Early Impact, Lasting Recovery

12-month Impact Report



Recovery in Community

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Foreword

BEN WHALLEY, GADDUM
ELIZABETH SIMPSON, MANCHESTER MIND

We are one year in, and it has been a busy one; setting up our partnership and the Recovery in Community Service – making sure it is embedded within discharge pathways to enable people to experience a supported, earlier and smoother discharge from hospital.

Funded by NHS Greater Manchester, this service was created to address a practical problem: people who are ready to leave hospital but cannot do so safely or successfully. People were either:

- too far away from home (out of area),
- waiting too long to be discharged and,
- when discharged, often left inpatient settings without enough onward support.

It has taken time, integration and lots of relationship building and we are proud of the way it has gone. Recovery in Community colleagues have demonstrated what is possible when we all work together in a different way – as one integrated system supporting people when, and where, they need to be supported.

Over the last year, we have seen that when we focus on removing the barriers to discharge, we not only support people to leave hospital, we enable them to stay well.

We have also seen the strength of partnership. By working as one team, Gaddum and Manchester Mind have embedded the service within the wider system and Recovery in Community has become part of how discharge happens rather than something in addition to it.

The foundations of our programme are lived experience – understanding and meeting the person where they are, working on a strengths and aspiration-based approach, and employing people with lived and living experience as well.

In the current economic climate every penny of public money must be accounted for, but we also know that all we do must demonstrate the impact it is having on the lives of the people we exist to support.

We therefore released a six-month interim evaluation which set out some key areas of impact. This was shared across the system, and we invited feedback around our performance.

And now we do the same at twelve-months – reflecting on our first year, exploring whether we have achieved all that we set out to do, and identifying the key milestones for year two.

We believe that the work of our skilled and passionate VCSE sector colleagues stands up to scrutiny, and - what's more - makes a compelling argument for the value of truly integrated system working.

So... we invite you to see this report as a moment for reflection and challenge - an opportunity to think more deeply about the pressures within our mental health system and about the choices we can make within it.

Above all, this report is a call to collective action: to work together to better support anyone experiencing mental health challenges, ensuring the best possible outcomes and enabling recovery as close as possible to home, community, and the aspirations of everyone who accesses mental health support.



BEN WHALLEY
CEO GADDUM



ELIZABETH SIMPSON
CEO MANCHESTER MIND

Executive Summary

About Recovery in Community

Recovery in Community supports people to leave inpatient mental health care to build resilience and ultimately stay well in their communities. We do this by working with people at three key stages of their journeys:

1. **People who are in Out of Area Placements (OAPs)**, supporting a planned return to Greater Manchester, ensuring mental health recover closer to home, rebuilding and maintaining community connections.
2. **Those preparing to leave hospital (Clinically Ready / Clinically Optimised for Discharge)**, ensuring social care, practical and other barriers are addressed, ensuring a planned and safe discharge, enabling a quicker and more effective discharge back to community.
3. **People post-discharge**, walking alongside individuals to strengthen their connection back into their communities of geography, identity and interest, managing day-to-day life and building their resilience, reducing the likelihood of readmission.

These priorities are intentionally sequential, reflecting a clear pathway through the system rather than three separate groups. Our immediate focus was on safely reducing Out of Area Placements; as that work progresses, the priority shifted to ensuring timely, well-planned discharge from hospital.

Ultimately, however, this progression will lead to a single shared ambition: that everyone we support is living well in the community. In that sense, the third group is not simply one stage among others - it is the destination.

Our aim is that, over time, this becomes our entire caseload: people supported to remain connected, resilient, and well within their communities, with inpatient care used only when absolutely necessary and for the shortest time possible.

235
people supported



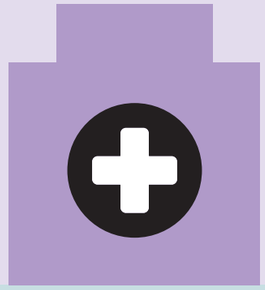
Of those 235 people,

164
people were discharged



51%
reduction in readmissions within 6 months

43
people discharged earlier



1,119
inpatient bed days avoided

82%
reduction in readmissions within 30 days

297%
Return on Investment (based on the base annual £642k service cost)

£2.55m
total system savings based on avoided readmissions and reductions in length of stay in hospital



Specifically in relation to recovering well in the community, people supported by Recovery in the Community service were:

5.7x

more likely to be in the community at 30 days

2x

over twice as likely at 6 months to remain in the community

> "If it wasn't for you, I'd be homeless now. You're good at your job, thank you!"
>
> A person describes how Recovery in Community has supported them.

What this means

When people receive timely, practical and relational support, discharge works differently. People leave hospital sooner, are less likely to return, and are better able to rebuild their lives.

> "This discharge feels different. I'm thinking about my future."
>
> A person describes how Recovery in Community has supported them.

We know that Recovery in Community operates within a wider and very complex system that is made up of the formal and informal community, the VCSE sector and statutory health and social care. It is therefore challenging to isolate any one case and make categorical statements around causation. But, in bringing together one year of data, alongside feedback from people and partners, we believe that Recovery in Community is demonstrating strong and credible outcomes.

Recovery in Community At a glance

4,509

direct interventions for

235

people who accessed the service



94% of people agree with the statement:

"My Recovery in Community worker has helped me access the resources I need in the community to stay well."

1,072

ward visits

698

home visits

1,936

phone calls

1,357

meetings with the person and other care professionals

109

community activities

Community activities...

...for relationship building:

21

cafe & park meet ups
e.g. Oxfam café

Meeting in parks for
'walk and talk'
(e.g. Crumpsall Park)



...for physical health:

3

different gym inductions across Manchester

4

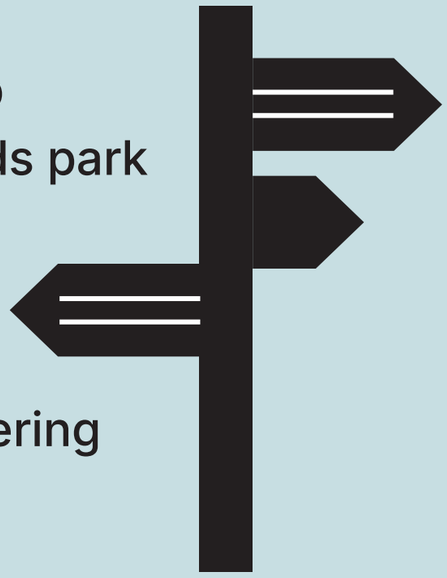
Andy's Man Club

4

Fat Lads Climbing events

...for social connectivity and wellbeing:

- Rainbow surprise lunch club
- Community Day at Platt fields park
- Whitworth Art Gallery
- Imperial War Museum
- Open Mic music events
- Community Garden volunteering
- Churches and Mosques



Travel and connection

18

people received free TfGM bus passes



Income

People need income to live independently:

£14,571

secured in direct payments

£7,714

total amount secured in regular annual payments

Homeless support

27%

of people we work with were homeless at point of referral



35%

of people were supported to find accomodation



79%

reported feeling more confident to stay in their home or placement

Meaningful activity

6 months post discharge

32%

of people were engaged in regular meaningful activity:

↓

20%

accessing leisure/culture or faith services

8%

were in work training or education

4%

were volunteering



Culturally Informed

15

people referred to Reducing Racial Inequalities services

“It had been very helpful having [My Recovery in Community case worker] here for home visits with her also being black, she could relate to aspects of the culture I have been raised and the way that has impacted upon me.

A person describes how Recovery in Community have supported them

Carer-Aware

27

carers identified (both clients and their carers) and referred to carers support

Housing crisis and stabilisation

Tia was homeless following discharge and living in unsafe conditions. She struggled to engage with services and was at risk.

Work focused on crisis support and advocacy. A housing decision was challenged successfully, securing temporary accommodation.

Once housed safely, her wellbeing improved and engagement increased.



Partnership and System Working

Recovery in Community is a partnership between Gaddum and Manchester Mind. Over the year, this has strengthened into a genuinely integrated approach:

Shared values and practice

Strong relationships across the system

One team working across organisations

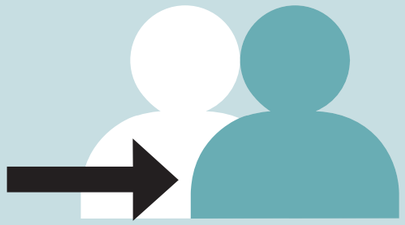
The service is embedded across:

- Wards
- Discharge teams
- Communities
- Community services



This enables:

- Earlier referrals
- Faster problem-solving
- Coordinated discharge



Connection, risk and hope

Andrew had experienced repeated admissions over the years and was facing discharge this time without stable housing. He was also very isolated and at times at significant risk.

First we focused on relationship. Through consistent peer support, Andrew began to feel listened to and engaged more openly. In parallel, practical support was provided to address housing and link him into services.

As trust developed, Andrew began to think differently about his future - expressing interest in education and even becoming a peer support worker himself. He was supported to explore community groups and connections locally.

There were moments of crisis, including suicidal thoughts. During these periods, contact was maintained and safeguarding escalated appropriately. He was also worked with to build his own more positive responses to dealing with crisis or uncertainty.

By the end of support, Andrew was living in the community, more connected, and ready to take his next steps.



Recovery in Community in a bit more detail...

When people stay in hospital for longer than they need to it is detrimental to their health, social connections and recovery. For the system, it also carries an unnecessary and significant financial cost.

Whilst our focus is on people, it has also been about reducing stays in hospital and reducing the risk of people being readmitted, by doing this we are both saving the system money whilst working towards achieving our Greater Manchester Mental Health and Wellbeing Strategy aims that:

- People's quality of life will improve through inclusive, timely access to appropriate high-quality mental health information, support and services.
- People with long-term mental health conditions will live longer and lead fulfilling and healthy lives.

People often stay in hospital because the things they need within their communities are not in place such as:

- Housing
- Employment, benefits, debt and other practical barriers
- Social networks and mental health support

Recovery in Community address these barriers through:

1. **Early engagement** – building trusting relationships
2. **Practical intervention** – acting quickly and solving problems
3. **Relational support** – building confidence and agency
4. **Continuity post-discharge** – reducing the gaps
5. **System integration** – embedding collaboration

We work alongside our NHS colleagues – both in primary and secondary care – and ensure this integrated approach plans appropriate interventions for safe discharge and community resilience.

We contribute to adult social care planning, and act as the conduit between clinical and social care systems to make sure things are joined up.

Team and Workforce

Structure



Peer support

This is a core and valued part of the model.

Peer workers provide:

- Mutual support through a skilled approach that utilises their own lived and living experience
- Relational connection
- Emotional support

Workforce support

Retention has been strong in year one.

Staff receive:

- Supervision and case support
- Clinical supervision
- Training across both organisations
- Peer support

Our Learning

We have continued to learn and refine our approach.
Key learnings include:

1. Start early
– timing changes outcomes

2. Focus on practical barriers
– housing and income drive success

3. Relationships matter
– trust enables engagement. This is true between both clients and Recovery in Community staff, and between Recovery in Community staff and our NHS partners.

4. Partnership is essential
– the system works better together

Trauma-informed and culturally aware support

Ahmed, a refugee, had experienced trauma and multiple admissions.

Initial engagement was difficult, requiring time and trust-building. With consent, his experiences were shared with clinicians to inform care.

Housing issues were resolved and support continued post-discharge, including attendance at appointments and support for family reunification goals.

A culturally informed, trauma-aware approach was key to engagement and recovery.





> “I can never thank you enough. You are just what I have needed for the last twenty years.”
>
> A person describes how Recovery in Community has supported them.

Readmissions

People are not just leaving hospital - they are staying well.

From

6.8%

average readmission rate within 30 days

→ 1.2%

for a Recovery in Community client

From

21.4%

average readmission rate within 6 months

→ 10.5%

for a Recovery in Community client

Supporting earlier discharge

This improves both patient experience and system flow

43

early discharges

1,119

days in-patient beds avoided

Financial impact

This service is having a significant impact

£1.68m

saved (avoided readmissions)

+

£869k

saved (reduced length of stay)

=

£2.55m

total return

297%

Return on Investment (ROI)

What people said about their experience with Recovery in Community:

81%

report improved discharge experience

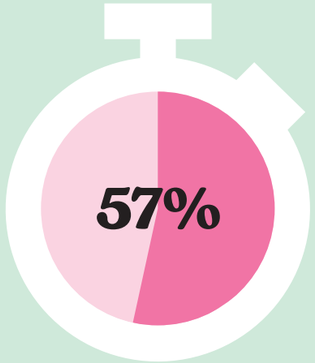
91%

felt their confidence had increased



57%

of people are discharged sooner



79%

felt more able to stay in housing

By 6 months:

32%

of people were in meaningful activity

94%

of people accessed support needed



People told us that Recovery in Community helped them:

- avoid homelessness
- build confidence
- reconnect with others
- begin to plan for the future

Multiple barriers, coordinated support

Mo's discharge was delayed due to a combination of mental health, substance use and housing challenges.

The key was not one intervention, but coordination. Through building trust and working alongside multiple agencies, the team supported access to detox and rehabilitation services, while also addressing practical needs such as identification, food access and housing.

This required sustained advocacy and persistence.

Mo successfully entered detox and then rehabilitation, creating a shift from stagnation to forward movement. Engagement improved and a clearer pathway to recovery emerged.





> “I think I’d still be struggling a lot and possibly be back in hospital.”

A response to the question, ‘If you didn’t access support from Recovery in Community, what would be happening?’

The Future

During the last year we have been exploring and evidencing a different way of working – recognising barriers, supporting across transitions, understanding that support looks different for each individual and understanding the needs of our colleagues within statutory services.

If this is all we can do then it is significant, but we believe this model has potential to impact other areas from physical health, waiting list engagement and ultimately leading to better health across communities.

In the months ahead, we aim to build on our evaluation, by bringing together insights from the following:

1. **One-year follow-ups**

   In our second year of delivery, there are significant opportunities to understand the longer-term impact of Recovery in Community in the lived experience of people who have been discharged from RiC. This will enable us to assess the sustainability of recovery, the durability of discharge outcomes, and the longer-term impact on system flow and cost savings.

   We believe this kind of evaluation would present unique insight into the Recovery in Community approach, and suggest areas for improvement or greater focus into the future. It will also inform what additional and longer-term support people might need.

2. **Learning from readmissions**

   While early data shows a significantly reduced rate of readmission for people supported by the service, understanding the reasons behind those who do return to hospital will be critical, as well as understanding what it is that reduces readmissions.

   By systematically analysing readmissions alongside discharge barriers and case journeys, we can deepen our insight into what enables sustained recovery and where additional intervention is needed.

   This commitment to continuous learning will ensure that the model evolves in response to real-world complexity, strengthening both individual outcomes and wider system effectiveness. It will lean heavily on lived experience insight on a case-by-case basis, and make unique and valuable suggestion that can improve outcomes for those we will support in the future.

3. **Strengthening peer support**

   Peer support has already shown itself to be a powerful element of the Recovery in Community model, helping to build trust, deepen engagement, and support people through the complexities of life post-discharge.

   Looking ahead, there is a clear opportunity to further strengthen this

offer, including the development of ongoing peer support groups to sustain recovery beyond the initial six-month intervention period – building in an approach to strengthen reciprocity and mutuality – two key themes of peer support.

Embedding lived experience more deeply across the pathway will enable people to remain connected, build resilience, and continue their recovery within their communities.

Expansion options

1. **Maintain and refine**

   Maintaining the integrity and impact of the Recovery in Community model will be critical, particularly in a context where funding does not keep pace with inflationary pressures.

   Protecting model fidelity – its relational, trauma-informed and community-connected approach – will remain a priority, even as delivery challenges increase.

   It is encouraging that both NHS Greater Manchester and our NHS delivery partners are recognising the value of the model through increased investment, alongside a growing appetite to invest in additional Recovery in Community modules.

   This provides a strong platform to sustain quality, while continuing to refine delivery based on learning and evidence.

2. **Targeted expansion**

   Future growth will be focused and deliberate, targeting the areas of greatest system pressure and unmet need.

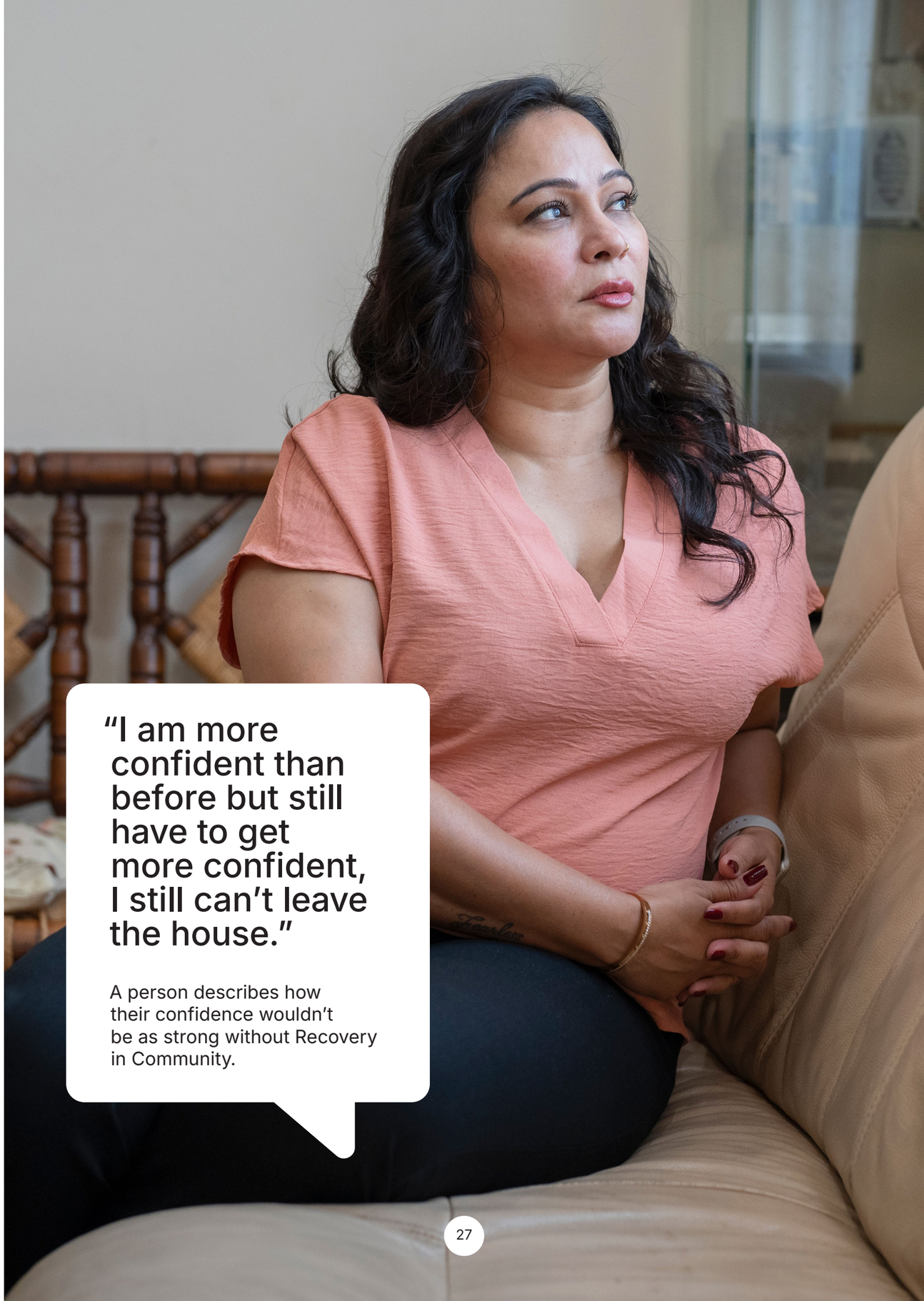
   In particular, there is a clear opportunity to extend the model to address key discharge barriers across health and social care thematics – for example physical health and those experiencing frailty – and where complex social, health and housing needs can delay or prevent timely discharge in any area.

   By applying the Recovery in Community approach to these priority groups, the service can further unlock flow in the system, reduce avoidable delays, and ensure that more people are supported to recover in the most appropriate and least restrictive settings.

3. **Wider system rollout**

   There is a significant opportunity to scale the Recovery in Community model across-and-beyond Greater Manchester. This can happen, but must be done in a way that reflects the strengths of the model itself: modular, adaptable, and rooted in partnership.

   Expansion should build on, and work alongside, existing local community assets – enhancing rather than duplicating provision. By taking a place-based approach and co-designing and delivering in partnership with local organisations, the model can retain its authenticity and effectiveness while supporting wider system resilience and transformation at scale.



> “I am more confident than before but still have to get more confident, I still can’t leave the house.”

A person describes how their confidence wouldn’t be as strong without Recovery in Community.

In conclusion...

Over the past year, Recovery in Community has shown what is possible when we place people, relationships and practical action at the centre of our system.

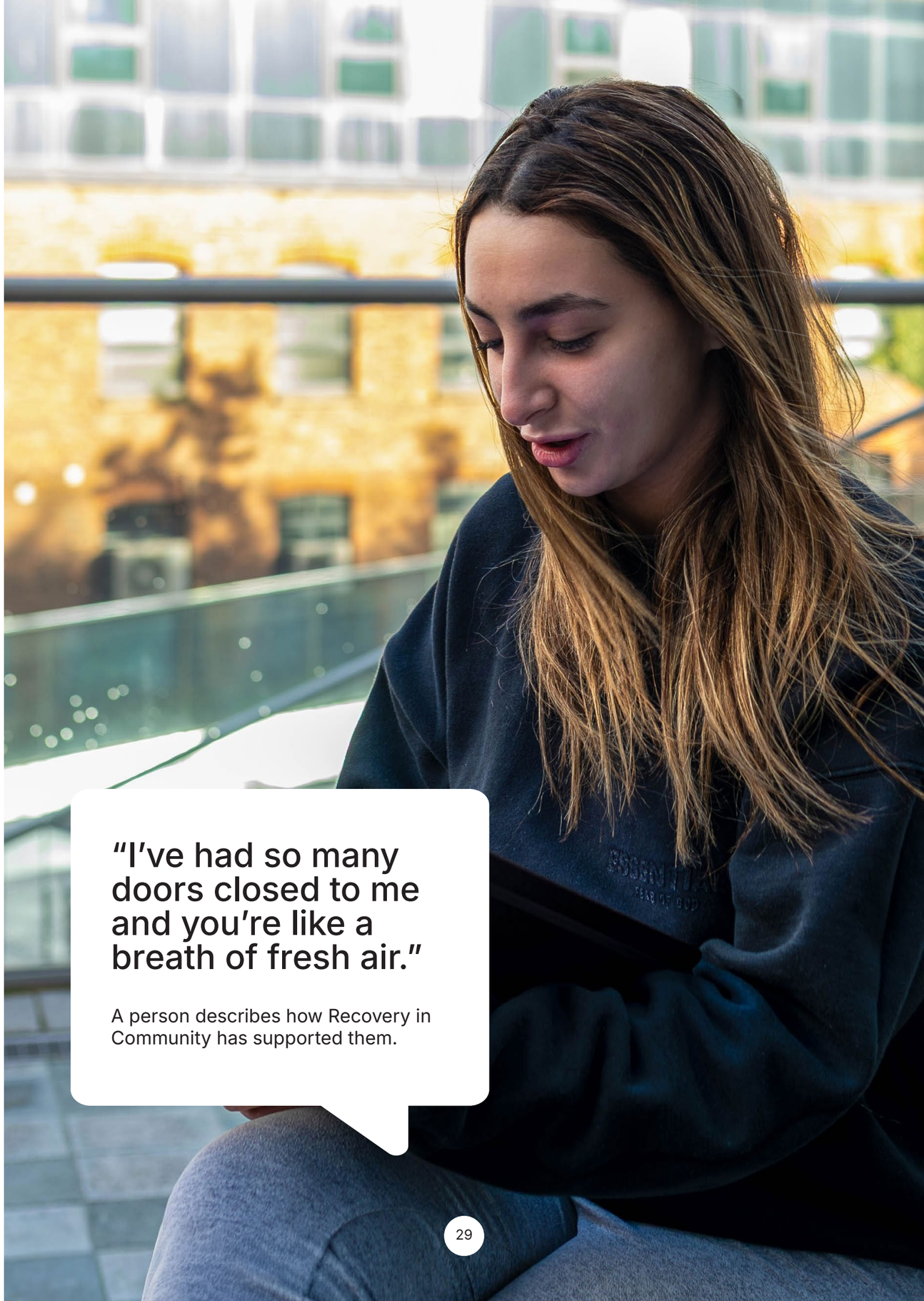
Behind every number in this report is a person who has left hospital sooner, felt more connected, and begun to see a different future for themselves.

This is not simply about flow through the system; it is about people reclaiming their lives, rebuilding confidence, and sustaining recovery in the places that matter most to them.

The impact we are seeing is significant and credible. Fewer people are being readmitted, more people are remaining in their communities, and the system is working more effectively as a result. Crucially, this has been achieved through partnership - across organisations, across sectors, and with people themselves.

But this is only the beginning. The challenges within our system remain, and the need for approaches like this has never been greater. This report is therefore both a point of reflection and a call to action: to sustain, to strengthen, and to scale what works.

If we continue to invest in this model, and in each other, we can ensure that more people leave hospital well – and stay well, in their communities in which they belong.



> “I’ve had so many doors closed to me and you’re like a breath of fresh air.”
>
> A person describes how Recovery in Community has supported them.

Qualitative feedback

We also ask the people that access our service
“If you didn’t access support from Recovery in Community, what would be happening?”

People said they would be back in hospital or still in hospital:

“I think I’d still be struggling a lot and possibly be back in hospital.”

“I would be concerned about my discharge plan and facing further delays.”

“I would have regular hospital visits.”

“I would have faced further delays to my discharge and had to be in an environment that was not good for me.”

“I also would not of gone to the doctors and addressed the problems I had.”



People said they would have been involved with the police:

“I would be struggling more. It takes away stress when you both (case worker and peer support worker) help me. If I had the stressful situations without you there I think something bad would happen maybe the police would come as I don’t understand what is happening and lose my temper.”

“If you hadn’t been here, I would have probably hurt someone and been Section 136’d.”

People said they would be homeless:

“If it wasn’t for you, I’d be homeless now. You’re good at your job, thank you!”

People spoke about how their confidence wouldn’t be as strong:

“I am more confident than before but still have to get more confident, I still can’t leave the house.”

“I would be less confident”

People said their mental health would be poorer:

“I would be in horrible state.”

“I would feel worse in my mental health and not as stable.”

“I would be struggling and I would still be in a bad mental health state and not going out or enjoying myself.”

People said their needs would not be met by other services or be culturally appropriate:

“It had been very helpful having [My Recovery in Community case worker] here for home visits with her also being black, she could relate to aspects of the culture I have been raised and the way that has impacted upon me. Talking to her been easy. She listens and empathises well. It has been excellent to have her support in addition to my care coordinator.”

“I would have been hassled by my care co.”

“Time would have passed but nothing would have moved forward. I have used RiC as a checkpoint to manage goals and recovery.”



Appendix

Internal case data
Partner data
Outcome measures
Service user feedback
Partner feedback
Financial assumptions

1. Internal case data

a. Number of cases and location of referrals

Location At Time Of Referral	Total	%
At Home	**1%**	**0.4%**
Acorn, North View	25	10.4%
Blake, Laureate House	3	1.3%
Bronte, Laureate House	12	5.0%
Clover, North View	17	7.1%
Forest, North View	17	7.1%
Meadow, North View	23	9.6%
Spring, North View	41	17.1%
Vale, North View	30	12.5%
Total Manchester Mental Health Beds	**168**	**70.0%**
Other NHS ward in Greater Manchester	20	8.3%
Other NHS ward in Manchester	1	0.4%
Total Other Manchester Beds	**21**	**8.8%**
Independent Sector - Cheadle Royal Priory	22	9.2%
Independent Sector - Other in GM	16	6.7%
Out of Area Placement - Outside of GM	12	5.0%
Total OAPS/Independent Sector	**50**	**20.8%**
Total	**235**	

b. Our readmission rate (30 days)

No of people discharged more than 30 days ago as of 30/04/2026:	164
Of those, no. readmitted within 30 days:	2
RiC 30 day readmission rate:	1.22%

c. Our readmission rate (6 months)

No of people discharged more than 6 months ago a of 30/04/26:	105
Of those, no. readmitted within 6 months:	11
RiC 6 month readmission rate	10.48%

d. Reducing Length of Stay

No of people who were discharged before their Expected Discharge Date:	43
Total number of days of admission reduced: (Sum of all days of earlier discharge)	1119

2. Partner data

a. Comparative readmission rates

We calculated the 30-day readmission rate based on the average rate of the Manchester readmission rate in the first 6 months of 2025. This data was provided by the Greater Manchester Health and Social Care Partnership Manchester Locality Lead commissioner in January 2025.

We have been unable to obtain Manchester data for readmissions at 6 months so we have used a national average of 21.4% from University of Cambridge study: Readmission after discharge from acute mental healthcare among 231 988 people in England: cohort study exploring predictors of readmission including availability of acute day units in local areas | BJPsych Open | Cambridge Core.

Proportion of Discharges Re-admitted Within 30 Days:					
Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
3.9%	10.9%	7.8%	3.8%	6.1%	7.8%

b. Average Length of Stay in Manchester

Average Length of Stay in Manchester is calculated at 104.8 days. This was provided by the Greater Manchester Health and Social Care Partnership Manchester Locality Lead commissioner in January 2025. This figure is lower than the average Length of Stay for a Recovery in Community client as it includes very short admissions including section 2 (assessment order) admissions which are not commonly referred into Recovery in Community.

3. Outcome measures

a. Reduction in readmissions

	Average for all people: (Per Appendix 1b)	**Average for people who access Recovery in Community:**	**Reduction in readmissions for people who access Recovery in Community:**
Readmission rate at 30 days	6.8%	1.2%	82% reduction
Readmission rate at 6 months	21.4%	10.5%	51% reduction

b. Housing & Welfare Rights Outcomes

Recovery in Community also provides a Housing & Welfare Rights Advice function, we supported 37 people with 85 housing and/or benefits issues.

- 33 people supported with housing issues
- 4 people supported with debt
- 25 people supported with benefits

Through welfare rights advice and intervention, we secured £14,571 in one-off payments and £7,714 per annum of regular ongoing payments.

c. Engagement in Meaningful Activity

At 6 months post discharge, 32% of people were engaged in regular meaningful activity:

- 20% of people were accessing leisure/ culture of faith services on a weekly basis
- 8% of people were in work training or education
- 4% of people were volunteering

4. Service user feedback

At the end of our time together, we ask people how we supported them to leave hospital, stay well in the community and stay in their accommodation. Below outlines the number percentage of people who ‘Strongly Agree’ or ‘Agree’ with the following statements:

Theme and Statements:	**% who agree or strongly agree**
Theme: Leaving Hospital	
“My Recovery in Community worker improved my experience of being discharged from hospital”	81%
“My Recovery in Community worker helped me be discharged from hospital sooner”	57%
Theme: Staying well in the community	
“My Recovery in Community worker has helped me access the resources I need in the community to stay well”	94%
“The care and treatment I received has been agreed in partnership with me with support from my Recovery in Community worker”	95%
“My Recovery in Community worker has helped me feel more confident that I can access the help I need from primary, secondary and community care”	91%
Theme: Staying in their housing or accommodation	
“Because of Recovery in Community I am feeling more confident that I can stay at home or in my placement”	79%
“The Recovery in Community team helped me access housing/ accommodation”	35%

5. Partner feedback

We have built strong, kind relationships with our partners in NHS and wider services. Here is some feedback we've received in their own words:

"I just wanted to say a massive thanks as your support is invaluable at resolving this situation and actually working the logistics out."

– Detective Inspector, Stockport, GMP

"The RiC team have been invaluable in helping us get the independent Sector discharges."

– Service Manager, North-West Bed Bureau and OAP

"Thank you it's been so helpful and made such a difference, it is invaluable.

You bring something different to what we can bring."

– Associate Director of Operations, GMMH

"This is great news. You have done an amazing job here."

– Samantha Barrow, Director of Clinical Services, Priory Healthcare

"I've heard great things from patients about the support that the RiC Team provides. A good discharge plan should include housing support, the CMHT and the RiC Team."

– Speciality Doctor



"I would be struggling and I would still be in a bad mental health state and not going out or enjoying myself."

A response to the question, "What would have happened if you didn't have Recovery in Community?"



"I would have faced further delays to my discharge and had to be in an environment that was not good for me."

A response to the question, "What would have happened if you didn't have Recovery in Community?"

Financial assumptions

1. Cost per bed per day

We calculated the cost of a mental health inpatient bed per night based on the average costs of the following providers for acute mental health beds per day.

This data was provided by the Greater Manchester Health and Social Care Partnership Manchester Locality Lead commissioner in January 2025.

Site:	Cost per bed per night
Priory acute	£749
Cygnet acute	£804
Elysium acute	£778
Sum of acute beds costings:	**£2,331**
Average of acute beds cost per night:	**£777**

2. Reduction in readmissions

We calculated readmission rates for people accessing our service as follows:

No of people discharged more than 30 days ago as of 30/04/26:	164
Of those, no. readmitted within 30 days:	2
RiC 30-day readmission rate (2/164):	1.22%
Manchester average 30 days readmission rate:	6.8%
Project readmissions based on Manchester average (164*6.8%)	11.1
Effective no. of people avoiding re admissions (11-2)	9
No of days of admission avoided (based on average LoS)	959
Cost savings of these avoided admissions	**£745,243.70**

No of people discharged more than 6 months as of 30/04/26:	105
Of those, no. readmitted within 6 months:	11
RiC 6 month readmission rate (11/105)	10.48%
National average 6 month readmission rate:	21.4%
Projected readmissions based on national average (105*21.4%)	22.5
Effective no. of people avoiding re admissions (22.5-11)	11.5
No of days of admission avoided (based on average Los)	1,202
Cost savings of these avoided admissions	**£933,997.51**

3. Reduction in length of stay

We totalled the number of days of avoided stay in hospital by comparing expected discharge date and actual discharge date. We then multiplied by this total by the average cost of a bed (See Appendix 1) to calculate savings.

Whilst 43 people left hospital sooner than their Expected Discharge Date, an additional 91 people reported that RiC helped them leave hospital sooner than they would have otherwise.

No. of inpatient days reduced	1,119
Average cost per day	£777
Total	**£869,463**

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