Emerging and developing work to digitally enable care across the East

directors of adass
adult social services
eastern region
connecting innovating improving

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East of England Adult Social Care

Foreword

In the East of England we are proud of our collaborative work and have put considerable time and effort into our Sector Led Improvement Programme. This has supported real improvements and innovation both locally and regionally. Improving our digital support offers is a key priority for the East, particularly accelerated by the need for digital solutions and to keep people connected and well during the pandemic.

We have all been affected by COVID19 which has impacted on our daily lives. Despite the many challenges, we have seen the adult social care sector, and more broadly local government, adapt at scale and pace to support communities through this time with increased and improved partnership working. We have notably seen that technology has had a significant role to play in supporting the work of councils, in collaboration with local partners and communities.

Councils are increasingly putting themselves at the forefront of using technology to sustain and enhance important work that helps people stay connected, safe and well. The East is not alone in adapting to new challenges to improve the experience and outcomes for people accessing care and support through digital solutions.

However, whilst progress is being made across the region, it is important to highlight that councils are facing extraordinary and ongoing funding pressures which often reduces their ability to invest in technology and digital services sustainably. This makes it challenging to find evidence to make the business case for technology, innovate at scale or move beyond one-off funded projects.

We know that technology alone will not solve all the challenges facing social care and the NHS, we recognise it can, under the right conditions, be an enabler of preventative, personalised and joined up care and support.

This report has been developed by the East of England Adult Social Care Digital Network to share practice and raise awareness about ongoing work in the digital field.

We hope you find the case study examples of interest and please do get in touch with the individual authorities if you wish to know more.

Gareth Hillier and **Sarah Rank**,
Joint Regional Chairs of the Eastern Region ADASS Digital Network

gareth.hillier@hertfordshire.gov.uk and *sarah.rank@norfolk.gov.uk*

Contents

Introduction

As a starting point, the Digital Network were keen to develop a report that shows the work being undertaken within the region in order to share practice and hopefully avoid duplication.

The report is split into a number of different categories which are important to improvement work, highlighting examples of what local authorities are putting in place to enhance digital capabilities and to improve the experience and outcomes for people. The categories broadly cover the following themes:

Assistive Technology to support people's independence

Keeping people supported and connected through day opportunities

Supporting the workforce with shared information to improve the experience and outcomes for people

Supporting carers in contingency planning

Supporting providers with data protection

Supporting people who access care and support to stay well and avoid hospital admission

County wide procurement of care technology

Case studies have been provided by Councils across the East including::

- Bedford Borough Council
- Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care System
- Cambridgeshire County Council and Peterborough City Council
- Central Bedfordshire Council
- Essex County Council
- Hertfordshire County Council
- Norfolk County Council
- Southend Borough Council
- Suffolk County Council
- Thurrock Borough Council

Assistive Technology to support people's independence

Norfolk County Council

Technology Enabled Care (TEC) lending library

The TEC lending library is like a local public library but instead of books, it lends assistive technology that can support an individual with their health and social care needs, or their carers to support them to provide care.

The project has two key aims:

1. To showcase the benefits of technology to those who are digitally excluded and find ways to support them in realising the benefits
2. To get technology to a wider public at the earliest opportunity after their need starts manifesting, and therefore support independence for longer and reduce the need for more formal interventions

Evidence clearly shows that technology can give better outcomes for those with care needs and support the resilience of the wider care network.

This project is trying to develop an innovative approach to engaging with the wider community well before individuals need to engage with formal services. Earlier intervention and uptake of technology should improve independent living and care outcomes across a broad set of cohorts. By allowing people to borrow technology and to try it at home they can find what works for them and then either purchase a device for themselves or if they are not able the project can give them one.

The lending library approach allows people to try out technology to make sure that they can get the benefits that are expected.

- It allows those who are digitally excluded to discover and access technology that is currently not available to them due to a range of socio-economic issues
- It allows people to gain confidence that technology might be a solution for them, especially if they have had limited experience of technology before
- It allows the wider public to try before they buy and to support them to remain independent at home for longer
- The TEC lending library can be a hub for the wider health and social care system, so that a GP or a pharmacist or community nurse can refer a patient to the library to access technology that might help them and the support they need to get up and running

- It can be a place to create networks of connected communities that can support each other to manage their needs and live as independently as possible
- It can help young people with learning or physical disabilities develop independence in preparation for their adult lives by supporting education, independent travel or completing everyday tasks

As more technology is offered via the lending library approach, more cohorts of people with needs can be supported and therefore more benefits can be realised.

The project is currently at pilot stage. Norfolk are working with the library service to understand the logistics of loaning devices, supporting the implementation and exploitation of those devices, how to recover the device after a loan period, how to identify individuals who need extra help with getting the technology up and running and how to link them to the current technology specialists within the system, like the Assistive Technology team at Norfolk County Council or the Digital Inclusion team at Norfolk Carers Matters. The pilot is focused on a small selection of technology designed to support carers to look after their older adult loved ones. This will help Norfolk to understand the logistical challenges of running this type of service and allow for a limited evaluation of impact.

Concurrently with the pilot, work is ongoing to pull together a system wide network of support involving the NHS, GP practices, pharmacists, children's services at Norfolk County Council, district councils and the voluntary sector. The work is well established and once the pilot is completed then further work will need to be done to develop referral pathways from professional and voluntary groups into the TEC lending library, as well as to identify the types of technology that can be supported by the project and identify sustainable financial and people resources that can support the digitally excluded to benefit from the initiative.

Some of the barriers and challenges in implementing the project included:

- Resources – currently the project team is finding the time to develop the pilot and understand how to make this type of project work at a logistical level. They are due to go live in two libraries in Norfolk towards the end of June
- Evaluation of the impact of devices needs to be better understood. How do we measure the social impact and what is the long-term impact on slowing the move towards formal services? Also, not all the people who come into contact with the service, would have ended up needing formal care, so how do we account for this in any impact evaluation?
- If the pilot is successful, then how do we build a wider service that includes the NHS, Children's Services, GPs, pharmacists and the voluntary sector?
- How do we fund supporting the digitally excluded so that they can also get the benefits from technology that is currently unavailable to them?

In the long-term, the vision is:

- To have a service where all parts of the health and social care sector can access help and guidance with identifying the right technology to support a person's care needs
- That people who have difficulty accessing technology for whatever reason are supported to be able to access it and realise the benefits that technology can bring
- That the wider Norfolk community can be informed about the advances in technology that can support care needs and can access this technology at an earlier stage and so prevent or slow the need for more formal care solutions
- Make sure that TEC is widely accessible, easy to use, and available for people when it can make a difference to maintaining independence
- Develop informal care networks via connected communities to support people to have choice and control over their lives and the support they can access

Contact: stephen.boddington@norfolk.gov.uk

Norfolk County Council

NATALI (Norfolk Assistive Technology Application (for) Living Independently

The technology enabled care project focuses on the development of a new Home Activity Monitoring (HAM) system, working across a new network infrastructure. It is designed to report to remote carers an indication of a person's wellbeing through patterns of normal activity within the home, and alerting to deviations from the normal.

Norfolk County Council's Assistive Technology Team provide early help and vulnerable adults Technology Enabled Care (TEC) solutions to promote independent living. One such solution is Home Activity Monitoring Systems, where Norfolk previously used the Canarycare system. The team see an increased potential for HAMs, if they:

a) provided more scope for monitoring (more sensor choice)

b) were more economical (initial procurement, and ongoing costs) to provide on a long-term basis as an early care intervention

Norfolk is building the UK's largest Internet of Things (IoT) Network called the Norfolk Innovation Network. This uses long-range wide area network (LoRaWAN) technology. The network is long-range, low-powered and supports 1000s of widely dispersed IoT sensors to help business, individuals and education design and build and deploy digital proof of concepts and services.

This could include an advanced Home Activity Monitoring system over this new, free to use network. This would support the council's Promoting Independence Strategy by providing an additional TEC service, within the council's control, to help promote vulnerable citizens' independent living. It would provide an improved means to monitor a person's safety and wellbeing and provide reassurance to remote carers. However, with the diversity of available sensors this technology could be desirable to many citizens, without care needs, removing the stigma of it being solely "care" technology. This could help promote earlier awareness, adoption and familiarity ahead of any future support needs.

This is still work in progress and in its infancy. Proof of concept and further development and sensor testing has been a collaboration between the councils' Information Management and Technology (IMT) department and adult social care Assistive Technology (AT) service. IMT have a dedicated innovation network project manager, working with the AT service county manager to explore the possibilities of a substantially improved HAM system available over the free Lora Wan Network.

The project has the backing of Norfolk County Council's Adult Services Technology Enabled Care (ASTEC) Board (consisting of senior management) and has been in development and testing throughout 20/21. Initial testing has been within IMT/AT staff homes (COVID19 restricted wider deployment) with initial design and development of the back end online portal to display the incoming data in a meaningful and interpretable way.

From the offset, the goal has been to only proceed beyond the initial testing in partnership and consultation with stakeholders that include citizens (potentially people who may access this, including carers), health and social care professionals, local technology companies and potentially academia.

At present a project working group is being formed to represent diverse stakeholders and two housing with care schemes have agreed to host engagement sessions to allow Norfolk to approach tenants and staff to find volunteers to test and provide feedback on the system. Norfolk intends to commence engagement work with people with lived experience and carers imminently, both to understand the most useful and appropriate sensors that could support independent living, and to develop the carers side of the system, the portal and app.

This project will also be discussed with Norfolk NHS technology innovation leads, having great potential to provide a valuable TEC resource, to both health and social care, therefore strengthening necessary partnership working around Norfolk's TEC landscape.

Further engagement could occur with the AT service's inclusion in the University of East Anglia's Health and Social Care Partnership, centered on co-creation and production of rehabilitation technology. The AT service will be introducing this project at an imminent partnership workshop.

Future potential barriers to adoption Norfolk hopes to overcome include:

- **Awareness and accessibility –** envisaged promoting this network and its potential sensor monitoring capabilities to Norfolk citizens whilst creating opportunities for purchase through local sites/shops, as well as free provision via the AT service for those with presenting needs
- **Ease of use –** the sensors will be easy to install and use, mostly being passive, connecting directly to a LoRaWAN gateway (mast), without the need for an additional hub. The intention is to further develop the online carer portal and create an app that is clear and intuitive to use
- **Technology/digital poverty –** costs will be free or minimised to the sensors only. There will be no need for SIM or Wi-Fi connected hub expenditure. A portal and/or app will be free to use. Connecting to a free network will also avoid ongoing costs
- **Inclusion –** the AT service, part of the council's Early Help and Prevention Services, continually reaches out to the most vulnerable members of society (visiting people's homes, and with inroads to organisations, charities, societies and support groups), providing free advice, assessment and provision of devices, and ongoing support as appropriate. This will become another resource used to promote independent living. As stated, Norfolk are eager to include people with lived experience in co-production from this point onwards to ensure they best understand, explore and utilise technology to meet the most diverse needs

Success would be to be able to utilise the great resources that the Norfolk (Lora Wan) Innovation Network provides in order to be able to offer an inexpensive, expansive and truly bespoke HAM system for any Norfolk citizen to use. This would include use within health and adult social care to increase available support for vulnerable citizens.

Contact: chris.metcalf@norfolk.gov.uk or alistair.cubitt@norfolk.gov.uk

Southend Borough Council

Virtual occupational therapy assessments

Southend has successfully implemented online virtual occupational therapy assessments to ensure people get the support and equipment they need as early as possible.

Occupational therapy assessments usually take place face to face, but this has not been possible during the pandemic. Rather than having huge delays, Southend Borough Council has proactively put into place a virtual approach, with clear guidance, that occupational therapy staff can follow to ensure people get the help and equipment they need to keep them independent for as long as practically possible.

Face to face occupational therapist visits have always been in place and working virtually has brought a different dynamic. Southend had to ensure a clear protocol which covered:

- Planning for the assessments
- Undertaking the assessments
- Occupational therapists follow up

Good communication is key. It is paramount the following is considered:

- The IT equipment and the support to access a virtual platform
- The safety of the person if a family, friend, carer or member of the family needs to support the individual to access IT
- The consent of the person receiving the virtual service to access documents, ensuring the person understands what will happen and the outcomes expected
- Contact numbers are provided just in case the call is cut off or if further support is needed

The assessments are not rushed and are as thorough as they would usually be face to face.

As an additional response to COVID19, the Occupational Therapy team are producing some 'how to' videos, these will be sent to individuals at the point of referral to allow the person to self-assess or self-purchase equipment that will meet their needs. If the video demonstrates how an individual can themselves highlight what they feel is right for them, it may reduce the time needed for initial assessment and hopefully speed up access to minor aids.

There has been a lot of positive feedback from the people being assessed, and from family members, about the virtual approach to occupational therapy assessments. Staff report that there are often quite a few laughs and once the initial awkwardness of something new passes, it has been very effective in helping to continue to deliver a service for the residents of Southend without significant delays due to the pandemic.

A face to face assessment continues to be the preferred route and the best option, but if this is not possible then there is no reason why the virtual assessment couldn't be considered as the way forward in cases where it is appropriate post COVID19.

Contact: laurabooth@southend.gov.uk

Hertfordshire County Council

Data inspired living

Hertfordshire County Council (HCC) have rolled out digitally enabled sensor technology with resulting data incorporated into a professional's dashboard as an integral part of an individual's care planning, with a view to utilising a person's real time activity and lifestyle data to better target future care planning. In addition, a secure communication device to enable virtual engagements has been rolled out to support this.

Over the past couple of years, HCC has piloted the use of digitally enabled assistive technology with a view to testing the potential of new technology, and ultimately replacing the existing analogue telecare equipment presently used. HCC are also wanting to use technology as a care planning/management tool for practitioners and to encourage more proactive care planning as opposed to the current reactionary model.

A small-scale Proof of Concept (PoC) pilot was undertaken in 2018/19; the results of which have informed a larger scale randomised control trial. This study aims to:

- Enable practitioners to be more proactive in care planning and delivery by using real life data to better inform and target care provision, and make care planning more outcomes focused and person centred
- Support people to continue to live independently
- Identify future financial savings by using assistive technology (in a safe and managed manner) instead of more expensive homecare
- Use AT as a preventative tool (keep people on small care packages/pre-care)
- Redistribute limited homecare resources, delaying the need for 24-hour care and preventing the escalation of care needs
- Provide informal care support/stress reduction/prevention of carer breakdown
- Get the size/length of mainstream and Specialist Care at Home (SCAH) packages of care right for each person accessing care and support

The first part of this journey was to develop an Assistive Technology Strategy across the range of partners and stakeholders and this has been agreed by members. This enabled HCC to commission a technology provider and deliver a PoC pilot to test out the use of this technology on a small scale in a managed environment. The technology was deployed alongside existing services, so residents had a safety net. The PoC pilot was evaluated by Hertfordshire Public Health, which recommended a further larger scale study (phase 2) in order to gain evidence for where the benefits may lie. This study is currently in the recruitment phase.

Phase 2 will also be evaluated by Hertfordshire Public Health.

Stakeholder engagement through the Stakeholder Assistive Technology Strategy set the headline direction for the journey ahead, signed up by members. For example:

Proof of concept pilot – the first delivery step was to commission a PoC pilot where not only could the use of this new technology be tested out but also to engage with people who access care and support and their families. This phase explored residential and informal carer attitudes to and engagement with AT, whether AT can meet their individual outcomes, and professional attitudes and perceptions to costs, benefits and impact on working practices. The lessons learnt from the PoC pilot, including data from a number of deep-dives and case studies, were fed into planning for the larger Phase 2 study, which is now being rolled out.

AT Phase 2 study – it is important to note that this is not only about deploying different technologies but about redesigning (where necessary) the operational processes which will enable the technologies to be embedded into care provision and delivery. This included commissioning a responder service to respond to preventative alerts, the creation of a professionals' dashboard that is robust and easy to understand and use on a regular basis, and ensuring ethnical and equality and diversity considerations were met.

As part of the engagement strategy there were a number of key components, including a robust engagement process with residents and their families, co-design of the technology and processes around the deployment of these technologies with practitioners, including health, care agencies and commissioners, the creation of an AT Steering Group and AT Champions, senior management and member sign in.

The engagement process was lengthy and complicated but critical to ensuring buy-in from multiple stakeholders, residents and their families. As part of the AT team, some frontline teams have been seconded in to provide expertise and frontline experience in working with colleagues from differing disciplines and organisations. The study (run by Hertfordshire Public Health) comprises of an intervention group (those with AT) and a control group (those without AT). Residents will be randomised into either the intervention or control group upon referral into the study. Residents, families, practitioners and care agencies will be engaged in the evaluation process through interviews and focus groups as well as the collection of quantitative data to determine where the benefits may lie. The results of the evaluation will inform future commissioning decisions.

Here are some of the barriers and challenges encountered:

- It is important to encourage an individual/organisational cultural change across various disciplines to accept the use of technology and incorporate this into care planning and delivery
- Ensuring that people we support and their families understand the rationale of this offer and that this is not designed to replace personal care
- Engagement with health to develop a whole systems approach
- Privacy, data protection and legal considerations – this involves the capturing and presenting of residents' sensitive personal information which needs to be done in accordance with various regulations/good practice guidance
- Ethical considerations – all involved in the pilot have given their informed consent and the pilot will initially focus on those with capacity to consent
- ICT (information and communication technology) implications – ensuring the technology used is robust and not hackable, internet and backup SIM connection is secure and robust and ensuring integration across various IT platforms

These are our aspirations:

- Supporting people's independence
- Sustaining people's ability to remain in their own home
- Identifying people's changing needs at an earlier stage
- Keeping people safe
- Better support for family carers
- Reducing social isolation and better engagement with communities
- Developing a professionals' dashboard that practitioners can use in their day-to-day job to better target care provision and identify emerging problems before they become embedded

Contact: david.coolbear@hertfordshire.gov.uk

Thurrock Borough Council

Assistive Technology to support people's independence

In 2018, Thurrock Borough Council embarked on a new Technology Enabled Care (TEC) programme to promote the use of Technology in supporting independence.

One specific example was the use of Brain in Hand, a TEC solution intended to help build confidence and independence through digital self-management.

Typically, users of Brain in Hand are younger people or working age adults with learning difficulties or mental health difficulties such as anxiety and depression.

The pilot demonstrated significant improvements in management of emotions and mood, increased independence and improved self-management, and resulted in net cost savings of £16,984 across 10 people who use it. The pilot project has now been expanded into the Complex Care Team with the prospect of further expansions.

The new TEC programme was promoted further with Thurrock Council also introducing two new approaches in Adult Social Care:

- **Community Led Support –** embedding social workers within local communities
- **Wellbeing Teams –** Domiciliary care teams run on Buurtzorg principles

The aims of the TEC programme are:

- Raise community awareness of telecare and telehealth
- Better outcomes through individualised TEC
- Encourage greater digital health literacy
- Combat loneliness
- Prevent, reduce or delay the need for social care or acute health interventions
- Support carers through greater use of TEC

As a result of the approach, TEC solutions are embedded in the everyday conversations that teams have with local communities.

When Thurrock launched the TEC programme, their steering group was keen to ensure that TEC solutions were deployed across all age groups to demonstrate its application and relevance to young as well as older people. They also wanted to provide better and more cost-effective support to young people.

A 10-year pilot project was commissioned for use by the Preparing Adulthood Team. The goal of the pilot was to evaluate the impact of a digitally enabled self-management system on both people who access care and support and use technology and those who support them. The specific aims of the pilot were to:

- enable people who access care and support to better manage their mood and emotions through guided self-management strategies
- increase levels of independence across daily living tasks, routines, social interaction, work/education, travel and progression to living independently
- improve the ability for people accessing care and support to self-manage anxiety, anger and stressful events
- improve people's confidence in their own abilities to self-manage, problem solve and make decisions
- develop coping strategies for young people with special educational and social care needs to transition into adulthood which can be significantly a daunting period in their lives
- ensure that all young people with special educational needs and disability (SEND) experience the best transitions in life with the support needed to achieve their full potential
- support young people with cognitive difficulties in making their own choices and decisions and to make best interest decisions
- improve service effectiveness and efficiency
- offer solutions to unmet needs
- ensure individuals with low level needs to achieve more with less support
- empower and enable young people to participate in solutions when any significant changes occur
- promote positive pathways strategy during transition
- promote the implementation of a strengths-based approach and shift from relying on services

Whilst not an explicit outcome, the Council wanted to evaluate whether requirements for formal services were reduced as evidenced by fewer commissioned hours of support, fewer visits to GPs etc. They also wanted to learn about the impact on carers and family members.

Thurrock Council introduced Brain in Hand (BiH), a self-management system that combines simple digital tools and practical human support when people need it. It complements the work support workers and social workers are already delivering by enabling the person who is accessing care and support to do more things for themselves where they can. Over time, this creates a ripple effect that reduces reliance on services and/or informal carers and enables the user to grow in independence.

Each user followed a structured step-by-step process of personal planning with a Brain in Hand specialist to help identify goals, pinpoint problems and develop solutions. These were translated into strategies and broken down into manageable steps alongside routines for daily tasks, organising and planning. Stored online and easily accessible via mobile software, the user's strategies can be drawn on as and when required to help navigate their day. This includes ways of coping with unexpected events, like the bus not arriving or lectures being cancelled. People can make notes in the moment of the things that have and haven't worked well for them and why.

A mood monitor in the form of green, amber and red traffic lights promotes self-monitoring and self-regulation by encouraging the person to pause briefly and reflect on how they are feeling throughout the day. A record of their traffic lights presses is stored on a timeline which they and their supporters can access. Importantly, the simple traffic light system allows a user to let someone know they need extra support, which connects them to a 24/7 responder service. It's a lifeline that helps people feel connected at all times providing a vital safety net of support.

The Transitions team were responsible for identifying potential people who could access the TEC as well as agreeing expected outcomes and tracking progress against those outcomes throughout the course of the pilot project. The Council recognised that evaluation of the pilot was crucial and so together with Brain in Hand, the transitions team developed a model to assess the financial impact of the intervention to inform a cost benefit analysis exercise. The transitions team were critical in the collection of data to populate the evaluation model and were able to collect before and after data for seven out of ten people accessing Brain in Hand.

They identified where users accessed a range of services across health, social care and education before and after their use of Brain in Hand, so that changes could be identified. These included GP visits, mental health care support, care home costs for people requiring long-term mental health support and semi-independent living services costs. Unit costs were derived from the Greater Manchester Combined Authority unit cost database.

The transitions team also carried out a series of one-to-one interviews with people who access care and support, their families and support staff to review achievement against personal outcomes and expected outcomes as well as provide the quantitative data to support the cost savings achieved.

Three members of the transitions team were trained to support people on the Brain in Hand system: one social worker and two support planners. A classroom-based training session was delivered to provide the staff with an in-depth understanding of the system. This included monitoring people's activity on their accounts and navigating the online dashboard. The dashboard is an online platform where members of staff are able to access accounts to further support people in managing their BiH. One member of staff was trained as a Brain in Hand champion in order to better support people and members of staff to use the system.

Nine people access the software from the Preparing for Adulthood Team.

The evaluation of the pilot showed that seven people reported significant improvements in management of emotions and mood, increased independence and improved self-management and eight wanted to continue using the system. Additionally, supporters stated that their practice had been informed and client relationships had improved in 50% of cases.

> "The system has been 'life changing for C' and they have been able to move from fully supported living to an independent flat with limited support"
>
> *Support worker for people who accesses care and support with autism, moderate learning disabilities and anxiety*

> "They previously called Preparing for Adulthood Team (transitions) once a day for approximately an hour and since the use of BiH, the person accessing care and support has stopped calling entirely, this resulted in a very significant saving in staff time"
>
> *Support worker for a person who struggles with low mood and anxiety*

> "We have noticed an impact on ABH's relationship with Preparing for Adulthood Team (Transitions), where there has been a shift from verbal aggression to being very calm and happy"
>
> *Support worker for person with autism*

Individual improvements in key outcomes demonstrated a saving of £28,684 against an initial investment of £11,700 a net position of £16,984 savings for a ten-person project. The savings identified related to a narrow range (one year) and the outcomes people described may provide longer term benefits that have not been looked at, for example, the preventative savings that might accrue from the alleviation of pressure on parents/carers or the stabilisation of someone's mental health.

Since recommissioning and expanding the rollout, Thurrock has introduced the digital support systems into the Complex Care Team (CCT), who work closely with the transitions team. One CCT practitioner has been trained as a Brain in Hand champion to ensure an in-depth understanding of the system and identifying referrals.

In addition, Thurrock is intending to open up the referral pathway to mental health services. Engagements will be delivered by Brain in Hand to continue support with ongoing referrals from all referrals teams and develop their understanding of the system and how it could facilitate support for people. Longer term, the Council will consider the best approach to embedding Brain in Hand resources across the social and health system.

Some of the barriers to the implementation across services in Thurrock include:

- Engaging people who access care and support with complex needs can be challenging, particularly when it comes to the adoption of new, innovative approaches. This has required a coordinated approach between social care practitioners, the Brain in Hand support specialist and an appropriate governance structure to mitigate any issues in a timely manner
- The project has been impacted by the COVID19 pandemic, which has brought unique challenges for the rollout, particularly supporting people with complex needs remotely

Conditions for success include:

- Ensuring that the outcomes that matter are agreed with the person at the outset
- Set clearly defined roles and responsibilities particularly important for the collation of outcome measurement data
- Ensure appropriate training and support are provided to allow practitioners to confidently adopt a new service
- Regular and effective progress tracking of referrals and outcomes

Contact:

Thurrock Council's TEC programme – Gavin Beard, gbeard@thurrock.gov.uk

Brain in Hand – Jennifer Dodoo, jdodoo@thurrock.gov.uk and Andrea Farnsworth andreafarnsworth@braininhand.co.uk • **www.braininhand.co.uk**

Keeping people supported and connected through day opportunities

Bedford Borough Council

Virtual Day Service zooming in to support online daily hobbies, interests and networks

Bedford Borough are adapting the day service model of care to provide a virtual offer of support hobbies and interests which keep people connected to their friendship social circles using IT platforms. The anticipated outcomes include improving people's quality of life through positive social and emotional wellbeing, daily virtual structure and virtual carer support.

During the initial stages of the COVID19 pandemic the day service buildings were advised to close in order to control the transmission of the virus and keep adults with learning disabilities and autism shielded along with those who had complex medical needs.

Due to the lockdown and shielding guidance the centres remained closed for seven months with people who usually access the services remaining at home with their families and staff teams providing them with 24/7 care and support within the home environment. Also due to the sudden reduction in daily routine with purposeful and meaningful support for hobbies and interests and the sudden loss of long-established friendship circles, Bedford Borough began to receive an increasing rate of welfare concerns from parents, carers and residential units describing rapid deteriorations in people who access care and support and in carers mental wellbeing.

Many elderly parents found themselves having increased responsibilities for moving and handling which was resulting in physical injuries and exhaustion. The loss of day services was forcing some family carers to consider the sustainability of their caring roles and look to source residential care to prevent ill health and family breakdowns.

The day centre staff team used IT equipment to stay in regular contact with people who access care and support and their family carers to be able to assess how the families were coping in the lockdown situation and whether care-management interventions were required. With coordination the team were able to facilitate friendship calls using virtual platforms so the person could regularly see and speak with their friendship circles to reduce anxieties and promote positive conversations around the pandemic. Staff use these platforms to speak with people drawing on adult social care on a 1-1 basis to offer constant emotional support and guidance and explained in a person-centred way what was happening throughout the pandemic.

Families felt assured that if the household was struggling with behaviours and anxieties that they could call staff and they would offer reassurance and de-escalation using face time calls as a tool to break the cycle of escalation and great worry.

Many people who usually accessed face to face care and support were displaying declines on the calls due to social isolation and lack of structure and routine so the day services began a community outreach programme where support was arranged directly with the family carer at the time when they most needed it. Staff supported on a 2-1 basis in the community so that family carers could remove themselves from the situation and have a rest from their caring responsibilities. During this time in the community, people were encouraged to communicate with others who would usually access face to face care and support, as well as staff, using virtual platforms so they could have a shared experience outside of their family home. This worked as a very successful support mechanism and de-escalation tool also promoting exercise and a sense of independence to work through anxieties and frustrations away from parents and carers.

Feedback was exceptionally positive with family carers stating it was the only way they could manage being shielded and the outreach support enabled the family to continue offering care and support at home.

The day service also used virtual technology to offer a daily structured virtual timetable to bring back some routine and purpose for people who access care and support. The people supported were introduced to purposeful and meaningful sessions using group face time calls at a set time each morning and afternoon. A staff member would offer the person and their friendship circles pre-planned support to maintain hobbies and interests using session resources that the day service staff had dropped on each individual family's doorstep for the planned support that day. This meant that people being supported were positively engaged which reduced the pressure on family carers to provide daytime hobbies and interests within the family home.

The day service worked with Bedford Borough Council's Sports Development Team and the Riverside Tennis Club to see if they could offer some qualified coaches to provide virtual sports coaching. The virtual offer now also includes, aerobics, Pilates and tennis sessions delivered by professional coaches to the group using virtual platforms. This will increase positive mental wellbeing and prevent any further decline in physical deterioration and lack of mobility.

Bedford Borough has supported many people who access care and support to seek funding for IT equipment and navigate software to access the sessions. Several staff members attended iPad training delivered by Apple during the lockdown to be able to support people through a virtual offer.

Some of the barriers included:

- People who access care and support and their family carers not owning IT equipment
- People who access care and support and their family carers not knowing how to use IT software to access platforms
- Residential care homes not having any IT equipment available for residents to use
- Residential care homes not having Wi-Fi for residents to use personal IT devices privately in their rooms
- Residential care homes not having staffing capacity to support a resident to log onto a call

Conditions for success:

- Residential care homes should have IT equipment available as part of the resources for residents with staff who know how to support people to use it
- If a virtual offer is being provided to a residential care home that will maintain a physical, mental and emotionally healthy resident then staff should be seeing IT support as part of their duties to help prevent social isolation and depression. Many staff say they just don't have time and do not value the importance of the resident staying connected to their social circle and being able to continue with meaningful hobbies and interests

Contact: julieann.peck@bedford.gov.uk

Supporting the workforce with shared information to improve the experience and outcomes for people

Cambridgeshire County Council and Peterborough City Council

Optimising reablement capacity and effectiveness via mobile technology

Cambridgeshire and Peterborough have invested in a mobile interface to the Mosiac Case record which also included a scheduling optimisation tool to best match reablement workers to people who need to access care and support based on needs, skills and location. This is part of the wider transformation of the Councils' reablement offer and part of the wider Adult's Positive Challenge programme.

A large amount of reablement workers time was taken up in travelling between visits and also to and from the office base to view and update case records. In addition, reablement workers were not always sighted on changes to people who access care and support and their circumstances, such as hospital admissions, in a timely way. Workers who needed to update a person's record, for example to record a case note for other involved practitioners to view, had to travel back to the office in order to make the updates, building in a delay in information sharing and a loss of direct care time.

Previously, rounds were allocated according to worker availability rather than optimisation of routes, and the weekly scheduling to make sure all visits were covered was a time intensive process.

The service implemented the Total Mobile app which integrates with the Adults Social Care case management system, Mosiac, meaning frontline workers' appointments, key summary information, progress notes and assessments forms are now available on their mobile device.

The service also implemented the Optimise function, a dynamic appointment scheduler which follows pre-determined rules based on skills, needs and locality, to assign reablement workers to people who access care and support.

Key stakeholders were engaged to participate in implementation workshops, which were held with the reablement workers, to understand what their requirements were. The rollout was done with a pilot team and then on a team by team basis to allow for learning to be fed into the go live process for future teams.

Cambridgeshire and Peterborough did not co-produce the solution with people who access reablement support, however, the ability for support workers to be able to see what happened in previous visits by being able to check before they arrived in the property meant the people being supported had an improved experience of the service. Feedback suggested they felt reassured that the support workers knew how they were the day before and could tailor their visit to meet their needs more effectively.

The success in the project has been delayed by the introduction of Covid safety measures, which has meant split teams and introduction of bubbles around shielding people who access care and support. The algorithms within the optimisation tool were not designed for such an eventuality and hence could not be utilised during 20/21. This means that although the use of mobile devices for reablement workers to access key documents has made a difference to risk, the evidence around increased capacity is not available as soon as hoped.

Moving forward, there will also be the need to ensure that the mobile devices supplied remain fit for purpose and compatible with the Total Mobile app, and there is a danger that as the current devices were bought in bulk they will also require replacement in bulk.

The ability to allow workers to update records remotely using the app was dependent on a system upgrade for Mosiac, which in turn has been delayed and is due to go live over summer 2021. This has further delayed some of the travel related benefits although the access to view the record via mobile devices has improved the service in respect of practice and management of risks.

Contact: lucy.davies@cambridgeshire.gov.uk

Suffolk County Council

Joining the ICS Shared Care Record

In the main, shared records have focused initially on health sharing with health but at the end of 2020, Suffolk County Council Adult Social Care joined the Health Information Exchange (HIE) Shared Care Record that covers the Suffolk and North East Essex Integrated Care System (ICS) and beyond. The following description outlines benefits gained and the impact of ICS boundaries on local authorities.

In 2018/19 Health System Lead Investment funding was used by the Suffolk and North East Essex (SNEE) Integrated Care System (ICS) to build on the West Suffolk Foundation Trust shared care record pilot between acute and GP health systems. Further HSL funding in 2019/20 brought an increase to the number of partners and the geographical reach of the shared care record across the ICS and beyond.

The SNEE shared records programme was developed with the ICS Digital Strategy to "Enable work as a system" by ensuring a common strategy and solution which covered ICS wide provision. The NHS National Information Board Strategy describes the need to develop easy access to clinical information so that clinicians have up to date information about their patients for care planning and delivery. Easy access would overcome the multitude of digital boundaries and clinical systems that separate the organisations that deliver the patient care pathway, frequently meaning that cross boundary access is difficult.

The problems to be solved were as follows:

- Dramatically reduce bureaucracy for practitioners and increase outcomes for people through shared records
- Raise social care as an equal partner with the SNEE ICS digital governance to influence the HIE programme from a social care perspective
- Technically implement HIE within Suffolk County Council
- Complete the organisational transformation and development needed for a greater adoption of the HIE across adults and children's social care
- Influence the Norfolk ICS to engage in the HIE to ensure full coverage for adult social care in Suffolk

Suffolk County Council put in place connection of Liquidlogic Adults System (LAS) to the SNEE Health Information Exchange, in context iframe accessed via usual log into case management system. Access to HIE within LAS is managed by role-based access controls. Practitioners identified as having a direct care role within the service can now access acute, GP, and community health information, with social care and mental health joining later this year.

Implementation of the HIE within Suffolk Adult Social Care was managed as a project as detailed in the following areas:

- **Project definition and understanding the capability of HIE offer (Spring 2020) –** design specifications for Liquidlogic, soft testing and researching other local authority use and contribution to shared care records across the UK
- **Project governance and direction and decision making –** project resource established, senior responsible officer (SRO), project structure and day to day management put into place
- **Funding and contract –** business case completed, formal sign off by Directorate Management Team, receive SNEE capital
- **Technical connection and security –** Suffolk County Council (SCC) Technical Lead identified, install into Liquidlogic for testing, establish Cerner and West Suffolk Foundation Trust connections via Health and Social Care Network (HSCN), live install
- **Information governance –** My Care Record, Data Protection Impact Assessment (DPIA) completion, privacy notice review, Adult Care Services and Children and Young Peoples Information Governance Boards approval
- **Risk and clinical safety –** review clinical safety case, Caldecott Guardian's sign off, research and create new Liquidlogic Acceptable Agreement for front end access
- **Business change and implementation –** stakeholder mapping, senior management engagement, end users of the system implementation workshop, eligible users of the system identified and best use of clinical information under GDPR (General Data Protection Regulation)
- **Data architecture –** joint work with Essex CC on clinical data to be seen and to be shared back into the HIE
- **Use care scenarios –** positive stakeholder engagement and change management
- **Communication plan –** communication planning and delivery methods to ensure excellent take up of the HIE with practitioners
- **User acceptable testing –** test plan and completion of testing in User Acceptance Testing (UAT) and live systems
- **Training –** research user and other LA engagement and bespoke local eLearning created
- **Go live with Adult Social Care –** which began December 2021
- **Children's Social Care implementation –** underway in Spring 2021

It was designed as an iterative programme of work across the ICS and beyond pulling from three waves of funding. Therefore it has built up a collaboration between acute and community trusts, GP federations, social care, mental health and more local providers. This collaboration influences the roadmap of connections across the ICS and wider Eastern Region (looking towards One London).

In some regards the information governance has been the largest and most challenging aspect of the programme, with the technical implementations across partners often depending on the supplier's upgrade roadmap. The My Care Record information sharing agreement has been a positive underpinning to the HIE technical rollout, with a big presence in acute and GP settings explaining to people that information will be shared between health and care to better improve the service that people receive.

Some of the barriers are explained below:

- Having a strong social care voice within the ICS digital governance amidst a global pandemic to influence and remind that this is a joint health and care programme and delivery not just health integrating with health
- The confusion of boundaries between health and care organisations and ICS boundaries, e.g. the northern area of Suffolk County Council, the Waveney team, sits within the Norfolk and Waveney ICS not the SNEE ICS and the N&W ICS has a different set of challenges that has pushed the development of a shared record further down their agenda and timeline
- Children's Social Care has a lower priority for shared care records with health, their main partner is education. They also very often have a different consent model for working with families compared to adult social care and this adds complexity to privacy, consent and acceptable use
- Having resources to implement HIE within adult social care within a global pandemic and enduring business continuity across adult social care whilst there is a reduction in transformation funding and focus
- General concerns about social cares' acceptable use of clinical information and potential data breaches in general in use of systems

Conditions for success are:

- Waves of funding from HSLI and a great central ICS project hosted at the West Suffolk Foundation Trust who initiated the pilot and manage the supplier relationship
- Investing in front end user and senior management communication and engagement throughout the life of the implementation within Suffolk social care to ensure cultural and organisational change at the forefront of the implementation project
- Regular project meetings between Suffolk County Council, Cerner and West Suffolk Foundation Trust
- Benefits work from the start of the project, shared with other LAs and Cerner national user group to help other LAs when approaching shared care records work
- Ongoing active engagement as a key stakeholder in continued rollout of HIE and the governance around HIE and My Care Record

Contact: treesa.carter@suffolk.gov.uk and james.hitter@suffolk.gov.uk

Supporting carers in contingency planning

Hertfordshire County Council

Online portal form for carers' contingency planning

Hertfordshire County Council (HCC) have created a digital referral process for Hertfordshire residents who care for a person to enable them to submit a contingency plan which can be used in the event they are unable to fulfil their caring tasks

Increasingly, Hertfordshire County Council are seeing the benefits of digitalisation – millions of us use and expect a digital channel in our everyday lives to pay for bills, do online banking, order items and interact with businesses. There are over 32,000 registered carers in Hertfordshire and the Council wanted to create a digital channel for carers (informal and formal) to submit key information on a person they care for, in the event they are unable to provide care due to an unexpected event or if they become unwell.

This information was being received through emails, partially completed forms and calls to the customer call centre, where the information would need to be rekeyed from these sources into the social care access system. This could result in incomplete information being received and more time spent obtaining additional information required. There was also the risk of this information being interpreted incorrectly with data errors and not having a secure platform for storing a person's personal information.

Following the success of the Hertfordshire Safeguarding adult's portal, the Council designed a Carers in Case of Emergency portal form for carers to complete online. This form captures all the key information required, that can be quickly accessed and ensure that support can be put into place for the person. The information submitted on the portal form is automatically ingested into the social care system, saving staff valuable time not rekeying the information and reducing the chance for errors or missing information.

There is a Hertfordshire Carers Community that Hertfordshire County Council have been working with throughout the design of the portal, as well as practice leads who formed part of the project team. The portal form was extensively tested with professionals and carers to ensure all the key information was being captured and the form was straightforward for the public to use.

Some of the barriers were:

- Carers accessing the portal form
- Support with completing the online form
- Identifying carers not known to HCC
- Highlighting awareness that there is a contingency available for use

Some of the conditions for success include:

- Creating a streamlined system where the information is held securely
- No re-keying of information, saving staff time and reducing the risk of errors in interpreting the information
- Form is completed in the the carers' own words
- Standardised templates designed for staff
- Better for the environment by reducing paper and postage costs
- Carers are issued with a Carers in Case of Emergency card
- Reduction in calls to the customer service centre
- Critical information is available 24/7 to Adult Care Services staff and the Emergency Out of Hours Service to access at any point

The Carers in Case of Emergency form is live on the Herts *website* which includes online guidance and video tutorials giving people support on completing the portal form.

Contact: acs.digitaltechnology@hertfordshire.gov.uk

Supporting providers with data protection

Central Bedfordshire Council

Supporting providers with data protection

Central Bedfordshire Council, in conjunction with Bedfordshire Care Group, have been supporting care providers across Bedfordshire, Luton and Milton Keynes (BLMK) ICS to complete the Data Security Protection Toolkit (DSPT) which is an online data protection assessment.

With the impact of COVID19 and as we move towards digital solutions, it is important to ensure our data is kept safe and secure. All health and care organisations must assure themselves they are implementing the data security standards and meeting their statutory obligations on data protection and data security.

The Data Security Protection Toolkit (DSPT) is an annual self-assessment which supports to measure if organisations meet the National Data Guardian's standards and GDPR. It shows care providers what they need to do to keep people's information safe, and to protect their business from the risk of a data breach or a cyber-attack. It covers both paper and digital records.

Care providers who work under the NHS Standard Contract must register with the Data Security Protection Toolkit. The government recommends all other adult social care providers register too. Many providers have not completed the DSPT and some care providers have not completed it to the standards required for other data sharing initiatives.

The DSPT offers lots of other opportunities to facilitate safe data sharing and care delivery. It is a requirement to complete the DSPT if you have an NHSmail account, you have access to any NHS digital records, or you contract with the NHS.

During COVID19 care providers were provided with an NHSmail as a secure email for data sharing without using DSPT. A waiver was put in place until 30 June 2021 and providers now need to reach at least Approaching Standards of the DSPT to maintain their NHSmail. Access to SystmOne also provides secure data sharing and providers need to have completed the DSPT to Standards Met to access.

Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care System (ICS) is working with care providers to deliver a sector led approach to address the challenges to support with enabling safe, timely and effective transfer of information between health and care services through:

- Training and completion of the DSPT
- Access to NHSmail accounts
- Access to SystmOne (for shared records) and other digital innovations

Working with Digital Social Care, the Council secured funding to support care providers across Bedfordshire, Luton and Milton Keynes to renew, commence or complete their DSPTs in line with the new national process for social care providers launched in September 2020, particularly with regards to supporting NHSmail and the rollout of SystmOne proxy access to care homes.

This was done through:

- Dissemination of information, support and guidance via Bedfordshire Care Group Forum, manager forums, digitalisation group, newsletters and quality and assurance teams
- Offering 1:1 support to providers that require extra assistance via Microsoft Teams
- Facilitation of mentoring support where organisations have multiple sites to ensure all sites are compliant
- Provision of a local helpdesk service via telephone, mailbox and Microsoft Teams
- Delivery of interactive, practical online workshops, during which providers would be supported to work directly on their DSPT submission
- Setting up webpage as a central point of information

Completion/renewal of the Data Security Protection Toolkit is the starting point for other online care opportunities to be implemented for care and support. This includes access to shared NHSmail which you can use to communicate with health and social care colleagues, Microsoft Teams for virtual meetings, networking and training, video consultations, correspondence with professionals, referrals, assessments, hospital discharge information, and implementation of resident care plans, along with SystmOne Proxy Access.

Some of the barriers and challenges were:

- Due to impact of COVID19, providers have conflicting priorities and initial engagement and take up of workshops was limited due to Easter, the second phase of vaccinations preventing staff from being available to train and managers taking time off using annual leave as they hadn't had a chance throughout the year
- Delivery of engagement started later due to attending all toolkit webinars to support delivery of training to ensure an appropriate approach
- Data opt out raised, however, currently engaging relevant colleagues to support in September as this has been postponed to September 2021
- Need to consider any implications in terms of the move from EU and where data is stored

Some of the conditions for success are:

- DSPT support project covers the Bedfordshire, Luton and Milton Keynes (BLMK) system
- Targeted approach in order to mitigate risk, identify provider status and signpost to relevant support to help them through the toolkit
- Provide a whole host of resources and regular check ins with providers to ensure that they are making progress
- As a result of this support since the project has started, 55 providers have attended various workshops and webinars, 50 providers have completed their DSPT 20/21 to Standards Met and 82.51% care homes have access to NHSmail across BLMK

You can access free information, guides and films about the DSPT on the Digital Social Care *website* where you can also register for regular national updates.

Contact: schhservicedevelopment@centralbedfordshire.gov.uk

Supporting people who access care and support to stay well and avoid hospital admission

Central Bedfordshire Council

Whzan

Whzan is a remote baseline monitoring system which uses specific software to generate the NEWS2 (National Early Warning System) score for residents in care homes.

To support Central Bedfordshire residents, especially the frailest, in care homes across each system helps to:

- Reduce A&E admissions from care homes – where patients have been discharged to or are a resident of a care home
- Reduce 999 call-outs to care homes
- Reduce unnecessary GP visits to care homes
- Improve the confidence and ownership of carers when dealing with health professionals

The use of remote monitoring supports proactive care and helps enable care home teams to identify when residents need early intervention from supporting clinical services, e.g. GP, community teams. Using Whzan enables care homes to monitor where resident's usual vital signs are logged such as blood pressure and heart rate so that the care home can identify whether there are changes that affect people's health.

Whzan kits have been rolled out across 21 care homes in Central Bedfordshire. Further funding has been received from the Integrated Care System to enable the implementation of Whzan across the rest of the care homes in Bedfordshire, Luton and Milton Keynes (BLMK) with multiple kits going into larger homes. The Council is expecting to extend this to all care homes. Whzan will also be piloted in Step Up and Step Down services and Learning Disability Homes too.

The kit consists of a tympanic thermometer, a pulse oximeter and a blood pressure monitor all of which link to a computer tablet via Blue Tooth. In addition to the readings from the instruments above NEWS2 includes respiration rates and alertness. The homes will receive the Whzan kit along with clinical training and support on how to use the portal.

The use of the equipment takes vital measurements of all residents at least monthly and when residents are unwell or there are concerns about a resident, as defined in the processes within the care home. Care home staff collect readings from residents using the kit on a routine or as needed basis, for example if there is a concern. The readings are automatically stored on the tablet and a web-based portal. Utilising NEWS2 (National Early Warning System), the computer tablet presents staff with red/amber/green feedback, giving an indication of general health. In combination with local clinical procedure and care plan, staff are able to take appropriate action.

The solution is identified as a remote monitoring and triage system with the following desired outcomes:

- Empowering care home staff to make informed decisions, improving confidence and reducing time spent understanding or reporting clinical concerns
- Reducing unplanned/unnecessary clinical/999 call-outs or A&E visits
- Improving information available to clinicians to assist with diagnosis or any ongoing monitoring of residents

Here is some feedback from the Ferndale Care Home Manager:

> *"Using digital technology has enabled us at Ferndale to be more proactive within our skill set and enabled us to give good information to professionals who we need to interact with where interventions with resident care is essential. The Whzan allows us to give accurate news scores when contacting the Doctor, 111 and greeting paramedics when medical help is needed. We can give good clear readings that help determine the level of care that a resident needs, fast response or a visiting doctor or nurse"*

This has been identified as a key barrier:

- Changes in staff where ongoing training is required

Some of the conditions for success include:

- High level of engagement with care home staff to use the equipment
- Uptake of clinical training to care home staff to use the Whzan kit confidently
- More informed exchange of information between the care home and clinicians
- Care home staff feel more confident to manage symptoms within the home following discussion with a clinician without the need to call an ambulance

Contact: cheryl.stimson@centralbedfordshire.gov.uk

Bedfordshire, Luton and Milton Keynes ICS

Yellow Bracelet

The Yellow Bracelet is a scheme to place a physical identifier to signal that a person is in receipt of a current care package if they are attended to by emergency services or admitted to hospital. It enables the attending staff to review the details and make informed decisions about conveyance, admission and discharge

The objectives of the scheme are to:

- Reduce avoidable admission
- Reduce delays in discharge of patients from hospital who already have a care package in place
- Reduce bed days spent in hospital
- Avoid delayed transfers of care and discharge to assess
- Provide better outcomes for people
- Allow healthcare professionals to communicate information in real time
- Allow care providers to maintain active control over their care packages

Funding has been secured for a 2-year project to rollout the Yellow Bracelet scheme across Central Bedfordshire, Bedford, Luton and Milton Keynes (BLMK). The Yellow Bracelet scheme provides a physical identifier to health care professionals, that a resident has a care package in place. The bracelet enables ambulance crews and staff in hospital to access information about the care package and key contact numbers in the event of an emergency.

Engagement has taken place across the care system to implement the rollout of the paperless communication aid which shares integrated care information. This helps to inform the health professionals to quickly and efficiently decide on the best course of action and care for the resident. The Council has been co-producing local service operational procedures for each service area to ensure they complement all current processes and provide real time data.

The Yellow Bracelet soft launch started on 24 May 2021 with a phased approach to rollout the bracelets across Bedfordshire. As part of the early adopters for Yellow Bracelet, 17 providers joined the initial phase and will continue to further rollout across BLMK. A video is currently being developed to further promote and raise awareness of the Yellow Bracelet locally. Information is also being produced in easy read for residents with learning disabilities.

The Council is currently working to support providers to access opportunities. They have established a Multi-agency and Multi-disciplinary Programme Board. The standard operating plans that underpin the use of the Yellow Bracelet have been co-designed. The scheme enables professionals from both health and social care sectors to access care package information. In so doing supporting them to make real time risk assessments and informed decisions on the treatment and care that an individual requires and achieve the best outcomes for them.

The Yellow Bracelet, keyring or information care, has a unique QR barcode which professionals can scan with their smart phone or tablet. This allows them to electronically and immediately access the details of the care package and telephone numbers for next of kin and care provider agency, so they can be contacted and kept informed. If the resident needs to go into hospital, the Yellow Bracelet will be placed on the person by the ambulance crew, so when they arrive at hospital the teams will also be able to scan the bracelet and access the information too.

The information is secure and can only be accessed by health care professionals who are registered on the Yellow Bracelet scheme along with their smart e-devices. The development process for which meets General Data Protection Regulations (GDPR) requirements. Information on the care package can be easily accessed, health and care professionals can communicate more efficiently, and family and care provider agency team can be contacted without any delay.

The following barrier has been identified:

- Some provider data software hosts are unwilling to share access which will result in a manual upload rather than API integration

Here are some conditions for success:

- Procurement of Yellow Bracelets to support rollout across BLMK in all care homes
- Engagement across the care system to enable paperless communication aid that shares integrated care information
- 1600 care packages identified for Yellow Bracelet in phase one rollout

Contact: cheryl.stimson@centralbedfordshire.gov.uk

County wide procurement of care technology

Essex County Council

Embedding care technology across Essex

An innovative procurement of a county wide care technology service which focuses on people who access care and support, their outcomes and the social value

Essex's vision for Adult Social Care is "Putting communities at the heart of Adult Social Care: enabling people to live their lives to the fullest".

Essex recognise that modern technology can play a crucial role in enabling people to enjoy independence and quality of life, even as their needs increase. The experience of the COVID19 pandemic also showed the importance of technology for helping keep people connected to their loved ones and to their care support, and helping them keep safe.

Essex wanted a procurement which covered their ambition and vision for Essex now, using the learning from the Alcove video carephone rollout and the South Essex Pathfinder, but that was also fit for the future.

In 2020, Essex County Council published an Invitation to Tender (ITT) for care technology. The bids were evaluated against 100% quality of service, based on a fixed fee model, including 20% Social Value Weighting.

The ITT was divided into two lots:

- **Lot 1** was an end-to-end care technology offer. This covered the purchasing, installation, decommissioning and recycling of technology but had a real focus on cultural change and innovation. The Council was clear that they didn't want the same technology on day one as year three of the contract
- **Lot 2** was a monitoring and response service

The procurement was a framework approach so NHS and other partners could join the framework during the duration of the contract if they wanted to.

Essex County Council successfully appointed Millbrook Healthcare and Community Integrated Care (CIC) to work collaboratively to deliver their ambition and optimise a £43m return on investment over the life of the contract.

The future vision is as follows:

- Aim to work in partnership across Integrated Care Systems to explore opportunities for test and learn pilots within pathways and evidence a return on investment
- Use big data across health and social care to move towards preventative interactions rather than waiting for crisis pinch points. For example, monitoring someone's daily activities through technology and when they move outside of 'normal' parameters then a prevention intervention can occur such as a phone call or visit

- Wish to explore an all-age approach and how care technology can support housing
- Recognise that there are opportunities to explore in other commissioned services such as reablement, domiciliary care, residential and supported living to name a few

Essex County Council undertook a pilot in South Essex with PA Consulting and Argenti which allowed them to also get feedback from people who access care and support and professionals. During COVID19, the Council also rolled out 2,000 Alcove Carephones to vulnerable people across Essex which again gave insights and feedback on the benefits of technology for improving people's quality of life. The Council also undertook market engagement sessions to help develop the thinking on the approach.

Key learning points were as follows:

- The pandemic meant the need to pause the procurement and restart it, but also gave greater focus on the potential of technology, on the importance of social value, and on a 100% focus on quality
- Following the rollout of the devices, there was recognition for a need to invest in culture change to create awareness and allow space for confidence-building and engagement with staff
- Digital skills were a barrier to take-up the technology
- Engagement with stakeholders at all levels is required to drive forward the ambition, high-level sign off doesn't mean you'll get the job done

Conditions for success were as follows:

- Improve best practice with innovation – by using care technology procurement and empowering/skilling staff and providers
- Transforming services with creativity – by enhancing strong partnerships with the NHS and others
- Meeting individual's needs appropriately – through educating and engaging with residents and ensuring carers are enabled to care
- Understanding demand with clarity – by creating robust data and analytics

As part of the framework, the new providers committed to delivering a combined £9.4m of Social Value benefits over the contract period. The Social Value will be realised through a number of people- and community-based initiatives:

- Increase sustainable employment within Essex
- Support community projects and reduce demand for public services
- Decarbonising and safeguarding initiatives
- Promoting Social Innovation

Go live date: **1 July 2021**

Contact: natasha.corness@essex.gov.uk

directors of
adass
adult social services
eastern region
connecting innovating improving