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FOR WHAT COMES NEXT

Digital Landline Switchover:

Digital Transformation and Innovation in Telecare for London and the South East

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Welcome

Matt Evans - COO & Director: Market Programmes, techUK

Agenda

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Time	Session	
10:00-10:40	Session 1	Keynote speech
		Panel Session
10:40-11:20	Session 2	Case studies from Sutton and Hyde housing providers
		Supplier case study
11:20-11:45	Coffee Break	
11:45-12:30	Session 3	Case studies from Redbridge and Hertfordshire
		Supplier case studies
12:30-13:30	Lunch and marketplace	

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Keynote speech

James Friend - Director of Digital Strategy NHS

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Panel Session

James Friend (NHS)
Matt Skinner (CareCity)
Vicky Hicks (BT)
Tim Mulrey (TSA)
Francesca Markland (NHS)

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Sutton: The approach taken by the London Borough of Sutton

Bradley Coupar (Sutton)
Nerys Hebden (Access Group)
Rupert Lawrence (Medequip)

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Case Study: Hyde Housing

James Barr (Hyde Group)
Steve Gates (Taking Care)

London Borough of Sutton: Innovating to Preventative with Digital Switchover

Bradley Coupar, Tech Enabled Care Services Manager, London Borough of Sutton

Nerys Hebdon, Head of TEC Customer Enablement, Access Group

Rupert Lawrence, Head of Medequip Connect

techUK, London and the South East Event

11 November 2024

access
freedom to do more

MEDEQUIP Connect
Technology Enabled Care Service

Sutton

The Innovate Programme

The South London Partnership is a cross political party sub-regional collaboration of 6 London boroughs: Croydon, Kingston upon Thames, Merton, Richmond upon Thames, Wandsworth and **Sutton** as the lead authority.

The SLP was granted an award of £4 million from the business rates retention scheme to run IOT trials over 3.5 years to **"pilot and research"** and **"Bring together technology and places to address real world challenges in our communities"** that can generate economic growth, support local businesses and help people live better, healthier lives.

www.innovateproject.org

‘We have **tried**, **tested** and **evaluated**’

Sutton

The Outcomes

Lives Saved

"When they found me, I was very, very ill, and if I'd been left longer, I don't know what would have happened." **Maureen** – elderly Sutton Resident who fell and broke her hip during the DORIS care trial. The ambulance service stated that Maureen would not be with us today if it weren't for the sensor.

Read More

Vulnerable Resident support using DORIS Care

- **Over 4 lives saved** as a result of proactive sensor alerts Maureen Video.
- **149 fuel poverty alerts** in January 2023 vulnerable residents likely to be experiencing fuel poverty.

> "Through the use of the DORIS devices we have been able to monitor not just the wellbeing of residents but also the health of the properties in which they are living. The sensors provided the insight needed to support residents with maintenance, repair and training in terms of the heating systems they have in their home and in some cases the need for benefit support to address fuel poverty concerns". **Bradley Coupar - Smart Place Project Manager and Social Worker**

- ILOs can prioritise resident calls based on a traffic light system that is emailed each day, visualisation of a person's activities can give indication of general decline.

> "*The data provided by these sensors has enabled us to have conversations with the residents to establish what support they need. On the back of this, we have referred residents to Sutton Connect, some for help with bills and others for help with benefits, etc. The fuel poverty alerts have enabled us to identify those who need support, but not necessarily from social services.*" **Lisa Lak ndent Living Officer, Sutton Housing Partnership**

Sutton

Sutton Housing Partnership

South London Partnership

IoT Solutions Group

What did we learn?

- **Data** - Better use of data can and will save lives.
- **ADL** - should be offered as standard not as a separate solution.
- **Data Visualisation** - enables greater insight and should be included as standard in any future telecare contracts and will enable the ability to right size care packages.
- **Actionable Insights are key** - Focus on an Outcome driven approach.
- **Don't** - Just buy the same technology with a sim.
- **Rethink** - What should we be getting from our new digital telecare.

Sutton

Sutton Housing Partnership

South London Partnership

Commissioning Process

1. Commissioning Technology Enabled Care Strategy
2. Soft Market Engagement
3. Competitive dialogue

Sutton Housing Partnership

Sutton

Reactive (examples)

careium

Tunstall

chiptech

appello

Preventative (examples)

Just Checking

IoT Solutions Group

MySense™

Anthropos

Canary Care

SHEILA

DEVELCO PRODUCTS

vayyar™

Sutton

access MEDEQUIP Connect Sutton

How we innovated with Access TEC

Highly Interoperable, Future-Proofed & Flexible

Integration with Health, Support & Care Apps

Enables both Reactive & Preventative Service

Multi-brand, Multi-purpose; All Insights to One Dashboard

access Connect MEDEQUIP Sutton

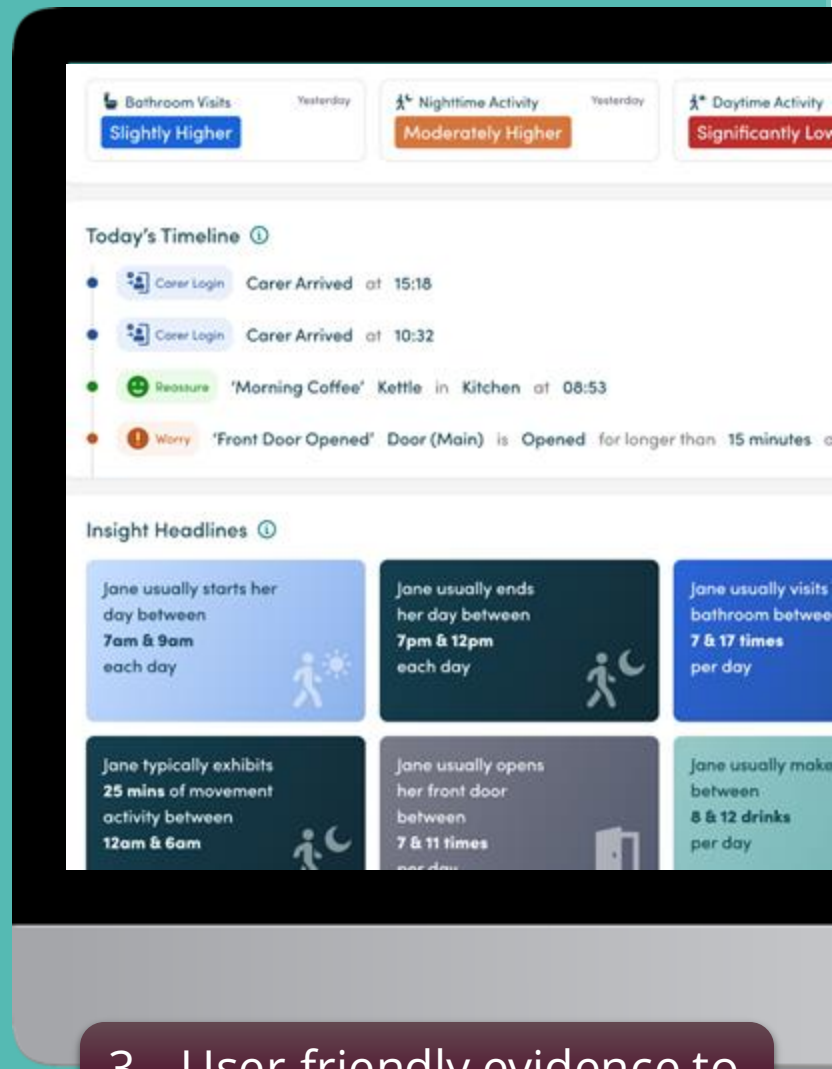
Enabling preventative integrated working

Report integration to Mosaic

Welfare check calls

Preventative responder service

Engage Family/ Carer with App



1. Activities of Daily Living Sensors & Alarm Packs

2. Proactive Monitoring: ARC, family/carer & responder

3. User-friendly evidence to right-size care at reviews

Medequip Connect Shop/Hub Open to the Public

https://www.linkedin.com/posts/tsa-voice_we-were-delighted-to-be-at-the-launch-of-activity-7194723697562193922-b9my?utm_source=share&utm_medium=member_desktop
https://www.linkedin.com/posts/at-today_technology-enabled-care-specialists-launch-activity-7199686617152843776-q2Wq?utm_source=share&utm_medium=member_desktop
https://www.linkedin.com/posts/accesstechnologyenabledcare_accessinsights-acesshscevent-event-activity-7203322461436657665-JpRx?utm_source=share&utm_medium=member_desktop

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Sutton Housing Partnership
MEDEQUIP
access

Commissioning for Success

Be Ambitious

- Upgrade to maximise the outcomes and benefits of digital and data insights.
- Avoid like-for-like reactive alarm solution during Digital Switchover.

Market Engagement

- Competitive dialogue process.
- TEC strategy centred on the benefits of a proactive & preventative service.
- 3-way partnership with Technology & Service Providers.

Future-Proofed Solution

- Right technology to enable scale & flex.
- Empower residents & support carers
- Enable the Local Authority to promote greater independence.

Questions?

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freedom to do more

MEDEQUIP
Connect
Technology Enabled Care Service

Sutton

Lessons from the Leading Edge

Hyde and Taking Care Part of AXA Health

Digital Landline Switchover:
Digital Transformation and Innovation in Telecare for London and the South East

11 November 2024
techUK, London

November 2024

Private and Confidential

Agenda

- Introductions
- The vision for Hyde Housing Association's "Analogue to Digital" transfer
- Opportunities and challenges for Hyde
- Opportunities and challenges for Taking Care
- Moving forward – What would we do differently next time?
- And where can we go from here?

Hyde Housing

50,000 homes

2,650 telecare connections to support residents' independent living and building compliance

74 Later Living or Supported Housing schemes with telecare

Our Vision

Obsolete analogue telecare systems – costly and problematic to maintain

Rationalise telecare systems into a single solution across Hyde homes

Big investment in digital across Hyde homes and with our customers to modernise in advance of digital switch

Spread upgrade costs across several financial years

Expected benefits of greater resilience, enhanced functionality and multiple lines

Our Journey

2017 - First business report on digital switch

2019 - Upgrades to digital enabled systems

2021 – New Group telecare partnering agreement with Taking Care

2022 – Project implementation to digitise upgraded systems

2024 – First digital connections via new provider

Our Challenges and Learning

Not where we want to be

No longer a single telecare hardware solution

Cost of continually attempting digital is unsustainable

Cords and pendants still in use – limited breakthroughs with AI or assistive technology

On-costs / subscriptions of new technology

Unclear path to achieve 100% digital connections

Opportunities and Challenges for Taking Care

- With one digital scheme provider it's taken 2 years of testing and engineer time to take 2 digital calls simultaneously
- ARC providers are being required to connect to a widening range of digital scheme equipment – some of which have only been operated in "test" mode beforehand
- A number of digital scheme equipment have an accompanying platform (ie. IOTComms) – that your ARC provider will need to work with: be ready to work with manufacturer AND platform provider to find a solution
- Tendency for manufacturer to blame the ARC, to blame the middleware platform and to blame the engineer
- Requirement to identify the key issue: Many more parties now involved

Agenda

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- Opportunities and challenges for Taking Care
- **Moving forward – What would we do differently next time?**
- And where can we go from here?

What would we do differently next time?

- Not assume that because the manufacturer and provider of the 24/7 monitoring platform are the same that their equipment will talk to each other
- Require confirmation (and sight!) of working schemes unit with ARC before you commit– not take manufacturer's "word" for it.
- **[Whatever you're told]** Most digital scheme equipment is not mature and you're going to be doing some "live" testing on behalf of the manufacturer – prepare to have to invest engineer and staff time (both at the property and monitoring centre)
- Recognise that there are sometimes analogue "workarounds" until the full digital alarm signal capability is fully available
- Often scheme upgrades (to get things working properly and connecting to ARC) require a firmware or software upgrade – with inevitable delays
- Different ARC platforms connect differently – ***be aware***

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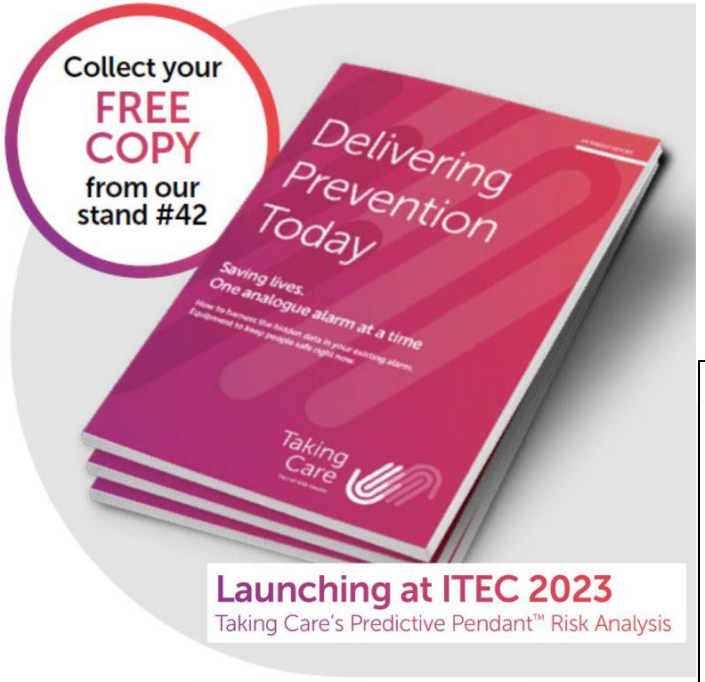
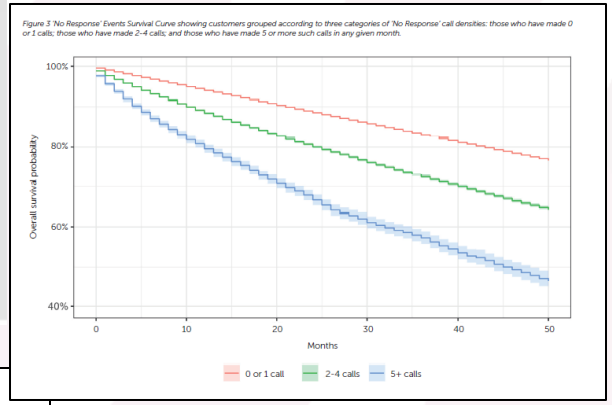
- **And where can we go from here?**

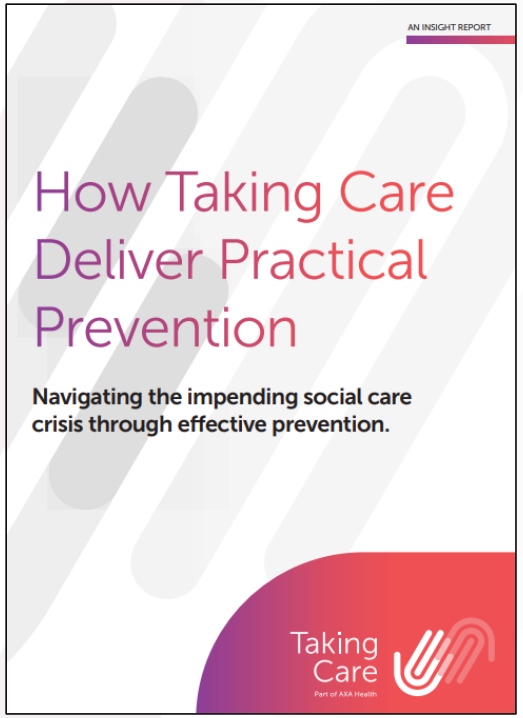
And where can we go from here – big digital data and AI



Call reasons as correlated to subsequent death	Frequency trigger (how many is too many)	Monthly risk	Prediction period	Risk ratio
1. Assistance Required	3 calls or more in a month	3.1%	3 months	4.8
2. No Response	5 calls or more in a month	4.4%	1 months	4.7
3. 999 Called	1 call or more in a month	1.5%	3 months	3.0
4. Total Calls	5 calls or more in a month	1.2%	1 months	3.0
5. Test	0 calls in a month (1 or more indicates lower risk)	1.0%	12 months	2.0
6. Accidental	10 calls or more in a month	3.1%	3 months	2.0

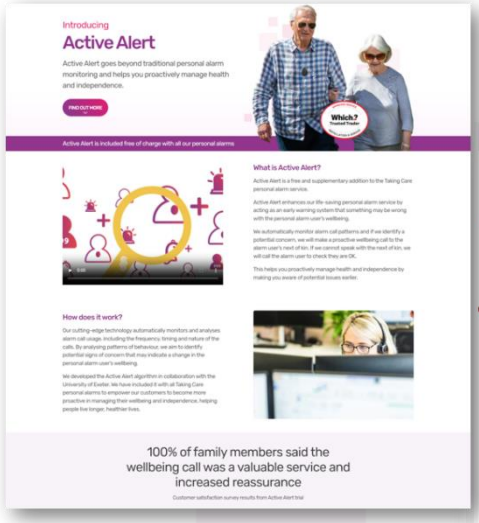


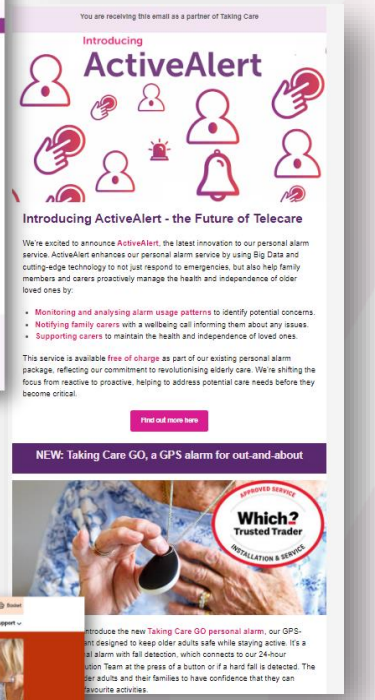
Call reasons as correlated to de-registration for reasons other than death	Frequency trigger (how many is too many)	Monthly risk	Prediction period	Risk ratio
1. No Response	10 calls or more in a month	2.7%	3 months	5.7
2. Assistance Required	3 calls or more in a month	2.5%	3 months	5.3
3. Total	10 calls or more in a month	1.5%	1 month	4.8
4. 999 Called	2 calls or more in a month	1.4%	6 months	3.1
5. Test	0 calls in a month (1 or more indicates lower risk)	0.6%	1 month	2.4
6. Accidental	5 calls or more in a month	0.9%	6 months	1.9

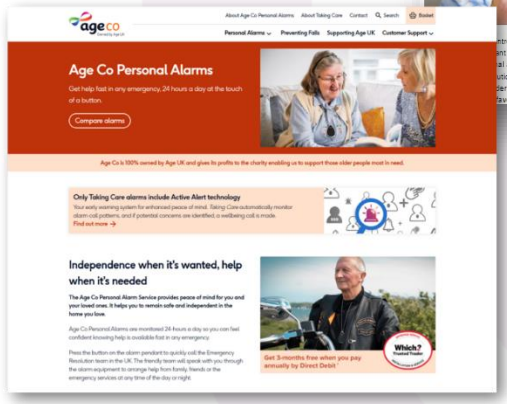


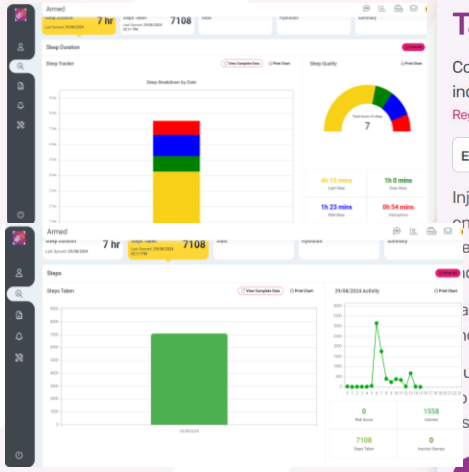
age NI · Taking Care · ARMED · HSC Public Health Agency · HSC Southern Health and Social Care Trust · Ulster University · BIG MOTIVE · Department of Health

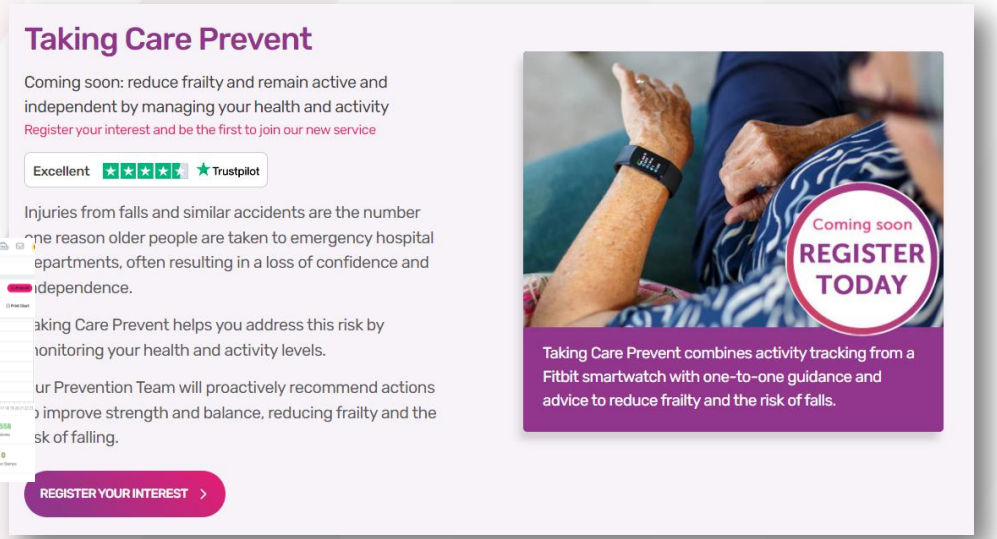
Which allows us to develop new and innovative propositions as a sector

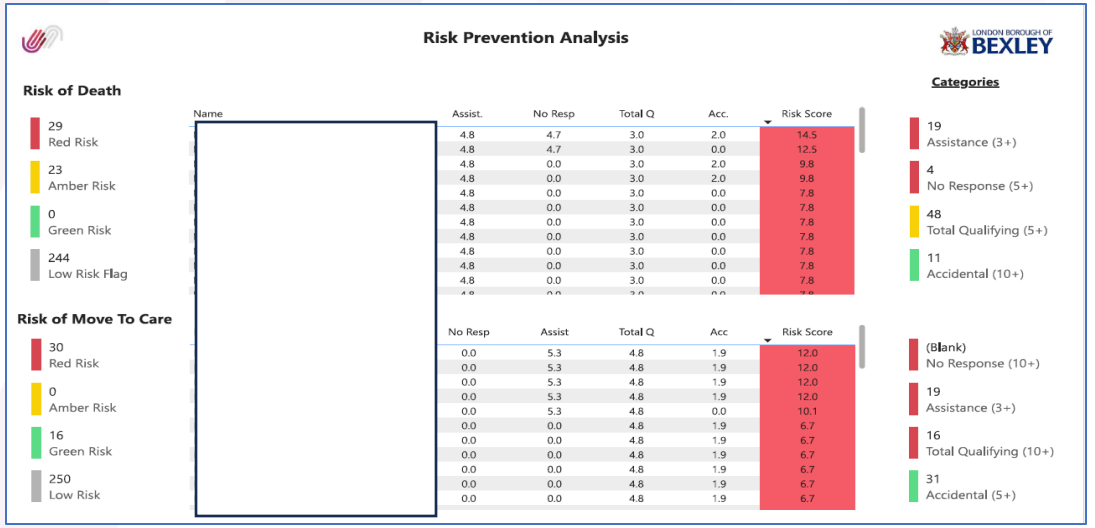












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Supplier Case Study

Everon

Integrated Model For Prevention Care

Getting to the problem before it becomes one

everon™

Smart Analytics & Outcomes

Ultimate Objective

1. Everon Group to deliver a vision of Connected Health, Housing and Social Care

2. By delivering data led trends that support the delivery of a proactive and preventative care model.

Everon Lyra Portal

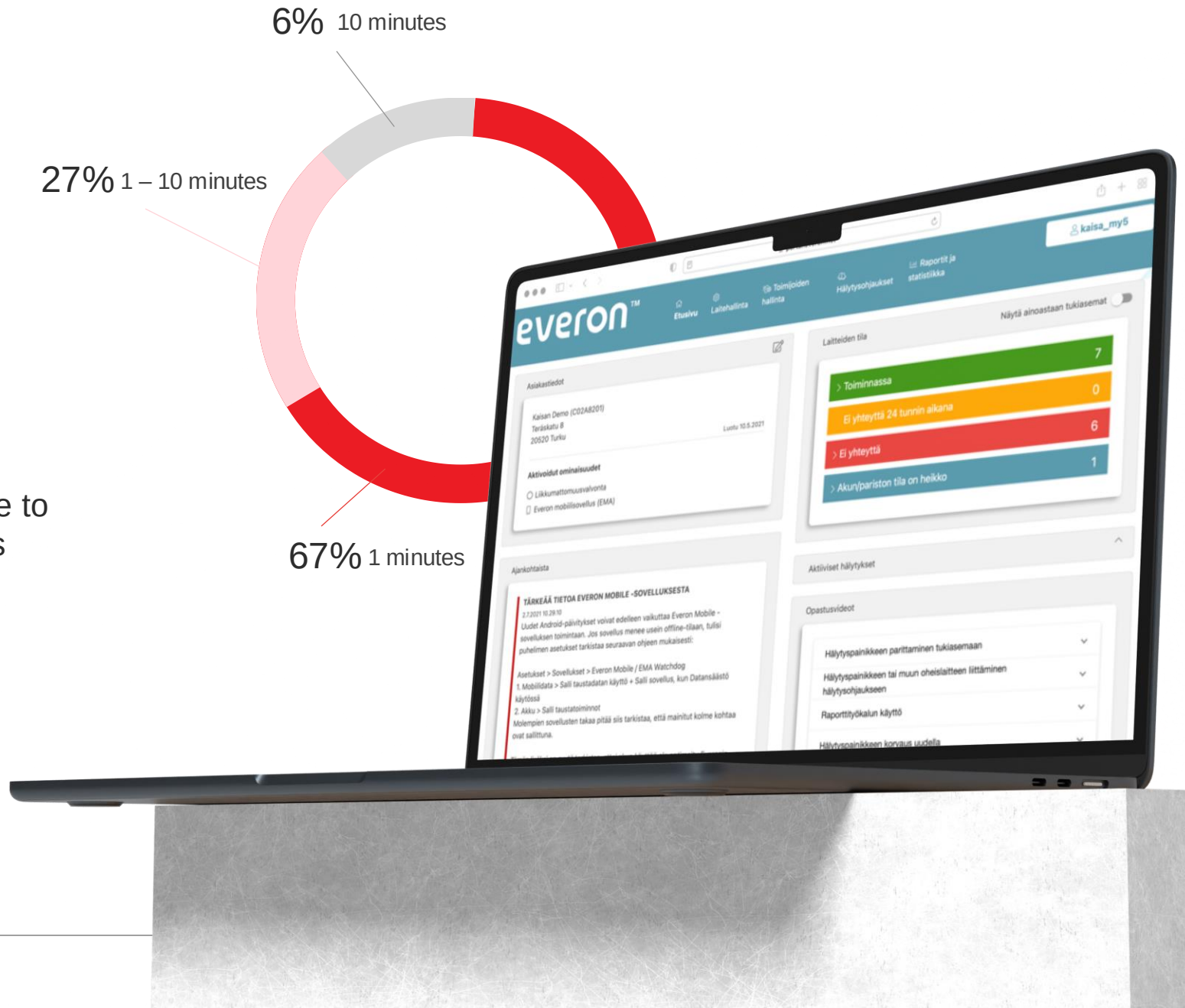
Device management

Manage users

Alarm routing by groups or individuals

Training available to service providers

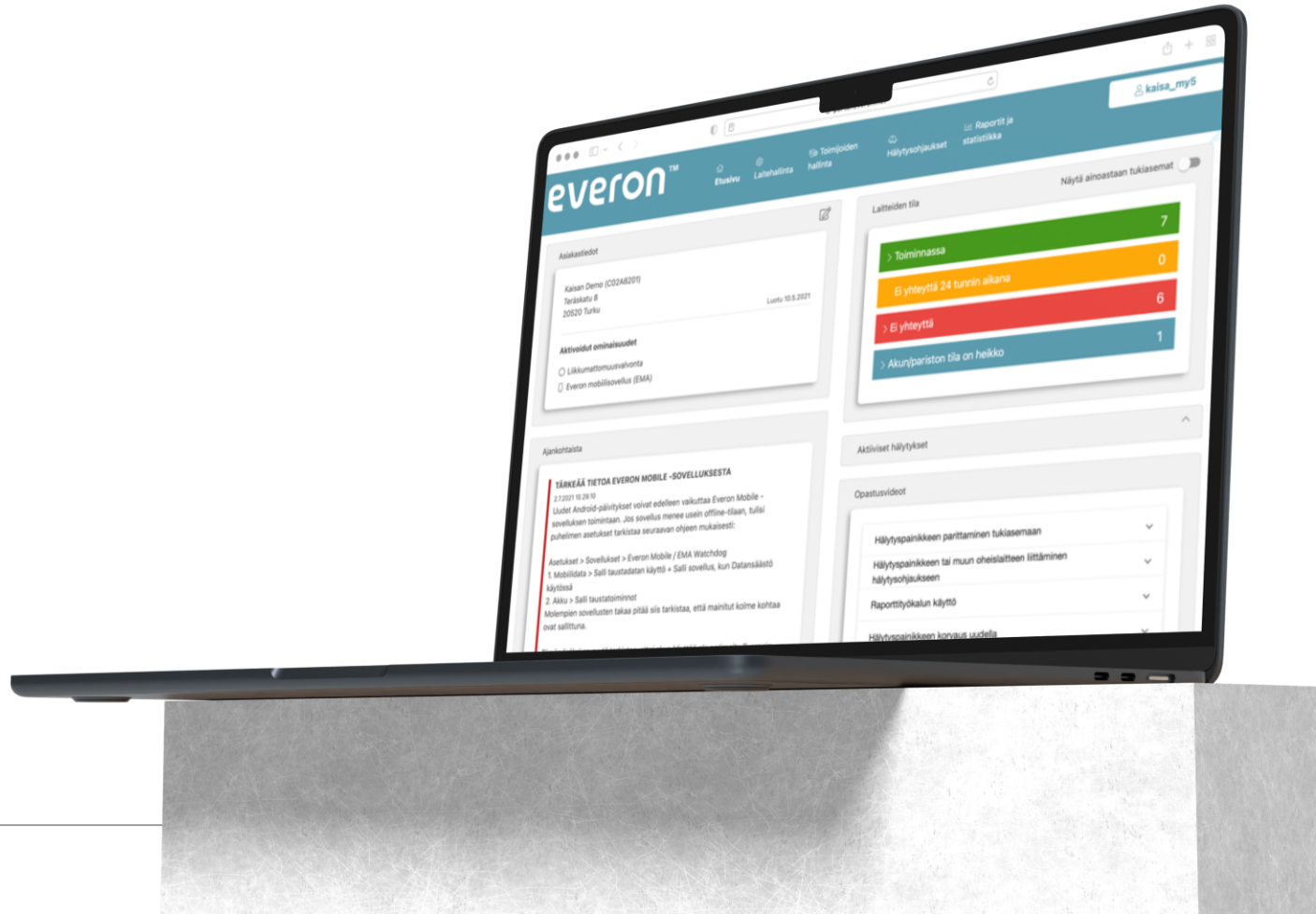
User friendly dashboard and reporting



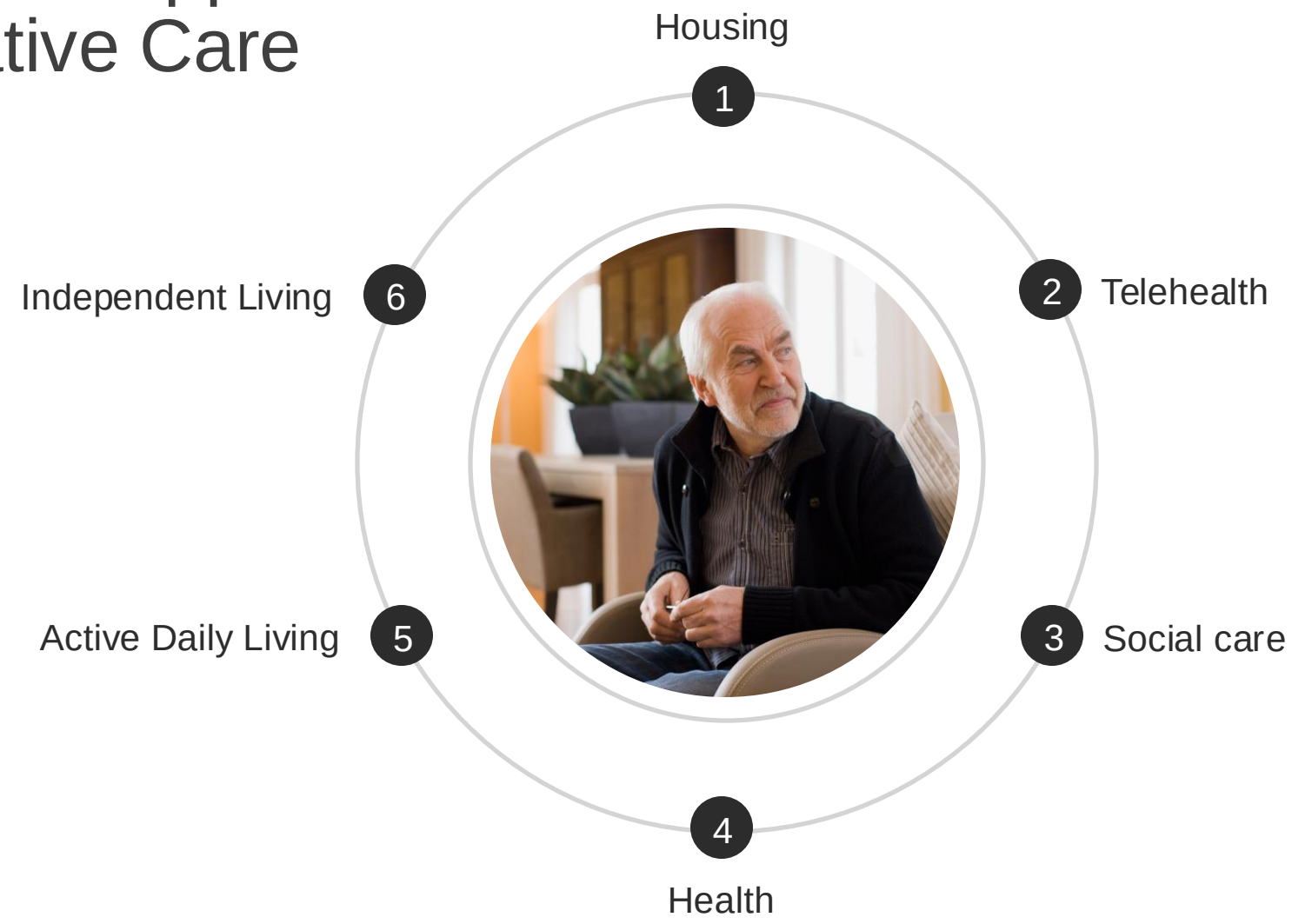
Everon believes Open Data Platforms are crucial in the Health & Social Care arena.

Why?

1. Transparency & Accountancy
2. Improving Healthcare Quality
3. Enhancing Research & Innovation
4. Patient Empowerment
5. Efficiency & Cost Effectiveness
6. *Predictive Analytics & Population Health Management*



Person-centric approach to Preventative Care



Active Daily Living

3 Steps for Better Health and Social Care Outcomes

App & Reporting

The app provides a clear indication of any identified risk for a clear and concise response from the family and or care teams

Remote Monitoring

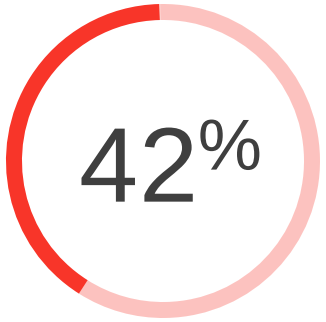
Gathering real time activity Data providing an objective view of the collated data

Machine Learning

Analysing behaviour raising any potential risk to the user

ADL – Validated Care Outcomes

1 Social Outcomes



Reduction in risk of care home admission due to TIHM

of TIHM users felt less anxious since joining the service

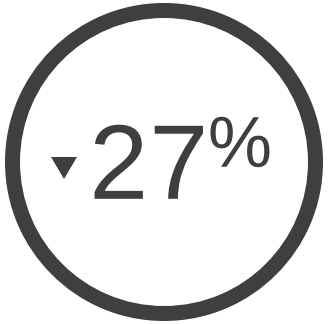
70kg of CO2e emissions saved per TIHM user per year

2 Patient Reductions

Reduction in ambulance callouts

Reduction in emergency admissions

Reduction in patient stays at hospital



Reduction in patients that required no treatment

Source: Technology Integrated Health Management (TIHM) service from Surrey & Borders Partnership NHS Foundation Trust and Howz. Health economic evaluation carried out by Kent Surrey Sussex AHSN. "KSS Insights, June 2021"

Origon 2025 Data Sources

1

Obsidian Pendant

2

Night Owl

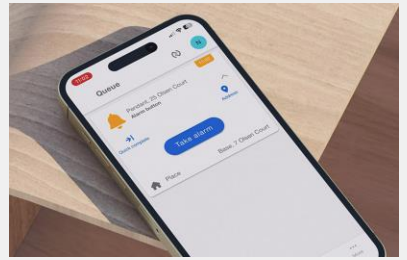
3

Environmental Monitoring

4

Everwatch

5



Mobile App

6

Video Door Entry

7

Lock Solutions

8

Pull Cords

9

Occupancy Sensors

Thank you

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Coffee break

11:20-11:45

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Redbridge: Developing a long-term approach for digital strategy

Matt Skinner (CareCity)
Callum Church (Redbridge)

Redbridge:

developing a long-term approach for digital strategy

Tech UK: 11 November 2024

Introduction

- **Callum Church, Redbridge Council**
- **Matt Skinner, Care City**
- **Culture Change**
- **Redbridge Care Tech Pilot**
- **Bringing it all together**

London Borough of Redbridge

NELFT NHS NHS Foundation Trust Best care by the best people

Care City

Redbridge Care Tech Pilot

- **Funded by the DHSC**, one of eight pilots in England
- Working in partnership:
  - **Care City** – Implementation
  - **Apteligen** – Evaluation
  - **Alcove** – Operational Delivery
- Deploying **care technology to 300 residents** across Redbridge
- **Learning through implementation** across:
  - Care homes
  - Extra Care
  - Reablement
- Testing technologies that will **proactively detect health conditions in advance to prevent falls** and illness:
  - MiiCare
  - Feebris
  - Whzan Guardian
  - Informetis
- Conducting **an evaluation** to help measure benefits and cost savings

London Borough of Redbridge

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Care City

Things we are learning

Implementation

- **Health monitoring technology is deployed in 9 care homes, covering 154 residents** and including 18 wearables that measure walking/gait - detecting fall
- **Conversational AI technology deployed in 3 extra care facilities** with 19 individuals
- **4D mapping technology that measures movement around a room** and falls due to be installed in two Sanctuary care homes across 114 rooms
- Working with domiciliary care to train them to use health monitoring tools to identify signs of someone falling ill and work with GPs to escalate

Things we are learning

- Really interesting to see care plans being changed due to night time waking being detected
- Teams adapting how they work with use of the technology
- Detection of people unwell, escalated before they deteriorate
- Wifi passwords can be a barrier!
- Really great engagement from providers who want to implement more care technology

London Borough of Redbridge

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Care City

Culture change – ways of working

Early adopters group
Frontline staff meeting monthly to develop understanding of tech and identifying barriers and challenges

Co-design with residents
Recruited a group of residents to help inform understanding of tech use and experience

Digital Skills
Identification, future training needs, skill base

Showcases
Showcasing technology to staff and partners so they understand what is available

Understanding resident needs

Key Findings

Occupational Therapy Support:
- Tools needed for self-reliance and daily task management.
- Enhance technology literacy for daily integration.

Cognition and Medication:
- Support for medication adherence due to cognitive confusion.
- Alarms and reminders, with staff monitoring compliance.

Declining Independence:
- Resistance to help despite need.
- Importance of building trust and reassurance.

Technology Use:
- Concerns about privacy and monitoring.
- Need for reassurance on tech reliability and security.

Volunteer Role:
- Feels pressure to appear strong, leading to reluctance to accept help.

Adoption Barriers:
- Cultural views on tech vs. family care.
- Need for continuous reassurance to build trust in tech

Insights

Barriers:
- Psychological resistance and cultural perceptions need addressing.

Medication Support:
- Reliable systems like visual aids and voice assistants.

Tech Literacy:
- Gradual introduction and support.

Staff Vigilance:
- Attentive and supportive staff.

Recommendations

Enhanced Occupational Therapy:
- Provide tools for self-reliance, like planners and medication organizers.
- Offer training on technology use, starting with simple, user-friendly devices.

Medication Adherence:
- Use smart alarms and reminders to assist with medication schedules.
- Employ staff to monitor and support medication intake diligently.

Building Trust in Technology:
- Gradual introduction and continuous support to build comfort with technology.
- Clear communication about tech reliability and privacy measures to alleviate fears.

Cultural Sensitivity:
- Acknowledge cultural concerns and work with family members to integrate technology without undermining their role.
- Emphasize the complementary role of technology to enhance care rather than replace family support.

Volunteer Role Support:
- Provide peer support and share success stories of others in similar roles who have benefited from technology.

London Borough of Redbridge

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whzan
DIGITAL HEALTH
THE BLUE BOX
VIRTUAL WARDS
CARE HOMES
OMICILIARY CARE
APHC
& MUCH MORE
WHZAN.UK
WEDNESDA
BOOKED 9 AM
ORGANISOR: CAL
TECHNOLO

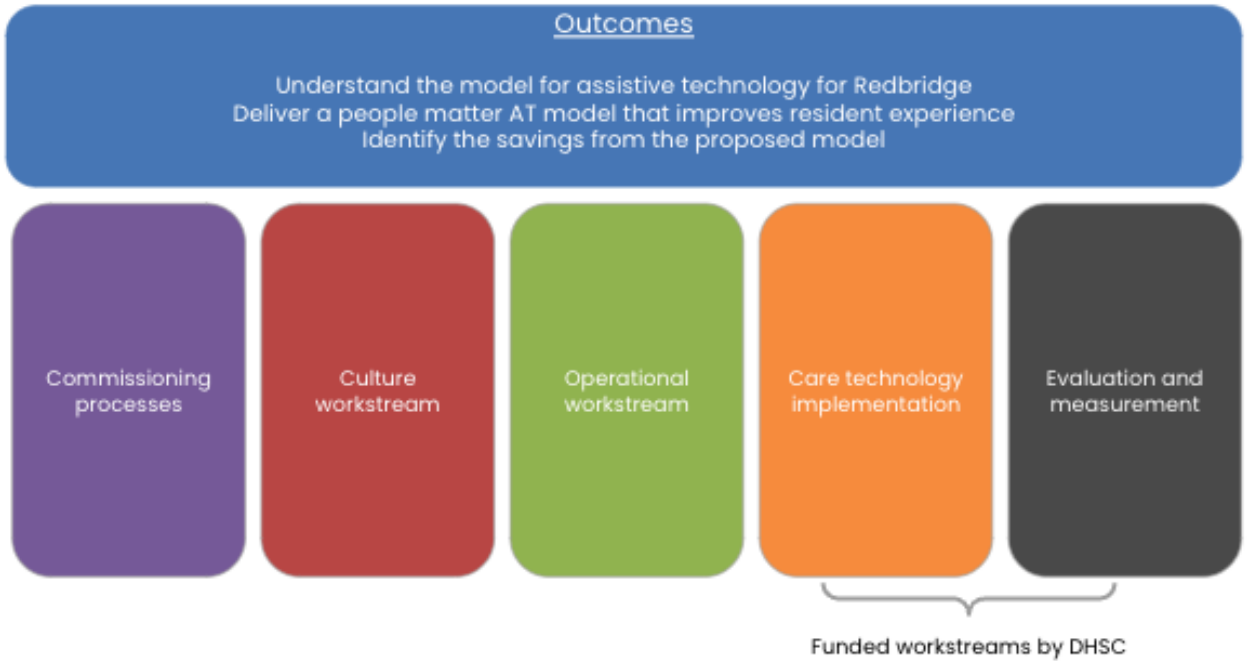
Care City

Financial benefits matrix

	Reduction	Delaying	Prevention
Cohort and Care Who might benefit the most? What changes to their care and support needs might we see?	**Remote monitoring** Elderly, disabled, people with chronic conditions Reduced emergency visits, better management of chronic conditions	**Wearable Health Devices** Older adults, individuals with dementia Early detection of health issues, improved safety	**Smart Homes & Sensors** Elderly or disabled individuals living independently Reduced falls, increased ability to live independently longer
Settings Which services and settings will we see changes through? How would we know this is happening?	In-home care, residential care settings Reduced hospital admissions, decreased staff costs	Residential care homes, private homes Demand management, cost avoidance	Individual homes, supported living settings Delayed transition to full-time care, lower emergency response costs
Measurement type	Cashable savings, cost avoidance	Reduced hospital stays, improved quality of care	Cashable savings, cost avoidance

Bringing it all together

Assistive technology strategy group Senior leadership group to talk about the learning and longer-term model



- Multidisciplinary team across Redbridge, NELFT, ICB **to bring together people with different perspectives** - no one person or team can fully understand the issue on their own
- Drawing on **commissioning processes**, **culture**, **operational**, **implementation** and **evaluation** workstreams
- Exploring **other areas where care technology can benefit** beyond the pilot activity
- **Surfacing hidden assumptions** – e.g. Who should hold the data? Who owns the technology? Who pays for the technology?

Thank you

Callum Church

Callum.Church@redbridge.gov.uk

Matt Skinner

Matt.Skinner@carecity.org

London Borough of Redbridge

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Care City

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Successes and Challenges in Hertfordshire

David Coolbear (Hertfordshire)
Julia Merritt (Hertfordshire)

Hertfordshire's Assistive Technology solution

11 November 2024

Hertfordshire

Our Journey – Some Challenges and Opportunities

How can we embrace new emerging technologies to better support our residents, improve care and help us deliver more with less?

- Analogue to digital at scale
- GDPR
- Ethical considerations
- Practitioner/resident engagement and acceptance
- Technology security, robustness and sustainability
- Cross-organisational working – seamless offer for our residents

Hertfordshire

Assistive Technology journey

- In 2019, Hertfordshire County Council outlined its vision to use modern digital technology to transform care services in Hertfordshire
- A dedicated Assistive Technology Team was established to underpin the delivery of the strategy's ambitions.
- In depth research and analysis led us to develop our own solution in Data Inspired Living
  - Unique to Hertfordshire
  - Support practitioners
  - Improve outcomes for residents

- Co production with practitioners and residents
- Continued development and iteration and a desire to share our innovation brings us here today

Hertfordshire

Our AT solution

Data Inspired Living

Data Inspired Living is a digital tool for social care practitioners to use as part of care planning for the residents we support.

It consists of an online dashboard, which provides a view of residents' routines at home using various small, discreet sensors that are placed around the home that help to build a day to day picture of someone's normal routine.

Connected Lives

Hertfordshire

LGC Awards 2024

Shortlisted for LGC Awards in 2 categories - Digital Impact and Innovation

- Over 900 entries for 22 categories
- Presented DIL to a panel of judges with great feedback
- Winner of Innovation Award

The judges were thoroughly impressed with their approach of co-producing technology that is adaptable and scalable, showcasing a true learning culture aimed at continual improvement.

The judges said their dedication, passion, and commitment to innovation serve as an inspiration to us all.

Data Inspired Living Equipment

Hub, Power Supply and Data Stick

Contact Strips

Smart Switch

Multi Sensor

Door Sensor

Toilet Flush Kit

Bed / Chair Occupancy Kit

Medication Dispenser

Make and models may vary

Data Inspired Living Dashboard

Mobility

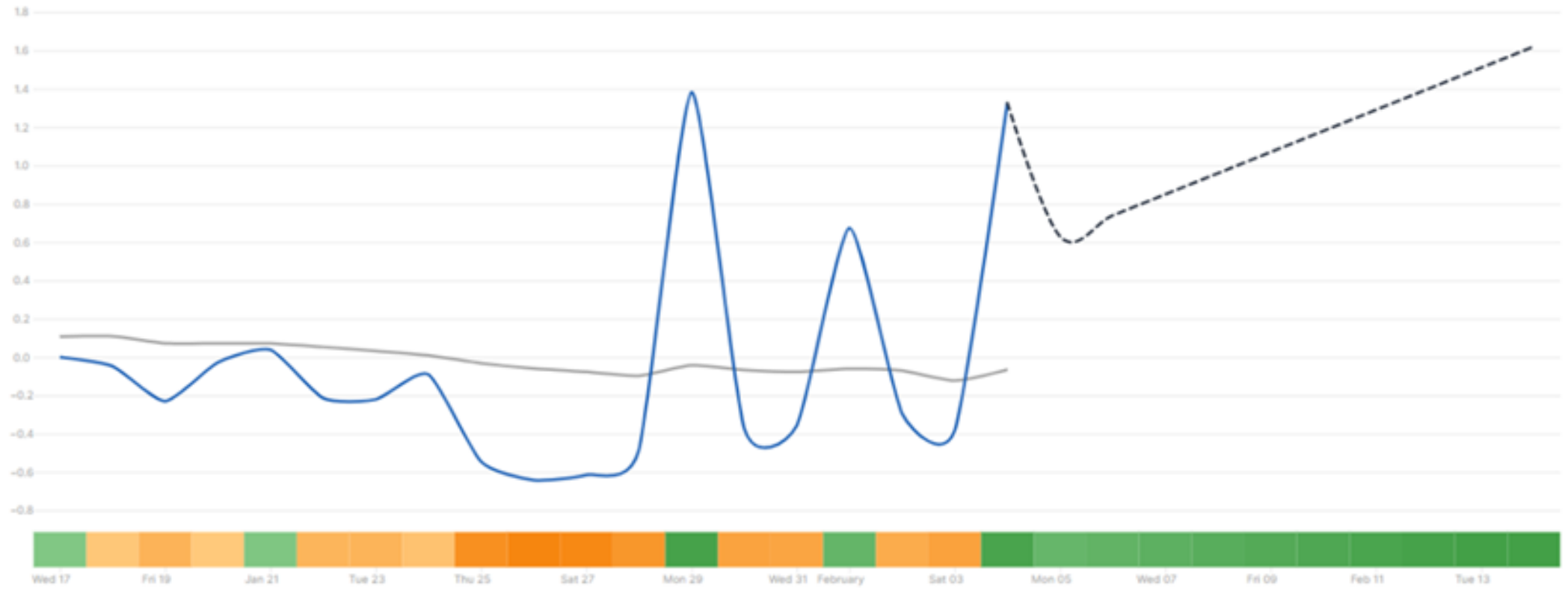
Last timestamp: 05/Feb/2024 17:54:56

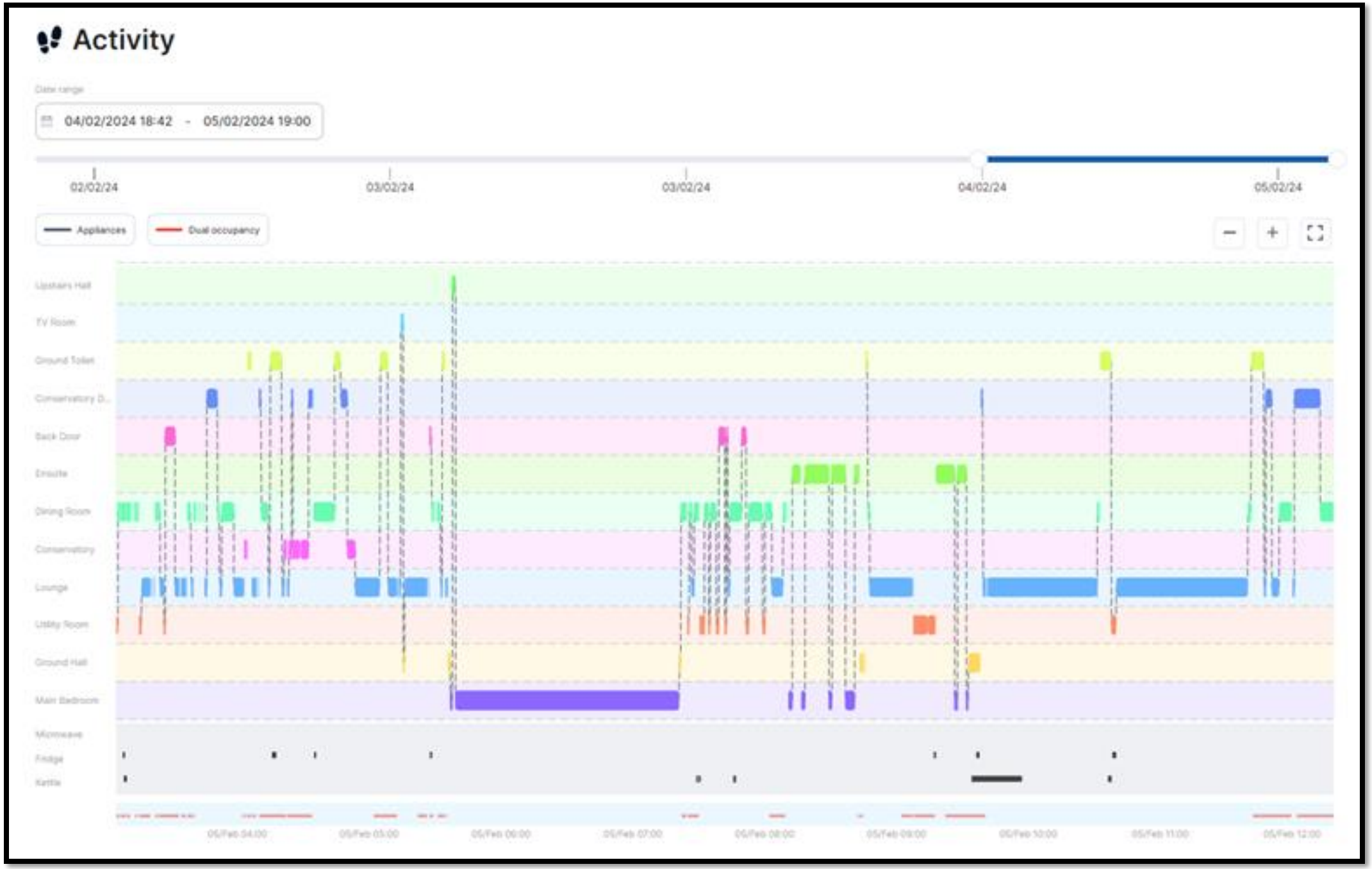
Date range

17/01/2024 - 05/02/2024

03/07/23 24/08/23 15/10/23 06/12/23 26/01/24

Smooth data | Trajectory | Trajectory 1 | Trajectory 2 | Baseline | No Data




Activity
Date range
04/02/2024 18:42 - 05/02/2024 19:00
02/02/24
03/02/24
03/02/24
04/02/24
05/02/24
Appliances
Dual occupancy
Upstairs Hall
TV Room
Ground Toilet
Conservatory D...
Back Door
Ensuite
Dining Room
Conservatory
Lounge
Utility Room
Ground Hall
Main Bedroom
Microwave
Fridge
Kettle
05/Feb 04:00
05/Feb 05:00
05/Feb 06:00
05/Feb 07:00
05/Feb 08:00
05/Feb 09:00
05/Feb 10:00
05/Feb 11:00
05/Feb 12:00

Toilet

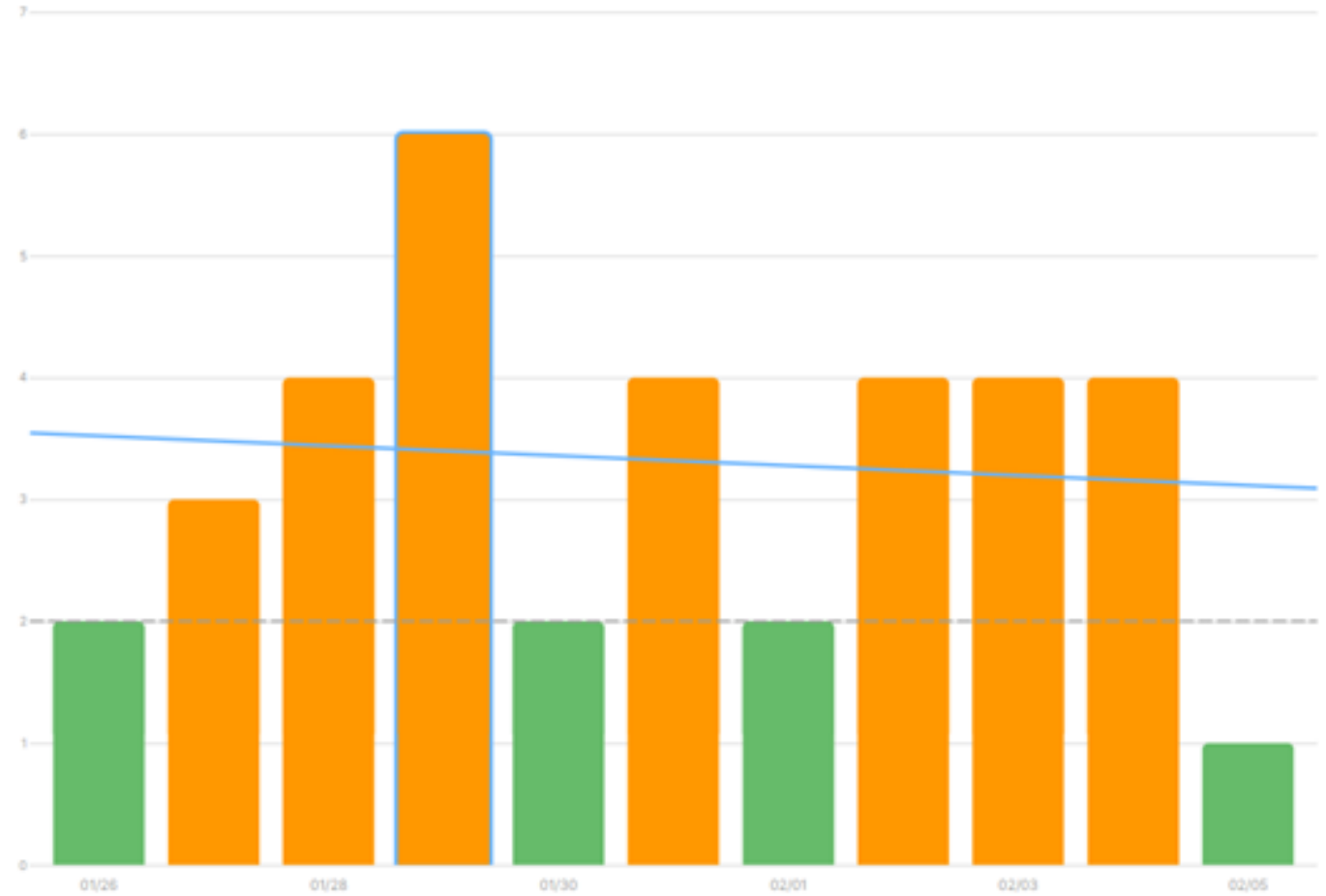
Date range

26/01/2024 - 05/02/2024

02/01/24 | 10/01/24 | 18/01/24 | 26/01/24 | 03/02/24

Below Threshold | Above Threshold | Trendline | Average Baseline

Data: Dual Occupancy



Toilet visits in 2024-01-29

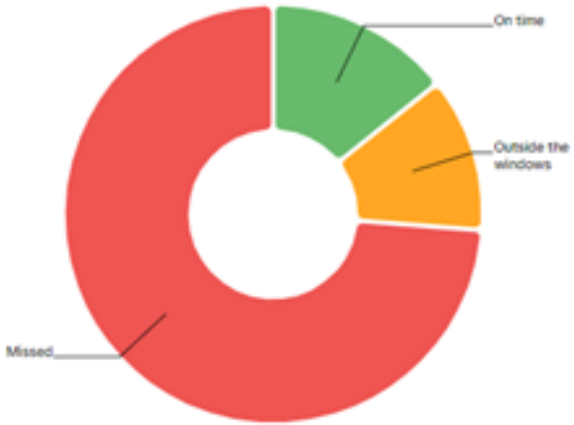
Medication

Date range

21/12/2023 - 03/01/2024

20/12/23 23/12/23 27/12/23 31/12/23 04/01/24

Medication timings



Improved outcomes for residents and benefits for the county council

Data Inspired Living

Residents

- ✓Maintaining independence
- ✓Remaining at home
- ✓Positive impact on health and well being
- ✓Reduction in homecare commissioned hours

Hertfordshire County Council

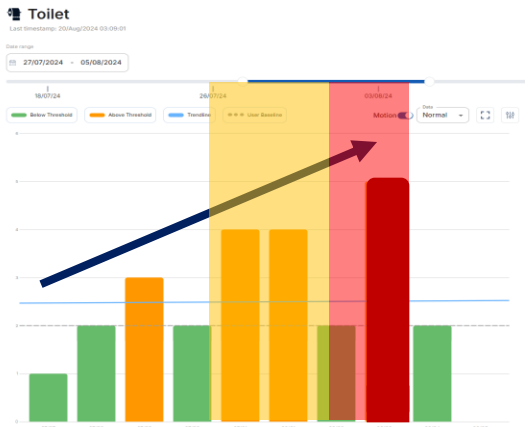
- ✓Cost savings by preventing a move/delay to a residential home
- ✓Reduction in ambulance call outs
- ✓Support frontline workers in creating time efficiencies

Connected Lives

Hertfordshire

Preventing hospital admission

Jennifer is an 86-year-old lady who lives on her own. She experiences recurrent urinary tract infections (UTI's) and this has previously resulted in hospital admission. **This example shows how a recent UTI was identified.**



Alerts were received at the point mobility showed a sharp decline and toilet use increased, indicative of an infection settling. An AT practitioner called Jennifer and spoke with her and Tina. Tina said she would call the GP and check for a UTI. Antibiotics were prescribed following this and Jennifer made a quick recovery.

Intervention

Motion sensors in all rooms
Smart plugs on microwave and kettle
Fridge sensor
Front and back door sensors
Toilet flush sensor
Access to the carer's dashboard

Outcome

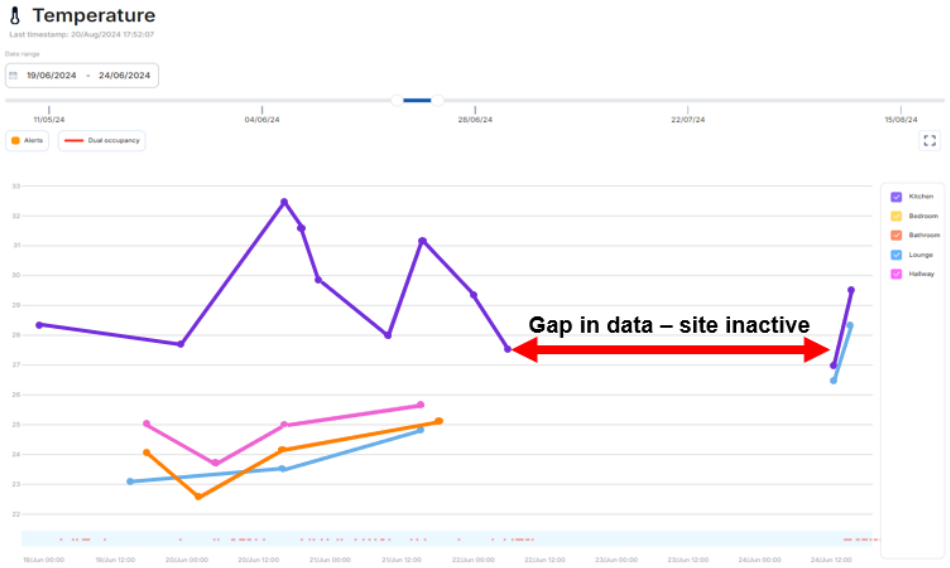
Resident feels safe and supported
No further hospital admissions
Reassurance for her and her sister
Early identification to resolve issues
Automatic alerts generated
Health and wellbeing maintained

AT also supports Jennifer by:

- Providing reassurance help is on hand when needed
- Access to a carer's dashboard for her sister which also provides reassurance
- Identification of changes to routine or pattern and alerts to highlight these
- AT can be personalised to the person and relevant sensors installed
- Identifying issues has been able to prevent Jennifer experiencing acute symptoms of a UTI and helping prevent further hospital admissions

Using AT as standalone care

Donald is a 66-year-old man who lives on his own. He doesn't have any family support and is very independent. **This example shows how we supported with a recent incident.**



AT also supports Donald by offering choice and control in the way he is supported:

Donald is not unique in not wanting formal care to support him at home and he is very independent and enjoys a good social life. There are concerns about self-neglect and issues relating to severe depression that would impact severely on Donald, were he not able to maintain a status quo with how he lives.

Intervention

- Motion sensors in all rooms
- Smart plugs on appliances
- Door sensor
- Fridge sensor

Outcome

Resident happy with service provided
Personalised to suit his needs
Early contact to support when needed
Health and wellbeing maintained

An alert was received to highlight that Donald's system was inactive. Donald's electricity had run out and he was unable to top up his emergency credit. The AT team had received an alert showing the site was inactive. Donald was supported to get his electricity supply back in place, have hot water for a shower, use his kitchen appliances and continue with his normal routine.


Herefordshire
And even when I'm out, I can link onto it,

Supporting other areas of HCC

DIL is continuing to develop and consider other features such as:

- Falls solution to integrate with our existing DIL platform
- 'Wellness' features to enhance social care provision and planning
  - Step count
  - Blood pressure
  - Sleep patterns
  - Signs of infection

Our Technology team is also working on a number of other initiatives across the council using digital technology and IOT to support a range of services:

- **Property**: LoraWan based desk occupancy System (IoT desk sensor strips)
- **Environment**: Waste Site customer information board (waste container locations, parking bay occupancy, messaging etc)

Hertfordshire

Continuing the journey

Data Inspired Living

- Fully backed by HCC (Members and Senior Leadership team)
- Working with colleagues in our health system and with Newton to continue this way of working to make sure we can drive costs down while reach as many of our residents as possible as early as possible.
- Reaching out to other Local Authorities to share our offer for further improvements and collaboration and to work with us on a trial basis and consider how we may commercialise DIL in future

DIL is embedded in HCC's digital strategy and recognises the role technology plays in addressing financial challenges

Connected Lives

Hertfordshire

Questions

For follow up please contact:

David Coolbear: david.coolbear@hertfordshire.gov.uk
Dave Mansfield: dave.mansfield@hertfordshire.gov.uk
Julia Merritt: julia.merritt@hertfordshire.gov.uk

Hertfordshire

Hertfordshire

Creating a cleaner, greener,
healthier Hertfordshire

techUK
FOR WHAT COMES NEXT

Supplier Case Study

MiiCare

miicare™

A preventative care platform empowering older adults to live independently

Empowering the service user to self care whilst reducing readmissions and length of stay in hospital

Ophir Levy
Co-founder and CTO

What we do

Digital coaching

- Companionship
- Personal safety
- Digital therapeutics
- Nudges

Optimizing response

- Optimise non-clinical tasks
- Minimise waitlists
- Emergency alerting

Preventative focus

- Prevent falls
- Prevent UTIs
- Chronic conditions
- Hospital to Home

The MiiCare Solution

A DIGITAL HEALTH COACH

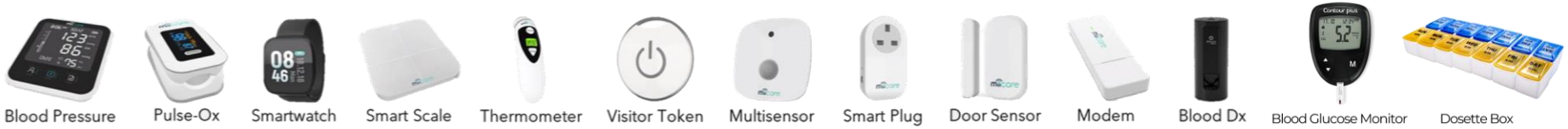
Our home hub (MiiCube) includes **Monica**, the digital health voice assistant, offering personalised digital health therapies for sleep, exercise, nutrition, and more.

AI-POWERED HEALTH INSIGHTS TOOL

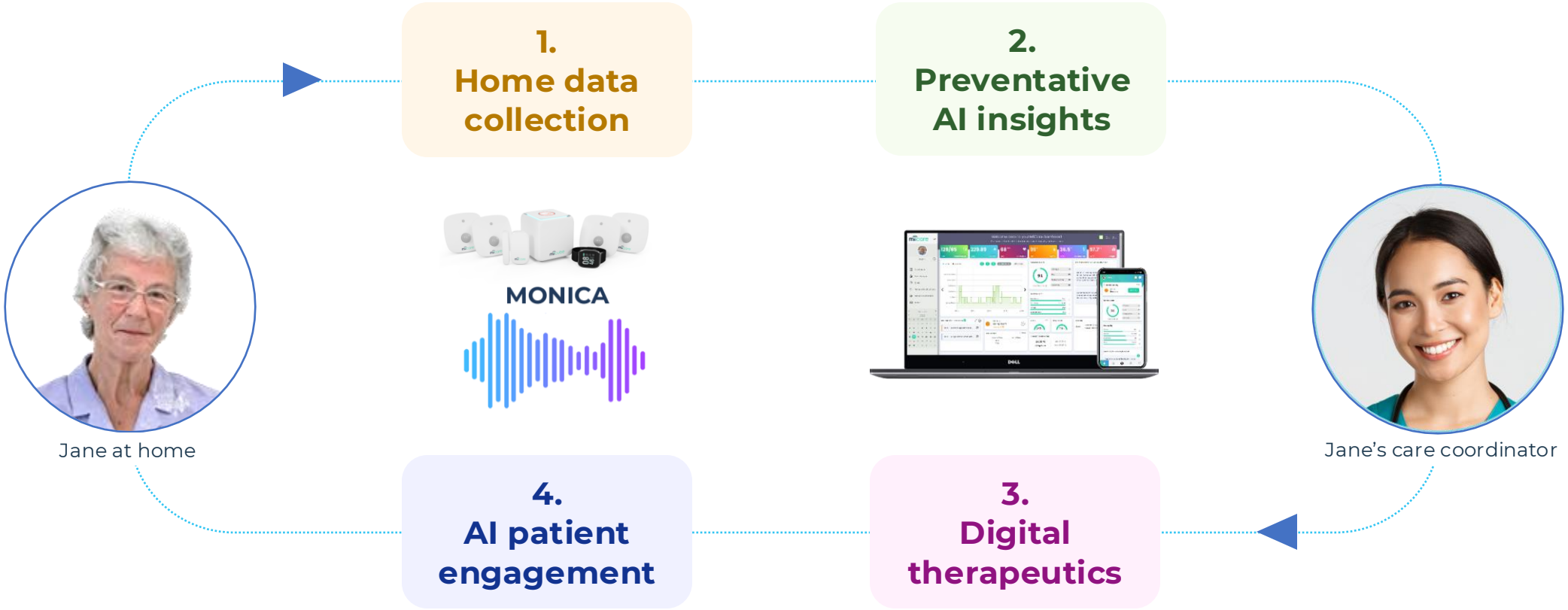
We gather user health data and utilise machine learning algorithms to **detect health issues early** and empower users to **manage chronic conditions** autonomously.

A HEALTH NAVIGATOR FOR CARE GIVERS

Our **dashboard** tracks the health and well-being of users and makes this data available to those who care. Also available as a mobile **app**, with population views to **prioritise** and **monitor** care in one platform.



How it works



MiiCare gathers data at home, generates preventative AI insights for care providers, and delivers digital therapeutics to older adults via 'Monica' the AI health coach.

CASE STUDY

BUCKINGHAMSHIRE

D2A post-discharge support with a private care service provider

Health Outcomes

91%

Of patients happy with the D2A post-discharge support.

77%

Reduction on unnecessary bed stays and readmissions.

68%

Less time spent in hospital beds vs the control group.

MiiCare are ready to help you transform your care?

UK

USA

Austria

techUK
FOR WHAT COMES NEXT

Supplier Case Study

Feebris

feebris

ENABLING SUSTAINABLE HEALTH AND CARE MODELS FOR AN AGEING POPULATION

"There comes a point where we need to stop just pulling people out of the river. We need to go upstream and find out why they're falling in."

Desmond Tutu

partnerships@feebris.com
www.feebris.com

feebris

In 2023 we:

Provided our virtual care solution to **>150 NHS** and social care sites across the UK

We underwent independent impact evaluation by YHEC evidencing **>5X ROI** for the NHS

Released **56 new novel features**, many co-created with our NHS partners

INTRODUCTION TO FEEBRIS

The enterprise system for precision healthcare out-of-hospital

Impact-driven

Feebris was born 5 years ago out of our mission to **ensure that no one suffers because they cannot access a doctor**.

We are **committed** to working with the NHS **to** ensure together we can **deliver on the promise of universal healthcare**.

We will always put **impact over profit**.

Unique Technology

The **only quality assured hardware agnostic solution**.

The **usability of a consumer product with medical-grade reliability**.

End-to-end infrastructure for integrated care.

AI-enabled decision-making for precision and efficiency.

Proven Impact

Working in global health and in the NHS, we have proven that our technology **improves patient outcomes and clinical capacity.**

We pride ourselves on the **high levels of adoption and transformation** we deliver across all our partners.

NHS Digital DTAC, DSPT DCB0129 · UKCA CE · ISO 13485:2016 · ico. Information Commissioner's Office · CYBER ESSENTIALS PLUS · The AHSN Network NHS England NHS Innovation Accelerator · Department for International Trade · Crown Commercial Service Supplier · HM Government G-Cloud Supplier

VIRTUAL CARE ACROSS THE CONTINUUM

Feebris supports safe and effective out-of-hospital care across the care continuum

PROACTIVE CARE

Feebris enables **carers and patients** to proactive manage complex health needs in residential settings, including **care homes**, and detect deterioration early

EARLY & SAFE DISCHARGE

Feebris powers **step-down virtual wards** at home, **freeing up hospital beds**, whilst ensuring safe recovery and **minimising risk of deconditioning**

MANAGING DETERIORATION

Feebris enables community nursing teams & HSAs to **manage acute exacerbations** at home to avoid hospital admissions

ALTERNATIVE TO ADMISSION

Feebris powers **step-up virtual ward** alongside community services, providing a safe & effective **alternative to a hospital admissions**

THE FEEBRIS PLATFORM

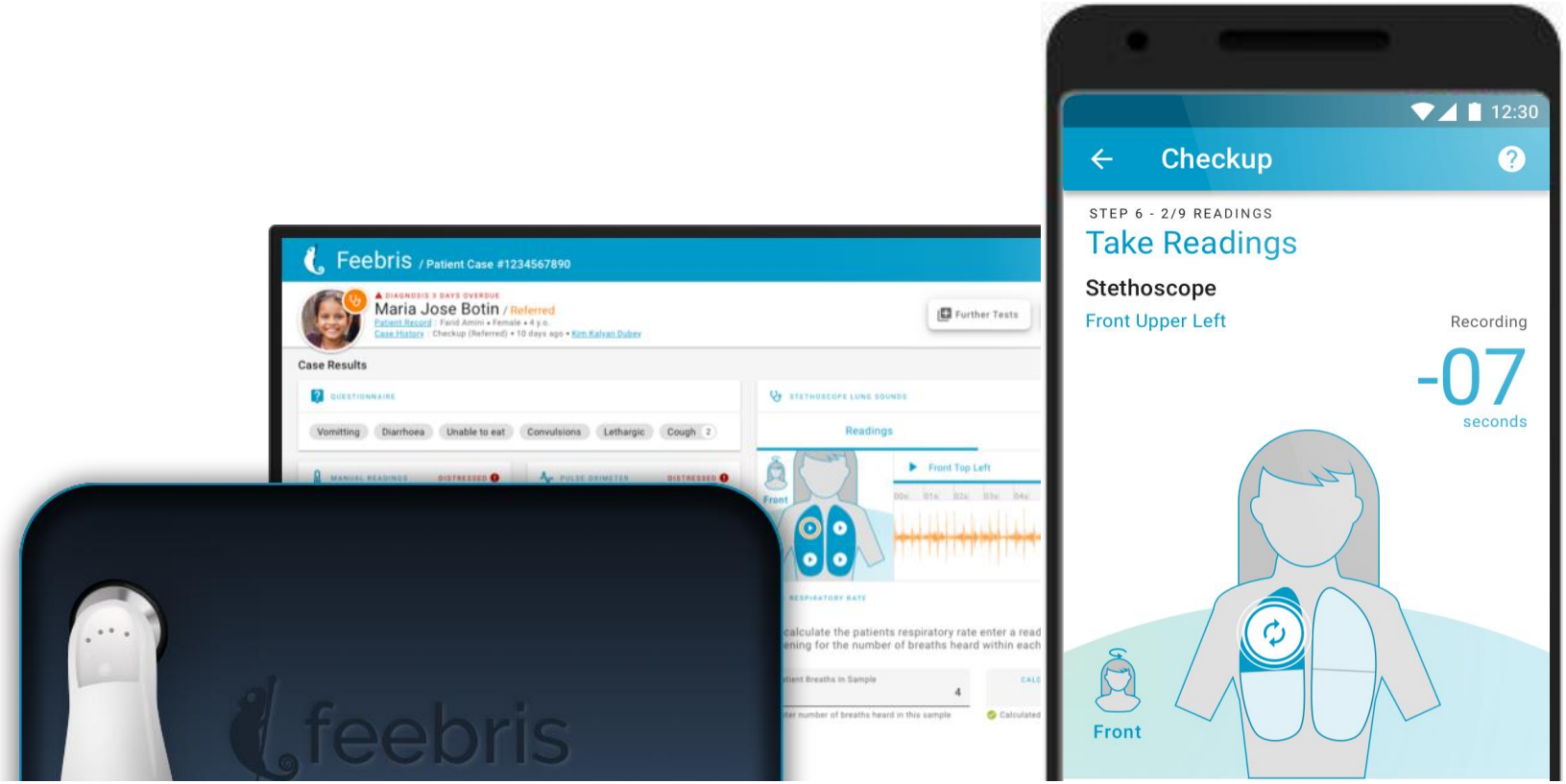
End-to-end management of healthcare in out-of-hospital settings

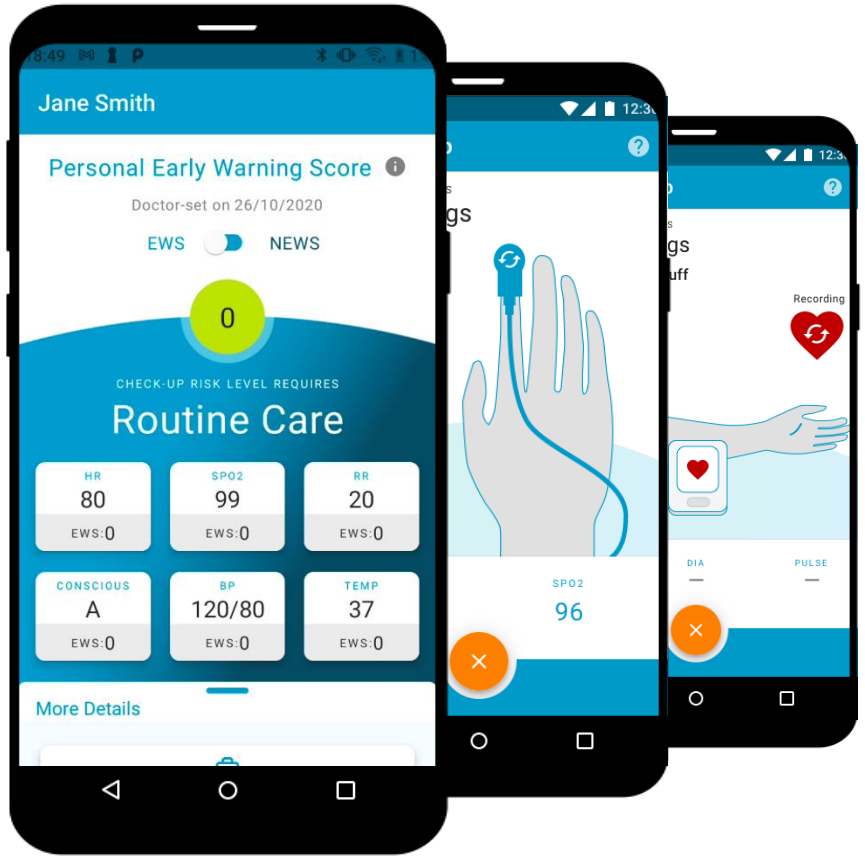
Community empowerment

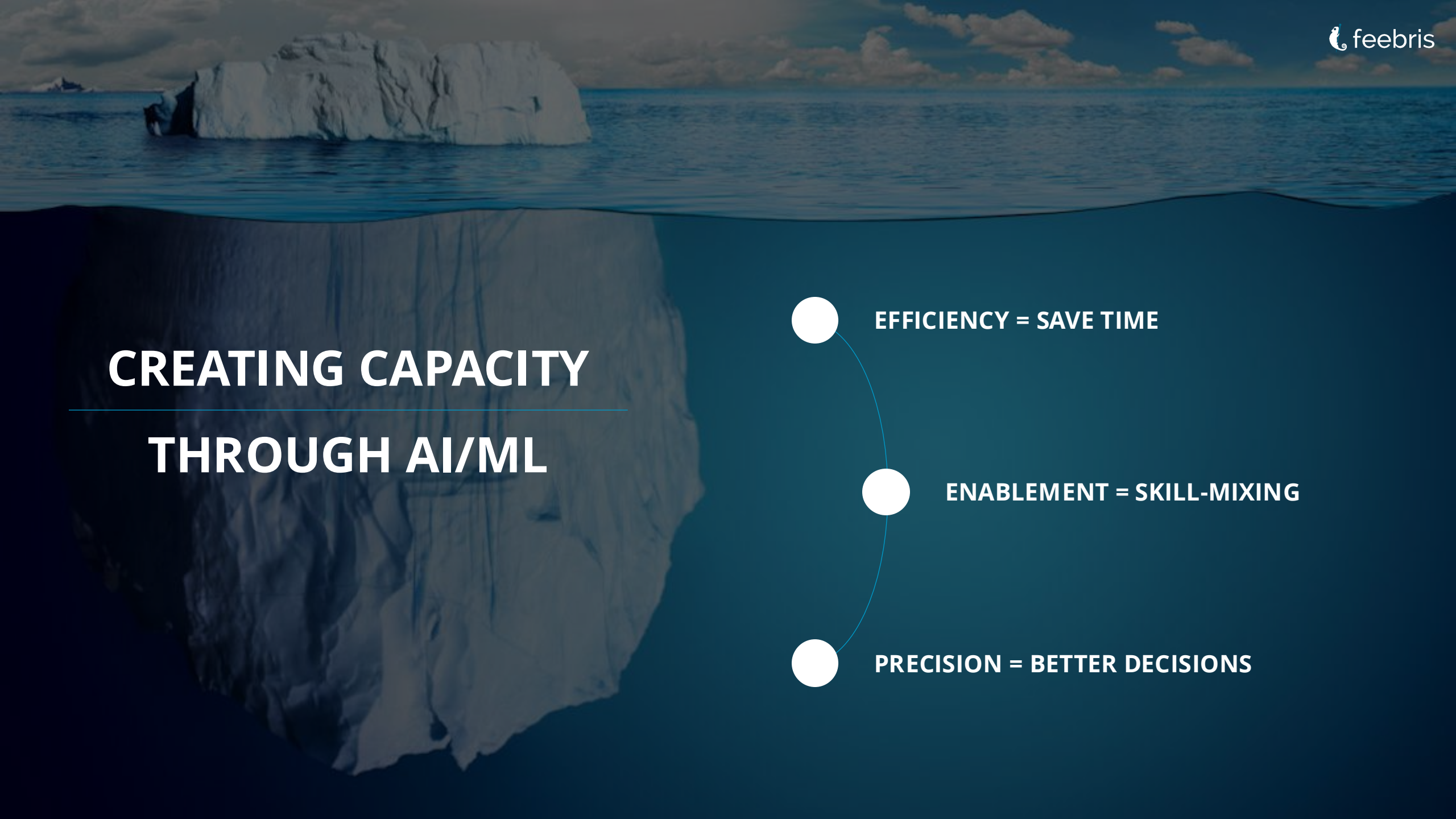
Enabling anyone to conduct a precise health assessment at home, with AI supporting each step to ensure clinical reliability.

System capacity

Bringing the right information to the right MDT member at the right time to increase capacity at scale.




Jane Smith
Personal Early Warning Score
Doctor-set on 26/10/2020
EWS
NEWS
0
CHECK-UP RISK LEVEL REQUIRES
Routine Care
HR
80
EWS:0
SPO2
99
EWS:0
RR
20
EWS:0
CONSCIOUS
A
EWS:0
BP
120/80
EWS:0
TEMP
37
EWS:0
More Details
SPO2
96
Recording
DIA
PULSE



feebris

CREATING CAPACITY

THROUGH AI/ML

- EFFICIENCY = SAVE TIME
- ENABLEMENT = SKILL-MIXING
- PRECISION = BETTER DECISIONS

feebris

TRANSFORMATION SERVICE

Technology alone does not equal change

CHANGE MANAGEMENT

ONGOING SUPPORT

END-TO-END LOGISTICS

CO-PRODUCTION OF INNOVATION

Improving lives together
Norfolk and Waveney Integrated Care System

CASE STUDY: NORFOLK & WAVENEY ICB

Delivering integrated patient-centred healthcare closer to the home, reducing pressure on acute services

1

ACUTE TRUSTS

EARLY DISCHARGE

Early and safe discharge, supporting patients to recover in a stress-free environment

3

CARE HOMES & GPS

PROACTIVE HEALTH

Ensuring timely detection of ambulatory care sensitive conditions and community management

2

COMMUNITY TRUST

ALTERNATIVE TO ADMISSION

Managing acute episodes at home. Integration with urgent care & out-of-hours services.

4

FREQUENT SERVICE UTILISERS

PROACTIVE HEALTH

Managing complex patients at home to reduce frequent hospital admissions

FEEBRIS: PROACTIVE & REACTIVE CARE IN CARE HOMES

41% of emergency admissions from care homes are for conditions that are manageable, treatable or preventable outside of a hospital setting (Health Foundation, 2019).

We empower care home staff to precisely detect issues early, especially ambulatory care sensitive conditions (e.g. pneumonia), and support clinical teams to access diagnostic quality information to intervene and prevent exacerbations. This reduces pressure on ambulance, 111, 999 and urgent care services.

TECHNOLOGY

Decision-support for carers to proactively detect risk and escalate appropriately. Modules for acute conditions, LTC management, frailty and falls. Integrations with primary care EPRs.

ADOPTION SUPPORT

End-to-end change management support to ensure sustainable embedding, including CPD-accredited training, ongoing live user support and impact reporting .

MODULAR CAPACITY SUPPORT

Optional services to support through fluctuating clinical capacity, including setting up and running Virtual Hub and health visiting services (CQC accredited insourcing and outsourcing).

feebris

HEALTH ECONOMIC EVIDENCE

-38% Fewer conveyances to A&E

-25% Fewer hospitalisations

5-6X ROI for health systems

£500,000 SAVED FOR EVERY 1,000 PATIENTS

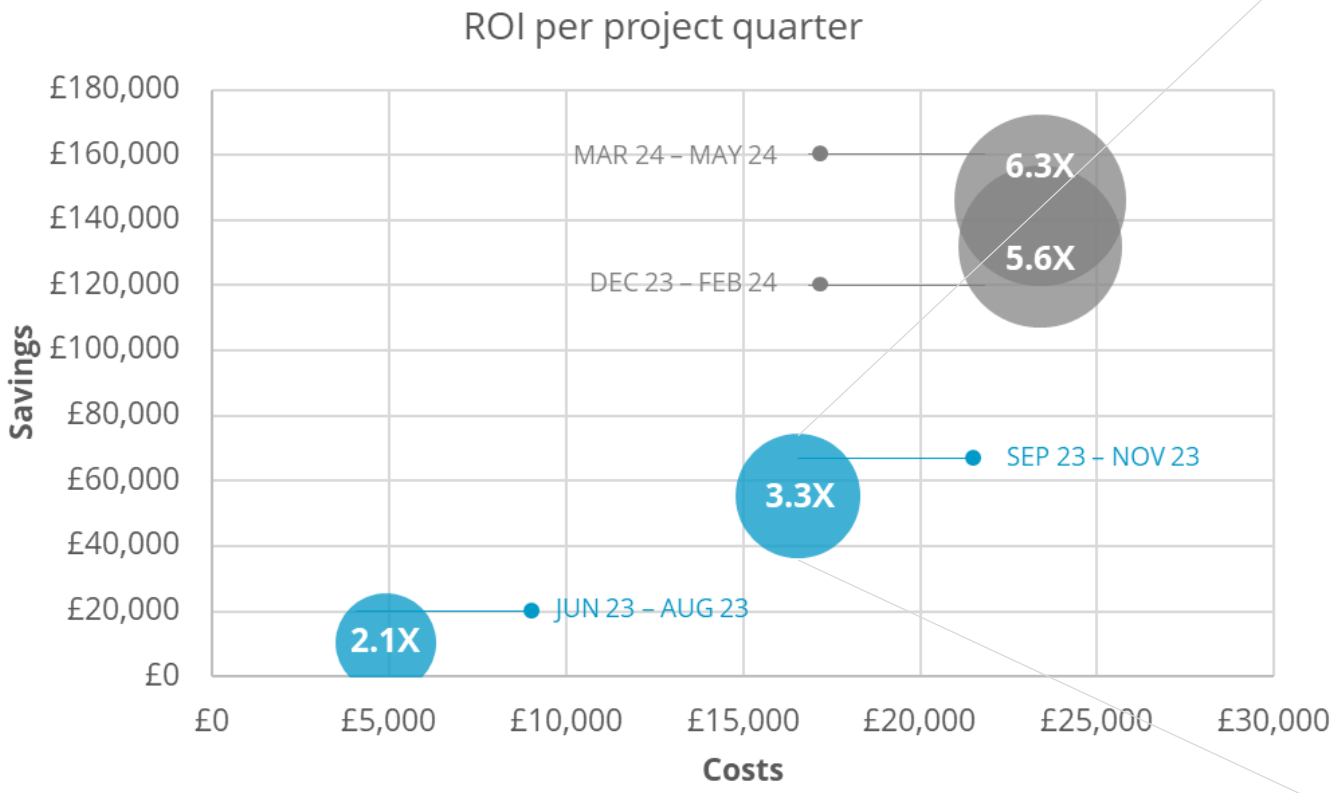
Independent health-economic **evaluation** by YHEC

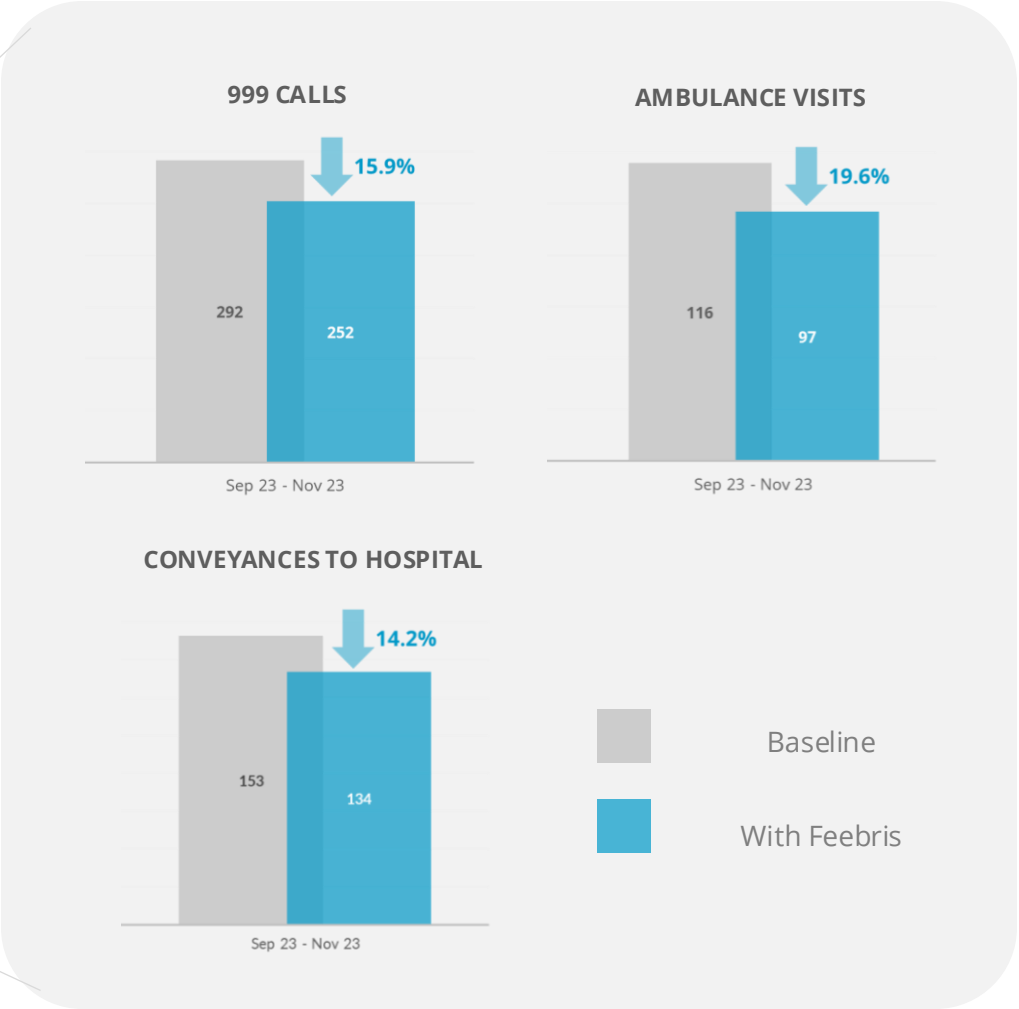
YHEC
York Health Economics Consortium

The AHSN Network
NHS England
NHS Innovation Accelerator

GENERATING ROI WITHIN YEAR

Proactive management of health for frail adults in Kent & Medway was found to generate ROI within the first 6 months





Data from KCC Interim Impact Evaluation Report available [here]

feebris

THANK YOU

partnerships@feebris.com
www.feebris.com

techUK
FOR WHAT COMES NEXT

Supplier Case Study

Whzan

whzan
DIGITAL HEALTH

SUNDERLAND
oursmartcity

A SUPER-CONNECTED
CITY WHERE PEOPLE
AND BUSINESSES THRIVE

Sunderland
City Council

Timelines in Sunderland

- 2015 – Sunderland NHS: Whzan Blue box used by patients with LTCs
- 2017 – Sunderland NHS: Whzan Blue box used in care homes, original NEWS score. First year savings from 8 care homes, 192 fewer non-elective admissions and 336 fewer A&E attendances, saving an estimated £756,000. *HSJ Winner –Value in Heathcare*
- 2019 – Whzan Blue Box in all care homes with Soft Signs and NEWS2
  – Sunderland City Council install 5G and free City Centre Wi-Fi
  – Whzan customise the Guardian monitoring dashboard for social workers, equipping homes with IoT monitoring, and informal cares with Whzan family and friends App (SHEILA) *Smart City of the Year*
- 2020 –*European Harvard Award for innovation and Technology*, with the above.
- 2022- Present – Sunderland City Council install a city wide LoRaWAN network. Whzan add LoRaWAN support to the home monitoring systems deployed across the city.

Whzan's App Customised - SHEILA

Guardian Systems

Home Sensors

IoT (Zigbee)

IoT Hub (Zigbee)

Falls

Virtual Sensors

Timers
Logic
Combinations
Functions

Wi-Fi

Falls

ARCs

LoRaWAN

LoRaWAN

Home Sensors

Trackers GPS/GSM

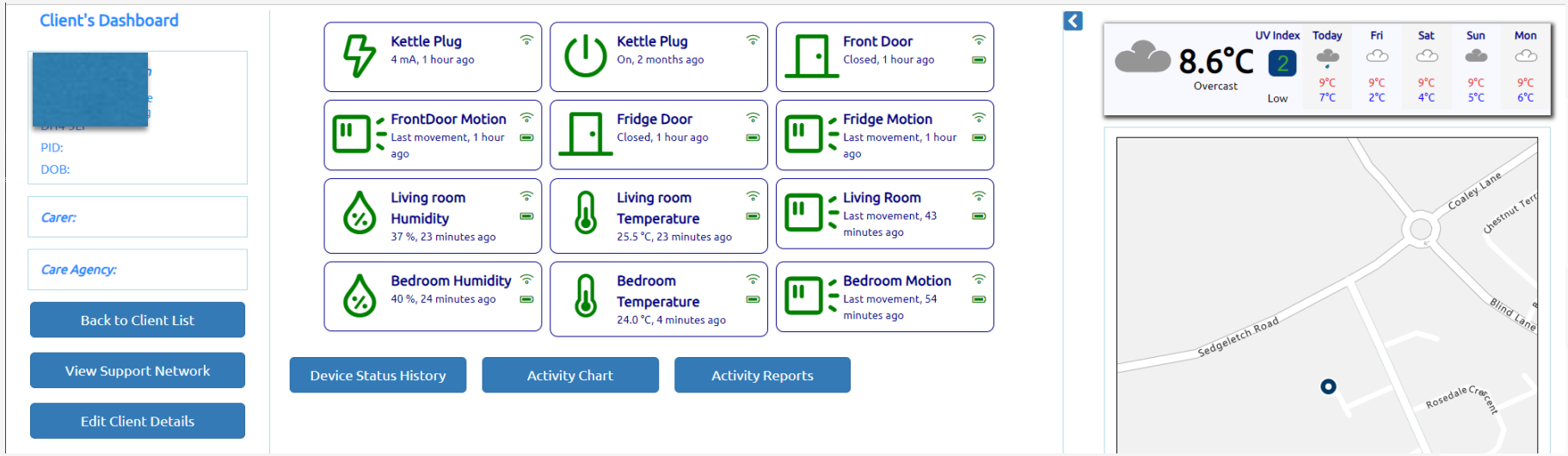
Controls Dashboard

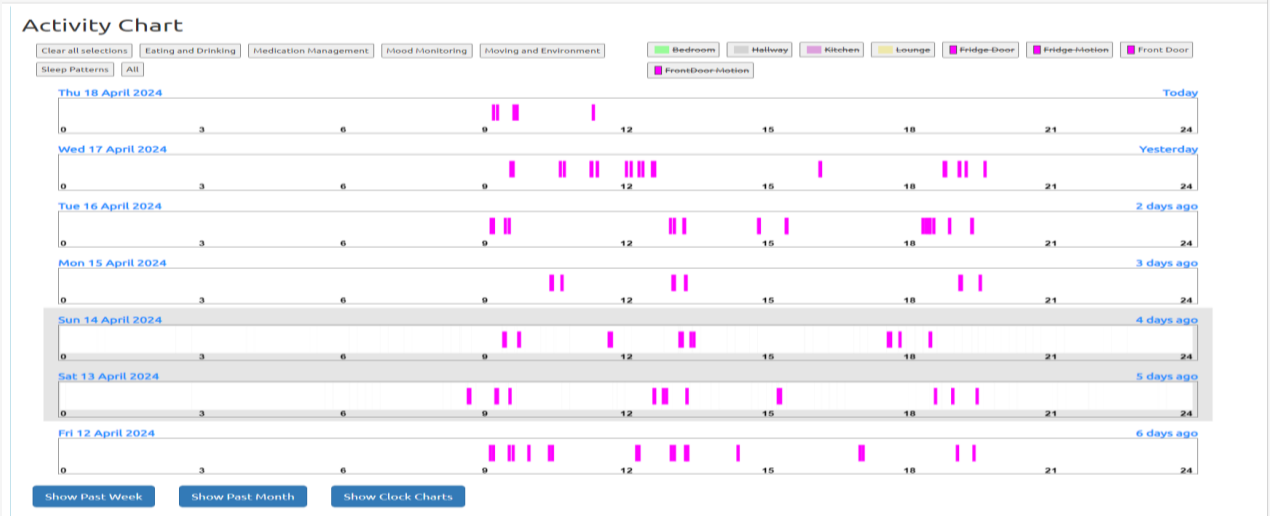
Family and Friends

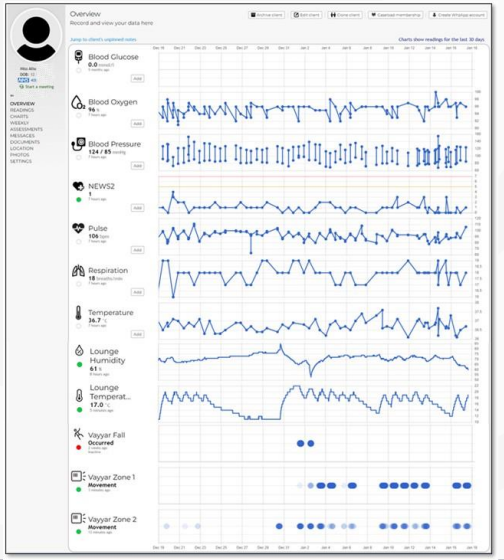
Activity Dashboards:
Sunderland City Council

Developed with

whzan DIGITAL HEALTH





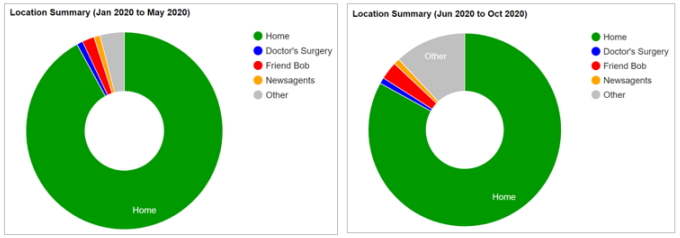


Guardian - Reports

Sunderland Connected City — SHEILA – Activity Monitoring Report

Location History

Location record for this resident for the period Jan 20 – Oct 20



	First half of period (Jan 20 – May 20)		Second half of period (Jun 20 – Oct 20)		
Location	**Number of visits to location**	**Time spent at location**	**Number of visits to location**	**Time spent at location**	**General trend**
Home	Departed home 59 times	92%	Departed home 163 times	83%	Decrease
Doctor's Surgery	Visited 3 times	1%	Visited 3 times	1%	Similar
Friend Bob	Visited 68 times	2%	Visited 74 times	3%	Similar
Newsagents	Visited 28 times	1%	Visited 32 times	1%	Similar
Other	(Not applicable)	4%	(Not applicable)	12%	Increase

Location Summary:

The resident is more active on their feet, as there has been a significant increase in the number of times they have left their home.

If the number of times they depart home increases significantly it may be an indicator of unrest, so try to establish the cause of this.

Sunderland Connected City — SHEILA – Activity Monitoring Report

Resident ID: A123456

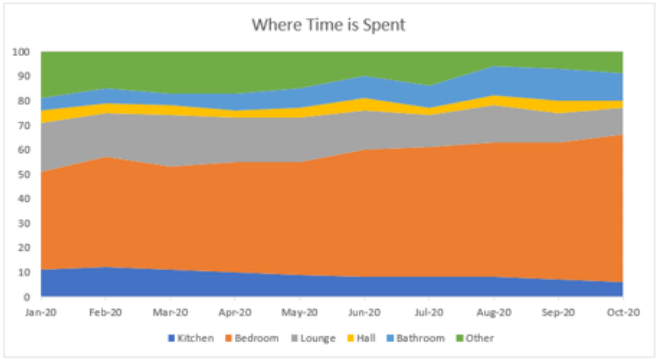
Name: Keith Chessell

Allocated Worker: Dave Young

Allocated Team: Social Care

Report Date Range: Jan 20 – Oct 20 (10 months)

Movement and activity data for this resident for the period Jan 20 – Oct 20



The trends for the period reported Jan 20 – Oct 20 shows:

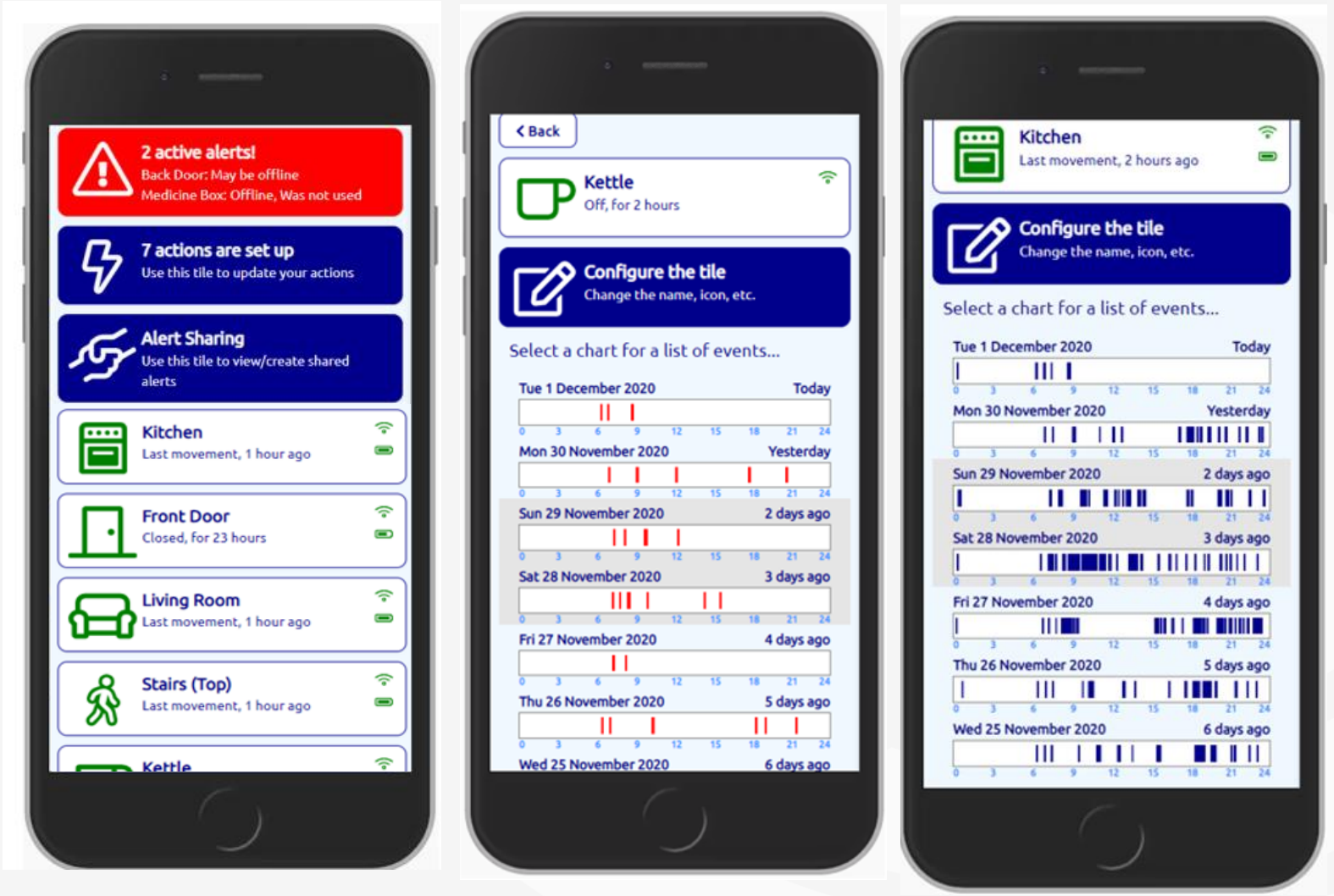
They are spending less time in these rooms than before	They spend about the same time in these rooms	They are spending more time in these rooms than before
Lounge	Hall	Bedroom
Kitchen		Bathroom
Other		

Health Indicators:

A reduction in time spent in the kitchen might mean that they are not eating or drinking as well.

An increase in time spent in the bedroom and bathroom may indicate growing health issues.

Guardian - Family & Friends App



Case Study

Mrs C lives in her home with her son and his family. Mrs C has Dementia and she is supported by her son and the extended family to manage this. Mrs C does wander on occasion, but reliably takes her handbag with her. The family though have become increasingly concerned around Mrs C's ability to continue to live independently and were considering residential care, but would prefer if Mrs C can remain in her home with the family for as long as possible.

AT Solution

IOT Gateway/Hub x1, Door contacts x2, Motion sensors x2, Presence Sensor x1, GPS device. Checking App shared and installed on the phones of Mrs C's son and family members.

Cost of AT Solution
Internet connection = Nil (as Mrs C's property had broadband)
Hardware & Software = £458.48 one off cost

Cost of Traditional Solution
Residential EMI care admission = £665 per week, Annual cost £ 34,570.50

Cost Avoidance to the Council
Mrs C remaining at home for 12 months longer = £34,570.50 - £458.48 = **£ 34,112.02**

whzan DIGITAL HEALTH

Thank you!

Sunderland City Council

techUK
FOR WHAT COMES NEXT

Lunch and supplier marketplace

Thank you for attending