Benefits Proposal

Opportunity Name:	**Independence Outside of Residential Care**		
Opportunity Description	Enabling more residents to live in independent settings outside of Residential Care		
Existing MTFS lines relating to opportunity	AC014: £0.16m		
Quantified opportunity over MTFS Financial Value (net of ongoing costs and net of existing MTFS value) *(inflation contingency)*	£0.50m (*£0.06m)*	**Confidence level of value**	*25% confidence weighting on total opportunity built into financial profiles*
Further benefit beyond the MTFS *(Inflation Contingency)*	Full run rate achieved in FY 31/32: £0.93m (£0.16m)		

Evidence behind opportunity, local levers and proposed solutions:

The case reviews and wider evidence show opportunities to place a portion of older adults into a more ideal setting giving them more independence than residential care.

1. Case Review Evidence

- Through a review of 35 cases, it was identified that **29% of the cases sampled** could have been placed in **a more independent** setting
- An additional **23% of older adults were identified as self-funders** who had entered our care through a depletion of funds.
- From the case reviews it was identified that half of those who could have been placed in a more independent setting could have been supported in homecare, and half could have been supported in extra care housing
- Through discussion of the evidence with the Director of Adults and Communities, it was discussed that a more sensible planning assumption would be for two thirds of avoided residential cases to be supported in homecare, and one third in extra care housing.
- **Enablers Identified:** Across the 35 cases enablers were identified for OA, with the top enabling themes were:
    - Internal Knowledge of Services
    - Community Awareness of Alternatives
    - Carer Support Model
    - Time to Step-Up Care
    - Self-Funder Management

2. Wider evidence of potential impact of a change programme

Multiple independent data sources to estimate a realistic future residential caseload for LCC.

Triangulation Methodology	% change achievable	OA who Could Avoid Residential Care Annually in Leicestershire	Explanation
Baseline	**0%**	**0**	**LCC has had an average of 867.6 long stay residential starts annually as of 2025**
Case reviews in LCC	29%	260	In case reviews, for OA in residential, practitioners felt 29% could have been placed into a more independent setting at time of assessment
Highest Newton Diagnostic Target	63%	546	The highest diagnostic target set in a previous piece of work by Newton is 63% of OA being able to be placed in a more independent setting
Highest Three Newton Diagnostic Targets Average	54%	468	The average of the highest three diagnostic target set in a previous piece of work by Newton is 54% of OA being able to be placed in a more independent setting
Phase 1b Estimate	45%	390	Phase 1b expected a reduction of up to 45% based on early analysis and previous Newton projects
Lowest three Newton Diagnostic Targets Average	38%	329	The average of the lowest three diagnostic target set in a previous piece of work by Newton is 38% of OA being able to be placed in a more independent setting
Matching the OA in Resi per 100k Population for Statistical Neighbour	27%	234	A close statistical neighbour of Leicestershire is West Northamptonshire, matching the population of OA in residential per 100k would mean a 27% reduction in residential placements (LG inform Mar 25 data)

Considering all the evidence developed through the diagnostic, a target range of 7.8% fewer residential starts is recommended. This is equivalent to the 29% opportunity identified through case reviews, multiplied by a 25% confidence weighting to account for the sample size of case reviews and uncertainty about scalability of the opportunity identified across the cohort.

In line with conversations with the Director of Adults and Communities, it is assumed that

- Two thirds of avoided starts could be supported in Homecare
- One third of avoided starts could be supported in Extra Care Housing

3. Local Levers (Current State & Strengths in LCC)

LCC already has several assets that can be built upon to unlock the opportunity:

- **ECH Capacity Plans:**
  - LCC have some existing capacity in ECH (Currently 6 schemes), LCC also has the potential to expand their nomination rights further over the 252 units in the county and are considering expanding their capacity with two new schemes.
- **Existing Provider Relations:**
  - There is currently existing work carried out with providers in the form of teleconferences being held within the county, these foundations can then be built upon.
- **Current Carer Options:**
  - LCC has already identified that improvements are needed for their carers strategy and have begun making changes such as increasing the numbers of carers assessments. These current investments can be rolled together as part of a larger end-to-end carer strategy/offering.

4. Proposed Further Solutions

The supporting evidence pack details a connected set of solutions that have been identified across three pillars.

a. Redefining our End-to-End Carers Offering

Objective: Creating a new offering to reach out to as many of the right carers in the community and provide a proactive support plan to support carers before they experience a crisis.

Includes:

- Designing an approach and tools that would enable LCC to outreach to carers that are currently not aware of the County who may benefit from LCC's offerings in the long term, to prevent breakdowns.

- Design an approach to be able to conduct further assessments for carers, enabling the county to support individuals who reach out for support.
- Redefine what the offerings LCC should provide to carers should look like based on analytical review on what would be most helpful to them with the aim of making it easier to be a carer and prevent a breakdown.
- Utilise a carer hub model to expand our reach and build a community that enables support when risks escalate, enabling us to understand or prompt for when someone requires help before a sudden breakdown.
- Hiring a Carer lead to own the department's council agenda and help define and drive the above offering.

b. Awareness, Knowledge and Prioritisation of ECH:

Objective: Building awareness of ECH and changing ways of working within the council, creating a better understanding of ECH in the community and ensuring ECH is prioritised where suitable.
Includes:

- A reset of ECH perception within LCC by improving the culture around it.
- Changing operational ways of workings, expectations and targets to enable workers to better assess for potential ECH cases.
- A phased introduction of ECH champions to start spreading awareness of options and encourage teams to use ECH instead of residential care.
- Introducing ECH navigators as part of the long-term investment in ECH to utilise the capacity and work through process challenges faster.
- Reviewing current marketing and making it targeted towards potential ECH candidates
- Creating more interactive advertising materials including videos of ECH offering, allowing an older adult and their family to visualise their care.

c. Building a Short-Term ECH Provision:

Objective: Creating a new provision of short-term extra care, allowing potential residents to use it as a trial and be given more time to assess their long-term needs.
Includes:

- A trial process for older adults who are unsure of their ability to cope in ECH rather than residential care.
- Enabling a better ability to assess the likelihood of success for older adults living in a more independent setting over a four-week period.
- Developing the early pilot programme into a larger scheme of up to 10 units alongside the planned development of further ECH capacity in the community.

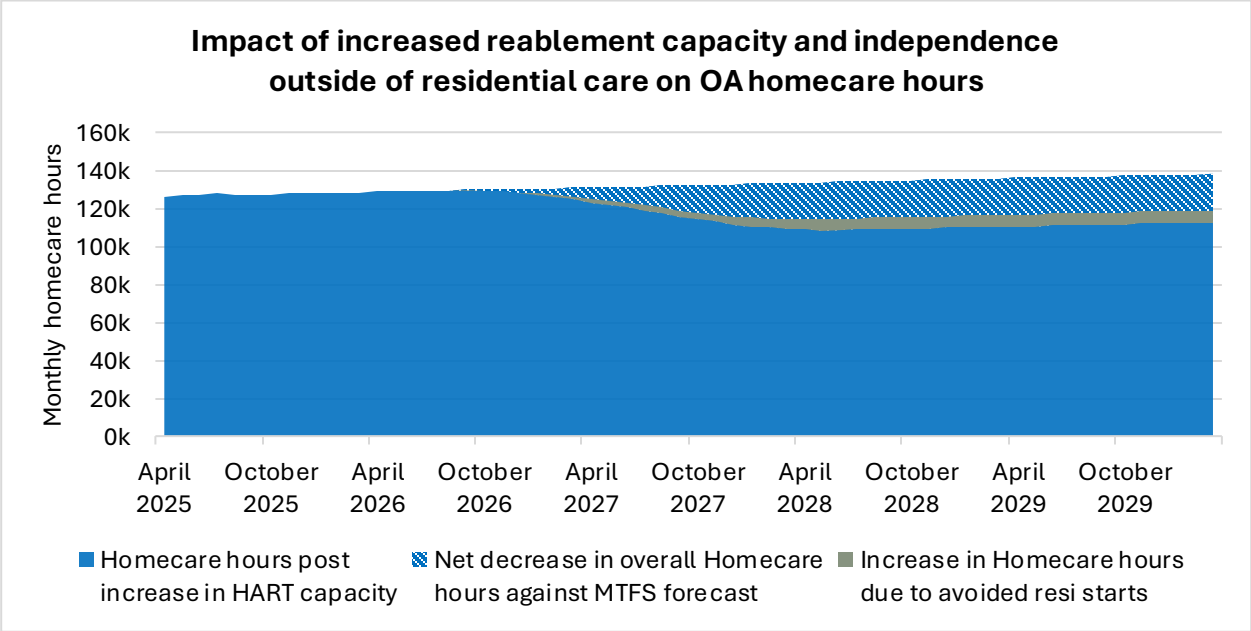
5. Summary of Dependencies:

a. Homecare Capacity

- Realisation of this opportunity is dependent on having sufficient capacity within domiciliary care; the upper end of the target, a 4.8% reduction in residential starts supported through domiciliary care, would require an additional 75.2k hours of domiciliary care capacity per year
  - *4.8% * 868 residential starts per year * 21.3 homecare hours per week * 84.7 weeks duration = 75.2k hours required*
- Increasing capacity of the HART reablement service as identified in the Reablement efficiency review opportunity will create more than this required capacity.
  - *As referenced in the Reablement benefit proposal document, scaling up HART to support an additional 699 finishers per year will create 310k hours of homecare capacity per year*

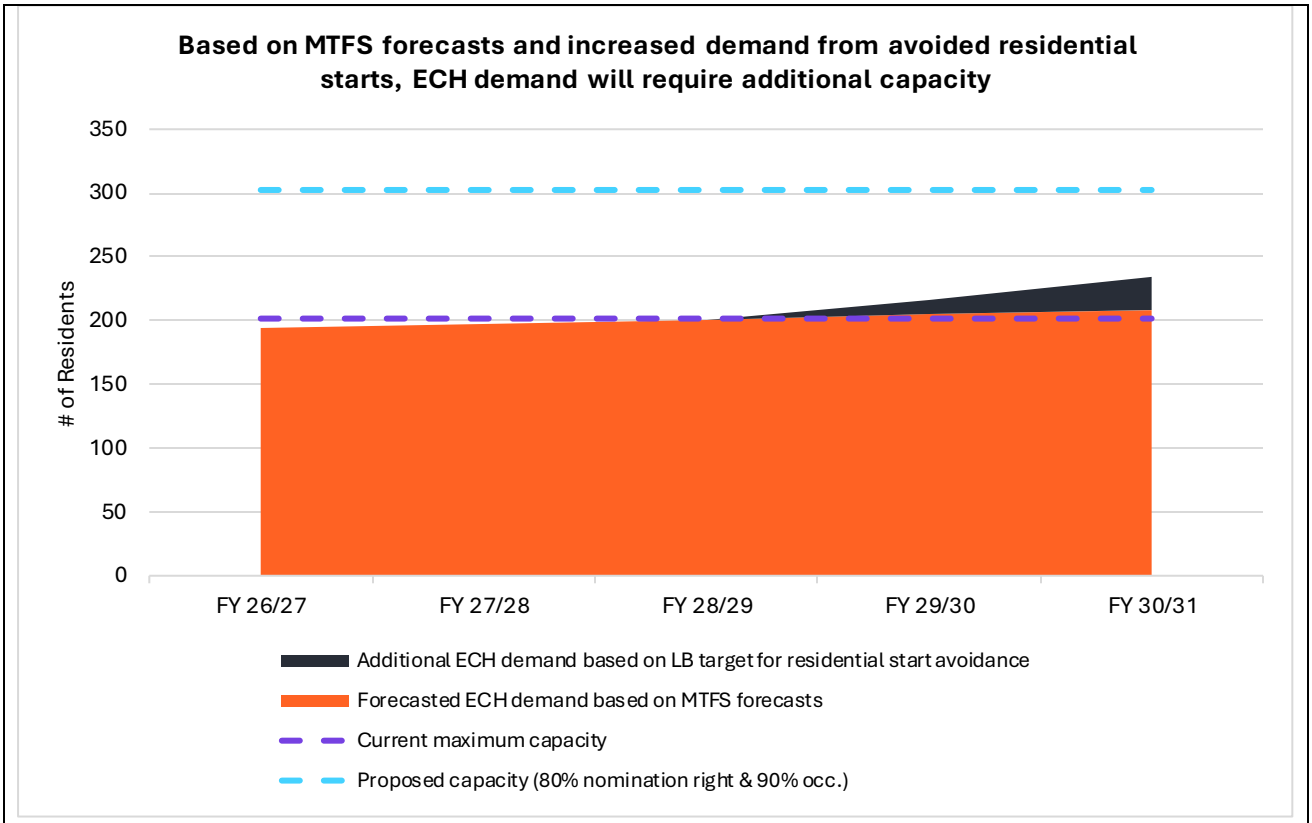
- A forecast of the monthly capacity and demand of homecare, following implementation of the Reablement initiative and this initiative, is demonstrated below.

MTFS forecasted homecare hours against reablement and independence outside of residential care opportunities



b. ECH Capacity

- Realisation of some of this opportunity is dependent on having sufficient capacity within ECH; a 2.4% reduction in residential starts supported through ECH will require an additional 32 units to be created by the end of the MTFS.
    - *i. Existing capacity of 8 places = 8 spare capacity*
    - *ii. 2.4% * 868 residential starts per year * 87.6 weeks = 26 additional residents from avoided residential starts*
    - *iii. Forecasted growth in existing demand = 14 additional residents from existing forecasted demand*



The full impact of this initiative cannot be realised until sufficient ECH capacity in the community has been developed. More work is needed to fully explore how the required ECH capacity could be delivered in LCC.

One option to build and commission new ECH units (e.g. Holliers Walk and Snibston), could be a provider funded scheme, which could be implemented which will require no cost to the council. The scheme would work as follows:

- The county looks for a private investor (or their capital) to fund the programme (no upfront capital from the county needed)
- The county makes a land deal with investor, for example selling land to investor at market value.
- The investor takes on all planning, development risks and funds construction. (no risk to the county in development and build)
- The investor is leveraged into doing so as the county will lease the assets when completed.
- When the asset is built, the county would sub-lease the units to a specialist provider at either a slightly higher or equal rate to what the council is paying back to the investor.
- The county then also gets nomination rights over a proportion of the units as it would have facilitated the development, planning and commissioning
- **Risks associated with this model:** If the provider becomes insolvent for a reason, then the county will bear the asset and a cost with no income stream. This risk can be minimised through careful study of which provider/partner to work with (e.g a housing association).

c. Successful ECH delivery

Through research we have identified case studies that demonstrate that ECH schemes can demonstrably reduce residential care demand and reduce care costs, if nomination rights, eligibility and allocations are well managed to ensure that ECH is used for those who can benefit most. For example East Sussex County Council's evaluation (Housing LIN Case Study 78) provides robust evidence that ECH reduces or delays moves into residential care, indicating that 63% of people living in the schemes would be placed in residential care, EMI or nursing care if they were not living in extra care

housing and concluded that the cost of extra care housing was on average half the gross cost of the alternative placements (referenced page 58, full paper here)

d. New FTEs Required:

- 3 FTE in ECH as navigators
- 1 FTE as carers lead to own the department's council agenda and define/ drive the above offering.
- 1 FTE in commissioning to foster strong provider relationships

6. Risks Overview:

Key risks identified are outlined in the table below:

Area	Opportunity Impacted	Risk	Impact	Current Mitigation
ECH - General	ECH	Availability of ECH on time	ECH opportunity is blocked	Further outline of detailed plan in design phase
ECH - General	ECH	Filling in the ECH capacity with the right mix of people	ECH Capacity is reduced , therefore opportunity reduced	Redesign of ways of working and processes around ECH allocation and review
ECH - General	ECH	Filling in the ECH capacity quickly otherwise the builder may have right to capacity	ECH Capacity is reduced , therefore opportunity reduced	Allocation of 3 FTE to manage this when ECH sites are open
ECH - General	ECH	The service user may not want ECH (due to lack of knowledge, location, lifestyle, inability to sell home, layout, safety concern)	Demand for ECH reduced, therefore opportunity reduced	Building better understanding of ECH to service users through short term ECH or content
ECH - General	ECH	The case workers may find the ECH route tedious and lengthy, minimising effort placed in to making it work	Demand for ECH reduced, therefore opportunity reduced	Redesign of ways of working around ECH processes and incentives/ KPI / expectations
ECH – Short Term	ECH	Workers allocate short term ECH for the inappropriate reasons, as part of a temporary solution they are working through.	Capacity for short term ECH is reduced , therefore opp reduced	Redesign of ways of working and processes around ECH allocation and review
ECH – Short Term	ECH	Temporary ECH capacity does not enable the throughput of demand to flow through, causing a backlog or resulting in people then abandoning the option.	Capacity is not enough for short term ECH , therefore opp reduced	Review post trial the demand and capacity requirements for temp ECH
Carers Offering	Homecare	We may not be able to identify the right carers that require our services and may need support in the future to prevent breakdowns	Number of carer breakdown reduced, opp reduced	Take forward learnings from out county council who successfully applied this (Hertfordshire)
Carers Offering	Homecare	When we engage with the community, the community may not engage back and reach out	Number of carer breakdown reduced, opp reduced	Mitigate as best as possible through effective approach strategy in outreaching
Carers Offering	Homecare	Carers may not flag escalating concerns and risks, and instead continue waiting until breakdown takes place	Number of carer breakdown reduced, opp reduced	Set the right community and structures to be able to learn more about the carers and encourage reaching out.
Carers Offering	Homecare	Capacity for assessment of carer may fill up resulting in a backlog and therefore waiting times and access to respite becomes high.	Number of carer breakdown reduced, opp reduced	Post design and trial, conduct a review on capacity vs demand of carer assessments
Carers Offering	Homecare	Following a hospital discharge, there is a risk of carer not being able to accommodate the return of the individual and therefore user can't stay home	Number of carer breakdown reduced, opp reduced	Design a carer offering that would enable better support for carers to care for users post hospital discharge – but risk remains through.

7. Supporting info – previous Newton projects associated with improving the carer's offering:

Hertfordshire: Proactive prevention for carer breakdown

Newton | Leicestershire County Council

A Newton project in Hertfordshire named the **"Connect and Prevent programme"** was set up from 2023 **to identify cares in the community** who were at risk of breakdown.

It did this by placing **a risk score on the carers within the community** and having an automated process of a letter being sent to carers at risk, inviting them to meet with a trained volunteer about their role as a carer.

In order to access more individuals within the community **a Carer's Hub** was stood up which improved wellbeing and resilience of carers by 20% -25%.

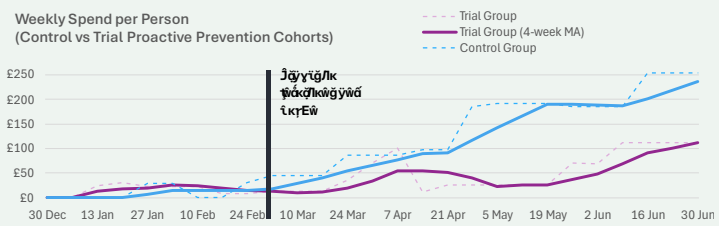
The programme as a whole:
- Enabled ~800 more people per year
- Helped ~4000 people per year achieving more independent outcomes
- Created a new carers hub, proactively contacting ~1000 carers at risk of breakdown per year.

It was underpinned by
- Performance dashboards
- Goal progression visibility mobile app
- AI driven resident insight platform

Hertfordshire created a new Carers Hub, targeting at risk carers of older adult residents using ACS data

The Carers Hub pilot targeted older-adult carers supporting older adults known to ACS, showing early positive results:

- Carers who have completed the process report a **24%** improvement in resilience and **21%** increase wellbeing
- Weekly support costs are **£120 lower** for the intervention group compared to a natural control, reflecting improved independence and reduced demand.



The hub is continuing to be established and onboarding a second practitioner, which will provide the capacity to achieve and exceed the **£1.2m** savings target, equivalent to **134 carer breakdowns.**

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Delivery approach and timelines

Our next phase should include ~3 months of detailed design and testing and impact measurement before wider rollout. This period will develop detailed operating models, confirm investment requirements, test assumptions, and ensure solutions are deliverable at scale.
Below outlines how this applies to each solution area.

a. **Redefining our End-to-End Carers Strategy**
   - **Months 0-3:**
     - Shaping the role of the carer's lead and what a new offering should look like
     - Continuing current work going on to increase the number of carer's assessments conducted within Leicestershire.
     - Hiring a carer's lead who understands and wants to codevelop a new offering to engage carers effectively.
   - **Months 3-9:**
     - Integration of all current work in LCC into a coherent end-to end strategy which captures:
       - Carer's assessments
       - Engagement of new carers
       - Earlier intervention with carer strain
       - Set up of a carer's hub
   - **Months 9-15:**
     - Once full impact has been seen, continuing to monitor changes and ensuring that LCC stays proactive rather than reactive will be essential to realise the entire potential of this solution.

b. **Awareness, Knowledge and Prioritisation of ECH:**
   - **Months 0-30:**
     - Build additional ECH Capacity
     - Begin design of overall culture change, including changes to ways of working, targets for LCC teams in Homefirst considering ECH, and understanding the overall culture shift that needs to occur to make ECH a priority
     - Development of new marketing materials and determine how to target the appropriate older adults
   - **Months 30-36:**
     - Roll out trialled developments across all teams and ensure ECH is being prioritised across the entirety of LCC where it is possible and that ways of working are not counteracting this effort.
     - Begin spreading advertising about ECH through the community and further develop materials including video footage.
   - **Months 36-48:**
     - Implement an improvement cycle to maintain culture changes within Homefirst teams and ensure culture change is remaining in place with a prioritised ECH to realise the full impact of the change

c. **Building a Short-Term ECH Provision:**
   - **Months 0-30:**
     - Build additional ECH Capacity to enable the roll out of an effective short-term housing model.
     - Design Process for the New Model
     - Understand how the flow of the short-term model will fit into the demand and capacity of ECH.
   - **Months 30-36:**

- Pilot scheme with one unit being utilised and block booked to understand issues with process and any changes which need to be made.
- Iterating the model and beginning a phased expansion (up to three units)

- **Months 36-48:**
  - Expand improved strategy to larger number of units (up to 10 depending on flow) to realise the full impact

Initial view of investments required to realise opportunity

	ECH Awareness and Knowledge	Short Term ECH Model	Reshaping our Carer Offering	Enabler – ECH Capacity
Summary	Cultural changes to prioritise ECH for decision makers as well as better community engagement with ECH	A short-term model of ECH allowing for longer assessments and trials for potential residents	Redesigning what we do for carers, including hiring a new carer's lead to head up the strategy	ECH available capacity is required on unlock half of the benefit. To have the capacity available, investment is needed in a new set of properties.
Requirements	- Cultural changes and changing ways of working to prioritise ECH - Development and distribution of new ECH information	- Trial of one unit and then expansion to 5-10 units	- New strategy development - Hiring a carer's lead	Plan, develop, Commissiong new properties Ensure properties are being filled in appropriately and quickly when commissioned
Investment needed	- Cost to develop new materials including videos and leaflets. - Cost of distribution of advertising materials.	- Each unit has a cost of £15k-£18k to run - Cost up to £180k	- Carer's lead hiring process and salary annually	Planning and building: Capital expenditure to develop ECH navigator FTEs required to enable filling the ECH units with the right people quickly.
Logic for investment	No cost for culture changes but costs for distribution to older adults and new marketing	Pilot programme will have one unit and then slowly expand up to 5-10 units	One FTE required as a carer's lead, initial cost of hiring them and salary	Planning/building: No cost for the county department, instead cost is covered through capital project fund and further potential reserves. Filling the units when commissioned: 3 FTEs year 1 then drop down to 2 then 1 FTE by year 3.
Total per area	**Initial Cost** – ~£20k **Annual Cost** – Negligible	**Initial Cost** – £18k **Annual Cost** – Up to £180k (Yr3+)	**Initial Cost** – £80k-£100k **Annual Cost** – ~£80k	**Initial cost:** ~£150k for FTEs in Year 3 **Annual cost:** ~£100k year 4, £50k year 5+

Benefits profile over the MTFS (net of ongoing investment)

	In-year spend reduction	Cumulative Benefit
FY 26/27	**-**	-£0.12m
FY 27/28	**£0.35m** *(£0.01m)*	**£0.23m** (£0.01m)
FY 28/29	**£0.12m** *(£0.02m)*	**£0.35m** *(£0.03m)*
FY 29/30	**£0.15m** *(£0.03m)*	**£0.50m** *(£0.06m)*

Benefit profile assumptions

- 867.6 Residential Starts Annually (Baseline Starts based on average over a year from Oct 2024-Oct 2025)
- Net avg. residential package cost is £578.90 based on CLPI data and weighting of 58% contribution from LCC.
- Net avg. Homecare cost is £353.61 based the top 25% of care packages by hours (excluding packages above 31.5 hours for homecare) from CLPI Data
- Net avg. ECH cost is £333.81 based the top 25% of care packages by hours (excluding packages above 31.5 hours) from CLPI Data plus cost of waking night support
- Avg. duration of residential care avoided is calculated at 84.7 weeks as this is the midpoint of:

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68.4 Weeks – The avg. duration of a maintenance package of care (residential delay)
107 Weeks – The average duration of a residential package of care (residential avoidance)

There is additional potential upside not built into the benefit profiles, including e.g.:

Any additional avoided starts we could support through better utilisation of existing ECH capacity in the short term (i.e. ensuring the right people are allocated when existing units become available)
Anything we could do to better manage self-funders to reduce capital drops

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<tr><td colspan="2">Expected impact:</td></tr>
<tr><td>Older Adults Impact</td><td>More older adults will be considered for more independent settings, allowing them to delay their entry into long term residential care and stay as independent as possible while still having their care needs met.</td></tr>
<tr><td>Staffing impact</td><td>Staffing levels will increase to accommodate further ECH capacity being filled, allowing for a carer strategy to be developed.</td></tr>
<tr><td>Service levels impact</td><td>A significant number of older adults (up to 189 starts annually) will require care in an alternative setting, split between ECH and homecare.</td></tr>
<tr><td>Officer Recommendation for next steps</td><td>The proposed opportunity should be progressed at the lower confidence level due to uncertainty of delivery. Should delivery prove successful, further targets can be considered for future MTFS inclusion</td></tr>
<tr><td>Newton Recommendation for next steps</td><td>The next step is to prioritise the beginning of a detailed design phase lasting around 3-6 months. This will allow for:

Solutions to begin being developed into detailed plans/ designs
Assumptions to be tested and challenged while piloting new ideas
Detailed timelines for solution implementation to be developed
Key stakeholders for change can be engaged and consulted on potential changes

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