BritishRedCross

Quality Account 2024

Statement from Lisa Hollins, executive director, UK

I am delighted to introduce our 2024 quality account. It outlines our approach to providing quality care and support to people in crisis in the UK.

Our services range from short-term support to help people access healthcare or return home from hospital, to longer-term comprehensive outreach work to address the issues that can leave people in chronic crisis.

We won two awards last year for our innovative new services, and received a positive evaluation from the National Institute for Health Research. We also partnered with the Institute for Health Equity at University College London to measure the impact of our health and care services for people facing structural inequalities.

We took a comprehensive, holistic approach to measuring our impact last year. We looked at the many structural and societal issues that can impact a person's health and wellbeing. And we focused our support on those elements that would make a significant difference to the health of the people we worked with. See page 8 for more on this work.

Last year, we refreshed our ten-year strategy, and recommitted to our three UK causes – health and care, displacement and migration, and disasters and emergencies. Our work will remain focused on achieving the greatest impact for those in crisis.

Our inventive, creative approach was recognised last year with two awards:

- Our work to support people who frequently use ambulance services to access emergency healthcare received an award at the Advancing Healthcare Awards Northern Ireland.
- Our project to support people who are homeless following treatment in hospital was recognised by the Royal Society for Public Health.

We supported more than 76,200 people to live independently at home last year, including 44,600 people we resettled safely in their homes after a hospital stay. We made sure people felt safe, looked after and comfortable, and helped them avoid unnecessary readmissions.

A British Red Cross team member with a colleague at Glangwili Hospital, Wales.

Our high intensity use teams worked with more than 1,300 people who had accessed urgent care services more often than expected. We reduced emergency hospital admissions for the people we supported by 57%* and helped them improve their long-term health outcomes. An incredible 89% of people supported by our high intensity use services improved their ability to manage their own health.**

Our patient transport teams made more than 19,000 journeys last year. The service helps people with health conditions or mobility issues access non-emergency appointments, and return home following treatment reliably and safely.

*Based on data for all our high intensive use services, excluding those in London.
**Source: 331 people with needs and outcome measures supported by high intensity use services from 01/01/2024 and 31/12/2024.

Our teams supported people in hospital, making their stay more comfortable and relieving pressure on staff. They addressed practical needs, such as providing blankets and pillows, and food and drink. They also offered emotional support to patients and their families.

Our hospital at home service (formally 'virtual wards') enabled patients to receive hospital-level care at home. We supported people while NHS clinicians provided treatment. The service we provided with the NHS in north Cumbria helped speed up recovery times and freed up hospital beds for patients most in need.

Our refugee services teams provided vital support to more than 43,600 people last year, including over 700 unaccompanied children. This was a record for us. We took more than 291,000 different actions to help people understand their rights and entitlement, access legal and financial support and find safe housing, education, healthcare and community support.

During the year, we continued to ensure the organisation remains in a sustainable financial position. This work saw us update our mobility aids service to a new direct-to-consumer model that will provide vital help direct to front doors. As well as saving money, the new approach will make sure anyone, anywhere can get a wheelchair when they need one.

I'd like to say thank you to all our volunteers and staff for their hard work, compassion and expertise, and for their continued commitment to improve the quality of our services.

I am very pleased to present our Quality Account for 2024. It sets out the progress we've made in improving our services and outlines how we will continue to work towards providing quality care and support to people in crisis.

British Red Cross volunteers receiving training on how to move a patient using a sling and hoist, Dundee, Scotland.

A British Red Cross team member supports a family reunion in Bristol.

British Red Cross staff members at the Grange University Hospital, Newport, Wales.

Who we are

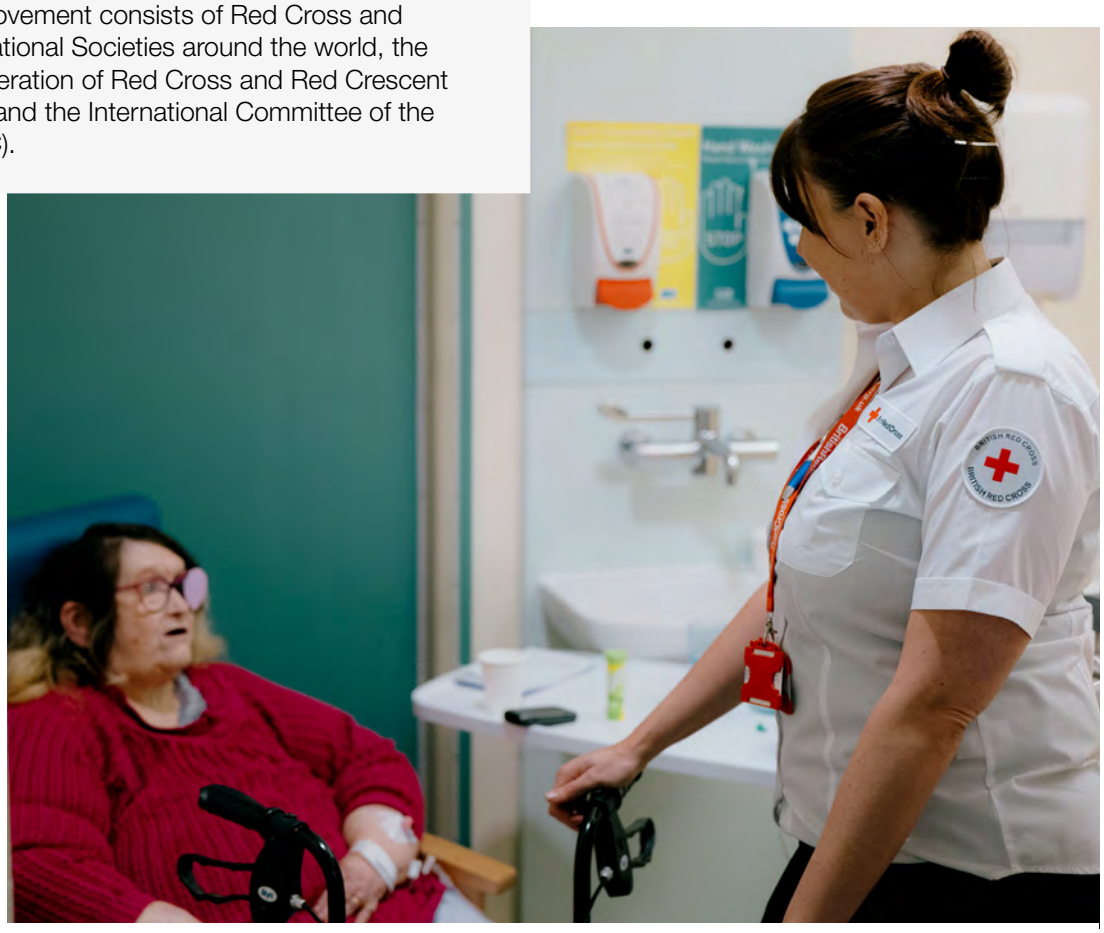
The British Red Cross is here for humanity. Together, we help people prepare for, respond to, and recover from crisis – providing hope and life-changing support. Our teams work side by side with communities, listen to their needs and put them first.

We are powered by more than 10,500 regular volunteers in the UK, over 17,600 community reserve volunteers and nearly 4,000 staff. It is their determination to help others, along with the generosity of our supporters, that allows us to reach people in crisis when they need us most.

We are guided by the seven fundamental principles of our Movement: humanity, impartiality, neutrality, independence, voluntary service, unity and universality. These principles commit us to putting people first in everything we do.

Part of the world's largest humanitarian network, stretching across the UK and 190 other countries, we are ready to respond when the worst happens. The Red Cross and Red Crescent Movement consists of Red Cross and Red Crescent National Societies around the world, the International Federation of Red Cross and Red Crescent Societies (IFRC) and the International Committee of the Red Cross (ICRC).

A British Red Cross team member with a patient transport service vehicle in Northern Ireland.



A British Red Cross team member with a patient at Glangwili Hospital, Wales..

Progress against our 2024 priorities

British Red Cross volunteers at the Grange University Hospital, Newport, Wales.

Our quality priority	Our objectives	How we did
We will roll out and embed our new outcomes framework.	**We will:** Start using the framework during 2024 to collect more outcomes data, ensuring that we can show evidence of the difference our services can make. Integrate the framework into day-to-day practice. Run workshops and training to support the roll-out.	**We have:** Started to roll out our new health outcomes framework, capturing data from a set of questions asked at the beginning of support, and then again at the end. Made good progress with completion rates and have started to use the data and insight to improve our services.
We will complete quality assessments against our new quality domains and standards.	**We will:** Complete a quality self- assessment for every service. Identify key themes and trends, and develop improvement plans in response to identified gaps.	**We have:** Completed a pilot quality standards self-assessment in a small number of services to test our approach. Evaluated the results and made the decision to digitise the process before rolling the self-assessment out across all our health and care services. Identified lots of good practice and some areas for improvement, and developed action plans. Completed a programme of 'mock' Care Quality Commission inspections of our regulated services. We are analysing the results to support continuous improvement and prepare for external inspections.

Our quality priority	Our objectives	How we did
We will embed the new national patient safety incident response framework (PSIRF) and the British Red Cross patient safety incident response plan.	**We will:** Engage with health and care networks to help inform the Patient Safety Incident Profile. Seek approval from the Integrated Care Board (NHS Nottingham and Nottinghamshire) to sign off our PSIRP. Create a transition plan to embed the PSIRF, and associated incident management procedures. Implement new ways of working to support the PSIRF. Set up quality improvement processes to proactively respond to areas where change is required, based on our patient safety incident profile. Monitor quality improvement actions. Monitor the changing data on patient safety across our health and care services to identify any changes that are needed. Analyse the safety culture survey results to inform any improvement work.	**We have:** Defined our Patient Safety Incident Profile by triangulating data from our incident reporting system, insights from our health and care network and results from the safety culture survey. Published our Patient Safety Incident Policy and Plan, which have both been signed off by our lead Integrated Care Board (NHS Nottingham and Nottinghamshire). Successfully completed accredited training for all our PSIRF lead roles. Implemented new ways of working to identify opportunities for learning. Optimised our improvement by allocating learning resources where they will have the greatest positive impact on patient safety. Adapted existing oversight processes to monitor improvement actions.
We will embed our new complaints, compliments, and comments policy and processes.	**We will:** Continue to roll out the new platform and processes. Use the training and support available to embed these processes.	**We have:** Rolled out the new complaints, compliments, and comments system across all health and care services.

British Red Cross staff on their way to provide a hospital at home service in Cumbria.

Our impact data

Experience data

Our service-user feedback surveys on our health and care and refugee support services offer us an insight into how people felt about their experience of our services. They also help us monitor the quality of our service delivery.

In 2024, we received feedback from 10% of the 62,256 people we supported with our health and care services, and from 9% of the 10,020 people we surveyed who used our refugee support services.

We found that most people experienced safety, choice and dignity when accessing our support.

In 2024, **over 90%** of people we supported across all our services, excluding high intensity use, reported reduced levels of anxiety. **Over 80%** of people reported an improved ability to manage their health.

97%

of people supported by our health and care services had a positive experience

Source: 6,134 feedback responses

Health outcomes framework

Last year, we continued to roll out our new health outcomes framework. This is a holistic set of questions asked at the beginning of our support, and then again at the end. The framework helps us measure the impact of our work, evidence our strategic goals of recovery and resilience, and inform our planning.

We are also able to provide an economic evaluation of the outcomes of our work. We measure the social, environmental, and economic benefits of a project, putting a value on its positive social and financial impact.

A British Red Cross team member with a patient transport vehicle in Newport, Wales.

Our service user feedback tells us that most people we support are experiencing...

...when accessing our support

Source: 5,697 (dignity), 5,690 (safety), and 5,674 (choice) feedback responses for health and care from 01/01/2024 to 31/12/2024. 744 (safety) and 732 (choice) feedback responses for refugee support from surveys sent out in March and Sep 2024

Our health and care services are helping people to reduce their anxiety and better manage their health

Source: 5,687, 5,673 and 5,665 feedback responses for support received, anxiety, and self-management, respectively.

Our impact on reducing health inequalities

We collaborated with the Institute for Health Equity at University College London last year to explore how our work in the UK helps people overcome inequalities and socially determined barriers to better health.

We mapped our activities to the initial six Marmot principles – the recommendations for how to tackle the wider social determinants of health outcomes – and used our health outcomes measurements and activity data to assess our impact.

Give every child the best start in life: Our refugee support services delivered over 2,000 actions to support children of displaced families. Two thirds (64%) reported that they found these helpful.

Enable people to maximise their capabilities and have control over their lives: 69% of people supported by our refugee service teams reported they were better able to make their own decisions. Of people supported by our high intensity use services, 48% said they had increased control over their lives.

Create fair employment and good work for all: 62% of people supported by our health and care services were supported to get better access to employment and 64% of people supported through our refugee services work were supported to get better access to education.

Ensure a healthy standard of living for all: Over 73,000 actions were taken across our UK services to help people access finances and meet their basic needs. 80% of people supported by our refugee support services told us we helped them meet their basic needs, and 69% of people supported by our high intensity support services stated that they no longer had a financial need at the end of our support.

Create and develop healthy and sustainable places and communities: 56% of people supported by our high intensity use services said they experienced reduced loneliness and increased connections to their communities. 66% of people supported by our refugee support services told us we had helped them to learn about their local area, life in the UK and meet new people.

Strengthen the role and impact of ill health prevention: We were successful in strengthening the impact of ill health prevention across a number of our services. You can see our findings related to quality of life, wellbeing and resilience to health crises on pages 7, 9, 10, 13, 14 and 15.

We will continue this work over the coming months. We'll develop an evidence base to help us further improve our services and ensure our work helps actively dismantle barriers to equitable delivery.

A member of our discharge to assess team in Scotland works with hospital staff to identify and provide the right support for patients living in their own homes.

Our services in focus

High intensity use service

Our high intensity use service supported more than 1,300 people who had accessed urgent care services more than expected. We worked with people to improve their long-term health outcomes and relieve pressure on the system. We took a holistic one-to-one coaching approach to improve people's existing strengths.

We conducted more than 4,300 face-to-face appointments and over 8,800 phone calls to provide practical and emotional support. We also provided more than 2,100 onward referrals to services such as Adult Social Care, Mind, Age UK, and the Samaritans.

Case study: Matt

Matt has a history of alcohol dependence and complex health issues. He recently lost his partner and his father, which exacerbated his alcohol use and saw him more frequently attend accident and emergency departments. Matt struggled to engage with or attend appointments, finding the offers of help overwhelming. As a result, he disengaged from services.

At the start of our support, Matt was unemployed and finding it hard to claim appropriate benefits.

Our team focused on building trust and a good relationship with Matt through regular, face-to-face meetings. We simplified the support options available to Matt, so it became easier for him to make informed decisions and prioritise which services to engage with.

We collaborated with other professionals, advocating for Matt, and used coaching techniques to empower him to identify his personal goals and work towards achieving them.

Matt successfully completed rehab and continued accessing relapse-prevention and aftercare services. The service empowered Matt to seek full-time employment and helped him secure a job. He is looking forward to enjoying a holiday for the first time in years and plans to relocate abroad in the future. There have been no further attendances at accident and emergency departments.

Matt said: "(I) felt the HIU approach was genuine and felt listened to for the first time by services."

92%

of people

supported by our high intensity use services said they had improved their wellbeing,

creating more than

£3m

in social value.

Our high intensity use services are supporting people to improve their wellbeing and build their resillience to a health crisis.

Improved wellbeing

92%

Improved ability to manage health and wellbeing

91%

Over **£3m** social value created for people supported

Source: 477 and 413 people with start and end of support scores for wellbeing and health activation, respectively.

In supporting people to build resilience, our high intensity use services aim to reduce accumulative use of urgent and emergency care services. This helps alleviate pressure on the health and care system, and reduces costs. Data available from one of our services in Stockport, Greater Manchester, shows we're reducing accident and emergency department attendances, non-elective admissions, and ambulance conveyances by 51% or more.

Case study: HIU Stockport

Our high intensity use services in Stockport has been supporting the health and care system by reducing…

A&E

59% of A&E attendances

H

63% of non-elective admissions

51% of ambulance conveyances

Source: 109 people's use of A&E services tracked 12 months post support (representing 97% of people supported).

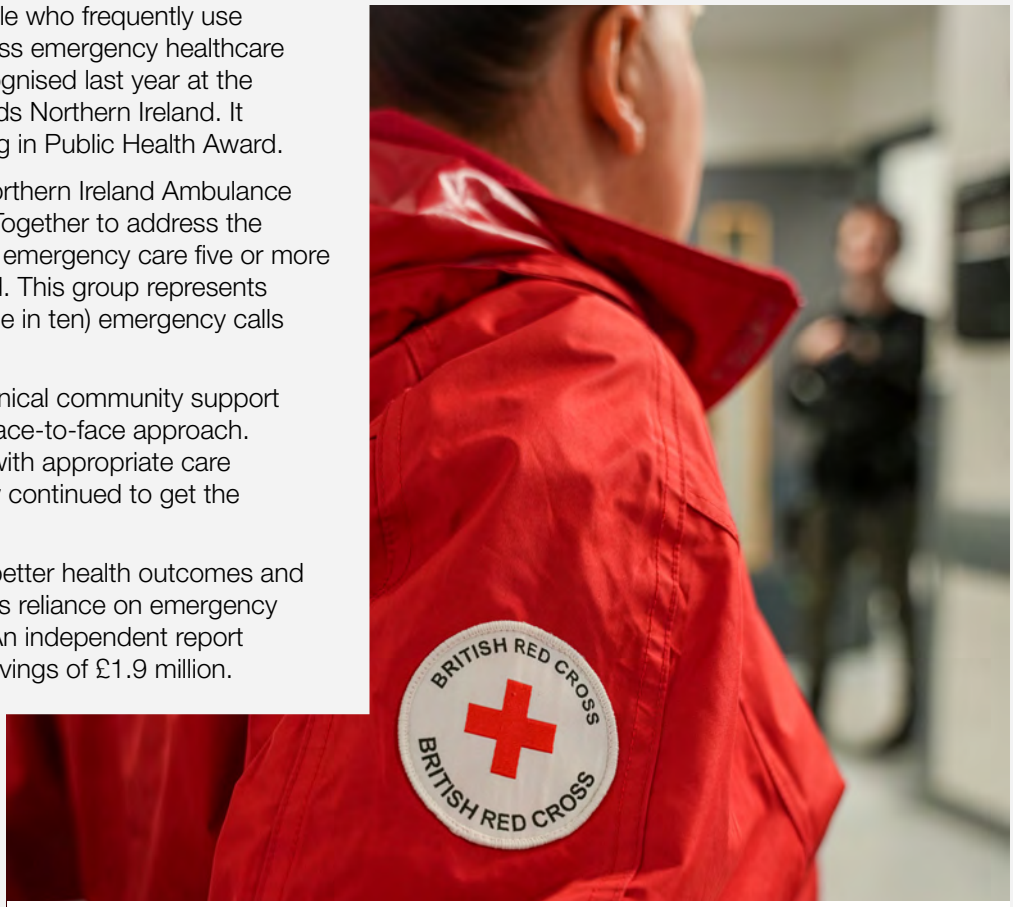
Northern Ireland Interact project

Our project to support people who frequently use ambulance services to access emergency healthcare in Northern Ireland was recognised last year at the Advancing Healthcare Awards Northern Ireland. It won the Partnership Working in Public Health Award.

We collaborated with the Northern Ireland Ambulance Service and NHS Charities Together to address the needs of adults who require emergency care five or more times within a 30-day period. This group represents approximately 20,000 (or one in ten) emergency calls in Northern Ireland annually.

We offered targeted, non-clinical community support through a person-centred, face-to-face approach. And we connected people with appropriate care pathways to make sure they continued to get the support they needed.

The project helps promote better health outcomes and significantly reduces people's reliance on emergency and primary care services. An independent report estimated it led to annual savings of £1.9 million.



British Red Cross team member in Wales.

Our foodbank project

Our pilot project with Trussell (previously known as the Trussell Trust) and the Norfolk foodbank to tackle the underlying causes of food poverty was extended last year to food banks in Hunstanton and Ramsey.

The project uses a multi-disciplinary approach to positively impact people who have needed to use a food bank. It provides advice and support to ensure they do not need to access emergency food again. The pilot was first developed in Norwich in 2022, where we worked in collaboration with Citizens Advice and Shelter to provide specialist guidance and support on housing and debt.

Our team attends ten food banks across Norwich on a fortnightly rotating basis. It works with food bank volunteers and partner agencies to help people access benefits, better understand their rights and entitlements, and connect with other relevant sources of support. In Hunstanton, we attend a food bank every week.

In the first nine months of 2024, our teams supported over 230 people in Norwich and 32 in Hunstanton. In the last quarter of the year, 79% of people we supported in both areas have not used the food bank further, compared to 60% of all those using the Norwich foodbank. A full project evaluation will be completed in 2025.

Supplies at a food bank

Case study: John

John didn't have enough money to buy food when our team first met him. During the two weeks before he came to his local food bank, he had been hospitalised due to self-harm. John reported being at 'rock bottom', struggling with alcoholism, and overwhelmed by the state of his finances and issues in his personal life. He said he was struggling to cope and was viewed as 'non-engaging' by other agencies. A partner agency referred John to us.

To help John get by, we supported him with emergency food. We met with him several times to better understand his needs and help him improve his situation.

John used to love fishing, but had abandoned it. We helped him buy some new fishing gear and take some fishing trips, so he could reengage with his hobby, and gain the mental space to start addressing his problems.

Our team supported John to make decisions on what to tackle next and how. He was referred to Citizens Advice to help him arrange a manageable debt repayment plan.

John's transformation over the months since we first met him has been remarkable. His finances are under control, and he has not needed to come to the food bank.

John now rents a workshop space, has resumed a previous hobby and is now selling his creations at craft fairs, rekindling a former passion.

We keep in contact with John to check he's continuing to thrive. He has not needed additional support for several months, a testament to his resilience and to the comprehensive, coordinated help he received. John's journey is a powerful example of the impact of holistic support.

Our home from hospital work

Our assisted discharge schemes support patients to return home from hospital, providing faster, safer discharges and preventing readmission.

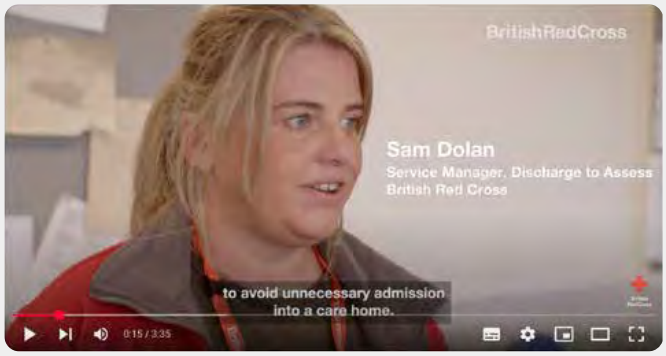
Last year saw our pilot 'discharge to assess' project in Dundee awarded a full contract. This followed a successful test period, which reduced the need for care home places among the people we supported.

The project is part of our work to trial new and innovative approaches to help people regain their independence at home after a hospital stay. It involves a dynamic and ongoing assessment over 21 days to evaluate whether patients are able to live independently at home and what needs to be put in place to facilitate this.

The service supports independent recovery. It reduces the likelihood of hospital readmission and reliance on residential care.

During our test period between April 2023 and July 2024, 75% of people initially believed to need to go into a care home were able to remain at home, and 36% of those remaining at home required no further package of care.

Last year, we expanded the project to Fife where it is called 'home to assess'. It has also seen positive impacts and has already been extended for a further 12 months.



75% of people we supported were able to remain at home and avoid unnecessary admission to a care home.*

*People taking part in our discharge to assess pilot in Dundee between April 2023 and July 2024.

Play video

A British Red Cross team member provides a discharge to assess service in Scotland.

Our assisted discharge schemes continue to deliver value to the health and social care system.

Over

£10m

value created for the health and care sector

Primarily through over 21,000 potential bed days saved

We have developed scenario models to estimate the demand that would have been put on the system without our support.

We estimate that our assisted discharge work saved more than £10 million in 2024, primarily by preventing the use of hospital beds for an estimated 21,900 days.

Supporting people who are homeless when leaving hospital

Last year, our work to support people who are homeless following hospital treatment in Lambeth and Southwark was recognised by the Royal Society for Public Health's Health and Wellbeing Awards. It won the Healthier Lives Award.

The service provides flexible, person-centred, one-to-one support to people while they are being treated and discharged. We build an understanding of their circumstances, health and wellbeing. Then we support them with a combination of practical and emotional assistance, to empower them to make their own choices.

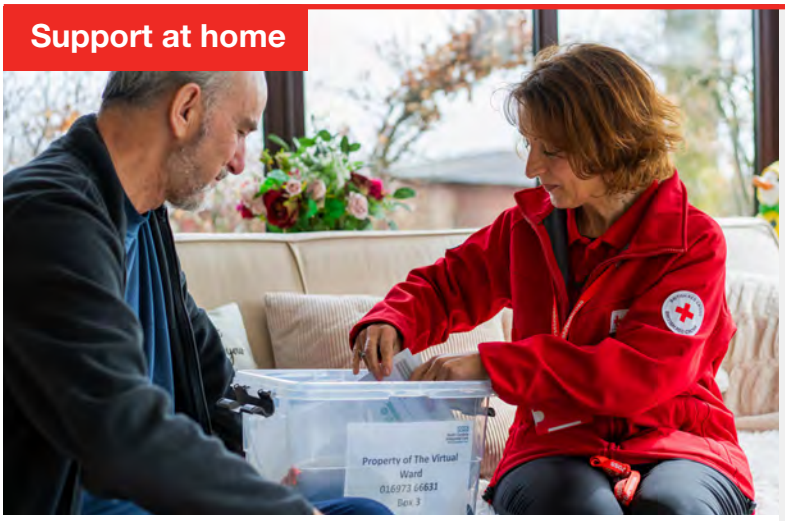
The service:

- improves health and wellbeing outcomes
- reduces the number of people being discharged to the street
- removes practical and emotional barriers to a timely discharge from hospital
- reduces the likelihood of readmissions
- saves the NHS money.

Alex Bigucci, Beth Thompson, Geeta Nargund and Simon Billingham at the award ceremony.

Professor Michelle Cornes, Visiting Professional Fellow at King's College London, found that the service saves the NHS £10,000 for every 20 patients seen.

Support at home



A member of our team provides a hospital at home service in Cumbria.

Our teams provided care and support to help people live at home and maintain their independence.

Our hospital at home service (formally 'virtual wards') enabled patients to receive hospital-level care at home. We supported people while NHS clinicians provided treatment. The service we delivered with the NHS in north Cumbria helped speed up recovery times and freed up hospital beds for patients most in need.

In April 2024, we introduced a new metric to our outcomes framework to identify unmet social needs and measure quality of life; 28 out of 48 of our services have started to collect this data.

Our support at home services support people to improve their wellbeing and live safely at home following a health crisis.

75% improved quality of life

£348,662 social value created

Source: 347 people with start and end of support score from 01/04/2024 to 31/12/2024.

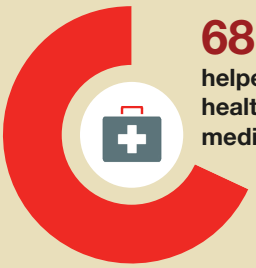
A British Red Cross Family Reunion Casework Coordinator supports a family reunion at Heathrow airport.

Our refugee support services

Our refugee support services used a feedback survey to capture self-reported outcomes for refugees, people seeking asylum and vulnerable migrants 6-12 months after they received support from us. The survey found that over 60% of those who needed health support received it.

Our Strengths and Needs Assessment Framework (SANAF) details the relevant strengths and needs that may affect someone's wellbeing. Our team in the south-east of England has been trialling the framework with people who have received casework support from us. So far, the number of people with at-risk physical health needs has decreased by 18% following our support, and the number of people with at-risk mental health needs has decreased by 26%. We are currently rolling out the framework to more service areas in 2025.

Our refugee support services are helping refugees, people seeking asylum, and vunerable migrants to access relevant health services and support…



68%
helped to access health services and medicines*

61%
helped to access mental health support**

…and to improve their physical and mental health.

% of those with at-risk needs according to our new Strengths and Needs Assessment Framework

Physical health needs***

32% Baseline

14% Last review

Mental health needs****

49% Baseline

23% Last review

*Source: 372 and 331 feedback responses, respectively, for accessing health services/medicines and mental health support, collected during March and September 2024; 305 initial and latest review scores for physical and mental health needs on SANAF collected between January and December 2024.

**Source: 372 and 331 feedback responses, respectively, for accessing health services and mental health support; 305 initial and latest review scores for physical and mental health needs on SANAF.

***Source: 1,961 and 1,706 feedback responses, respectively, for experience and knowledge.

****Source: 5,697 (dignity), 5,690 (safety), and 5,6974 (choice) feedback responses for health and care. 744 (safety) and 732 (choice) feedback responses for refugee support.

Our quality priorities for 2025

Our quality priority for 2025	What success will look like
We will roll out and embed our new outcomes framework across all of our UK operations.	**We will:** Continue to embed the British Red Cross outcomes framework across our health and care services, driving up response rates, and ensuring teams are confident to use the framework to deliver high-quality personalised support. Implement the outcomes framework across our other UK operations. Analyse the data responses to identify interventions and activities that drive the greatest improvement and impact for people we support. Continue to use the insight from the outcomes framework to inform service improvement and to actively dismantle any barriers to equitable delivery.
Digitise self-assessment against our quality standards.	**We will:** Complete the development of a digital quality standards self-assessment tool and roll this out across all health and care services. Design training and supporting materials for the quality standards self-assessment process. Develop reports from completed quality standards self-assessments and use the data to support continuous improvement. Continue with a planned programme of assurance reviews against our quality standards during 2025. Identify good practice and improvement themes, and use the data to support continuous improvement.
Embed the Patient Safety Incident Response Framework (PSIRF) ways of working throughout health and care services, and review our PSIRF processes to ensure the framework is being implemented in a way that improves patient safety.	**We will:** Update our Patient Safety Profile based on new and emerging trends and insights from PSIRF in 2024. Increase PSIRF capability by training current staff in PSIRF lead roles. Provide accredited training for new staff. Assess the impact of improvement on the patient safety environment and culture. Review PSIRF processes to ensure the framework is being implemented in a way that improves patient safety. Explore opportunities to enrich patient safety by collaborating with other secondary and tertiary healthcare providers who have implemented PSIRF.
We will embed our new complaints, compliments, and comments policy and processes.	**We will:** Ensure all teams are using the new complaints, compliments and comments system. Share learnings that emerge through complaints, compliments and comments, where appropriate, to drive improvement.

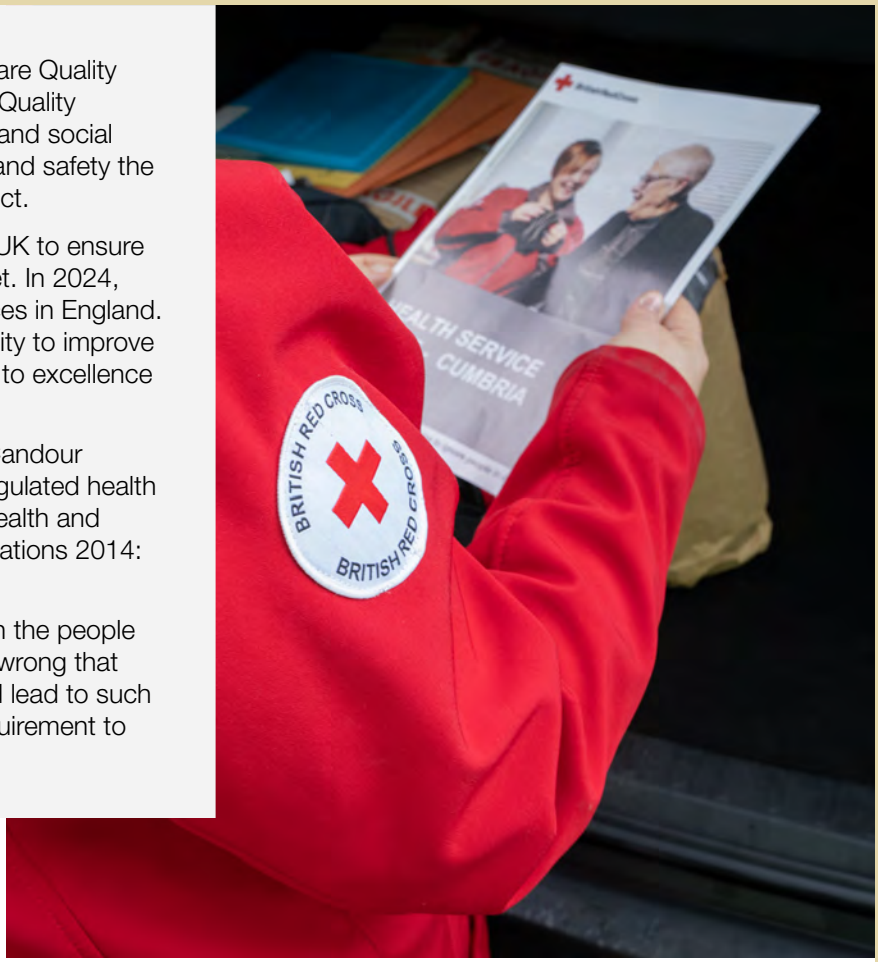
Regulatory compliance statement

Our services in England are registered with the Care Quality Commission where this is required. It is the Care Quality Commission's responsibility to regulate all health and social care provision in England and ensure the quality and safety the people who use our services have a right to expect.

We are in contact with our regulators across the UK to ensure that all our mandatory requirements are being met. In 2024, there were no inspections of our registered services in England. We see inspection and regulation as an opportunity to improve the quality of our services and we are committed to excellence and best practice.

As an organisation, we are clear on our Duty of Candour obligations. The Duty of Candour applies to all regulated health and care providers in England and is set out in Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20.

We are committed to being open and honest with the people we help and their families when something goes wrong that appears to have caused significant harm or could lead to such harm in the future. No incidents met the legal requirement to exercise our duty of candour in 2024.



A member of British Red Cross staff in Cumbria.

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