only pays a fixed cost per service user. Service user data indicates also lower levels of readmissions, so overall costs for a typical service user are comparatively lower.

The calculations to the right of the tree are expected cost values for a typical service user accounting for the probabilities associated with each branch, subtracting the expected cost of a social admission for a BRC service user implies a positive impact to commissioners. This expected cost is calculated by multiplying the relevant probabilities and costs. For example, the cost of the control is calculated (the small difference from the tree diagram relates to rounding differences):

*Control cost = Social admission (with readmission) + Social admission (without)*

*= 7.4% x (£490 + £490 + £251) + 92.6% x (£490)*

*= £91 + £454*

*= £545*

# Sensitivity analysis methodology

### Accounting for uncertainty

In order to measure the economic impact of BRC's services a number of assumptions are made. One of these, the impact of BRC's assisted discharge scheme requires identification of the reduction in the length of stay in secondary care. To systematically account for this uncertainty, specific modelling techniques can be employed to establish a distribution around the estimated economic impact. Such tools include the Monte Carlo method.

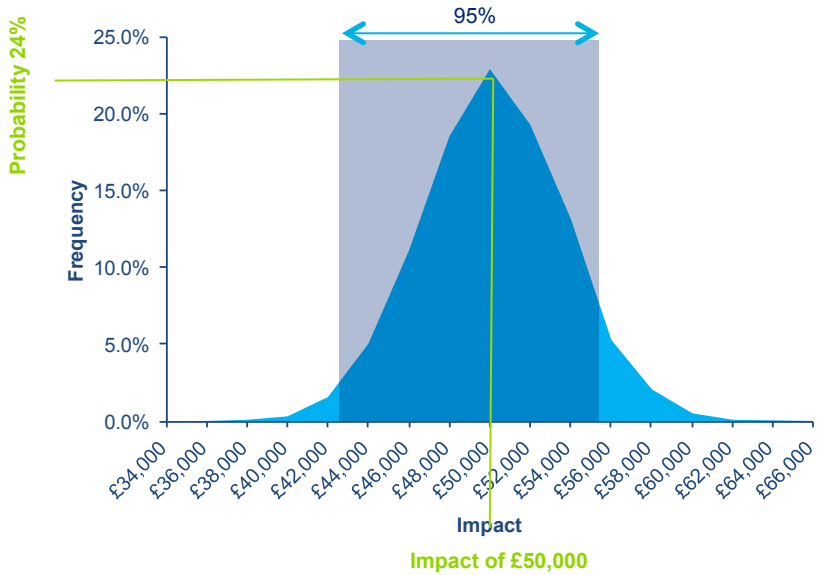
A Monte Carlo approach is employed to account for uncertainty in one key assumption or parameter driving cost in each case study. In most instances the parameter selected is length of stay, but when this is not possible, the cost of a hospital episode, or the proportion of service users receiving an alternative treatment is used.

The simulations are primarily undertaken assuming the parameters follow a normal distribution. Future work could look to extend this uncertainty analysis to allow for uncertainty across a wider range of parameters and to identify the appropriateness of the assumption of normality.

Monte Carlo approaches are used in a wide variety of applications including in science, finance and economic impact analysis. The approach is discussed explicitly in the Green Book (HM Treasury, 2003) as a key tool in economic impact analysis where uncertainty exists in the underlying assumptions or modelling and has been applied, for example, in the National Audit Office's report on autism (Clark et al. 2009).

The Monte Carlo approach allows the uncertainty for a particular parameter to be considered and the end impact on the overall economic analysis to be quantified.

**Illustrative distribution of impacts using the Monte Carlo approach**



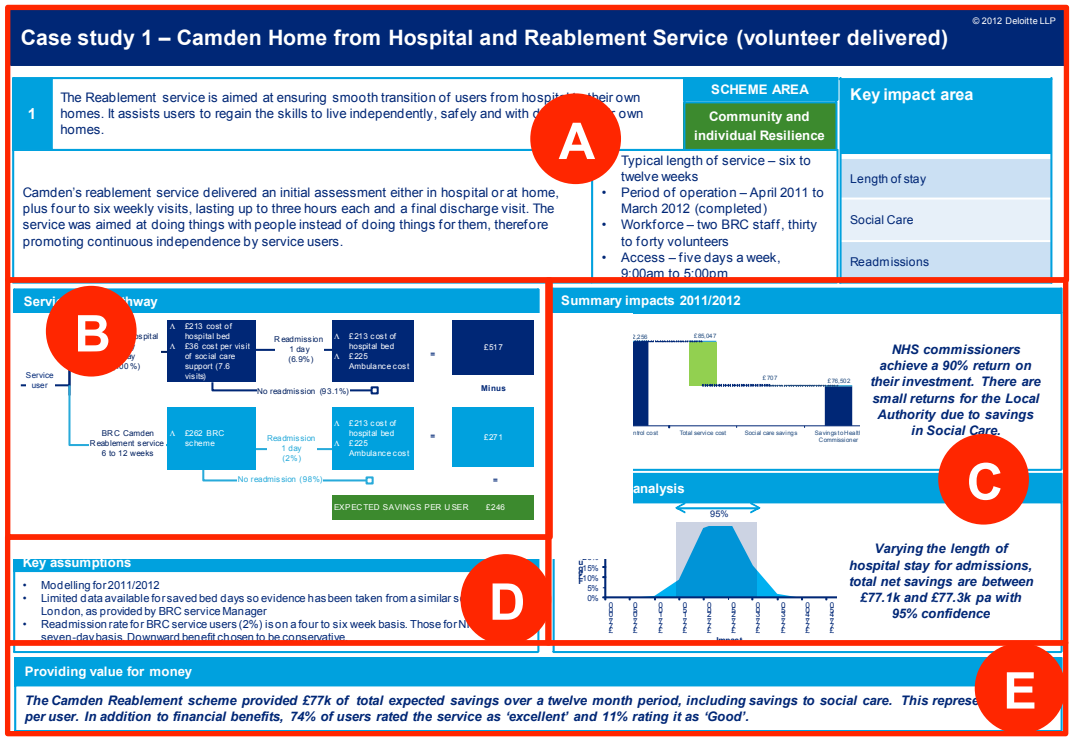

The graph presents the distribution of the total economic impact from the BRC scheme. On the x-axis is the range of potential impacts with the probability of a particular impact presented on the y-axis.

To interpret this graph consider that the possible impact of the scheme is £50,000. Reading across the y-axis, corresponding to a £50,000 impact, the probability of the impact actually being £50,000 is estimated to be around 24%.

Using this graph the probability of a particular range can also be established. For example, allowing for possible higher and lower impacts we can be 95% certain that the impact is between £42,000 and £56,000. This 95% confidence interval is highlighted by the shaded area identified. Throughout the report, the 95% confidence interval is reported for each case study.

# Case study dashboard explained

Each case study has a separate dashboard setting out the background, key results and underlying assumptions for the estimation of the economic impact. A breakdown of the dashboard is provided below.




**A** Provides the background to the scheme and key areas the scheme aims to impact

**B** Breakdown of a typical user pathway for the service

**C** Key results from the study including a breakdown of who the impacts accrue to and distribution of impacts based on changing key parameters in the model

**D** Description of the material assumptions underlying the analysis expanded on in the appendix

**E** Key conclusions

# Case studies

# Case study 1 – Camden Home from Hospital and Reablement Service (volunteer delivered)

## Background

The Camden Reablement service was initially commissioned as a three-month pilot from January to March 2011. Following the successful implementation of the pilot, the team was able to secure additional funding from the NHS, delivered by Camden Council and operating from April 2011 to March 2012. The BRC team worked closely with other agencies, such as Carelink (providing the personal care element of the service) and the Post Acute Care Enablement (PACE) team from Royal Free Hospital.

The service delivered an initial assessment either in hospital or at home, plus 4 to 6 weekly visits, lasting up to three hours each and a final discharge visit. The service focuses on supporting people to develop or regain their own skills and capabilities, rather than simply undertaking tasks for them. In doing so the service promotes continuous independence by service users.

Main benefits of the programme include:

- Reduction in delays in transfers of care. The service aims to reduce length of stay in hospital, by working with the PACE teams.
- Reduced input from social care services, as their analysis of care needs for each service user allows the council to save up to a day of social care assessment.
- The service is primarily delivered by 30 to 40 volunteers, run by two coordinators.

Data from BRC indicates 85% of service users are over 65 years of age. Users report some degree of frailty, as 30% report having a physical impairment and 52% a mobility impairment. Service satisfaction is high, as 74% of users rating the service as 'Excellent' and 11% rating it as 'Good'.

Together with Carelink and the PACE team, the British Red Cross Reablement service has partnered with Hospital at Home service from University College London Hospital for further work with Camden's Clinical Commissioning Group, as part of a new integrated care pathway. This should result in further work going forward.

## Positive impacts to service users

Mr H, a 74 year old, had been admitted to hospital twice in a period of four weeks, as he suffers from diabetes, heart problems and obesity. He was referred by University College Hospital for help settling him back into his home. The BRC's Next steps reablement team met Mr H at home upon discharge and helped him settle in. Upon arrival, they noticed that Mr H's possessions had been moved due to an arranged cleaning by social services, which caused Mr H significant distress. BRC were able to calm Mr H down and started to assess what level of support he had from friends and family. At this point Mr H disclosed that he had stopped his family visiting him twenty years ago.

The reablement team assisted and escorted Mr H with food shopping and collecting his prescription from the pharmacy. Following a discussion of his health needs, it emerged Mr H needed incontinent pads, as well as a referral for podiatry. All of this was arranged for him through a district nurse, as well as hospital transport for his outpatient appointments.

Reablement focused on introducing him to a healthier, cleaner routine, with additional activities. An OT arranged to have a bath seat and railing so Mr H could have a shower at home. Following four weeks of visits, his personal hygiene had improved and Mr H showed interest in learning new routines. He was able to visit local shops independently.

The most important outcome for Mr H, however, was enabling him to reunite with his family. The BRC team liaised with his family, neighbour and social worker to organise a small family meeting in Mr H's home, the first one in 20 years. Mr H was deeply touched by his family's love and support.

**Source: Service Evaluation Report**

***"Thank you for being so supportive and positive towards him"*** *(Mr H's sister, 2011)*

***"Your service certainly made a difference"*** *(Mr H, 2011)*

# Case study 1 – Camden Home from Hospital and Reablement Service (volunteer delivered)

**1**

The Reablement service is aimed at ensuring smooth transition of users from hospital to their own homes. It assists users to regain the skills to live independently, safely and with dignity in their own homes.

**SCHEME AREA**

**Community and individual Resilience**

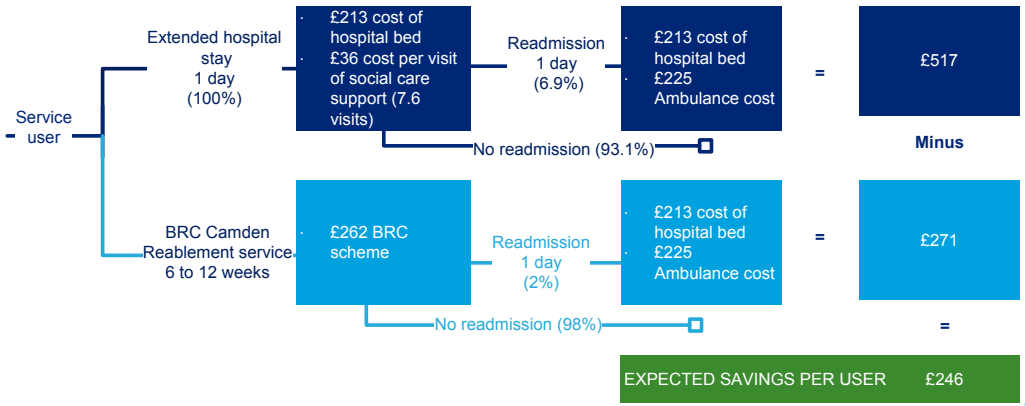
**Key impact area**

- Length of stay
- Social Care
- Readmissions

Camden's Reablement service delivered an initial assessment either in hospital or at home, plus four to six weekly visits, lasting up to three hours each and a final discharge visit. The service was aimed at doing things with people instead of doing things for them, therefore promoting continuous independence by service users.

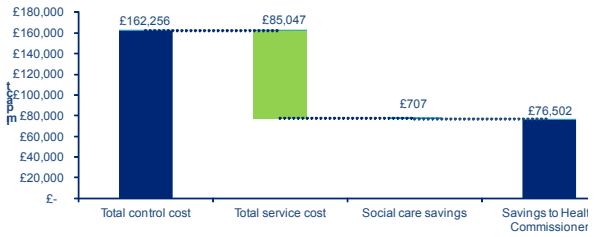
- Typical length of service – six to twelve weeks
- Period of operation – April 2011 to March 2012 (completed)
- Workforce – two BRC staff, thirty to forty volunteers
- Access – five days a week, 9:00am to 5:00pm

## Service user pathway



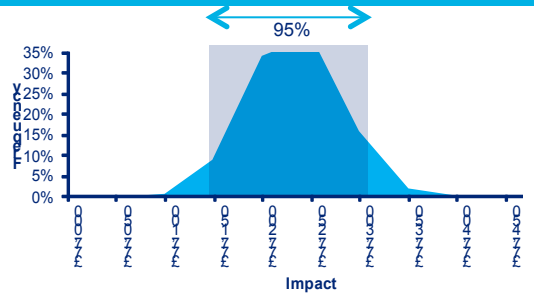

Key: (%) Percentage users ■ Alternative pathway for service users ■ BRC service users' pathway

## Summary impacts 2011/2012




***NHS commissioners achieve a 90% return on their investment. There are small returns for the Local Authority due to savings in Social Care.***

## Sensitivity analysis




***Varying the length of hospital stay for admissions, total net savings are between £77.1k and £77.3k pa with 95% confidence***

## Key assumptions

- Modelling for 2011/2012
- Limited data available for saved bed days so evidence has been taken from a similar scheme in London, as provided by BRC service Manager
- Readmission rate for BRC service users (2%) is on a four to six week basis. Those for NHS are on a seven-day basis. Downward benefit chosen to be conservative.

## Providing value for money

***The Camden Reablement scheme provided £77k of total expected savings over a twelve month period, including savings to social care. This represents £246 per user. In addition to financial benefits, 74% of users rated the service as 'excellent' and 11% rating it as 'Good'.***

# Case study 2 – Herefordshire Village Wardens (volunteer delivered)

## Background

The Village Warden Scheme has been operating in Herefordshire since 2005. Building on an initial signposting programme, the scheme considered ways of making the services more accessible for people in villages and rural areas of Herefordshire.

Village Wardens are primarily volunteers who live in the community they work in, so are able to draw on a range of local networks such as parishes, neighbourhoods and local health services. The services provided by the wardens are spread across four broad areas:

1. Managing finance: receipt of benefits and grant entitlement, budget management skills, debt and cost management and payment of bills.
2. Health and wellbeing: registration and attendance to local health services, prescription collection, referral to urgent treatment.
3. Home and physical environment: Risk assessment of home and physical environment, including referrals for assessments for aids or adaptations to prevent falls, fire prevention measures, arrangement for repair or replacement of cooking equipment, shopping and preparation of light meals.
4. Community engagement: Providing companionship to clubs and local activities, development of personal support networks, intergenerational luncheon with local schools, walking group for people with dementia, among others.

Due to the complex needs of service users, particularly around adequate nutrition and management of long-term conditions, the service is delivered over 26 weeks, considerably longer than most other BRC models. This contributes to avoid premature admittance into residential care.

In April 2012, this service merged with the Home from Hospital service, aiming to provide additional impacts in reducing hospital admissions and readmissions following a hospital episode. The Local Authority has granted £108k for the development of this merged service.

It is expected that the service will support approximately 500 people, focusing on users over 75 years of age, with recent history of falls, with poor mental and physical health, living alone with limited support networks. Users who have been recently discharged from hospital and in need of transitional support are also targeted.

## Positive impacts to service users

Mrs P was a self referral and asked her local village warden to support both her and her partner through ill health. She had recently returned from hospital following a serious operation and was feeling very vulnerable and weak. She was the carer for her husband who had mental health issues and was unable to help her.

The village warden gave her support in the home and took her shopping to build up her confidence. As they were not receiving attendance allowance for her husband, the village warden arranged for Age Concern to do an assessment, which was successful.

The situation had recently deteriorated and Mrs P confided her partner had become physically violent towards her. The village warden encouraged her to seek help to protect herself and help for him. Mrs P agreed the warden could look into this and sought guidance from the BRC Safeguarding Officer. Subsequently the warden asked for their permission to contact Social Services. Following this, a referral was made to Herefordshire Carers Team which has agreed to allocate a support worker for the partner. The family have agreed to this and the warden was present for the first appointment.

**Source: Service Evaluation Report**

***"It is difficult to put into words the benefits I have derived through the help of the village warden. Removing many of the worries and the hassles gives you an invaluable 'peace of mind' and confidence there is help out there in emergencies."***

*(Service user feedback, 2011)*

# Case study 2 – Herefordshire Village Wardens (volunteer delivered)

**2**

Community based service aimed at providing a link between isolated older people and local communities, in order to overcome barriers of access to services.

**SCHEME AREA**

**Community and individual resilience**

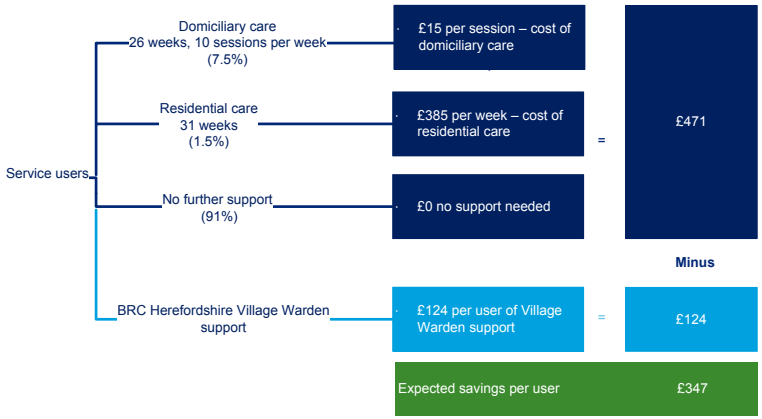
The Herefordshire Village Warden Scheme has been operating since 2005, with the support of the Local Authority. It provides mainly low-level support to vulnerable elderly Herefordshire residents in four main areas: managing finance, health & wellbeing, home and physical environment and community engagement. Village Wardens draw on informal networks to provide additional community resilience in one of the most sparsely populated areas of England. The programme is primarily delivered by volunteers.

- Typical length of service – up to twenty-six weeks
- Period of operation – From 2005
- Workforce – five BRC staff, one-hundred and twenty volunteers
- Access – five days a week, 9:00am to 5:00pm with flexibility over weekends and evenings

## Key impact area

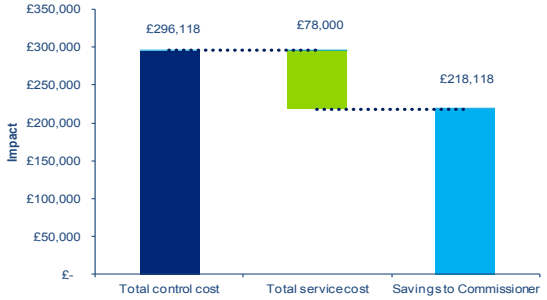
- Residential Care
- Domiciliary care
- Signposting

## Service user pathway




Key: (%) Percentage users  Alternative pathway for service users  BRC service users' pathway

## Summary impacts 2011

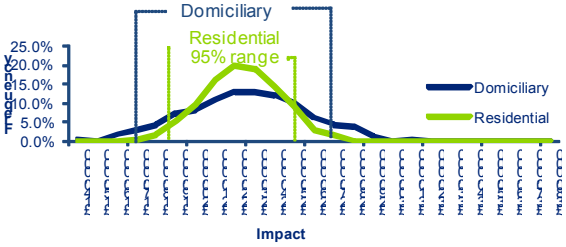



***Local Authority commissioners receive almost 2.8 times the value of their investment as savings***

## Key assumptions

- Tested variability in benefits if 5%-10% of service users required domiciliary care and if 1%-2% of service users required residential care
- Used figures of £15 for domiciliary care support, as provided by BRC service manager

## Sensitivity analysis




***Varying the proportion of residential users, net benefits are between £190k and £250k pa with 95% certainty. Varying domiciliary care users benefits range between £170k and £270k.***

## Providing value for money

***The Village Warden service provides expected savings of approximately £350 per user, approximately £190k-£250k for the programme as a whole. Over 70% of service users agree (or strongly agree) that the programme has helped them maintain their independence. It is expected that additional benefits will be achieved when merging with Home from Hospital scheme.***

# Case study 3 - Bristol A&E Assisted Discharge Service

## Background

The Bristol A&E assisted discharge service is an innovative pilot project commissioned to facilitate discharge from A&E and the Medical Admissions Unit of the Bristol Royal Infirmary. The pilot has been running since March 2012, commissioned by NHS Bristol and the funding has been matched by the BRC.

Service users with access to the service received support in a number of areas:

- Transport home;
- Scaled approach to care ranging from two hours to five hours (2+3); and
- Where the referrer indicates, an overnight sitting services when observation is particularly important.

The resettlement element of the service includes a number of core activities aimed at reassuring and supporting the service user whilst reducing the likelihood of readmission. Additionally BRC staff:

- Perform short term risk assessments for fires and falls in the service user's home, referring to suitable external agencies (such as Care&Repair) where appropriate;
- Support low-level activities including shopping, collecting prescriptions and preparing a meal; and
- Follow up each referral with a telephone conversation the following day, to ensure the service user is suitably settled and requires no further assistance.

The programme runs daily from 4:00pm to 12:00am seven days a week, during the peak times where social admissions to hospital are most likely. The service provides employment to around 14 people.

Elderly people are the main users of the service, with approximately 70% of referrals being over 70 years of age. Younger users are generally adults with learning disabilities.

Given the pilot nature of the scheme, the impact assessment has been undertaken prospectively based on expected user figures for a full year 2012/2013. These figures reflect increased demand for service due to winter climate and extended area coverage, as provided by the BRC.

## Positive impacts to service users

Mr C is 64 years old and suffers with chronic joint pain. He was brought into A&E after his knee became swollen and painful. He was given painkillers and crutches to get by until the swelling went down. Although medically fit to go home, hospital staff were concerned about how he would cope and referred him to the Assisted Discharge service. His impaired mobility meant he would have to sleep downstairs and attempt to walk to and from the bathroom alone. As Mr C lived on his own and had no support it was felt that he would have had to remain in hospital if the British Red Cross had been unable to assist.

Due to concerns regarding Mr C's mobility around his house and Mr C feeling very anxious about being left alone overnight, the referrer requested overnight sitting. This was to help reduce the risk of Mr C needing to re-attend A&E over the course of the evening.

Mr C was safely transported home and resettled. The reassurance provided helped Mr C to feel calmer and more relaxed in his home environment. Mr C received assistance to prepare a meal and was settled downstairs so he could sleep on the sofa overnight. As part of the risk assessment trip hazards were removed and all pathways cleared. The Assisted Discharge service provided Mr C with the practical and emotional support he needed to be safe and comfortable within his home environment and successfully prevented the need for a return to A&E.

**Source: Service Manager**

***"Both volunteers treated me with kindness and compassion but didn't patronise me. They were keen to try and meet my every need, were friendly and very helpful.***

*(Service user feedback, 2012)*

# Case study 3 - Bristol A&E Assisted Discharge Service

**3** Assist in resettling individuals at home following admission to A&E. Services provided include transport home, short risk assessment, basic house work and a follow-up visit the next day.

**SCHEME AREA**

**A&E**

Bristol's discharge service aims to reduce admissions to the Bristol Royal Infirmary's A&E and Medical Admissions Unit. The programme operates provides a scaled approach to care according to need, including transportation, plus two-hour, five-hour resettlement or an overnight service.

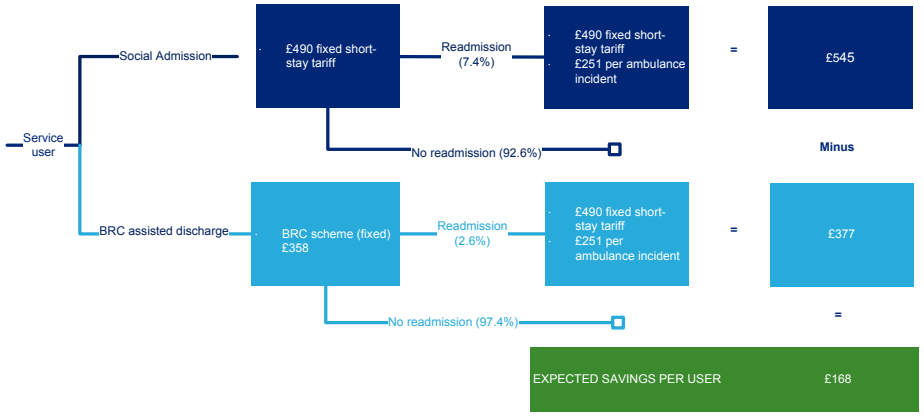
As part of the referral process, A&E staff confirm that users would otherwise be admitted to hospital if the BRC scheme was not in place. This process assures that the service is targeted at true prevention of social admissions.

- Typical length of service – two days
- Period of operation – From March 2012 (pilot)
- Workforce – 14 BRC staff, 0 volunteers
- Access – seven days a week 4:00pm to 12:00am

## Key impact area

- Social admissions
- Readmissions
- Signposting

## Service user pathway

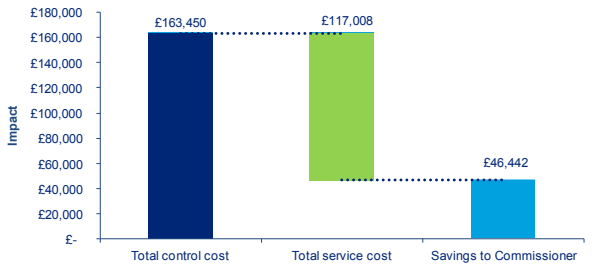



Key: (%) Percentage users | Alternative pathway for service users | BRC service users' pathway

## Key assumptions

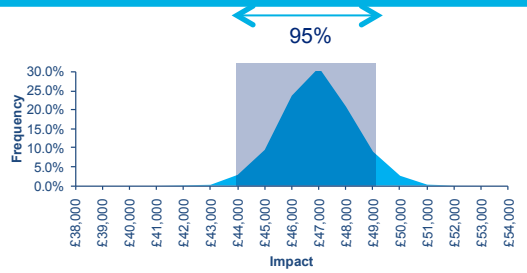
- Volumes and service cost have been provided by BRC's Service Manager assuming increases in demand due to expansion to the scheme's geographic coverage and winter climate
- A&E seven-day readmission at University Hospitals Bristol NHS Foundation Trust are assumed to be 7.4% for control group, from NHS data
- Readmission rates provided by the BRC for service users

## Summary of prospective impacts 2012/2013




***Healthcare commissioners could receive a 40% return on this service***

## Sensitivity analysis




***Varying the number of admitted service users, the total net savings could be between £44k and £49k pa with 95% of confidence***

## Providing value for money

***The Bristol scheme could provide considerable benefits to commissioners and service users. Savings to commissioners are expected to be around £46k in 2012/13 (approximately £168 per service user). In addition to financial benefits, 100% of users report the scheme is 'excellent' or 'good'.***

# Case study 4 – Blackpool Victoria Hospital - Fylde Coast Enhanced Hospital to Home Discharge Service



## Background

The Hospital to Home discharge service is funded by Blackpool NHS PCT a group of GPs of the Fylde Coast, with start up funding provided by the BRC. The scheme, based in Blackpool Victoria Hospital, commenced in 2011 with the aim of reducing length of stay and preventing hospital admission (for primary care referrals). Referrals come from A&E, Acute Medical Units, or from GPs wishing to avoid hospital admission for their patients.

Following discharge from A&E or the acute medical unit, a member of the Hospital to Home team transports service users back home from hospital. Once home, a short risk assessment is undertaken to reduce any safety risks from fires or falls. Neighbours and relatives are advised of the service user's return home and the member of the Hospital to Home team then assists in preparing a light meal and a hot beverage. If required, additional assistance is provided with shopping or collecting prescriptions.

Further contact is made the following day to ensure the service user continues to be safe and well, with volunteers providing companionship and support. An information pack with contact details of other support services and agencies is discussed with the service user and when necessary, the Hospital to Home team makes referrals or assists with referrals to these services and agencies.

If the service user requires, the team is able to provide further support with weekly visits for up to four to six weeks. As well as reducing admissions and readmissions, in most cases the service users have not had a benefits assessment and this is arranged for them where appropriate. Most common signposting referrals include Meals on Wheels, Blackpool Carers centre, or falls prevention programmes.

Demographic data indicates that 86% of service users are over 75 years of age. 98% of service users rated the service as "excellent". At present, the team is looking to expand the service to provide coverage on weekends from 2:00pm to 6:00pm.

## Positive impacts to service users

Mrs R is a 92-year-old lady who is the main carer for her husband, an elderly man with Alzheimer's. After a spell in hospital Mrs R found that her mobility had deteriorated and she was referred to the Hospital to Home Discharge service for transport home. The team escorted Mrs R home and carried out a risk assessment to reduce the likelihood of her suffering a fall. During the assessment, Red Cross staff noticed that Mrs R struggled to move using her zimmer frame on carpet and suggested that some aids and adaptations might help her move around her home more easily. With Mrs R's agreement, they contracted the Red Cross medical loans service to secure her a tri walker with wheels which would significantly improve her mobility.

Mrs R's granddaughter also highlighted concerns about her grandparents and their ability to cope following Mrs R's spell in hospital. The Hospital to Home Discharge team suggested a referral to adult social services for an assessment of suitability for domiciliary care. The team also offered to contact Blackpool carers at the hospital to give Mrs R support and help her apply for carer's allowance.

On the second visit to Mrs R's home, the Hospital to Home Discharge team were able to bring Mrs R the tri walker, which improved her mobility significantly. In her own words it helped her 'keep her legs going'. Mrs R granddaughter had received calls from Blackpool carers and adult social services, both agencies making appointments to see the family and provide further support. The family were extremely grateful for the rapid work in arranging further support in such a short amount of time and thanked the British Red Cross for their involvement.

**Source: Service Manager**

***"I've been telling everyone about what a good job the Red Cross did. "***

*(Service user feedback, 2012)*

# Case study 4 – Blackpool Victoria Hospital - Fylde Coast Enhanced Hospital to Home Discharge Service



**4**

Assisted discharge service aimed at A&E, Acute Medical Unit and primary care discharge (from April 2012 ). Service users are supported to resettle comfortably and safely at home, avoiding social admissions.

**SCHEME AREA**

**A&E**

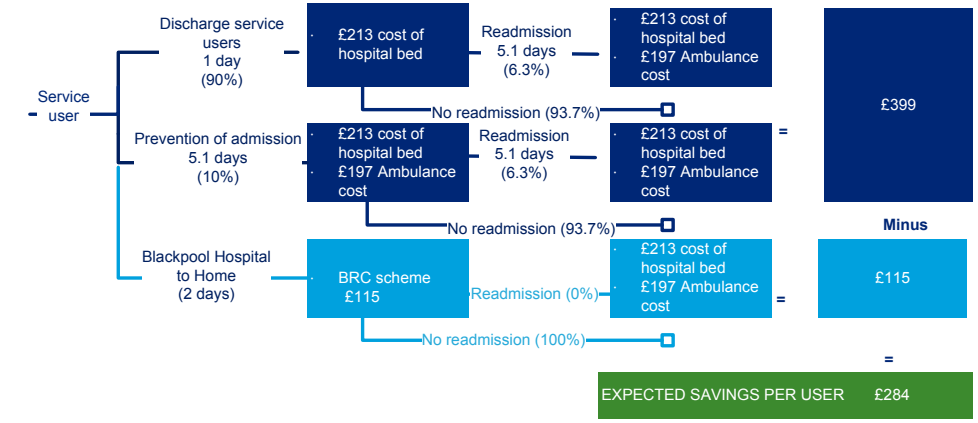
## Key impact area

- Social admissions
- Length of stay
- Signposting

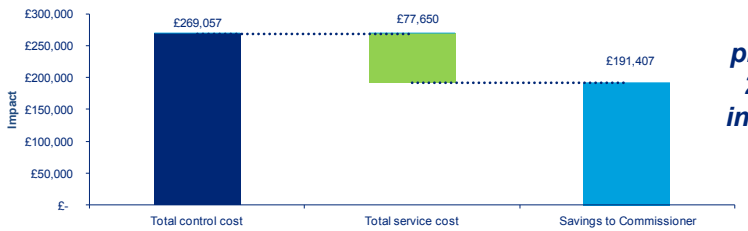
The Hospital to Home scheme provides support to service users who would benefit from being resettled at home following a hospital discharge. The project is aimed at service users who are over 16 years of age, live alone and have no other support. The core service provides a short risk assessment, assistance in preparing a light meal and signposting to other agencies/services.

- Typical length of service – two days, with potential for referral for up to six weeks
- Period of operation – from December 2011
- Workforce – six BRC staff, six volunteers
- Access – 2:00pm to 10:00pm Monday to Friday

## Service user pathway

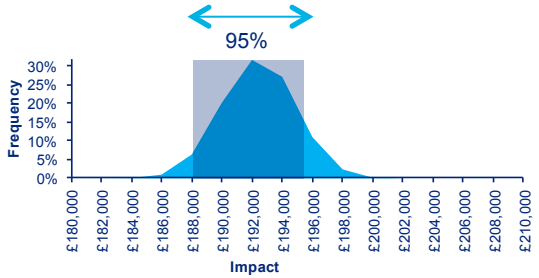



## Summary Impacts 2012




***The service provides close to 250% return on investment due to lower levels of readmissions***

## Sensitivity analysis




***Varying the length of stay of readmission, net savings range between £188k and £195k pa with 95% of certainty.***

## Key assumptions

- Volumes have been extrapolated to the end of 2012 based on average referrals per week of 12.9
- BRC data indicated no readmission to hospital within seven days of discharge
- Ratio of discharge/prevention service users provided by BRC service manager

## Providing value for money

***Blackpool Victoria's Hospital to Home scheme delivers close to £200k in savings to commissioners a year, approximately £280 per user. Service users report high level of satisfaction with the service as 98% of them rate it as 'excellent'.***

# Case study 5 – Torfaen Intermediate Care Services

## Background

The programme was established in 2005 and had initial funding from the Wanless grant from the Welsh Assembly. The programme set up community-based services to prevent inappropriate admissions and improve discharge by providing time-limited care to individuals aged 18 years and over.

Over time, the service has evolved to accommodate to changing needs of the community. In 2009 for instance, it became apparent that some of the service users were being admitted to hospital following a breakdown in medication regimen, despite prompting. The Intermediate care team, therefore, proposed to the local health agencies that a policy was put in place that allowed them to administer medication. From 2010, the team has also provided palliative end of life care, which is funded on a spot purchase from the Aneurin Health Board.

Unlike most of BRC schemes, this service is delivered by staff, not volunteers, who also provide a personal care element providing additional value add. Service users receive support for up to six weeks, with the type of support varying slightly depending on whether they have been discharged from hospital or whether they are at risk of admission.

- Prevention of admission: Receives referrals seven days a week, from medical practitioners who would otherwise admit service users to hospital. This provides up to four visits a day for four to six weeks.
- Discharge users: Receives referrals from hospital staff five days a week, as discharges are not planned during the weekend. It provides a maximum of three visits per week for four to six weeks.

Data from BRC indicates that over 90% of service users are over 60 years old, 81% rated the service as excellent with 85% stating they had been treated with excellent dignity and respect.

## Positive impacts to service users

Mr C was referred to by a social worker for help with personal care. Due to poor mobility as a result of his age, he found it impossible to carry out some everyday activities. His wife was his main carer, but she had been admitted to hospital as a result of her leukaemia.

The intermediate care service visited Mr C and found him distressed and missing his wife. He agreed to have the service visiting twice a day – once in the morning to help with his personal care and make him breakfast, and once at lunchtime to make him a warm meal and prepare his tea. There was an extra visit twice a week to carry out household chores, such as cleaning.

Without this support, Mr C would have had no option except to go into respite care.

After his wife was discharged from hospital, the intermediate care service team also supported her with her personal care until she had recovered enough to be independent.

While the team was supporting the couple, Mrs C's condition deteriorated and she was readmitted to hospital where she passed away. The team continued to support Mr C until he could make arrangements to go and live with his daughter.

**Source: Service Manager**

***"It was lovely to have someone to come and help me. Thank you for everything"***

*(Service user feedback, 2011)*

# Case study 5 – Torfaen Intermediate Care Services

**5**

Assist individuals by offering a flexible and personalised care package so they can maintain/regain their independence by preventing hospital admission or following hospital discharge. Services provided include personal care, shopping, paying bills, basic housework, administering medication and assisting services beneficiaries to access other services.

**SCHEME AREA**

**Community and individual Resilience**

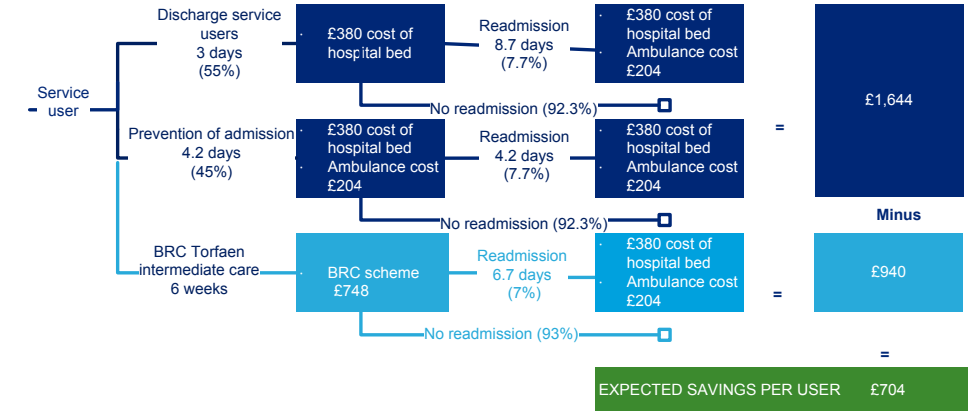
## Key impact area

- Social admissions
- Length of stay
- Social care
- Readmissions
- Signposting

Torfaen's intermediate care scheme is a long-running service with two key priority areas: reducing delays in transfers of care and preventing hospital admission. The programme has been running over capacity for the past year and has identified a number of areas that could result in stand-alone programmes, such as medication administration and palliative/end of life care.

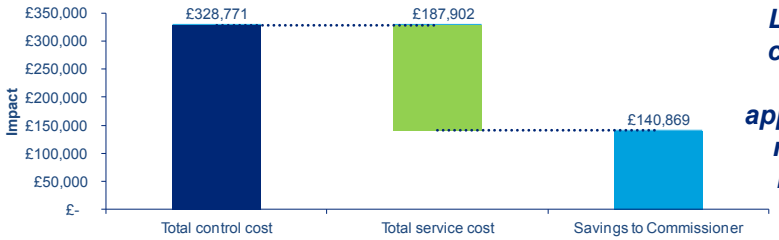
- Typical length of service – six weeks
- Period of operation – 2005 to 2012
- Workforce – five BRC staff, no volunteers
- Access – seven days a week for prevention users, five days a week for discharge

## Service user pathway




Key: (%) Percentage users | Alternative pathway for service users | BRC service users' pathway

## Summary impacts 2011/2012

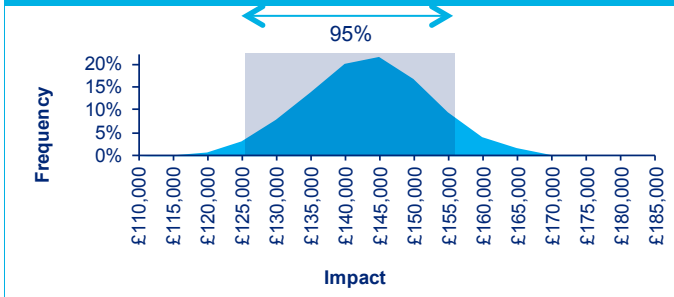



***Local Authority commissioners receive approximately 30% return for their investment as savings***

## Key assumptions

- Modelling for year 2011/2012
- Palliative care paid as spot purchase, so service users and cost have been excluded
- Readmission rates and ratio of user types provided by BRC

## Sensitivity analysis




***Varying the length of stay for prevention of admission users leads to net saving between £125k and £155k pa with 95% confidence***

## Providing value for money

***The Torfaen scheme provides substantial benefits to commissioners and service users. Expected savings to commissioners in 2011/2012 have been estimated as £140k, an average of £704 per service user. In addition to financial benefits, 81% of users note having a positive experience.***

# Case study 6 – Nottingham North and East Crisis Intervention Community Support Service



## Background

Nottingham North and East Crisis Intervention Community Support Service (CICSS) offers support to vulnerable individuals who are over the age of 18 and reside in the Nottingham North and East Consortium area. The service provides low-level support for the prevention of admission to hospital. Work with service users is focussed on delivering improvements in eight main areas: nutrition, general wellbeing, social networks, finance, community engagement, medication, mobility and daily living activities. Service users are asked to rate their current situation in these areas at the beginning and at the end of the programme and results show improvements in most areas.

The team responds to referrals within an hour, providing a rapid response to GPs, cardiac nurses and community nurses. In addition to this, the commissioner has pointed out the service is well received and has good user feedback. Because of its success and its ability to provide support at short notice, the service is in heavy demand with referrals for end-of-life care and other hospital-based support.

The CICSS is primarily staff delivered and is registered with the Care Quality Commission (CQC), which allows them to provide quality assured domiciliary personal care. Volunteers are involved toward the end of the service and provide additional companionship and support.

The domiciliary care element has been included since 2011, aimed mainly at easing health crisis needs instead of replacing social care services. It includes some personal hygiene, sanitary care, incontinence pad disposal and toileting management. Due to the success of this element of the service in North and East Nottingham, it has now been extended to West Nottingham. There is the possibility of a joined-up approach if a project for this type of support goes to tender.

Approximately 70% of the service users are over 80 years old and 74% of them rate the service as ‘excellent’.

## Positive impacts to service users

Mrs W is an 85 year-old lady who lost her husband last year. Due to her recent bereavement, she feels lonely and frequently calls the out of hours service, so her GP requested that the CICSS provided emotional support to Mrs W ensuring she felt supported at home.

In their initial visit to Mrs W, the CICSS team identified that Mrs W was suffering from low mood and confidence due to her recent bereavement. They found she was struggling to cope with her daily living tasks because of her mood. The CICSS team tried to lift Mrs W’s spirits, providing comfort and reassurance in this hard time. They also signposted Mrs W to Age UK’s Harmony counselling service, so she could have additional support managing her bereavement.

From conversations with Mrs W, it also emerged that Mrs W was unable to manage her medication effectively, so the CICSS team, in agreement with Mrs W’s GP, intervened to ensure she was taking her medication correctly at the right times. It was agreed to visit her initially twice daily for medication prompts, beyond the initial scope of offering companionship and reassurance. Mrs W medication system was not effective, so the team arranged for the medicines to be delivered in a blister pack. To ensure correct monitoring of her medication intake, the team ensured to have the pack locked in a medication safe.

In addition to these services, Mrs W was signposted for a benefit review, which enabled her to secure a care package. The CICSS team liaised with the care agency so that the best possible care was in place once she was discharged from the service.

Both the out of hours GP and Mrs W’s GP have identified a substantial decrease in calls from Mrs W while the CICSS service had been in place, indicating that she is now more able to cope with her daily activities.

**Source: Service Evaluation Report**

***“I think the service is very worthwhile and makes people feel part of the world again. I also appreciate the help I received with my medication…and I thank you all very much”*** *(Service user feedback, 2011)*

# Case study 6 – Nottingham North and East Crisis Intervention Community Support Service



**6**

The scheme provides support to individuals going through a health crisis so that they can remain living in their own home and avoid hospital admission. Services provided include personal care, medication prompting, collection of prescriptions, assistance with light meal preparation, escorting outdoors and paperwork.

**SCHEME AREA**

**Community and individual Resilience**

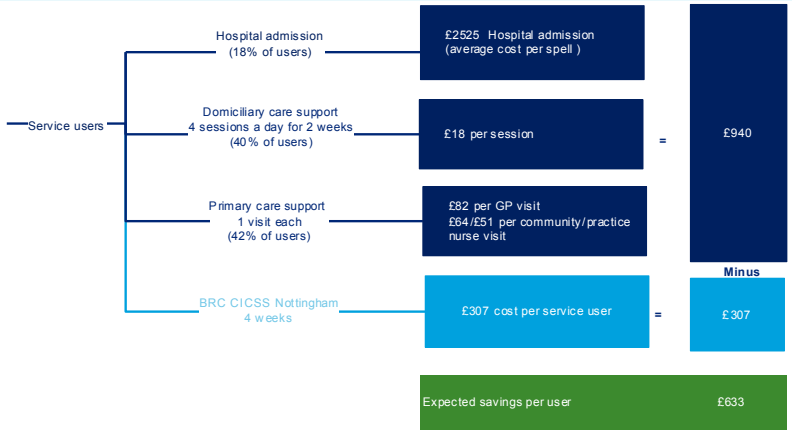
**Key impact area**

- Social admissions
- Primary care support
- Signposting

The CICSS programme aims to tackle the challenges posed by service users requiring lower level care support. It provides rapid response to referrals and is open on a daily basis from 7:00am to 11:00pm. Because of its success and its ability to provide support at short notice, the service is in heavy demand with referrals for end-of-life care and other hospital-based support.

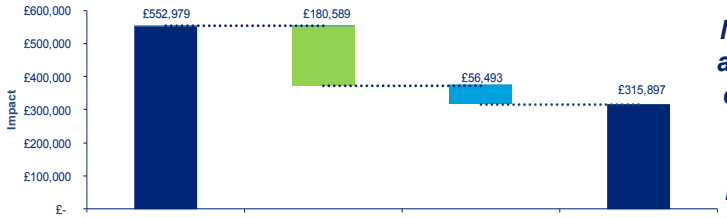
- Typical length of service – four weeks
- Period of operation – 2009 to 2012
- Workforce – twenty BRC staff with limited volunteer support
- Access – 7:00am to 11:00pm, seven days a week

## Service user pathway




Key: (%) Percentage users  Alternative pathway for service users  BRC service users' pathway

## Summary Impacts 2011

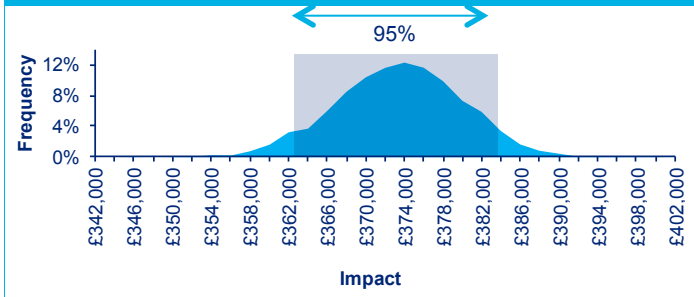



***NHS commissioners achieve a 75% return on their investment. There are small impacts for the Local Authority due to savings in Social Care.***

## Key assumptions

- Modelling for 2011
- Readmission rates not considered due to lack of information
- Total cost of hospital admission provided by commissioner/service manager

## Sensitivity analysis




***Varying the cost of hospital spell, total net savings are between £362k-£384k pa with 95% confidence.***

## Providing value for money

***The CICSS scheme provided approximately £316k savings in 2011, an average of around £600 per service user. In addition to financial benefits, 74% of users rate the service as 'excellent'.***

# Summary of case studies

The six case studies demonstrate a range of positive economic impacts, with commissioners receiving returns of 40% to 280% depending on the scheme considered. The benefits accrue to both health and social care commissioners with savings resulting from reduced demand for secondary, residential and domiciliary care. Initial benefits relating to the prevention of admissions to hospital are often further enhanced by reduced readmission rates.

Service users also report high levels of satisfaction with these schemes with over 70% rating them as 'excellent'. Most users highlighted they felt treated with dignity and respect, as well as recognising the service helped them maintain or regain their independence.

The magnitude of these returns are consistent with those reported in previous publications estimating the benefits from preventative support by the New Economics Foundation (2012). This publication found that returns to commissioners were of over three and a half times the cost of the scheme. Other evidence of a positive return to reablement services specifically is also noted for example in Arksey et al. (2010) .

Although differences in returns to commissioners are shown across the schemes, it is not clear whether these differences are driven by the effectiveness of the particular scheme or other differences such as:

- The underlying demographics of service users across schemes;
- Conditions reported for the sample of service users used to analyse the schemes;
- Differences in the schemes in targeting savings in health or social care; and
- The service model commissioned, as well as the duration of the support provided and maturity of the schemes.

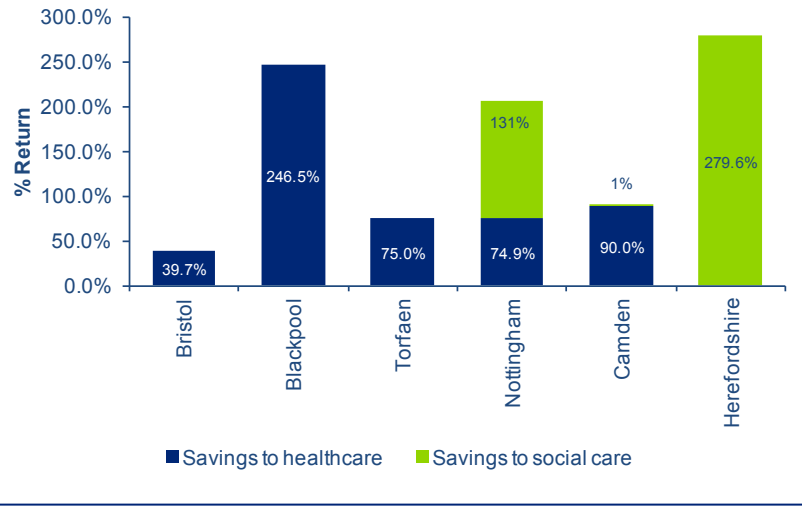
Additional analysis could be undertaken to identify the drivers of these differences for the evaluation of future schemes.

**Distribution of savings across BRC schemes**

| Scheme | Type | Savings to health care commissioner | Social care savings | Savings per service user |
|---|---|---|---|---|
| Camden | Community | £76,502 | £707 | £246 |
| Herefordshire | Community | £0 | £218,118 | £347 |
| Bristol[(1)] | A&E Discharge | £46,442 | £0 | £168 |
| Blackpool | A&E Discharge | £191,407 | £0 | £264 |
| Torfaen | Community | £140,869 | £0 | £704 |
| Nottingham | Community | £315,897 | £56,493 | £633 |

(1) Prospective evaluation

**Breakdown of returns in health and social care**



# BRC economic impact

# Total economic impact

BRC is currently delivering 103 schemes across the UK delivering social support. These schemes are estimated to cost health and social care commissioners approximately £5.4m.

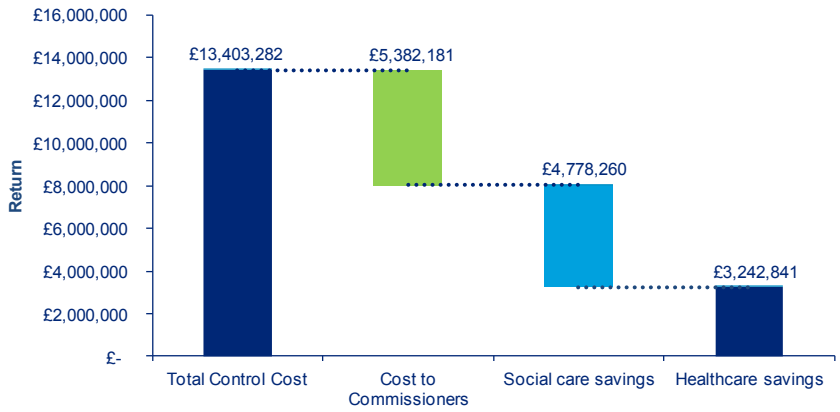
It is estimated that these BRC services prevented commissioners from spending £13.4m on alternative services, as such the BRC has saved healthcare commissioners £3.2m, and social care commissioners £4.8m. Total net savings relate to an overall return of 149% for commissioners on their expenditure on BRC schemes. These savings accrue to both Local Authorities and healthcare commissioners from:

- Preventing hospital admissions or reducing the length of stay in hospital;
- Reducing hospital readmission rates;
- Preventing or minimising the use of expensive domiciliary and residential care; and
- Facilitating early discharge from hospital care.

In addition to savings to commissioners there are a number of additional impacts which the schemes deliver:

- Service user benefits. From the six case studies considered over 70% of users reported that the service was excellent suggesting the schemes are highly valued.
- Signposting. BRC regularly provides information and referrals to a wide range of independent and statutory sector organisations promoting integration between services. Fast, increased access to these services could provide additional benefits to service users.
- Volunteers. Other impacts are related to the use of volunteers, who service users feel provide additional valued time and commitment. Research in this area has been undertaken by CSV (2006) and highlights the reduction in social isolation and the contribution to independence and well being of service users.
- Other impacts. This study has considered only the direct, tangible benefits to commissioners. Other impacts relate to increased support to carers, and usage of other BRC programmes such as medical loans.

**Distribution of net savings across BRC schemes**




To estimate the total impact of all BRC schemes being currently delivered across the UK, BRC has matched each scheme to one of the six case studies undertaken in this report based on its characteristics (as shown in the appendix). For example, schemes with a reablement element have been matched against Camden. A&E based schemes have been matched to Blackpool given the prospective nature of the Bristol case study.

# Conclusions

### Summary findings

Based on analysing six BRC schemes, BRC is found to be delivering substantial savings to health and social care commissioners through their care in the home services. Returns from these schemes are estimated to range from 67% to 280%, suggesting these schemes should form a core part of commissioned services particularly in the environment of tightening funding allocations. The schemes are also consistent to the new policy reforms across the UK. For example, in England both the Health and Social Care Act 2012 and the White Paper "Caring for our Future" include a renewed focus on reablement, preventing avoidable readmissions and supporting better integration between services. 'Caring for our Future', in particular highlights the need of further development of voluntary services, as well as support from community groups and networks.

BRC is currently delivering over 100 care schemes, supporting several thousand service users. If these schemes receive a similar benefit to the case studies it is estimated that the schemes delivered savings of £8m to health and social care commissioners. The overall return of the schemes is estimated to be 149%.

In addition to savings to commissioners, there are a number of additional impacts which the schemes deliver such as intangible benefits delivered to service users such as reduced social isolation and increased independence (CSV, 2006), employment to 332 BRC staff and wider economic impacts to the broader economy from the onward spending of wages and the returning of working age users to employment.

The estimated impacts are consistent to other research conducted by the New Economics Foundation (2012) and Arksey et al. (2010).

### Future areas of research

There are a number of areas which could be investigated in the future to improve the evidence base around the benefits from home care schemes.

- **Further collection of data on the control or counterfactual**. This study has utilised, where available, anonymous service user information to determine the likely services service users would receive if they did not receive the BRC service – based on the views of Deloitte experts. This information was not readily available across all programs increasing some of the uncertainty around the scheme impacts. In the future, programs could look to more systematically collect this type of information, facilitating more accurate ex-post evaluation.
- **Dynamic benefits**. This study has considered the shorter impacts of the BRC schemes on users demand for other health and social care services. Longer term benefits from the service could be usefully considered, this has been considered in past research for example for example Hilary Arksey et al. (2010) in "Home care re-ablement services: investigating the longer-term impacts (prospective longitudinal study)".
- **Extended Monte Carlo approach**. The Monte Carlo approach employed assumes parameters considered follow a normal distribution. The analysis could in the future be extended to consider joint distributions, other potential distributions and further assumptions.
- **Estimating the total impact of BRCs schemes.** The total impact of all BRC schemes is estimated based on a matching methodology based on the six case studies. As more information is available this matching could be expanded to provide a broader evidence base to estimate the total impact.



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