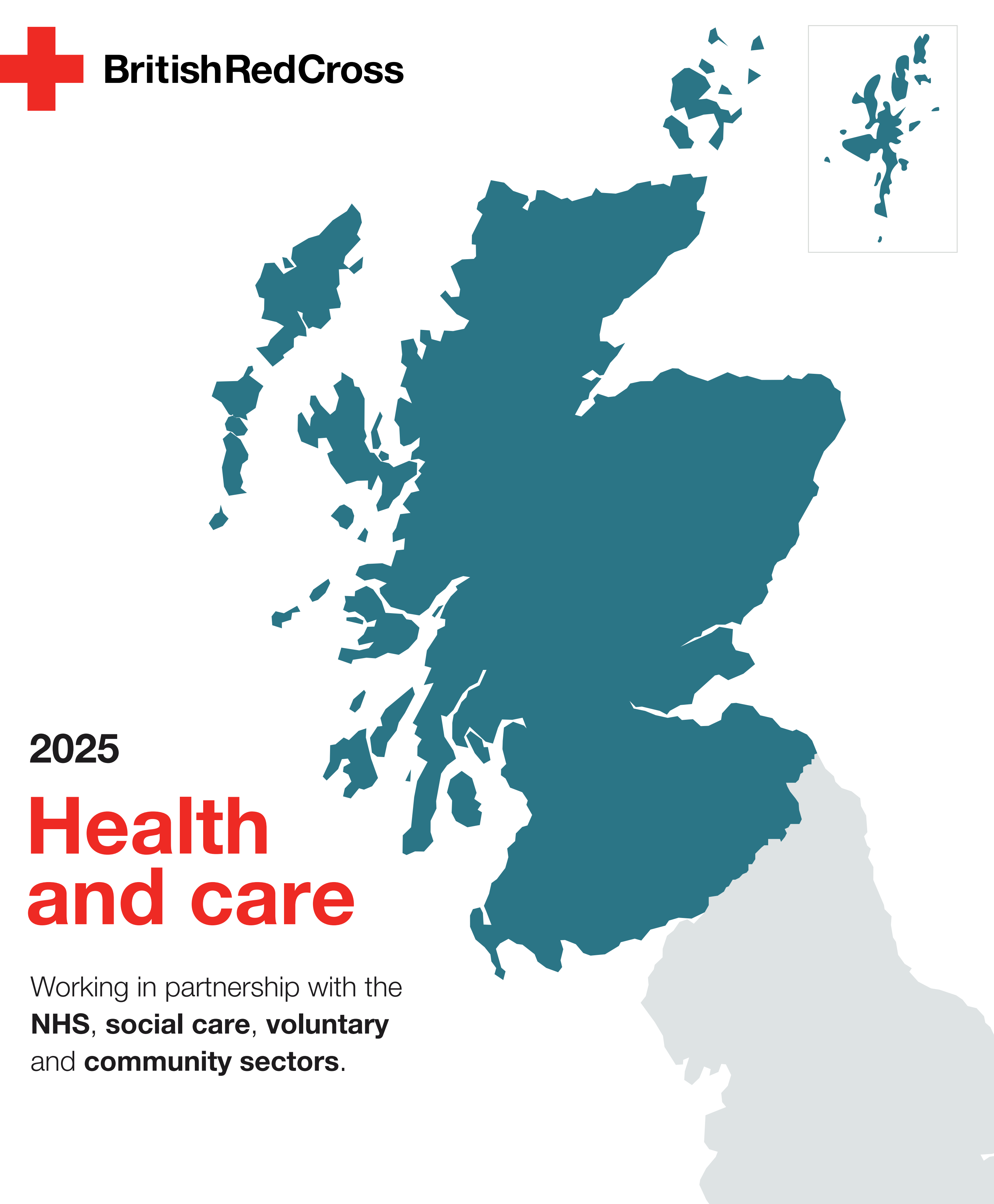
British Red Cross



2025

Health and care

Working in partnership with the **NHS**, **social care**, **voluntary** and **community sectors**.

Here for humanity

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Why the British Red Cross?

Photo © BRC

Our track record

For over 150 years, we have **mobilised the power of humanity** so that individuals and communities can prepare for, respond to and recover from crises – both at home and around the world.

The British Red Cross has been supporting health and social care systems since the NHS was established. We want nothing more than to see that partnership **deepen and grow.**

We have **vast experience** in providing valuable support to people when they most need it across the UK.

Our **UK-wide infrastructure** enables us to deliver quality assured, scalable and efficient services, delivered responsively and flexibly according to local needs.

Our approach

The British Red Cross offers health and care solutions across the four nations of the UK, Isle of Man and Channel Islands, delivering **tried and tested services** that have a strong track record of positive impact.

We co-design **bespoke services** to meet the needs of your local context, drawing on evidence and insight of what works. We also design, **test, and evaluate new approaches** to improve health outcomes.

(Scotland) Photo © Jeremy Sutton-Hibbert/BRC
(Northern Ireland) Photo © Dan Mellor/BRC
(England) Photo © Fabio Di Paola/BRC
(Wales) Photo © Phil Greenwood/BRC

Our impact

Assisted discharge schemes

Investment put in

£1

£2.42

Social value generated

- **Improved quality of life** for people helped
- **Reduction** in health systems usage
- **Jobs** and **economic growth** in local areas
- Positive **environmental impacts**

In 2024 **British Red Cross support created over**

£8 million

in value for **health and social care** sector.

In 2024 over

20,000

hospital bed days saved.

Accident and emergency department support

77%

of NHS staff felt that the British Red Cross made a significant contribution to **improving patient flow** in the department, **reducing delayed transfers and discharges.**

87%

of NHS staff felt that the service made a **significant contribution** to **freeing up their time and improving their wellbeing.**

High intensity use

58% reduction in visits to accident and emergency departments

71% reduction in ambulance conveyance

67% reduction in non-elective admissions

Sources: 2022 surveys - evaluation of our NHS surge support services and a sample of 50 patients supported in the Stockport high intensity use programme. 2024 UK health Power BI dashboard.

Our services

Photo © Dan Mellor/BRC

Index of health services

Integration and positioning

Services

	Services	Working with hospitals	Working with community providers	Working with primary care	Working with social care
1	**Hospital at home support**	●	●	●	●
2	**Assisted discharge**	●	○	○	○
3	**High intensity use**	●	●	●	●
4	**Reablement**	●	●	●	●
5	**Discharge to assess**	●	●	○	●
6	**Short-term bridging care**	●	●	●	●
7	**Accident and emergency department support**	●	○	○	○
8	**Patient transport**	●	●	○	●
9	**Support at home**	●	●	○	●
10	**Social prescribing and local co-ordination**	○	●	●	●
11	**‘Waiting well’ health coaching**	●	●	●	○

1 Hospital at home support

We provide practical and emotional support for people in their own homes, while they are being cared for as part of a hospital at home service. By delivering a variety of support, we enable clinical teams to focus where they are needed most while making sure people feel safe, listened to and engaged in their own health care.

The challenge

- Moving care closer to home
- Stretch targets for hospital at home bed occupancy
- Patient flow through acute hospitals
- People who no longer require hospital care residing too long in an acute bed
- Supporting people to actively manage their own health – patient activation
- Lack of social support for lonely and isolated people
- Delays due to transport issues
- Anxiety and concern about being cared for at home

The service

A team of professionals working as an integral part of, or as an extension to, a multidisciplinary team, **responsible for the care and support of people residing in the hospital at home**.

Holistic support planning, goal setting and interventions that help improve a person's **wellbeing**, **independence** and **resilience**, with an option to include regulated activities such as **personal care**.

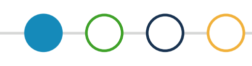
The impact

- **Removes practical and emotional barriers** to a timely discharge from an acute bed
- **Reduced** likelihood of **readmission**
- People feel **well supported and less anxious**
- People regain their **independence**
- Equity of **access to a hospital at home**
- **Removing barriers** to using remote health monitoring technology, **enabling digital inclusion**
- People are **supported in a safe environment**, with access to food and support options should their needs escalate
- People are better informed and **connected** with other services and **social support networks**
- **Empowerment** of carers through **increased support**

*"It's been **absolutely one of the best things that they do for us**…we were getting **care homes** that **were refusing to take patients**. Whereas **we don't tend to get that so much now**."*

NHS health professional

2 Assisted discharge



We support patients to return home from hospital at the point they no longer require hospital care, improving patient flow by enabling faster, safer discharges and preventing readmission.

The challenge

- Patient flow through hospitals
- People who no longer require hospital care residing too long in an acute bed
- Delays in ambulance services and accident and emergency departments
- Lack of social support for lonely and isolated patients
- Medically fit people deconditioning
- Delays due to transport issues
- Anxiety and reduced confidence of patients when returning home from hospital
- Reducing extended length of stay

The service

A team co-located in a hospital and working in an integrated way with discharge hubs and wards, responding promptly to referrals and co-ordinating the transition home, including transport.

The team offer a mix of immediate practical and emotional support for up to 72 hours to ensure returning home is a smooth transition.

The impact

- **Reduce bed occupancy** of patients who are ready to leave hospital
- **Speed up** the discharge process
- **Improve flow**
- **Remove practical and emotional barriers** to a timely discharge
- **Reduce** likelihood of readmission
- People feel **well supported** and less anxious
- People **regain their independence**
- People return home to a **safe environment**, with **access to food and support options** should their needs escalate

"I am so grateful for all you have done to help me get back on my feet and ***feel so much more confident about moving forward*** *– I don't know what I would have done without you."*

Person supported

"...the British Red Cross was there ***within 20 minutes*** *and freed up a bed."*

NHS staff

3 High intensity use

We offer an assertive outreach programme for people who access urgent and emergency care regularly because they are falling through gaps in the health and social care system.

The challenge

- Health inequalities
- Barriers to access or engagement
- Reduction in attendance, admissions and length of stay
- Reduction in 999 calls and conveys
- Decline in a person's health or mental wellbeing, exacerbated by an underlying unmet social need

The service

A holistic and strength-based, one-to-one coaching approach that can be tailored to support any part of the health and care system.

The service supports people who access emergency departments, mental health, ambulance, primary care or adult social care services regularly. **It is able to improve health outcomes at the same time as reducing attendances, emergency admissions and ambulance conveyance.**

The impact

- **Improved health and wellbeing** outcomes
- Activation leads to **improved locus of control**, **confidence** and **resilience**
- 40% reduction in **accident and emergency department attendances**
- 40% reduction in **non-elective long stays**
- 40% reduction in **calls and conveys**
- 40% reduction in **psychiatric liaison attendances**
- 40% reduction in **mental health bed days**

"I know Jack really appreciates everything you have done for him. You have managed to develop and maintain a relationship with him; which is so important in helping him to understand ***he can trust people, especially professionals*** *– thank you!!"*

Social worker

4 Reablement

Our service – provided at home – focuses on people's strengths, promotes their wellbeing and helps them live independently. It rebuilds confidence after a spell of illness, deterioration in health, an injury, a hospital admission or an acquired disability. Typically support lasts for up to six weeks.

The challenge

- Patient flow through acute hospitals
- People who no longer require hospital care, residing too long in an acute bed
- Functional decline following an episode of ill-health or hospital stay
- The 'do to' traditional approach to home care

The service

The service supports people to do things for themselves in their own homes. It is a 'doing with' model, in contrast to traditional home care which tends to be a 'doing for' model.

Reablement services help people to retain or regain their skills and confidence, enabling them to continue to live as they wish in doing ordinary activities like cooking meals, washing, dressing, moving about the home and going out.

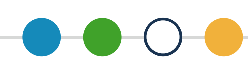
The impact

- **Removes practical and emotional barriers** to a timely discharge from hospital
- Reduced likelihood of **readmission to hospital**
- People feel **well supported** and **less anxious**
- People **regain their independence**
- Reduce the likelihood of **requiring ongoing care or residential care**
- Can help to **reduce the amount of care a person needs** from carers and family
- **Improvement** in confidence, functional ability, mobility, independence and wellbeing
- For staff, this is a rewarding approach where improvements lead to a **feeling of real achievement**

"I cannot thank you enough for your help and professionalism, your service has been fantastic."

Person supported

5 Discharge to assess



Our specialist service enables people to leave hospital as soon as they are clinically able, by providing an immediate assessment and developing a short-term personalised support plan, consistently monitoring progress. Focus is on maximising functional independence at home, personal care, social and emotional needs and restoring people's confidence.

The challenge

- Patient flow through acute hospitals – specifically those who could be discharged but are awaiting a care package
- Functional decline resulting from an episode of ill-health or hospital stay
- Independent living assessments completed in hospital may not reflect the reality of the person's home environment
- Moving care closer to home
- Lack of social support for lonely and isolated people
- Anxiety and concern about being cared for at home

The service

Support follows an enablement approach, 'doing with' rather than 'doing to'. It starts with a personalised assessment in their own home, actively involving the individual in developing their support plan, agreeing independent living goals and then reducing formal care input in line with progress towards their goals. Support includes personal care and administering medication, and progress is reviewed on a visit-by-visit basis.

The service increases people's quality of life, their choice, control, overall wellbeing and independence, which offers peace of mind to family, carers and loved ones.

The service can also support palliative or end of life patients in their home.

The impact

- **Removes practical and emotional barriers** to a timely discharge from hospital
- **Reduces** likelihood of readmission to hospital
- **Improves the efficacy of independent living** assessments
- Reduction in the amount of care **required and reduced reliance on residential care**
- **Improvement** in confidence, functional ability, mobility, independence and wellbeing

*"Things are very much in your hands, **she's [the support worker] not doing things to you she's helping you, it's that feeling of control**."*

Person supported

6 Short-term bridging care

We provide short-term personal care and support (including regulated activities) in a person's home, so their care needs can be met.

The challenge

- Patient flow through acute hospitals – specifically those who could be discharged but are awaiting a care package
- Moving care closer to home
- Supporting virtual ward bed occupancy
- People who no longer require hospital care residing too long in an acute bed
- Lack of social support for lonely and isolated people
- Anxiety and concern about being cared for at home

The service

Personalised care and support for people who don't have the ability to meet their own care needs.

Support is typically provided following hospital discharge, while waiting for a care package, being treated on a virtual ward, stepping down to lower acuity support, palliative care, or as an alternative to hospital admission.

The service offers a **quick response** to need by **deploying skilled staff to support palliative or end of life patients in their own home**, including regulated and non-regulated activities.

The impact

- People **regain their independence**
- People remain in their own home with **improved** or maintained **quality of life**
- Removes barriers to a timely discharge from an acute bed, **reducing pressures** on health and care systems
- Meets personal and other care needs
- Reduced likelihood of **readmission**
- Patients feel **well supported and less anxious** in a safe environment
- Families don't become overwhelmed, are able to **continue to provide care** and have improved quality of life
- People are **better informed and connected** with other services and social support networks

*"They couldn't do anything different. I was treated with respect and dignity throughout my journey, **they made me feel like a human being, not a patient**."*

Person supported

7 Accident and emergency department support

We offer emotional and practical support to people, their families or carers, while in the accident and emergency department, with the option to include transport home. Our practical tasks support NHS colleagues to operate the accident and emergency department efficiently.

The challenge

- Four hour accident and emergency department wait time target
- High volumes of people presenting at emergency departments
- Lengthy waits, both in the department and in ambulances outside of departments
- Stretched capacity of NHS staff in assisting people while they wait for triage or treatment

The service

Teams are deployed within emergency departments, providing emotional and practical support to people, their relatives and carers, including transport home and follow-up welfare calls if required.

Teams provide emotional support for people who are experiencing confusion, distress or disorientation.

They also offer practical support to meet someone's immediate physical needs. This could mean providing a blanket, sick bowl, or pillow, as well as food and drink. The team liaise with healthcare professionals and relay information to patients, relatives and carers.

The impact

- Vulnerable people will **feel better supported** and less anxious
- Inappropriate use of accident and emergency departments is **reduced**
- People can **return home more quickly** following assessment and/or treatment
- **Reduction** in **social admissions**
- NHS accident and emergency department staff **feel more supported**

77%

Of NHS staff surveyed felt that the British Red Cross made a **significant contribution** to **improving patient flow** in the department and **reducing delays**.

87%

Felt that the service made a **significant contribution** to **freeing up NHS staff** and **improving their wellbeing**.

8 Patient transport

We offer non-emergency patient transport services for people with medical conditions or mobility issues who do not require emergency care, but need assistance travelling to and from healthcare facilities.

The challenge

- Delayed transfers of care
- Congested discharge lounges and waiting rooms
- High 'did not attend' and missed appointment rates
- Delayed episodes of care and treatment resulting from unavailability of suitable transport

The service

Timely and reliable non-emergency patient transport services that help reduce delays and missed appointments.

The service ensures that people with medical conditions or mobility issues, who do not require emergency care, are supported in getting to and from the right health setting and returning home.

The impact

- Enhanced **personal experience**
- **Safer transition home** following a stay in hospital or treatment in a healthcare setting
- Reduced '**did not attend' rates**
- **Timely transfers of care** and discharges from hospital

> *"They couldn't do anything different. I was treated with respect and dignity throughout my journey,* ***they made me feel like a human being, not a patient***."

Person supported

9 Support at home

Our one-to-one support typically lasts between 4 and 12 weeks, helping increase a person's resilience and independence after an injury, illness, stay in hospital or another crisis. It can also be preventative support to help people maintain their independence and wellbeing.

The challenge

- Lonely and isolated people
- Negative health outcomes associated with being lonely or isolated
- People with long-term conditions or restricted mobility are at higher risk of becoming lonely and isolated
- People's ability to remain independent in their own home
- People with social challenges seeking support from clinical services

The service

Building **rapport** and **trust** on a one-to-one basis with people, **having conversations to set personalised goals** and understand their wellbeing, family and relationships, social life, living environment, cultural background and any risks specific to them.

Interventions include welfare checks, home risk assessments, cost of living support payments, community transport, social visits, shopping, and connecting to resources and local services.

The impact

- Improved **wellbeing**, **independence**, **choice control** and **resilience**
- **Reduced feeling of loneliness** and social isolation
- **Increased connectedness** with other people and sources of support
- **Reduced reliance on clinical services** for non-clinical purposes.

"It was so ***nice to know there was someone to take an interest in my needs*** *- I have no local family and I'm getting on a bit these days, so I need more and more support..."*

Person supported

"If this service did not exist, our patients would most likely have been added to a social work waiting list to be reviewed for support. This would have a direct impact on the length of time the patient would remain on our team's caseload while awaiting allocation. Time would be required to complete a social work referral, and as a team we would struggle to find some patients that immediate support they require, that the British Red Cross often support us with."

NHS partner

10 Social prescribing and local co-ordination service

These services are aimed at preventing, delaying or reducing the need for formal care by building relationships with people who are often referred by primary care and social care. We connect them to activities and groups in their communities to meet their practical, social and emotional needs.

The challenge

- Many low-scale, isolated social prescribing services have insufficient impact
- Increasing pressure on front door services and high demand for formal care
- People experiencing enduring feelings of loneliness
- People who have limited social support networks
- Unmet health and social needs which, if unaddressed, lead to a reduced independence, choice, control and general wellbeing, placing more pressure on statutory health and care

The service

Delivering **personalised support** and **strengths-based interventions**, **combining the principles of social prescribing** with **health coaching to build people's resilience**.

Goals are agreed with a focus on **creating sustainable connection to local resources**, aligned with the person's interests. **Service teams are embedded in their community** and are **key partners of adult social care**.

The impact

- **Reduced pressure** on front door services
- **Reduced demand** for formal care **helping to tackle the high demand** on social care services
- **System savings**, helping to **reprioritise and transform funding** from formal care into prevention
- **Reduced loneliness** and social isolation
- **Improved sense of wellbeing** and **self-empowerment**
- **Improved levels of health** activation
- **Increased connectedness** with other people and sources of support

79% of the **people supported** by local co-ordination services **report an improvement** in their **overall wellbeing**

73% of the **people supported** by local co-ordination services **report an improvement** in their levels of health activation

"I have had **nothing but positive experiences** *with the local co-ordination service and* **all the workers are always happy to help**.*"*

Person supported

11 'Waiting well' health coaching

Our practical and emotional coaching support improves the health and wellbeing of people residing on an elective care wait list. The service promotes independence and encourages people to maintain activity levels, ensuring they are fit for their surgery when it is scheduled.

The challenge

- People with long-term conditions or restricted mobility being at higher risk of becoming lonely and isolated
- Prevention of attendance or admission to hospital
- Prevention of non-attendance to health appointments
- Support people to remain independent in their own home

The service

The service delivers skilled intervention which seeks to **activate individuals to better self-manage, build resilience in preparation for future interventions** or manage long-term conditions.

The approach is person-centred and tailored to individual goals and needs. The approach can also work in anticipatory care scenarios or can be further enhanced by targeting those who are accessing urgent and emergency care while 'waiting'.

The impact

- Activation leading to **improved choice and control**
- **Education** and **coaching** leading to improved health outcomes, wellbeing and resilience
- **Reduced feeling of loneliness** and social isolation
- **Increased connectedness** to other people and resources
- **Reduced reliance** on clinical services

"I appreciated the support; it made my situation more manageable. ***I was given good advice and useful information to help me carry on.****"*

Person supported

Health and care operations

Photo © Jeremy Sutton/BRC

Health and care operations

Our portfolio of **high-quality health services** is designed to be **integrated into existing health and care systems and pathways,** and is tailored to the local context. It aims to make sure people **get the support they need, before, during and after they use the NHS**.

Working together has already produced **fantastic results**: from **faster, smoother, and safer hospital discharges**; to making sure **thousands of patients** can **access their health appointments** across the UK.

There's nothing to stop our partnership going from **strength to strength**, helping to build a more comprehensive health and care system, where **people no longer fall through the cracks or experience inequity.**

What we do

Promote healthy lives

We help people **manage their health** and **build resilience**.

Empower healthy recovery

Our **person-centered, trauma-informed** approach supports **recovery**.

Rebuild wellbeing

We assist those most at risk in creating **healthier lives** and **avoiding crisis**.

How we do it

Give people the **person-centred dedicated, timely, bespoke and flexible support** that they need to achieve their independent living goals

Provide a **return on investment** for the health and care system

Integrate with teams and pathways in health and care systems

Deliver **nationwide evidence-based service models,** aligned to the local commissioner context and needs

Leverage the social value of time given by volunteers

Insight, improvement and innovation

Insight

Our **health inequalities explorer tool** explores **location-based health inequalities** across different UK geographies, through four groups:

Summary indicators

- Left behind areas
- Index of multiple deprivation
- Access to physical healthcare
- Access to digital healthcare

ONS health index

- Health outcomes
- Social determinants of health
- Preventable risk factors

Secondary care indicators

- Discharged beds
- Beds not meeting criteria to reside
- Bed availability

Demographic indicators

- Age
- Gender
- Ethnicity

Improvement

The British Red Cross has dedicated insights and improvement teams, promoting **continuous improvement**.

- Business intelligence
- Co-production
- Practical systems supports
- Quality assurance
- Evaluation, feedback and data quality
- Foresight, research and data science

Innovation

Innovation is critical, enabling us to remain **effective**, **impactful** and **optimise the value of our work**. We apply an innovation process as we develop services.

1

Search

Detecting signals of change in the form of changing user or market requirements, policy or technological advances.

2

Select

Assessing the fit with the organisation, our strategic objectives, core skills, knowledge and competencies.

3

Implement

Having the knowledge required, executing the project, problem solving and launching the innovation.

4

Capture

Realising the defined benefits, capturing and sustaining the value, and stimulating further innovation.

Monitoring, reporting and evaluation

Monitoring and reporting

We monitor and report on our activities, both their short and long-term outcomes, at a frequency agreed with our commissioners, including but not limited to:

Demographics

Response times

Type, nature and number of episodes of support.

Referrals

- Numbers
- Sources
- Locations
- Times received
- Onward referrals

- Support plan goals and progress
- The impact and outcomes of our support activities
- Specific case studies and their outcomes

Evaluation

We analyse the data we gather from our research, reporting and monitoring to help us generate actionable insights and recommendations that will improve outcomes and increase social impact.

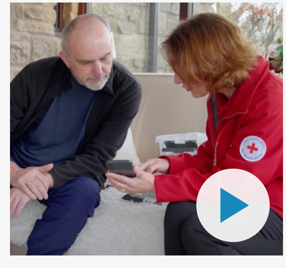
Explore the links below to find out more and read our reports in full.

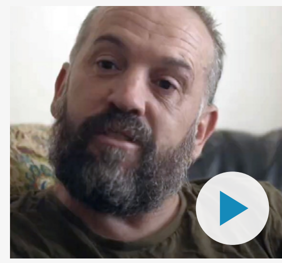
Getting hospital discharge right

Our report 'Home to the unknown: Getting hospital discharge right' sets out recommendations to improve care when patients return home from hospital.

Health film

This film features our patient transport and emergency department teams based at Grange university hospital in Newport, our hospital at home team based in Cumbria and our community crisis support service in Nottingham.





Seen and heard: Understanding frequent attendance at A&E

The report is based on new research, which was conducted in collaboration with Dorset Integrated Care Board and builds on our 'Nowhere else to turn' report released in November 2021.

From hospital to home animation

Watch our animation showing Bert's journey from hospital to home, and how the British Red Cross volunteer, Sharna, helped him.

Photo © Artur Tixiliski/BRC

What we stand for

Our seven fundamental principles

These principles sum up our ethics and are at the core of our approach to helping people in need.

Every day, we're **adapting**, **innovating** and **learning**.

When the unexpected happens, we are **calm**, **quick** and **efficient**.

We respond smartly, using **clear processes** and systems.

Dynamic

We move forward as one team.

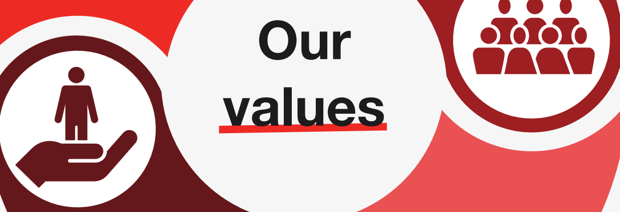
We treat each other with **dignity** and **respect**.

Every person's uniqueness is **valued**, **supported** and **celebrated**.

Our individual backgrounds and experiences make our organisation **stronger**.

Inclusive

We are open to all.



Compassionate

We stand for kindness.

People come first, no matter who or where they are.

We have **genuine**, open-minded conversations.

Together, we're a **united force for good**.

Courageous

We are bold.

We show our strength by **doing the right thing**.

We **aren't scared** to test our **creative ideas**.

As humanitarians, we go the **extra mile** to **help people in crisis**.

Our commitment to equity, diversity and inclusion

Photo © Dan Mellor/BRC

At the British Red Cross, equity, diversity and inclusion is very important. We know that getting this right is critical for us to live our values and fundamental principles.

We want to be a safe and inclusive organisation that learns and grows to proactively dismantle barriers, eliminate discrimination and create equity.

We want to be an organisation where...

Our people learn, understand and take action to **dismantle discrimination**, and create a safe and **inclusive** environment.

Our workforce is built on diverse skills, experiences and capabilities **at all levels**.

We embed equity and remove barriers to participation across **everything we do**.

Contact us

Please contact us and we'll put you in touch with your regional representative, who will support you and your local requirements.

British Red Cross

redcross.org.uk

Health team

health@redcross.org.uk

Here for humanity

When an emergency turns someone's world upside down, we take the time to **listen to what they truly need**.

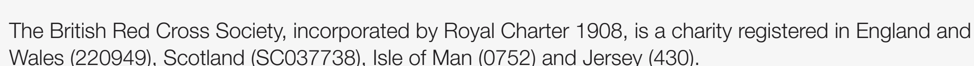
Photo © Fabio Di Paola/BRC

Photo © Dan Mellor/BRC

From **services** to **programmes**, we put **people at the heart of everything we do.**

Bringing **hope**, **dignity** and **kindness**.

We are the movement that connects **human kindness** with human crisis.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