Adult Social Care Sandbox: Design Sprint Session 1

17 October 2024

/loti-ldn

Loti.london

#LOTIxSandbox

London local government's collaborative innovation community

The purpose of today

- Bring you up to speed with all the ideas generated.
- Confirm which ideas we will take forward.
- Share details of how you can get involved.

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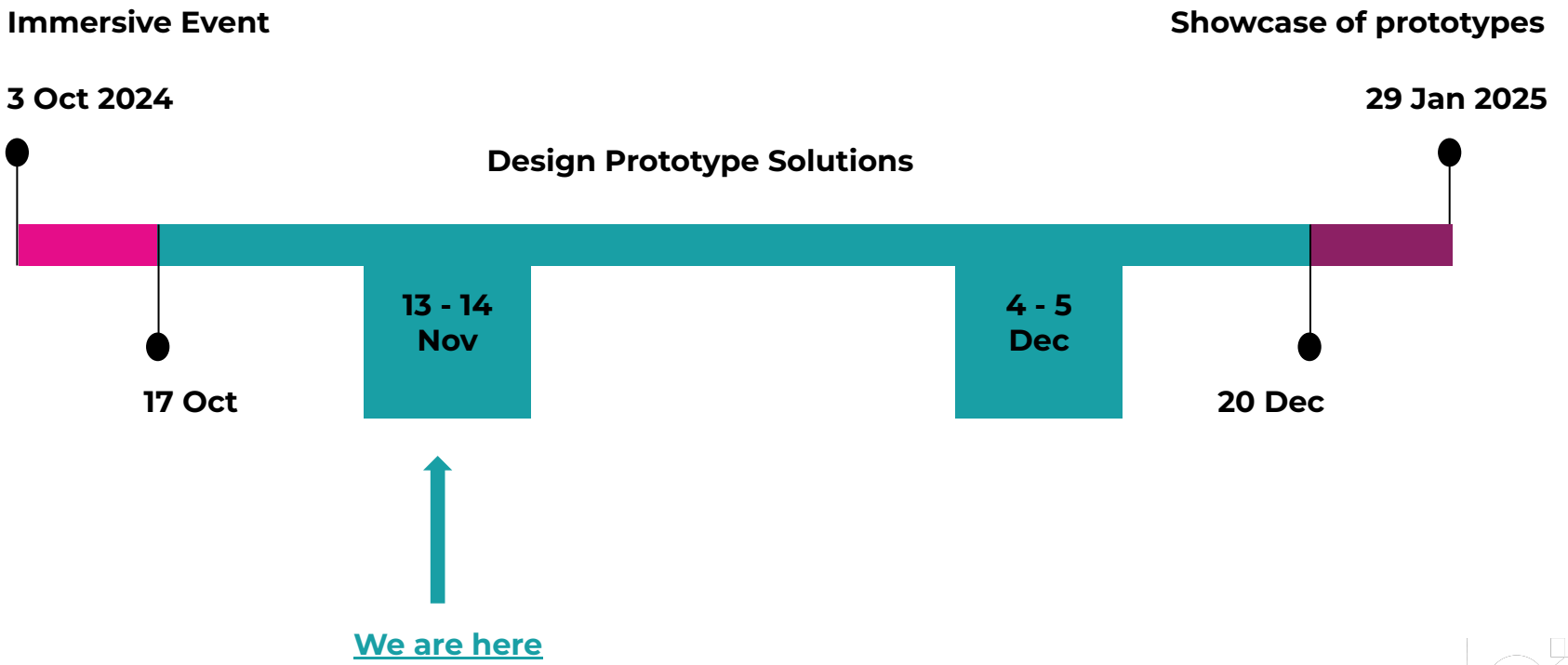
Timeline


Immersive Event
3 Oct 2024
Showcase of prototypes
29 Jan 2025
Design Prototype Solutions
13 - 14 Nov
4 - 5 Dec
17 Oct
20 Dec
We are here

A quick recap of the immersive event

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Join the LOTI x Sandbox conversation!

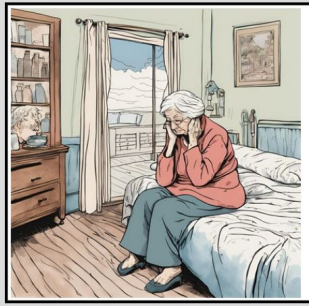
AT HOME

Mrs. S is a 70 year old woman living with diabetes. She's usually out and about early in the morning to pick up her newspaper and go on a short walk, and likes to spend the evenings with a cup of tea and a crossword on her porch.

A few weeks ago, began to feel ill and decided to call her GP. However, she was asked to book an appointment online, which she struggled with.

She went to the pharmacy, where she was informed there was a wait time of about 50 minutes.

A few days ago, she received a call from the community organisations. They organised weekly social drop ins where she usually met up with other seniors in the area, played a few games and exchanged news and updates on their lives.



Weeks had passed since she first started feeling ill when her niece Emily dropped in to visit. She found her sitting in her bed breathing quite heavily. Mrs. S seemed quite disoriented and confused when asked what she is feeling

Remembering a similar episode in the past that had led to a nasty fall, Emily immediately calls 999, and an ambulance arrives to take Mrs. Smith to the nearest hospital.

Ibrahim is a 40-year-old man living in East London. Almost a year ago, he was diagnosed with early onset Alzheimer's disease.

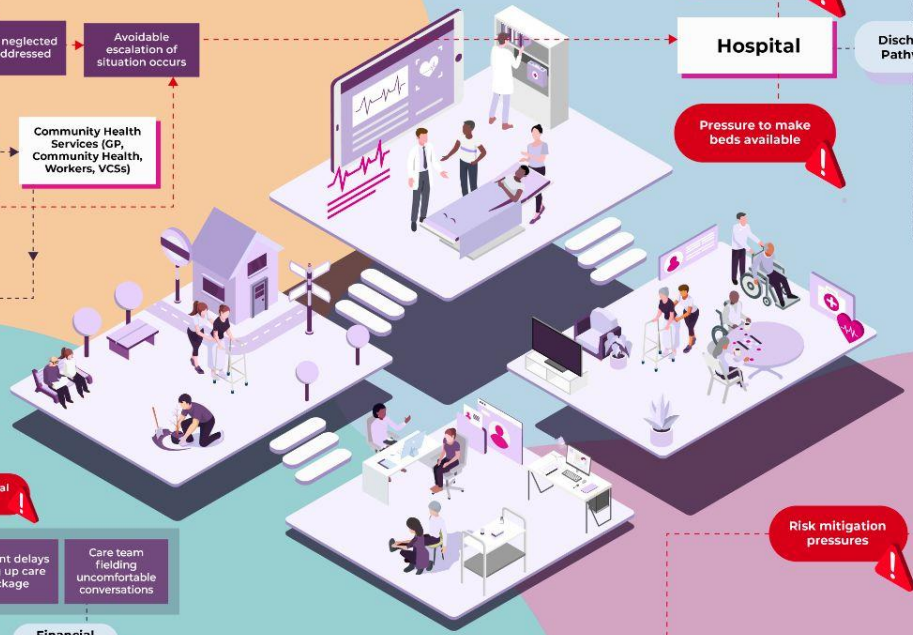
He lives with his wife, Aleesha, who has been his primary caregiver since the onset of his illness. Aleesha assists him with daily activities such as bathing, dressing, and eating

She also manages his medications and keeps track of his medical appointments.

In the evenings, Aleesha reads to Ibrahim or watches television with him, trying to maintain a sense of normalcy in their home life.

Despite her efforts, Aleesha notices that Ibrahim's condition is deteriorating, and he often becomes agitated and confused. The strain of caregiving is taking a toll on her physical and emotional health.

Health and Social Care System Map



Resident
Experiencing declining health / challenging circumstance

Social Isolation

Family/Friend Carers

Issue is neglected / not addressed

Avoidable escalation of situation occurs

Hard-to-access community health services

Comorbidities, Self Neglect

Community Health Services (GP, Community Health, Workers, VCSs)

Police, Housing, Ambulance Services, etc

Extended wait due to shortage of beds

Hospital

Pressure to make beds available

Discharge Pathways

Resident develops further illness

Resident has increased complexity of care needs

Recovery at home

Recovery and Reablement at home

Discharge to bedded facility for short term Rehab

Discharge to bedded facility with potential long term care needs

Transfer of Care Hub

Care homes have incomplete information

Resident moved to inappropriate care setting

Risk mitigation pressures

Care Providers

Frail/ill patients face multiple moves between hospital and care homes

Care facilities having to set up and dismantle support within short period

Adult Social Care

Mental Health, Disability Services, OPPD

Asynchrony between financial and care assessments

Resident frustrated at lack of clarity

Resident delays taking up care package

Care team fielding uncomfortable conversations

Complex referral systems

Contact teams need to do a lot of 'investigation' re: basic case information in order to refer them to right team/other depts

Contact teams need to manually re-enter referral information into internal system

Initial Contact

Contact teams receive 1000s of emails from care providers per day

Contact teams need to manually sort through to find high priority emails

Financial Assessment

Needs Assessment and intake

Lack of availability / visibility of care providers

Commissioning services

Case Management

ASC staff have to get creative or rely on personal contact

Key

- Service/ Team
- Process
- Systemic Challenge
- Pain experienced by resident, staff, etc
- Desirable pathways through the system*
- Undesirable pathways / interruptions in the system


People
Tech
Data
Process
Effective Change

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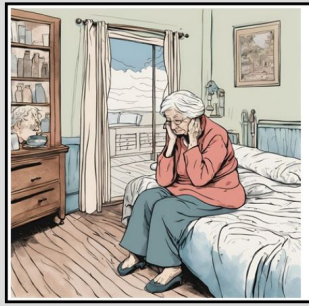

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PAIN POINTS

Reduced access to community, primary care, and social support

- Long wait at the pharmacy
- Put on hold at the GP
- Closing down of community centres and services
- Living away from family
- Escalation of health issues
- Avoidable hospital admissions

Challenging transition from hospital to care setting

- Increased frailty from hospital stay
- Increased complexity of care needs
- Complex pre-admission assessment process

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PAIN POINTS

Limited support carers

- Limited care support available for carers
- Hard-to-find information about support available to carers

Challenges with finding and navigating social care

- Hard-to-find information on social care support
- Long wait times through assessment process
- Complex and out-of-sync needs and financial care assessments
- Increased administrative burden on carers and staff

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Overarching themes

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- **Rehumanise the system** for people receiving care *and* people working in it
- Adopt a **relationship and strengths-based approach** throughout all of our interactions
- **Harness data and technology** to support people, practitioners, services and systems
- Think and **act as an integrated system** involving people, support networks, voluntary sector and the more formalised system
- Create space within and between systems for **experimentation and learning**

Existing solutions

Existing Solutions: The following is a (non-exhaustive) list of existing solutions generated through conversations at the Sandbox event. Please do continue to help us build this out.

Theme	Solution
Supporting person-centred care	Modular about me, Universal Care Plan, Three Conversations Model,
Improving financial support for carers	Lightning Reach portal to find financial support for carers
Removing financial assessments	Free homecare provision in Hammersmith and Fulham
Owning data at a personal level	Modular data owned by the person: Mydex Social care passport for service users: Netcall, Jane Guercio
Improving data sharing and accessibility	London Care Record ; GP connect ; Universal Care Plan
Strengthening networks within communities	Neighbourhood Lab ; The Tribe Project; an app like Peanut for carers
Volunteering in social care via Third party services	UBDS IT Consulting

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Community based 1st Responder Programmes	Good Sam ; Hatzola
Intelligent note taking	Magic Notes
AI supported email and demand management system	Citizens Advice Scotland, Andy Peel Help First
Leverage Large Language Models to process patient data	Newton Europe, Xantura
Digital Inclusion Initiatives	Good Things Foundation
Using predictive analysis to predict needs	Tunstall (Patricia Wynn)
Testing impact of AI at front door of Adult Social Care	AI4ASC CC2i David Plummer, Frazer Nash Consultancy) Yokeru
Creating more accessible Information and Guidance	AI generated what's app number (AI4ASC CC2i as above) Better Care by Looking Local: Animation led platform supporting people through assessment Animations by Looking Local: social care journey Kirklees Council (Katie Lister)

Longlist of ideas

People

Integrate people into community-based support:

- At point of diagnosis: referral to social prescribing, community navigators
- Invest more in community support, including central teams individuals can be referred to
- Build resilience of carers e.g. through community groups, networks, apps
- Utilise circle of care if already in place

Augment GP services with other parts of the system:

- Utilise specific roles to support access and navigation e.g. “Patient Account Managers”, “Care Navigators”
- Undertake different functions in other parts of the system, e.g. triage in pharmacy (remote or in person)

Utilise other parts of the systems to relieve primary care, e.g.

- Triage in pharmacy (remote or in person)

Support people to be prepared if crisis does occur, e.g. Prepare “go-bags” with information and supplies for vulnerable patients in case of emergency

Utilise volunteers to support care processes:

- Test volunteer-led assessments and reviews
- Scale volunteer first responder models (e. GoodSam) for rapid community support during emergencies
- Introduce third-party volunteering services for social care, incentivised by local businesses

Ways of Working

Adopt a person-centred care approach: drawing on the many tools available

Build comfort across system with enabling-approach to risk through recruitment and training

Support for carers:
- Create “At point of diagnosis” support package for carers
- Utilise existing community hubs as drop-ins for carers
- Improve carer support through employers, e.g. with enhanced leave

Focus on relationships in care provision:
- Provide consistency in care provision (including if stays in hospital)

Test new integrated approaches to discharge:
- Test an integrated approach to discharge at point of hospital admission
- Create integrated, holistic support post-discharge

Foster a culture of innovation and improvement within systems:
- Establish ongoing improvement and innovation schemes within systems
- Run a place-based test which adopts a “one team” approach across a whole system
- Create single goals to align incentives across institutions
- Find opportunities co commission and measure differently, e.g. running and regulating a care home focused on bringing in “life”

Funding & Data

Funding

Support family carer finances, e.g. through enhanced allowances, providing payment for family carers, exploring other financial rewards, e.g. use of local facilities

Remove financial assessments for homecare:

- Test free universal provision of homecare (e.g. Hammersmith)
- Provide immediate access to a standard package of care at point of request

Make Continuing Health Care funding more equitable e.g. so social care can appeal

Data

Develop a cost-model to predict and communicate care costs

Enable people to own their own data: Create a virtual dossier/passport owner by the person, with a modular approach to what they choose to share

Use data to flag multiple attempts by individuals to access support

Adopt predictive analysis: to better anticipate needs: at a population & individual level. Predictive home-based behaviour analytics to flag changes & trigger a response

Remove two-factor authentication to access case management systems

Measure differently: Introduce KPIs that measure “learning” within a system

Start a national conversation to build confidence/remove fear on data sharing

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Technology & AI

Expand digital inclusion efforts to get people online

Support independence through use of assistive technology to supplement care:

- Make use of data from ubiquitous technology such as smartwatches
- Support independence at home via tech-driven reminders, nudges, check-ins

Use of AI / holograms to provide support to people with dementia

Improve assessment process:

- Inclusive and accessible Information and Guidance, powered by AI
- Streamline needs/financial assessments, using API integration to source information required
- Build user-friendly Local Authority portal to select/access services (akin to deliveroo)

Use automated processes to support people to access services:

- Tech to prioritise access for vulnerable patients in primary care (e.g. number recognition)
- Generate an automated referral to community care if can't get through to GP
- Generate automated follow-up for missed appointments and communications

Use AI to support systems and individual case workers:

- Intelligent note taking to capture assessment and review conversations
- AI supported front-door of Social Care and GP - including triage

Improve data sharing across agencies:

- An e-platform for data sharing across agencies
- Creating a single, centralised carer record
- Leverage Large Language Models to process patient data

Build a TrustPilot/Comparison Tool to support the public sector to commission tech

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Ideas we're taking forward

Things we considered

1. Can we show demonstrable difference in January 2025?

2. Do we have sufficient time, resource and capacity to design and develop prototypes?

3. Can LOTI add value?

Ideas we'll develop further in the design sprint

1. HMW use **community interventions** to support people live well, independently?
2. HMW improve **transfer of care processes** to better support patients and staff?
3. HMW make the **local authority needs and financial care assessments** more responsive and accessible?
4. HMW improve the **triaging of messages** in local authorities to help social workers provide a responsive service?

We would love your input:

Take 2 minutes individually to reflect on the themes and then please share your initial thoughts in the chat

- **I like...**
- **I wish...**
- **I wonder...**

How you can get involved

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Sign up to attend in-person design workshops:

13 November

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14 November

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Contact genta.hajri@loti.london for further information.

Thank you