Benefits Proposal

<table>
<tr><td>Opportunity Name:</td><td colspan="3">A&C Targeted Prevention</td></tr>
<tr><td>Opportunity Description</td><td colspan="3">How we can help residents achieve better outcomes and live more independently for longer through targeted early intervention.</td></tr>
<tr><td>Existing MTFS lines relating to opportunity</td><td colspan="3">N/A</td></tr>
<tr><td>Quantified opportunity over MTFS Financial Value - net of ongoing costs and net of existing MTFS value (inflation contingency)</td><td>£3.90m
(£0.36m)</td><td rowspan="2">Confidence level of value</td><td rowspan="2">Medium</td></tr>
<tr><td>Further benefit beyond the MTFS (Inflation Contingency)</td><td>Full run rate achieved in FY 31/32:
£6.33m (£1.01m)</td></tr>
<tr><td colspan="4">Evidence behind opportunity and local levers

<u>Leicestershire context</u>
Compared to its statistical neighbours, LCC benchmarks above average for the proportion of older adults receiving long term support, with 50 out of every 1000 residents aged 65 and over in receipt of long-term care in 2024/25. Matching the average rate across its statistical neighbours would equate to an 11% reduction in caseload LCC.

This proposal outlines an opportunity to intervene with residents before a crisis or escalation in need occurs through earlier identification of residents most at risk, and proactive outreach to connect these residents with services and interventions that will reduce their risk and therefore reduce or delay their need for long-term formal care.

<u>Identifying the residents we could prevent requiring long-term support</u>
We reviewed the case notes for a sample of 200 residents to understand the primary reason why people escalated into long-term care. This exercise found that for older adults, the most common primary reasons why a resident entered long-term care were:
• A fall [23% of older adults]
• A physical health crisis [18% of older adults]
• A decline in physical health [15% of older adults]
• Dementia or cognitive decline [11% of older adults]
These four causes combined accounted for two-thirds of older adults escalating into long-term care.

Taking residents with the primary escalation reasons above, for a smaller sample of 61 residents we conducted deep dives to examine their journeys into care to understand all the causes for the resident entering care, whether the entry into care was preventable and what would have had to be different to prevent the entry. Of the 61 residents we reviewed during case reviews, for 27 cases (44%), practitioners agreed that we could have intervened earlier and as a result, prevented them from starting long-term formal care.

When examining the case notes for the residents whose starts were preventable, we found the people could be broadly split into two cohorts:</td></tr>
</table>

a) A 'falls cohort' [59% of preventable starts]

We found commonality between residents whose primary cause was a fall, a physical health crisis, or a physical health decline. For these residents, we found that in most cases they had a history of falling (even though this was not always captured as the primary cause for a long-term care start), and the interventions they would require to be better supported were similar across these individuals where it was felt that an escalation into long term support could have been prevented, e.g. enablement, OT, home adaptations and equipment, assistive tech, etc. As such, we can group these residents into a 'falls cohort'.

b) A 'cognitive decline cohort' [26% of preventable starts]

The other residents were those experiencing dementia or cognitive decline. For these residents, we also found that their carers were often experiencing strain, with short breaks and respite cares identified as some of the routes to providing better support. We can group these residents into a 'cognitive decline cohort'.

<u>Evidence that these care starts are preventable</u>

To be able to prevent residents from entering care we need to be able to do two things: 1) identify them as being at risk and 2) engage them and connect them to the appropriate support. We have evidence that LCC has the foundation required to do both:

a) We could identify residents at risk earlier using data

Take the falls cohort described above as an example. From the data held by adult's services alone, we see that on average we have had 4 contacts with a resident before start their first ever long term package of care. This suggests that there is a window of opportunity where we have the chance to proactively engage residents before they reach crisis.

Case notes provide even richer data, containing the observation made by practitioners during their interactions with residents. Using a method called text analytics, we can analyse these case notes to see which risks were identified in the falls cohort prior to their start in long-term care. We can compare this to the risks identified across all residents who contacted us to see which risks are significantly more prevalent in the falls cohort. We can see that the following risks are flagged significantly more frequently:

- Health issues such as falls, hospital admissions, healthcare visits and general illness.
- Activities of daily living such as personal hygiene, mobility and toileting.
- Housing issues, especially bathroom-related issues, and financial issues.

Knowing that these risks correspond with a resident being more likely to enter long-term care, we can identify those residents we have engaged with who have also had these risks flagged in their case notes as being the people we should intervene with now, before they hit crisis point.

b) The right support offers already exist in Leicestershire

From the deep dives, we built an understanding of what types of support would be needed to prevent residents entering long-term care.

For the falls cohort, practitioners identified that residents could have been better supported had they accessed specific falls prevention support, assistive technology, OT or enablement and equipment or home adaptations. This reflects that these residents' escalations were driven by their physical needs.

For the cognitive decline cohort, the key potential support offers were short breaks for the carer or respite care, and community group support, reflecting the prevalence of carer strain.

For both these cohorts, these support offers do already exist across the County.

Delivery approach and timelines

We have the evidence to suggest that the foundations are in place for LCC to be able to prevent long-term care starts. What is needed is an operational approach to ensure we can bring data together to proactively identify residents at risk and then understand their needs holistically, so we are able to connect them to the right support to meet these needs.

a) *Identifying residents at risk*

Xantura's OneView platform is an example of a tool that would enable us to leverage our data to systematically identify residents at risk of entering long-term care. The platform allows us to combine and match data from different sources back to a single resident, for example social care and health data. This combined dataset can then be used to understand at scale what the risk factors associated with falling or experiencing cognitive decline are. We then apply these risk factors to the population of residents who have not entered care yet to identify individual to reach out to.

b) *Holistically understanding residents' needs and connecting them to support*

A potential solution is a hub-and-spoke neighbourhood model of care, similar to an approach currently being piloted with housebound residents experiencing COPD in North West Leicestershire. Under this approach, MDT meetings would be setup to bring together professionals from disciplines such as social care, OT, mental health, primary care etc. This group would be responsible for holistically understanding the needs of the residents identified as being at risk, enabled by the breadth of disciplines represented, and then identify the most impactful support offers to onwards refer residents to and monitor the impact of these referrals. Providers would then be responsible for delivering the preventative support to residents, and to feedback to the group the outcome of the initial referrals.

This is an outline approach, and detailed design work would need to be undertaken in the next phase.

These proposed changes to ways of working can be delivered as part of a joint endeavour with Health partners, as there will be significant benefits to Health as a result of these new ways of working, for example through reduced A&E admissions. As part of design and mobilisation phases, we would look to engage with health partners to share understanding of the potential impact of this proposal and collaborate on approach for joint delivery. Joint delivery of this proposal will also enable reduced cost of investment for LCC.

Outline delivery timelines

We propose a phased approach to design and implementation. The first 6 months would be used to conduct a detailed design phase. An initial operational pilot is launched for prevention in the falls cohort for 3 months, followed by a year-long implementation period. At the conclusion of this first implementation phase, the operational pilot for the cognitive decline cohort would be launched, again followed by a 12 month implementation period.

Design phase activities

There are key questions we would need to refine our answers to in the detailed design phase:

a) *Identification of residents at risk*

- What technology or tooling do we need to be able to identify residents at risk?
- Which subsets of the population do we want to identify, and which subsets do we not want to identify?

b) *Operational delivery of prevention*

- What team do we need to engage residents and deliver preventative support?
- How do we engage residents who aren't asking for or expecting support?

- What are the most impactful support offers available to support residents?
- Which of these offers will we use? How do we agree SLAs and capacity with the providers?

c) *Implementation and evaluation*

- How do we phase delivery?
- What lagging and leading metrics will we use to measure impact?
- How will we collect the data required to evaluate impact?

Impact timelines

Through this phased approach, we anticipate:

- Falls cohort residents start being engaged after 9 months; cognitive decline cohort residents engaged from 24 months.
- Data from health services becomes available to use after 15 months. Prior to this, only 45% of the benefit is accessible.
- There's a lag of 6 months between a resident being engaged and their start being prevented.
- Benefit from a prevented start is spread evenly over 108 weeks following the start being prevented.

Operational impact

We consider an achievable prevention target based on a range of evidence sources:

Triangulation Methodology	% change achievable	Long-term care starts prevented	Explanation
Baseline	***0%***	***0***	***LCC had 1,571 first-time starts in long-term care in 2024/25***
Case trawls and reviews in LCC	**13%**	**200**	**In case trawls, 66% of older starts in long-term care were caused by falls, physical health crises or declines, or dementia / cognitive decline. Case reviews found that a weighted 19% of these starts were preventable – combined this means that 13% of all older adult long-term starts are preventable.**
Best statistical neighbour	27%	424	Buckinghamshire has 27% fewer older adults receiving long-term care per capita.
Average of other Newton diagnostics	18%	283	In previous Newton diagnostics, we have found on average 18% of older adults starts in long-term care are preventable.
Median statistical neighbour	14%	220	Essex has 14% fewer older adults receiving long-term care per capita.
Average of statistical neighbours	11%	173	LCC's statistical neighbours have on average 11% fewer older adults receiving long-term care per capita.

The agreed target is an 11% reduction in the number of older starting in long-term care for the first time annually, equivalent to preventing 173 starts a year.

Benefits profile over the MTFS (net of ongoing investment)	**Benefit profile assumptions**

	In-year spend reduction *(inflation contingency)*	Cumulative benefit *(inflation contingency)*
FY 26/27	-£0.12m	-£0.12m
FY 27/28	-£0.03m (*£0.00m*)	-£0.15m (*£0.00m*)
FY 28/29	£1.30m (*£0.07m*)	£1.15m (*£0.07m*)
FY 29/30	£2.75m (*£0.29m*)	£3.90m (*£0.36m*)

- There is on average 1.9% growth in OA service users within the MTFS, and there is 3% annual inflation due to NLW and running cost growth within the contingency.
- Weekly package costs have overlap with Independence Outside of Residential Care and Reablement opportunities removed.
- We assume the project starts on 1st August 2026.

NB: At full run rate, annual benefit net of ongoing investment would be £6.33m (£1.01m inflation) achieved in FY31/32 i.e. outside of the MTFS period.

Initial view of one investment required to realise opportunity

- £175k annual licensing cost for platform to match data and identify residents to target. This has been taken as 50% of the annual OneView license cost, and assumes the cost is shared between A&C and CFS.
- Some LAs we work with consciously choose to move resource towards more preventative services to create a permanent changed way of working. Service have identified capacity within existing service FTE to embed new preventative ways of working, therefore no further investment required into FTE. This is to be reviewed post pilot phase.
- £425 one-off cost per resident engaged, with assumption that twice as many residents are engaged as are prevented. This cost covers intervention including home and group exercise programmes, and home assessments and modifications.

Risks & Dependencies (Known today)

- GDPR and privacy issues may mean organisations external to LCC don't share data they hold on residents.
- To enable the full value of the opportunity, we will need access to health data.
- Care providers are reluctant to pass information back up the chain to LCC.
- Residents aren't expecting to be contacted, so may not accept referrals to support to prevent their entry into long-term care.
- Support offers that residents are referred to may be ineffective.
- The support offers residents are referred to may have insufficient capacity or unsuitable SLAs.
- To effectively identify residents and deliver interventions, we will be reliant on working together with partners across the system, including health and the voluntary sector.
- There is potential further upside through collaboration with Health on delivery of this proposal, through shared cost of delivery. Incentivised through potential health savings through proposed changes.

Expected impact	
Residents impact	Taking a proactive preventative approach will mean we intervene with residents before they reach crisis point, enabling them to live more independently for longer and leading to better outcomes for them.
Staffing impact	It Is likely new ways of working will be required for staff to operationally deliver a preventative approach, e.g. the use of technology in the workflow, moving from referral-based to proactive engagement, group supervision working.
Service levels impact	Targeted prevention activity should reduce future service demand, leading to improvements in service levels.

How would LGR impact this opportunity?	LGR will bring more data on residents into LCC's scope, e.g. housing data, and so should improve the extent which we can identify residents at risk.
Officer Recommendation for next steps	Move to pilot delivery model and evaluate impact to consider moving to next steps. (falls cohort)
Newton Recommendation for next steps	The next step is to prioritise the beginning of a detailed design phase lasting around 6+ months. This will allow for: • Outline solutions to be developed into detailed operational plans / designs • Detailed timelines for solution implementation to be developed • Metrics and evaluation criteria to be designed and agreed • Key stakeholders such as health and the voluntary sector to be engaged and consulted on potential changes to ways of working • New teams, governance and processes to be stood up and piloted