A BLUEPRINT FOR TRANSFORMATION OF HEALTH AND CARE IN THE COMMUNITY

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

THE URGENCY FOR CHANGE: RISE TO THE CHALLENGE OF AN AGEING POPULATION

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.

In England alone, 1 in 5 people is projected to live with at least one major illness by 2040, a nearly 40% increase since 2019 (Health Foundation, 2023). Addressing these challenges requires bold solutions to ensure equitable and sustainable care. A shift from the traditional hospital-centred model to a community-first approach is inevitable.

Care homes reflect these broader challenges, experiencing increasingly more complex needs, chronic staff shortages and counter-productive financial incentives. Nevertheless, the sector holds unique potential for transformation – **prove that we can sustainably meet the needs of the most vulnerable people through a truly integrated health and care model.**

OUR THEORY OF CHANGE: AN INTEGRATED CARE MODEL FOR FRAILTY

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:

(1) **Proactive Health:** Equipping care staff with the skills and tools to proactively identify health issues, avoiding exacerbations through timely intervention from the right health services.

(2) **Co-ordinated and Multi-Professional Services:** Enabling care co-ordination through connected digital infrastructure and joined-up services, to deliver person-centred care for people living with complex needs.

(3) **Hospital-Grade Care:** Ensuring people receive the right care in the right place for them, including hospital-grade healthcare in their place of residence.

This multi-part white paper aims to provide a practical blueprint for embedding each pillar of the model, using real-world evidence and insights from projects across the UK. We begin by focusing on **Pillar 1 - Proactive Health in Care Homes.**

FROM THEORY TO PRACTICE: MEASURING WHAT MATTERS FOR SUSTAINABLE CHANGE

To put theory into practice, we take a look at a transformation initiative in Kent and 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 (Figure 1).

To evaluate impact, it is critical to have an impact map with clear KPIs and outputs that align with the sustainability of services (Figure 2).

The evaluation covered: 1,000 residents across 24 care homes; 90 care staff members; a period of 12 months (Sep 23 – Aug 24). Comparisons were conducted historically as well as against a matched control group in the region which did not have the initiative.

Details of the assessment are available in the full report.

Figure 1: Pathway Evolution

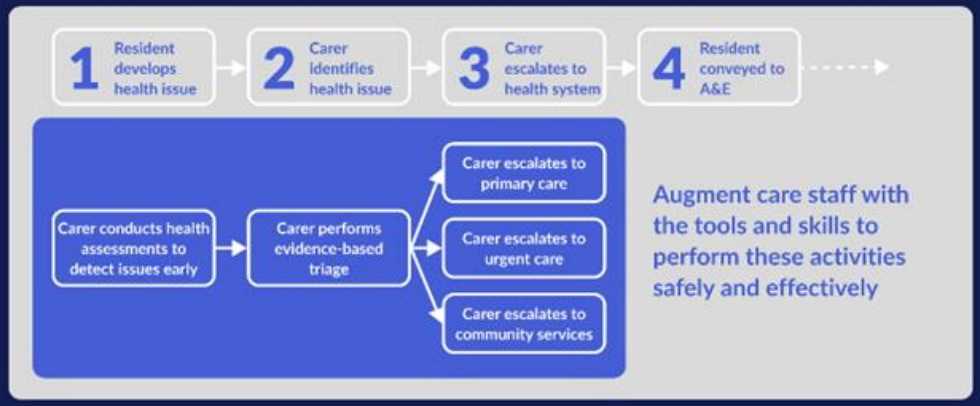
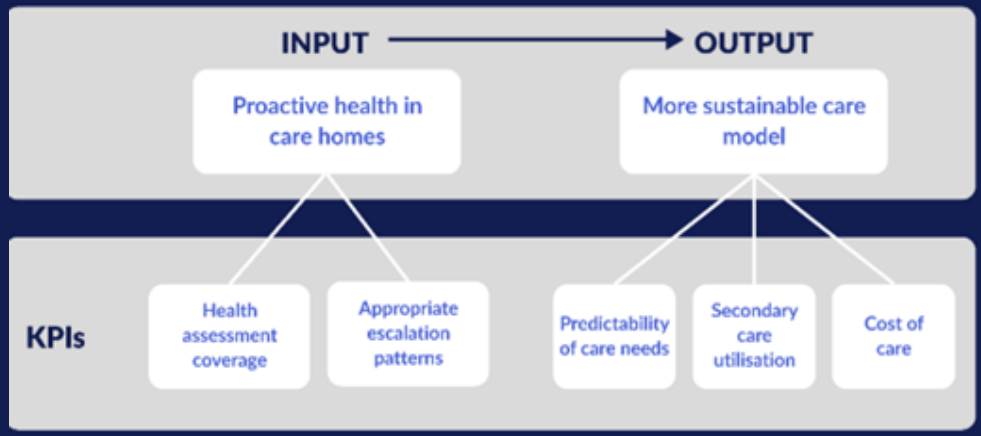


Figure 2: Impact Map



THE IMPACT CASE: PROACTIVE HEALTH DRIVES SUSTAINABILITY OF SERVICES

The reductions in utilisation of ambulance services and hospital admissions were estimated to amount to approx. **£527k in cost reduction**, with over **860 hospital bed days saved** and **5.2X Return on Investment**.

How do we evaluate **effective adoption**?

- **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).

How do we evaluate the **sustainability of the care model**?

- **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

IMPACT AT SCALE: SCALING ACROSS CARE HOMES IN AN ICB (E.G. KENT & MEDWAY)

3,073 fewer conveyances to A&E

2,318 fewer non-elective hospital admissions

23,184 fewer bed days creating

Capacity for at least **5,000** elective admissions

£14.2m in savings

IMPACT AT SCALE: SCALING ACROSS CARE HOMES NATIONALLY

79,325 fewer conveyances to A&E

59,842 fewer non-elective hospital admissions

598,417 fewer bed days creating

Capacity for at least **120,000** elective admissions

£366.4m in savings

RECOMMENDATIONS FOR SCALE:
EVOLVING FINANCIAL FLOWS

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.

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 outputs. A similar framework for social care would incentivise evidence-based practices that reduce pressure on health services and hold providers accountable for delivering tangible improvements, aligning their financial motivations with broader national health objectives.

RECOMMENDATIONS FOR SCALE:
DEVELOP THE CARE WORKFORCE

Developing the care workforce is essential to delivering prevention and early detection for ageing populations. Equipping care staff with skills and augmenting them with the right digital technology reduces the need for more intensive and costly medical interventions, while improving the overall quality of life for those in care.

Unlike nurses, whose training typically spans three years or more, care staff can be upskilled relatively quickly through targeted programmes tailored to the specific needs of community-based care.

Successful Example: introducing 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. Care City CIC supports the introduction of the role in care homes with apprenticeship funding.

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