Technology Enabled Care (TEC) and Reablement

- ASH Panel 24th February 2022 Gerald Hunt

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ADASS / NHS X /TSA Regional/ System /National TEC Leadership & Opportunity

- North Somerset Hosted the ADASS Tech Leads recent regional ADASS/TSA Workshop, Regional ADASS leader for TEC
- National Representation on ADASS / LGA Digital and TEC Board
- NHS X Digital Care at Home Board Representation
- Healthier Together Digital Board Representation and Chair of Digital Population Working Group

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Digital Population Working Group (DPWG)

- Monthly meeting with BNSSG LA and Sirona representatives, CCG Digital lead and Healthier Together (HT) Digital team
- Reports to the Digital Change Authority & Healthier Together Digital Board
- Governance for HT Digital projects including:
  - Care Home digital maturity
  - BNSSG Digital Inclusion
  - Technology Enabled Care (TEC) Collaboration
- Delivery Plan in place to digitally prepare the 3 LAs and Sirona for joining the Integrated Care System in March

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Technology Enabled Care (TEC) Collaboration

Collaboration between the three LAs and Sirona

- Fortnightly meetings to meet and share ideas/progress

Communications combined between all organisations to raise TEC awareness and for telecoms digital switchover

Referral and response pathways mapped and compared

Conversations booked with the 3 TEC teams and Sirona to find opportunities for further practical collaboration

Meetings with other TEC teams across the country are underway

Financial evaluation of TEC consistent for the 3 LAs

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Care Home Digital Maturity

Digital surveys released and responded to by care homes in late 2020 for care home digital maturity status on NHS Futures platform

- 95% response rate from NS, <50% in Bristol & SG
- Data used to rank digital maturity of all care homes
- Updated weekly with NHS mail/DSPT information from NHSE
- Updated surveys sent out in Jan 2022 to all care homes and domiciliary care providers
- Learning from NS to be applied to Bristol and SG to increase responses

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Digitising Social Care Records

Background: North Somerset Council, on behalf of BNSSG ICS were successful in bidding for NHSX's "Digitising Social Care Records" funding phase one £60k.

Aim: to allow authorised professionals in care homes and domiciliary care organisations to view shared records on Connecting Care

Key Deliverables:

- ❑ Bring 3 domiciliary care providers (NS Strategic Providers) and an additional 15 care homes onto Connecting Care
- ❑ Propose a dataset to be a national standard for information sharing with domiciliary care
- ❑ Understand the digital maturity of providers in BNSSG
- ❑ Understand causes of friction in transfers of care
- ❑ Produce a "Blueprint" for other areas to learn from - Providers in NS setting national digital care standards for Providers

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DSCR -Why is this important?

People want their health and care to be joined up

Interoperability

Health & Social Care Bill 2021/22

"Respondents told us that they want to be listened to. **They don't want to have to repeat their story multiple times** with multiple providers. **They would like services to be more joined up** and are **open to the increased use of technology** in order to support this."

"Support works best when it is joined up and person-centred… they wished services spoke to one another."

NHS Long Term Plan Engagement Programme

"Promote a multidisciplinary team approach **where professionals work together in an integrated way** to provide tailored support that helps **people live well and independently at home** for longer"

NHS Long Term Plan

"By **removing the barriers that stop the system from being truly integrated**. We want to help Integrated Care Systems play a greater role, delivering the best possible care"

Integration and innovation: working together to improve health and social care for all – White Paper

healthwatch

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Acoustic Monitoring – Unified Tech Fund (UTF)

Background: North Somerset Council, on behalf of BNSSG ICS, have been successful in bidding for NHSX's "Digitising Social Care Records" funding £670k

Aim: To demonstrate at scale the benefits of acoustic monitoring with the first national delivery of a centralised commercial monitoring service. Pilot delivery in North Somerset of ARMED and WHZAN tools.

Key Deliverables:

Upscale the acoustic monitoring provision for at 600 unit with approaching 400 in North Somerset whilst establishing a centralised monitoring system. Implementation of central monitoring system is first in UK.

We will pilot ARMED and WHZAN in several care homes and community settings predominantly in the North Somerset area, working with Sirona on deploying at least 137 individual devices as part of the DTA pathways and ongoing reablement pathway. It will be the intention if successful to deploy the most effective application across BNSSG, the purpose of the pilots to establish evidence-based outcomes and plans for future use and upscaling where applicable.

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WHZAN

WHZAN BLUE BOX

- All-in-one telehealth case
- It measures vital signs, records photos, performs multiple assessments and questionnaires including NEWS2.
- Signs of deterioration or illness are identified earlier, for a clinical response or carer support.

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ARMED

ARMED

ADVANCED RISK MODELLING FOR EARLY DETECTION

- Utilises wearable technology to collect key metrics associated with frailty and the risk of falling.
- To prevent falls and identify other risks, collecting the right data and analysing it to identify patterns are key.
- Data from wearable devices is complemented with regular weigh-ins and grip strength tests.
- The data is analysed using sophisticated predictive analytics.
- Machine learning allows alerts to be raised to identify any risks.
- Community trials have identified that warning flags are being raised approximately 32 days in advance of a potential incident, allowing for early intervention and appropriate support.
- Gradual deterioration can be spotted before it is too late, empowering independent living for longer.

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Innovation and sustainability grant

TEC and community asset bids – Total £700k

- Total £700k match funding by CCG/NHS X
- Acoustic monitoring can reduce staffing requirements which will reduce the amount of people having to drive to the setting
- Transitioning to digital care records
- Wzhan Blue Boxes will enable staff to check and record vital statistics to reduce the amount of visits required by community nurses or visits to the GP surgery.
- ARMED system will enable early detection of issues which will potentially prevent hospital admissions which would require ambulance attendance etc.

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Technology Enabled Care

Risk management with a strength based approach

- Virtual assessments between therapists / individuals
- Digital Social Care Records
- Increased efficiency in work scheduling
- Encouraging and supporting service users to access online shopping
- Encouraging Direct Payments so that service users can source own solutions.
- Virtual Welfare calls such as the Wellness Service
- Wzhan Blue Boxes and Armed systems to encourage proactive health management and reduce use of emergency and health services.
- Pendant and Carelink system can reduce physical call outs
- Recommissioning Day Care services to take a “without Walls” approach to offer more

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Reablement and TEC Hub

Revised Reablement pathway launched 17th January 2022

- Single Reablement Provider AYC aligned with Occupational Therapists,12 additional carers funded via D2A business case.
- Delayed Care Act assessment to maximise independence opportunity and reduce DTA length of stay.
- TEC Assessment alongside reablement service, TEC Hub offering a TEC assessment and range of tools as an alternative or blended with traditional care support.
- Expanded 24/7 Wellness /Rapid Response service which integrated to deliver monitoring assurance and emergency response.

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Reablement Referrals Pathway 1

D2A admin email forms to ART Hospital Admin

ART Hospital Admin create contact and reassign to Duty Therapy LAS tray.

Admin email copies to Access Your Care and Brokerage

Brokerage email D2A start date and document in LAS case notes

Other outcome

(i.e-advice and information only
-wellness
-**TEC referral**
-ref to care nav
etc

No likely Reablement needs identified

Triage discussion between AYC and duty therapy *(screen for whether reablement assessment is appropriate).*

Possible Reablement needs identified

Access Your Care (AYC) complete reablement assessment

Joint reablement assessment between AYC and duty therapy

Duty therapy complete reablement assessment (for cases that are likely to not require any care calls)

AYC email brokerage assessment date

Duty therapist case note notify assessment date to brokerage

AYC email brokerage start date

Appropriate for reablement POC

Reablement assessment completed *(either face to face, over phone or virtual as appropriate and proportionate)*

Other service provided
-therapy input
-**equipment**
-**TEC**
-wellness
etc

NOT appropriate for reablement POC – care manager assessment needed

Transfer case to ART CM managers tray for social care assessment

Suitable for ongoing POC

Care manager feels reablement service needed

Joint reablement assessment between AYC and care manager (ART team)

Care manager case note notifies assessment date to brokerage

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The story so far

It's early days

- 28 packages taken
- Reduced length of stay for Pathway 1 reduced backlog for Sirona and bed blocking
- Significant reduction in number and size of ongoing packages – 37% reduction in packages from first two weeks of up to 6 week cycle of reablement
- Projected to far exceed MTFP savings of £350k

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TEC issued

Since January 17th

- Water boiler preventing the need for a lunchtime care visit
- Amazon Echo show to support regular check ins with daughter, no care required
- Falls detector
- Linked smoke alarm
- Alexa
- Solution for strangers at the door - under development

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Residential Reablement and TEC Case Study

- Motorcycle accident in 20's caused traumatic brain injury
- Visually impaired
- Aged 59
- Lived independently with DP support previously, routines carefully managed
- Admitted due to behaviour change during pandemic, no medical reason found
- P3 Discharge
- Assessed by D2A as needing permanent placement, 1:1 support for everything in care home as unable to learn a new environment
- Case manager suggested residential reablement, referred for assessment, therapy involvement
- 1st home visit more successful than expected
- 2nd home visit used canary care and care link so that she could be alone
- Plan: to return home with DP for 30 hours, Canary Care, Alexa, Memrabel, Care link and falls detector

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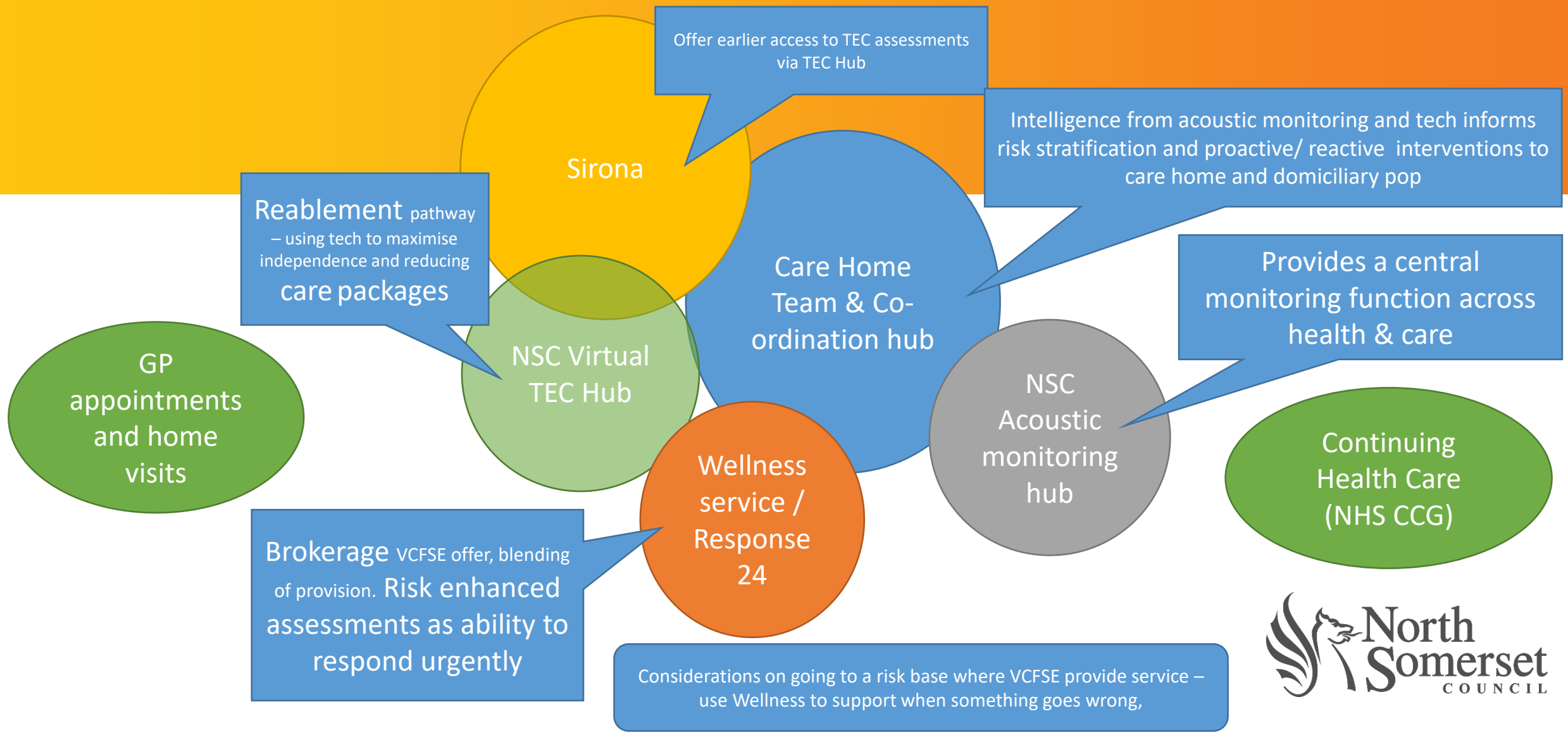
Integrating TEC into pathways



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