# EVALUATION OF CARE IN THE HOME SERVICE MODELS

## Report of Findings

for British Red Cross, Wales and Western

Elizabeth Folkes, Tony Garthwaite, Mark Llewellyn and Marcus Longley

Welsh Institute for Health and Social Care · University of Glamorgan

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## SCOPE OF REPORT

This report is an account of the views and experiences of British Red Cross (BRC) managers, staff, volunteers, and other stakeholders across five different locations in the Wales and Western territory. It is based on our analysis of data from interviews, discussion and focus groups, and other sources that took place between October 2010 and February 2011.

Thanks are due to Liz Urben and Chris Hopkins of BRC for commissioning this study and providing direction at the outset. As with any such research project, this study was only possible thanks to the contributions of the participants. Their willing engagement with the study, openness and honesty is gratefully acknowledged. The report uses thematic analysis to comprehend the different sources of data presented during the course of the evaluation. Conclusions are based on our understanding of the evidence presented to us by the respondents and any errors of interpretation are solely due to the authors. We trust that this independent analysis will help BRC with its ongoing work programme.

Elizabeth Folkes
Tony Garthwaite
Dr Mark Llewellyn
Professor Marcus Longley

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# 1 · INTRODUCTION AND METHODOLOGY

## 1.1 INTRODUCTION

The Welsh Institute for Health and Social Care (WIHSC), University of Glamorgan was commissioned to undertake an evaluation of five British Red Cross (BRC) programmes across the Wales and Western territory, all of which are focused on delivering 'care in the home'. The overall aims of the research study were to help BRC to understand how to grow care in the home by:

- Understanding the different models of delivery and what differentiates them;
- Identifying what's replicable;
- Understanding how volunteers can best deliver these services; and
- Offering insights on how to broker in other providers.

## 1.2 METHODOLOGY

Five Case Study sites were identified by BRC, and WIHSC took a qualitative approach to the evaluation in order to ensure that a deep understanding of the themes and issues arising was reached. The five sites all had a 'Home from Hospital' and/or other 'care in the home' scheme. The five selected were: Bristol, Cornwall, Herefordshire, Swindon, and Telford.

In the main, research was undertaken with managers, staff and volunteers at each of the sites, either through interviews or discussion groups. In addition to this, data was gleaned from monitoring reports and internal evaluations, as well as from the perspective of local commissioners wherever this was possible. In total, the research team spoke to 46 people during the course of the study, 24 of whom were volunteers.

It is important to see this report for what it is – a snapshot of local service delivery undertaken between October 2010 and February 2011. By definition therefore, the study was limited by the resources available to complete each of the Case Studies, and the people available at that time to meet with the researchers. Undoubtedly events will have moved on in each of these sites, and to a certain degree the accounts presented in the next chapter will have been surpassed by events over the last few months.

### 1.2.1 Analysis

Once an accurate account of each of the five Case Study sites had been produced, a thematic strategy was employed to analyse the data in order to see commonalities and differences between sites and the perspectives of respondents.

Data was coded on the basis of content. None of the responses were weighted as more significant than any others, such that all views are entirely comparable throughout in terms of their importance. Verbatim quotations (*in italics*) are used in this report to capture recurrent, or otherwise resonant, points of view. WIHSC does not necessarily endorse the opinions expressed. Such quotations are only used to portray viewpoints accurately and clearly.

The report is obviously not a verbatim transcript but an exploration of the themes and issues raised by respondents through the research process. So whilst encapsulating the main themes and highlighting the key points, this document seeks to be faithful to what was said by them.

### 1.2.2 Report structure

The structure of the following sections mirrors that of the methodology. There are two substantive chapters. The first reports the Case Study evidence, and the second draws on this data and identifies common challenges and implications for the BRC in light of the desire to grow 'care in the home' services. This section also draws upon a seminar held in June 2011 and a series of deliberations and conclusions in the light of the evidence presented therein.

# 2 · RESEARCH FINDINGS – CASE STUDIES

The following sections provide a detailed description of each of the five Case Study sites. Details of precisely which local schemes were evaluated in the research along with other 'facts and figures' can be found in Table 1 below.

## 2.1 BRISTOL


**Summary**

- Innovative, 'non traditional' schemes targeting highly vulnerable and marginalised groups
- Partnership working with other agencies
- Younger, diverse volunteer base


### 2.1.1 Background

Home from Hospital began in Bristol in 2007 as a two year pilot, financed from core BRC funds and the local PCT. In 2009, Bristol was awarded £59,000 of 'Tesco' money over a two year period to extend the existing Home from Hospital scheme, and to run three pilot community care projects working with highly vulnerable, marginalised client groups.

### 2.1.2 Staffing

Services are delivered by two full-time staff, a Service Manager, co-ordinator, and approximately 30 volunteers.

### 2.1.3 Key features

Bristol adopts a commendably innovative approach to service development and they have been very adept at responding to funding opportunities, spotting potential for partnership working and identifying groups in need. The Home from Hospital scheme has successfully expanded to include the three acute hospitals in Bristol and now receives around 288 referrals a year. The service is well promoted in hospital wards and departments and has built good links with the Accident and Emergency staff enabling some patients to go straight home with BRC support, thus preventing hospital admission. A programme working approach incorporating the Medical Equipment service has been adopted which has included joint promotion of the services.

South Gloucestershire PCT have recently approached BRC regarding the introduction of a Home from Hospital scheme serving patients discharged within its geographical area incorporating transportation and rapid response. When visited by researchers, a six month pilot had been agreed but, with no lead in time for the project, there were some concerns around capacity to deliver the service proposed.

The three community care projects represent a departure from the BRC's traditional approach to health and social care and the more conventional schemes both in terms of volunteer profile and client group. Bristol has a number of younger volunteers motivated by gaining new skills and experience, many of whom are in full-time employment which has enabled the Home from Hospital scheme to routinely offer weekend and evening visits.

**Table 1** · Case Study sites – facts and figures

| | Schemes Evaluated | Funding | Staffing | Active Volunteers | Beneficiaries |
|---|---|---|---|---|---|
| **Bristol** | Home from Hospital (HfH) – 2007+<br>Tesco pilots – 2009-11:<br>1. Brain injured adults – Therapeutic Care (TC)<br>2. Female sex workers – TC, skin camouflage, and First Aid<br>3. Sickle Cell families – HfH, TC, and First Aid | HfH = currently BRC (£40,000 per annum) – 2011 onwards = PCT?<br>Pilot projects = 'Tesco money' (£59,000 over 2 yrs) | 1 Service Manager<br>1 F/T co-ordinator | 30 | HfH = 288 (18 years+) |
| **Cornwall** | HfH – 1991+<br>Home support scheme (Care and Response) – 2004+ | Cornwall County Council (£80,000 per annum) | 1 Service Manager<br>1 Team Leader<br>6 P/T co-ordinators (4.0 Whole Time Equivalents - WTE) | 80 | 1,400-1,700 across both schemes (Service Level Agreement based on 1,200) – 18+ (but mostly elderly) |
| **Hereford** | Village Warden (VW) Scheme – 2006+ | Hereford County Council (£70,000 per annum) | 1 Service Development Manager, 7 P/T wardens | 8 | VW = 278 (75+ years, living within parish) |
| **Swindon** | HfH – 1999+<br>Home support scheme (Care at Home) – 2007+ | PCT funding administered through Swindon Borough Council (£30,000 per annum) | P/T Co-ordinator (27 hrs/wk) Managed by SM Bristol | 21 | HfH = 120<br>Care at Home = 37 (18+ years) |
| **Telford** | HfH – 2003<br>Home support scheme (StayWell) – 2008+ | HfH = £22,583 Telford & Wrekin Council, £24,120 PCT<br>StayWell = £20,250 PCT | 1 Service Development Manager, 3 P/T co-ordinators (30 hrs/wk, or 2.4 WTE), 1 assistant co-ordinator (18 hrs/wk) | 40 | HfH = 250 (18+ years)<br>StayWell = 250 (65+ years) |

The introduction of the community care projects presented a challenge to some existing volunteers and it was necessary to recruit additional volunteers who felt more comfortable and confident working with such marginalised client groups. A structured model of service delivery did not fit well with the chaotic and unpredictable lifestyles of the beneficiaries and, together with issues around trust, meant it took longer to engage with beneficiaries and implement support than anticipated. Taster sessions, such as therapeutic care and emergency first aid, were felt to be an excellent way to get potential beneficiaries to engage. It was also felt that working in partnership with existing organisations in the field was the key to establishing relationships with harder to reach client groups. That said, partnership working has also presented many challenges. Financial instability and high staff turnover within one partner organisation had made it difficult to move forward with the scheme.

## 2.2 CORNWALL


**Summary**

- Well established county wide service supporting around 1,400 beneficiaries a year
- Collecting discharged patients and transporting home is an integral part of the service offer
- Volunteers frequently required to travel considerable distances


### 2.2.1 Background

A Home from Hospital scheme has been running in Cornwall for around 20 years. The care at home scheme (Care and Response) arose out of a central government funded intermediate care service pilot seven years ago. Cornwall county council took over this funding but integrated the two streams into one service known locally as Care and Support.

Funding is locally regarded as relatively secure. The contract with Cornwall County Council was renewed in April 2010 for a further three years but with no inflationary increase. The service receives £80,000 per annum based on a service level agreement of 1,200 referrals per year receiving a minimum service input of three visits, each of three hours duration with travel time included. For the past four years the service has managed to respond to around 1,400 referrals a year.

### 2.2.2 Staffing

The service is delivered by a staff team comprising the Service Development Manager, a Team Leader and six part-time co-ordinators (4.0 Whole-Time Equivalents, WTE) together with around 80 volunteers.

### 2.2.3 Key features

The service is based in Truro but covers the whole county so a wide spread of volunteers is needed. Transport is an integral part of the Care and Response offer with many of the beneficiaries living some distance from the district hospitals. The service is well promoted within the hospitals and has become an important component of discharge planning for ward staff. At the main hospital, Treliske, the service is advertised around the clock on plasma screens in the patient waiting areas. Referrals are accepted from anyone and self referrals are encouraged, the majority of referrals though come from Occupational Therapists.

Typically volunteers are required to collect patients on discharge and settle them back into their own home whilst carrying out an assessment of their support needs. Both Home from Hospital and Care and Response are based around a six week intervention package comprising such activities as low level banking, light housework, shopping, collecting prescriptions, providing short-term respite for carers and bereavement support. Volunteers are also able to transport beneficiaries to pre-existing hospital appointments or follow up consultations. A number of volunteers who are ex-health professionals act as 'supportive friends' accompanying the patient into the consultation (if they wish) and helping to clarify any information given therein.

Given the rurality of the area BRC serves in Cornwall, transport is a crucial feature of the service but this presents a major cost challenge. The continual rise in fuel prices has not been matched by an increase in funding, and volunteers who may have been previously reluctant to claim expenses can no longer afford to subsidise the service out of their own pocket. The service is already stretched to capacity as it regularly sees an additional 200 people a year on top of its service level agreement. This year they are anticipating responding to nearly 1,700 referrals as other forms of support suffer financial cutbacks. Previously the service has been able to absorb these extra numbers without compromising their level of support but this will become increasingly difficult to do without more funding. Mindful of BRC values, they are reluctant to turn anyone in need away.

The universality of BRC and its ability to access hard to reach, vulnerable clients has been a valuable resource for other agencies locally. Twelve months ago the BRC were asked by the regional Fire and Rescue Service to include a basic risk assessment when visiting people at home and to signpost them on to receive free smoke alarms and other safety measures. A similar initiative alerts the Benefits Agency to people who may not be receiving their full entitlements.

## 2.3 HEREFORDSHIRE


**Summary**

- Founded upon principle of 'good neighbour'
- Accessibility, local knowledge, and trust are central elements.
- Wardens live within the parish and are members of the community they support. They are able to respond quickly in a crisis and gain access where other agencies struggle.
- Aims to aid the development of community resilience


### 2.3.1 Background

The scheme started in October 2006 as part of Herefordshire's Local Public Service Agreement building on the success of their Signposting service. The scheme currently receives £69,950 per annum from Hereford County Council but future funding is uncertain. On average the wardens support around 300 clients a month and maintain a watching brief over a further 200+ potential clients.

### 2.3.2 Staffing

There are seven Village Wardens. Five are based in villages and are paid for 12 hours per week. Two wardens are based within the city of Hereford: one is paid for 15 hours and one 35 hours per week. The hourly cost of a Village Warden is calculated at £12.23. In addition to the Wardens there are approximately eight volunteers who are managed by the Service Manager in Hereford.

### 2.3.3 Key features

The Village Warden scheme aims to support the health, well-being and independence of older people in Herefordshire through the principle of the good neighbour. Wardens focus on four main areas which mirror the Supporting People Outcome Framework: finance, health, home and physical environment, and social inclusion. Additional tasks include signposting to other services, health promotion, community development, data capture, learning and development.

Originally the scheme was restricted to supporting people aged 75 and over living within the parish boundary. The participating parishes were selected on the basis of this demographic plus having a demonstrable commitment to older people as part of their parish plan. Areas where the BRC were already providing a service were excluded. In practice the Wardens do provide support for people under 75 too but remain fairly rigid in terms of geographical boundaries. Village Wardens themselves are required to live locally. Being local means that the Warden can engage swiftly in a crisis and is on hand even when other agencies are unable to reach communities e.g. during snow or floods. The Warden is also able to gain access to people who would otherwise be reluctant to engage with welfare services. The Warden often acts as a communication portal, disseminating information on behalf of other agencies and signposting parishioners towards other support agencies.

Ideally the scheme should incorporate one-to-one support with a focus on building community resilience. Wardens are expected to build up a team of local volunteers and operate in a supervisory capacity. In practice this hasn't happened. Wardens report that potential volunteers have been discouraged by the formalities of recruitment and induction that are required to become a BRC volunteer. It is also suggested that many Wardens are reluctant to delegate the hands-on aspect of their role to volunteers as this is what attracted them to the post in the first place.

With funding threatened, the sustainability of the scheme has been much discussed. A new model has been proposed where the Village Warden is a volunteer supported by funds from the parish precept and overseen by a central management infrastructure which includes a support worker ('super warden') post.

## 2.4 TELFORD


**Summary**

- Effective programme working, strong leadership and team-work
- Proactive planning for service development
- Commitment to raising profile of service with commissioners and potential partners


### 2.4.1 Background

Telford and Wrekin was originally incorporated into the Shropshire area but when PCT funding streams were reconfigured in 2003, BRC areas were reorganised to correspond with commissioning boundaries. Initially the Telford service consisted of a traditional Home from Hospital scheme. A home support scheme – StayWell – began in 2007 as a 15 month pilot and thereafter has continued to be funded by the PCT as part of their prevention of admission programme. Home from Hospital receives £22,500 per annum from Telford and Wrekin Borough Council and £24,000 per annum from the PCT, and StayWell receives £20,000 per annum from the PCT. Both schemes are currently funded until

March 2012. The schemes receive a similar number of referrals with the service as a whole supporting approximately 500 clients a year.

### 2.4.2 Staffing

The service is delivered by a full-time Service Development Manager, three part-time co-ordinators (2.4 WTEs), one part-time assistant co-ordinator and around 40 volunteers.

### 2.4.3 Key features

The StayWell scheme is particularly well developed in Telford. It has an open referral route but requires some professional health or social care input to confirm that there is no medical need for a hospital admission and therefore most referrals result from the local admission avoidance programme pioneered by the PCT. This programme includes an accelerated pathway to appropriate services which aims to have a 24-hour turnaround from an initial assessment to the drawing up of care packages. Rapid response therefore is an established feature of the StayWell service. The current service level agreement requires first contact with the client to be made within 72 hours but, in practice, 99% of referrals are responded to within 24 hours. Initial assessments are carried out by a co-ordinator who then assigns the referral to a volunteer.

A programme working approach is firmly embedded in the way that the service is structured locally. The Telford office has a single telephone number that is answered by all staff and one assessment form for all parts of the service. Co-ordinators are assigned a specific area of responsibility such as volunteer recruitment or promotion but are empowered to deliver all arms of the service. A strong team spirit has been fostered and volunteers likewise are expected to be fairly 'multi-disciplinary' and are recruited in the knowledge that they may be called upon to deliver a number of aspects of the health and social care programme. Over 20% of the volunteers are also trained in Therapeutic Care.

The need to modify and expand the health and social care offer is recognised and there is a good deal of proactive planning of new service directions and seeking out opportunities for partnership working. There is an emphasis on raising and retaining the profile of the BRC with other agencies. At a managerial level this includes activities such as sitting on the Older People's Partnership Board, for the co-ordinators this involves conducting a weekly hospital ward round. The team are encouraged to continually review their way of working in the context of the changing landscape of local services and they have already started to explore extending office hours in order to respond to an increasing number of evening and weekend discharges.

## 2.5 SWINDON


**Summary**

- Traditional model of Home from Hospital
- Having hospital base maintains profile of service and encourages referrals
- Attempts to assign volunteers to referrals within own community


### 2.5.1 Background

Home from Hospital has been operating in Swindon since 1999. Following a 12 month pilot scheme funded by Tesco monies in 2007, the service was extended to include Care at Home. Home from

Hospital continues to be the main arm receiving around 150 referrals per year compared to 30 referrals for Care at Home. The service is commissioned by Swindon Borough Council with funding provided by the PCT of £30,000 per annum. The service is currently in the middle of a two year contract, with a service level agreement equating to 10 referrals a month.

### 2.5.2 Staffing

Managed by the Service Manager in Bristol, services in Swindon are delivered by a part-time coordinator working 25 hours per week and 21 volunteers.

### 2.5.3 Key features

The co-ordinator attempts to keep travel costs and time commitment at a manageable level by assigning volunteers to local referrals. Coming from the beneficiaries own community, they know what is available locally and can often provide a useful link to other forms of social support. Volunteers also play an important role in championing the scheme at a local level.

In many respects the Swindon scheme follows the traditional Home from Hospital model, retaining a base in the hospital as well as a desk in the main BRC office in Wotton Bassett. Having a presence at the hospital helps to maintain the profile of the scheme especially as the office is shared with the Occupational Therapist and social work team. This enables the co-ordinator to be actively involved in discharge planning and facilitate regular contact with ward staff.

## 2.6 GOLDEN THREADS: WHAT MAKES A GOOD SCHEME?

Looking across the five Case Study sites, the following themes emerged to a greater or lesser extent in all of the programmes. They can therefore be seen as 'golden threads', present in each of the locations and different elements of the services examined.

#### Prompt Response

All schemes placed great emphasis on responding to referrals quickly, aiming to make contact with clients within 24 hours, although none had service level agreements that required such rapidity of response. Responding swiftly in times of crisis was seen by many as fundamental to the identity of the BRC and a principal component of the organisation's offer that is highly regarded by commissioners and referring agencies:

> *"One thing the commissioners say, and the feedback they get from people working with us, is that they really appreciate our speed of response and flexibility. But we need to keep pace with changes – I'm seeing more evening discharges and at weekends. We should be able to respond to referrals outside of office hours if need be" (Manager)*

#### Clear boundaries

The type of low level interventions provided often do not require specific skills, experience or training and the clearly defined limitations of the role both in terms of time and tasks make it easy for volunteers to set boundaries. As a time-limited service, volunteers work with their client to enable them to retain or regain their independence, frequently signposting them to other agencies:

> *"During the time volunteers are visiting they are always looking for ongoing needs so we can work out who we will need to refer back and who to. Volunteers do it because they care so they do worry about what is going to happen to the user. [We] have to remind themselves it is about*

*empowering. It about getting the balance right and setting boundaries whilst working all the time towards closure. It's the only job were you are trying to be made redundant!" (Co-ordinator)*

*"It's a fine line between dependence and independence. We are a crisis organisation and if they need help after six weeks they need someone else. That's made clear to them from the start" (Volunteer)*

### Flexible, tailored support

Typically support packages were negotiated directly with the clients and as such were flexible and tailored to individual need and local circumstances. This meant that they were more personal and responsive, and less formalised than other support services, without lengthy assessment procedures and paperwork, and not confined by pre-determined care plans:

*"I think people commission us because we have a can-do approach. I think we have a reputation that if we can do it we will and we are flexible in our approach" (Manager)*

*"Often people have other carers coming in but they can't do a lot of things we do. Carers might do shopping for someone but we have the time to try and help them do it themselves. Or perhaps the carers aren't allowed to carry heavy things – like someone's weekly shop. For most of them it's not about getting the shopping – they are lonely. They want care and support in the real sense" (Volunteer)*

### Volunteers and the 3 'R's – Recruit, Retain, Respect

Volunteers formed the bedrock of most of the schemes visited and the value that they bring to the delivery of the service was something staff deeply respected and wished to retain. All of the volunteers spoken to could be described as adaptable, flexible and resourceful. They were not afraid to use their initiative and were confident that the support they provided made a real difference to the lives of beneficiaries:

*"I get great satisfaction out of it. It gives something to you because what you give to the user is satisfying. You've brightened up their day, you can see at the end of the six weeks there is an improvement, they are getting back on their feet. It is rewarding. There is a reward from both sides. I think it is absolutely terrific that from such a small thing both sides actually gain from it" (Volunteer)*

In general, volunteers were felt to be extremely dedicated to their work. They value the reputation of the BRC very highly and are deeply committed to upholding the organisation's principles and values. Several volunteers commented on how the manageable time commitment and short term nature of the contact with clients (unlike other befriending schemes) attracted them to the BRC.

*"Home from Hospital is ideal because it's not a long term commitment, short-term with the same person. You're not stuck with someone long-term if you don't get on with them, six weeks is ideal! (Volunteer)*

*"Some ladies are delightful and you could carry on with them indefinitely. With some of them I have popped in after the six weeks is over on social basis. It's not difficult that it is time-limited as it is explained to them that it is just to get them up and running after they come out of hospital" (Volunteer)*

### Red Cross Brand- special credibility, confidence and trust

Staff and volunteers repeatedly spoke of the value of the BRC brand which is strongly identified with core values of humanitarian assistance. This encourages the trust of clients, commissioners and other service providers, and aids volunteer recruitment. It enables BRC to gain access to people who are otherwise reluctant to engage with care services, statutory and otherwise – BRC can then signpost to other services:

*"It helps that it is Red Cross – social services is an awful word for many people to hear. Old people panic – they only hear about the bad side of social services. Red Cross fills that gap" (Village Warden)*

*"Everybody knows Red Cross and it has its reputation although most people think it's only overseas. But it is a good way in. having the red cross name behind does help, it helps people feel more confident about it" (Volunteer)*

### Broad eligibility criteria and free to all in need

BRC place very few limitations on who can be helped. At grass roots level, volunteers report that no other agency provides quite what BRC does – a broad, open and human response:

*"It is reassuring for me that I can refer the patients on to this service – unlike other services it's not means tested and there is no issue with red tape, so it's really the only service that will always support patients straight away" (Referring agency).*

# 3 · UNDERSTANDING THE CHALLENGES AND IMPLICATIONS

In addition to the 'golden threads' identified within the Case Study sites, a number of challenges also came to the fore. In many ways these could form the starting point for the BRC in seeing its way to implementing its priorities for the future, especially as the implications of the data in some areas are relatively far-reaching. On the basis of the information that was gathered during the research and from a meeting of senior managers from across the territory,[1] the following themes emerged as especially significant.

## 3.1 KEY CHALLENGES

### 3.1.1 Service development

There are clear challenges that the current political and economic climate present in terms of the restructuring of commissioning and the attendant funding uncertainties. Understandably there was a considerable degree of uncertainty expressed about the future of funding and the fact that short-term renewals make it hard to plan for service development. Respondents noted that it was often difficult to evidence the benefits of 'care in the home', particularly in terms of cost savings which is often at the forefront of commissioners' minds. Comments were made that BRC is generally poor at recording outcomes even though this is one of the recognised strength of these services, all of which has a negative impact on the ability of services to develop locally. Indeed, there were concerns that the need to secure external funding *may* lead to managers accepting contracts that there is not enough local capacity to deliver.

Participants recognised the imperative to build relationships with local commissioners and understand their agendas, needs and constraints. This process has been aided and facilitated by devolving responsibility to service managers. However recent upheavals in Local Authority/Primary Care Trust structures were reported by all the schemes, which have led to difficulties and delays in engaging with the appropriate commissioning staff. Addressing the changing profile of commissioning includes exploring the implications of an increase in direct commissioning by service users through personal care budgets and the like. The BRC remains firmly committed to the core principle of crisis response which effectively rules out providing long term interventions. A possible role for BRC was identified as facilitating the transition between statutory and private arrangements for care.

Internally there is a perception that health and social care services are the lowest priority for the society. Respondents appreciated that BRC is an emergency response organisation and are not opposed to this being the main focus, but were concerned for the survival of 'care in the home' in the current climate of cutbacks imposed on external funders. In addition, participants reflected candidly on the fact that some newer projects are seen as having a 'looser fit' with BRC's traditional 'core' activities. Whilst this may present interesting opportunities in terms of service development, there are both presentational and organisational implications of this. As such, the society was exhorted to embrace a broader definition of resilience – whether through building stronger communities or protecting people from crisis as a means to resolve the potential dilemma.

[1] A seminar was held on June 9th 2011 with eight senior managers from BRC Wales and Western and UK Office. The purpose of the meeting was to consider all of the evidence gathered in the course of the study, and bring together expertise to inform the implementation of BRC's new strategic direction for health and social care.

Overall, respondents recognised the need to develop the services offered – e.g. by extending operating hours in order to receive weekend/evening referrals as discharge practices change, or by registering with the Care Quality Commission for personal care services. Operational staff and volunteers wanted to be more involved in the development of services, using their knowledge to identify where there is potential to extend BRC's offer by building on extant provision, establishing new partnerships, or embedding programme working.

### 3.1.2 Communication

Amongst respondents, internal communications were perceived as poor, with little contact between areas and territories and, in some areas, between different local BRC services. In its most extreme form these gaps between operational staff and strategic management have lead to difficulties whereby the society's strategic direction has not been communicated effectively. Working well across areas is also hampered by the historical divisions between geographically delimited 'patches', each of which retains control over its own resources, and all too often guards these in a somewhat protective manner. Many of these difficulties would be ameliorated through establishing opportunities for sharing learning through a set of networks and/or forums. The annual conference, for example, was cited as a means through which information could be communicated broadly.

In addition to these internal issues, respondents identified that there is little public awareness of what BRC do in the UK in terms of health and social care. In some ways this has positive benefits (in that services are not inundated and swamped with demands that they cannot meet), but the negative aspects were felt to be much greater. Raising public awareness of the health and social care programme was also seen as very important for future development. The BRC is well known for emergency response but not social care. Re-branding BRC as key player in health and social care whilst managing its reputation and emphasising its humanitarian purpose as its core was agreed as fundamental but it was recognised that this may be rather difficult to achieve.

As an example of this, there was considerable discussion around shared learning. The view that had emerged from the Case Studies was that many staff felt that more could be done to encourage this within the BRC and there is a need to move away from the culture of working in isolated silos. This perspective, although tempered by realism and the constraints of time and resources, was echoed by the mangers. Mentoring, shadowing, forums for sharing good practice, regional and national reference groups and conferences were all suggested. It was agreed that more information could be exchanged at service manager and co-ordinator level but it would be easier to follow up such ideas at territorial rather than national level.

### 3.1.3 Standardisation

Whilst the vast majority of the schemes across the five Case Study sites are broadly consistent in terms of types of care provided and the way volunteers are deployed, standard procedures in terms of record keeping, information systems, and others are all too often not shared between schemes. There is an accompanying wide variation in the amount of time that needs to be spent on volunteer induction (ranging from two hours to two days), as well as more broadly in training staff and volunteers, and in relation to contract reporting to commissioners.

Staff and volunteers indicated that it would be beneficial to develop a standardised BRC 'offer' to which they could 'bolt on' specifics according to the agenda of commissioners and/or local needs and priorities. Respondents also requested that an IT system that is compatible with all the 'care in the home' services across the territory be developed, which would standardise and simplify processes and

could be tailored to different areas. It would also be useful to standardise some paperwork and procedures to bring operational consistency across areas.

Managers noted that given the importance of this brand in winning contracts there is a need to think carefully about the reputational issues that may be thrown up in moving to a position where BRC delivers more services. The risks inherent in expanding the reach and breadth of BRC are those associated with an increase in service delivery which includes the risk of damaging this reputation. As the workforce, voluntary or otherwise, involved in delivering care increases and/or that role expands to include personal care tasks, so does the risk of exposure to poor practice and corresponding damaging coverage in the press or elsewhere. Therefore the complex issue of extending the offer to include personal care (and the implications this has for a volunteer delivered service) needs to be considered carefully. That said, there is widespread support for a standardised, quality assured national offer providing that there is some degree of flexibility in the offer and the opportunity for local discretion.

Overall, getting the right balance between being a national organisation with a standardised health and social care programme and the local care provider is important. The question the BRC needs to ask itself is how far it sees itself as a corporate provider of social care at a local level or a local provider of social care.

### 3.1.4 Volunteers

On the basis of this research, volunteers were very specific about what part of service they wish to work in and as such cross-programme 'multi-disciplinary' volunteers not much in evidence. Key attractions of 'care in the home' services for volunteers centred on the provision of one-to-one support, being able to manage time commitments through a time-limited intervention, delivering very simple forms of care, and receiving quality support from coordinators. Volunteers interviewed for this study universally felt valued by the BRC, and in turn valued the society's reputation. They are very committed to upholding the values and principles of the BRC and feel they bring humanity and compassion to their roles. Volunteers also reserved universal praise for service co-ordinators and service managers, noting that they were well organised, efficient, and caring.

Respondents across the board noted how important it is not to lose sight of the fundamental principle that the BRC is a voluntary movement, and challenged senior managers to strike the right balance between numbers of volunteers and paid staff as BRC evolves. Participants acknowledged that this balance will be different for different services, but generally felt that the society should think about more creative ways to deploy volunteers across the whole programme of activity.

### 3.1.5 Partnership working

It was felt that the BRC needs to be more open and flexible in its approach to working with other agencies. Whilst the society retains considerable expertise in any number of specialist areas, respondents noted that using existing organisations as gatekeepers is the best way to engage with the most vulnerable and hard-to-reach groups. Staff and volunteers at operational level have been very good at local networking and identifying potential for partnership working, and this works needs to be built upon. Particularly, the BRC was charged with being more proactive and less reactive about partnership opportunities, and giving greater consideration to the sustainability of services and the impact on partners and beneficiaries should the society stop providing care and support to a particular group.

The BRC has much to contribute in strategic alliances with other support agencies (private and third sector) not least the organisation's considerable expertise at recruiting and managing volunteers. A note of caution was sounded though about the need for BRC to be aware of potential criticisms of overshadowing smaller, local organisations and to avoid being perceived as threatening. Partnership working must aim at fostering capacity within the third sector rather than building empires. It was acknowledged that BRC may not initially be comfortable to take a supporting rather than leading role, and this will involve adopting a more collaborative way of working than BRC have traditionally employed.

## 3.2 IMPLICATIONS FOR THE 'CARE IN THE HOME' OFFER

In order to understand the implications of the issues above the following sections focus on three areas that are within BRC's gift to remedy and, if resolved, would represent an important step in responding to concerns raised during the study.

### 3.2.1 Better understand the commissioners' perspective

Drawing on the Case Study research – and triangulating those findings with other work in this field – there are perhaps five key dimensions for the society to consider when formulating its approach to implementing their strategic intent.

First, commissioners in health and social care are now increasingly aware of the relevance to them of the concept of **'resilience'** – the ability of individuals/families/carers (and by extension, of communities) to maintain for longer periods their independence of formal services, or to rely on less intensive support from those services. They appreciate the complexity of the concept of resilience, and the multiplicity of factors which enhance or undermine it, but understand that a rich and varied third sector presence is integral to its existence. This provides fertile ground for discussions about new approaches by the BRC, but cautions against the assumption that standardised provision by a limited number of providers is necessarily the best option.

Second, the most effective relationship between the BRC and commissioners is one that is characterised by **'collegial relationships'** – where people naturally work together to solve problems, without regard to their organisational relationships. Such relationships can be built, but they often take many years, and depend upon a high level of strategic, operational and values-based understanding and compatibility between the organisations.

Third, BRC is able to connect with the sort of **'public sector ethos'** which still characterises most commissioners. This is typically expressed in terms of:

- providing a holistic service, which meets all the needs of the individual client;
- meeting needs above the considerations of contract or formal responsibility;
- being flexible in the face of unpredictable circumstances; and
- relentlessly focusing on outcomes rather than inputs or processes.

Fourth, **public confidence** in the provider is a *sine qua non* for most commissioners. Such confidence may depend upon existing brand strength as much as current or recent performance, and by the absence of undesirable association (e.g. 'BRC is better than Social Services because BRC don't take your kids away, like Social Services do'). It is also bolstered – or undermined – on a daily basis by the quality of the basic human interaction between BRC representative and client – whether such people are personable or not.

Finally, success depends upon **credibility**. Each of the above factors may be fatally undermined by a failure to deliver the basic requirements of any service; similarly, community resilience, collegiality, the public service ethos and confidence are also boosted by a strong local track record in delivery of the basics.

### 3.2.2 Share good practice more effectively

The need to share good practice and generally improve internal communication were identified as issues needing attention. During the research, it was evident that operational challenges were being met in different areas but, because the solutions were not shared across boundaries, similar challenges remained unresolved elsewhere. Whilst many of these may at first sight be regarded as local in nature, such as recruiting volunteers, they involve functions often common to all and, therefore, likely to be of wider relevance.

Existing practice should be viewed as a rich base of resources. Better sharing and communication of good practice would not only assist problem solving but would facilitate mutual learning and enable action to follow reflection. As the practice would be evidence based, this process would be grounded in the needs of the organisation and support working together towards agreed and common goals. Therefore, the chances of organisational success would be improved.

Good practice needs to be shared in a systematic way using a variety of communication tools and taking advantage of technology such as video and telephone conferencing to keep costs down. Exploiting BRC's charitable status could give a significant advantage here, and the society should be bolder about approaching organisations for support, for example requesting the use of facilities from local businesses or educational institutions.

### 3.2.3 Engage across the national/territory/local spectrum

Like many major organisations, BRC functions at a variety of different levels – international, national, regional and local – across the spectrum of strategic and operational activities. A stronger alignment of understanding of policy and practice from the national through to local levels and vice versa would provide a number of benefits. It would support the corporate image and reputation of BRC, facilitate stronger links between strategic and operational functions and provide a framework for local discretion.

Greater clarity of the national position on strategic direction would ensure organisational and policy alignment, help local decision making and prevent mismatches of actions. Importantly, accountability would be clarified if a 'line of sight' was obtained through the organisation where aims and objectives were consistently understood and applied by all. The research suggested that a renewed emphasis on achieving this is needed alongside a communication strategy capable of delivering it in practice.

# 4 · CONCLUDING THOUGHTS

Overall, the BRC has three main aims in talking forward this agenda this work:

- To be recognised as a key provider of care in the home support to people in a crisis
- To reach more people who are in a crisis through the provision of an integrated care in the home support package
- To reach people who are more vulnerable in a crisis and, in particular, may find it difficult to access existing care in the home support

In order to deliver against this new strategic direction, two key questions appear to be especially pertinent:

1. In order for BRC to have a greater reach and enhanced quality care in the home offer, what issues does the society need to address and how should it address them?
2. What services should make up the quality assured national offer BRC aspires to?

In order to put these questions, and the study as a whole, in appropriate context the following table represents an attempt at 'horizon scanning' the policy landscape and scoping possible BRC responses.

**Table 2** · Horizon scanning and potential responses

| Policy Directions | Possible Responses | Challenges (among others) |
|---|---|---|
| **More control for individuals**<br>Personalisation, Self Directed Support/Citizen Directed Support, others<br><br>**'Big society'**<br>New role for volunteers, mutuals, co-ops, community resilience and social capital<br><br>**New commissioning and payment arrangements**<br>NHS reforms and professional-led consortia (England), Commission on Funding of Care and Support (Dilnot Commission – July 2011), Regional health and social care integration (Wales)<br><br>**Enhanced role for carers**<br>New legislation (Wales) and greater respect for their role | Develop strategic and operational partnerships (as lead, and as support)<br><br>Act as catalyst for capacity building within voluntary sector<br><br>Be more aggressive in the market and lead consortia<br><br>'Professionalise' the BRC offer e.g. develop a personal care offer among other social care/social services | Working in (equal) partnership with others<br><br>Taking staff and volunteers on the journey<br><br>Allowing the right amount of local flexibility<br><br>Negotiating a new ratio between staff and volunteers<br><br>Keeping up to date with/ leading evolving policy agendas |

Much has happened, both internally and externally, since the original study was commissioned. Many of the comments contained in this report need to be seen in the context of an evolved and evolving position that BRC holds in relation to growing 'care in the home' services. The challenges in delivering against an ambitious target are contained herein, and provide very few surprises. A good number of these issues fall within the remit of the society and something can therefore be done to militate against their worst effects. Other issues (like the funding situation and commissioning arrangements for health services in England) are clearly beyond the gift of the BRC but will, in the fullness of time, be resolved. The BRC needs not only to be prepared for the moment when they are determined, but be more active in helping to shape these agendas in the meantime.

What has been confirmed through this study is the strong and positive position the society holds in the minds of commissioners, staff and volunteers, and beneficiaries. Given this platform, BRC finds itself almost uniquely well-placed to exploit the opportunities that will undoubtedly arise. Working through the identified challenges will move the society considerably closer to where it wants to be.

**Welsh Institute for Health and Social Care**

University of Glamorgan
Glyntaf Campus
Pontypridd
CF37 1DL

www.glam.ac.uk/wihsc
wihsc@glam.ac.uk
01443 483070