WHITE PAPER

A BLUEPRINT FOR TRANSFORMATION OF HEALTH & CARE IN THE COMMUNITY

From Theory to Action: Part 1 – Proactive Health in Care Homes

March 2025

Care City is an innovation centre for healthy ageing and regeneration. Their work focuses on delivering health and social care transformation of local benefit and national significance. Care City uses innovation both to improve health and care outcomes and to open new routes for local people into and through health and care careers.

Kent County Council is the local authority for the county of Kent in the southeast of England, responsible for delivering a wide range of public services, including healthcare and education.

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Feebris is a virtual care company trusted by 200+ healthcare and social care providers to seamlessly extend hospital-grade monitoring and triage into the homes of the most complex patients, wherever they live. Feebris' technology delivers transformation across the care continuum, from proactive health management of high-risk patients to admission avoidance and hospital-at-home programmes for high acuity care.

Contents

Key messages

Healthcare systems worldwide are under unprecedented strain, facing growing demands from an aging population and scarce resources. Financial constraints, workforce shortages and a shifting burden of disease are some of the key factors reshaping the way we approach delivery of care, prompting a fundamental shift – from the traditional hospital-centred model to a community-first approach. In England alone, projections show that by 2040, **1 in 5 people will live with at least one major illness** - a 37% rise since 2019 (Health Foundation, 2023). These changes will put increasing pressure on public services, demanding bold solutions to ensure equitable and sustainable care for all.

Care homes represent a microcosm of these challenges, given the growing complexity of residents' health needs, chronic staff pressures and counter-productive incentive models. Nevertheless, the sector holds **immense potential for meaningful transformation**, paving the way for truly integrated, sustainable care delivery for the frailest members of society.

We propose an **Integrated Model of Care** for health and care services that can meet the needs of frail older adults and ensure sustainability of services. Underpinned by digital technology, data and appropriate financial incentives, the model has three core pillars which we illustrate using care homes as an example: **(1) Proactive Health in Care Homes; (2) Co-ordinated and Multi-Professional Services for Care Home Residents; (3) Hospital-Grade Care in Care Homes**.

This multi-part white paper aims to provide a practical blueprint for embedding the three pillars of the model, using real-world evidence and insights from different parts of the UK. Combined, the different parts will form **a cohesive blueprint for delivering sustainable health and care services for the frail members of society**. We begin with Pillar 1 – Proactive Health in the Care Home.

To put **theory into practice**, we take a look at a transformation initiative in Kent & Medway, led by Kent City Council, where care staff in care homes are **equipped with digital technology** (virtual care platform, Feebris) and **change-management support** (inc. CPD-accredited training and service integration support) to identify health issues early and escalate health issues effectively.

The intervention illustrates how integrated workflows bridging care and healthcare can power proactive management of complex needs. With **digital technology acting as the connective tissue between services**, the process of identifying, assessing and escalating health concerns to the appropriate clinical services can be streamlined. This can in turn dramatically **reduce service inefficiencies**.

The Kent & Medway initiative led to both **effective adoption of proactive workflows** and **significant impact on the sustainability of services**.

- **Workflows evolution**: 75% care homes delivered regular health assessments for their residents
- **Improved care staff confidence**: 50% fewer care homes who over-escalate to emergency services
- **Streamlined escalation**: 43% fewer urgent/emergency care escalations ("Hear & Treat" calls).
- **Sustainable Care Service Resourcing**: 8X fewer care homes experiencing high volatility in care needs (improving predictability of staffing needs).
- **Reduced Pressure on Health Services**: 73% fewer care homes experiencing frequent conveyances to hospital and 20% fewer non-elective hospital admissions
- **Savings**: cost reduction of **£527,000 per 1,000 residents per year**.

Scaled across an ICS (e.g. Kent and Medway), the impact is projected to amount to at least **£14.2m in savings for the local health system** driven by reduced utilisation of ambulance services and non-elective hospital admissions.

Scaled across the UK, the impact is projected to amount to at least **£366.4m in savings**.

To further boost this transformation at scale, this white paper recommends **evolving incentive framework for social care**, by introducing a Quality and Outcomes Framework similar to that in primary care. This would incentivise evidence-based practices that reduce pressure on health services, aligning their financial motivations with broader national health objectives. Coupled with this, the paper also recommends **developing the care workforce with the skills** essential to adopt more integrated workflows at scale.

Data-driven technology can provide the **real-time evidence** to: (1) enable the effective evolution of financial flows, linking outputs to financial rewards; (2) the transparent approach to assessing proficiency of the workforce against integrated workflows, with clear expectations of responsibility and accountability.

In times of tremendous system pressures, we believe local initiatives, such as the one described in Kent & Medway, provide a unique opportunity to spearhead a blueprint for sustainable change that can be scaled nationally.

We Need to Talk about Ageing

"The true measure of any society can be found in how it treats its most vulnerable members."

Mahatma Gandhi

As the global population ages at unprecedented rates, societies are faced with the challenge of redefining how we care for those with the greatest care needs, under the pressures of our workforce shortages and national budget constraints. High-income countries are facing particularly high rates of chronic conditions, requiring a shift from hospital-based care to community support. Japan's model, which funds preventive and long-term care through national insurance, is recognised for helping older adults manage health conditions at home. Similar approaches across Europe underscore a global shift toward policies that emphasise sustainable, community-centred eldercare to meet these expanding needs effectively.

By 2040, it is expected that around 9.1 million adults in England— roughly 1 in 5 —will be living with at least one major illness, a 37% rise from 2019 (Health Foundation, 2023). Much of this increase is attributed to the ageing baby boomer population and prolonged life expectancies. This trend is expected to place new pressures on the healthcare and care workforce, especially when the working-age population is expected to grow at a much slower rate (4% - Office for National Statistics, ONS, 2022).

Care & Nursing Homes

A microcosm of challenges and opportunities for a new ageing model of care. On the one hand, increasingly complex health needs, chronic workforce pressures and ineffective funding models. On the other hand, opportunity to embed integrated care workflows that meet the complex needs of our most frail people sustainably.

Pathway	Challenges	Opportunities
1 Resident develops health issue	**Greater Health Needs** **37%** More people living with >1 major illness by 2040	**Embed Proactive Care** **30%** Health events (e.g. falls) preventable proactively
2 Care staff identifies health issue	**Care Workforce Shortages** **24%** Care staff turnover, 480k staff gap by 2035 (+30%)	**Boost Retention with PD** **28%** Greater carer retention with development
3 Care staff escalates to health system	**GP Workforce Shortages** **20%** GP positions that remain unfilled	**Streamline Escalation** **63%** Increased capacity via streamlined workflows
4 Resident conveyed to A&E	**A&E over Capacity** **58%** Patients at A&E seen within target 4-hour	**Improve Community Triage** **42%** A&E conveyances from care homes avoidable
5 Resident admitted into hospital	**Hospital Bed Shortages** **30%** Hospital beds filled with patients fit for discharge	**Enable Community Acute Care** **41%** Admissions from care homes avoidable
6 Resident discharged from hospital	**Long-term Deconditioning** **55%** Patients with increased care needs post admission	**Alternative to Admission** **82%** Hospital-related functional decline avoidable

Challenge & Opportunity 1: Workforce Shortages, Retention & Development

If we were to address the demands of our ageing populations with our current service models, significant workforce expansion would be required across the health and social care sectors. By 2035, it is expected that an additional 480,000 staff will be needed in social care (~30% increase on today's workforce), alongside 3,000 more GPs and 9,000 additional community nurses by 2026/27 (Skills for Care, 2024; NHS Long Term Plan, 2019). To meet future care needs, social care spending would need to increase by £14.6bn by 2032/33, a 5.1% real terms increase per year (Health Foundation, 2023).

Yet, recruiting and retaining staff in social care is already a challenge (24.4% turnover rate), especially among younger people, with a 44.6% turnover rate among care workers aged under 25 (Skills for Care, 2024). On the surface, this could be attributed to low pay. Even before the most recent cost-of-living crisis, 1 in 5 care workers was living in poverty, compared to 1 in 8 of all workers (Health Foundation, 2022).In 2019/20, entry-level posts in supermarkets were better paid than many care workers, which was in reverse in 2012/13 (Bottery, 2022).

A closer look suggests that investing in learning and development is also essential for retention, with data suggesting up to 28% boost to retention for care staff who receive professional development support and qualifications (Skills for Care, 2024).

Challenge & Opportunity 2: Complex Health Needs and Avoidable Health Events

Ambulatory-care sensitive conditions (ACSCs) are conditions for which effective management and treatment should limit the need for emergency admissions to hospital. ACSCs are more prevalent among older adults, especially those living with complex co-morbidities. The most common ACSCs include pneumonia, urinary tract infection, asthma, diabetes, chronic obstructive pulmonary disease, hypertension, heart failure and anaemia (Nuffield Trust, 2024; NHS England, 2024). In a system at capacity, such as the NHS, these admissions exacerbate pressure on the elective backlog. The consequences of a hospital admission from conditions such as ACSCs often exceed the admission itself, with 55% of patients experiencing increased care needs post discharge (Kortebein et al., 2008).

Care home residents[1] typically experience multiple long-term conditions and frailty, making them more vulnerable to frequent exacerbations and acute infections (British Geriatrics Society, BGS, 2016). On average, residents visit A&E 0.98 times and are admitted as an emergency 0.70 times annually, often for ACSCs (Health Foundation,

[1] Care home residents is used throughout this document to refer to residents of all types of care facilities, including residential homes and nursing homes.

2019). A single hospital admission can pose significant risks, including high rates of hospital-acquired infections, increased confusion and stress, falls and an overall risk of deconditioning.

However, a lot of these events are entirely avoidable: 30% of health events are avoidable with proactive care; 42% of A&E visits and 41% of hospital admissions are avoidable through early intervention; and 82% of functional decline is avoidable with community-based care (Health Foundation, 2019; Sourdet et al., 2015).

Challenge & Opportunity 3: Misaligned Financial Incentives

Over the last decade, although both demand for and spending on social care have increased, fewer people are receiving support (The King's Fund, 2024). Whilst more funding will help the sector, the structure of that funding is key to ensuring alignment with ageing trends and maximising impact on services.

The care sector is highly fragmented, with 80% of care homes being single-home providers. Many providers lack the economies of scale or financial resilience to invest in improvements, such as digital technology and training programmes, which are crucial to evolving the sector to meet the needs of our ageing population (LaingBuisson, 2023). Additionally, current funding models fail to provide sufficient incentives to invest in programmes designed to prioritise proactive care and reduce reliance on healthcare services.

Yet, initiatives focused on early detection of deterioration have been shown to improve outcomes for residents by preventing hospital admissions and reducing the risk of deconditioning (The King's Fund, 2021). Guidance issued by NHS England in 2023 emphasises the unique opportunity Integrated Care Boards (ICBs) have in aligning providers behind the delivery of personalised and co-ordinated multi-professional support and interventions for people living with complex needs and frailty (NHS England, 2023). In addition to setting strategic programme agendas, ICBs can ensure funding streams incentivise the right care co-ordination between social care and healthcare providers.

The Theory of Change

Extensive research has long highlighted the need to improve care models for ageing populations, emphasising the importance of enhancing quality of care and prioritising better integration between health and social care. For instance, the British Geriatrics Society has put forward a range of recommendations to strengthen healthcare delivery in care homes, focusing on areas such as multidisciplinary collaboration, proactive management of residents' health and tailored training for care staff to address the complex needs of older adults (BGS, 2016). Additionally, The King's Fund has outlined a range of changes required to make community healthcare at scale a reality, including directing future funding growth towards community health and care services and greater focus on operational integration at service level rather than organisational integration (The King's Fund, 2024-b).

Building upon this body of evidence and thought leadership, we have identified three pillars of transformation that are critical for delivering an **Integrated Care Model for frail older adults**. Using care homes as an example, we articulate the role of each pillar and the role digital technology and financial incentives must play in enabling the transformation of the care model.

An Integrated Care Model

Transforming the model of care in care and nursing homes to effectively meet the needs of ageing populations by evolving three key pillars of care delivery, leveraging digital technology, data and appropriate financial incentives as enablers.

Fundamental pillars of the integrated care model

1. **Proactive Health in Care Homes:** Equipping care staff with the skills and tools to proactively identify health issues, avoiding exacerbations of ill health by facilitating timely intervention from the right health services.
2. **Co-ordinated and Multi-Professional Services for Care Home Residents:** Enabling care co-ordination across multi-disciplinary teams, through connected digital infrastructure and joined-up services, to deliver person-centred care for people living with complex needs.
3. **Hospital-Grade Care in Care Homes:** Ensuring people receive the right care in the right for them place, including hospital-grade healthcare in their place of residence, minimising hospital admissions unless in the best interests of the individual.

Critical enablers of the integrated care model

- **Digital Technology and Data:** Digital and data-driven technologies are the connective tissue of this transformation, augmenting the workforce to ensure standardisation and effectiveness, and generating the right data to unlock evidence-based decision-making across the system.
- **Financial Incentives**: For this evolution in services to be possible, the financial incentives for the care sector need to change. This includes both direct financing of clinical services (e.g. for hospital-at-home nursing workforce in care homes, as advocated by the BGS, 2021) as well as novel outcome-based incentive models, as advocated for in the Hewitt Review (2023) and further discussed by the NHS Confederation as a route to incentivising alternatives to hospital admissions (NHS Confederation, 2024).

There have been several projects aiming to show that by improving different components of the care model, such as strengthening the role of MDTs and augmenting carers with digital technology, we can enable reductions in hospital admissions (Health Foundation, 2019-b; The King's Fund, 2021). However, the evidence base for how we transform the care model in a way that is sustainable for both care and health providers remains sparse.

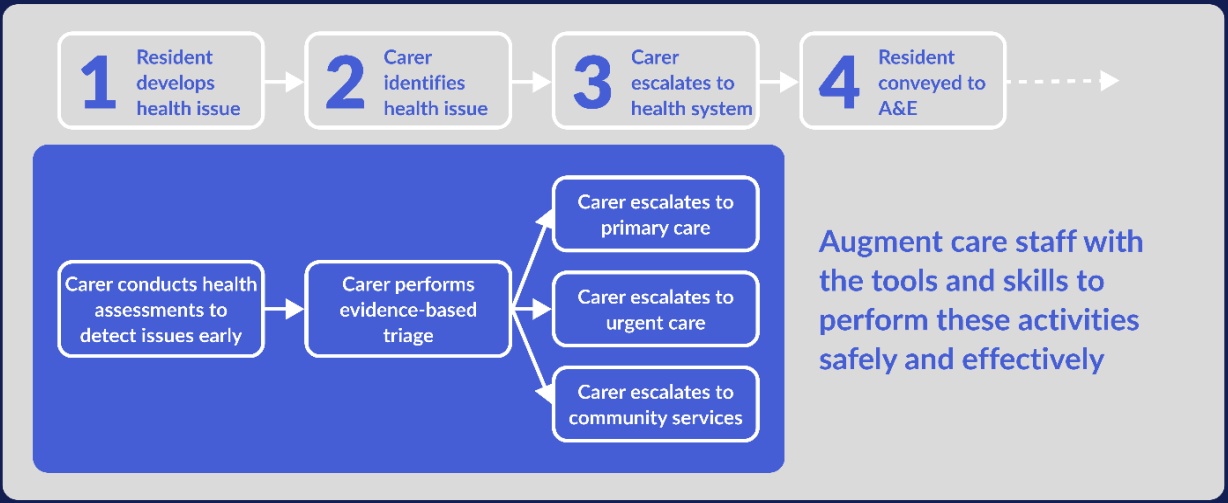
This multi-part white paper aims to provide a practical blueprint for embedding the three pillars of the model, using real-world evidence and insights from different parts of the UK. Combined, the different parts will form a cohesive blueprint for delivering sustainable health and care services for the frail members of society. We begin with Pillar 1 – Proactive Health in the Care Home.

From Theory to Practice

Pillar 1: Proactive Health in Care Homes

In this chapter, we provide a deep dive into opportunities to equip care staff with the skills and tools to proactively identify health issues, avoiding exacerbations of ill health by facilitating timely intervention from the right health services. Figure 1 provides a top-level pathway overview.

Figure 1. Overview of pathway evolution.

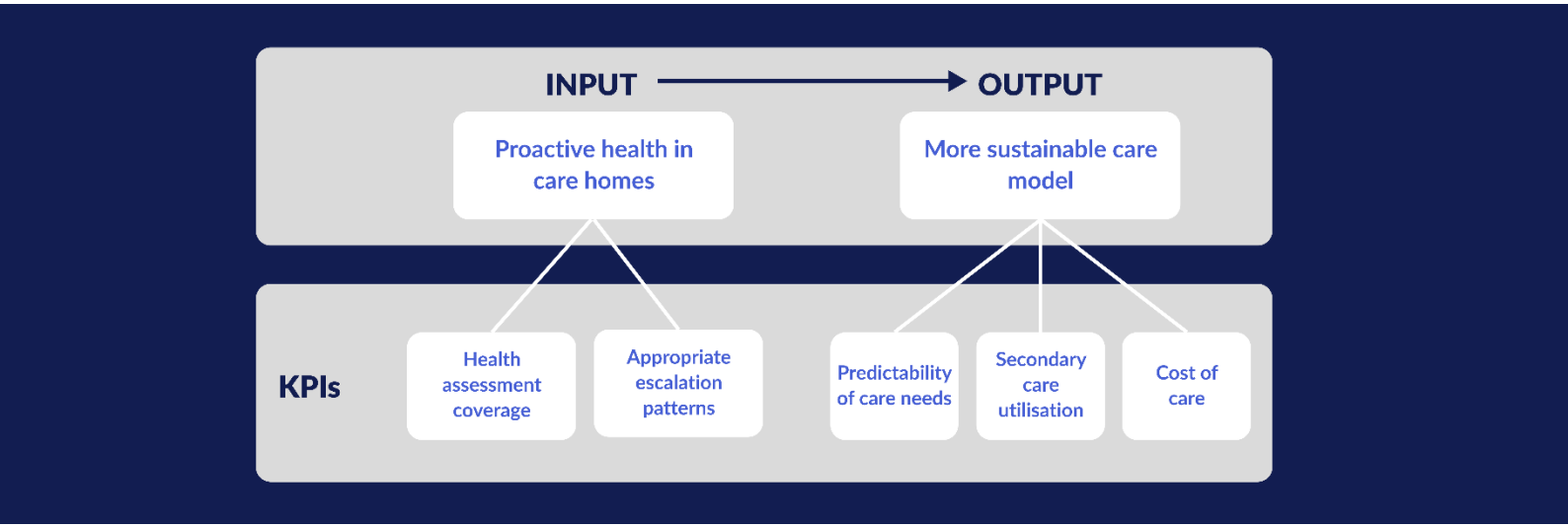


To put theory into practice, we take a look at a transformation initiative in Kent & Medway. Spearheaded by Kent City Council (KCC), the initiative equips care staff in care homes with **digital technology** ((virtual care platform, Feebris) and **change-management support** (inc. CPD-accredited training and service integration support) to identify health issues early and escalate health issues effectively. The approach aims to improve health outcome, while alleviating pressure on the care and healthcare workforce associated with emergencies.

When evaluating the impact of such initiatives, it is critical to have a clear impact map (Figure 2), with KPIs that can be measured using qualitative and quantitative methods, and outputs that align with the sustainability of services.

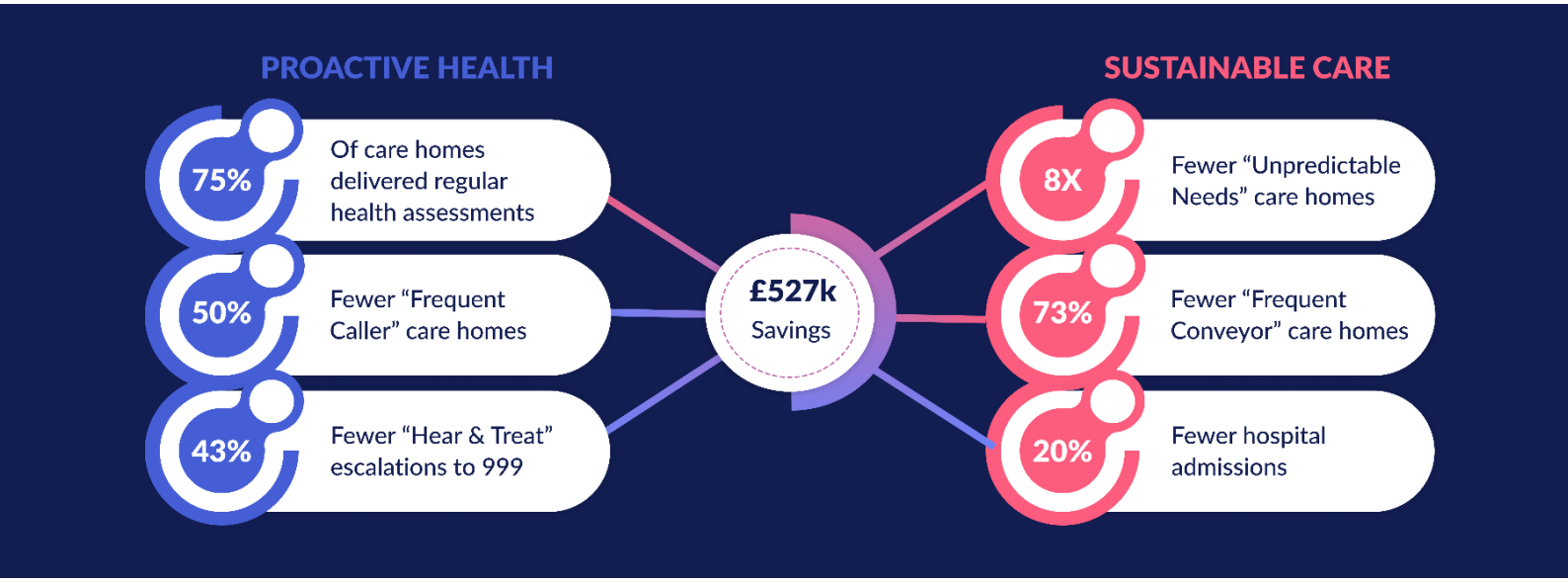
The implementation details of the initiative can be found in Appendix 1 (available upon request; please email impact@feebris.com) and the methodology of collecting and processing data for impact assessment (involving 1,000 residents across 24 care homes between September 2023 and August 2024) is described in Appendix 2 (available upon request; please email impact@feebris.com).

Figure 2. Measuring what matters – an impact map for evaluating changes in the health and care model.



1. Delivering Proactive Health in Care Homes

A total of 90 carers received CPD-accredited training in using digital health tools to be able to deliver evidence-based health assessments and follow a structured protocol of escalating concerns.



a) Adoption of Proactive Workflows: 75% of Care Homes Deliver Proactive Care.

Care homes reported the technology helped them to spot illnesses in residents that were otherwise not appearing to be sick or displaying any symptoms. In routine check-ups, one care home discovered that a resident had low oxygen levels, indicating that they were suffering from a silent chest infection – the most common ambulatory care

sensitive condition, leading to avoidable hospital admissions. They were then able to treat it in the home with support from the GP.

"The technology has had a positive effect on our home and our residents. It gives the staff extra reassurance that the people within our care are ok, as it will flag up any causes for concerns which we can act on immediately to get medical attention. It has also reduced hospital admissions and the need to call emergency services, which in turn reduces the pressure on these services as we are able to manage any health concerns ourselves with the local GP and community service available to us. We also have a record that we can look back on if a resident becomes unwell to see if there is noticeable pattern to the onset symptoms being using the dashboard." - ***Care Home Manager***

"We found that we were doing routine checks and noticing issues that we weren't aware of before. We found out that one lady had high blood pressure and contacted the GP to conduct tests. She was then put on medication. We've been monitoring her BP ever since and she's actually had a reduction in the amount of medication given recently because it's under control now. Normally, for that person, we wouldn't have been checking their blood pressure." - ***Care Home Manager***

b) Care Staff Confidence: 50% Fewer "Frequent Caller" Homes.

Staff highlighted the programme's ability to support with increasingly complex responsibilities, particularly in aiding care staff without a clinical background. The digital platform integrates RESTORE2, offering actionable recommendations to guide effective decision-making. Through timely intervention, this can enhance quality of care while boosting carer confidence.

"It [the system] tells you whether it needs GP opinion or not and it recommends an action to you. Care home staff are not nurses and they are expected to do a lot more than they were years ago and don't necessarily have the knowledge to interpret blood pressure or things like that. It's good to have the Feebris [system] because it tells you what the recommended action is." – ***Care Home Manager***

c) Inappropriate Escalations: 42.8% Fewer "Hear & Treat" Escalations to 999.

The programme highlighted the critical role of clear escalation pathways in ensuring care home residents receive timely and appropriate care while reducing unnecessary pressure on emergency services.

"Once you conduct the observations, it [the system] guides you as to what you're supposed to be doing, whether you're supposed to be phoning 111 or others. And it's very helpful because sometimes you just don't know, should I or should I not, and this tells you what to do. If you're on our own, it's really good because it's like someone is sitting there advising you." – ***Carer***

2. Improving Sustainability of Care

The intervention reduced costs by £526,530 over 12 months, saved 860 bed days and delivered 5.2X ROI.

a) **Predictability of Care Needs: 8X Reduction in the Number of Care Homes Experiencing High Volatility in Care Needs.**

The intervention cohort included 8 "unpredictable needs" care homes, i.e. care homes that have high variability in the number of conveyances, reducing to just 1 home during the intervention period.

"*For the residents that are admitted to hospital, 9 times out of 10 they'll go to a nursing home rather than come back here. It has a big financial impact on us, and a big impact on staffing. We end up not having enough residents so we then have to adjust and reduce the staff count. We're losing money at the moment. We've not been full since before Covid and a lot of care homes are in the same position.*" – ***Care Manager***

b) **Rate Of Conveyance: 72.7% Fewer "Frequent Conveyor" Care Homes**

The intervention cohort included 11 "frequent conveyor" homes, i.e. care homes that have high numbers of conveyances to hospital, reducing to just 4 homes during the intervention period. For 66.7% of the homes, the reduction in conveyances correlated with the introduction of proactive care.

c) **Rate of Admission: 20.0% Reduction in the Number of Hospital Admissions**

By enabling early detection of health issues, a reduction in hospital admissions was achieved across the year. A number of ACSCs in particular are impacted by early detection and better management in the community, e.g. acute respiratory infections, hypotension leading to falls, urinary tract infections.

3. Key Lessons Learned

a) **Pump-Priming Transformation:** The way health and care budgets are currently structured can present a barrier to delivering transformation. Investing in developing the evidence to underpin business cases can alleviate pressure and accelerate the transformation agenda. This is particularly important when tackling currently fragmented patient pathways that stretch across the interplay of care and healthcare. The KCC project provides a great example of a Council pump-priming innovation that benefits both the care and healthcare sectors.

b) **The Importance of Quality Assurance:** As carers adopt new workflows that support the healthcare of their residents, it is crucial that they are equipped with decision support tools that quality assure the clinical information they capture. In the absence of quality assurance measures, the care sector could end up generating large amounts of unreliable data, eroding trust with clinical professionals and leading to more inefficiencies in the escalation process. In the KCC project, it was observed that specific processes that benefit from quality assurance are: using medical devices such as pulse oximetry and computing risk scores such as NEWS2. The appropriate technology can augment carers and quality assure the information they generate.

c) **Standardising Escalation Pathways:** In many regions, the escalation process can be quite complex, including GP-specific programmes of work, urgent care services, community nursing services, geriatric/frailty services. Faced with that complexity, carers might default to keeping risk to a minimum and calling 999. It is therefore essential that when embedding digital solutions, the escalation pathways reflect the local infrastructure and automate the information as much as possible to reduce variability between individual carers and care homes.

d) **Proactive Change Management:** When transforming complex workflows that include multi-disciplinary collaboration, change management is essential and should be delivered proactively and continuously. This includes proactively monitoring adoption with the care workforce, identifying patterns of use and intervening early – e.g. providing retraining or onboarding of new staff (to address churn). It also includes implementing creative adoption initiatives, e.g. user champion initiatives, that drive engagement and help develop new habits among care staff.

e) **Efficiencies of Scale:** There are opportunities to realise efficiencies of scale when projects like the one led by KCC are deployed across the region. This includes cost efficiencies such as bulk tech orders. Importantly, scale also creates prioritisation efficiencies; this is particularly relevant when it comes to activating integrations with services and other systems. For example, the supplier landscape for digital care records is quite fragmented, making the activation of integrations for a small number of care homes inefficient. The same applies to integrations with wider services (e.g. urgent care) where both data governance and careful change management are required. Implementing such initiatives at scale justifies the effort and aligns stakeholders behind a system-wide commitment.

Recommendations for Scale

1. Invest to Save

> "The challenge of shifting our focus to prevention and proactive population health management [...] acts as the glue that binds all partners in ICSs."
>
> Patricia Hewitt, Chair, NHS Norfolk and Waveney; Hewitt Review, 2023

The programme described in the previous chapter offers a practical blueprint to implementing Pillar 1 of an integrated care model. If scaled to Kent & Medway's care services, the impact of the initiative is estimated to amount to:

- Avoidance of over 3,073 A&E conveyances
- Prevention of over 2,318 hospital admissions
- Reduction of over 23,184 bed days corresponding to capacity for at least 5,000 elective admissions (i.e. reducing the backlog)
- **£14.2m** in **savings**.

The projected outcomes underscore the potential for significant improvements, both in terms of resident and patient care and system efficiency. Investing in this project will enable the ICB to better target resources to those most in need, doing so in a sustainable manner and ultimately alleviating the mounting backlog of care. It should be emphasised here that whilst the projected savings may not be entirely cash-releasing instantly (with the exception of medication costs), this scale of impact should create opportunities to reduce service inefficiencies (e.g. reduce agency spend) and free up resources to make a dent in the elective backlog.

Expanding the intervention nationally across the UK's 16,700 care homes would amplify these benefits significantly, with the projected impact including the following:

- Avoidance of over 79,325 A&E conveyances
- Prevention of over 59,842 admissions
- Reduction of over 598,417 bed days corresponding to capacity for at least 120,000 elective admissions (i.e. reducing the backlog)
- Approx. **£366.4m** in **estimated savings**.

2. Restructure the Incentive Model to Boost Health Outcomes

Shifting care provision into community settings, particularly through initiatives emphasising preventive interventions, offers not only significant RoI but also improves quality of life for ageing populations. However, current payment models largely fail to encourage social care providers to adopt these critical measures, creating a misalignment between national health objectives and operational realities in social care.

The Hewitt Review (2023) put emphasis on the importance of introducing more effective payment models that incentivise and enable better outcomes for local systems and populations. It highlighted the role of ICBs in driving initiatives linking health and social care while shifting the provision of care into the community, given, for instance, the direct RoI derived from initiatives prioritising prevention.

Redesigning financial incentives in social care can draw inspiration from models like the Quality and Outcomes Framework (QOF) in primary care, which links financial rewards to measurable improvements in quality of care and health outcomes. By establishing a similar framework for social care, providers could be incentivised to prioritise interventions that reduce hospital admissions and enhance preventive care. Such a model would encourage evidence-based practices and hold providers accountable for delivering tangible improvements, aligning their financial motivations with broader national health objectives.

Adapting this approach to social care would not only improve outcomes for individuals but also drive efficiency across the system. Metrics could focus on key indicators like reduced pressure on urgent care and secondary care services, improved patient satisfaction and enhanced quality of life for ageing populations. Tying financial incentives to these outcomes would create a performance-driven culture that supports long-term sustainability and shifts resources toward the most impactful care strategies.

Data-driven technology and transformation initiatives, such as the one described in the previous chapter, can provide the real-time evidence to enable the effective implementation of outcome-based payments. Implementing this on an ICB level in Kent & Medway can serve as a blueprint for the rest of the country.

3. Develop the Care Workforce of the Future Today

The social care workforce can be a powerful resource for strengthening healthcare delivery, with the appropriate commitment to incentivisation and professional development. In the UK, there are over 1.5 million people employed in adult social care - more than double the number of registered nurses in the NHS. Unlike nurses, whose training typically spans three years or more, carers can be upskilled relatively quickly through targeted programmes tailored to the specific needs of community-based care. This scalability makes the social care workforce an invaluable asset for addressing

immediate pressures on the health system while also contributing to long-term sustainability.

Developing the care workforce is essential to delivering prevention and early detection for ageing populations effectively within community settings. Equipping care staff with skills and augmenting them with the right digital technology can reduce the need for more intensive and costly medical interventions, while improving the overall quality of life for those in care. This could serve as a powerful incentive to attract and retain talent, helping to tackle long-standing challenges in the sector while strengthening the system's resilience to the growing needs of the ageing population.

Spotlight: Putting Theory into Practice

A very tangible way we can imagine this working is through a model being developed in North East London: the introduction of Nursing Associates in non-nursing care homes. The Nursing Associate role is a highly trained support role within nursing, bridging between unregulated Healthcare Assistants (HCA) and Registered Nurses. Nursing Associates are regulated by the Nursing and Midwifery Council (NMC) and work under the direction of Registered Nurses to deliver care based on agreed plans.

The model, being led by Care City, has supported several care homes in introducing this new role with apprenticeship funding to support their training and an innovative cross-organisational delegation and supervision model. This role within a care home is perfectly well suited to championing and supporting care staff to undertake the health monitoring activities outlined in this paper. Digital skills training to use the health monitoring kits would add further opportunities for learning and development for people in these roles.

Increased nursing knowledge within care homes supports more preventative activity and keeps residents well for longer in the place they call home. Equally, it facilitates faster hospital discharge by ensuring the availability of necessary support. It also creates a new opportunity for career progression that will help with staff retention and attract new people to work in care.

The challenge for care homes is how to fund the Nursing Associate role in the long term. The invest to save the case outlined would provide a perfect mechanism for offsetting some of the costs of this role (circa £40k per year). By leveraging the cost savings achieved through reduced hospital admissions and improved care, this approach can offset the expense while ensuring that care homes benefit from the presence of skilled health professionals.

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