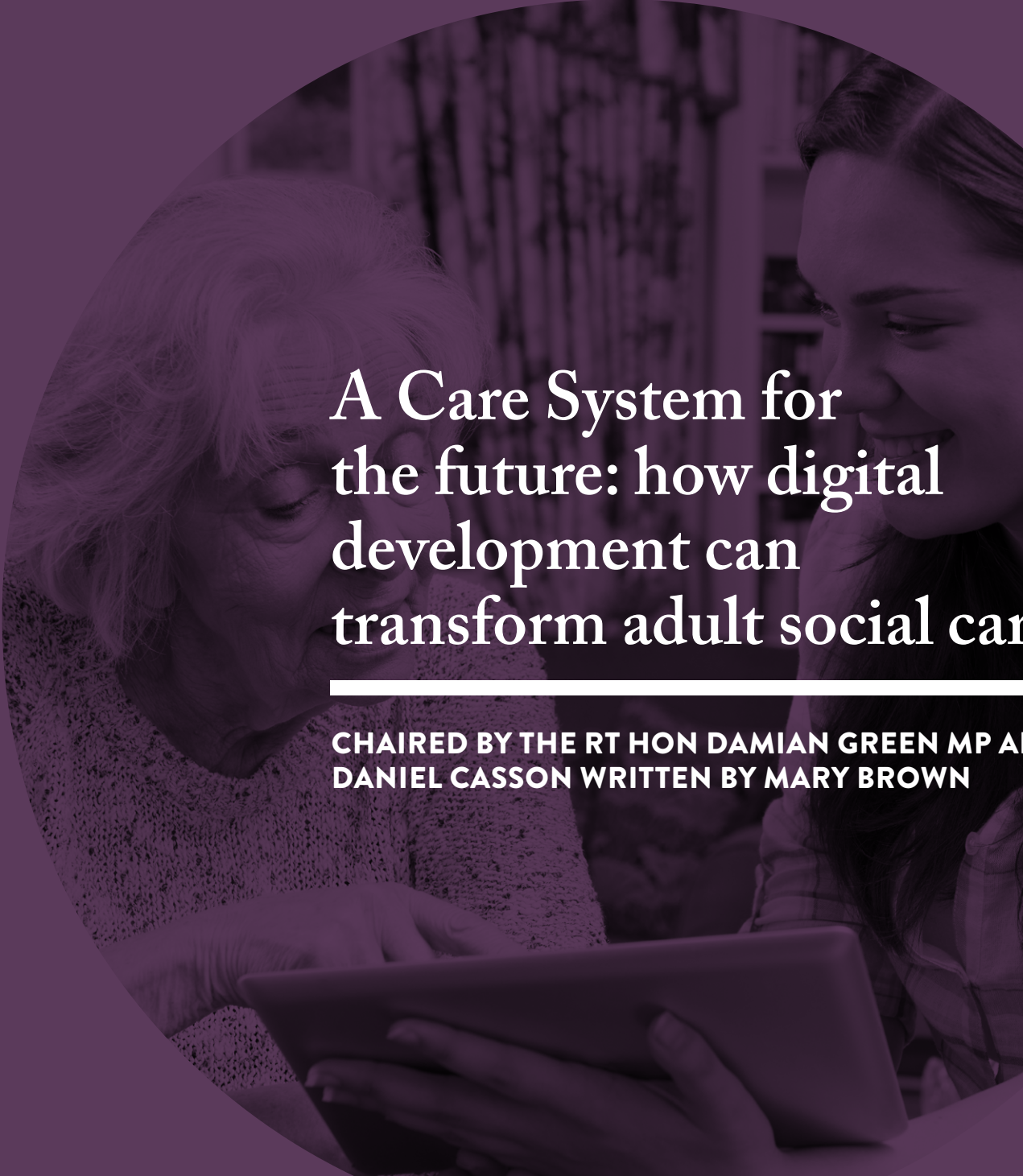

PUBLIC POLICY PROJECTS

INSIGHTS



**A Care System for
the future: how digital
development can
transform adult social care**

**CHAIRERD BY THE RT HON DAMIAN GREEN MP AND
DANIEL CASSON WRITTEN BY MARY BROWN**

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ABOUT PUBLIC POLICY PROJECTS

Public Policy Projects (PPP) is an independent policy institute offering practical analysis and development across a range of sectors, including health and social care. The institute is independent and cross-party, and brings together public and private sector leaders, investors, policymakers and commentators with a common interest in the future of public policy. Public Policy Projects publishes annual Insights and Global Insights reports in a series of policy areas, including integrated care, social care, genomics, rare diseases, women's health, health inequalities, environment and energy. All these programmes, and their corresponding events, publications and conferences, receive contributions from sector leaders from around the world.

ABOUT PPP SOCIAL CARE POLICY NETWORK

Chaired by former Deputy Prime Minister, Rt Hon Damian Green, PPP's Social Care Policy Network is comprised of over 20 senior thought leaders within the social care sector. Given that social care reform is a key policy issue in 2022, PPP has brought together these experts to discuss four key issues within the sector. The network aims to inform the social policy debate, from within the industry, the public sector, academia, and charity.

ABOUT PPP'S LIVED EXPERIENCE PANEL

Acknowledgements Within the Social Care Policy Network is a Lived Experience Panel, whose members have a wealth of experience in the current social care system on the ground. The panel is made up of recipients of social care, family members of individuals receiving social care, social care staff, and informal carers. The lived experience perspective has been essential to guiding discussion for the sessions and contributing to the recommendations of this report. Their contributions have meant that these policy recommendations will practically improve the experience and lives of those who are most personally affected by the current care system.

Foreword



THE RT HON DAMIAN GREEN MP AND DANIEL CASSON

The Covid-19 pandemic promoted a shift towards the increased uptake of digital services across all sectors, including health and care. Post-pandemic, the care sector must fully adapt to these new ways of working, and fully integrate technology into care so use of new technology becomes business as usual.

As Integrated Care Systems (ICSs) have gained statutory footing in July of this year, the care sector has become more closely integrated with health services at a local level. Aiding this integration is the implementation of a Shared Care Record for everyone accessing health services, where all health and social care data can be accessed by all health and care professionals via one shared online platform.

For digital tools to be best implemented into the care sector, products must work for care professionals, and those being cared for. The incorporation of the voices of end users into the process of implementing new technology is essential, to ensure the most appropriate technology is being used for optimal benefit. “Nothing about me, without me” must be a core principle of technology design within the sector. Comprehensive guidance should be put in place to encourage best practice in this area.

There is so much to be said in this area, and PPP plans to work further on the prevention agenda in care, which must focus more heavily on improved quality of life for individuals, rather than a care sector working only to achieve NHS targets.

The NHS Transformation Directorate (NHSTD) has done incredible work so far in ensuring both that the care sector progresses quickly and uniformly in terms of digital transformation, and in terms of the integration agenda: it is the first time that so many individuals in care have been employed centrally by the NHS. The sector as a whole must build upon the work done so far, to ensure a smooth digital transformation.

This report brings together the thoughts and ideas of so many Adult Social Care experts regarding the future of the care sector, and the opportunities which digital advancements can bring. Any document published in this area can quickly become outdated, due to the fast-moving nature of both the care sector, and digital advancements. However, this report should be utilised as a thought-piece to guide action and further work on the area, as a guideline for future development.

Recommendations

1. The NHS Transformation Directorate should make further effort to positively engage Digital Social Care Record (DSCR) suppliers not currently on the Assured Provider List (APL). While having done well to ensure DSCR suppliers who are accepted onto the Assured Provider List (APL) fulfil an exhaustive list of requirements ensuring that they are fit for purpose, there needs to be an explicit, public bridge with other suppliers to engage, support and encourage them to meet the criteria of the APL.
2. There should be greater discussion in DHSC of how best to ease the burden for health and care providers operating in multiple ICS footprints who will have to deal with a variety of ShCR formats.
3. Among the technical standards that DHSC have committed to which technology providers must demonstrate to gain social care accreditation, DHSC should include a standard ensuring the inclusion of end-users at every stage of the design, production, and implementation process. This standard does not apply to the mainstream consumer technology available in guides from local government and will be highlighted as such.
4. The NHS Transformation Directorate should rejuvenate the way it consults with the adult social care sector in terms of digital development and transformation becoming business as usual. A good example of this is the UK Rare Diseases Framework Board and Forum. A Digital Social Care Board and Forum should include care providers, technology providers, and members with lived experience of navigating and using the care system. This will facilitate better engagement of technology providers with care providers and their users, for the best understanding of the needs of staff and system users to ensure the best and most useful products.
5. Local authorities should provide an independent, standardised and comprehensive guide of available assistive technologies to all those who access personal budgets or Direct Payment Allowances, alongside supporting Independent Living Centres. This may reduce the need for more expensive professional care and provide informed choice to allow people to live as independently as possible.
6. Local authorities must support digital inclusion among people in receipt of adult social care, by ensuring that a meaningful portion of the promised investment into digital technology is allocated to funding for devices which help people in care settings communicate easily with friends and family, and digital training for people in receipt of care to be able to use these devices safely and confidently.
7. Technology providers must prioritise simplicity of design, and getting basic technologies right first time, in order to maximise staff engagement with technology
8. The Care Quality Commission (CQC) should include basic digital training in their Mandatory Training Courses package, including basic digital skills, using electronic care recording, the most common assistive technologies, communication technologies and basic data collection
9. The social care workers app should be reconfigured and re-marketed to best support the care workforce

Introduction

Digital transformation across the adult social care sector is happening at a rapid pace. Despite being initially slower to adopt technology than colleagues working in the NHS and other health settings, since the start of the Covid-19 pandemic the care sector has been quick to adopt digital social care recording (DSCR) systems, alongside a range of transformative assistive and support technology. In the face of the immense strain on England's social care system, due to an ageing population combined with chronic funding and workforce challenges, the effective implementation of the right technology could support the people providing care and support and those in receipt of support and provides an opportunity for a better quality of life.

Technology can facilitate better usage of data to support people who require care and support across a range of care settings. Better capture and sharing of data will help services integrate, through both electronic care recording and the shared care record. Assistive technology and other medical devices can help those with chronic or age-related conditions live longer, healthier and more independent lives. When designed correctly, physical digital infrastructure can help the social care workforce deliver care more efficiently, and existing infrastructure can be redesigned to help people achieve better outcomes and improve the quality of their lives. Targeted use of new forms of communication technology can reduce isolation and loneliness for people in receipt of care, who are often at great risk of social isolation.

The Covid-19 pandemic has prompted a global shift towards digital communication tools and enhanced focus on basic connectivity. This was particularly true in health and care where digital communication tools became vital to maintaining care delivery while minimising infection risk in care settings.

In 2016, the digital switchover was announced, signalling the transition of telephone services from analogue to digital, internet-based

networks by 2025.¹ This switchover has implications for the telecare sector and the people who depend on its services. While the switchover will be costly and complex, it could prove to be the catalyst for real time data gathering and reporting in social care. There is, as such, a unique opportunity for the care sector to introduce new and innovative ways of working.

Despite advances seen across the sector, technology adoption is not uniform and many providers still operate with completely paper-based systems.² This inconsistency stems from the configuration of the social care sector, the historical fragmentation of which has made uniform rollout of technology difficult. The social care sector is made up of a plethora of care providers who are funded by various parties: by local authorities, the NHS, and people paying for care privately.

The market for digital tools in social care is varied and complex, with each care provider able to choose between a wide range of



caretech suppliers. This variety creates vibrancy within the market, with competing companies driving continuous innovation and improvement, leading to products that meet the specific needs of care providers - so long as care providers are guided by trusted and independent advice to navigate this complex market.

There are a myriad of workforce issues, some well-documented and others less so, that present obstacles to digitally transforming social care. Firstly, the recruitment crisis and rapid staff turnover rate, combined with an acute lack of resourcing for the workforce present a challenge when implementing new technologies. A lack of training and awareness of the benefits of technology mean that some care professionals can be reluctant, or lack the confidence, to adopt new ways of working, despite the benefits they may bring. High staff turnover rates can also mean lower skills and knowledge retention in the workforce as a whole – often holding back providers from adopting even the most basic technology.³

The sector has also been continuously hampered by a lack of funding specifically for digital transformation of social care. The introduction of the Health and Care Levy, announced in September 2021, was estimated to provide an extra £12.4 billion per year for health and social care.⁴ In the government's adult social care reform white paper, *People at the Heart of Care*, £150 million of this was dedicated to support the digital transformation of social care. However, since these reforms were announced, instability and inconsistency from central government has prevented funding from reaching care providers. It was announced in September 2022 that the Health and Social Care Levy would be reversed, and it has since become unclear whether any of the promised reforms will be fulfilled.⁵ Additionally, in 2021

the government made a commitment to establish a Centre for Assistive and Accessible Technology in the National Disability Strategy.⁶ However, this has since been revoked, being ruled as unlawful.

In November 2022 UK Chancellor Jeremy Hunt announced in his autumn statement a significant additional investment into social care: approximately £7.5 billion over the next two years. While the introduction of the Dilnot reforms, including the care cap and the means test extension, have been delayed for at least two years, the other promises of the 2021 white paper, including digitisation, should still be enacted to a degree.⁷ Funding dedicated to the NHS will also contribute to digital transformation in the care sector, in the form of money given by the NHS Transformation Directorate to ICSs specifically for social care digital transformation.

With this injection of cash into the sector, it is time for the government to make good on their commitment to “fix social care” as promised by Boris Johnson in 2019. As public engagement with digital technology is at an all-time high, there is now a unique opportunity to transform the delivery of social care, and usher in a new wave of technology based care which can improve care quality and ease issues by increasing efficiency and productivity.

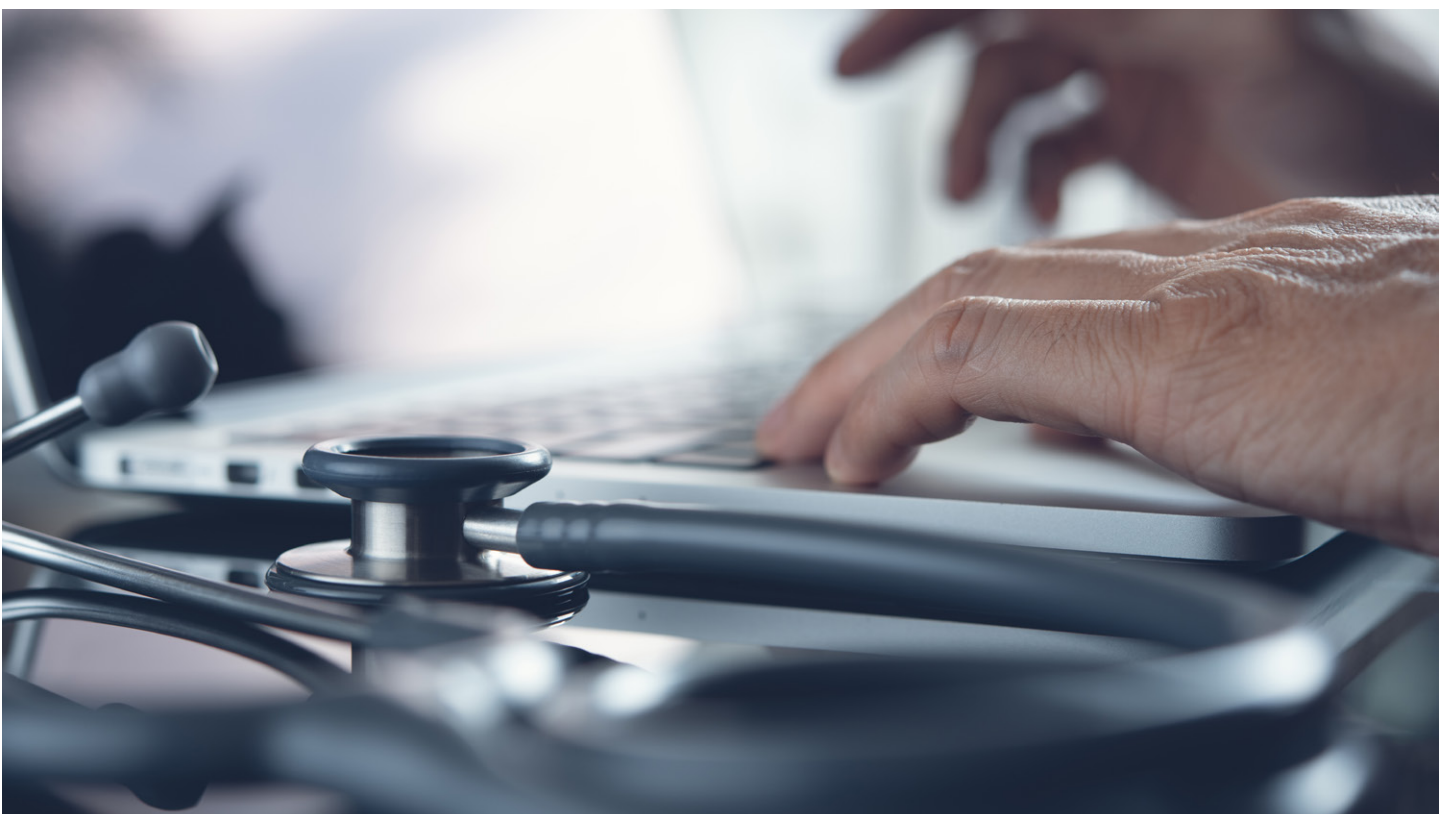
This report makes a series of recommendations to national government, local government, care providers and technology providers which, if implemented, will aid in the digitisation of the care sector for the benefit of people being supported and cared for, the social care workforce, and the NHS. This report reflects the discussions of two roundtables chaired by The Rt Hon Damian Green MP and attended by senior stakeholders in adult social care as well as a ‘lived experience’ panel, made up of experts with direct experience of using and receiving care from England's social care system.

Chapter One

DIGITAL SOCIAL CARE RECORDS (DSCRS)

High quality care recording underpins good care. Digital social care records (DSCRs) can facilitate better and more timely communication of important information between service users and staff, can minimise risks such as medication errors, generate patient data to improve overall care, and make data easier to store, retrieve and act on.⁸ Digital care recording increases the quantity and quality of data that care providers can access, which provide better insights into the care and outcomes of an individual's care pathway highlighting opportunities to provide better care and plan ahead. DSCRs can also facilitate better integration of health and care services via the shared care record. More joined up care and information sharing between care providers and clinicians has to be the key to better care provision, and to reduced pressure on care and health services.

It is currently the choice of the provider whether they use paper or a DSCR, and some use a mixture of the two.⁹ Despite the benefits of DSCRs, recent figures show that only 45 per cent of adult social care providers have any form of digital care recording, and upwards of 60 per cent of care homes are using internet connections that will not support full digital transformation.¹⁰ Only 40 per cent of social care providers are fully digitised, with the remainder using paper-based records.¹¹ However, digital transformation is occurring quickly. While general practice took over a decade to transition to the almost complete adoption of digital for patient recording, the same trajectory is occurring in the care sector in less than 6 years.¹² Current government plans laid out in the Data Saves Lives strategy for health and social care state that by March 2024, at least 80 per cent of social care providers should have a DSCR in place that will be able to connect to a shared care record. The Digital Social Care Records programme at the NHS Transformation Directorate (NHSTD) expects this number to be 60 per cent by March 2023.¹³



A significant barrier to implementation of full digitisation is access to an appropriate internet connection: over 60 per cent of care homes are still using internet connections that will not support full digital transformation.¹⁴ Reliable internet connection will play a key part in getting DSCRs functioning across the UK, alongside facilitating other online tasks including video contact with health professionals, or online calls to friends and families. In October 2022, NHS Digital launched the Care Home Connectivity project, working with local authorities and ICSs to decrease reliance on asymmetric digital subscriber line (ADSL) and remove poor fibre to the cabinet (FTTC) across care homes.¹⁵

PPP's Social Care Network agreed that currently, there is a lack of basic information sharing occurring between care providers, those in receipt of care, and their family members or friends, particularly in the context of domiciliary care. Where direct records do exist, these are often not completed until the end of the working day, so there appears to be little scope to make real time changes in care provision and adapt to the circumstances of those receiving care. Along with the introduction of more DSCRs, information sharing standards should be set to ensure accountability for care workers, and for the peace of mind of those receiving care and their loved ones.

The Care Software Providers Association (CASPA) have outlined five principles for digital transformation and interoperability for care software, to ensure it delivers a positive impact and better outcomes for people receiving care and those who support them.¹⁶ The North Star principles state that DSCRs should be:

1. Focussed on each individual person receiving care.
2. Intuitively integrated into the operational workflow.
3. Time saving, ensuring no duplication of effort.
4. Able to appropriately report and share information.
5. Inclusive of care providers and people receiving care in decision making processes.

There is a plethora of DSCRs available on the market, with providers implementing a variety of different configurations. Different care providers have different electronic communications systems, with different features, and there tends to be huge disparities in the type and quality of care recording and information sharing. The NHSTD now provides an assured supplier list of DSCRs, whose product has been assured against the Digital Social Care Records Dynamic Purchasing System (DPS) core requirements.¹⁷ This is the main procurement and accreditation mechanism to filter solutions that care providers can use government funding to purchase and deploy across their services. Not all care record suppliers are on the assured providers list, and there is no barrier to entry for any good care records to be adopted by a care provider. However, by providing the assured supplier list, the NHSTD is nudging good practice. As of the 15th of December, there were 10 assured providers on the list. 75 per cent of ICSs have plans in place, approved by the Digital Social Care Records Programme, and ready to roll out digital systems at a national scale.

The care sector, and the NHSTD, are undoubtedly working towards a well-connected care sector with fully operational DSCRs, with the aim that the sector will achieve 80 per cent adoption by March 2024.

While the NHSTD has done well to ensure that DSCR suppliers who are accepted onto the Assured Provider List (APL) fulfil an exhaustive list of requirements ensuring that they are fit for purpose, there are many others which have innovative, creative ways of working yet are not on the assured

suppliers list. While the NHSTD funding via the ICSs can only be assured for care providers who use one of the assured providers there are some care providers who will choose other DSCRs for a variety of reasons. The issue for the NHSTD is how these DSCR suppliers not on the APL are engaged positively. There needs to be an explicit, public bridge with these other suppliers to engage them positively while acknowledging that they have not yet evidenced that they meet the criteria to be on the APL. Whether this can be done by the NHS or a third-party body is yet to be seen.

RECOMMENDATION:

The NHS Transformation Directorate should make further effort to positively engage digital social care record (DSCR) suppliers not currently on the Assured Provider List (APL). While having done well to ensure DSCR suppliers who are accepted onto the APL fulfil an exhaustive list of requirements ensuring that they are fit for purpose, there needs to be an explicit, public bridge with other suppliers to engage, support and encourage them to meet the criteria of the APL.

CASE STUDY: LOG MY CARE

Founded in 2017 in response to the growing pressure on the UK care sector, Log my Care is a care management platform that gathers insights to help care providers allocate resources and speed up day-to-day tasks. Log my Care's Starter Plan is free to use, making it the only free care management platform on the UK market.

Kerrie Weaver (Quality and Training Manager) and April Parker (Registered Manager and Operations Lead) from CCT Community Enablement Team share their experience of Log my Care.

CCT Community Enablement Team provide a variety of support for the community across Nottinghamshire and Derbyshire. They have been using Log my Care for several months, and love that they can use one platform for everything they need. Before, the team were using paper-based records for care plans and risk assessments. April recalls how much pressure and stress paper-based systems put on their staff:

"Working on the floor of our care home, we saw the impact the admin was having – it took too long and prevented us from spending more time with residents."

They found that paper-based systems meant that large amounts of time were spent on record keeping and reviewing and that documents were duplicated unnecessarily. They also faced an increase in pressure from the CQC to go digital.

Staff were initially apprehensive about switching to a digital care management system but were soon fully convinced that digital records were the right way to go. They found that digital systems were easy to use and straightforward, with little need for extra training.

Having used digital care records for several months in various settings, Kerrie and April are recommending other services in their network to try it too. April highlights how "the Care



Office has made communication with external professionals including doctors much easier. Information that would in the past have been burdensome to compile now sits at our fingertips in real time." Through the use of food and fluid charts and mood logs, they can easily evidence trends and changes in behavior to healthcare professionals.

Kerrie highlights that they now also use Log my Care during their initial training for new care staff, "They add their care logs on dummy profiles and start using the system from day one. They just tap, tap, tap and the system generates a log for them". The system generates real time data and useful visuals for information sharing with external professionals.

There is clear evidence of success with Log my Care's online systems, with 97 per cent of staff saying that implementing Log my Care is the best thing they have ever done.

CASE STUDY: THE GOOD CARE GROUP

The Good Care Group (TGCG) is a national provider of 24-hour, live-in care. They provide care to older adults and are passionate about enabling their clients to remain in the comfort of their own homes and communities. They primarily support people living with dementia, but also specialise in stroke, end of life and care for people living with Parkinson's.

TGCG identified a need to digitise care records, primarily to improve client safety and minimise risk. Previously, paper notes would be collected or posted in from client placements across the country and could be checked with some delay. They wanted a way to access real time records and to provide better support to their professional carers, particularly for medication management.

Further areas of opportunity to address included:

- Being better able to monitor clients through the digitisation of care records
- Professional carers are lone working across the country which can be isolating. They wanted to introduce a better way for carers to connect with one another and learn from one another's experiences
- Paper care records lack transparency. For clients' loved ones who do not live locally, there was no easy way to see what care had been delivered that day or how their loved one was doing

TGCG developed a system in house, as no providers on the market offered a system which suited the unique requirements of a live-in care provider, and therefore 'Good Care Together' was created. Working with a user-experience expert and their IT development partners, they set about designing a 'Carer Community' platform with carers, for carers. Professional carers were involved in discussion groups where they articulated the challenges they were facing with paper records and put together wish-lists for a new system. Once the system was in



the test stage, groups of professional carers were asked to give feedback on how easy it was to use, as well as whether the proposed training provided enough information and clarity. In discussions with carers, they identified system features which were low-cost to develop but which they reported would have a high impact for them – for example the ‘social forums’ provide a chance for carers (as remote workers) to connect with each other. Special interest groups were created by demand, on topics such as ‘cooking and recipes and ‘dementia’. They also took time to understand how people would access the system, sending out surveys to professional carers to understand which devices they use for work in order to make sure the platform was mobile-friendly for all. Without such an approach they believe they would have faced wide-spread adoption issues, whereas in reality they faced almost none.

Good Care Together offers a range of benefits: the carer portal enables carers to log all care documentation, carers are not reliant on paper records, and the system offers reminders such as for medication and training dates. For TGCG the carer community offers genuine insight into care delivery and client outcomes, as well as generating rich data. Care managers are able to log in to the system and see in real-time what’s going on in the placement. Strategically they have been able to analyse aggregated data to observe, for example, the correlation between chest infections and hospital admissions, antipsychotic usage and incidence of behaviours that challenge. This has allowed them to design and implement preventative measures to keep clients safe and deliver on market-leading outcomes.

The client-facing side of the system, ‘The Client Community’, enables family members to log on and view care records providing them with reassurance that the care plan is being followed. They can view a calendar of the week’s activity, allowing them to view medical appointments, and planned activities. Following recent client feedback via annual focus groups they’ve most recently developed a message board feature which enables carers and clients’ loved ones to issue notes to one another.

CASE STUDY: CAREPLANNER

CarePlanner is a home care management software company based in the southwest of England, with over 2,000 agencies and 90,000 care workers currently using their system. CarePlanner has grown alongside the care sector, working with its users to grow their system and giving agency managers the power to manage their administration and finances digitally.

CarePlanner has long championed the use of data, and their reporting suite helps providers to recognise long-term patterns and share information with partners more easily. A key focus has been how providers and local authorities can better share data to facilitate their support of local communities.

Recognising the fact that care data, although plentiful, is highly siloed and fragmented, CarePlanner wanted to find ways for providers to be empowered to share the data they collect ➤

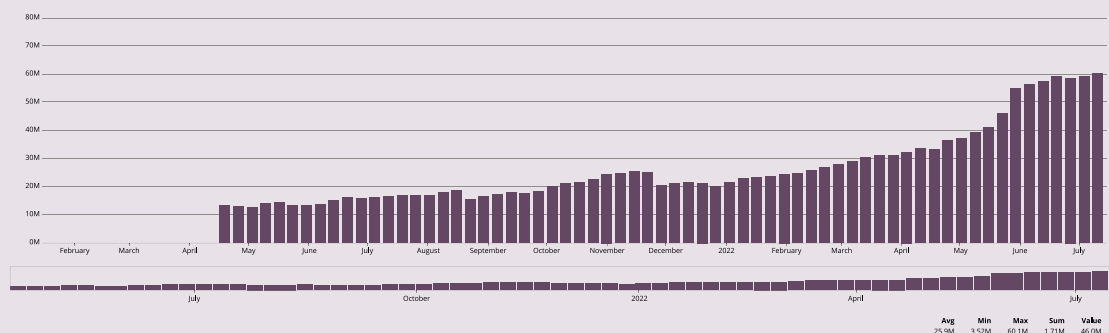
with relevant organisations and public bodies, a goal further encouraged by the ambitions the government presented in its Innovation and Integration white paper at the start of 2021.

Their solution was to develop an open application programming interface (API), which allows for the immediate exchange of data between two systems. CarePlanner worked with Hillingdon Borough Council to build a system that utilised their respective APIs so that care providers could immediately share call monitoring data for local authority contracts. This enabled Hillingdon, and subsequently Essex County Council, to confirm the completion of contracted calls quickly and secure payment for the providers.

Essex wanted to further expand the range of data they collected, and CarePlanner were able to leverage an economy of scale to adapt the system to their additional requests at no extra cost. This provided Essex County Council with further crucial care information, including the source of call monitoring data, and the emergency rating of a service user.

Ron McNab, Care Compliance & Electronic Call Monitoring System Manager for Hillingdon, said of the collaboration: "At Hillingdon we deal with around 26,000 Home Care calls per week provided by nearly 50 different care providers. It has therefore been essential to be able to automatically process large amounts of data from multiple organisations and it is systems such as CarePlanner's that allows us to do so effectively."

The increased usage of CarePlanner's API indicates a positive application of data and digital design to long-standing challenges in social care. Frequently, it is the nature of local authority's contracts that dictates the potential of care providers, as they can only plan and provide for the length of time they have on those contracts. Solutions like CarePlanner's Local Authority System can play a role in building the foundations for longer-term plans to develop.



Chapter Two

THE SHARED CARE RECORD (SHCR)

Integrated Ccare systems (ICSs) will have a significant role in reshaping the digital landscape of health and care, and the main tool for the ICSs to coordinate health and care is the shared care record (ShCR). ShCRs are a digital record of important patient and user information, created from GP medical records, which can be seen and used by authorised staff in other areas of the health and care system, helping organisations move from a system where each organisation holds separate records for an individual, to one where a record is shared across the system.^{18,19} The ShCR will allow all health and care staff to access an individual's information, providing more cohesive, joined up care.²⁰ DSCRs are to contribute to the shared care record, improving care for those impacted by the adult social care system by improving communication between health and care professionals.

The ShCR will facilitate more holistic, joined up, and better-informed care for individuals, reducing the need for repetition of health and care history for the benefit of patient and system. By having access to their own record, people will have more insight and control over their health. The shared care record is also able to bridge gaps between providers and create smoother transitions in care, by facilitating proper digital communication between hospitals, all primary care, care providers and hopefully community-based resources.



A core benefit of electronic data sharing, and the integration of this information into the ShCR, is data generation and sharing. Digital care recording increases the quantity and quality of data that care homes, care providers, and ICSs have access to. Better quality and higher volumes of data surrounding an individual's care pathway will provide better insights into what care was provided and what the outcomes were, highlighting opportunities to provide better care and to plan ahead. ShCR will contain information to provide teams with a more comprehensive understanding of issues facing people in care, which will help to personalise care and drive preventative measures which will enhance the quality of life of individuals and help prevent incidents and accidents for those in receipt of care.

DHSC has set out clear goals for the digitisation of social care and the adoption of electronic care recording. The social care reform white paper, *People at the Heart of Care*, committed investment upwards of £150 million for the digitisation of social care, with a focus on facilitating electronic care records.²¹ However, this figure is dwarfed by the £2 billion allocated to the digital transformation of the NHS in *A plan for Digital Health and Social Care*.²²

DHSC has adopted a more ambitious approach to digitising the NHS than it has for social care. 86 per cent of NHS trusts already have electronic health records in place, and the goals outlined by government are that 90 per cent of NHS trusts are to have an EPR in place by December 2023. By March 2025, all clinical teams within an ICS should have access to a complete view of a patient's health and social care record to contribute to.²³

Rolling our DSCRs to feed into the shared care record can be costly. In light of this, the Adult Social Care Digital Transformation Fund of £25 million has been made available to ICSs by the NHS Transformation Directorate to support care providers to adopt DSCRs, alongside rolling out sensor-based falls prevention and detection technologies, and test other care technologies.²⁴ Several ICSs are matching this funding for care providers to further support digital transformation within their remit.

However, while steps to achieving the shared care record are being taken, the makeup of the social care system and the range of technology providers presents a challenge for the implementation of the shared care record. ShCRs are being developed and implemented in patches which are aligned with ICS geographies. Different ICSs are implementing shared care records at different speeds, with little greater coordination to ensure the uniform implementation. This creates challenges for care providers, as many care providers will have to deal with multiple shared care records which all behave differently in how they manage their information. This creates an added layer of complexity, which may slow the progress of uptake for the ShCR.

There are currently several requirements of ShCRs, the Information Governance Framework for Integrated Health and Care requires they should:

1. Have a consistent approach to Information Governance policies, processes and systems to ensure good practice.
2. Identify the flows of data, and at each point in the process to determine who the controllers and/or processors are.
3. Identify and understand the legal basis for processing data for every function including ensuring transparency about purpose and process, supporting good practice, and promoting public engagement.

4. Manage access controls and records management.
5. Consider patient and service user objections to processing.
6. Adhere to current published guidance on cyber security for health and care.
7. Ensure that any relevant due diligence checks are carried out where processors or sub-processors are involved.
8. Document the decision-making process to demonstrate accountability.

Each individual ICS has the flexibility to create its own ShCR bound by the framework, there is a need to understand the operational issues faced by care and health providers which span ICS borders, because they will need to comply with and be able to work with the various forms of ShCRs that each ICS puts in place. While there are benefits to tailoring the ShCRs to the needs of an area, some coordination will benefit health and care providers operating in multiple ICS footprints. There should be greater discussion of how to ease the burden for the health and care providers who will have to deal with a variety of ShCR formats.

RECOMMENDATION:

There should be greater discussion in DHSC of how best to ease the burden for health and care providers operating in multiple ICS footprints who will have to deal with a variety of ShCR formats.

Chapter Three

CARETECH AND ASSISTIVE TECHNOLOGIES

Assistive technology is an umbrella term, referring to any device enabling individuals to perform tasks that they would be unable to do without additional support. If implemented correctly, assistive technology promotes independence, choice, control, and enablement, and has the potential to greatly improve the quality of life of people in receipt of social care.²⁵

Assistive technologies can be life enhancing, for example helping people to get out of bed or remember their medication, along with many other aspects of daily living. Significantly, assistive technology can offer dignity and independence, offering more scope for people to care for themselves in their own homes. According to Skills for Care, assistive technologies offer benefits including:

- Around the home: eating and cooking; money and budgeting; personal care and safety.
- Communication: speaking; hearing; writing; vision.
- Family and Travel: shopping; travelling; local community; family and social network.
- Health and Wellbeing: memory; leisure; health; relaxation.²⁶

Assistive technology and carettech can be incredibly cost-effective for providers, reducing the time and effort it takes for care professionals to assist with particular tasks. In some cases, it can eliminate the need for a carer altogether, granting greater dignity and independence end-users, particularly younger disabled adults.



While having great potential to revamp care delivery, previous attempts at implementing care tech on a large scale have yielded mixed results. In 2010, the Department of Health set up three large scale programmes to look at the use of telecare technology in care settings, in the London Borough of Newnham, Kent and Cornwall.²⁶ It was estimated that three million people in the UK could benefit from the use of assistive technology at this time. However, the top-down approach of the 3 Million Lives Programme meant that technology was given to care homes that did not fulfil the needs of the workforce or residents, and there was little understanding of how it should be used.

Much of the technology provided was of no use to care professionals and stayed on shelves for years afterwards. Critics say that the 3 Million Lives programme did little to engage front-line practitioners, was overly industry-led and did little to promote its benefits to care practitioners and service users, which was to some extent a waste of resources and funding.²⁸ In the future, DHSC, technology providers and care providers must learn from this mistake and adopt a user-driven approach to technology implementation.

In the design and implementation of assistive technology, co-production with end users is essential. According to Think Local Act Personal (TLAP), a partnership spanning government, social care and service user representation organisations, the term 'co-production' refers to "a way of working, whereby everybody works together on an equal basis to create a service or to come to a decision which works for them all".^{29, 30} Tech implementation needs to include person-centred assessments, and prescribers of technology need training so they have the knowledge and confidence to recommend the most suitable solutions. For co-production of assistive technologies in the care sector to be achieved, DHSC must step in to ensure that care and technology providers have a mechanism to include end users in the technology design and acquisition processes, thereby providing a meaningful voice to those reliant on technology for their independence and quality of life.

For this to happen, care providers and tech providers need to work constructively together. This type of co-production and communication will result in better, more personalised and appropriate products for those in receipt of care, and moreover it will reduce unnecessary costs by lowering the chances of products being designed and bought which do not satisfy customer needs. Technology produced in this way will respect the end users' rights and choices, protect personhood and identity, respect the end users' homes and relationships, provide control, and be affordable, accessible and inclusive. While the nature of the care sector is that of a healthy competitive market, tech suppliers who do not serve the needs of end users are naturally replaced by solutions better aligned with the needs of each provider and each care setting. However, ensuring co-production from the start of the design process will mean that care providers do not waste scarce resource on the wrong assistive technology.

The Digital Social Care Advisory Group (DSCAG) of NHS England is a group comprised of key stakeholders within the care sector, to discuss and be informed about digital advancements in social care, as related to NHS England.³¹ Consultations between people in the sector, and the NHS are important for shaping the digital landscape of social care, and the NHS transformation directorate has made great steps to ensure this consultation. However, technology providers must also be included in this partnership, and efforts should be made to ensure the consultation between technology providers and end-users. A Digital Social Care Board and Forum, similar to the Rare Diseases Board and Forum should be created.³² It should include care providers, technology providers, and social care end-users, and should facilitate consultation between the groups, centring the needs of end users.

Many technologies and platforms currently in operation are not designed with end-users in mind. A clear set of standards must be provided to all technology providers in the social care sector which promotes co-production and good user experience. DHSC's A plan for digital health and social care promises the setting and enforcing of technical standards which technology sellers must demonstrate to gain NHS and social care accreditation.³³ This must include standards around co-production, and the inclusion of end-users (including both the workforce, and those in receipt of care) at every stage of the design, production, and implementation process.

RECOMMENDATIONS:

Among the technical standards that DHSC have committed to which technology providers must demonstrate to gain social care accreditation, DHSC should include a standard ensuring the inclusion of end-users at every stage of the design, production, and implementation process[DC1]. This standard does not apply to the mainstream consumer technology available in guides from local government and will be highlighted as such.

The NHS Transformation Directorate should rejuvenate the way it consults with the adult social care sector in terms of digital development and transformation becoming business as usual. A good example of this is the UK Rare Diseases Framework Board and Forum. A Digital Social Care Board and Forum should include care providers, technology providers, and members with lived experience of navigating and using the care system. This will facilitate better engagement of technology providers with care providers and their users, for the best understanding of the needs of staff and system users to ensure the best and most useful products.

Personal Budgets for Assistive Technology

Where appropriate, assistive aids and technology should be promoted and easily accessible for those in receipt of domiciliary care. Personal budgets are provided to an individual by local councils to pay for social care and support, and they provide flexibility over what support is arranged and provided.³⁴ Approximately 1 in 4 people accessing social care receive direct payments in England.³⁵ Personal budgets and direct payments tend to be offered to individuals to help them employ a personal assistant or a care worker from an agency.³⁶ However, the Network believes that people should be encouraged to use personal budgets to procure assistive technology that could aid independence, rather than external carers, where possible.

In order for individuals to be encouraged to use their personal budgets to buy the right assistive technology for themselves, they must be well informed and up to date about the options available to them. Independent Living Centres (also known as 'Assisted Living Centres', 'Disabled Living Centres', or sometimes 'Centres for Independent Living') are organisations which provide a place to find out about assistive equipment, adaptations, and telecare for disabled people. Many centres exist and are located across the UK and can be a great tool for individuals looking to procure assistive technology to continue living independently, however some centres have closed due to cuts in funding.³⁷ Local authorities should look to financially support independent living centres to ensure adults with additional needs can have choice and agency over the technology they use to support themselves.

Alongside these, local authorities should promote assistive technologies to those accessing personal budgets, via the provision of an independent, standardised and comprehensive guide of

the available assistive technologies, their benefits and costs. Not only will this raise awareness of the options available to those choosing to live independently, but it will also empower people to make decisions about their own care and help to reduce the demand for an already overstretched workforce.

The guide must include products and tools for specific social care needs, alongside mainstream consumer technology available for all. Much of the technology that can make a real improvement to someone in receipt of care is already widely available, including smartwatches, or voice activated technology systems (such as Amazon's Alexa). Inclusion of this kind of technology in guides provided by local councils will help spark a cultural shift within social care, increasing the acceptance of consumer technologies as life enhancing.

At the same time, the Network expressed concern that the use of assistive technologies should not detract from the personal relationship-based care provided by social care professionals, which for many people is vital for good care and emotional wellbeing. Technology can provide the time and space required for better relationship-based support, both within care homes and for domiciliary care.

RECOMMENDATION:

Local authorities should provide an independent, standardised and comprehensive guide of available assistive technologies to all those who access personal budgets or direct payment allowances, alongside supporting independent living centres. This may reduce the need for more expensive professional care and provide informed choice to allow people to live as independently as possible.

CASE STUDY: HFT

Hft is a national charity that creatively supports more than 2,200 adults with learning disabilities across England and Wales to live the best life possible, with services ranging from residential care to supporting people to live independently in their own homes. Hft has a dedicated Personalised Technology team who offer assessment, installation and tech support services, as well as a range of training options to encourage the use of technology.

Established in 1962, Hft is funded by local authorities, as well as through donors, supporters and volunteers. Against the backdrop of budget cuts, the care workforce crisis and the Covid 19 pandemic, Hft have increasingly sought to use technology to support people to live independently. A particular focus is the digital switchover, which will take place by 2025. This shift will affect the whole charity and having strong Wi-Fi across all its sites is just the starting point.

New digital lines have already started to be installed at some of Hft's services, because the traditional analogue call systems are not robust enough and don't meet Hft's full requirements in terms of longevity, reliability and flexibility.

One of Hft's services in Newcastle was being converted into self-contained flats, for which a new system was required. Requirements included cost effectiveness and suitability for future ➤

iterations of technology. Hft wanted the ability to offer independence to the people living in the flats, including support personalised to their needs, but also to have staff notified of specific circumstances that require intervention.

The team began testing Everon's Lyra system, a digital Wi-Fi / 4G system that links to a range of sensors and offers the ability for remote system access for tech support and system updates. It has allowed Hft to offer a range of solutions to their users, including pendant alarms to call for support, door sensors and epilepsy sensors. Alerts go through to multiple staff smartphones, and staff members who action an alert can either close it down upon resolution or request additional support if necessary. For those individual's able to use video calling, Hft also utilises the Amazon Show.

This solution allows Hft staff to log into the system remotely to see the status of each alarm, the history and outcomes of any alerts, enabling staff to build patterns of behaviour to enhance care and support for individuals.

Staff have given extremely positive feedback, citing the ability to respond faster to incidents, reassurance that the technology is in place and the ability to offer support when it is required.

Hft's Team Cluster Manager, Rebecca Allonby, commented: "The Everon system benefits everyone at the service. The individuals are able to be more independent and call for support when required, both day and night, providing efficiencies across the service.

"The staff team like the fact they can call for support from one another using either their panic buttons or the Everon app, ensuring safety for them and the people they are supporting.

"As a manager I am able to view the data collected and analyse any trends in support and behaviours and implement procedures to prevent or limit future incidences."

Chapter Four

DIGITAL SKILLS

According to The King's Fund, 4.3 million people who report having no digital skills, and of these around 75 per cent over the age of 65. Further 23 per cent of disabled adults do not use the internet, compared to just 6 per cent of people without a disability.^{38,39} This demographic split means that many people in receipt of social care are at higher risk of digital exclusion. Many who are in receipt of care are unable or nervous to use technology, including assistive technology, as well as devices for accessing the internet (laptops, tablets and smartphones). A report by Hft finds that many care providers report digital barriers which prevents them from ensuring those they support remain connected. 77 per cent of care providers report a lack of digital skills among the individuals they support.⁴⁰

Loneliness is a problem impacting many of those in receipt of care: 1.4 million older people in the UK report often feeling lonely.⁴¹ Loneliness and social isolation have been routinely linked to serious health conditions, and have been shown to significantly increase a person's risk of premature death from all causes.⁴² Alongside a 50 per cent increased risk of dementia, this also includes a 29 per cent increased risk of heart disease, 32 per cent increased risk of stroke, and higher rates of depression, anxiety and suicide.⁴³

There is evidence from Age UK suggests that loneliness is correlated with digital exclusion, as those who do not use the internet are more likely to feel isolated. The same study suggests that healthy internet usage is associated with improvement to general well-being by providing a sense of community and connection with likeminded people online.⁴⁴ Digital communication can be a vital



tool for reducing loneliness and increasing support. Several members of the social care network explained that during lockdowns, communication technology was a lifeline for many in care, especially for those with autism or other learning difficulties, many of whom could not understand why they could not see their friends and family.

For digital communication to help reduce loneliness, social care users must not only be provided with digital communication devices, but also educated and actively encouraged to use them. Co-production of assistive technology to make it accessible and user friendly will further encourage uptake. Additionally, there must be concerted efforts to change attitudes to technology among older people who may be hesitant the idea, including public awareness campaigns of the benefits of communication technology.

RECOMMENDATION:

Local authorities must support digital inclusion among people in receipt of adult social care, by ensuring that a meaningful portion of the promised investment into digital technology is allocated to funding for devices which help people in care settings communicate easily with friends and family, and digital training for people in receipt of care to be able to use these devices safely and confidently.

CASE STUDY: HAMMONDCARE

HammondCare is a global organisation which promotes quality dementia care through research, evaluation, practice, education and consultancy. In the UK, they work with charities, business and research organisations that wish to benefit from their international expertise to provide excellence in dementia care, or to evaluate impact to inform future strategy.

The Partnering in Care Program was a special education programme for visitors to residential care homes during the Covid-19 pandemic. The program enables family and friends to continue to visit their loved ones in a way that manages risk in an intelligent and measured way. The program informs and educates visitors on topics that help minimise the risk of COVID-19 transmission.

In early 202, the impact of extended lockdown on resident wellbeing and physical health became apparent. HammondCare sought to enable ongoing visits for essential care and support. This was supported by survey results from April 2020 which showed that the majority of residents and family supported continued visits, even with the heightened risk of COVID-19.

In July 2020, HammondCare developed and implemented the Partnering in Care program. The objective was to educate visitors on infection control and COVID-19 to enable safe visits during the pandemic.

The program design includes both online and face-to-face components. The educational modules cover information about COVID-19, infection control, carer wellbeing and raising and reporting concerns. The online learning is followed by a small group, mandatory face-to-face or online workshop, led by a dementia consultant, and attended by pastoral care coordinators. ➤

Technology has been used to deliver both online learning through an interactive education platform, and, when COVID-19 restrictions limit gatherings, the 'face-to-face' workshop via video conferencing. Those that cannot manage the technology are supported onsite. Over 1800 people had completed the Partnering in Care program.

The program has become an integral part of HammondCare's model of care and an operational necessity for the wellbeing of residents. This model of education and partnership is adaptable to other aged care providers; and is adaptable to care beyond the pandemic.

This program has been a positive initiative that balanced the safety and wellbeing of residents with the very real risks of the pandemic; all the while, adhering to government guidelines. It also sought to support care workers by enabling families to be part of care, especially at the vital time of dining when workload for staff can be significant, and the impact of malnutrition can be catastrophic for the older person. Families and friends play a key role in care and this access is essential to support overall wellbeing.

Evaluation of the program demonstrated that people felt more comfortable visiting after completing the program and reported an increase in knowledge about COVID-19 and infection control.

Chapter Five

THE WORKFORCE

As mentioned previously, digital technology in social care has the potential to support the social care workforce and improve the quality-of-care provision. By automating various time-intensive processes such as monitoring and data recording, technology can allow carers to spend more time on their caring duties and build stronger bonds with those they care for.

However, there are inconsistencies in digital capabilities and confidence within the care workforce, and this skills gap is more pronounced than in other comparable sectors. Some care workers are apprehensive or underconfident to embrace new technology in their workplace, in part because some do not have adequate digital skills. A report by Hft finds that 56 per cent of care providers report that a lack of digital skills among staff was a barrier to digital uptake. However, many care workers are digitally literate to some extent, and claims that care workers are unable or unwilling to use technology may be a harmful stereotype.

Care providers must ensure that technology implemented in care settings does not create an additional burden to care workers. Care workers need to be adequately resourced and trained to realise the benefits of new technology. The reality is that many staff find technology currently operational in care settings badly designed and poorly implemented, making it difficult for staff to use. While ambitious and complex technologies may offer the potential to transform care, what is truly needed for the digitisation of social care is to get the basics right first. All technology implemented into care homes, or for use within domiciliary care, must be simple and user friendly, and implemented through open dialogue with care staff. The more complex the technology, the more likely it is that care



professionals will become dissatisfied, potentially disengaging with the technology entirely. Currently, persistent and basic issues with technology are inducing a degree of disillusionment among the workforce, and this can perpetuate a reluctance to engage in new technologies.⁴⁵

RECOMMENDATION:

Technology providers must prioritise simplicity of design, and getting basic technologies right first time, in order to maximise staff engagement with technology.

A common barrier for the implementation of technology into adult social care is that staff do not understand the technology and the benefits it may bring. If the workforce is aware of the benefits that a particular technology may bring, it will be easier to persuade them to use that technology, even if there are teething problems or difficulties in implementation. Research by Carers UK found that many people, including care workers, are unaware of how technology can support care delivery. Once the benefits of technology-enabled care and support were explained, 85 per cent of people would use it to support health and care delivery.⁴⁶ Education will be key to increasing the interest and confidence in using digital technology for care.

As important as educating the workforce on the benefits of technology is training them to use it. This could include, where relevant, training on data analysis, the ability to install programmes and other more complex tasks. Having digital and data expertise at a senior level will become increasingly essential as more technology is incorporated into the sector, and the data it produces proliferates. Recruitment strategies should focus on recruiting a broad pool of individuals, including those with digital and data expertise, to ensure the current workforce is properly supported to transition into a digital era of social care. This must be recognised through higher pay, and the development of qualifications in this field. It is essential that the care workforce is adequately resourced to realise the benefits of new technology coming into the sector.

RECOMMENDATION:

The Care Quality Commission (CQC) should include basic digital training in their Mandatory Training Courses package, including basic digital skills, using electronic care recording, the most common assistive technologies, communication technologies and basic data collection.

The Care Workforce App

The rollout of the NHS App over the course of the pandemic has been a huge success - largely due to the introduction and widespread usage of the COVID pass. As of 28th September 2022, the app surpassed 30 million downloads in the UK.⁴⁷ Via the app, individuals can:

- Order repeat prescriptions
- Book appointments
- View personal health records
- Access NHS Covid Pass
- Register for organ donation
- Find out how NHS uses personal data
- View one's NHS number⁴⁸

In May 2020, during the height of the UK's Covid-19 pandemic, DHSC announced the launch of an app for social care workers in England. The app promised guidance, learning resources, discounts and other support, including mental health and wellbeing toolkits and resources.⁴⁹ Developed with NHSX, and the NHS Business Services Authority, it was to be introduced under the CARE brand, and it was to act as a single channel of communication between the government and social care workers. While the app reportedly had 10,000 downloads the day of its launch, little has been reported since, and there appears to be a lack of awareness in the sector of such an app.⁵⁰

However, care professionals could greatly benefit from such an app, as a unifying brand to connect the workforce, and ensure that the workforce is well informed of news and issues within the care sector. The care workers app can also connect individuals in the care workforce, increasing support and morale.

RECOMMENDATION:

The social care workers app should be reconfigured and re-marketed to best support the care workforce.

CASE STUDY: LUDLOW STREET HEALTHCARE

Ludlow Street Healthcare (LSH) is an independent mental health organization that strives to ensure dignified, compassionate and safe therapeutic care for adults with the most severe and complex mental health and behavioral needs.

Data collection concerning adverse incidents and the use of restraints varies across organizations in method and quality. The use of restraint is typically reported using a metric of restraints/1000 bed days. LSH sought to move away from using this metric as frequency data alone are not necessarily clinically meaningful in supporting intervention and the reduction in use of restraint.

Additionally, in multi-site health and social care organizations where clinicians work peripatetically, any time gap between the occurrence of an incident involving restraint and the awareness of the incident by clinicians and operational managers can add a layer of risk. Existing systems tend to be focused on board and health and safety level governance data and can therefore not meet the needs of clinicians to know what is happening with their patients in real time.

Aimed to develop a data system to accurately monitor the use of restrictive interventions, to ensure a live global overview and to collect meaningful clinical data to support the use of data informed practice aimed at reducing the use of restraint.

The resultant 'live data system' processes and analyses real-time incident and restraint data at differing levels of granularity, with data recorded in a bespoke electronic form, coded in MS SharePoint and linked to an MS Excel document. This automates the data input and graphical output processes. ▶

Restraint data can now be filtered by organization, individual ward/unit, individual patient(s), time, or other details including location, staff members involved or by severity of the incident. Global graphical data are used in monthly and quarterly local and national governance fora, assisting senior management and clinicians with remote monitoring and the implementation of strategies to prevent crises.

Service users and careers have access to the restrictive intervention data for themselves and the site in which they receive care, and regulators can access live data remotely to support oversight and accountability. Clinicians receive automated email notification of all incidents involving their patients as soon as the data enters the system, which was invaluable during periods of restricted movement during the pandemic.

This electronic data system has the potential to be scalable globally across mental and behavioral health systems. The product would be a software platform that can be distributed commercially to multiple mental health settings, to assist in the governance of the use of restraint in mental health care. Data is structured to allow for the development of deep learning models that assist with predicting patterns of behavior using multivariate predictive analytics.


Each of LSH's 19 sites use the Live Data System, and 12 million data points have been obtained to date. The system has supported the early detection of specific 'hot spots' of increased incidents by senior staff and allowed for earlier escalation of areas and issues of concern to clinical teams, supporting patient safety. It also allows for robust governance of clinical process adherence in the area of learning following the use of restraint, such as debrief and restrictive intervention review, supporting patient safety.

Since the system has been deployed, the organization has consistently reduced the absolute number of individuals subject to restraint as well as reduced the proportion of incidents to which a restrictive response is used.

Automated reporting saves hundreds of human hours per year, per clinician. In a healthcare context, this allows clinical staff to be deployed working clinically rather than working at terminals producing reports.

CASE STUDY: PRINCIPAL CARE HOMES

Principle Care Homes (PCH) is a new care home provider building and acquiring care homes, currently with two projects underway in Chelmsford and Fleet. To support the adoption of technology in their care homes, PCH have employed Subhaan Iqbal as Head of Systems, and are currently in the process of shortlisting the right systems for their sites.

The headline requirements are scalability, automation and the ability to remove manual processing. Being at the beginning of their journey, PCH hopes to deliver new and innovative methods for staff to undertake their work, while providing better care to their residents. 

The majority of care homes utilize several different systems, which usually rely on manual input by staff. This data must often be duplicated across several systems, opening the door to potential keying errors and the lack of a single source of truth. These systems do not generate workflows or aid in decision making but serve simply as data collection.

PCH aims to bring together several best-in-class systems and integrate them, including:

- HR systems (ATS, HRIS, LMS, rostering and payroll)
- Care systems (CRM, care planning, eMAR, assistive technology, nurse call and acoustic monitoring)
- Back office (accounting, billing, maintenance and procurement)

The integration of these systems will remove the need for duplicate data entry and ensure that information is stored in the relevant system. This will also reduce the discrepancies between the data within each system.

PCH will automate manual tasks such as the recording of daily vitals for residents, using sensors to record the information which will feed directly into their care planning system. Digitizing these processes will allow them to use BI dashboards to report on any data category. This will be possible as the team and residents carry the same unique identifier through each system ensuring all their data stays connected.

They plan to use AI to ensure their systems are proactive in directing the teams' attention to those residents who need it most. This process is guided by all of the data they hold on each resident, and the AI will interpret any change to the baseline of each resident.

All of these initiatives have been created to give more time back to their teams, to provide higher quality care for residents. These initiatives also ensure that residents have a more dignified and enriched experience in care.

CASE STUDY: RADAR HEALTHCARE

Radar Healthcare combines digital innovation with hands-on experience in healthcare environments, providing quality risk management software since 2012.

Avery Healthcare is well known in the care industry, with 4000 residents and 5000 workers in 60 care homes across the country. Avery Healthcare wanted to record and document metrics and data which specifically related to their residents' wellbeing, data that isn't regularly recorded on off-the-shelf systems including daily outdoor activity. As this was important to them, Avery healthcare had created a system for themselves to help them to record this.

However, they needed a more effective way to measure events, they needed a system that would not only drill down into the risk around the home, but also the well-being of the residents and the staff. ➤

Avery Healthcare's objectives were to ensure documenting and recording data was easy for their workers, including agency staff who are unfamiliar with the system. The data needs to be up to date; with 60 locations, resident and staff data must be correct for analytics to perform well for future strategy, including saleability.

To Sharon Winfield, COO at Avery Healthcare, motivation within the workforce is important to ensure high staff retention. However, she says it can be difficult to keep home managers engaged when so much of working in care is around regulation as opposed to the care of actual residents. Her statement is powerful justification for digital transformation in care, as she states: "We now demonstrate positive outcomes, so we can use that as evidence to the CQC. If we encourage staff posting positive events as well as incidents on Radar Healthcare, we are going to be able to present these great experiences in our homes to our investors, the CQC and other regulators".

Radar Healthcare's auditing module allows care workers to complete a range of audits on the go instead of being under a pile of paperwork. This dynamic way of doing audits takes the dread out of the task and helps organisations when external auditors come into their homes.

Like many care home operators, Avery Healthcare has been through a tough couple of years. The organisation offers counselling to help staff maintain their mental wellbeing when times are tough. Radar Healthcare has been able to support teams in that journey, particularly when it comes to end-of-life cases

Knowing your team is doing a great job ensures that they continue doing the same brilliant work – something Avery Healthcare does every day. Avery Healthcare continues to expand in size and develops its offerings all the time, and Radar Healthcare will adapt alongside to accommodate any changes they make to their services, improving the quality of care for both residents and staff.

Conclusion

The care sector has a unique opportunity to incorporate digital technology and improve the delivery and experience of care for all involved in the system. Although later than other sectors to begin the process of digitisation, its trajectory towards full digital transformation, having now started, is rapid. The adult social care sector can now learn from other sectors about how to best implement technologies and systems. What is essential for the implementation of all technologies into a care setting is that they are designed with, and for, their end users, and implemented in a context which works well for care professionals and people who require care and support.

Otherwise, there is a risk of both the carers and the cared for becoming dissatisfied with technology and disengaging with it entirely, negating the benefits that the sector desperately requires in terms of efficiency and quality of care. The introduction of technology is an opportunity that the social care sector cannot afford to miss; it is imperative that care providers, technology providers, local authorities and social care professionals come together and collaborate to design and implement the most appropriate technology for every person accessing care.

Much positive work is already being done to ensure the effective implementation of technology into care settings, to improve the lives and experiences of end users. This work must be built upon and rolled out within each ICS in order that all can benefit from the available technology

Members

PPP'S SOCIAL CARE NETWORK MEMBER LIST

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While the PPP Social Care Network has been involved in the discussions on which this report is based, membership does not imply agreement with the recommendations.

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