North Somerset Council

Report to the Adult Services and Housing Policy and Scrutiny Panel

Date of Meeting: 23rd February 2023

Subject of Report: Service Development: Reablement / TEC / Falls Pilot Update

Town or Parish: All

Officer/Member Presenting: Gerald Hunt Principal Head of Commissioning, Partnerships and Housing Solutions

Key Decision: No

Reason:

Recommendations

To note the ongoing developments in these service developments.

1. Summary of Report

The report summarises the progression of service development in these areas.

2. Policy

Our vision for adult social care in North Somerset is: To promote wellbeing by helping people in North Somerset be as independent as possible for as long possible.

3. Details

TEC:

Background and strategic context

North Somerset is home to 215,574 people and 24 per cent of the population are aged 65 or over compared to the UK average of 19 per cent.

It's forecast that in the next 25 years the population of people aged 85 and over will double. As people age the risk of developing illnesses and becoming frail increases, leading to greater need for health and social care. The pressure on the Health and Social system to meet the challenges of rising demand, acute workforce shortages and limited funding, is a huge national and local challenge.

One opportunity to mitigate these challenges is investment in technology enabled care (TEC) as part of our transformation journey. We have prioritised investment in TEC and broader transformation as critical to meeting these challenges, but an indicator of the

partnership focus of this agenda is that all current TEC posts in a team of six FTEs are externally funded via national awards or partnership contributions.

Our vision for adult social care is to promote wellbeing by helping people in North Somerset to be as independent as possible for as long possible.

Equally, the Bristol, North Somerset and South Gloucestershire (BNSSG) Integrated Care System (ICS) has an ambitious digital and information sharing programme of which we are part. The use of technology and digital solutions is essential to transformation and ensuring sustainable, patient-centric, integrated services.

In line with the ICS Design Framework BNSSG ICS seeks to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience, and access
- enhance productivity and value for money.

Our leadership on TEC within the system is recognised by our contribution to this work via the Digital Board and Digital Population workstreams, as well as the national awards and close working with NHS Transformation team. We also chair the regional ADASS TEC support group where this social care voice in an area dominated by the voices of the acutes is heartening.

The Adult Social Care Reform white paper – People at The Heart of Care, published in November 2021 sets out a shared vision for adult social care which puts people and families at its heart, TEC is a key element in this reform and we have been pioneering all three priority areas:

- to ensure that all care providers have access to the necessary infrastructure that they need to enable digital care including access to high-speed connectivity and devices
- fall prevention technologies, such as acoustic monitoring, that can reduce frequency and severity cutting hospital admissions, length of stay in hospital and the need for long term care
- digital social care records that ensure data is captured at the point of care, provides access to appropriate NHS data and supports transfer of data between care settings, resulting in less repetition of information that can lead to errors and improving productivity.

TEC achievements

We have a proven track record of leading digital and innovative programmes to improve the health and wellbeing of the population, engaging our partners and community to co-design solutions. We have been a driving force in BNSSG ICS and successfully led programmes of work to support digital transformation, more of which below.

Nationally acclaimed projects

- On behalf of NHS Transformation (formerly NHS X) we have received over £2m in funding. Two of these awards are to deliver UK first delivery models on behalf of

BNSSG ICB, North Somerset, Bristol City and South Gloucestershire councils. BNSSG is the only NHS Digital Accelerator system, delivered and sponsored by a local authority, ensuring the voice of social care is central to policy development both at a local system and national level.

- We received nearly £700k as part of Unified Digital Fund subsequently extended to over £1.5m to deliver an initial 600 units of acoustic monitoring in care homes using the UK's first central monitoring system sustained by a cost-effective subscription service for care providers.
- We also received funding as part of NHS Transformation, Digitising Social Care Records to support care providers particularly smaller care homes and the UK's first work with domiciliary care providers on designing a dataset for national standards for information sharing with domiciliary care providers. Greater take up of digital systems was encouraged from an innovation grant targeted at care providers as part of our Covid financial assistance to them, encouraging them to match investment on TEC, carbon reduction measures, and community engagement projects. The Innovation Grant of £700k was match funded by the ICB and further drew in NHS national funding as part of the above awards. The funding will support inclusion of additional care home providers across the BNSSG ICS footprint, to further progress our vision for all care providers to adopt digitalised care records by 2024. Records will be shared via the Connecting Care platform to support informed hospital admissions and discharges from and to care home settings.
- Before these schemes we were also awarded funding by LGA/ NHS Transformation, to support a project to design and develop a hydration app as a tool for care staff to improve hydration care in care homes.

Reablement Pathway and TEC

- We have redesigned reablement pathways in North Somerset adopting a 'TEC and therapy first' approach, as part of a system wide discharge to assess business case to reduce length of stay. This included the development of an in-house virtual TEC hub that has assisted dramatically improved reablement outcomes (delivering over £1.25m in 2021/22). We are currently working closely with community health and acute partners to integrate our TEC support offers to reduce length of stay and increase P0 pathways to support effective hospital discharge arrangements.
- In the first twelve months of the reablement pathway, 37% per cent of service users passing through the service have ended with no ongoing care needs, buts referral to other services include 213 physio referrals, 152 requests from the voluntary sector, 174 referrals for TEC support and 140 referrals to the Wellness service.
- We have invested in and transformed our wellbeing and rapid response services. We've identified the need to develop infrastructure to support wider TEC use that will reduce ongoing packages and promote greater independence. TEC is only as effective as the pathway it's delivered in, and we recognised that to deliver a shift in care practice and commissioning, we expanded our Wellness Service (a telephone support service offering scaled telephone assurance and TEC support to older people) and merged with our Rapid Response service (an emergency response service to all no response calls, welfare concerns and emergency support including personal care, to all our pendant alarm service users.) to provide a 24/7 monitoring

assurance and response care service, that will form the building block of how we move from planned care to more dynamic responsive care offerings.

The deployment of urgent support backed by growing reliance on TEC to monitor conditions and provide assurance and wellbeing to service users and their families is critical to this shift in delivery models. This recognises that care needs are volatile and not linear and future commissioning models need to deliver care and support when needed not necessarily as planned.

The TEC we are currently deploying and described below will ensure we can assess both clinical and wellbeing needs on a consistent and regular basis. Working with our partners in primary and urgent care (GP Care Home Support and SWAST), the voluntary sector (NS Community Hub) our community health provider (Sirona) and the Wellness /Response service and the new Acoustic Monitoring Service, we can build capacity to deliver urgent and ongoing support to support our service users but also other long-term care patients living in the community. Current work matching population health management data of the overlap of services to support primary care's most frequent and complex cohort is a critical next step in identifying further investment in these services.

Working with the New Locality Delivery Partnerships - Falls project

Building on our partnership working and focus on aligning health and social care capacity is the current falls project. This started in November 2022 working with LDP health partners and SWAST, the aim was to improve the current community-based falls response service in preparation for winter, with a view to:

- enhancing outcomes and experience for those who fall, through improving initial response times and reducing the risk of long lies
- improving system efficiency, focusing ambulance capacity where it's needed most and building on existing community-based provider models. (NHSE 2022)
- preventing more SWAST call outs and conveyances to hospital by increasing clinical rapid support from the locality partnerships and alternative transport arrangement, working jointly with Response24
- widening referral pathways, preventing more green and amber calls going to SWAST.

To date from 106 calls relating to falls, with an average response time of 25 minutes, 66 have been assisted by Rapid Response back onto their feet, and only 14 have needed ongoing attendance at hospital. 41 of these calls have used TEC devices (WHZAM) to support virtual clinical assessment. We are currently exploring how this pilot can be expanded.

TEC Offers

Acoustic Monitoring

As mentioned earlier, we were successful in securing funding to implement 600 units of acoustic monitoring to be installed across the ICS. Acoustic monitoring listens for noises in a client's room and alerts if there's a problem. The technology adapts to personalised background noises. The advantages include eliminating the need within a care setting for regular check-in with the client, that frequently is done every couple of hours and will disturb the client during the night.

It has a proven track record on reducing the number of falls - a common cause of hospital admissions from care homes and, particularly when delivered centrally, will allow care providers to reduce overnight care staff capacity.

Improved quality of sleep improves wellbeing and in the context of dementia care settings leads to more relaxed behaviour during the day, which also leads to reduced staffing.

The deployment of this equipment on scale will offer tangible financial support to care providers, assist with the workforce challenges, and improve the quality and assurance of care provider services, particularly given the prevalence of agency night care staff. The use of technology also enhances the staff experience, upskilling their role and changing staff from a task focus to a person-centred focus on improving sleep quality.

We are currently onboarding care homes and have agreed a pricing point with the monitoring service (delivered by our Rapid Response provider) of £6 per unit per week - a cost-effective solution for providers.

The equipment is being installed from March 2023 but was initially piloted in one large home during 2020. Following additional funding we are now aiming for over 1,800 units in at least 24 care homes across the three local authority areas.

The future vision is to distribute this and similar equipment such as radar to community settings, substantially reducing the need for overnight care costs by using the central monitoring functions and either locating community services near these care homes or using our expanded Rapid Response services.

As well as the acoustic monitoring, we'll be evaluating the benefits of the WHZAN Blue Box and ARMED wearable devices to support hospital discharge arrangements.

Blue Box technology has shown benefits in reducing unplanned hospital admissions. Care staff can easily record an individual's blood pressure, oxygen saturation levels, temperature and blood pressure, the information is recorded using a tablet and stored in the cloud.

ARMED uses 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. 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's too late, empowering independent living for longer.

In presenting this report, officers will demonstrate the effectiveness of TEC and the Falls pilot with examples of case outcomes.

Currently we utilisng the Adult social Care Discharge Grant and the LDP's Aging Well Funding to expand these services, and the following slides illustrate further how these service developments are broadening to deliver potentially integrated health and social care solutions for our area.

Response 24 - Links to Aging Well and Urgent Care programmes

Anticipate and Manage Proactively

Carelink/Other monitored alarm
Planned overnight care
Emergency continence support

Support for Sirona re community rounds when system is under pressure – EoL/Health related tasks

Signposting and referrals to preventative services "Check and Connect" approach, falls prevention events and "Fall Proof" training

Identify frequent flyers – referrals to Sirona's falls service, Wellness Service and other VCSE services

TEC – Increase take-up, monitoring support and reactive response, Whzan tele-health monitoring, Connecting Care updating professionals, link to any number of peripherals

Emergency planning response
Winter pressures, System pressures/events, industrial action, severe weather conditions – e.g. holding blankets for distribution

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Tipping Point

Carelink
No response calls – identify deterioration and make referrals to other services

Falls Response
Carelink
111
Brisdoc
GPs
Self referral/NoK

Whzan monitoring

In person and telephone welfare checks

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Deploy Home First Services

Emergency Short Term Domiciliary Care Support

- Geriatric Emergency Medicine Service Response – taking people from A&E who need short term personal care support (no admission need) and referral route directly into Reablement
- Adult Social Care Emergency Duty Team default emergency care response, to avoid social admission to hospital
- Carers Emergency Response via Carelink – short term emergency care for cared for, to avoid social admission to hospital

Social Care Links to Aging Well and Urgent Care programmes

Higher acuity care at home

Community Dementia Intensive Support team (domiciliary care)

- Wrap around offer to people with dementia. Preventing hospital admission
- Support more P1 discharges that P2/3 beds or get people home from a P2/3 bed
- Need to secure funding for a pilot.

Health Related Tasks

- Domiciliary care providers and R24 having training to support them undertaking more health related tasks to free up Sirona capacity.
- Nursing Solutions interested in a training and support offer around this.
- Linking with Clare Amour and Cath Williams

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Home after a hospital intervention

Reablement

- Supporting predominantly P1 for just over a year
- Working closely with Sirona to improve the offer – taking people from P1 sooner and looking at straight from hospital.
- Expanding to provide a robust offer to P2/3

Live-in and Waking nights

- NSC brokerage team have access to live-in and waking night staff at short notice
- Using flexibly and on a case by case basis to support admission prevention and discharge
- Adding sitting service from April 23

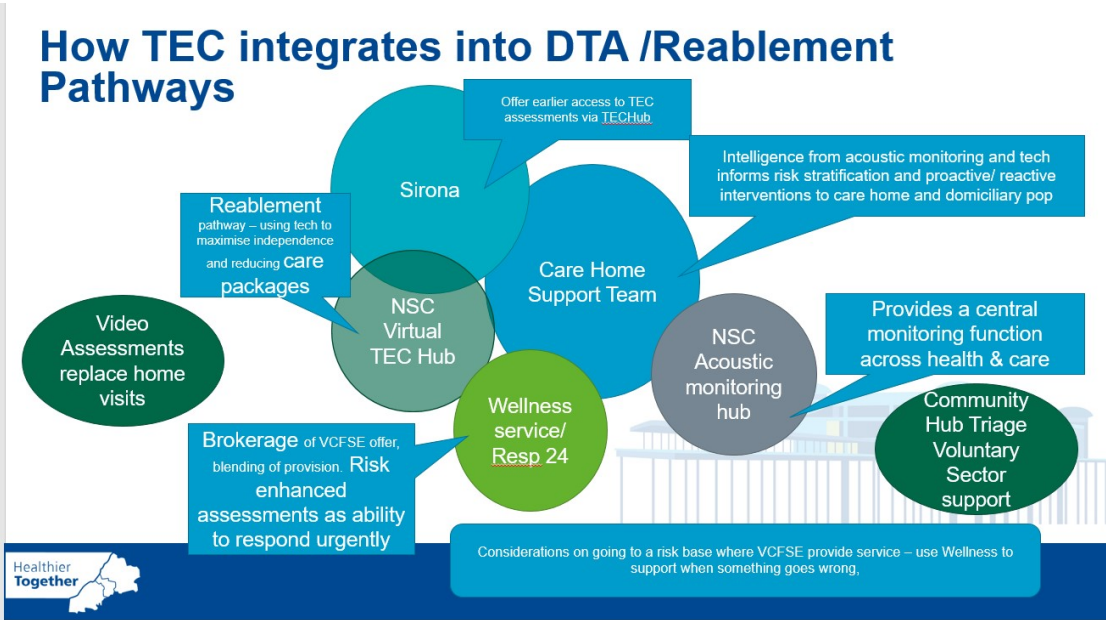
Strategic Domiciliary Care Contracts

- Being re-tendered 2023/24
- Split in line with the ICPs in North Somerset.
- Lead providers to be engaged with the Aging Well programme

"Our TEC services will support a Risk Management and Strength based approach to Care Assessments. The outcomes will enhance Wellbeing, reduce Care Packages & support the reduction of Hospital admissions and quicken discharges."

- Virtual assessments and assurance calls e.g. Wellness Service to reduce physical visits
- Digital Social Care Records all care providers by 2024, national lead for more effective hospital discharges and admissions
- Increased efficiency in work scheduling for domiciliary care
- Encouraging and supporting service users to maximise independence, improve wellbeing
- Wzhan Blue Boxes and Armed systems to encourage proactive health management and reduce use of emergency and health services.
- Pendant alarms e.g. Carelink complimented by Wellbeing service and the above monitoring systems can reduce physical call outs.
- Capacity to respond is crucial Wellbeing/Rapid Response merger will provide 24/7 response, . Future access to clinical decision making via Care Home Support Hub.

Response 24 – Link to Technology Enabled Care



4. Consultation

All of this work is subject to engagement with partners at both Local Delivery Partnerships and with our Care Providers, in particular Access Your Care who have contributed significantly to how they services have been developed and progressed.

5. Financial Implications

TEC has delivered significant inward funding from NHS Transformation to North Somerset, TEC reablement services have delivered in excess of current MTFP saving requirements. We believe the model of health and social care delivery will deliver significant further savings to both health and social care.

6. Legal Powers and Implications
N/A

7. Climate Change and Environmental Implications
Funding of additional TEC will support the reduction in care journeys. Reductions in care packages will reduce carbon emissions from care visits.

8. Risk Management

None identified

9. Equality Implications
[Have you undertaken an Equality Impact Assessment? Yes/No

These initiatives are designed to have positive equality impacts particularly in relation to older people who are disproportionately impacted by hospital discharge delays and access to care packages.

10. Corporate Implications
N/A

11. Options Considered
N/A

Author:
Gerald Hunt Principal Head of Commissioning, Partnerships and Housing Solutions
07766366097 gerald.hunt@n-somerset.gov.uk

Appendices:
None

Background Papers:
None