

Shaping the Future of Care in Surrey

A Personalised Approach

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Stuart Cole – Independent Living Services Manager

Enabling You With Technology





Jodie's Story





Benefits to our residents

Reduction in
social isolation

Increase
connectivity

independence

Quality of life

Choice and
control

Safety

Communication

Education

Employment

Leisure

Activities of
daily living



So what have we learnt so far?

TECH when personalised and outcomes focused proves its worth

Improved benefits tracking & evaluation

Modernising service delivery / provision

Excited workforce with room to grow

Improvements in referral numbers & quality

ADASS working group with TSA

Opportunities are vast

Clear when measuring outcomes who is really benefitting from tech

Health opportunities



Moving from Pilots to Practice

- TECH is part of our everyday work & a core part of Social Care
- Workforce confidence without overwhelm
- Changes to culture
- Our paperwork supports our decision making
- Public and staff perception
- Coproduction
- Carers – how can tech impact
- Assurance in governance & accountability with partners
- Endorsed by teams and tech spend is reflected in their budgets
- Market engagement and e-market place
- Twin track approach – cost savings and avoidance



Key Areas of Focus

Front Door - Prevent, Reduce, Delay

Reablement

Older people

Mental Health

LD&A

Hospital Discharge incl Pathway 0

Connectivity & Digital Inclusion

Public Health – health inequalities



"Providing personalised outcomes for Surrey residents and communities through the use of technology-enabled care services. Using technology and data insights that promote independence at home as well as in formal care settings, we will transform social care into a proactive, responsive and inclusive service that ensures no one is left behind"



Rishna's Story





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Mole Valley Life

MOBILE • INDEPENDENT • SOCIAL



**Your life. Your journey.
Share it with us.**

Mole Valley Life



Certified Organisation



Operated by Mole Valley District Council, Mole Valley Life supports people who may require assistance in their everyday lives, to remain independent and connected to their communities.



Mole Valley Life

"The service has enabled Mum to stay at home for as long as possible, giving her the best quality of life in her later years."



Alarm
Receiving
Centre (ARC)



Technology
Enabled Care
Services
(TECS)



Wellbeing &
Responder
Service



Community
Transport



Living Well
Centre



Information
and Advice/
Hospital To
Home

With an emphasis on preventative work with Older and Vulnerable People

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Vision



Creating connected communities by enabling and empowering people with a trusted, safe and innovative remote monitoring service.



We work with partners proactively to create an ecosystem for people who use our services, which uses data and analytics to assist evidence-based decision making to achieve outcomes for the person based on their need.

Connected Care

Discharge/
Assessment

Connected
Care

Reactive
Care

Community
Wellbeing
Responder

Community
Outreach

Personalised
Assessment

Informal/
Formal
Carers
involved

Community
Connections

SMART Home

Connected Care
Data & Insights

Hydration and
Nutrition/
Medication
Reminders

Community
Lifeline
Alarm

Telecare
Peripherals

GPS
Location

Non-Injury Falls
Lifting Service

No Response

Wellbeing
Check- in

Virtual Check
In

Community
Connections
(Social)

Technology
Adherence/
Digital
Inclusion

“Enabling” Service Approach



Enabling You With Technology



Connected Care – A hybrid model of care

Key Features

- Virtual check-in to ensure medication adherence, reminders for meals, appointments
- Data and insights from activities of daily living which detect subtle changes in behaviours
- Family/ carer dashboard access

Benefits

- Remote nonintrusive monitoring – no cameras or microphones
- Early detection of changes can identify potential issues such as UTI's
- Step down and reassurance to informal care network

John's Story

John lives alone has a range of complex medical needs including impaired hearing, Lewy body dementia and is on blood thinners.

The connected care sensors were installed to support early discharge from hospital.

The Alarm Receiving Centre received an alert on with the event description 'Too long in room' stating that "Client has been in Hallway since 19:44. Last activity in Hallway was at 22:23".

Unable to obtain a response from the client, the operator contacted the ambulance for assistance who categorized as a **Cat1** response. Following up with deterioration call to John, the ambulance personnel confirmed that the client had fallen in the property & sustained a head injury. Due to his use of blood thinners, it was deemed necessary to take him to Epsom General Hospital.

Looking at the advanced movement report it would appear that John fell at around 7.44pm. The default 'Too long in room' alert is configured to contact the ARC should the resident spend more than 3 hours solely in the area. The ambulance arrived on-site at 11.27pm with the resident leaving for hospital at 00:10am.

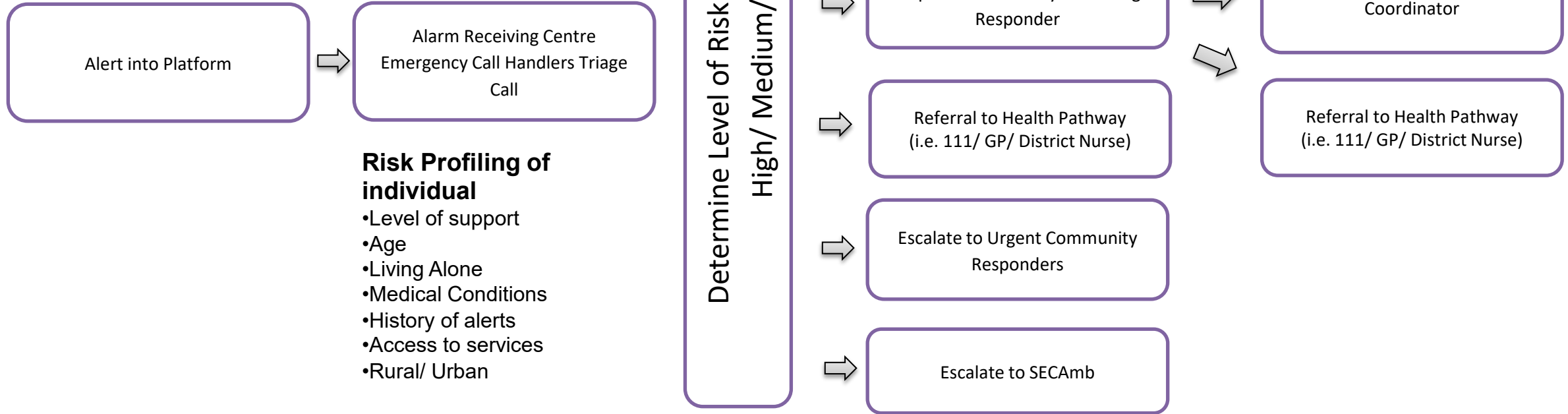
John's Story

Without the monitoring & subsequent alert from the Connected Care system it is likely that John would not have been found until the morning care visit.

With the known risks of long lie, hypothermia due to the incident occurring in January and during the night & blood loss coupled with the use of blood thinners, without the early intervention it is safe to assume that John would have experienced significant deterioration on the hallway floor overnight & would (at a minimum) have spent a significantly longer time in hospital.



MVL Triage



MVL Maintain Contact with Service User



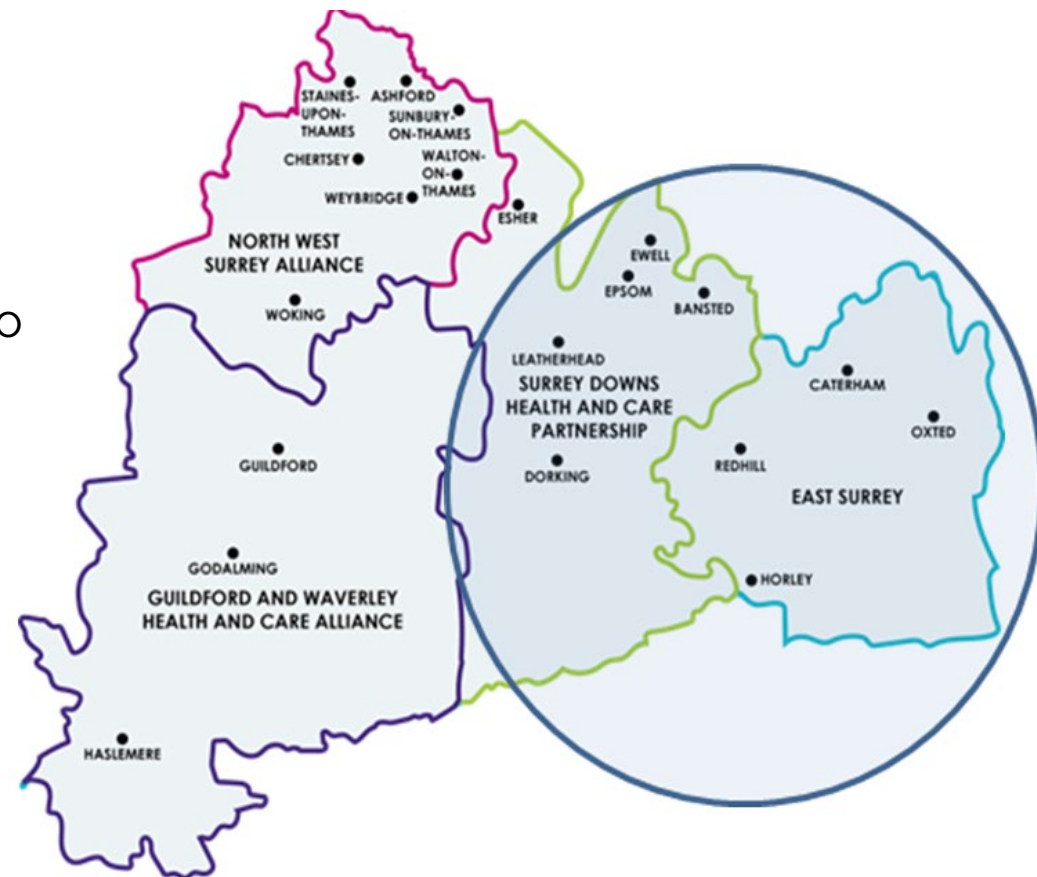
Service Impact (Jan '24 – Dec '24)

- **1,848** Community Responder call outs
- **91%** of call outs resolved at the scene without escalation to SECAmb
- **27 minute** average response time
- **24 minute** average duration on site

By preventing unnecessary use of emergency services and conveyance to A&E,

Calculating on 5% (92) of falls resulting in a hospital stay with an average length of stay of 10 days.

*The Community Wellbeing Responder Services gives a ROI of **£3.02** for every **£1** spent*



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Post Discharge/ Long Lie Pathway

The Trust has been working in partnership with Guildford and Waverley Health and Care Alliance and Mole Valley District Council on a pilot project that offers follow up welfare telephone calls to older patients within 48 hours of their discharge home.

Guildford and Waverley residents over 50 who've had a short stay in hospital (from 2 -14 days) and are being discharged with no further clinical follow up and have no new care and support needs, receive a 'check in call' if appropriate, offering them additional support if needed. It's an opportunity to say if they are finding it difficult to cope, either physically or emotionally after discharge.

Since January 2024, around 12 patients a day have benefitted from receiving a call from a trained Community Responder employed by Mole Valley District Council, asking them if they need any further support or additional services.

Emma Sutton, Delivery Programme Manager for Guildford and Waverley Health and Care Alliance:

"We know a number of people are at risk of readmission simply because their need was not anticipated. A welfare call can act as reassurance or comfort and be sufficient for most patients, and some may require further signposting to support available or a follow-up home visit."

Sarah Holbrook, Lead Nurse, Patient Flow at Royal Surrey:

"We've had very positive feedback from patients who have been called following discharge from hospital. One quick call can make all the difference and allow a person to remain happy and healthy at home, confident that they know how to get the support they need when they need it."

"We have produced information leaflets about the welfare calls as we want these to be given to eligible patients being discharged. These will be available on all of the wards and should be given to patients who meet the criteria."

Bill's Story

Mole Valley provide a Hospital to Home Discharge Service which offers short term personalised support to pathway of patients and to enable them to return home safely and access existing local services.

With an immediate 72-hour package of support and a further provision of 6 weeks extended support when required.

Bill was given an alarm and key safe FREE for six weeks on discharge and he was referred to our service. His wife had died two weeks previously and he was feeling lonely & isolated (they had been together for 70 years). We contacted the care home where he used to visit his wife regularly (and stay for lunch) and they agreed he could still come for a meal.

Bill was subsequently referred again after a cataract operation and he needed help with laundry & cleaning. We then set up a meeting with the lady who cleans for other residents in his development, and they have reached an amicable arrangement.

He has also been recommended to community transport, which he has subsequently joined and is now being taken regularly to the Fairfield Centre for lunch and company.

After conversations with Bill, we also discovered that he was one of the mechanics working with the 'Dam Busters' and has some great memories of his years in service.



It is a marvelous service and I feel safe with it.

Thanks

12.00-13.00 Market Place & Lunch

Panel Session – The Future of Telecare Over Mobile Networks–Facilitated by Richard Keyse (2iC-Care). **Panellists**-Max Stevens (CSL), Richard Bailey (Mobius), Chris Hockley (BT/EE), David Christie (Virgin/O2), Shaun Moscrop (Chubb), John Livermore (Openreach), Paul Shead (Enovation) & Emily White (Chiptech).

13.00-13.45

13.45-14.30 Market Place

THE FUTURE OF TELECARE OVER MOBILE NETWORKS

EXPERT PANEL SESSION

CHAIR

Richard Keyse
2iC-Care

David Christie
Virgin/O2

Chris Hockley
BT/EE

Paul Shead
Enovation

John Livermore
Openreach

Max Stevens
CSL

Shaun Moscrop
Chubb

Emily White
Chiptech

Richard Bailey
Mobius

Mole Valley Life UK Telehealthcare MarketPlace 2iC-Care