# Preventive and proactive care: research report

**December 2024**

Better Care Fund
Support Programme

# Contents

# Executive summary

Local areas are investing in a wide range of preventive and proactive care initiatives, recognising the potential of these initiatives to support people to maintain independence, prevent, reduce, or delay care needs, and avoid unnecessary admissions to acute care and residential or nursing care. This research report compiles a snapshot of initiatives from all nine regional areas across England to understand what programmes local areas are undertaking, how successful they have been, evidence of effectiveness and impact, and challenges they have faced. The focus was on initiatives targeted at adults where the primary goal of the intervention is to prevent the escalation of health and care needs that could result in a demand for acute care, or larger and more complex packages of social care, including admission to a residential or nursing care setting. The sample of initiatives is not exhaustive but does give a sense of local priorities and key themes in prevention and proactive care, as well as opportunities to improve the evidence base.

**'...the primary goal of the intervention is to prevent the escalation of health and care needs that could result in a demand for acute care...'**

Evidence was gathered from existing resources, including the Better Care Exchange, and through a call for evidence. Below, key information on the evidence is summarised.

## Summary of initiative types

### Number of initiatives

**Total number of identified initiatives**

A total of 86 initiatives were identified and categorised into different types of preventive and proactive care, aligned with the Better Care Fund's (BCF) list of scheme types, expanded to include non-BCF funded activities.

### Scheme type prevalence (in descending order)

| | |
|---|---|
| **Prevention and early intervention** | 41 |
| **Community-based schemes** | 25 |
| **Home-based intermediate care services** | 14 |
| **Integrated care planning and navigation** | 13 |
| **Assistive technology** | 9 |
| **Home adaptation schemes** | 4 |
| **Workforce initiatives** | 4 |
| **Bed-based intermediate care services** | 3 |
| **Urgent community response** | 3 |

**Note:** It is important to note that some initiatives fall under multiple scheme types. As a result, the total number of initiatives under each scheme type does not sum up to the overall number of initiatives reviewed.

## Summary of initiative types

### Funding source

| | |
|---|---|
| **BCF** | 36% |
| **Non-BCF** | 34% |
| **Combined funding** | 8% (received both BCF and non-BCF funding) |
| **No available information about the funding source** | 22% |

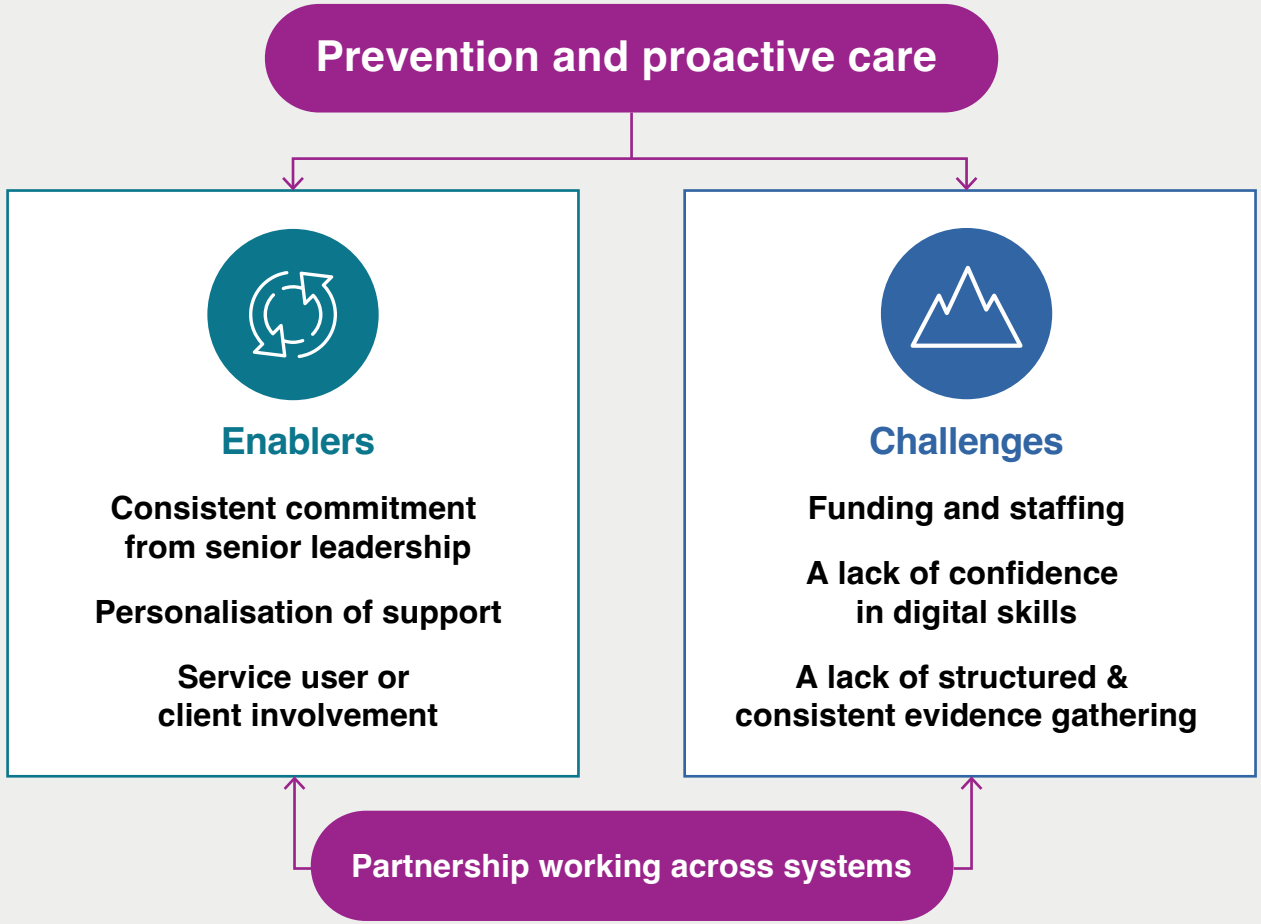
**Note:** Home-based intermediate care services scheme type received the highest average funding, reflecting large programmes, while workforce interventions received the lowest, mainly covering staff time and training materials.

The evidence base for preventive and proactive care interventions varied in type, quality, and quantity across initiatives due to their size and maturity. Most initiatives received strong feedback from service users, carers, and health and social care staff. However, it was less common to find initiatives that could systematically demonstrate financial or social returns on investment. The table below summarises the strength of evidence found through the desk-based review from sources such as the Better Care Exchange and the call for evidence for the impact of interventions by scheme type.

| Strength of evidence identified through a desk-based review and a call for evidence for the impact of interventions per scheme type | |
|---|---|
| **Prevention and early intervention** | Falls management has a well-established evidence base, showing a proven financial return on investment (ROI). Social prescribing has emerging evidence but lacks detailed ROI analysis and comparisons with control groups. Other interventions show varied evidence, with a less established evidence base overall. While these initiatives often project financial savings and receive positive feedback from users and professionals, such as in hydration-focused projects, overall comprehensive evidence is still limited. |
| **Community-based schemes** | Mixed evidence, with around 20 per cent of the initiatives reviewed having completed economic and impact evaluations that demonstrated cost-effectiveness and positive returns on investment. Primarily qualitative feedback, with more comprehensive evaluations expected in the future. |
| **Home adaptation schemes** | A wide evidence base for the impact of home adaptations, including positive estimates of return on investment, as well as positive impacts cited for individuals' wellbeing, independence and service use. However, there is limited evidence on the comparative effectiveness of different delivery approaches (for example, handyperson services compared to small grants). |

| Strength of evidence identified through a desk-based review and a call for evidence for the impact of interventions per scheme type | |
|---|---|
| **Assistive technology** | Improved quality of life and independence, mostly based on qualitative feedback and self-reported outcomes. Limited evidence on broader impacts and return on investment. |
| **Urgent community response** | There is strong evidence that these interventions can prevent unnecessary hospital admissions and reduce avoidable ambulance call-outs, supporting the development of cost-saving models based on average admission and call-out costs. However, data on the long-term outcomes of such interventions remains limited. |
| **Home-based intermediate care services** | Evidence varies, with some initiatives demonstrating cost-effectiveness. Most rely on qualitative feedback or preliminary data, with few formal evaluations. |
| **Bed-based intermediate care services** | Limited evidence is available, with little data on hospital (re)admissions. Further evaluation is needed. |
| **Integrated care planning and navigation** | Qualitative evidence shows a reduction in unplanned health events and improvements in wellbeing. Due to overlaps with other schemes, specific impacts are hard to attribute. |
| **Workforce initiatives** | Positive feedback from participants but limited formal evaluations exist to demonstrate broader health and care outcomes. |

Some factors were repeatedly cited as key enablers to success, while there were also recurring challenges. The graph below provides a visual representation of these factors and challenges.



**Key enablers:**

- Consistent commitment from senior leadership was vital when trying to develop and implement new approaches. This gave teams the support to pilot new approaches and revise them when needed, particularly when developing new relationships and ways of working from scratch.

- Partnership working across systems was essential. Preventive and proactive care initiatives often cross boundaries between primary care, secondary care, community care, social care, housing services and other areas. They also often require the public sector, voluntary, community and social enterprises (VCSE) organisations and the private or independent sector to collaborate closely. Where this works well, stakeholders come together around an agreed problem. Some of the most successful initiatives also use these relationships to access a range of funding streams to improve their capacity to deliver support.

- Personalisation of support was also a recurring feature. Strength-based approaches were often used to work with individuals to improve their wellbeing and quality of life while maintaining their independence. One of the key features of many community-based interventions was the development of personal relationships and trust with community members, which enabled staff to deal with sensitive issues and identify appropriate support.

- Service user or client involvement in designing services was widely praised. Co-design approaches shed light on what 'good' looks like for service users, what barriers initiatives need to address and how they can best be implemented. Many initiatives used a discovery phase to gather information and test ideas widely, and then they built programmes that addressed the specific needs of their local population.

**'One of the key features of many community-based interventions was the development of personal relationships and trust with community members...'**

**Challenges:**

Funding and staffing were the two most cited challenges. The general pressure on health and social care budgets means that, although local areas try to prioritise preventive and proactive care, this can be difficult to do in practice. Reserved pots of funding for piloting new approaches can help, and some services specifically highlight the role of BCF funding in enabling innovation. However, there is a risk that initiatives receive funding for a pilot phase but then struggle to secure a sustainable funding solution to expand or sustain the service after the pilot period is over.

Staffing was a challenge in two ways. First, existing staff might need new skills to adapt to new ways of working. Successful initiatives tended to invest in giving frontline staff the support and training needed to deliver new services or the same services in new ways. Second, recruitment and retention of staff can be difficult. Certain professions, such as occupational therapists, were particularly difficult to recruit for.

Partnership working across systems was not always easy, representing both a challenge and an enabler. For example, effective partnerships were often reliant on relationships among key personnel. If the lead from one part of the system left, the initiative would lose not only a member of the delivery team but also their champion within that organisation. In addition, some system partners take longer to be convinced of the value of a new intervention. In some cases, this was because impacts from prevention activities are slow to materialise or difficult to measure compared to some activity measures. This can impact service delivery, for example, because other services don't refer people to the new service or provide sufficient support. To overcome this, initiative leads need to clearly articulate what the service does, who it is for, and what the expected benefits are. They also need to reach out to relevant stakeholders to share that understanding and bring them along for the implementation journey.

A lack of confidence in digital skills was also a challenge for some initiatives. An increasing number of prevention and proactive care initiatives use digital tools, such as phone apps or assistive technology. Some service users, care staff, families and carers do not feel confident using these tools and may, therefore, be unable to adopt them or use them as intended. Initiatives sought to address this through specialised, user-friendly design, support to build skills and confidence, and adapting technology to meet user needs, such as sensory issues. In addition, initiatives also had to address practical issues, such as individuals lacking Wi-Fi or security concerns around managing the flow and storage of sensitive data.

Going forward, whilst the evidence base around preventive and proactive care interventions is growing, the extent and quality of evidence collected as part of this research has shown that there is a risk that opportunities to collect robust evidence are missed, existing evidence is not shared, and that there is limited in-house capacity and resources available to invest in evaluating evidence. Access to resources and support for robust programme evaluation can highlight initiatives with the potential to be scaled up and challenges and enablers that local areas should take into consideration when making planning decisions. The Better Care Exchange is a platform which already hosts a range of helpful resources and is accessible to a wide range of system partners. It can play a role in collecting and disseminating evidence on a more systematic basis.

**‘Access to resources and support for robust programme evaluation can highlight initiatives with the potential to be scaled up and challenges and enablers that local areas should take into consideration when making planning decisions’**

Finally, recommendations for the focus of future work include:

- Enabling local areas to effectively evaluate the impact of initiatives through resources and support. A particular focus should be on supporting the calculation of return on investment (ROI) where appropriate.
- Adopting a whole-system approach by developing infrastructure to support evaluation and evidence gathering, as well as encouraging local areas to systematically publish this evidence to spread good practice and scaling of preventive care across health and social care systems.
- Focusing on structural issues, such as staffing, senior leadership buy-in, and partnership working, to create a more integrated, system-wide approach to preventive and proactive care, ensuring that all components work in synergy to improve outcomes at scale.

We are very grateful to all the local areas who provided evidence to support this research and the BCF team for helping to facilitate this evidence gathering.

Section 1

# Introduction

Contents

# Section 1. **Introduction**

## Preventive and proactive care

Preventive and proactive care can play a vital role in improving overall health and wellbeing outcomes and mitigating the pressure on health and social care systems. Preventive initiatives can describe a wide range of interventions encompassing primary, secondary and tertiary prevention strategies. Proactive care aims to optimise health outcomes and patient experiences by actively managing individuals' health to delay the progression of existing conditions, maintain independent living and promote overall wellbeing (Institute for Work & Health, 2015; NHS England, 2023a).

Preventive and proactive care can help slow the onset of health deterioration, help individuals maintain independence, and reduce unplanned healthcare utilisation, the need for domiciliary care, or admission to residential or nursing care by mitigating avoidable declines in health. This project focuses on interventions where the primary goal is to prevent the escalation of health and care needs among adults that could result in a demand for acute care or larger and more complex packages of social care, including admission to a residential or nursing care setting.

**'...the primary goal is to prevent the escalation of health and care needs among adults that could result in a demand for acute care or larger and more complex packages of social care...'**

## Research aims

Alma Economics was commissioned by the Better Care Fund Support Programme to collect evidence from across England to understand what preventive and proactive care initiatives local areas across England have invested in and the extent to which these initiatives have been effective and cost-effective.

The aim of this work is to a) support wider work to gather evidence related to initiatives which enable people to stay well, safe and independent at home for longer and b) act as a source of peer learning for local areas, providing implementation, evaluation and economic information to facilitate local investment decision-making. To achieve this, the project sought to answer the following research questions:

- How are preventive and proactive care initiatives funded?
- Are there predominant scheme types for funded initiatives?
- What are the delivery mechanisms and processes of initiatives?
- What are the demographics of supported people?
- Are there any geographical patterns?
- How have initiatives demonstrated impact and quantified value for money?
- What challenges have delivery organisations faced?
- What are the lessons learnt that can be applied in the future?

The rest of this report outlines the methodological approach to this research, summarises background information about the evidence that was collected, and seeks to answer the questions above across a range of different types of initiatives.

## The health and social care context

Demand for health and social care services in England has increased as the population grows, and people live longer with more complex conditions. The capacity challenges facing both health and social care are well documented. In the year 2022-2023, 2 million people in England made new requests for adult social care support of whom 69 per cent were older people and 31 per cent belonged to the working-age population. 835,000 received publicly funded long-term social care, and 225,000 received short-term care to maximise independence (The Kings Fund, 2024). The provision of health and care services accounts for a large and increasing proportion of UK government spending. In 2022-2023, the UK spent 11.3 per cent of GDP on health compared to 9.9 per cent of GDP before the COVID-19 pandemic. There has been an increasing focus on the potential of prevention to mitigate some of the pressures faced by health and care systems.

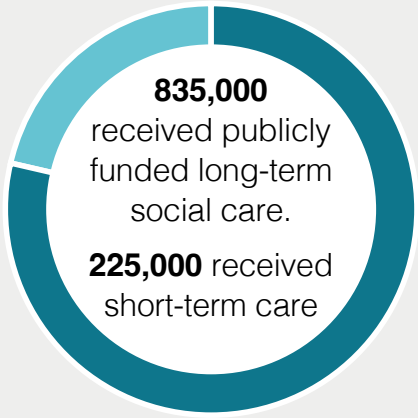
There are several sources of funding for preventive and proactive care initiatives in England. This includes the Better Care Fund (BCF), Public Health Grant, and funding through wider budgets for health and care managed by the NHS or councils. The majority of the evidence we reviewed concerned BCF-funded initiatives.

**2m**

In 2022-2023, 2 million people in England made new requests for adult social care support

**9.9%** Pandemic **11.3%**

**In 2022-2023, the UK spent 11.3 per cent of GDP on health compared to 9.9 per cent of GDP before the COVID-19 pandemic**



Section 2

# Methodology

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# Section 2. **Methodology**

This section summarises the approach taken to identify and review evidence relating to proactive and preventive care initiatives in England, using a desk-based evidence review and a call for evidence.

## Defining preventive and proactive care initiatives

For this research, we considered the following categories of initiatives:

1. **Prevention and early intervention schemes**. This includes social prescribing and risk stratification of local populations.
2. **Community-based schemes** such as anticipatory care initiatives.
3. **Home adaptation schemes**, including Disabled Facilities Grant (DFG) initiatives.
4. **Assistive technology**, including telecare and the provision of assistive equipment in the home or community.
5. **Urgent community response**

In addition, the following types of intervention are included in specific cases where one of the primary purposes was to avoid admissions to acute settings or residential care:

6. **Home-based intermediate care services**.
7. **Bed-based intermediate care service**.
8. **Integrated care planning and navigation**.

Finally, the following category was added to capture an emerging theme within the material we received from local areas during the project:

9. **Workforce initiatives** focused on giving staff across the health and care systems the skills to deliver proactive and preventive interventions.

A more detailed set of scheme types that were considered in scope is included as an annex to this report. This classification aligns with existing BCF classifications.

## How we pulled the information together

## Identifying and collecting evidence

We carried out an initial desk-based review. The review focused on (i) defining the types of initiatives in the scope of this project, and (ii) identifying publicly available information on local initiatives through exploring publicly available BCF documentation from local areas and assessing whether local areas routinely made other information about preventive and proactive care initiatives available online.

BCF planning templates are publicly available for local areas. We found that these could be used to track overall levels of spend through the BCF, but they did not contain the level of detail about individual interventions that was needed for this research. In addition, while some health and wellbeing boards (HWBs) do publish additional information about initiatives, this is not done consistently or systematically. For this reason, we focused on collecting evidence from the Better Care Exchange and through a call for evidence.

### Better Care Exchange (BCX) platform

To further develop the evidence base, the research team accessed the BCX platform, a social network for health and social care sector representatives. This platform facilitates the sharing of expertise related to integrated care and best practices. Through the BCX platform, we identified reports and documents on various prevention and proactive care initiatives across England, funded either by BCF alone or through a combination of BCF and other sources, such as the NHS and county councils. As most information shared on the BCX platform is not publicly available, the BCF team ensured that the authors of the evidence provided consent for its inclusion in the research.

To increase the relevance of material collected from BCX and the subsequent call for evidence, we only considered evidence from initiatives implemented since the launch of the BCF in 2015. We did not restrict our search to BCF projects only and considered evidence funded through any source if the intervention itself was in scope.

### Call for evidence

To address gaps in the existing literature and identify non-publicly available information, we conducted a call for evidence. This was shared with all HWB chairs and better care managers (BCMs). The call for evidence was also shared on the Association of Directors of Adult Social Services (ADASS) bulletin and the BCX Platform. The research team also attended meetings with BCMs and regional care and health improvement advisers to try to collect the widest possible range of information.

Our goal was to gather information while minimising participant burden. We requested only readily available information rather than commissioning new work. A total of 18 responses were received to the call for evidence.

## Development of Research Extraction Sheet

To ensure a comprehensive search process, we created a research extraction sheet (RES), which acted as a log of all collected evidence. The RES included: (i) details of each source, (ii) scheme type, (iii) the organisation(s) with oversight of the initiative, (iv) expenditure, (v) location and duration of implementation, (vi) the demographics of the supported people, (vii) the evaluation of the initiative in terms of effectiveness, return on investment (ROI) and the potential of replicating or scaling-up, (viii) quality scoring of the evidence, (ix) evidence-base utilised to inform investment decisions in initiatives, (x) identified barriers of the implementation, (xi) lessons learnt and, (xii) geographical patterns and differences.

## Analysis

After collecting information and developing the RES, the research team carried out a quantitative analysis of the evidence, providing descriptive statistics to present the breadth and variety of identified evidence. The evidence was then reviewed and summarised by scheme types, discussing specific examples of initiatives under each category.

We conducted a comprehensive review of all identified evidence without excluding any sources due to the quality of the evidence. However, to understand the quality of the data we identified, we applied Nesta's five-level standards of evidence framework (Puttick and Ludlow, 2013). This framework helps categorise the robustness of evidence, ranging from basic descriptive reasoning to rigorous, replicable evaluations. The levels are defined as follows:

| | |
|---|---|
| 1 | **Level 1:** Organisations can logically explain their initiative and why it matters, using a theory of change, existing resources, or subjective data from beneficiaries. However, this level does not yet provide measurable impact. |
| 2 | **Level 2:** Evidence shows positive change among those receiving the intervention, though it does not confirm causality. Common methods include pre- and post-surveys or cohort studies, which suggest an effect but do not directly attribute it to the intervention. |
| 3 | **Level 3:** At this level, evidence can demonstrate a causal relationship, typically using a control or comparison group. Rigorous methods, such as randomised control trials (RCTs), help isolate the initiative's impact, provided there is a sufficient sample size |
| 4 | **Level 4:** Evidence is validated by one or more independent evaluations, confirming the impact. It shows that the intervention can be delivered at a reasonable cost and is replicable across different locations, indicating scalability. Methods include replication studies and fidelity evaluations. |
| 5 | **Level 5:** This highest level of evidence indicates that the intervention can be consistently replicated and scaled, with detailed manuals and systems ensuring ongoing positive outcomes. Organisations must demonstrate that others can implement the initiative while maintaining its effectiveness and financial viability. |

### Summary of qualitative evidence

For each type of scheme, we outlined the intended outcomes, target demographics, funding amounts, and delivery costs. Following this, we provided a summary of the identified evidence of impact for each scheme, along with insights into the potential for scaling-up or replication, barriers and challenges encountered, and key lessons learnt.

Our assessment and discussion of the evidence of impact included all available data, not just those derived from quasi-experimental or causal econometric methods. Given the quality and nature of the data received, it was important to consider a broader range of evidence, such as self-reported outcomes, qualitative feedback, and other non-causal data sources. This inclusive approach enabled us to present a comprehensive view of the interventions' impact, even in cases where more rigorous methodologies, such as control group comparisons, were not identified.

**'Our assessment and discussion of the evidence of impact included all available data, not just those derived from quasi-experimental or causal econometric methods.'**

### Case studies

In addition to the broad review, we selected several case studies to provide in-depth examples of effective practices. The selection criteria for these case studies were twofold. Firstly, we chose initiatives that demonstrated high-quality evidence, ensuring that the examples provided were well-documented and robust. To be included, studies had to score a minimum of Level 2, which ensured that they showed at least some indicative change among participants. However, despite our broad review, none of the evidence identified reached above Level 3, reflecting limitations in the availability of robust, causal data. Secondly, we aimed to cover a diverse range of scheme types, illustrating the different approaches within preventive and proactive care.

## Challenges and limitations

The team encountered several challenges that posed difficulties for analysis. Evidence gaps within sources reflected the fact that, in most cases, we were reviewing existing documents which were not tailored to this project's research questions. Obtaining detailed funding information for initiatives was the most difficult. Many proactive and preventive care initiatives are funded through multiple sources, and there are differences in how some costs are captured (for example, core staffing costs were sometimes funded from a different budget than other costs). The complexity of funding streams made it challenging to compile accurate and complete financial data, affecting the ability to fully assess the financial aspects of these initiatives. Publicly available local BCF templates do provide some detail on spend, but these rarely cover individual initiatives in detail, as their purpose is to outline all BCF activity in an area.

Another challenge was limitations within the evaluations identified. For example:

- Some initiatives were recently established, and there was not enough data and evidence to draw firm conclusions about their impacts.
- Some initiatives had been implemented as a pilot and evaluated at the conclusion of the pilot with plans to scale up the service in future. However, information about the impact of the intervention at scale and any challenges or enablers relating to that was not available.
- Most evaluations covered a short period of time (often a pilot period or a year). However, they targeted outcomes that would materialise over longer time periods or are difficult to quantify, for example, individuals staying in their own homes for longer, or improved wellbeing relative to a counterfactual. This is also a challenge that was referenced by local areas themselves.

We focused on collecting evidence from the BCX and from submissions received through the call for evidence. There are likely to be other relevant initiatives being implemented in England that are not included in this report where there is little information in the public domain or on the BCX platform or because potential contributors were unaware of the call for evidence or lacked time to respond. However, this report's conclusions do align with other discussions of the evidence base in this area (**Social Care Institute for Excellence**, 2021).

Another challenge was classifying initiatives by type. The interdisciplinary nature of many initiatives, often delivered by multiple organisations and with multiple strands of effort, led to overlapping classifications. Many initiatives could reasonably fit under multiple scheme types. We recorded the scheme types listed by local areas in the research extraction sheet. This report includes details about individual initiatives under the most relevant scheme type based on the reviewers' judgment. However, this may not fully capture the nature of some initiatives.

Section 3

# Quantitative overview of evidence

Contents

# Section 3. **Quantitative overview of evidence**

This section summarises the features of the evidence reviewed, including sources of information, scheme types, funding sources, expenditure, and a regional breakdown of the identified initiatives.

## Source of evidence

We used a variety of sources to collect evidence for proactive and preventive care initiatives funded across England to ensure a comprehensive review. A detailed description of the methodology is presented in section two above. Most of the evidence was received from the call for evidence, and a significant minority came from the BCX platform. A small number were added through our initial desk-based evidence review or snowballing (tracing references in documents to identify additional relevant documents).

Table 1: **Number of identified initiatives per source of evidence**

| Source of evidence | Number of initiatives |
|---|---|
| BCX | 23 |
| Call for evidence | 60 |
| Other | 3 |

## Scheme type

Below, we provide a list of initiatives categorised by scheme type. It is important to note that some initiatives fall under multiple scheme types. As a result, the total number of initiatives under each scheme type does not sum up to the overall number of initiatives reviewed. The most common scheme type recorded by local areas was prevention and early intervention. 41 out of 86 initiatives we reviewed fell into this category. This was likely due to it being the broadest category of initiatives, covering a wide range of projects, including social prescribing, risk stratification and identification and support for individuals with lower levels of need. There was overlap with other scheme types for 15 of these initiatives, as well as broader links with population health and integrated care approaches. An accessible version of the data can be seen in Table 2.

Table 2: **Number of identified initiatives per scheme type**

| Scheme type | Number of initiatives |
|---|---|
| Prevention and early intervention | 41 |
| Community-based schemes | 25 |
| Home adaptation schemes | 4 |
| Assistive technology | 9 |
| Urgent community response | 3 |
| Home-based intermediate care services | 14 |
| Bed-based intermediate care services | 3 |
| Integrated care planning and navigation | 13 |
| Workforce initiatives | 4 |

## Funding and expenditure

Funding was categorised into three main types: (i) BCF, (ii) non-BCF, and (iii) combined. The number of initiatives in each category is outlined below. Information was available for 67 out of 86 initiatives. An accessible version of the data can be seen in Table 3.

**41/86**

41 out of 86 of most common scheme was **prevention and early intervention**

Table 3: **Number of identified initiatives per funding source**

| Source of evidence | Number of initiatives |
|---|---|
| BCF | 31 |
| Non-BCF | 29 |
| Combined | 7 |
| Not available | 19 |

The average budget by scheme type is presented below. Data covering the amount of funding per initiative was only available for 35 initiatives. For instance, no detailed funding data was available for the home adaptation scheme reviewed, and in some cases, it was not clear if budgets included all costs of the scheme or only some elements, for example, staffing. The costs of initiatives that fall under multiple scheme types are accounted for in each relevant scheme. As a result, the cost averages below reflect these repeated allocations. An accessible version of the data can be seen in Table 4.

Table 4: **Average cost of initiatives per year by scheme type**

| Scheme type | Average cost per year |
|---|---|
| Prevention and early intervention | £542,000 |
| Community-based schemes | £568,000 |
| Home adaptation schemes | N/A |
| Assistive technology | £1,138,000 |
| Urgent community response | £265,000 |
| Home-based intermediate care services | £3,145,000 |
| Bed-based intermediate care services | £865,000 |
| Integrated care planning and navigation | £909,000 |
| Workforce initiatives | £116,000 |

Initiatives ranged from small-scale training or pilots costing a few thousand pounds to extensive service provision spanning multiple years and covering large geographical areas. The highest average cost is for home-based intermediate care services. This reflects a few very large programmes covering the entire reablement service offered in an area. The lowest average was for workforce interventions, which largely consisted of a small amount of staff time and the preparation and delivery of training materials.

## Regional breakdown

The regional breakdown of initiatives is presented below. Some initiatives were implemented in multiple regions, which is why the number of initiatives per region does not add up to the total number of unique initiatives. An accessible version of the data is available in Table 5.

Table 5: **Regional breakdown of initiatives (in descending order)**

| Regions | Number of initiatives per region |
|---|---|
| East of England | 20 |
| Greater London | 18 |
| South East | 16 |
| North West | 9 |
| East Midlands | 7 |
| North East | 7 |
| West Midlands | 7 |
| South West | 6 |
| Yorkshire and the Humber | 2 |

Section 4

# Analysis by scheme type

Contents

# Section 4. **Analysis by scheme type**

## 1 Prevention and early intervention

Initiatives in this area targeted the promotion of health and wellbeing and improved quality of life. Alongside this, local areas also had clearly articulated aims of how these initiatives would relieve pressures in other areas of the system and generate financial savings through (i) reducing the utilisation of primary and secondary health care and social care by providing alternative pathways to seeking support quickly and (ii) addressing the drivers of long-term health and care utilisation through reducing, delaying or preventing the escalation of need.

| Overview of Prevention and early intervention | |
|---|---|
| **Intended outcomes** | Diversity of outcomes between different programmes. High-level focus on reducing healthcare utilisation and reaching a greater number of higher-risk groups. |
| **Target demographics** | Adults at risk of developing health and social care needs. Adults with existing health and social care needs. Older adults.<br>**Core20plus5** groups – this refers to the most deprived 20 per cent of the population, identified by the Index of Multiple Deprivation. This also includes priority groups identified at the local level. The five clinical priorities are maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis, and hypertension. |
| **Funding/delivery costs** | The average annual budget for these initiatives was £542,000 per annum. |

| Summary of evidence | |
|---|---|
| **Evidence of impact** | Falls management is the area with the most well-developed existing evidence base and the initiatives we reviewed cited that evidence base. For example, research by Public Health England, based on evidence from a randomised controlled trial, estimated that the financial return on investment on falls management exercise (FaME) interventions is £0.99 for every £1 spent. This is due to cost savings in primary and secondary healthcare, as well as social care. The societal return on investment, which takes into account the impact on the quality of life for participants, is £2.28 for every £1 spent (Public Health England, 2018). Some initiatives identified through this research are currently undergoing evaluation. Once completed, these evaluations – some of which are also referenced below – will offer more detailed insights into how to implement FaME programmes to maximise the benefits of their delivery.<br><br>Social prescribing has emerging and increasing evidence to demonstrate impact. The national evidence base for social prescribing is improving, including improvements in both qualitative data on service usage and quantitative data on impact (National Academy for Social Prescribing, 2023). In the initiatives we reviewed, there was evidence of service user satisfaction and self-reported improvements in wellbeing (for example, in the Green Social Prescribing example from Surrey) and some evidence of reduced healthcare utilisation in limited case studies from the use of the Joy app in Wokingham, but there was no evidence demonstrating detailed returns on investment or comparing outcomes to a control group.<br><br>Other interventions were less homogenous, were harder to group together, and had a less well-developed evidence base. However, initiatives did demonstrate clear theoretical routes to financial savings (though the impact was not yet evidenced) as well as positive feedback from professionals and individuals. For instance, hydration-focused projects (such as the North Somerset pilot project in 2021) have a clear route to financial savings through improved health, leading to reduced admissions and length of stay in acute care and lower utilisation of other health services, including General Practice. |

| Summary of evidence | |
|---|---|
| **Evidence to support scaling-up or replication** | For falls prevention and social prescribing, there are existing toolkits to support local areas to put programmes in place, such as the Falls Management Exercise (FaME) toolkit (NIHR, 2024a) or the Green Social Prescribing Toolkit (NHS England, 2023b). |
| **Barriers and challenges** | Barriers and challenges identified included persuading clinical partners to invest time and resources in prevention activities (where impacts may be longer term and difficult to measure) when they have short-term priorities and need to demonstrate savings quickly.<br><br>Another common challenge was recruiting and retaining the right number of skilled staff to meet demand. For instance, Postural Stability Instructors who run FaME courses need to complete a 3-month training qualification, so it is difficult to quickly replace any staff leavers.<br><br>One challenge specifically faced by local areas implementing social prescribing initiatives was the capacity within the voluntary and community sectors to take higher numbers of referrals. A further challenge is the level of need of individuals being directed to social prescribing services. It is more difficult and more resource-intensive to handle referrals for individuals with complex needs who may need multiple onward referrals. |
| **Lessons learnt** | For FaME interventions, local areas found that this works best as part of a wider falls prevention, rehabilitation and exercise pathway that meets the needs of older people at risk. This could include suitable home adaptations and other support.<br><br>For social prescribing, building a network of relationships that underpin the flow of referrals was key. Where joint working is strong, social prescribing can play an effective role in guiding individuals to the best resources for their needs, rather than what happens to be funded by a single organisation. Social prescribing needs to be part of a broader strategic conversation about the range of community provision that is available. |

## Selected examples

### Falls prevention

| **Steady Steps** Leicestershire, Leicester and Rutland | | | | | |
|---|---|---|---|---|---|
| **Timeframe** | **Description of service** | **Target Demographic** | **Target Outcomes** | **Reported outcomes** | **Funding** |
| Ongoing (since 2017) | 24-week falls management exercise (FaME) based programme. Classes delivered by postural stability instructors, including exercises for flexibility, strength, endurance, flexibility and gait skills. The classes take place in a range of community settings, with around 14 participants in each cohort. | Older adults at risk of falling | Support eligible adults aged 65 and over to improve their mobility and strength, to prevent or reduce the frequency of falls. | The initial implementation study fed into the development of FaME toolkit (NIHR, 2024a).<br>Local evaluation by physical activity officers has shown the following outcomes for participants: higher confidence, improved functional strength and mobility, reported decrease in falls, reported decrease in falls leading to injury, increase in activity levels. No additional information on the methodology used for the local evaluation was found.<br>External academic evaluation underway (NIHR, 2024b). | Combined (BCF and Public Health grants)<br>£253,000 per annum |

| **Strength and Balance programme** Lincolnshire | | | | | |
|---|---|---|---|---|---|
| **Timeframe** | **Description of service** | **Target Demographic** | **Target Outcomes** | **Reported outcomes** | **Funding** |
| 2-year pilot (2023-2025) | 24-week falls management exercise (FaME) programme – same model as above | Older adults at risk of falling | Support eligible adults aged 65 and over to improve their mobility and strength, to prevent or reduce the frequency of falls. | Formative process evaluation underway (NIHR, 2024c). | Non-BCF (Public Health Grants) £170,000 per annum |

| **FaME exercise classes** Torbay and South Devon | | | | | |
|---|---|---|---|---|---|
| **Timeframe** | **Description of service** | **Target Demographic** | **Target Outcomes** | **Reported outcomes** | **Funding** |
| Ongoing (since 2005) | 24-week falls management exercise (FaME) programme – same model as above | Older adults at risk of falling | Support eligible adults aged 65 and over to improve their mobility and strength to prevent or reduce the frequency of falls. | External academic evaluation underway (NIHR, 2024b). | Combined (Initial BCF funding post-pandemic and ICB funding) £120,000 per annum |

| **Proactive Intervention (Innovation in Falls Prevention)** Norfolk |
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| See case study on page 40 |

## Social prescribing

| **Enhanced Care Navigation** Wandsworth | | | | | |
|---|---|---|---|---|---|
| **Timeframe** | **Description of service** | **Target Demographic** | **Target Outcomes** | **Reported outcomes** | **Funding** |
| Ongoing (began in 2020 and funded until March 2026) | A variation to Wandsworth Council's pre-existing social prescribing contract to provide a pathway to social prescribing for those who could not or would not access it through their GP service. Service is integrated with other Wandsworth Council adult social care engagement activities. It employs 1.8 full-time equivalent link workers and sees between 450 and 500 clients a year. | Local residents | Tackle health inequalities.<br>Prevent, reduce and delay the need for health and care services.<br>Improve integration between health and care services.<br>Build strength and capacity of voluntary and community sector. | No return on investment has been calculated.<br>The intervention is seen as a key contributor to the wider council approach to "meeting residents' needs at the Front Door" through information, advice and support. In 2022/23, 82 per cent of residents who approached Adult Social Care services had their needs met at the Front Door (target of 72 per cent). | Non-BCF<br>Circa £100,000 per annum |

| **Social Prescribing – linking with primary care** Bedfordshire | | | | | |
|---|---|---|---|---|---|
| **Timeframe** | **Description of service** | **Target Demographic** | **Target Outcomes** | **Reported outcomes** | **Funding** |
| Ongoing (since 2018) | The project enables GPs, nurses and other primary care professionals to refer people via social prescribing to a range of local, community-based, non-clinical services via community wellbeing champions. | Adults contacting GP/health care professional for a social problem | Supporting people in accessing local voluntary and other services.<br>Improve participants' health, confidence and independence. | Rolled out to additional GP practices over time. No further impact metrics are available in the material reviewed. | Combined (BCF, council, NHS and local VCSE organisations)<br>Total funding amount not available. |

| **Joy** Wokingham | | | | | |
|---|---|---|---|---|---|
| **Timeframe** | **Description of service** | **Target Demographic** | **Target Outcomes** | **Reported outcomes** | **Funding** |
| Ongoing | A social prescription app ('Joy') that enables health and social care professionals to link clients to local services. It can improve the experience of individuals with social care needs, enhance their confidence, and facilitate the launching of new social health initiatives. While this app is used in multiple local areas, the evidence available was from Wokingham. The Wokingham Integrated Partnership use the app to link up over 130 local services to enable easier access. The app is now also being used to send text messages to people as reminders for health checks and to update GP records. | Joy is used by social workers, the voluntary sector, acute hospitals, police, GPs, community nursing, library staff, fire fighters, health coaches, social prescribers, community navigators, people in the community. | Improving health and wellbeing.<br>Reducing the need for statutory care support. Enhancing service access and utilisation.<br>Improving integrated partnerships working across health, care and VCSE and other organisations. | For individuals who used the social prescribing app in Wokingham, there was a reported 23 per cent decrease in GP appointments, and 71 per cent saw improvements in wellbeing. More details on the methodology used are not available.<br>The partnership also expects the social prescribing programme to lead to fewer avoidable admissions and fewer GP appointments for non-clinical reasons. | A combination of BCF, public health, adult social care<br>Total funding amount not available. |

| **Green Social Prescribing(GSP)** Surrey | | | | | |
|---|---|---|---|---|---|
| **Timeframe** | **Description of service** | **Target Demographic** | **Target Outcomes** | **Reported outcomes** | **Funding** |
| 2-year pilot programme completed in 2023 | Set out to test how to embed green social prescribing into communities, which focuses on using nature and 'green spaces' in improving the mental health and wellbeing of communities in Surrey. Led by a partnership between the county council and ICB and working with the wider cross-sector Green Health and Wellbeing Network. Some funding also provided to VCSE organisations to develop new nature-based health and wellbeing provision. 400 people engaged in Green Social Prescribing activities with 30+ delivery partners. | Surrey-wide with a particular focus on **Core20plus5** populations | Improve mental health outcomes.<br>Reduce health inequalities.<br>Reduce demand on the health and social care system.<br>Develop best practice in making green activities more resilient and accessible. | Forms part of the national evaluation of Green Social Prescribing 'test and learn' sites. Interim findings from the national evaluation indicated that over 8,500 people were referred to a green social prescribing activity between April 2021 and March 2023. Positive improvements in mental health and wellbeing were reported, particularly in communities experiencing high levels of social inequalities that impact health and wellbeing. Lessons learned were incorporated into the Green Social Prescribing toolkit. The final evaluation has yet to be published (NASP, n.d.; NHS England, 2023b).<br>In surveys of Surrey residents during the 2-year 'test and learn' approach, participants reported improved connectedness to nature, greater happiness, higher life satisfaction, and reduced anxiety. Professionals also provided positive feedback on the impact of GSP on participants' mental health. | Non-BCF (initial funding from DEFRA with some match funding from the local area)<br>Total funding amount not available. |

## Other

| **Improving hydration for care home residents** North Somerset | | | | | |
|---|---|---|---|---|---|
| **Timeframe** | **Description of service** | **Target Demographic** | **Target Outcomes** | **Reported outcomes** | **Funding** |
| Pilot undertaken in 2021. | A team of health, social care, the private and voluntary sector representatives in North Somerset carried out a discovery phase with residents to develop an understanding of what people wanted and then developed a prototype app to support carers to track and maintain hydration. | Adults living in residential or nursing care homes. | Reduce dehydration, which can increase the risk of other problems such as urinary tract infections (UTIs), pressure sores and confusion.<br>Reduced health care utilisation by care home residents. | The North Somerset initiative has forecasted benefits of over £3m over ten years. This is based on £3.3m from the reduction of UTIs in residents leading to fewer/ shorter hospital stays and £900,000 from reduced utilisation of GPs and ambulances.<br>Evidence from projects aimed at improving hydration for care home residents in Torbay, South Devon and Hampshire is promising. A hydration awareness project in Torbay and South Devon cut UTIs requiring antibiotics by 18.5 per cent, eliminated hospital treatments for UTIs, and reduced falls resulting in hospital admissions by 63.6 per cent.<br>In 2018-19, Hampshire County Council and Wessex Academic Health Science Network worked on improving hydration in 17 care homes. Quantitative data showed a minor reduction in falls and related injuries. Qualitative feedback indicated improved wellbeing and hydration awareness among staff, residents, and family members (Hampshire County Council et al., 2020; NHS England, 2023c). | Non-BCF (funded by NHS Digital)<br>£85,000 |

| **Making it Happen** East Sussex |
|---|
| See case study on page 42 |

## **Case study:** Proactive Intervention (Innovation in Falls Prevention) – Norfolk County Council

### Summary

Norfolk County Council's falls prevention scheme supports residents in Norfolk to live independently at home for as long as possible. The scheme aims to prevent, reduce, and delay the need for long-term care services by taking a proactive approach to health and wellbeing. It does so by collaborating with local partners, using shared data, leveraging digital technology and artificial intelligence to predict older adults who are at greater risk of falls, and offering them proactive interventions.

The scheme was conceptualised through Norfolk County Council's 'Connecting Communities' transformation programme, and, after 12 months of preparation, the pilot commenced in February 2023.

### Delivery

To identify those in need of proactive support, the council's adult social care service first built a secure digital platform that integrated data from multiple systems – including social care, housing, and council tax records – in partnership with district councils. This platform created a single, holistic profile for each resident by employing Natural Language Processing (NLP). NLP is a branch of AI that analyses large volumes of unstructured text data – such as practitioner care notes – to extract relevant information about a resident's health, living conditions, and needs. This analysis helps predict which residents are at the greatest risk of falls and would benefit most from proactive support.

Each resident identified by the platform is offered the scheme's proactive intervention through three stages: (i) initial outreach by the ProtectNow NHS team/ South Norfolk Help Hub; (ii) bespoke intervention referral based on their individual needs and priorities, such as environmental adjustments, mobility and keeping active, social isolation and local groups, financial services, or health services, and (iii) two follow-ups from the ProtectNow NHS team/ South Norfolk Help Hub to support referral uptake and gather feedback on intervention impact.

### Impact

Since February 2023, when the pilot began, over 1,300 Norfolk residents have been contacted as a result of the scheme, and it is expected that 11,000 more will be contacted in the next two years. Of those contacted, 77 per cent responded to the initial call. Of these, 52 per cent then agreed to have a holistic conversation with the ProtectNow NHS team/ South Norfolk Health Hub about proactive interventions, with a 42 per cent uptake of onward referrals.

## **Case study:** Proactive Intervention (Innovation in Falls Prevention) – Norfolk County Council (continued)

The scheme has seen a promising reduction in the number of people having serious falls following the uptake of onward referrals. At the start of the pilot, the team developed an internal dashboard recording falls over time, the average weekly rate of care for individuals in the control pilot group (no interventions) and pilot group (interventions), and residential starts for each group. After 12 months of implementation, the scheme saw a £175 per week reduction in individual social care costs for residents who received the intervention compared to the control group, and all supported residents reported no recent falls following the intervention. The scheme has received positive feedback from beneficiaries, with 71 per cent agreeing that the support was beneficial and 53 per cent continuing with their recommended changes.

Moreover, of those who received interventions as part of this scheme, outcomes included a reduction in fractures from 4.2 per cent to 0.5 per cent, and a 15 per cent reduction in residents fearing the impact of a fall. Assuming that the decrease in fracture rates (from 4.2 per cent to 0.5 per cent) remains constant, this equates to annualised cost savings of £76,000 per year if 20 per cent of those with fractures received hospital care (assuming that, on average, a hospitalised fall results in £3,358 additional care costs per annum).

**Challenges and lessons learnt**

A number of lessons learnt have emerged from the scheme's pilot phase, informed by its ongoing implementation and resident feedback. These include:

- Referrals are most successful when tailored to residents' priorities and interests, alongside their immediate needs. In practice, this means that initial outreach should follow a fluid, flexible approach which enables residents to talk conversationally (as opposed to following scripted questions).
- The scheme has taught the council important lessons about using AI to support health outcomes, including legal, cultural, and ethical considerations, as well as information governance.

Given the initial success of the pilot, Norfolk County Council is looking to increase collaboration with local partners – including district councils and health services – to capture more data. They are also investigating how the proactive intervention approach could be applied to improve health outcomes beyond falls prevention, such as to reduce social isolation.

## **Case study:** Making it Happen – East Sussex County Council

### Summary

The Making it Happen (MiH) initiative, run by the East Sussex County Council public health department, follows an asset-based community development (ABCD) approach[1] to strengthen and support local community capacity for collective action. Launched in 2019 and running until March 2025, MiH aims to improve wellbeing and reduce health inequalities across East Sussex, specifically targeting neighbourhoods with higher levels of deprivation.

### Delivery

MiH is delivered through a strategic partnership led by the Sussex Community Development Association in collaboration with five local VCSE organisations, 3VA, Action in Rural Sussex, Hastings Voluntary Action, and Rother Voluntary Action. MiH is supported by community development workers (CDWs) who work in the five districts where the programme operates and engage with people in their local environments, such as community centres and schools. They listen to community members' hopes and ideas, encouraging connections and supporting collaborative efforts for positive change. CDWs focus on connecting people to existing positive initiatives rather than addressing only problems and needs.

Workers build trust and relationships, encouraging people to share their passions and priorities. 'Pop up' events in various neighbourhoods and 'Neighbourhood Sparks' events in locations like Peacehaven and Bexhill allow residents to map local positives, share ideas, and make decisions on community project funding. 'Community, Connection and Cake!' is a network for those interested in community-centred approaches, providing opportunities to connect and celebrate local achievements. Feedback from residents highlights the positive impact of community involvement on their lives, such as the emotional and practical support found in social clubs like the **Crochet Club** in Hailsham. MiH also provides **grants** to support people in communities to run their activities or projects, either helping them get the equipment or even start a book club.

1 According to Nurture Development Organisation, "Asset Based Community Development builds on the assets that are found in the community and mobilises individuals, associations, and institutions to come together to realise and develop their strengths. […] From the start an Asset Based approach spends time identifying the assets of individuals, associations and institutions that form the community. The identified assets from an individual are matched with people or groups who have an interest in or need for those strengths. The key is beginning to use what is already in the community. Then to work together to build on the identified assets of all involved."

## **Case study:** Making it Happen – East Sussex County Council (continued)

### Impact

To evaluate the scheme, various evidence collection methods were employed including: (i) story collection, grant reviews, (ii) community surveys, (iii) stakeholder surveys, and (iv) stakeholder focus groups (Care et al., 2024).

MiH is effectively supporting people to make connections, initiate projects and activities, feel more confident in their local place and bring local community assets into use. Since October 2022, MiH has facilitated over 2,000 meaningful connections. These connections, defined as significant interactions that result in learning or substantial change, are distributed as follows: 28 per cent with individuals, 31 per cent with local community groups, 30 per cent with government, business or voluntary sector assets, and the remainder with local physical assets like parks or public spaces, networks, faith organisations, or assets related to heritage and culture. Most observed changes were at the personal level of those accessing MiH, including increased self-confidence, self-esteem, lifestyle changes, and self-reported improvements in physical and mental wellbeing, along with the development of new skills and capabilities.

There is some evidence that ABCD approaches lead to a positive social return on investment. For instance, an SROI pilot feasibility study conducted for the Leeds ABCD Evaluation estimated a value range of £5.27-£14.02 for every £1 invested in more established sites (Woodward, 2021). However, more evidence is needed.

### Challenges and lessons learnt

Several key lessons also emerged from the MiH initiative, as highlighted in the responses to the call for evidence:

- MiH projects are bringing unused or underused local assets back into use, but access to physical spaces remains a significant frustration for participants. Some anecdotal evidence suggests that people feel less need to engage with statutory services like GPs, as they find support within the community instead.
- The diverse range of activities in the MiH programme shows that people have lots of ideas and passions for making positive changes in their communities. The MiH structure and approach are key in nurturing, exploring, and developing these ideas. Getting involved in one activity often leads to participating in others, creating a 'web effect' of community engagement.

## **Case study:** Making it Happen – East Sussex County Council (continued)

- Though improvements in social capital are more noticeable within the same groups than across different demographics, the most effective activities intentionally aim for diversification. Connections are not just more numerous but also deeper and more collaborative, leading people to work and learn together rather than just side by side.
- CDWs play a crucial and highly valued role. Their ability to allow failure and focus on learning fosters natural, relational community support, helping communities learn from setbacks without being discouraged.
- The ABCD approach gives people an active role in deciding on their activities. This involvement helps build residents' confidence to participate more broadly in the future. The peer-to-peer aspect of many activities allows people to use their lived experiences to shape how services are delivered.
- There are a few examples of collaborative relationships with local councillors and authorities, but navigating formal service structures remains challenging, even with CDW support. Strategic stakeholders who have interacted with MiH generally have positive experiences, but these interactions often benefit from MiH's community connections and knowledge without fostering true collaboration.

The Making it Happen initiative exemplifies the power of an ABCD approach in fostering community resilience and improving wellbeing. By investing in local assets and facilitating meaningful connections, MiH not only addresses immediate needs but also builds a foundation for sustainable community-led development. As the programme continues and evaluations progress, its successes and lessons will offer valuable insights for similar initiatives nationwide.

# 2 Community-based schemes

Community-based schemes aim to support individuals in living independently and thriving in their community. The initiatives in this scheme type focus on connecting people to essential services, activities, organisations and other community members, fostering a sense of belonging, a support network and community integration.

| Overview of Community-based schemes | |
|---|---|
| **Intended outcomes** | To live independently and thrive in the community. |
| **Target demographics** | Residents of specific local areas (for example, Hackney, Camden). Older people. Other vulnerable populations, such as patients recently discharged from hospital, people with complex needs, minoritised groups, or people at risk of homelessness. |
| **Funding amount and delivery costs** | Detailed spending information available for 12 initiatives. The average annual budget for these initiatives was £568,000. |

| Summary of evidence | |
|---|---|
| **Evidence of impact** | Out of the 25 schemes identified, five had undergone impact and/or economic evaluations, while eight were undergoing or planned for future evaluations at the time of the Call for Evidence. The initiatives that had completed evaluations demonstrated cost-effectiveness. For example, the Hospice in your Care Home (Case study) had an estimated return on investment of £1.48 for every £1 invested, while the Minding the Gap initiative (discussed in Selected Examples) showed a positive return, generating £3.40 in social and economic benefits for every £1 invested.<br><br>Evidence on the impact of nine initiatives was based on qualitative feedback or summary statistics, including the number of people accessing the services, referrals to other services, and self-reported outcomes such as increased independence. The qualitative feedback was generally positive, reflecting high levels of satisfaction with the corresponding services. |
| **Evidence to support scaling-up or replication** | Out of the 25 initiatives, 13 were identified as scalable, recognising the potential for broader implementation or replication in areas lacking similar services. The value of pilot programmes or a 'test and learn' approach was also emphasised as a means to inform and refine future expansion efforts. Additionally, the integration of digital and remote working options to enhance service delivery could further support the replication and scaling of such initiatives. |
| **Barriers and challenges** | Barriers and challenges identified included staffing issues, such as recruitment difficulties and high turnover, as well as the need for multi-disciplinary collaboration. Financial constraints also posed challenges, with funding shortages affecting service delivery and the sustainability of programmes. Adapting to new working models and mindsets was another common challenge, requiring time and effort to manage organisational restructures. |

| Summary of evidence | |
|---|---|
| **Lessons learnt** | Collaboration and co-production in service development, ensuring services can adapt to the evolving needs of the community, is key to the success of community-based initiatives. Working closely with stakeholders, including councils and system partners, was key to developing effective services that avoid duplication and meet community needs. Communication and engagement were also frequently highlighted as essential, particularly in building relationships and securing the support of key stakeholders like GPs. Additionally, relationship-building within teams was recognised as critical for promoting better care and enhancing workforce satisfaction. Less frequently mentioned but still significant were the lessons on allowing ample time for change implementation, particularly when restructuring teams or developing new models. |

## Selected examples

| **Camden Integrated Neighbourhood Teams** Camden | | | | | |
|---|---|---|---|---|---|
| **Timeframe** | **Description of relevant service** | **Target Demographic** | **Target Outcomes** | **Impact** | **Funding** |
| Established in early 2023 | The Camden Integrated Neighbourhood Teams initiative aims to foster closer collaboration across all forms of care and support within local networks, improving outcomes for residents. Camden borough has been divided into five geographical neighbourhoods, with plans to establish a co-located integrated neighbourhood team (INT) in each. The first of these, the East INT, is being developed in the Kentish Town area as a 'test and learn' model. This team will bring together health professionals, like community nurses, and care professionals, such as social workers, to deliver a more innovative and integrated approach to health and care support. | People working in Camden's health and care sector and local people. | Encouraging collaborative neighbourhoods.<br>Improved skills and collaboration of health and social care professionals within the community. | Although this initiative has not yet been evaluated, emerging learnings have emphasised the need for sufficient time to implement change across different organisations' governance and processes and to restructure teams into new neighbourhood alignments. | BCF<br>Approximate funding for the initiative overall was £300,000 received from BCF to establish the East INT Test and Learn model. |

| **The Community Wellness Outreach project** Reading | | | | | |
|---|---|---|---|---|---|
| **Timeframe** | **Description of relevant service** | **Target Demographic** | **Target Outcomes** | **Impact** | **Funding** |
| Started in 2024 and will run to the end of June 2025. | The Community Wellness Outreach project provided an outreach service enabling NHS Health checks in communities in Reading in 2024, primarily to address the risk of cardiovascular conditions. | All people above 18 years old but people at risk of developing cardiovascular conditions are a priority. | Reducing the need for statutory care support.<br>Improving health outcomes and reducing health inequalities. | Summary statistics of the project suggest a consistent monthly increase in project attendance. By the end of April 2024, 471 people had participated, out of which 73 individuals were referred to other services, including health behaviour change support, weight management and mental health support. | Non-BCF (Health Inequalities Funding)<br>£811,000 (Note: it is unclear whether this is per annum or project total) |

| **Minding the Gap** Camden | | | | | |
|---|---|---|---|---|---|
| **Timeframe** | **Description of relevant service** | **Target Demographic** | **Target Outcomes** | **Impact** | **Funding** |
| Set up in 2015 | The Minding the Gap project aims to support vulnerable young people in reducing crisis presentations, supporting transitions to adult services, and improving the experience of care and clinical outcomes. The project consists of three elements: (i) the Hive Youth Club, made up of multidisciplinary practitioners; (ii) a transitions service, employing a clinical psychologist based in adults MH to support 16-24-year-olds transition to adult mental health services; and (iii) counselling and psychotherapy in community settings for young people who do not meet adult mental health thresholds. | Young people, 16-24 years old | Reducing the need for statutory care support.<br>Improving the experience of care. | In its third year, the project was independently evaluated, and it was found that over 70 per cent of young people at the Hive Youth Club showed a significant increase in their resilience and social engagement. It also demonstrated a positive return on investment, with £3.40 social and economic benefit for every £1 invested. | BCF<br>Total funding amount not available. |

| **The Living Well and Early Help service** Isle of Wight | | | | | |
|---|---|---|---|---|---|
| **Timeframe** | **Description of relevant service** | **Target Demographic** | **Target Outcomes** | **Impact** | **Funding** |
| Established in 2017 | The Living Well and Early Help service was set up in response to adult social care demand data identifying that over 55 per cent of older people living on the island did not meet the threshold to receive council-funded adult social care, and 40 per cent of all local people who approached adult social care were deemed ineligible for council-funded adult social care. Those who were not able to receive alternative community support were more likely to later re-present to adult social care with higher care needs. The Hub aims to fill this gap by delivering holistic, person-centred, low-level wellbeing support services to residents of the Isle of Wight in partnership with local communities, the voluntary sector, and town, parish and community councils. | People living in local communities | Living independently in the community.<br>Reducing the need for statutory care support and hospital (re)admission | By 2023, the service received over 500 monthly attendances and, between April 2022 and July 2023, it supported 4,509 local people, with only 1 per cent of these needing onward referral to health and social care statutory organisations for additional support. | BCF<br>Total funding amount not available. |

| **The Living Well and Early Help service** Isle of Wight (continued) | | | | | |
|---|---|---|---|---|---|
| **Timeframe** | **Description of relevant service** | **Target Demographic** | **Target Outcomes** | **Impact** | **Funding** |
| | The Hub provides care support for low-level needs, builds volunteer-led community solutions (for example, establishing local volunteer groups to help with tasks such as grocery shopping, providing companionship, and supporting home maintenance), and delivers advice, guidance and support for people who fund their own care. | | | | |

| **Hospice in Your Care Home** Wigan |
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| See case study on the following page |

## **Case study:** Hospice in Your Care Home – Wigan and Leigh's Care Home Support and Development Board

### Summary

Hospice in Your Care Home (HiyCH), first piloted by Wigan and Leigh Hospice in November 2015, delivers education, training and support on palliative and end-of-life care to providers working in community care settings within Wigan borough. The service, now known as the Practice Development Team, aims to enhance the care and comfort of residents in the last few weeks of life by increasing staff confidence and motivation to deliver person-centred care. It is overseen by Wigan's Care Home Support and Development Board.

In addition to improving resident experiences, the HiyCH service aims to reduce pressures on acute hospital and end-of-life services by preventing inappropriate or avoidable hospital admissions, lowering the volume of deaths in hospitals, and enabling earlier identification of end-of-life and advanced care planning.

### Delivery

HiyCH provides palliative and end-of-life training and support through three educational programmes: (i) a formal course delivered for three months, (ii) clinical skills workshops and (iii) training sessions provided in hospice and care home settings when needed. Since October 2022, HiyCH has hosted this via the **Wigan Borough Palliative and End of Life Care Learning Hub**, a central learning hub based at the Woodview Centre. The hub delivers education and training free of charge in dedicated clinical skills rooms and training spaces. Sessions are primarily delivered by HiyCH leads with contributions from other experienced practitioners, including GPs, district nurses or hospital staff working across Wigan.

The training, previously offered only to nursing and residential home staff, expanded to offer palliative and end-of-life educational support to all social care and health professionals.

### Impact

The service positively supports over 400 residents annually, and its return on investment is estimated at 1.48:1. This means that for every £1 spent, the service generates £1.48 in benefits.

## **Case study:** Hospice in Your Care Home – Wigan and Leigh's Care Home Support and Development Board (continued)

Lancaster University conducted an independent evaluation of the service's processes and outcomes in 2017 to determine its impact since its inception in 2015. The evaluation found that, from November 2015 until February 2017, 34 referrals were received (of which 29 were appropriate), and all were responded to within 24 hours. Across the seven care homes involved in the project since inception, the service succeeded in reducing hospital admissions by 25 per cent (from 234 to 176) in the periods between July to December 2015 and July to December 2016, whilst the number of advanced care plans in the seven care facilities had increased from 13 to 31 by January 2017. A significant relationship was also found between the number of hospital admissions and the amount of training the staff received in a care home. In other words, the more training care homes had, the more likely they were to reduce admissions in this time period. Importantly, after the intervention, staff and care home organisations felt more confident about their skills and ability to provide palliative care.

The positive feedback given by participants about their involvement in the project was positively influenced by the HiyCH team's delivery method. Key contributors to this were the team's flexibility in delivering the project and their support of care home staff based on rapport and trust building. These efforts resulted in measurable improvements in communication between staff, residents and families, as well as symptom management, end-of-life care and fewer hospital admissions.

### Challenges and lessons learnt

Key challenges included the need for additional resources (including staff) to implement the initiative effectively, which depends on securing additional funding. For example, the cost of the education package is high in terms of the time required from care home staff, totalling 2,421 hours, equating to a cost of just under £30,000 for their attendance. Barriers revealed during the evaluation conducted in 2017 were prominent regarding staffing levels and staff availability to attend training sessions.

The initiative has the potential to be expanded in the current locality, but it can also be replicated in other areas where it has not yet been implemented.

# 3 Home adaptation schemes

Home adaptation schemes support people who need to make appropriate alterations to their homes to improve accessibility and safety, thereby supporting them to continue to live independently in their own homes and reduce the risk of accidents or falls that could lead to acute health and social care needs. Home adaptation schemes are available through multiple funding streams. For example, the Disabled Facilities Grant (DFG) is a well-established funding mechanism for home adaptations and forms part of the Better Care Fund. It is a statutory requirement for local authorities to provide grants for individuals who are eligible with an individual cap of £30,000 in England.

| Overview of Home adaptation schemes | |
|---|---|
| **Intended outcomes** | To support the maintenance, adaptation, and improvement of homes to ensure that they are suitable and safe for people's needs. |
| **Target demographics** | Vulnerable people (that is, older people, people of all ages with disabilities, people on low incomes), particularly those whose home living conditions have the potential to detrimentally impact their health. |
| **Funding amount and delivery costs** | No budget/delivery cost information available. |

| Summary of evidence | |
|---|---|
| **Evidence of impact** | Overall, the evidence received in this area was largely qualitative. Initiatives reviewed received good feedback from users and met needs that otherwise would have been likely to escalate.<br><br>The Healthy Housing Hub in Derby did demonstrate a quantitative impact in external evaluations (see Case study below). There is also wider quantitative evidence that home adaptations can be cost-effective. For instance, research suggests that home assessment and modification can have a financial return on investment of £3.17 per pound spent by creating savings for health and social care services. When non-financial returns such as improvements in wellbeing are included, this can rise to as much as £7.34 for every pound spent (Public Health England, 2018).<br><br>However, there is less evidence on what specific approaches work best, for instance, whether a handyperson service is expected to deliver more benefits than non-means-tested small grants. Indeed, the answer may be different in different local areas. |
| **Evidence to support scaling-up or replication** | Two of the four initiatives addressed the potential for scaling-up or replication. Local areas found that successful cross-organisational and intra-organisational working was key to success. Involving a range of organisations, including local housing teams, housing providers, and health and social care teams, allows both effective delivery and a clear view of how activity leads to benefits. For example, involving health representatives in the design and management of housing initiatives can make it easier to understand and maximise the impact that a programme has on healthcare utilisation.<br><br>Staffing also emerged as a success factor. Having designated programme managers and assessment staff drove forward multi-agency delivery by ensuring that individuals' housing needs were clearly identified and addressed. |

| Summary of evidence | |
|---|---|
| **Barriers and challenges** | Challenges included low or short-term funding, impacting service planning, innovation, and development, as well as the unavailability of appropriate accommodation, effective partnership working, and assessing service impact.<br><br>One consistent challenge for home adaptation schemes was funding. DFG budgets have not risen as fast as demands for the service. As a result, local areas found it difficult to fund innovative use of the DFG budget, given the pressure for 'standard' DFGs. This may also be one reason why local areas contributed a relatively small number of DFG-related initiatives to the call for evidence for this research. |
| **Lessons learnt** | Holistic needs assessment (encompassing children, family and parents/carers as well as the customer) is important to understand what support is needed, the importance of partnership working to achieve common goals, collecting customer feedback, encouraging innovative and experimentative approaches, and ensuring appropriate staffing (such as dedicated project co-ordinators or data analysts). |

## Selected examples

| **Staying Put Agency** Middlesbrough | | | | | |
|---|---|---|---|---|---|
| **Timeframe** | **Description of relevant service** | **Target Demographic** | **Target Outcomes** | **Impact** | **Source of funding** |
| Established in 1991, BCF-funded since 2017. Case study reviewed is from 2018. | A home improvement agency offering specialist support and advice to older people, disabled people, and people on low incomes, to help them maintain, adapt, and improve their homes. It provides practical advice and assistance, disabled facilities grants, handyperson service, telecare and hospital discharge service, low level repairs, home improvement loands, private works service, winter warmth projects. | Vulnerable adults requiring support to stay in their own homes. | Reduced falls.<br>Continued independent living. | In 2017-18, 341 major adaptations were delivered. In addition, handyperson service provided over 2,200 minor adaptations. Overall, it supported over 3500 vulnerable clients, with 95 per cent stating they were happy with the service received. | BCF<br>Total funding amount not available. |

| **Pilots of discretionary services through DFG** West Sussex | | | | | |
|---|---|---|---|---|---|
| **Timeframe** | **Description of relevant service** | **Target Demographic** | **Target Outcomes** | **Impact** | **Source of funding** |
| Pilots took place in 2018 | Two trial non-means tested services on top of statutory DFG provision. A minor adaptations service (up to £1000) and a deep clean service (up to £1500). | Vulnerable adults living in housing that is currently unsuitable for their needs. | Reduction in waiting times for adaptations.<br>More flexible use of the funding.<br>Common approach across the county. | Huge demand for pilot projects and positive feedback from customers. Both pilots extended and continued. | BCF<br>Total funding amount not available. |

| **House2Home** Shropshire | | | | | |
|---|---|---|---|---|---|
| **Timeframe** | **Description of relevant service** | **Target Demographic** | **Target Outcomes** | **Impact** | **Source of funding** |
| Ongoing | Uses the DFG budget to smooth relocations to suitable housing for families whose current homes cannot be adapted. It does this by providing funding to adapt a prospective home, which means families are not limited to properties (both social and private sector housing) that already have suitable adaptations in place. | Families whose current homes cannot be adapted to meet the needs of family members. | Support families to move into permanent homes rather than waiting in (potentially unsuitable) temporary accommodation. | The programme has supported 87 people across 21 families in the area, with excellent user feedback and benefits for family wellbeing, and a reduction in spend on temporary accommodation. | BCF<br>Total funding amount not available. |

| **Healthy Housing Hub** Derby |
|---|
| See case study on the following page |

## **Case study:** Healthy Housing Hub – Derby City Council

### Summary

The **Healthy Housing Hub**, established in 2012 by Derby City Council and Public Health England, focuses on assisting vulnerable individuals whose living conditions negatively impact their health.

### Delivery

The Healthy Housing Hub provides a number of low-cost, health-focused interventions, such as access to a handyperson, repairing boilers or gas fires, installing central heating, removing trip hazards, ensuring electrical installations are safe, and aiding those facing fuel poverty. Individuals are often identified by health and care workers through direct referrals, highlighting their priority health needs and unsuitable or unsafe housing conditions. Referral sources include GPs, community matrons, community care workers, carers, occupational therapists, social workers, the police and fire service.

In March 2018, preliminary data for 2017-2018 suggested that the Hub dealt with 1,659 referrals. Of these, 504 were more complex cases, primarily referred by health, care and community-based colleagues due to high risk and multiple vulnerabilities. The 504 more complex cases received 1,224 different types of interventions to address 692 identified hazards in the homes, with the top four being falls prevention works, personalised advice, heating improvements and income maximisation. The Hub also facilitated 571 onward referrals to other services or groups appropriate to client needs.

### Impact

According to Derby City Council (2018), the Healthy Housing Hub has demonstrated significant success. A study conducted in 2013-2014 found that individuals with a history of falls who received services from the hub experienced a 39.5 per cent reduction in A&E visits, a 20 per cent reduction in inpatient admissions, and a 53.8 per cent reduction in acute hospital length of stay overall compared to a control group. Additionally, 86.3 per cent of these individuals reported improvements in their health and wellbeing, anxiety levels, peace of mind, security and confidence at home.

Moreover, 91 per cent of hub clients remained in their homes after 12 months rather than in a residential or nursing setting. There was also a marked difference in contact with the East Midlands Ambulance Service not requiring hospital conveyance compared to the control group (that is, individuals receiving emergency inpatient treatment or residential care but did not receive hub support).

## **Case study:** Healthy Housing Hub – Derby City Council (continued)

### Challenges and lessons learnt

The primary challenge faced by the Healthy Housing Hub is the condition of older private-sector properties in Derby. This means that the demand for support is high.

The success of the Hub has led to increased demand for its services and referrals of more complex cases.

Yet, the uncertainty of long-term funding forced Derby to limit how widely they promote the service, despite opportunities to expand the Hub's reach and realise its 'invest to save' benefits.

# 4 Assistive technology

Assistive technology initiatives offer services and tools to help individuals requiring care and their carers. The call for evidence received nine initiatives that fall within the assistive technology and equipment scheme type. Assistive technology initiatives aim to enhance caregiving processes by facilitating communication and interaction between beneficiaries and health and social care organisations, as well as their families and friends. They enable individuals to remain safely in their own homes for as long as possible. Services provided by assistive technology will often include non-technical interventions and aids for daily living; however, the initiatives that we reviewed are all related to digital interventions.

Assistive technology can complement in-person care in various ways. Remote monitoring devices allow healthcare providers to track patients' vital signs and health metrics, enabling timely interventions without the need for frequent in-person visits. Communication tools facilitate regular video calls between carers and patients, ensuring continuous support and reducing feelings of isolation while maintaining the personal connection essential for effective care. It can also be tailored to the needs and strengths of an individual.

| Overview of Assistive technology | |
|---|---|
| **Intended outcomes** | To help individuals stay independent and safe in their own homes, enhance mental and physical health, reduce stress, anxiety, and loneliness, and support overall wellbeing. To decrease reliance on statutory services by improving efficiency and accessibility of care. |
| **Target demographics** | Mainly adults with low-level needs or vulnerabilities . |
| **Funding amount and delivery costs** | Detailed spending information available for two initiatives. The average annual budget for these initiatives was £1,138,000. |

| Summary of evidence | |
|---|---|
| **Evidence of impact** | The evidence base indicates that assistive technology initiatives can enhance individuals' self-reported quality of life and support their independence. For most initiatives, qualitative information and self-reported statistics were gathered. Due to the personalised and small-scale nature of these interventions, it was challenging to extrapolate estimates of return on investment. The Social Care and Digital Innovation project was an exception (discussed in 'Selected examples'), providing estimates on savings: £10,484 in cashable savings (for example, due to increased numbers of assessments) and £26,972 in non-cash benefits (for example, attributable to hospital avoidance and fall prevention) over the two years of the project. Broader research suggests that there is limited evidence regarding the overall impact of digital assistive technology (LOTI, 2020). |
| **Evidence to support scaling-up or replication** | Out of the nine initiatives, four are discussed as having notable potential for scaling-up. The Social Care and Digital Innovation project in Derbyshire (discussed in 'Selected examples') is already being discussed with other councils and the NHS for broader use, with ongoing efforts to develop standards in collaboration with the Royal College of Occupational Therapists. The Komp Device for Wellbeing Check-Ins in Dorset aims to combat social isolation and is exploring further research with Oxford University to assess its impact on individuals with dementia. The Virtual Care Agency – Alcove Video Carephone pilot in Norfolk has demonstrated successful integration of virtual and physical visits, with plans to expand and collaborate with domiciliary care agencies to enhance capacity. Additionally, the Telecare and Lifeline Service in Stoke-on-Trent, which is a comprehensive 24/7 community alarm service, supports a large number of people and shows potential for replication due to its effective management of high-volume activations and emergency responses. |

| Summary of evidence | |
|---|---|
| **Barriers and challenges** | Several challenges of using digital tools persist. Service users and their families may lack the skills or ability to interact with video streaming or other technological aspects of the different initiatives. They may have sensory needs or learning difficulties, which means that adaptations need to be made to enable access. The lack of Wi-Fi within some users' homes can also hinder the use of digital tools. Staffing issues, such as lack of staff buy-in for virtual training reported by the Social Care and Digital Innovation project, can further impact service delivery. Lastly, financial and capacity constraints on local authorities have limited the ability to sustain and scale up these initiatives. |
| **Lessons learnt** | Easy-to-use and user-friendly tools are key success factors identified throughout, helping keep people engaged and confident in using digital media. Some initiatives that allowed the development of personalised devices seem to enhance the quality of care provided and empower individuals and their carers to navigate their health and wellbeing with greater confidence and ease.<br><br>Beyond assistive technology, digital technology offers further benefits for network building and integrated care coordination. It enables health and social care professionals, carers and community groups to offer more accessible support for individuals with social care needs. It builds confidence in people to self-manage their social health needs while supporting their personal safety and preventing the need for domiciliary care, or admission to residential or nursing care or hospital. |

## Selected examples

| **Cassius** Suffolk | | | | | |
|---|---|---|---|---|---|
| **Timeframe** | **Description of relevant service** | **Target Demographic** | **Target Outcomes** | **Impact** | **Source of funding** |
| Not available | Cassius, Suffolk County Council's care technology service, offers cutting-edge care technology that blends in with mainstream technology and can be used to complement face-to-face care. This initiative offers a range of core products that support people in living independently at home and give carers peace of mind, real-time information, and backup support if needed. Examples of the technology include digital reminder clocks that provide personalised reminders for daily routines such as medication or hydration, sensors that track movements around the home and alert carers if a door is left open or if there is a change in usual activity, and smartwatches that offer emergency call functions, GPS tracking and movement monitoring. | People over the age of 18 with a range of health and care needs and their carers. | Living independently at home.<br>Reducing the need for statutory care support. | This record of evidence for the initiative is based on the experience of a single person. The initiative helped the individual follow a daily routine, including managing medication. Initial reservations from the family about digital care solutions were resolved by taking the time to build relationships and coproduce a solution. | Not available |

| **Cassius** Suffolk (continued) | | | | | |
|---|---|---|---|---|---|
| **Timeframe** | **Description of relevant service** | **Target Demographic** | **Target Outcomes** | **Impact** | **Source of funding** |
| | Cassius was offered to a 19-year-old with diagnosed autism, dyspraxia and ADHD. There was an initial expectation that he would need support from carers or support workers. Instead, the adult social care team identified a solution to his needs through Cassius. For this individual, Cassius allowed them to follow a structured daily routine, including medication management, enabling them to live independently without needing extensive carer involvement. The family initially had reservations about digital care solutions, but these concerns were addressed through relationship-building and coproducing a tailored care plan with the family and the individual. | | | | |

| **The Social Care and Digital Innovation project** Derbyshire | | | | | |
|---|---|---|---|---|---|
| **Timeframe** | **Description of relevant service** | **Target Demographic** | **Target Outcomes** | **Impact** | **Source of funding** |
| Not available | The Social Care and Digital Innovation project enables council carers to perform remote assessments for home equipment adaptations using smartphones and video/audio tools for virtual referrals and assessments. | People who need home equipment adaptations | Living independently at home.<br>Reducing the need for statutory care support. | The initiative has significantly improved service efficiency, client satisfaction, and financial savings within the home adaptation services through the introduction of remote assessments. 83 per cent of clients expressed satisfaction with remote assessments, which reduced wait times and allowed faster responses. The initiative has already realised £10,484 in cashable savings and £26,972 in non-cash benefits over the two years of project implementation, with long-term forecasts estimating substantial future savings. | Non-BCF (NHS Digital)<br>Total funding amount not available. |

| **MiiCare** Luton | | | | | |
|---|---|---|---|---|---|
| **Timeframe** | **Description of relevant service** | **Target Demographic** | **Target Outcomes** | **Impact** | **Source of funding** |
| Not available | MiiCare is a digital tool that combines sensors, a smartwatch, and health devices to monitor the health of vulnerable adults at home. For instance, the MiiCube, which hosts 'Monica' – a digital health coach, interacts with individuals to offer support, such as medication reminders, fluid intake prompts, and emergency callouts to family or carers. The system also includes home sensors that monitor movement and behavioural patterns, alerting caregivers to potential health issues or changes in activity. Additionally, health devices track vital signs, and the smartwatch provides motivation for daily activities, such as setting and tracking goals for steps and sleep quality. | Families of older adults, care agencies with caregivers who provide home visits to clients, and care communities with dedicated staff responsible for the well-being of older adults. | Living independently at home.<br>Reducing the need for statutory care support. | The identified benefits of MiiCare include supporting personal safety, reducing the risk of urinary tract infections (UTIs), reducing domiciliary calls, and identifying health issues to prevent hospital admissions. | Not available |

# 5 Urgent community response

Urgent community response (UCR) services offer at-home urgent care to vulnerable people, including adults at risk of falls or with complex health needs. Support is provided within two hours and includes a range of health and social care needs, such as physiotherapy, occupational therapy, and medication prescribing. This can form part of a system's intermediate care offer, although definitions of intermediate care vary.

| Overview of Urgent community response | |
|---|---|
| **Intended outcomes** | To provide rapid treatment, rehabilitation and secondary prevention as an alternative to hospital admission, which enables individuals to remain independent, healthy, and safe in their usual place of residence. |
| **Target demographics** | Vulnerable people (that is, those who have recently fallen or are at risk of falling or those facing circumstances that may lead to a hospital, residential or inpatient admission). |
| **Funding amount and delivery costs** | Detailed spending information available for one initiative. The annual budget for this initiative was £265,000 (see Community Rapid Response team case study below for more detail). |

| Summary of evidence | |
|---|---|
| **Evidence of impact** | There is good evidence that many individuals who receive an urgent community response intervention are not admitted to the hospital and do not require an ambulance call out. This can be used to develop assumptions around cost savings based on average costs of admissions and call outs (see Community Rapid Response team case study below).<br>However, there was no evidence about the long-term impact on individuals; for example, do individuals remain at home in the long term compared to a comparison group? |
| **Evidence to support scaling-up or replication** | All three initiatives are exploring the potential for scaling-up. This includes regional rollout, extending operating hours, and widening target demographics. |
| **Barriers and challenges** | Challenges included managing inappropriate referrals and the workforce, particularly upskilling agency staff to deliver and dealing with understaffing. |
| **Lessons learnt** | The importance of multi-disciplinary team working, ensuring flexibility in care delivery (such as planned intermediate care), and providing workforce support (such as bespoke training and rolling recruitment). |

## Selected examples

| **Falls First Responder service** North Tyneside | | | | | |
|---|---|---|---|---|---|
| **Timeframe** | **Description of service** | **Target Demographic** | **Target Outcomes** | **Impact** | **Funding** |
| Evidence covers 2017-2019, but the service has continued since then. | The service aims to provide a timely response to falls in the home, reducing the length of time a person may be on the floor.<br>The Falls First Responder Team sits within the council's Care Call service and receives referrals from the North East Ambulance Service.<br>The team has a dedicated car loaded with falls equipment and links with community health services. If someone has a minor injury, they can arrange for the person to be treated at home without needing to be conveyed to the hospital. The service had an average response time of 19 minutes and avoided an ambulance response for 296 people between December 2017 and May 2019. | Older people who experience a fall. | Ensure effective treatment, rehabilitation and secondary prevention for those who have fallen. | It is estimated that the service is saving the health economy approximately £300,000 per year by reducing ambulance callouts. | BCF<br>Total funding amount not available. |

| **Recovery at Home** Surrey Downs | | | | | |
|---|---|---|---|---|---|
| **Timeframe** | **Description of service** | **Target Demographic** | **Target Outcomes** | **Impact** | **Funding** |
| Ongoing | The scheme provides rapid, at-home health and social care support as an alternative to hospital admission or individuals leaving the hospital. The service supports an average of 555 patients per month. Domiciliary care is provided and linked to multi-disciplinary team support across medical and therapeutic care. | Individuals experiencing short-term spikes in health and social care needs or recently discharged from the hospital with ongoing support needs. | Prevent hospital (re) admissions.<br>Support independent living at home.<br>Reduce unnecessary long-term care packages. | There is a 5 per cent reduction in Emergency Department attendance for adults and a 17 per cent reduction in overnight non-elective admissions. Closure of one acute ward as a result of patients receiving care at home. | Not available |

| **Community Rapid Response Team** Hertfordshire |
|---|
| See case study on the following page |

## **Case study:** Community Rapid Response Team – Hertfordshire County Council

### Summary

The Hertfordshire Community Rapid Response Team (CRRT) was launched in April 2022. Overseen by Hertfordshire County Council and implemented across Hertfordshire, the service aims to provide an urgent response to critical issues for older adults that may otherwise lead to admission to an acute care setting or residential/nursing care within 48 hours. These circumstances include the deterioration of a chronic illness, a caregiver breakdown, or unplanned interruptions to the care and support the individual already receives.

The CRRT's primary objective is to empower individuals to maintain their independence, health, and safety in their familiar living environment, their home. This is achieved through rapid assessment and support in the community, which not only enhances people's experiences, outcomes, and quality of life but also gives them and their carers control over their care and support closer to home.

### Delivery

The CRRT is run by social care practitioners from the adult care services older people's teams. The CRRT teams have been co-located in Hertfordshire's community healthcare trusts to provide a single point of access to a range of urgent care services. The annual funding for new staff roles is £265,000, in addition to the realignment of an existing team of seven social workers and community care officer roles.

Individual stories illustrate how the service functions in practice.

- Jacob, 84, received a cancer diagnosis and was regularly feeling too tired to look after himself, leading to mental health deterioration. A referral was made from district nurses to CRRT, who assessed the case and, within the same day, Jacob was admitted to a care home to receive the necessary support and avoid further deterioration in health.
- Sarah, 85, lives with Alzheimer's disease. Her son, and main carer, was suspected of having suffered a stroke but refused to leave his mother alone to visit the hospital. An urgent referral was made to CRRT from a GP practice social prescriber, and within one hour, a care provider was commissioned to stay with Sarah overnight, support her and establish a better understanding of her needs to guide a comprehensive care plan for her. This enabled her son to go to the hospital and receive the care he also needed.

## **Case study:** Community Rapid Response Team – Hertfordshire County Council (continued)

### Challenges and lessons learnt

We do not have evidence of specific barriers to implementation or lessons learnt from the service. The service's future ambitions are to extend operating hours further, expand the services to include working age adults and evaluate how the service is targeted.

### Impact

In a pilot phase between April 2022 and November 2023, the team supported 1,020 people, of whom 92 per cent avoided hospital admission and 96.5 per cent remained in their own homes. In that period, the service saved over £3,400,000 because of reduced hospital non-elective admissions (£3,468 per admission) and over £200,000 from replacing the need for ambulance callouts (£276 per callout).

Professionals from different departments (Hertfordshire Community NHS Trust, adult care services, Community Rapid Response Team), as well as care recipients, have given very positive feedback about the service's approach to providing urgent support. A key reported success was a significant decrease in the waiting time for accessing support after a referral to the council was made, with the service citing reductions from weeks to as little as two hours.

# 6 Home-based intermediate care services

Home-based intermediate care services, including interventions at home to support faster recovery from illness and maximise independent living, formed 14 of the 86 initiatives that were reviewed. These focus on supporting adults with health and care needs, such as those resulting from disabilities, illness or injury, long-term care needs, or recent hospital discharge, to regain independence, build confidence, and improve quality of life. This support enables people to live in their own homes and, in many cases, provides an alternative to hospital admission where out-of-hours care is required. Councils found that these services helped them to effectively manage long-term care budgets and demand.

| Overview of Home-based intermediate care services | |
|---|---|
| **Intended outcomes** | To restore and increase independence of individuals in their own homes, improve health and wellbeing, prevent hospital (re)admissions . |
| **Target demographics** | Carers, vulnerable adults, with a special focus on older adults and those requiring care during transitions back from hospital stays. |
| **Funding amount and delivery costs** | Detailed spending information available for five initiatives. The average annual budget for these initiatives was £3,145,000. |

| Summary of evidence | |
|---|---|
| **Evidence of impact** | The evidence base for the initiatives varies in strength, with 11 initiatives out of the 14 being either evaluated or relying on self-reported outcomes or preliminary data.<br><br>Four initiatives provide specific evidence of cost savings and a return on investment. For instance, a programme called Two Carers in a Car (discussed in 'Selected examples') demonstrated cost savings of £2.5 million by improving the independence of care recipients and reducing the need for full-time care provision. Three initiatives are awaiting final evaluation results, while the rest of the initiatives have preliminary data or qualitative feedback but lack formal evaluations or comprehensive return on investment analysis.<br><br>Personalisation of care plans to address individual needs, a holistic approach integrating various services, and strong coordination among health care professionals, social workers, and caregivers are key success factors. Emphasising independence and providing timely, flexible support can also contribute to successful outcomes. |
| **Evidence to support scaling-up or replication** | Out of the 14 initiatives, seven have highlighted the potential for replication and scaling-up. These include plans to expand geographically, such as rolling out the initiative to other locations, extending the service to other population groups (such as those with lower needs), or additional service areas, contingent on securing further funding. |
| **Barriers and challenges** | Challenges raised by home-based intermediate care services included demand exceeding capacity, barriers to information sharing (for example, accessing patient records across databases), and managing the competing provision of multiple services alongside home-based intermediate care. Initiatives also reported challenges related to the individuals receiving support. For example, the Independent Living Team, discussed in 'Selected examples', reported poor mental health, isolation, and low self-esteem among those receiving care as key barriers to delivering support. Other initiatives reported similar barriers and found that building trust and understanding between support workers and individuals receiving the support was a way to overcome this. |

| Summary of evidence | |
|---|---|
| **Lessons learnt** | Most initiatives provide these services through partnerships and multidisciplinary teams (MDTs) that work between carers, GPs, and hospital-based services. Alongside MDT approaches, many initiatives also benefitted from informal individual and community support networks to assist with the provision of support.<br><br>The digitisation of patient records can also positively support joint working by improving ease-of-access and timeliness, as well as facilitating onward referrals. |

## Selected examples

| **Two Carers in a Car** Shropshire | | | | | |
|---|---|---|---|---|---|
| **Timeframe** | **Description of service** | **Target Demographic** | **Target Outcomes** | **Impact** | **Funding** |
| Established in 2018. Support provided seven days per week, eight to ten hours per night between 10pm and 6.30am | The 'Two Carers in a Car' service, established in Shropshire, offers specialised night-time care provided by a team of two professional carers. This service operates daily from 10pm to 6:30am, delivering targeted support to individuals recently discharged from the hospital or those requiring short-term night-time assistance. Designed as an alternative to more intensive forms of care such as full-time residential placement or continuous night-time domiciliary care, the service focuses on addressing specific night-time needs. This includes providing help with tasks like toileting, assisting with getting into bed, or offering reassurance during the night.<br><br>The goal is to provide support for only a few hours during the night as needed, rather than continuous care. By providing this tailored night-time support, the service aims to facilitate smoother transitions from hospital to home, reduce the need for full-time residential care, and prevent unnecessary hospital readmissions. It offers a flexible solution that adjusts to the individual's needs, helping to maintain independence and comfort while minimising the reliance on more extensive care options. | Anyone needing support out of hours | Supported living at home.<br><br>Reducing the need for statutory care support and hospital (re) admission. | Between July 2018 and January 2020, total savings were estimated at over £2,500,000 as a result of both: (i) care recipients becoming self-supporting due to the reabling nature of the service, leading to fewer acute care admissions and saving approximately £1,400,000, and (ii) replacing the cost of full night care provision. | BCF<br><br>Total funding amount not available. |

| **Norfolk First Support** Norfolk | | | | | |
|---|---|---|---|---|---|
| **Timeframe** | **Description of service** | **Target Demographic** | **Target Outcomes** | **Impact** | **Funding** |
| Not available | Norfolk First Support delivers reablement-at-home services, supporting individuals for up to six weeks in regaining independence, rebuilding confidence, and managing long-term conditions. The service works closely with individuals to identify meaningful goals for the individual and design appropriate support which is delivered by occupational therapists and reablement support workers. Weekly multi-agency meetings allow support to be reviewed and adjusted as required, for instance, reducing a support package from a double up (two workers visiting four times a day) to a single assist (one worker visiting twice a day). | People over 18 years of age who have been discharged from the hospital or are facing difficulties at home. | Living independently at home.<br>Improving health and wellbeing. | The Care Quality Commission inspected the initiative, giving it an overall 'good' mark. More specifically, the initiative was characterised as 'good' in safety, effectiveness, caring, and responsiveness, and it 'requires improvement' in how well-led it is. | BCF<br>Total funding amount not available |

| **The Independent Living Team Central** Bedfordshire | | | | | |
|---|---|---|---|---|---|
| **Timeframe** | **Description of service** | **Target Demographic** | **Target Outcomes** | **Impact** | **Funding** |
| Not available | The Independent Living Team provide support for up to eight weeks with daily living activities to increase independence and improve quality of life. | Vulnerable people | Living independently at home and in the community.<br>Building self-confidence and improving quality of life. | This record of evidence for the initiative is based on the experience of a single person. By the eight-week mark, the individual was ready to start using public transport to access a local supermarket once each week.<br>Achieving this independently improved the individual's confidence further and within three months, they were considering employment opportunities. | Not available |

| **Home-based reablement** Lincolnshire County Council |
|---|
| See case study on the following page |

## **Case study:** Home-based reablement – Lincolnshire County Council

### Summary

The Home-Based Reablement scheme, commissioned by Lincolnshire County Council and delivered by a private provider, aims to restore independent functioning to people recently discharged from hospital, people with disabilities, or people recovering from illness or injury. One of the primary goals of this approach is to prevent acute care readmissions or higher social care needs. To achieve this, the scheme provides support seven days per week both within an individual's own home and on discharge from hospital. In October 2022, additional BCF funding was used to increase the scheme's capacity and referral acceptance rates from hospitals and improve the flow of hospital discharges. An emergency department (ED) service was also established in December 2022 to provide immediate reablement support directly from ED.

The scheme responds to recommendations in the hospital discharge policy and operating model that people should be discharged from the hospital and assessed in their own home at the right time and that often, people can do more for themselves than they or their hospital consultants had anticipated. Effective and timely reablement support is crucial for restoring an individual's independence, confidence, and wellbeing, and reduces long-term reliance on hospital and other care services by lowering the likelihood of relapse.

### Delivery

The primary aim of the reablement service is to restore and enhance independent functioning by enabling individuals to relearn how to perform daily activities themselves. The approach is highly flexible: visits can be adjusted in duration to meet the individual's needs and progress. This adaptability ensures that the support provided is aligned with the person's evolving level of independence and helps achieve all planned outcomes.

In addition to the routine home-based support, the reablement service includes an emergency 48-hour support model that starts directly from the ED. For instance, if an individual arrives at the ED with a condition like a broken wrist following a fall, and there is a concern about their confidence in returning home, the service intervenes by meeting them at the ED. They are then transported home and provided with intensive support for up to 48 hours. During this period, the service helps to make the home environment safe and comfortable, installs necessary equipment like fall alarms, and works to rebuild the individual's confidence in their home setting.

## **Case study:** Home-based reablement – Lincolnshire County Council

### Impact

To date, the scheme has supported a total of 6,486 individuals. The scheme was last evaluated in 2023 and is continuously reviewed through monthly contract and governance meetings.

The scheme has successfully avoided hospital admissions where possible and achieved timely hospital discharge, with 99 per cent of referrals accepted within 24 hours, reducing unnecessary strain on hospital and care services. Based on the additional funding available through shorter discharge times, it is expected that there will be approximately 16,943 more reablement contact hours over a 12-month period. For example, over winter 2022/23, of the 383 people within the service, 177 people were successfully reabled to independence. Of the 206 that were not fully reabled, some needed an extension to the service, whilst others required a long-term package of care at home, with a reduction in the immediate support required.

### Challenges and lessons learnt

The scheme has faced a number of challenges, including demand exceeding capacity, as well as referrals being inappropriate and not meeting the criteria for support.

The scheme has also identified potential for increased integrated working with partners. For example, the Home-Based Reablement scheme has, on occasion, successfully delivered individual support in partnership with the Lincolnshire Community Health Service.

# 7 Bed-based intermediate care services

Bed-based intermediate care services offer temporary bed-based support to maximise independence and prevent unnecessary hospital admissions through reablement and rehabilitation. These services also often support safe discharge processes by providing settings for individuals who are medically ready for discharge but have ongoing health and care needs that cannot be met at home, though that is not the focus of this research.

| Overview of Bed-based intermediate care services | |
|---|---|
| **Intended outcomes** | To maximise independence and prevent unnecessary hospital (re)admissions through reablement and rehabilitation, enabling people to live independently with a reduced package of care. |
| **Target demographics** | People from the local community at risk of hospital (re)admissions or recently discharged from hospital. |
| **Funding amount and delivery costs** | Detailed spending information available for all initiatives. The average annual budget for these initiatives was £865,000. |

| Summary of evidence | |
|---|---|
| **Evidence of impact** | We did not find detailed evaluations of existing approaches in this area. Some initiatives could demonstrate that bed-based settings were being utilised. However, there was no clearly quantified evidence of the impact on acute care admissions/readmissions. Future evaluations may provide more evidence in this area. |
| **Evidence to support scaling-up** | All three initiatives supported the potential for scaling-up or replication. In one case, this is already underway. |
| **Barriers and challenges** | Key challenges included service coordination across delivery partners, including local trusts and GP practices, and establishing clear referral processes and criteria that ensure that the individuals referred are suitable for the range of services that can be provided in these settings. |
| **Lessons learnt** | It is important to develop robust referral systems that accurately capture the needs of prospective care recipients. |

## Selected examples

| **Winsford and Northwich Community Intervention Beds** Cheshire | | | | | |
|---|---|---|---|---|---|
| **Timeframe** | **Description of relevant service** | **Target Demographic** | **Target Outcomes** | **Impact** | **Funding** |
| Ongoing | Started to address a cohort of patients unnecessarily admitted to hospital due to 24-hour nursing care needs that could be met in a care home with nursing care. It is delivered jointly between nursing home staff, the care community teams (CCTs) and GPs. The ICB commissions nursing home beds on block contracts in the local geographical footprint for the use of patients registered at local GP practices. The team has also expanded their support to palliative care patients who could not obtain a hospice bed and would have otherwise been admitted to the hospital. | Individuals with short-term high-level needs | Prevent avoidable hospital admissions.<br>Keep individuals living in the community. | Beds commissioned have been in use over 85 per cent of the time. Individuals in these beds would otherwise likely have been admitted to hospital. No assessment yet of the total number of hospital bed days saved. | Non-BCF (place transformation and discharge funding and existing resources)<br>£240,000 for four beds commissioned at three care homes in two CCT footprints. |

| **Wellbeing Support Service** Stoke on Trent | | | | | |
|---|---|---|---|---|---|
| **Timeframe** | **Description of relevant service** | **Target Demographic** | **Target Outcomes** | **Impact** | **Funding** |
| Ongoing (Dec 2023 – March 2025 | Wellbeing Support Service will prevent hospital admissions by providing a short-term, targeted support service that enables people to remain at home. This short-term support includes welfare checks, help with essential tasks, and coordination of resources, ensuring that individuals are well-supported, and their home environment is conducive to their health and wellbeing. The service aims to stabilise individuals' conditions and support their recovery or maintenance of health within the home, reducing the need for hospital care.<br><br>The service integrates bed-based support with a network of local resources, combining direct home assistance with comprehensive community connections. This involves signposting and referring individuals to a range of voluntary, community, and faith sector services that can provide additional support and engagement. By linking individuals to these local services, the Wellbeing Support Service enhances overall care, ensuring that people receive immediate practical help and longer-term community-based support. | People at risk of hospital admission<br><br>People recently discharged | Prevent admissions | The service has not been evaluated yet, but it has supported 298 people so far. | BCF<br><br>£285,282 per annum |

| **Active Recovery Beds** Lincolnshire |
|---|
| See case study on the following page |

## **Case study:** Active Recovery Beds – Lincolnshire County Council

### Summary

Active Recovery Beds is an ongoing service established by Lincolnshire County Council and Lincolnshire Integrated Care Board in December 2022 and is delivered by Lincolnshire County Council across Lincolnshire. It started as a solution to significant pressure on Home Care providers caused by an increase in the number of people needing four 'double-up' calls (that is, needing the support of two carers) per day. The service provides short-term recovery and reablement in a bed-based setting, targeted at individuals in the community to prevent admissions to hospital and to those who have been discharged from hospital with ongoing care and support needs. The goal is to provide individuals with time to recover with support from on-site occupational therapists and Social Workers to then enable them to return home.

### Delivery

Currently, it is provided in four care homes within Lincolnshire. The beds are placed in the same designated area and the care homes provide additional services and equipment, such as a kitchen or washing machine, to encourage independence. The service is provided for a maximum of 28 days, but the current average stay in Active Recovery Beds is 21 days. Funding for the project is £2,070,000 per annum for up to 60 beds

### Impact

A formal evaluation of Active Recovery Beds is currently being set up. The initiative has supported 361 individuals since December 2022. In one month, February 2023, the beds saved 217 hours of home care.

To address this, a more robust referral process was introduced. Initially, some recipients accepted the service without a clear understanding of their own needs, which hampered the ability to deliver effective active recovery. To mitigate this, a manager is now required to sign off on each referral, ensuring that the patient's condition aligns with the program's objectives before they are admitted.

The service is now exploring the opportunity to amalgamate Active Recovery Beds with Community Health Service Transitional Care Beds to offer beds that bring together more services in the same place at the same time.

# 8 Integrated care planning and navigation

Integrated care planning and navigation initiatives aim to better coordinate health and social care services to offer more joined-up support to individuals. The initiatives bring together a wide range of health and social care services, improving people's experience in accessing care and reducing the time required to consult multiple professionals. Initiatives in this scheme type had significant overlap with community-based schemes and prevention and early intervention.

| Overview of Integrated care planning and navigation | |
|---|---|
| **Intended outcomes** | To better coordinate health and social care services to offer more integrated care which achieves the best individual outcomes. |
| **Target demographics** | People with complex, rising, or long-term care needs, older people. People in need of urgent care to prevent unnecessary hospital (re)admission. |
| **Funding amount and delivery costs** | Detailed spending information available for five initiatives. The average annual budget for these initiatives was £909,000. |

| Summary of evidence | |
|---|---|
| **Evidence of impact** | The 13 initiatives that fell under this scheme type had a significant overlap with community-based schemes and prevention and early intervention initiatives. The key benefits of these initiatives typically included avoiding unplanned health and care events and improving wellbeing outcomes for those receiving these services. However, due to the overlap with other schemes, the impact identified in most initiatives could not be solely attributed to the integrated care planning and navigation aspects. A small number of initiatives were categorised solely as integrated care planning and navigation, but no evaluation of their impact was identified.<br><br>Successful integrated care can be achieved by developing centralised hubs that co-locate diverse services to streamline access and robust engagement from GP practices and system partners. Access to comprehensive, up-to-date data can also enable effective integrated care planning. |
| **Evidence to support scaling-up or replication** | Of the 13 initiatives, seven discussed scaling-up or replication. This included expanding operating hours, adopting a model within another area of healthcare, expanding the cohorts supported (for example, reaching people earlier or targeting certain demographic groups), and accepting referrals from a wider range of services. |
| **Barriers and challenges** | Challenges included establishing and utilising referral channels across different services, establishing productive partnership working, workforce capacity and staff turnover, increasing client engagement, wider systemic challenges (for example, rising NHS waiting lists or COVID-19), and pressure on staff to prioritise urgent over preventive care. |
| **Lessons learnt** | Establishing buy-in and commitment from all delivery partners, transforming existing working models to avoid the need for additional recruitment, ensuring person-centred approaches to care, effective communication across delivery teams, and recognising the value of personal relationships in care delivery were some of the lessons learnt identified. |

## Selected examples

| **Grove View Integrated Health and Care Hub** Dunstable | | | | | |
|---|---|---|---|---|---|
| **Timeframe** | **Description of relevant service** | **Target Demographic** | **Target Outcomes** | **Impact** | **Funding** |
| Established in Spring 2023 | The Grove View Integrated Health and Care Hub, established by Central Bedfordshire Council in partnership with the Bedfordshire, Luton, and Milton Keynes Integrated Care Board, is a state-of-the-art facility designed to bring together a wide range of health and social care services. Opened in spring 2023, the hub integrates over twenty different services, including primary care, mental health support, community care, and social care. It houses services such as Bedfordshire Talking Therapies, the children's and adolescent mental health services (CAMHS), out-of-hours GP clinics, blood clinics, and other essential out-of-hospital services. | People with complex care needs or long-term conditions. | Expected to streamline access to pathways and reduce waiting times for health and social care. | The Hub enables local populations to access services closer to home by bringing together services that have historically been fragmented or provided in multiple locations under one roof. It will improve people's experience of accessing health and social care by streamlining pathways and reducing the time required to access multiple providers. No evaluation was identified. | BCF<br>Total funding amount not available. |

| **Keeping in Touch (KiT) programme** Wokingham | | | | | |
|---|---|---|---|---|---|
| **Timeframe** | **Description of relevant service** | **Target Demographic** | **Target Outcomes** | **Impact** | **Funding** |
| Not available | The Keeping in Touch Programme (KiT) provides 1:1 coaching to people with rising care needs in Wokingham.<br><br>The initiative found gaining the support of referring professionals a challenge due to time-consuming referral processes. This was resolved by developing a straightforward referral pathway. This pathway is built on existing routes within health and social care teams, making it easier for busy health and care professionals who serve as KiT coaches to use. | People with rising care needs. | Improving referral processes. Improved collaborative partnerships. | Initial results have demonstrated effective pathways, meaning that the programme has successfully established clear and efficient routes for clients to receive the support they need. This includes effectively identifying and engaging with vulnerable individuals, connecting them with appropriate services, and providing consistent, personalised coaching to address their specific needs. In the first few months, the programme interacted with over 230 clients and collaborated with over 80 organisations, ensuring that individuals received timely and relevant support, ultimately contributing to the programme's overall success and positive outcomes.<br><br>At month eight, referrals averaged 22 per month; two full-time coaches, expanding to four; 100 people 'active' at any one time; 10 contact points on average per client; average of 2.5 referrals / signposting per referral; over 95 per cent of clients satisfied or very satisfied with the service; reporting of one safeguarding issue a month. | BCF<br><br>Costs £9,000 per month. |

| **Proactive Anticipatory Care (PAC)** Kingston and Richmond | | | | | |
|---|---|---|---|---|---|
| **Timeframe** | **Description of relevant service** | **Target Demographic** | **Target Outcomes** | **Impact** | **Funding** |
| Started as a pilot from May 2021 to September 2023 and is now implemented across all primary care networks (PCNs). | Adopting an anticipatory care model, this initiative facilitates weekly meetings between patients with chronic conditions and a multi-disciplinary team of GPs, community, social care and hospital-based staff, working together to provide more proactive and coordinated care. | People with multiple long-term conditions and frailty who are becoming reliant on emergency care as their health deteriorates. | Enables care recipients to stay healthier for longer, maintain or improve functional ability, and increase positive experiences of personalised care. | During the pilot phase, 470 patients were accepted onto the caseload, with an additional 300 accepted since the rollout was implemented in September 2023. Outcomes suggest that, for patients that have been on the PAC programme for four months or more, unplanned care service utilisation has reduced by 50 per cent, and length of stay for unplanned non-elective reasons has reduced by 57 per cent.<br><br>**Note:** Proactive Anticipatory Care is categorised under prevention or early intervention, community-based, home-based intermediate care and integrated care planning and navigation. Because it falls under multiple categories, we cannot attribute its quantitative impact evidence solely to integrated care planning and navigation. | Non-BCF<br><br>(Various pots of system-wide funding including non-recurrent and recurrent allocations and workforce resources.)<br><br>Total funding amount not available. |

# 9 Workforce initiatives

As part of our call for evidence, we also received submissions that were clearly linked to providing preventive and proactive care but fell outside our original typology of schemes. Four initiatives focused on training and support for the health and care workforce to develop new skills and adapt to new integrated and prevention-focused ways of working. These interventions have been included as they respond to one of the common challenges outlined elsewhere in this report, namely that staff may lack the knowledge and skills to deliver prevention activities through new approaches and ways of working.

| Overview of Workforce initiatives | |
|---|---|
| **Intended outcomes** | To support the health and social care workforce in developing the necessary skills and capabilities to effectively deliver preventive and proactive care interventions. |
| **Target demographics** | Health and social care staff. |
| **Funding amount and delivery costs** | Detailed spending information available for three initiatives. The average spending was £116,000 per annum. |

| Summary of evidence | |
|---|---|
| **Evidence of impact** | All initiatives demonstrated learner satisfaction through surveys, and organisations reported qualitative improvements in skills and service delivery systems. No long-term or quantitative evaluation of the impact of training beyond this, although evaluations are ongoing for at least one initiative. |
| **Considerations to support scaling-up or replication** | Training interventions can be applied elsewhere using existing materials. Some initiatives were already being rolled out in new locations. |
| **Barriers and challenges** | Key challenges include how to deliver training, for example, model, location, virtual or in-person. Engaging potential participants in a new piece of training could also be challenging. This was addressed by getting senior management in relevant services to advocate for training and support their teams in attending. |
| **Lessons learnt** | Most initiatives followed a co-production approach to design training and found this a very helpful way of designing an intervention which met local needs. |

## Selected examples

| **Neighbourhoods Workforce Development** City of London and Hackney | | | | | |
|---|---|---|---|---|---|
| **Description of relevant service** | **Target Demographic** | **Target Outcomes** | **Impact** | **Funding** | **Funding** |
| Ongoing, began in 2022 | Based on consultation with staff and an assessment of staff needs, it was identified that staff need support to work with changing approaches to service delivery, engage in co-production with residents, understand and navigate power dynamics with members of the public and create a learning system. | Health and social care staff. | Enhanced skills and capabilities across staff.<br>Staff more able to deliver integrated support to health and care. | A range of pilot sessions and courses have been run in the pilot phase, and new resources will be incorporated into a Neighbourhoods Staff Handbook. | Combined (BCF and other system funding)<br>£200,000 total |

| **Social Care Training Hub** Lancashire and South Cumbria | | | | | |
|---|---|---|---|---|---|
| **Description of relevant service** | **Target Demographic** | **Target Outcomes** | **Impact** | **Funding** | **Funding** |
| Ongoing, began in 2023 | Established in 2023, this ICB initiative supports adult social care organisations with staff training and workforce development.<br>The hub brings together training and support for social care staff, including e-learning, resources and information about placement and apprenticeship opportunities. | Social care staff | Focus on developmental skills (not mandatory care sector training).<br>Avoid inappropriate hospital admissions. | A wider evaluation of the hub is ongoing but a number of improvements have been noted.<br>The retention rate of apprentices has been encouraging. Since the hub was established in early 2023 only one of 54 apprentices who completed their programme have left the organisation they worked with. | Non-BCF<br>£300,000 over 2.5 years |

| **Why Weight to Talk** Cheshire West and Chester | | | | | |
|---|---|---|---|---|---|
| **Description of relevant service** | **Target Demographic** | **Target Outcomes** | **Impact** | **Funding** | **Funding** |
| Ongoing, began in 2021 | Food Active (part of the Health Equalities Group, a North West public health charity) was commissioned to co-develop the training with a multi-stakeholder working group. Stakeholders co-designed training content, objectives, mechanisms for delivery, and training format. They also supported recruitment for the training.<br>The training was delivered as a 90-minute interactive session and was available as both an online and face-to-face option. | Health and social care staff | Help staff understand the factors that influence obesity or being overweight.<br>Give staff tools to have positive conversations and be aware of where to refer individuals or appropriate resources to signpost. | Over the last two years, 362 individuals have taken part in training from health and social care organisations.<br>Learner surveys show that the training has been successful in increasing participants' knowledge and understanding. The training has shifted focus to help practitioners understand that significant barriers often make it much harder to maintain a healthier weight. | Not available<br>£16,000 total |

Section 5

# Conclusion

Contents

# Section 5. **Conclusion**

Local areas are investing in a wide range of initiatives, and there is much diversity in their approaches to improving outcomes. Key learnings from our research underscore the need for a more systematic approach to evidencing the impact of initiatives in order to promote further local investment in preventive and proactive care. For instance, while many initiatives received strong positive feedback from service users, carers, and health and social care staff, only a few could robustly demonstrate impact on health outcomes or financial or social returns on investment. A sector-wide effort to develop a framework for evidence gathering, testing, and scaling-up these initiatives could improve the evidence base available to support decision-making.

The evidence base for preventive and proactive care interventions varies widely in type, quality, and quantity, reflecting the diverse maturity and size of the initiatives. Most of these initiatives, though promising, lack the infrastructure needed to evaluate their broader impact effectively. This situation is especially evident in areas like assistive technology or home-based care, where qualitative feedback and self-reported outcomes are common, but clear returns on investment remain difficult to ascertain. Successful models like the Falls Prevention Programme offer valuable lessons. This programme has demonstrated positive returns on investment through a structured approach to data collection and monitoring. It highlights the importance of building the infrastructure necessary to evaluate and scale initiatives across the system. A national framework could support more consistent evidence-gathering and long-term impact evaluation.

The table below provides a brief summary of the strength of evidence we found for the impact of interventions by scheme type.

| Scheme type/services | Strength of evidence of impact |
|---|---|
| **Prevention/early Intervention** | Falls management has the most well-established evidence base, with a demonstrated financial return on investment and positive societal impacts. Ongoing evaluations will provide further insights into optimising these programmes. Social prescribing has an emerging evidence base with qualitative information indicating improvements in user satisfaction and wellbeing. However, detailed ROI analysis and comparisons with control groups are not yet fully established. Other interventions show varied evidence, with a less developed evidence base overall. While these initiatives often project financial savings and receive positive feedback from users and professionals, such as in hydration-focused projects which reduce healthcare costs through improved health, comprehensive evidence remains limited. |
| **Community-based schemes** | The evidence base for the identified schemes included both quantitative and qualitative insights. Of the initiatives reviewed, 20 per cent had completed economic and impact evaluations, demonstrating cost-effectiveness and positive returns on investment. The remaining evidence primarily comprised qualitative feedback, highlighting high levels of user satisfaction, service access, and positive self-reported outcomes, such as increased independence. With additional evaluations underway or planned, the evidence base is expected to expand, providing more comprehensive data on the impact of these initiatives. |
| **Home adaptation schemes** | Initiatives built on a wider evidence base for the impact of home adaptations, including positive estimates of return on investment. Positive impacts were also cited for individuals' wellbeing, independence and utilisation of health and social care services. However, a lack of evidence was available on the comparative effectiveness of different approaches to delivering home adaptations, for example, handyperson services, small non-means tested grants. |
| **Assistive technology** | Assistive technology initiatives were found to improve individuals' quality of life and independence, with most evidence being measured using qualitative feedback and self-reported outcomes. Due to the personalised and small-scale nature of these interventions, it was difficult to determine a clear return on investment and evidence the full scope of medium- to long-term benefits. Overall, based on the evidence reviewed as part of this research, there is limited evidence available on the wider impact of digital assistive technology. |

| Scheme type/services | Strength of evidence of impact |
|---|---|
| **Urgent community response** | There is strong evidence indicating that urgent community response interventions often prevent hospital admissions and reduce the need for ambulance call-outs. This evidence supports the development of cost-saving assumptions based on the average costs of admissions and call-outs. However, there is a lack of data on the long-term impact, such as whether individuals who receive these interventions remain at home longer compared to those in a comparison group. Moreover, it should be noted that evidence on hospital admission avoidance in crisis scenarios is easier to evidence than medium- to long-term benefits of multi-component interventions (such as low-level assistive technology, carer support, or links to social prescribers). |
| **Home-based intermediate care services** | The evidence base for the initiatives varies in strength, with most relying on self-reported outcomes or preliminary data. Around 20 per cent have demonstrated cost savings and positive return on investment, while approximately 10 per cent are still awaiting final evaluations. Many initiatives lack formal evaluations or comprehensive ROI analysis, offering mainly qualitative feedback. This feedback highlights that personalised care plans, a holistic approach integrating various services, and strong coordination among healthcare professionals and caregivers are key factors contributing to positive outcomes. |
| **Bed-based intermediate care services** | There was limited evidence available on the effectiveness of approaches in this area. While some initiatives showed the utilisation of bed-based settings, there was no quantified data on their impact on reducing acute care admissions or readmissions. Further evaluations are needed to provide more detailed insights into the outcomes of these initiatives. |
| **Integrated care planning and navigation** | The initiatives under this scheme type showed overlap with community-based and prevention and early intervention schemes, making it difficult to attribute specific impacts directly to the integrated care planning and navigation components. While key benefits included reducing unplanned health and care events and improving wellbeing within vulnerable communities, only a few initiatives were classified solely under integrated care planning, with no specific evaluation available for their impact. Qualitative evidence suggests that effective integrated care relies on centralised hubs, strong engagement from GP practices and system partners, and access to comprehensive data to support care planning. |
| **Workforce initiatives** | Interventions to upskill the workforce received positive feedback from participants, but it was challenging to demonstrate the results of this for health and care outcomes. |

Initiatives repeatedly cited some key success factors:

- consistent commitment from senior leadership, giving teams the support to pilot new approaches and adapt existing ones
- partnership working across systems, particularly between primary care, secondary care, community care, social care, and housing services, as well as the public sector, VCSE organisations, and the private sector
- personalisation of support, tailoring approaches to each individual and prioritising relationship building
- service user or client involvement, to understand what 'good' looks like for service users, what barriers initiatives need to address, and how they can best be implemented.

Challenges that remain across preventive and proactive care initiatives include:

- funding, recognising wider pressures on health and social care budgets which can make prioritising preventive and proactive care difficult to do in practice
- staffing, including upskilling existing staff to adapt to new ways of working as well as facing barriers to recruitment and retention
- partnership working across systems. Many preventive and proactive care initiatives required collaboration across different organisations. Project teams and governance often relied on key individuals to represent their organisation's views in decision-making and advocate for the new initiative in their organisation. This created a risk that staff turnover in these key individuals could have a detrimental impact on collaboration
- a lack of confidence in digital skills among people being supported, their carers, and other health and care staff. This can negatively affect the impact of some digital initiatives, such as apps or assistive technology

- a lack of structured and consistent evidence gathering. The evidence base around preventive and proactive care initiatives is developing and opportunities to collect new evidence or share existing evidence should not be missed. Existing platforms for sharing evidence, such as the Better Care Exchange, can help.

Future work could focus on:

- enabling local areas to effectively evaluate the impact of initiatives through resources and support. A particular focus should be on supporting the calculation of return on investment (ROI) where appropriate
- adopting a whole-system approach by developing infrastructure to support evaluation and evidence gathering, as well as encouraging local areas to systematically publish this evidence, to spread good practice and scaling of preventive care across health and social care systems
- focusing on structural issues, such as staffing, senior leadership buy-in, and partnership working, to create a more integrated, system-wide approach to preventive and proactive care, ensuring that all components work in synergy to improve outcomes at scale.

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# Annex: Detailed list of preventive sub-scheme types

Local health and wellbeing boards report their BCF activity against a set of scheme types. The full list of scheme types can be found in BCF planning guidance. We have used these scheme types as a guide for the scope of the research.

| Scheme type/services | Sub type |
|---|---|
| **Prevention/early Intervention** | Social prescribing<br>Risk satisfaction<br>Choice policy<br>Other |
| **Community-based schemes** | Integrated neighbourhood services<br>Multidisciplinary teams that are supporting independence, such as anticipatory care |
| **Home adaptation schemes** | Adaptations, including statutory DFG grants<br>Discretionary use of DFG<br>Handyperson services<br>Other |
| **Assistive technology** | Assistive technology including telecare<br>Digital participation services<br>Community based equipment<br>Other |

| Scheme type/services | Sub type |
|---|---|
| **Urgent community response** | All |
| **Home-based intermediate care services** | Reablement at home (to prevent admission to hospital or residential care)<br>Rehabilitation at home (to prevent admission to hospital or residential care)<br>Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) |
| **Bed-based intermediate care services (reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)** | Bed-based intermediate care with rehabilitation (to support admission avoidance)<br>Bed-based intermediate care with reablement (to support admissions avoidance) |
| **Integrated care planning and navigation** | Support for implementation of anticipatory care |
| **Workforce initiatives** | Category added based on call for evidence. Focuses on giving workforce skills to implement preventive and proactive approaches |

## About the Commissioning Organisation

Better Care Fund
Support Programme

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)
- Ministry of Housing, Communities and Local Government (MHCLG)
- NHS England (NHSE)
- The Local Government Association (LGA)

The LGA has managed the BCF Support Programme since 2016.

The 2023-25 BCF Support Programme brings together the unique expertise and experience of the LGA in partnership with ADASS and Newton Europe to create a stronger improvement partnership.

Alma Economics provided support for this research.

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Better Care Fund
Support Programme