

The Case for Home-Based Intermediate Care

2023

**Better Care Fund
Support Programme**



Our Partners

The 2023-25 Better Care Fund Support Programme is delivered by a partnership of the LGA with ADASS and Newton Europe.

This document has been produced by the LGA & Newton Europe.



NEWTON

Authors' Note

This document has been produced for local and national audiences with the following objectives:

- Explain the benefits of home-based intermediate care in terms of outcomes for people and system operations and flow.
- Identify the return on investment possible from home-based intermediate care.
- Explore best practice from operational and professional delivery lenses.
- Help make the case for investment into improving home-based intermediate care locally and nationally.

We hope that the document is an interesting read and a valuable resource in support of improving outcomes for people across the country.



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Executive Summary

Getting people home from hospital or helping them maintain their independence in their own home for longer are long-held policy goals; they also underpin the Better Care Fund policy and support programme, as well as the Local Government Association's integration vision.

The Better Care Fund Support Programme has commissioned this paper to articulate the benefits, challenges, and opportunities of delivering home-based intermediate care (HBIC) by using evidence and learning from 19 health and care systems.¹ In doing so, the paper considers how HBIC can be one of the most valuable investments systems can make to achieve those goals, and thus improve people's outcomes and staff wellbeing, transform operational performance, and reduce spend.

There is also a financial imperative for improvement of HBIC. This paper shows that, when summed across all systems in England, improvement of HBIC could produce a £3.4bn a year reduction in long-term care spend (compared with a £15.3bn per year annual spend on adults' long-term packages and an approx. £27.8bn per year spend on hospital beds). There is a further saving implication on acute and community hospital and long-term care budgets when the cost impact of delayed discharges (and therefore increased deconditioning) due to lack of HBIC capacity is also considered.

Benefits of good HBIC

HBIC is an important function for high performing health and care systems and will play a growing role as they work towards a more integrated future focused on prevention and population health. HBIC is valuable in several ways:

Improved outcomes for people

Effective intermediate care at home aids a faster and more resilient recovery and maximises an individual's independence to manage their day-to-day activities, which in turn reduces the likelihood that the individual will require long-term care. Similarly, HBIC can intervene to safely avoid the need for escalation in care, either to hospital or to bed-based care and support. On average, about 70% of HBIC recipients regain full independence.

¹ Evidence provided by Newton Europe, based on systems reviewed over the past five years.



Operational delivery and staff wellbeing

Improved operational performance, increased staff wellbeing, and improved staff retention are all strongly correlated. With HBIC working effectively, the overall operational pressure on the system reduces, easing the burden for operational managers and improving wellbeing among staff (particularly in hospital teams but also elsewhere in the system).

Health and social care spend

One of the most reliable ways to reduce spend on health and social care is to safely manage a reduction in demand for health and social care services. Effective home-based intermediate care interventions are among the best ways of reducing this demand within the community.

But the benefits are not automatic

Challenging operational and commissioning environments typically lead to worse performing HBIC and worse outcomes for a population. Based on evidence and good practice witnessed through this research, this paper sets out ways that HBIC commissioners and leaders might achieve the following:

- Integrated, system-level accountability and clear clinical leadership.
- Commissioning excellence, to ensure rigour in right-sizing of integrated HBIC teams.
- Operational excellence, to improve outcomes and reduce operational strain on staff.
- Implementing a 'pull-model' from acute and community hospital settings.
- Multi-disciplinary skillsets within teams, and enhanced multi-disciplinary team (MDT) working more generally.
- Locality-based structure of teams centred around primary care networks with area- or system-level specialist practitioners to support local delivery of HBIC interventions.
- Rapid response functionality within the community to help reduce hospital admissions.
- Improved links and co-working with primary care, the voluntary sector, and onward care teams.



Putting the evidence into practice

Although there is variation in care models, services, and performance across health and care systems, there are several common factors which have been witnessed through this research to inform improvement actions:

Demand-side barriers: Referrers in acute and community settings do not typically refer into HBIC often enough, and when they do, the referral is often at a later stage than would be ideal. For example, of the 19 systems, 35-50% of discharge setting decisions were deemed 'non-ideal' when reviewed by a multi-disciplinary peer group. Roughly half of these were due to risk aversion or a lack of creative or multi-disciplinary decision-making.

- **Operational performance:** HBIC services commonly form a bottleneck in the system, rather than relieving operational pressures. Most HBIC services studied have the potential to realistically increase their capacity by 50%-120% by improving their operational performance alone (without the need to recruit more staff). It is worth noting that there will typically be demand beyond this level.
- **Commissioning of resource and location of staff:** While operational improvements can and should be made within HBIC, it's also true in several cases that systems are under-resourcing HBIC teams. This can mean the overall capacity and/or skill mix are not matched to demand. Determining the required skill mix within HBIC teams – particularly across practice or clinical lines – is a complex process too, with services often being created as single-discipline teams lacking diverse skillsets.

As evidenced in this paper, improvements can be made across each of these areas by:

- Transforming working relationships with referrers (through better communication and realignment on referral criteria), so that referrals into HBIC services more than double.
- Improve capacity to take on new referrals, through effective prioritisation and short-interval control, while improving long-term outcomes.
- Increase the number of staff and optimise the skill mix within HBIC teams and adopt more outcome-based commissioning practices to incentivise teams to maximise the independence of the people they serve.



Next steps

A key task for system leaders is to determine the best place to start. For some services, this will be to increase staffing levels (where this results in a net saving). For sufficiently staffed but under-performing HBIC teams (or in situations where recruitment is impossible), a pragmatic first step is to focus on operational improvement to deliver more value and better outcomes. This in no way works against ambitions of integration but instead should be thought of as a pre-cursor to it. Finally, systems further along in their journey may have high-performing, sufficiently staffed teams, but integration may offer further practice, commissioning, and operational benefits. Each has its own investment requirements, benefits timelines, and considerations for people delivering and receiving services.



1. Introduction

1.1 Context

The challenges faced by health and social care systems today are complex and deep rooted - from budgetary constraints, workforce, and other resourcing challenges, to operational difficulties and service misalignment.

Effective home-based intermediate care services (HBIC) have a significant role as one part of a complicated puzzle in meeting some of these challenges.

Their ability to alleviate system pressures (particularly acute admissions and bed occupancy) and maximise the independence of a population (by reducing demand for residential, nursing, and domiciliary care) is broadly understood.

However, many system leaders recognise that being able to put a clear value on these services, and therefore sufficiently invest in optimising and expanding them, is complex.

1.2 Purpose

This paper has been written and published by the Better Care Fund. It is the result of a work programme which has drawn on evidence from 19 ICSs (Integrated Care Systems) in England, whose 65+ population amounts to 45% of the national 65+ population.

In drawing together this evidence, this paper discusses the role and potential for home-based intermediate care services in health and care systems across England.

This paper aims to provide the following:

- A framework for how to value intermediate care services.
- An explanation of why many systems can achieve more, and guidance on how to approach this.
- An evidence-based guide to calculating the return on investment from home-based intermediate care services.
- A framework for investing in home-based intermediate care services – how to start, where to focus, and how to align with the transition towards integrated intermediate care.



1.3 Definition

Home-based intermediate care has a broad and flexible definition. For the purposes of this paper, it will refer to what is usually an amalgam of commissioned services providing short-term support for elevated health and care needs in the place the person calls home: their own house, supported living, residential or nursing homes (though distinct from regular, ongoing care provided by care home staff), or any other type of residence.

This definition includes but is not limited to reablement teams, community physio and occupational therapy teams, community nursing teams, Hospital@Home, virtual care, Virtual Wards,² and specialist dementia and Alzheimer's teams. Typically, individuals who use HBIC services are adults and do not differentiate service delivery by age, though they tend to be older adults. For further information on the role of home-based intermediate care, please see Appendix 1.

² Virtual wards support patients, who would otherwise be in hospital, to receive acute care and treatment in their own home. This includes preventing avoidable admissions into hospital or supporting early discharge out of hospital. Under the national programme definition, a virtual ward is not a mechanism intended for enhanced primary care programmes; chronic disease management; intermediate or day care; or proactive deterioration prevention. Virtual wards are being included within the definition of HBIC here as they can often be delivered best in coordination with other services required to support the individual at home.

2. The national direction of travel

Over the last 10 years, there has been consistent movement towards integration of health and care systems, whether that be the introduction of STPs and subsequently ICSs or the government issuing the *“Health and social care integration: Joining up care for people, places and populations”* white paper³. Health and care systems in England have a clear mandate to press on with integrating health and social care functions.

For home-based intermediate care, this will likely feature the following:

- Integrated teams comprising multiple disciplines (including care), and enhanced MDT working more generally.
- An emphasis on strength-based working, centred on maximising the independence of the individual.
- Locality-based teams centred around local communities (ideally along grouped Primary Care Network (PCN) boundaries) with area- or system-level specialist practitioners to support local delivery of HBIC interventions.
- Fast response functionality within the community to help reduce hospital admissions, such as Urgent Community Response (UCR).
- Strong links and co-working with primary care, the voluntary sector, and onward care teams.
- A ‘pull-model’ from acute and community hospital settings.
- Integrated, system-level accountability and clear clinical leadership.

³ Health and social care integration: joining up care for people, places and populations, Various Authors, www.gov.uk/government/publications/health-and-social-care-integration-joining-up-care-for-people-places-and-populations

3. The value of home-based intermediate care

The value of home-based intermediate care is explained in more detail in Appendix 4.

3.1 Describing the value of home-based intermediate care

Distinct from the cost of running the service (staffing, office expenses, other overheads), the value of the service can be described as the benefit to the system of having that service.

Through this research, the value of HBIC was seen to manifest itself in several ways including in:

- outcomes for a population
- operational delivery across the health and care pathway
- staff wellbeing
- health and social care spend.

3.1.1 Better outcomes for a population

- Maximising an individual's independence (e.g. following a stay in hospital), thereby reducing the likelihood they will require long-term support to manage their day-to-day life (either with domiciliary care or in a residential or nursing home).
- Avoiding admissions into acute settings, through urgent community response and thorough escalation planning, often in conjunction with primary care colleagues, and thereafter supporting their recovery in a familiar home-based setting.
- Reducing the likelihood of going down bedded care pathways, which demonstrably exposes the individual to, among other factors:
 - frequent moves between settings
 - increased risk of hospital-acquired infections and delirium
 - decompensation, such as reduced muscle strength and reduced respiratory capacity.⁴

4 Reducing delays in hospital transfers of care for older people, John Bolton, ipc.brookes.ac.uk/files/publications/Some_key_messages_around_hospital_transfers_of_care.pdf

- Enabling rehabilitation, reablement, and recovery in the individual's own home (as soon as it is safe to do so) by providing a 'pull-model' out of hospital, which is also more likely to alleviate bed pressures in acute settings.
- Ensuring an individual is more likely to get appropriate long-term support by assessing them for that support as part of an HBIC intervention.
- Avoiding re-admission into bedded care settings through proactive escalation planning.⁵

3.1.2 Reduced operational strain and improved staff wellbeing

- Arranging discharge for patients requiring onward support requires a significant amount of time and effort from ward staff. This can lead to discharge teams inadvertently needing to decide between the best outcome for an individual and the most timely one. HBIC services with sufficient capacity help to relieve this situation and enable positive discharge setting decision-making. There is a particular benefit where services adopt a 'pull-model'.
- HBIC services delivering on their admission avoidance mandate can significantly reduce the average occupancy of a hospital, leading to lower average bed occupancy and a more manageable workload for staff.⁶
- Improved operational performance and increased staff wellbeing go hand-in-hand,⁷ as operational control helps avoid high caseloads, duplicated efforts, and dissatisfactory outcomes.

3.1.3 Reduced spend on short-term bedded care and long-term support

HBIC's value extends to a real financial value that can be quantified, and typically presents itself as cost avoidance, either for acute bedded support or long-term care.

5 In one system, 11-12% of patients aged over 75 were readmitted having been discharged through a reablement pathway, compared to 30% for the wider 75+ cohort. This has been witnessed in other systems.

6 An MDT of frontline practitioners in a central England ICS reviewed 177 cases of patients who had been conveyed to hospital in the previous 12 months, with the group agreeing that 31% of these conveyances could have been avoided by having their needs better met in the community. With an observed average admission rate of 51% for this patient cohort, this means roughly 16% of admissions could be avoided through more effective urgent community response.

7 Improving performance by improving staff wellbeing: North Bristol NHS Trust, NHS Employers, <https://www.nhsemployers.org/case-studies/improving-performance-improving-staff-wellbeing>

Quantifying the value of home-based intermediate care

For an individual who goes through an HBIC service, a typical journey might look like the following:

Case study: Bill lived at home with his wife and received one visit per day from a domiciliary care worker to help him with his washing and bathing. After a fall at home, Bill spent eight days in hospital while clinical staff provided treatment and identified the best next step. Initially unsure about whether it would be safe for Bill to go home with his usual package of care, the acute discharge team referred into the local reablement service to help Bill regain his confidence with daily tasks, particularly focusing on his personal hygiene and mobility around the home. The alternative would have been referring Bill for a higher level of domiciliary care to support him with all his daily tasks (four visits per day). Instead, Bill started with four visits per day of reablement, and after getting his confidence back, learning some new techniques for bathing and meal preparation, and being provided with some equipment to help with his mobility, Bill was able to resume his normal life and restart with one visit per day from his domiciliary care provider.

Had Bill gone straight to domiciliary care, instead of receiving reablement, it is likely that the initial package he would have received on discharge from hospital would have stayed the same for an average of around 72 weeks. The cost of that support would, at least in part, have been covered by the adult social care budget. Instead, through a short intervention of reablement, he regained his independence and only needed a relatively small domiciliary care package to support his ongoing long-term needs. The cost avoidance is the difference between the support option required to get him home without reablement (four visits per day), and the actual package he received after reablement (one visit per day).

Figure one shows an example of HBIC services reducing long-term care requirements. HBIC can also deliver value to systems in the form of reduced spend on acute bedded care, either through reduced admissions (e.g. through effective prevention or admission avoidance pathways) or reduced length of stay (e.g. by providing a 'pull-model' from hospital settings).

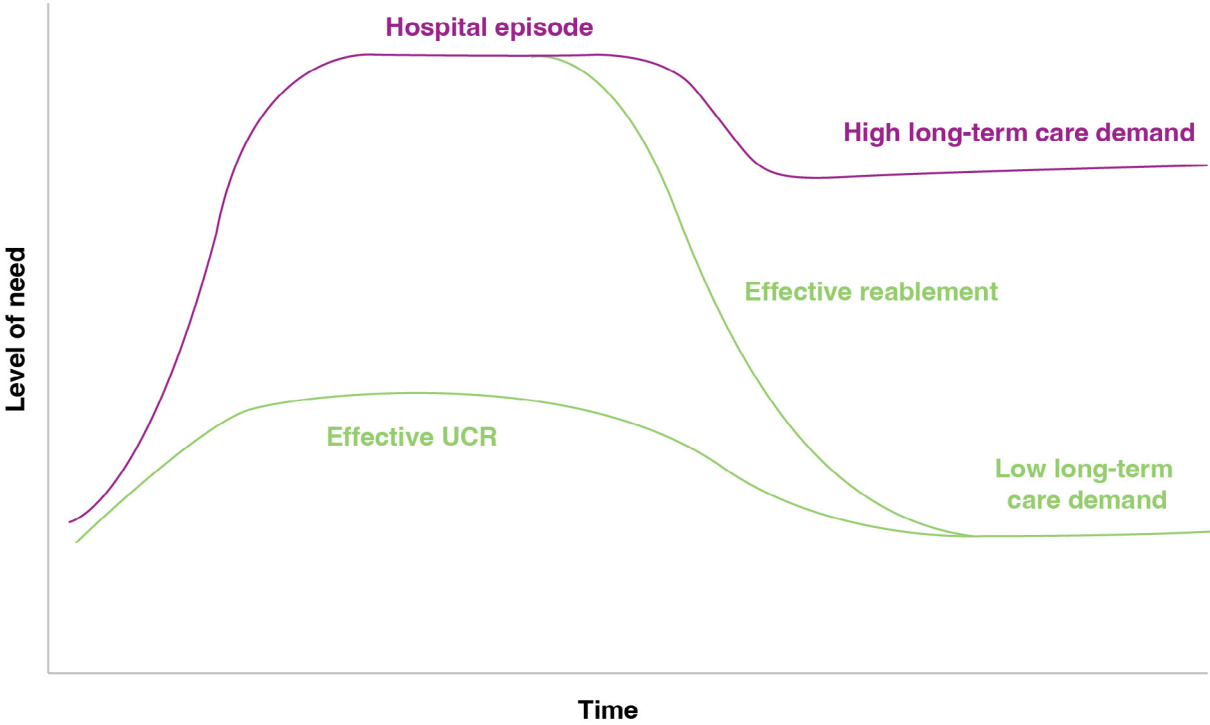



Figure 1: HBIC services add value to systems in several ways, including reduced admissions (including through effective Urgent Community Response), reduced length of stay in hospital, and reduced long-term care demand.

These three value streams are often undervalued. The net value of just one of these value streams – long-term care demand reduction - is £31.9m per year, per million population.⁸

The *potential* value of HBIC services can be calculated (using target values), as a way of understanding what additional value HBIC services can deliver. Conservative estimates based on operational diagnostics of 19 systems in England suggest that the potential net value is as high as £60 million per year per million population of long-term care demand reduction. Therefore, there is a further £28.1m per year of cost savings available, whilst improving outcomes for people. There is an additional opportunity to improve the value of HBIC when it comes to admission avoidance and reduction of acute length of stay (£29.1m per year and £3.6m per year respectively), amounting to a further 7% reduction in demand for acute bed demand.

⁸ Calculated as an average of seven representative systems across England. Throughput per million population = 4951/yr, Average benefit per year = £6,718.46/yr/#, Average duration of benefit = 72 weeks (1.38 yrs), Average spend per million = £14M.

The page features decorative geometric shapes. In the top right corner, there is a cluster of overlapping triangles in shades of green and blue. In the bottom left corner, there is a large, complex geometric shape composed of several overlapping triangles in shades of light blue, teal, and pale green, extending towards the center of the page.

When summed across all systems in England, this means there is £3.4bn per year overspend in acute and long-term care settings that could be resolved with improved home-based intermediate care (compared with a £15.3bn annual spend on adult social care long-term packages and approximately £27.8bn per year of spend on acute beds).

4. The challenges in achieving valuable HBIC

HBIC's unique positioning within health and social care systems - sitting at the interface of several different organisations, across health, social care, primary care, the voluntary sector, and others - creates a difficult environment for change.

Home-based intermediate care is often a complex patchwork of services, typically split along practice lines, and which overlap at various stages of an individual's journey. Each of these services usually have their own intake criteria, role within their system, and operational incentives.

It is within this environment that system leaders engaged in this research described the complexity of leading improvement efforts. Though stated as far from easy, opportunities were identified to tackle 'in-house' operational issues within HBIC, and to work in a more unified way with system partners.

Analysis of HBIC services conducted for this work programme identified that:

- Up to 28% of acute admissions could have been avoided through an intervention from an HBIC team.
- Patients stay longer on acute wards in some systems than they do in others, with HBIC services either not being used at all to support discharge or brought in later than they ideally would have been.
- 35.5% of individuals supported by long-term care (either domiciliary, residential home, or nursing home) could be more independent if they had accessed HBIC services.

Overall, and recognising the complexity, the systems studied identified opportunities for their own HBIC services to be more effective, and better utilised. The reasons for this can be split into three groups:

1. Demand-side barriers
2. Operational performance of HBIC services
3. Commissioning of resource and location of staff

4.1 Demand-side barriers

Between 35-50% of discharge setting decisions studied for this work programme were deemed 'non-ideal' when reviewed by a multi-disciplinary peer group in terms of the outcome achieved for the individual. The same peer group identified opportunities to increase referrals into home-based intermediate services by as much as three times. There were several reasons found as to why these demand side barriers exist:

- **Criteria-led referrals:** Referrers faced with several (ostensibly similar) HBIC options often encounter delays, disputes over eligibility, and failed discharges. Overly strict criteria among HBIC teams lead to people falling through the gaps. HBIC criteria often fail to comprehensively cover all individuals who could be safely supported at home. The detail of HBIC criteria is often poorly understood or communicated with referrers and requires consolidation and simplification.
- **Lack of capacity** in HBIC can lead to a culture of not referring to those services, as discharge staff look for the path of least resistance on discharge. This is entirely understandable when optimising for a local metric (e.g. bed occupancy) but is unsustainable in the long-term and often results in the patient not achieving their ideal outcome.
- **Risk aversion on referral:** Referrers limit their referrals into HBIC to those patients they are *sure* will be able to stay at home, rather than referring individuals with higher needs and who may require complex support at home. However, analysis shows that it is these individuals who often benefit from the greatest improvement from an HBIC intervention (see Figure 2).

HBIC is even more effective for residents with higher starting needs, despite the challenges

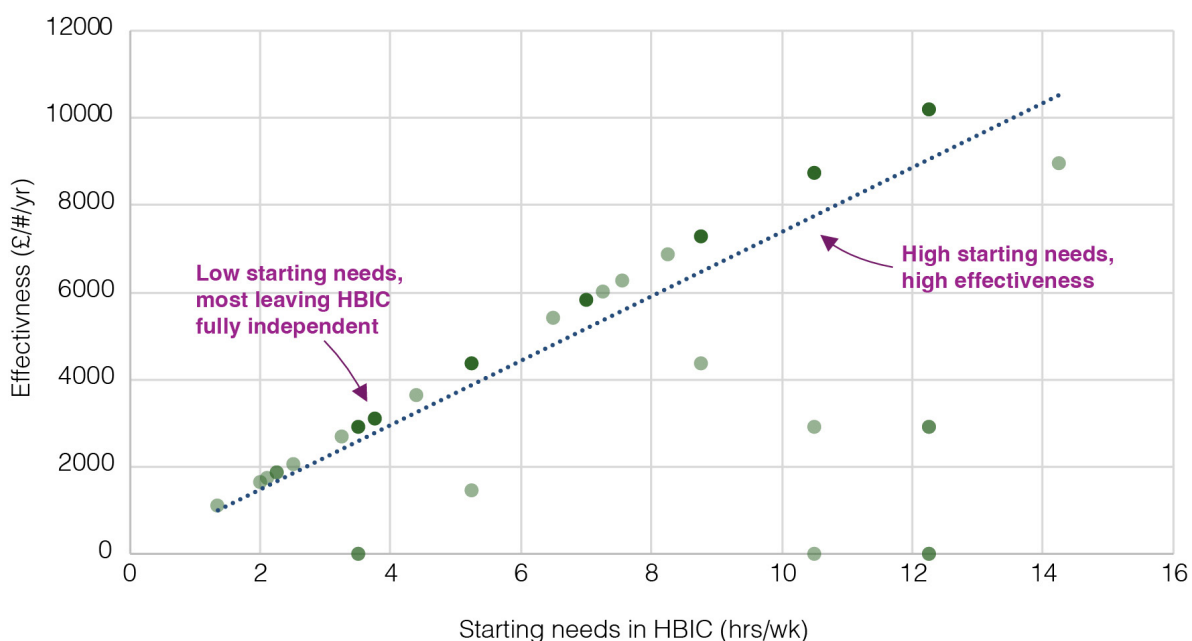


Figure 2: Effectiveness of an HBIC intervention (in terms of onward care cost avoidance, £/#/yr) plotted against the needs of the individual when they started HBIC (in terms of hours of support per week), for a random sample of 164 individuals for a typical reablement service in a South West ICS. This chart shows that interventions are even more effective when the starting needs of the individual are higher despite some practitioners believing HBIC can only successfully intervene with low-needs individuals. Demand-side risk aversion and delays accessing long-term care following HBIC prevents this from becoming more commonly adopted. Sometimes HBIC is not successful from an effectiveness point of view (see bottom-right of the graph), and space in more appropriate ongoing settings needs to be prioritised for these individuals to avoid blocking up HBIC capacity.

4.2 Operational performance of HBIC services

The research identified that the capacity of HBIC teams, or their ability to take on new referrals, can be a significant factor behind systems under-utilising these functions. Often, capacity falls short of meeting demand for those services. It was also identified that capacity issues are, in part, addressable through improved operational performance. The following examples were identified during the research:

- **High length of stay:** Just as in hospitals (where higher patient length of stay leads to a higher bed occupancy), long stays in HBIC services lead to higher 'occupancy' in those teams and reduces their ability to take on new referrals. Conversely, shortening the average length of stay enables teams to take on a higher rate of referrals.

Opportunities were identified in some systems to shorten the length of stay of an individual by reducing any 'non-ideal' time they spent on the service.

'Ideal' in this case means the time on caseload where the HBIC team are fully enabled, working towards reablement or other goals, and where the HBIC team are the most appropriate team for that individual to be seen by (as opposed to any other team e.g. domiciliary care). 'Non-ideal' length of stay was seen to occur in several ways, including:

- Delays waiting for a long-term care assessment.
- Delays waiting for long-term care to be procured.
- Delays waiting for specialist input (e.g. from a dementia specialist), meaning the HBIC intervention does not work towards the right goals for the individual.
- Delays waiting for equipment, such that the HBIC intervention is not fully enabled.
- Poor feedback loop between frontline staff and scheduling, such that the HBIC intervention lasts for longer than it should before the scheduled visits end or takes longer than ideal to 'step down' support over the course of the intervention.

On average, this 'non-ideal' length of stay equates to roughly 1/3 (conservatively) of an individual's typical HBIC intervention. If this were translated into capacity, the HBIC service would be able to accept up to 50% more referrals if this 'non-ideal' length of stay were removed.

- **Low utilisation of frontline practitioners:** It was found that frontline practitioners in HBIC teams can spend as little as 29% of their time with individuals or otherwise working towards their independence goals. Reasons identified and raised through this research include:

- Time spent on admin tasks can be excessive; a typical practitioner spends around 33% of their time completing visit record paperwork, assessment paperwork, or on other administrative tasks.
- Whilst a necessary element of home-based interventions, travel time between visits is often not optimised and therefore takes a greater proportion of the frontline practitioner’s day than would be ideal.
- Gaps in the schedule can appear in ‘throughput services’ like HBIC, as individuals are discharged from the service. Systems that put in place a short-interval control approach to managing the schedule (i.e., a fast feedback loop between changes on the caseload and the scheduling function) were witnessed to better avoid downtime of frontline staff.
- The hours of operation of an HBIC team play a significant role in how effectively frontline workers are utilised. For example, a typical reablement service will have their busiest periods of the day first thing in the morning and last thing in the evening, but it was witnessed in some systems that the available staffing resource was misaligned with these times, leading to an under-utilised middle period of the day (see Figure 3).

Utilisation of a typical reablement workforce

Time spent with service users as a percentage of total staff time, mapped out across a typical working day

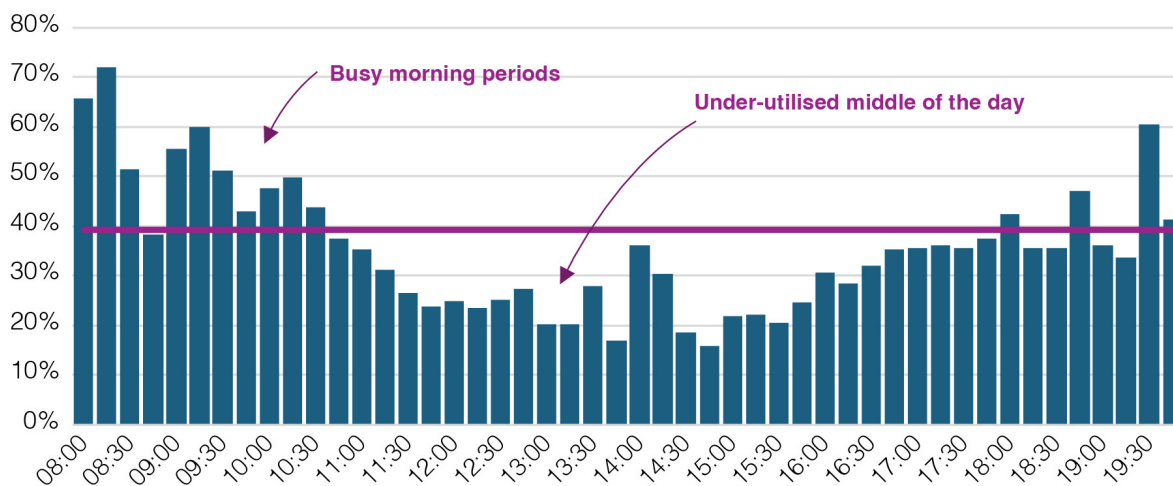


Figure 3: Utilisation of staff within a typical reablement service, mapped out across the day. Resource in reablement teams is often misaligned with the busiest periods of the day, leading to services lacking capacity for individuals requiring early morning visits, despite having an under-utilised team in the middle of the day.

Raising utilisation of staff from its current average of 40% to 60% would translate into a capacity increase of 50% (i.e., the ability to take on 50% more referrals).

4.3 Commissioning and location of staff

- In many of the health and care systems studied, there were not enough staff in HBIC teams in the community, and too high a proportion of staff in acute or community hospital settings. System leaders engaged shared that they were often looked to for solutions which they said are difficult to implement, while practical steps were often not prioritised.
- At the root of this, there are more opportunities to determine what staffing resource is needed where, and for system partners to collaborate to the extent that is required to form a system-wide resourcing plan. This would lead to commissioning of staff that is more proactive, collaborative, and aligned with a system's ambitions of an integrated future.
- In systems studied, resource was often commissioned to meet newly available sources of funding or to meet a specific set of key performance indicator targets (e.g. the two-hour community response target for the national Urgent Community Response standard). This resulted in staff being siloed into function-oriented teams and dispersed the accountability for meeting KPI targets across multiple outfits (when all such targets could be met with a single HBIC function).
- Those systems with multi-disciplinary teams were witnessed to be more effective, owing to the teams' ability to think more diversely about options to support individuals and share positive risk management decisions. For example, reablement interventions from services which are therapy-led (and have a high-proportion of physio and occupational therapy team members) were more effective than those not therapy-led. However, in some systems, an integrated skill-mix in community teams was not being incentivised.
- Other practical barriers to integrated working have their root in complex commissioning challenges, such as there rarely being a single IT system across health and care.

5. How to maximise the value of home-based intermediate care

This section details how the value of home-based intermediate care can be maximised, using examples of good practice from systems across England. Whilst regional refinement is of course required to ensure solutions meet local needs, what follows is a list of general principles adopted by HBIC services adding the most value to their systems.

5.1 Demand-side improvement

- MDTs review historical cases to establish the number of people who should be benefitting from HBIC in their area and identify and prioritise local barriers to those individuals being referred. The process of reviewing historical cases is one that involves colleagues from both referrer-side teams and HBIC teams – as well as supporting teams from primary care and the voluntary sector - and is performed in an open, creative, objective, and positively challenging environment.
- Referral criteria for HBIC services are refined, simplified, and well-communicated across the system, and represent the path of least resistance for discharge decision makers to ensure HBIC is considered whenever possible.
- Referrals into HBIC functions are made early and often, primarily to avoid hospital admissions and to limit the amount of time individuals spend in bedded care once they have been admitted.
- Clinical leadership across the system support positive risk management within HBIC teams, and similarly promote the HBIC pathway in hospital teams.


“Personally, I would like to see more re the cultural issues to be addressed as part of change management. There is a lack of awareness of community services - a perception of not being able to cope - leading to hospital admission and little opportunity to meet and develop relationships. To address risk aversion, we can think what it would take to make practitioners feel the transfer is safe enough for them to discharge earlier. Perhaps something like a virtual governance structure allowing for “handover” to a central service that can monitor individual outcomes could help with this. A safety net to allow for discharges not to go as planned in all cases would also be great especially in building confidence of the acute colleagues that making decisions about earlier discharge to their community partners does not just result in re-admission to the acute.” – **COO, NHS Community Trust**

5.2 Operational excellence

- The length of stay on caseload is optimised through frequent multi-disciplinary reviews of each individual, their current status, and their next steps, as well as in-situ care assessments and prioritised procurement of domiciliary care on discharge (with support and leadership from local authority colleagues).

Case study: A reablement service in the east of England had a very large caseload, which prevented managers from holding effective daily caseload review meetings. They still wanted the benefits of short-interval control, and so an alternative was created, making use of a simple digital tool. Daily data collection on the condition of the individual was embedded in the visit notetaking process using the HBIC workers' phones. This system was used to update the status of SMART goals each day for every individual. This data was then automatically aggregated for operational managers to view live, providing them with a simple but effective view of the reablement status for everyone on their caseload. This allowed them and their managers to pick out individuals whose progress had stalled (to understand further and help instruct future input) or those who had achieved their goals and could be stepped down/ discharged. This had several benefits - including reduced average length of stay, reduced average weekly need, improved effectiveness - and made MDTs more targeted. See appendix 8.

- The utilisation of frontline practitioner time is maximised. Systems maximise the percentage of time that a typical frontline practitioner spends with an individual or doing another activity directly working on progressing the person's journey, compared with the total time on shift. Best practice nationally is about 60% of shift time.
- Decision-making within HBIC teams is optimised. Frequent multi-disciplinary input on the caseload is encouraged to enable creative, positive decision-making on progressing individuals, which in turn maximises effectiveness and reduces time on caseload further.




Case study: One HBIC team in central England is made up of a mix of therapist, nursing, and social care staff. The initial assessment is done agnostic of profession and is reviewed in daily multi-disciplinary team meetings. This initial assessment contains useful information about the individual (physical condition and baseline, daily routine, living environment, family situation) and so this assessment feeds into the Care Act assessment for the provision of long-term care, should the person require it. This has led to a smoother handover of care and increased effectiveness.

- A culture of improvement is embedded through regular ‘improvement cycles’ at caseload-, service- and system-level. Improvement cycles include effective, data-fed operational or strategic meetings – held at an appropriate frequency – aimed at identifying operational priorities and assigning actions to improving priority problem areas. This is enabled through live, sufficiently detailed KPIs at the hands of operational managers and leaders.

5.3 Commissioning

- Systems are rigorous in ‘right-sizing’ an ideal HBIC staffing resource within a health and care system, both in terms of number and skill mix of staff (including skillsets across health, social care, and voluntary sector signposting). Such skillsets will mostly be in the form of multiple disciplines within a single team, but in some cases will look more like clearly defined and prioritised relationships between teams or organisations.

Case study: In an ICS in central England, an HBIC service had legacy worker contracts which hindered its ability to operationally manage the way the service leaders thought was best. In particular, frontline worker hours of operation were such that the time they were able to spend with individuals lay outside of the busiest times of the day (early morning and evenings). System commissioners supported the service through an HR Redesign and a consultation period to make the necessary adjustments. The resulting changes are anticipated to create a 120% increase in total capacity with zero increase in cost.

- 
- Commissioners and system leaders avoid reactive commissioning of teams to meet short-term system pressures. Commissioners take a proactive view in collaborating with operational colleagues to design and recruit to such teams.
 - Commissioning teams are incentivised towards outcomes (including taking on patients with more complex needs and comorbidities, where those individuals would otherwise go on to non-ideal outcomes), with the commissioning framework designed to support this. Commissioners across health and social care collaborate on service commissioning in most, if not all, areas of home-based intermediate care.
 - At a national level, commissioners support pragmatic steps towards integration (see Section 6), enabling local flexibility to right size resource for HBIC, and providing leadership with support on how to do this whilst minimising disruption for health and social care staff. This could include, for example, reconsidering how current frameworks for commissioning community health services allow local commissioners to build the best models of intermediate care in their communities.

Case study: A reablement service in the north-west of England was renewing their reablement delivery contract with several of their providers. As well as delivery of high quality and safe care they wanted the provider to drive efficient use of resources and incentivise effective service delivery. A contract framework was drawn up, which paid the private provider a set number of hours for each start, with the freedom to deliver as many hours of reablement as were safely required (overseen by the council's reablement team). This ensured nobody stayed on the service for too long, allowing the capacity to be used more effectively elsewhere. A gain share mechanism meant providers shared the financial benefit of reducing ongoing care, which incentivised the providers to support individuals to reach an optimum level of independence.

6. A practical route to integrated home-based intermediate care

Through this research, some practical steps have been identified that have been used by systems to improve their home-based intermediate care functions in the short-term, and work towards an integrated future as set out in Section 2. The below describes the steps that have been witnessed as leading to improvements.

For some services, the best starting point will be to **increase** the staffing of HBIC services, since without adequate staffing HBIC will have insufficient impact regardless of its operational performance.

For other systems with sufficiently staffed but under-performing HBIC teams, the next pragmatic step is to focus on operational **improvement** to deliver more value and better outcomes for its population. This in no way works against the ambitions of integration but instead can be thought of as a pre-cursor to it, something which reduces the risk of investment into integration.

Finally, systems further along in their journey may have high-performing, sufficiently staffed teams, but **integration** may offer further practice, commissioning, and operational benefits.

6.1 Increase

For services lacking capacity in their HBIC services (i.e., for all systems where there are significant delays accessing HBIC services), the first step identified is to invest in increasing the size of those teams, and thus their capacity.⁹ It is likely that true demand for HBIC services, at least in the short-term, is greater than what is currently being referred, and increasing the size of the teams was found to be the quickest way of ensuring future demand-side improvements do not encounter difficulties due to lack of capacity in HBIC teams. This may seem at odds with the journey towards integration, but it falls in line with the move towards prioritising locality-based care. Significant to note, this step was found to be preferable to other alternative options to alleviate delays in P1, such as commissioning more acute or community hospital beds or commissioning interim residential beds. This increase can be achieved by shifting resource from acute hospital settings and does not necessarily have to come from additional hires into the system. Systems engaged in this work agreed that proactivity is required to increase this capacity in HBIC ahead of operational crises and that though not easy, the impact of this change is almost immediate.

⁹ One caveat to this is when HBIC services themselves are blocked up due to capacity shortages in onward services like home care, in which case system leaders might choose to prioritise resource in those areas instead. Additionally, other barriers exist to recruitment of staff e.g. availability of suitably qualified workforce.

Workforce considerations shared by systems:

Shifting resource from acute and community hospital settings into HBIC teams may be required. There are a number of factors to consider with this, including the workforce appetite and potential TUPE requirements.

6.2 Improve

Teams can next focus on the operational improvement themes highlighted in Section 5, including those requiring multi-disciplinary input. (Integrated teams make multi-disciplinary ways of working far easier, but systems can still address siloed ways of working and poor collaboration across practice lines). Health and social care work together to jointly manage HBIC improvement and jointly prioritise change management resource from their teams to support the improvements. The details of this will vary from system to system. Digital transformation at this stage can be viewed through the lens of future integration, and digital platforms are aligned where possible. Improvement efforts take time to design, rollout, and embed into ways of working (typically 6–12 months) and system leaders shared the importance of taking this into account when planning such improvements.

Workforce considerations shared by systems:

Change management resource will likely be required to help manage this improvement and support teams through the change process.

6.3 Integrate

Finally, systems can transform the structure, staffing, and commissioning methodology to deliver on the ambition laid out in Section 2 of integrated HBIC services. This is tested in an iterative and locally tailored way, prior to making any long-term commissioning decisions. Integrated teams are first trialled in a small area within the larger system (e.g. a single Primary Care Network patch, or similar), with the goal of designing an integrated model that can then be replicated across the system. Systems are given the flexibility from national commissioners to do this. Staffing ‘right-sizing’ is a regular monitoring exercise, rather than something to be designed once and set in stone. Job descriptions are iteratively updated before ultimately being confirmed in long-term commissioning plans. Transformation efforts are designed to account for the fact that staff may be coming from different professional backgrounds, with different pay-scales, levels of professional development, and levels of supervision. The design and development of KPIs for which this new service will be accountable requires significant time investment. So too will the place- and system-level governance structure where those KPIs will be reviewed and decisions made. Timescales for rolling out a fully integrated model of

HBIC will vary significantly between systems, but a one-to-two-year timeframe (from starting integration efforts to launching a system-wide integrated offer) was found to be achievable for many.

Workforce considerations shared by systems:

A staff consultation will almost certainly be required at some point in the integration process, and thus a trial team (voluntary secondment, without consultation) is an important sandbox for defining a model to roll out across the system and can reduce the risk of failure for such a transformation. Consultation will need to be factored into programme timelines and significant resource invested in managing communication with staff.

6.4 Summary of recommendations, split by stakeholder

A range of stakeholders need to act to support the improvement of HBIC, and to ensure its value is maximised. Based on good practice witnessed through this research, the suggested role each stakeholder plays in this transformation is summarised in the table below.

Stakeholder	Recommendations
<p>National leadership</p>	<ul style="list-style-type: none"> ■ Outline a model of care in line with the suggestions in this paper and a clear path to operational transformation, allowing for an appropriate amount of local flexibility. ■ Encourage ICS leadership to think creatively about the role of HBIC in the future, including how HBIC is commissioned. ■ Ensure the value of HBIC is well-understood through effective communications work with system leaders. ■ KPI setting – local flexibility but centred around net value, rather than outdated metrics (e.g. hours of care delivered). ■ Targeted funding for HBIC transformation, with local flexibility on how it is used (e.g. building out the UCR function of an existing integrated team, short-term funding to support the dual running of services to enable the transformation work).

Stakeholder	Recommendations
<p>ICS leadership</p>	<ul style="list-style-type: none"> ■ Understand how transformation compares with other priorities in their system (through rigorous assessment and baselining), and whether <i>Increase, Improve or Integrate</i> is the first step. ■ Invest in required transformation, change management, and programme management support. ■ Review commissioning practices of HBIC and ensure that providers' priorities are aligned with maximising independence of population and support efficient delivery of HBIC. ■ Ensure operating model proactively prioritises HBIC capacity and avoid reactive measures (e.g. buying temporary beds). ■ Ensure the value of HBIC is well-understood through effective communications work with management and frontline staff. ■ Support the HBIC provider in their discussions with hospital managers, onward care managers, and other partners, to build relationships and develop effective SOPs to maximise use of HBIC where appropriate for both discharge and step-up or admission avoidance. ■ Ensure organisations and teams have a rigorous culture of continuous improvement.

Stakeholder	Recommendations
<p>HBIC provider</p>	<ul style="list-style-type: none"> ■ Have sight of operational priorities by measuring the correct operational KPIs. ■ Ensure operational managers are trained in interpreting and acting on evidence. ■ Maximise capacity of their service, through maximising utilisation and optimising length of stay. ■ Maximise demand for HBIC, through working closely with providers (as well as other measures, such as supporting reviews of historical cases to calculate the real potential demand). ■ Maximise effectiveness by taking on more complex cases, whilst ensuring their team is suitably empowered and trained to deal with such individuals, and by working with onward care to prioritise HBIC discharges so caseload does not get blocked with delays waiting for onward care. ■ Share learnings with other providers to understand new ways to overcome local blockers.

7. Appendix

7.1 Appendix 1: What is home-based intermediate care?

For the purposes of this paper, home-based intermediate care refers to any commissioned service or closely tied group of services operating within a health and care system that perform(s) all or most of the following functions:

- Goal-oriented interventions that focus on maximising independence/supporting retention of independence across all Care Act domains (see Appendix 5), to minimise reliance on further onward care.
- Rapid Response functionality within the community to avoid unnecessary hospital admissions (Urgent Community Response).
- Enable timely hospital discharge home.
- D2A capability, namely that an in-situ assessment takes place within the course of HBIC following discharge, for those individuals requiring (or who have the possibility of requiring) onward care.

The other marker of HBIC services referred to in this paper is the time-limited nature of the service delivery. Reablement has a widely recognised six-week funding limit, after which individuals must fund their own care, though this is rarely enforced. Indeed, the best reablement services in the country by value see their 'time on caseload' rarely exceed three weeks, on average. Interventions are relatively short, but hugely impactful for the individual. Interventions by other HBIC teams, also, are rarely long-term. In this way, the operational drivers of these teams (namely improving the condition of their caseload in a timely way) are not dissimilar to those within hospital teams and look quite different to long-term domiciliary or residential care.

7.2 Appendix 2: Further context to this paper

Home-based intermediate care has become a complex patchwork of services, typically split along practice lines, but often overlapping at various stages of an individual's journey. Each of these services usually have their own distinct intake criteria, role within their system and operational incentives. This setup can lead to non-ideal patient pathways and duplicated effort. ICSs are not currently able to get the most out of their HBIC services, as discussed in this paper, leading to worse outcomes for their population, greater operational strain and higher spend. HBIC services are often under-performing – for a variety of reasons – and could be adding more value to systems. Typically, they require operational, staffing and/or commissioning transformation to fulfil their potential.

Meanwhile, efforts to simplify and operationally improve home-based intermediate care services face severe challenges. On a local level, for example, operational pressures take time and energy away from frontline practitioners who want to improve their ways of working. Local- or system-level commissioning, too, when faced with severe operational pressures, often act in the interest of short-term pressure alleviation (e.g. commissioning short-term beds in response to acute occupancy pressures) rather than focusing on the long-term sustainability of the operating model in their area. Such measures are at the same time understandable and detrimental to the system's ability to deliver great outcomes for its population. For as long as systems prioritise short-term pressure alleviation, they forego the opportunity to bolster and improve their intermediate care functions, and thus the solutions are temporary, and the pressures will return.

National guidance on home-based intermediate care must tread a fine line. What works for one system may not work for another – one size does not fit all. Written at too high a level, national guidance can be overly generic, and not provide useful instruction to leaders faced with the overwhelming challenge of 'integration'. Detailed operational and reporting requirements, however, can be overly prescriptive and lead to systems commissioning services to meet specific national guidelines, without having a rigorous, cross-system process for commissioning the right services for their area.

7.3 Appendix 3: The future of home-based intermediate care


Multi-disciplinary working: Ideally in the same team or function to minimise communication gaps and enhance operational performance, practitioners across practice lines (nursing, PT, OT, reablement support workers etc) will work together, share insights and decision making.

Locality-centred: At a local level, these teams or functions will ideally be modelled to fit around groups of PCNs, and the teams will foster close working relationships with clinicians in their PCN to share risk management and enhance clinical decision making. Such a setup improves the local 'right-sizing' of teams, enables more effective interventions and maximises the independence of the local population.

Urgent Community Response: Rapid response to an escalation in need becomes a core function of these local teams. Staff delivering HBIC will provide rapid-response interventions either at the individual's home through direct referral from another practitioner (e.g. 111, paramedic, or GP) or at the hospital front-door to avoid an admission. In this way, home-based intermediate care teams will help reduce unnecessary or avoidable admissions and alleviate bed occupancy pressures in bedded care. This can be a core function of the HBIC service, and not (necessarily) require a specifically designated "UCR team"; operational performance will improve to the extent where schedules can be rapidly adapted to meet escalation requirements, though such an improvement will require significant enhancement to digital tools.

Community and ASC links: These teams will foster close working relationships with other community stakeholders, including care providers and voluntary sector teams, and be able to support referrals from them as well. The working relationships between these teams and social workers will be crucial (to ensure appropriate long-term support options are swiftly procured, and to reduce delays on discharge from HBIC), and may in some cases necessitate the inclusion of social workers into the HBIC teams themselves. If significantly more people go through HBIC, then there is likely to be a need for additional social work assessment capacity or a trusted assessor model. Both are likely to require investment.

Input from specialist practitioners: A small number of specialist functions remain at a system- or area-level (not at a locality-level), with the number of staff 'right-sized' to meet the requirements of the system or area e.g. Alzheimer's teams or nutritionists. There will be relatively few of these distinct function teams compared with systems today (given the move towards multi-disciplinary working), and a significant part of their role is to educate frontline HBIC teams and support them with individuals as required, as opposed to having their own separate intake pathway and caseload.



Single, clear D2A pathway: A digitally enabled ‘pull-model’ from the community will support rapid, timely discharge of patients from bedded care, to support them safely at home. Practitioners in bedded care will adapt their discharge methodology to enable discharge as soon as the individual can safely be supported at home, knowing that enhanced clinical and rehabilitative input can meet the individual’s needs after leaving hospital. Fast response times will be needed to achieve this. Care assessments will be performed in-situ alongside the HBIC intervention at home (See Community and ASC links). Most systems will require significant improvement in digital tools to enable this, as the rapid communication and coordination required will likely be very difficult to achieve in most systems today.

Commissioning of long-term care: Commissioning of long-term support is rapid on discharge from HBIC, leading to zero delays waiting for onward care. To achieve this, commissioning of onward care following an HBIC intervention will need to be prioritised above most other pathways.

Operational excellence: Aside from the multi-disciplinary skillset required by these teams, operational excellence will maximise their capacity to support their populations which, in turn, helps enable effective referral practices becoming embedded across the system, helping to alleviate bed occupancy pressure and reduce the demand for long-term care (see Section 5).

Service commissioning, clinical leadership, and operational accountability: Local operational KPIs will feed into a system-level operational accountability structure. Local, counter-productive operational incentives that feature in most systems today (e.g. to place an individual into long-term care to free up a bed) are thus minimised. Multi-disciplinary teams are supported by clear lines of operational accountability and clinical leadership, working in parallel to support operational and clinical excellence. Health and social care will collaborate more closely on service commissioning, and in many cases share joint commissioning responsibility for HBIC teams.

7.4 Appendix 4: The value of home-based intermediate care

Effective intermediate care at home can maximise an individual's independence (specifically, their independence against Care Act domains, see Appendix 5), which in turn reduces the likelihood that the individual will require long-term care, either domiciliary care or in a residential or nursing placement. Each individual is unique, and what's deemed the most ideal outcome for an individual differs by case, but generally independence is well-correlated with what the individual and practitioner consider 'ideal' for the individual (i.e. the greater the independence achieved, the more ideal the long-term outcome for that individual).

HBIC's Urgent Community Response (UCR) function service can help avoid admissions, by safely treating individuals in their own home, thus reducing the number of occupied bed days in an acute bed, freeing up that capacity for those who need it most. Similarly, high-performing D2A teams can 'pull' patients out of hospital days earlier than they might otherwise leave, safe in the knowledge that they are providing the right care in the right place for the individual: their home.

One way to think about the value of an effective HBIC service is to picture a scenario where those services did not exist:

- Admissions to acute hospitals would rise by 18%, and LoS would see a similar percentage increase; the resulting occupancy spike would see 30–40% more beds being required.
- The number of older adults requiring long-term support would increase by 61%, with a significant increase in admissions to nursing and residential homes.

HBIC's value extends to a real financial value that can be quantified, which presents itself as cost avoidance, either for acute bedded support or long-term care:

1. Reduced spend on long-term support through increased long-term independence
2. Reduced spend on acute bedded care through reduced admissions
3. Reduced spend on acute bedded care through reduced length of stay

7.4.1 Reduced spend on long-term support through increased long-term independence

One of HBIC's key roles is to safely reduce the long-term care needs of an individual through a short-term intervention. This leads to increased independence for the individual and a net reduction in spend. This is sometimes called the 'reablement' benefit. This term is used in this report to refer to increasing independence across both social care domains and health domains.

7.4.2 Reduced admissions into acute care

HBIC can reduce the number of admissions into acute care by responding quickly to escalations in the individual's home, or by reacting quickly to avoid admission at the hospital front door. Through these teams, individuals can get quick access to a range of health and social care professionals to meet their immediate needs, and plan for a period of rehabilitation or reablement (or other form of short-term support) and avoid the individual requiring a bed in an acute hospital. See Equation 2.

Value of reduced admissions into acute care	=	Admissions avoided through HBIC	x	Marginal cost of hospital bed night	x	Average length of stay
£/yr		#/yr		£/day		days/#

Equation 2: The value of reduced admissions into acute care

7.4.3 Reduced length of stay in acute care

Similarly, HBIC can ensure that individuals can be safely supported at home as soon as the acute care they require in hospital is over. Though operational difficulties exist on discharge from acute care, effective HBIC services with suitable capacity can be very effective in reducing the average length of stay in hospital wards. See Equation 3.

Value of reduced length of stay in acute care	=	Admissions into acute care	x	Marginal cost of hospital bed night	x	Reduction in length of stay
£/yr		#/yr		£/day		days/#

Equation 3: Value of reduced length of stay in acute care.

7.4.4 The net value of home-based intermediate care

These three 'value streams' sum together and into the total gross value of home-based intermediate care. The net value of HBIC services can therefore be calculated as the gross value of home-based intermediate care minus a system's spend on home-based intermediate care services, including their staffing costs, office spend, and other overheads. See Equation 4.

Net value of home-based intermediate care	=	Gross value of home-based intermediate care	-	All-up cost of HBIC
£/yr		£/yr		£/yr


Equation 4: *The net value of home-based intermediate care*

The average net value of HBIC services across England is £60.7 million per year per million population, though this varies significantly across England. Local understanding and ownership of these calculations, and therefore local understanding of the current (and potential) value of HBIC, is required from system leaders. The same can be said of the ROI models described in Appendix 6.

7.5 Appendix 5: Care Act domains

The Care Act domains are used for the purposes of this paper to define the scope of reablement services; HBIC services have a broader scope, involving elevated health and care needs.

- Washing (not bath or shower)
- Showering / Bathing
- Being appropriately dressed
- Mobility & being able to make use of the adult's home safely
- Toileting
- Maintaining a habitable home environment
- Developing and maintaining family or other personal relationships
- Making use of necessary facilities or services in the local community



Reablement services can measure the independence level of individuals against these domains, set target levels by each, monitor progress over time and adapt the intervention activities accordingly to maximise breadth, depth, and pace of progress. Independence level, as assessed by a reablement worker or other qualified practitioner, can fall on spectrum such as the following, in order of decreasing independence:


- Can achieve alone with no support or aids
- Can achieve alone with use of aid or equipment
- Can achieve with verbal guidance
- Can achieve with supervision and physical intervention if required
- Dependent on physical support to achieve objective

7.6 Appendix 6: Return on investment

On average, for every £1 of upfront investment in improving home-based intermediate care, the resulting benefit to the system amounts to £7-9/year once the operational benefits are fully realised. It can justifiably be seen as one of the highest-ROI investments that system leaders can make. Caution is advised when using this statistic, however, as the way in which these benefits are realised have some nuance and require careful interpretation when considering the returns an individual system can make.

Whilst the steps for moving towards integrated HBIC services outlined in Section 6 - A practical route to integrated home-based intermediate care - will not apply to all systems, this sequence will be a common route for many looking to improve outcomes for their population and reduce spend. In all three steps, however, investment is required in home-based intermediate care:

- **Programme costs:** Transformation on a system-level is very difficult. Each of the three steps (Increase, Improve, Integrate) entail significant logistical and change management challenges, and require significant investment in change management resource, learning and development, tools, technology and systems. In addition, transforming services often requires 'dual running' services. This is done to maintain quality of care delivery alongside a significant shift in resource, standard operating procedures, and/or management structure. This dual running involves a short period of increased staffing costs. Programme costs also include costs associated with consultation of staff, among other costs.

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- **Long-term costs:** To achieve many of the improvements laid out in this paper, systems will be required to increase spend in HBIC. This is mostly due to increased staffing spend, mostly during the 'Increase' phase (see 6.1 Increase). Improve and Integrate also bring associated increases in spend - investment in new technology to adopt efficient multi-disciplinary working practices, for example – though the increased staffing cost will be by far the largest increase. For most systems, however, this will not be an overall increase in *system spend*, but rather an increase in spend on home-based intermediate care and an associated reduction in spend on other forms of health and care (e.g. acute hospital settings), as staff can in many cases be moved from one area of the system into HBIC. Systems will differ in how much this increase and reduction in spend is balanced across health and social care. Determining this split and the fallout for budgets should be an area of priority for commissioners from health and adult social care prior to starting any major transformation efforts.

The benefits of these transformations take a significant amount of time to ramp up to full run-rate (typically about one year), during which time the investments outlined above will have to be made. There is therefore a short (one to three years) cash deficit associated with investment in home-based intermediate care, which can be noted and appropriately managed by commissioners at a system and national level.

The graphs below illustrate this picture for a typical system, starting the Increase phase at year zero, investing in the Improve phase 12 months later, and then Integrating their HBIC services 12 months after that. Figure 4 shows the times over which the benefits of the transformation come through (light purple and blue), contrasted with the more immediate programme investment that is required (dark purple) and the increased long-term costs in home-based intermediate care (green). Note that this long-term spend is almost entirely staffing, and therefore the *net increase in long-term staffing spend for the system is zero*, assuming the system can achieve these transformations by shifting staff from elsewhere in the system. Figure 5 demonstrates how this would affect the cash position of the system.



Benefits & Costs £/yr (Gross)

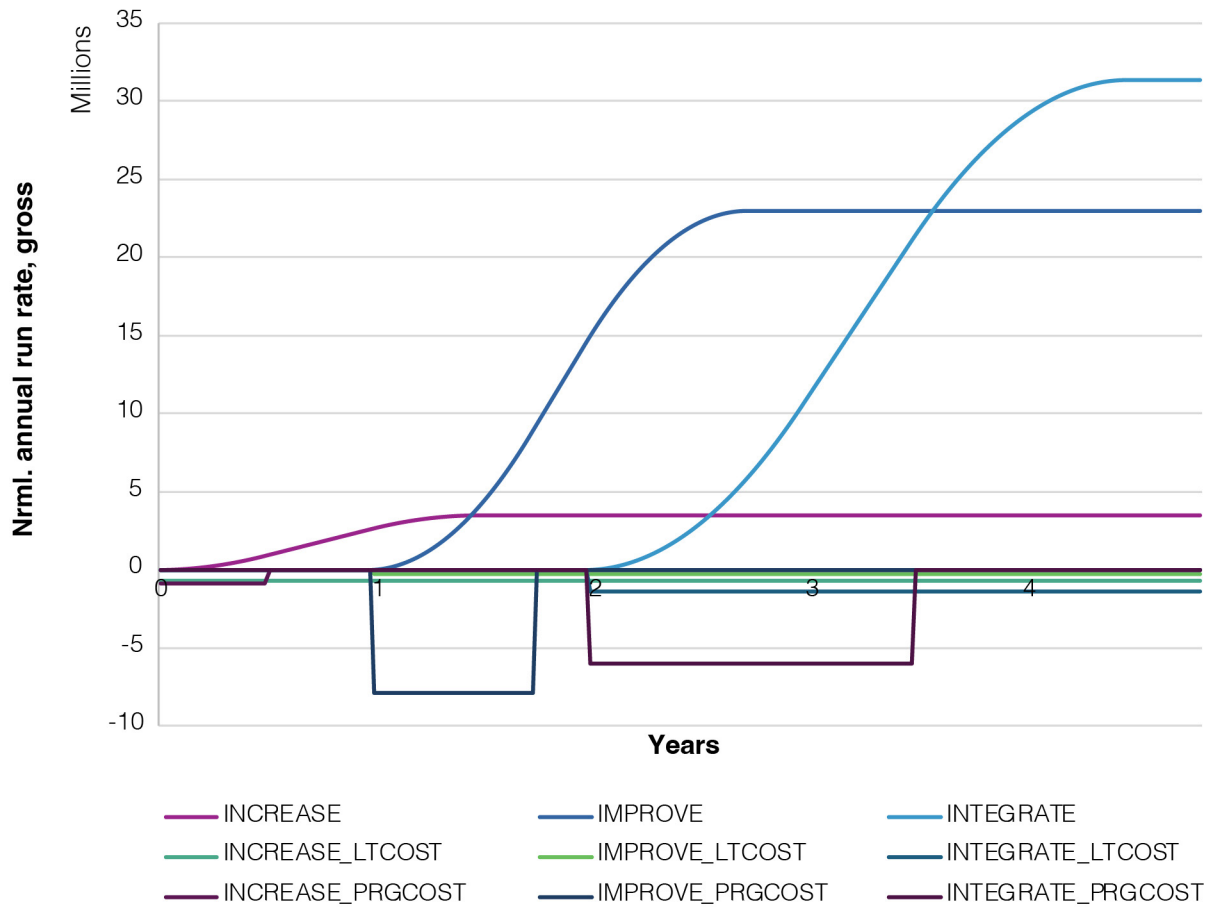


Figure 4: The annualised run rates of benefits and of cost when implementing the Increase, Improve, Integrate framework. Values used are for a typical system with a 65+ population of 250,000. Programme costs (short-term, often lasting considerably less than a year) are shown in dark purple and increased staffing spend in home-based intermediate care is shown in green. Note that the increased staffing spend in HBIC is net zero for the system, as there will be a compensatory reduction in staffing spend elsewhere in the system as staff are transferred across. The benefits of the programmes take time to roll through (light purple and blue). In this model, Increase starts at Year 0, Improve starts at Year 1, and Integrate starts at Year 2. The values used in this model are found in Table 2

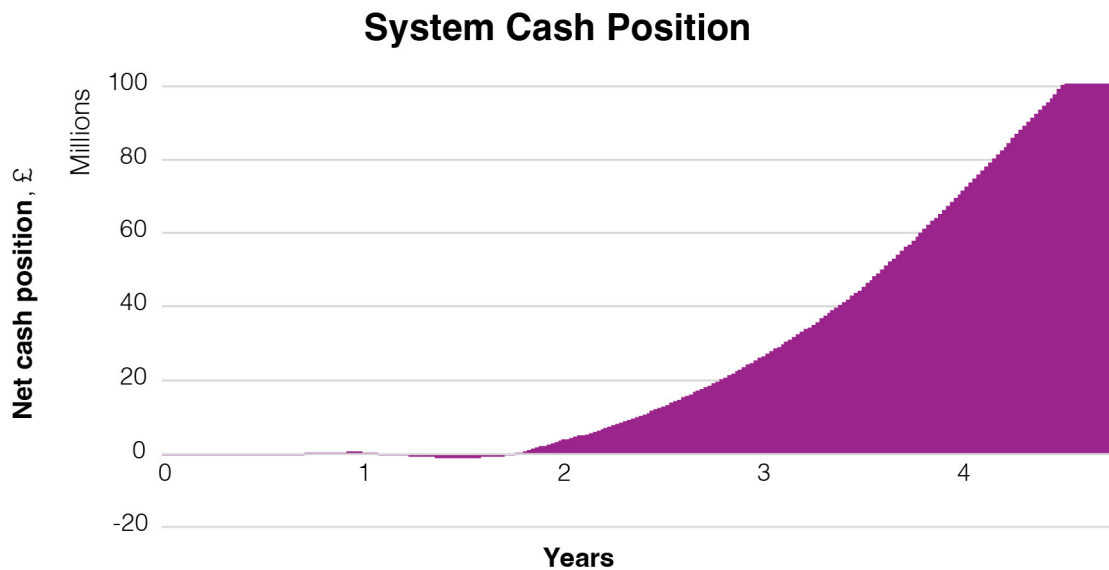


Figure 5: Health and social care system cash position against time (where zero is no change). Values used are for a typical system with a 65+ population of 250,000. As shown, there is a short period (typically between one and two years) in which the system is at an overall cash deficit compared to where it started, due to upfront programme costs. However, once the benefits ramp up, the cash position improves at a steady c. £44.4m/year per million population (using the timeline of transformations cited). Note that this model excludes the additional staffing costs in HBIC, as this is assumed to be netted off by a compensatory reduction in staffing spend in other areas of the system. The values used in this model are found in Table 1.

Values for benefits, long-term costs, and programme management costs used in these graphs are for a typical system with a 65+ population of 250,000, and can be seen in full in Table 1.

Transformation	One -off programme cost, £	Additional annual running cost, £/yr*	Annual system benefit, £/yr
Increase	462,733	687,488	3,437,442
Improve	5,939,785	292,183	22,954,806
Integrate	8,961,539	1,374,977	31,314,129

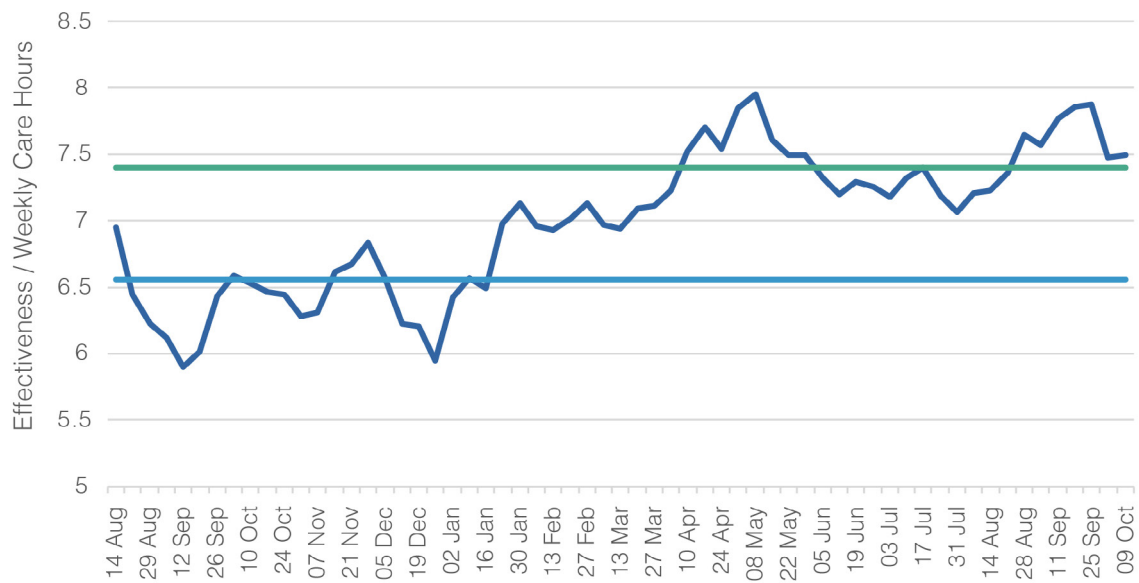
Table 1: Data used in Benefit, Cost and System Benefit graphs. Values used are interpolated values from representative transformations in systems across England.

7.7 Appendix 7: Data used in this report

Operational measures used in this report have, where indicated, been calculated from data held by Newton, a strategic delivery partner working extensively alongside health and social care systems to improve and innovate local services. Newton has worked with systems across England and, as part of diagnostic and implementation programmes, has developed extensive experience and data resources for use in such analysis. The data used in this report comes from 19 such systems, whose 65+ population amounts to 45% of the national 65+ population. Each of these systems have worked with Newton between 2018-2022. Where possible, averages have been calculated as weighted averages. Some caution with interpreting measures is advised, particularly when extrapolating to other systems not used as a reference system for this analysis, as local factors will drive significant variation between regions. Sources of other types of data (e.g. demographic or spend data) are fully referenced in the report itself.

7.8 Appendix 8: Example case study evidence

See below results for the first case study in Section 5.2.





The Better Care Fund was established in 2013 as one of the most ambitious programmes ever introduced across the NHS and local government to support local systems to successfully deliver the integration of health, social care and housing. It represents a unique collaboration between:

- The Department of Health and Social Care (DHSC)
- Department for Levelling Up, Housing and Communities (DLUHC)
- NHS England (NHSE)
- The Local Government Association (LGA)

The LGA has managed the BCF Support Programme since 2016. The 2023-25 BCF Support Programme is expanded and will be in place for the next two years. It brings together the unique expertise and experience of the LGA in partnership with ADASS and Newton Europe to create a stronger improvement partnership.

**Better Care Fund
Support Programme**

