**Annex A**

Social Services, Health & Housing Policy Overview Committee

# TO EXAMINE THE USE OF ASSISTIVE TECHNOLOGY BY ADULT SOCIAL CARE TO SUPPORT INDEPENDENT LIVING

## *Draft Report*

## 2010/11

Members of the Committee:

Cllr Judith Cooper (Chairman)
Cllr Peter Kemp (Vice Chairman)
Cllr John Major (Labour Lead)
Cllr David Benson
Cllr Beulah East
Cllr Pat Jackson

**THE USE OF ASSISTIVE TECHNOLOGY BY ADULT SOCIAL CARE TO SUPPORT INDEPENDENT LIVING**

# Contents


**Chairman's Foreword** *(to be confirmed)* i

**Summary of Recommendations** 1

**Introduction**

Background and Importance 2
Overview: What is Assistive Technology? 2
Why is Assistive Technology Important? 2
What are the implications for Hillingdon? 3

Reasons for the Review 6
Connections with other work 7
Key Issues and Terms of Reference 7
Methodology 8

**Findings & Recommendations**

1. **September** – The role and function of assistive technology and an update on progress made in Hillingdon. 10
2. **October** - Partnership working and future challenges 17
3. **November** – Resource Implications 23

**Conclusions / Closing Word** *(to be confirmed)* xx

# Backing Documents:

*Annex A*

- Fictitious case studies to investigate how Assistive Technology might work in real world scenarios. *(to be included?)*
- Further case study information *(to be included?)*

*Annex B*

- An illustration of some items of telecare equipment *(to be included?)*

# CHAIRMAN'S FOREWORD

***To be agreed.***

## Summary of Recommendations

This review examines the use of assistive technology by adult social care to support independent living. Following the evidence received, we make the following recommendations.

1. **Good quality information and signposting must be provided for both carers and service users to enable then to understand their Assistive Technology (AT) / Telecare options to assist them to make informed choices (to address their needs).**

2. **That officers be requested to provide a strong business case for any re-branding exercises (should these prove necessary) in the current economic climate.**

3. **That officers be requested to ensure periodic reviews of service costs take place to ensure best value whoever the (service) provider might be.**

4. **The emerging body of evidence from various national review pilots has shown how valuable Assistive Technology (AT) / Telecare can be to users and carers. It is therefore essential that the status and profile of AT / Telecare is strengthened so that social care and health professionals consider this technology as an option for all service users and carers.**

5. **The early evidence from the Whole Systems Demonstrator pilots has shown how important partnership working is. To ensure services are delivered as effectively and efficiently as possible, information sharing rules and procedures must be developed.**

6. **The ongoing re-ablement project has shown that AT / Telecare could have significant benefits for people who are not fair access to care (FACS) eligible. The Committee recommends that AT / Telecare assessments should be extended to include preventative services as soon as possible.**

7. **That telecare support be provided free of charge for a limited period (no longer than 6 weeks) after hospital discharge as part of the re-ablement project to provide assistance and help reduce the number of re-admissions to hospital.**

8. **That the Committee is sympathetic to the development of a comprehensive in-house model, centred on local call centres, and request officers to fully explore the cost implications of this option as part of the ongoing Medium Term Financial Forecast work.**

# Introduction

## Background and Importance

## Overview: What is Assistive Technology?

In 2004, the Audit Commission defined assistive technology as:

*"any item, piece of equipment, product or system that is used to increase maintain or improve the functional capabilities and independence of people with cognitive, physical or communication difficulties".*

As the term assistive technology is so broad this report will focus on the following:

- community equipment
- minor adaptions
- door entry systems
- telecare and telehealth

## Why is Assistive Technology Important?

### Demographics and Importance

The ageing population in Hillingdon changing demographics makes the application of assistive technology critical to enabling disabled residents and those with long-term conditions, especially dementia, to remain independent in their own homes. Without it the cost implications for the council and key partners such as the NHS would be considerable.

Hillingdon has a population of approximately 253,000. It is estimated that there are currently 34,000 people aged over 65 in the Borough. This is projected to increase by 8.4% in five years to 37,100. The numbers of people aged 85 and over is expected to increase by 11% within this period to 5,500. The 2001 census did identify that there were 36,000 people in Hillingdon who considered that they had a limiting long-term illness and 45% of these were older people. Stroke is one of the main causes of disability and is concentrated in the older population. In 2008/9 (the last year for which validated data is available) 3,209 people were reported by GPs as living with stroke. This is projected to increase to 4,351 by 2015.

Dementia is primarily a condition faced by older people and the ageing population in Hillingdon indicates that this is going to be a major cause of need in the future. Projections suggest that the number of older people with

dementia is likely to increase by 7% to 2,694 in the five years to 2015. 67% of the increase can be attributed to the over 85s, which is expected to grow by 11% within this period. People with learning disabilities are more susceptible to dementias as they get older. Projections suggest that the number of people with learning disabilities living into old age is increasing and it is predicted that there will be an increase of 7.6% between 2010 and 2015.

## Local Aspirations

Extensive consultation nationally and locally shows that the vast majority of older and disabled people wish to remain independent in their own homes. Assistive technology has an essential role to play in ensuring that this aspiration becomes a reality. The use of assistive technology in the form of telecare as an essential mechanism for addressing the needs of the ageing population and in making savings in the cost of care provision was identified in a Department of Health study published in October 2009 by John Bolton about the use of resources in adult social care and also the Audit Commission publication *Under Pressure* published in February 2010.

## Community Equipment Service

Hillingdon has a high performing community equipment service which has been jointly funded with Health since 1993. This service provides daily living aids on a loan basis to people who meet the eligibility criteria for social care or who are registered with a Hillingdon GP. The service is available to children as well as adults and the equipment available ranges from simple items such as walking sticks or raised toilet seats to more complex items like electric hoists or four-section electric beds. A pooled budget arrangement means that clinicians across health and social care, such as occupational therapists, are able to prescribe equipment according to their clinical competence, which prevents users having to see different people according to where their equipment needs are identified as meeting a health or social care need.

During 2009/10 the Council and the PCT were part of a collaborative procurement exercise that was led by the Royal Borough of Kensington and Chelsea (RBKC) and involved six London councils and PCTs in total. The key objective behind the collaboration was to secure greater efficiencies through increased economies of scale. An initial saving of £60k was achieved and opportunities for this to increase are created by the possibility of other councils entering into the framework agreement that is hosted by RBKC. This sets common prices and terms and conditions that other councils would be bound by should they wish to join it. The more councils that join the greater the opportunities for savings on equipment cost.

The tender resulted in Medequip Assistive Technology Ltd being appointed and the new contract started on the 1st April 2010 and is currently in the early stages of implementation as prescribers get used to new ordering systems, especially information technology.

**Minor Adaptations and Door Entry Systems**

The minor adaptations service provides adaptations up to the value of £1000 to individuals' homes. Minor adaptations would include equipment such as grab rails by a door or near a toilet or bath. It could also include some ramps.

Door entry systems includes the installation of key safes, coded entry systems and flashing light door bells for people with a hearing loss.

Both the minor adaptations and door entry systems services were included within the collaborative procurement exercise referred to above.

**Telecare**

**Telecare is a subset of assistive technology.** It is the name given to a range of equipment (detectors and sensors) that will raise an alarm with another person in an emergency. The alarm might be raised with a carer who lives in the same home as the person with the telecare equipment or they may live nearby. More usually the alarm is picked up by a locally based alarm centre, which in this borough is Careline. Examples of telecare detectors include fire, flood, gas, carbon monoxide and falls. The following are examples of telecare sensors: exit, bed, and chair sensors. These are particularly helpful for people with dementia who are prone to wandering. Telecare equipment can be very sophisticated, e.g. safer wandering devices that are linked into the GPS system and enable a person who goes wandering to be located and systems that remind people to take medication.

During 2009/10 439 older people received telecare systems. This includes people with the lifeline system and those who have a broader range of sensors and detectors as well. A target of assisting 450 older people and 20 younger disabled younger adults has been set for 2010/11.

The main beneficiaries of telecare are older people, especially those with dementia, but it can also assist people with other disabilities such as learning disabilities, mental health needs and younger adults with physical and/or sensory disabilities.

The responsibility for the supply, installation, maintenance and collection of telecare equipment transferred to Careline from a private provider on the 1st April 2010. This action brought these functions together with the response service into one place with the intention of creating cost and process efficiencies.

The effectiveness of telecare as an alternative to residential care is dependent on there being a robust response service that users, carers and family members as well as professionals can rely on. At present the response to an alert entails contacting identified key holders or the emergency services where this is not possible. From the 1st October 2010 it is intended to run a pilot mobile response service that will operate 24/7 and will involve both Careline staff as well as staff from the in-house Home Care Team. The beneficiaries of the pilot will be service users whom care management staff have identified as being vulnerable to admission into residential or nursing care or a potential Hospital Accident and Emergency attendance. The purpose of the pilot is to clarify the volume and nature of call outs and therefore the level of staffing required to support the service.

**Telehealth**

*Telehealth* refers to a system which enables the management of an individual's health condition at a distance or in their own home. For example, technology can enable a person to monitor their own vital signs, such as blood pressure, pulse rate, or temperature or a remote monitoring centre can take readings of physiological data and warn a clinician, e.g. a GP, if the measurements fall outside the expected parameters.

Telehealth systems can provide an early alert system for people with conditions such as chronic pulmonary obstructive disorder (COPD), heart disease, diabetes and hypertension, etc.

The development of telehealth in Hillingdon is in its very early stages in Hillingdon and preliminary discussions with NHS Hillingdon to look at the options for taking this forward took place on the 28th June 2010. The Committee may wish to note that exploring the feasibility of establishing an integrated telecare and telehealth service is one of the tasks within the Wellbeing Strategy action plan.

## Reasons for the review

Hillingdon is facing a combination of challenges and included within these are:

- an ageing population leading to increased demand for services and greater budget pressures;
- the national and local policy priority and popular aspiration of preventing avoidable admission into institutional care;
- a contracting council budget arising from national financial situation.

Assistive technology has an important role in addressing these challenges. The review provides an opportunity for the Committee to identify recommendations that will assist in the more effective use of this technology to the benefit of Hillingdon's residents.

## Key questions

- What is the role and function of assistive technology?
- How has this developed elsewhere (with reference to best practice)?
- How will the pilot mobile telecare response service work?
- What services does Hillingdon provide?
  I. To whom?
  II. Service location?
  III. How are these services accessed?
- Are any changes proposed in the equipment that will be made available?
- How does the Council work in partnership with service providers and other stakeholders? Is there any overlap with or duplication of the work of other partners?
- Bearing in mind the current economic climate, what future savings might the successful implementation of assistive technology bring?

## Connected work (recently completed, planned or ongoing)

The use of assistive technology links into the Hillingdon Sustainable Community Strategy theme of improving health and social care by enabling people to live independently at home. It also links into the following strategies and plans:

- Wellbeing Strategy
- Older People's Plan
- Disabled People's Plan
- People with Physical and/or Sensory Disabilities Strategy 2008 – 2013
- Commissioning Strategy Plan 2009 - 2014
- Disabled Children Strategy 2009-2011
- Carers Strategy 2008 – 2013

As a key preventative measure, assistive technology also links into the Support, Choice and Independence programme within Adult Social Care, Health and Housing which is seeking to implement the personalisation of adult social care services in Hillingdon.

## Aim of the Review

To examine the assistive technology (community equipment, Telecare and Telehealth) pilot in adult social care in Hillingdon and to make recommendations that will strengthen the delivery of partnership arrangements and services to people with dementia and physical disabilities.

## Terms of Reference

1. To review how assistive technology has been employed by other London Boroughs and to review current best practice.
2. To examine the pilot study of community equipment, Telecare and Telehealth services in Hillingdon, including, service proposals, (provision to) client groups for those people suffering from dementia.
3. To identify opportunities to strengthen the role and functioning of the partnership arrangements for assistive technology, within the context of national guidance and good practice.
4. To make recommendations that will help officers and partners address any identified gaps on the role and function of assistive technology to develop services.
5. To make recommendations to Cabinet / Cabinet members based upon the findings of this review.

## Methodology

In the current year we used three meetings to examine this issue. In September 2010, officers from Adult Social Care provided a background report on assistive technology and also took the opportunity to demonstrate some of the key technologies to the Committee. We also held three witness sessions to discuss and receive evidence relating to the review.

Meetings held in September and October with a further one in November involved taking evidence from a range of witnesses:

### First Witness Session: 1st September 2010

**First session**

- This first session (including an officer background report) provided an overview of the role and function of assistive technology and an update on progress made in Hillingdon. This witness session also examined several fictitious case studies in detail (Annex A) to illustrate how assistive technology might be used in a number of different scenarios and to develop further lines of questioning to use at later witness sessions. Witnesses included:
    - Head of Commissioning
    - Head of Access and Assessment
    - Equipment demonstration – Careline Manager
    - User/carer perspective

### Second Witness Session: 14th October 2010

This session examined partnership working and highlighted a number of future challenges faced by the Department to deliver excellent services for people with long term health problems. Witnesses included:

- Representative from Newham
- NHS Hillingdon representative
- Age UK

**Third Witness Session: 9h November 2009**

The final session examined the resource implications of any proposed delivery models, e.g. social enterprise schemes, income generation opportunities. The witnesses included:

- Head of Finance
- Joint Commissioning Service Manager

The next section of the report provides presents the main findings and concerns arising in the evidence. We then make recommendations to Cabinet, which we believe will help address these issues.

## Findings & Recommendations

At the September meeting, officers provided an overview of the role and function of assistive technology and an update on progress made in Hillingdon.

In recognition that the demographics of the country were changing, the government launched *Building Telecare in England* in 2005 to promote telecare as a means of enabling more people to stay independent in their own for as long as possible. The Committee heard that this move was supported by the creation of a non-ring-fenced grant, the Preventative Technology Grant, in 2006 and in 2008, the two-year Whole Demonstrator programme was established with the purpose of providing robust evidence of the effectiveness of telecare and telehealth technologies.

The Whole Demonstrator programme, currently underway, sought to identify the extent to which the effective integration of technology and Health and Social Care services could:

- promote people's long term health and independence
- improve quality of life for people and their carers
- improve the working lives of health and social care professionals
- provide an evidence base for more cost effective and clinically effective ways of managing long term conditions.

We heard that Adult Social Care had applied to be part of an extension of this trial earlier this year but unfortunately had not been successful.

Referring to the policy framework, officers explained that the benefits of telecare, as a way of securing the independence of older and disabled people, was reflected in the health and social care White Paper *Our health, our care, our say: a new direction for community services* (2006). The important role of telecare had also been recognised in the Department of Health concordat that spearheaded the transformation of adult social care, Putting People First (2007) and by the Secretary of State for Health and the Prime Minister in their Parliamentary speeches on the future of care provision made on the 22nd October and 2nd November 2009 respectively.

**Components of a Telecare Service**

Any telecare service comprises of a number of processes and functions and these can be summarised as follows:

- enquiries and referrals about and for telecare;
- assessment for telecare;
- purchase of telecare equipment;
- equipment installation and collection (when no longer required);
- maintenance of equipment;

- monitoring for alerts;
- alert response.

Referring to the position in Hillingdon, officers explained that since the 1st April 2010 responsibility for the equipment purchase, installation, collection and maintenance functions, as well as that for monitoring alerts and the alert response had been placed with Careline[1]. Before this date only the monitoring and alert response functions were with Careline and the other functions were contracted to Medequip Assistive Technology Ltd. The responsibility for undertaking assessments has always sat with assessment and care management and it is intended that this will continue.

We learnt that the decision to place all of the functions apart from assessment with Careline was taken for a number of reasons which included;

- reducing the number of organisations involved in the delivery of telecare would improve efficiency by reducing confusion about roles and responsibilities;

- complexities arising due to having partners with incompatible IT systems that would be eliminated by having an in-house provider, thus improving efficiency;

- Careline's fixed costs meant that it would be a more cost effective option. The equipment purchase, installation, collection and maintenance functions were included as part of the West London transforming community equipment services tender that the Royal Borough of Kensington and Chelsea led in 2009. Only Medequip Assistive Technology Ltd submitted a bid for telecare and appointing them to provide this service would have resulted in the council incurring a charge for each item of equipment installed and collected, as well as a separate maintenance cost;

- placing all functions with Careline (apart from assessment) was an integral part of the strategic development of the service that could see it offering services to other local authorities and health economies.

We noted that the intention is that Careline will also provide a monitoring service for those people identified as being at risk should they not receive a

[1] Careline is a 24 hour monitoring service staffed by trained operators which offers vulnerable people help and security at the touch of a button connected to their phone line. It provides a 24 hour, 365 days a year emergency service, enabling clients to live as independently as possible within their own home.

call from their domiciliary care agency and that in these case, the alerts will be identified through the council's Electronic Call Monitoring Service (ECMS).

## Accessing Telecare in Hillingdon

### Eligibility for Telecare

We were pleased to learn that anyone who is a Hillingdon resident, or someone acting on their behalf, can apply for telecare. The main way of doing so is through Hillingdon Social Care Direct (HSCD). Presently, there are two levels of telecare service in Hillingdon:

a) *Bronze service* – This is the basic service consisting of lifeline, smoke detector and bogus caller alarm. It is a universal service available to any Hillingdon resident for a monthly charge of £4.91. The charge is for the monitoring service and not the equipment. Anyone just wanting the bronze service can approach Careline directly.

b) *Silver service* – This level of service is available to Hillingdon residents following a community care assessment. This enables residents to access more complex detectors and sensors to support independent living also at a *monthly charge of £4.91 per month.* Assessments for the silver service are currently undertaken by the Critical, Substantial Teams, Review and Specialist Teams within Adult Social Care and also the Hospital.

Officers explained that Hillingdon Hospital was a key source of referrals and these accounted for 45% of referrals during 2009/10 and so far was responsible for 38% of referrals during the first quarter of 2010/11 *(updated information to be inserted)*

### Monitoring and the Response Service

Having examined service provision and eligibility, the Committee looked at monitoring / the response service and how telecare would work in practice. Officers explained that unless a carer was self-monitoring, an alert would be received by the Careline switchboard. Careline staff would then seek to contact the resident. If the resident could not be contacted current protocols stated that they would try to telephone an identified responder, i.e. someone who lives nearby who can visit if necessary.

We noted that the increasing number of single person households would mean that restricting telecare to those people who had responders would severely limit the number of people who could benefit from this service. In these circumstances, officers explained that clients had a key-safe affixed outside their front door so that it would be possible for emergency access to be gained where necessary.

In cases where the responder could be contacted or if there was no responder and it was not possible to contact the resident, then Careline would telephone the emergency services. This does not apply in sheltered housing as there is a limited mobile response service paid for through the tenants' rent that means that staff will visit if the tenant cannot be contacted or where further assistance is required.

**Reablement Service**

The Committee heard that an essential component of the emerging Adult Social Care Strategy for the next three years was that no one should be admitted to residential care from hospital or the community without being considered for a period of reablement. The provision of telecare was an integral part of this and it was intended that the Reablement Team will consider all referrals for telecare.

While there were clear benefits to be had from the technology we acknowledged that some people, especially older people, might be intimidated by new technology and enquired whether systems could be adapted to suit the needs of specific user groups, such as dementia sufferers, which might be frightened by a combination of lights and sounds emitted from some of the devices. To address this issue, we learnt that the intention was to build up telecare provision incrementally so that the user would gain confidence and familiarity with the technology over time.

**Mobile Response Service Pilot and Safer Wandering Pilot**

Officers explained that a **mobile response pilot** was being developed in response to an ageing population and increasing incidence of dementia. The key aspects of the service were:

- The pilot was being developed to avoid the numbers of admissions into residential or nursing care.
- To be successful it was essential that residents, their families and professionals had confidence in the support structures intended to enable people to live safely in the community.
- The mobile response service would be available 24/7 and would be provided by the in-house Home Care Team.
- Using the in-house Homecare Team ensured access to personal care should this be required and represented a part of its transition to become a reablement service.
- The pilot would start in October consisting of new users identified by care management or through the Hospital.
- Participants in the pilot would be those identified by professionals as being at risk of residential, nursing home or hospital admission.
- the purpose of the pilot was to:
  - identify the number of attendances required;
  - identify reasons for attendances;

    - quantify resources required to support the service.
- The key success measures would be:
    - period admission to residential/nursing home avoided;
    - hospital attendance/admission prevented.
- In view of the cost of the mobile response service, it was unlikely that it would become a universal service. However, this would not prevent residents nor their families seeking to buy into it should they wish to do so. It was not intended that this option would be made available in the early stages of the pilot.

Officers explained that the **safer wandering pilot** was closely related to the mobile response pilot. People at risk from wandering would have wrist watch like device attached to their wrist which would set off an alert if the person went beyond a pre-set distance from their home. The alert will initially be detected by the equipment supplier, Evron, who will then notify Careline. The intention is that the mobile response service will then go out to the person, whose exact location will have been identified through GPS, and encourage them to return home. It is envisaged that the safer wandering device will be used in conjunction with exit sensors.

**Practice in Other Boroughs**

There are a number of variations in the models of telecare service provision. To compare and contrast the approach taken in Hillingdon, we examined practice in other London Boroughs. We noted that the following approaches had been taken:

- *Bromley* – there were four levels of service each incurring a different weekly charge;
- *Camden* – provided two levels of service and had outsourced the monitoring function to a company based in Kent;
- *Ealing* – access to telecare was restricted to people at risk of falls or people with a dementia diagnosis. The monitoring function was provided by Tunstall, which was one of the main equipment suppliers in the country. Their Homecare Service provided a mobile response during office hours;
- *Newham* – a branch of Newham Homes (the council's arms-length management organisation) called Newham Telecare Network provided all aspects of the telecare service, including the initial assessment.

**Areas for Development**

Officers highlighted that there were a number of areas which required further work. These included:

- *Performance indicators* – We heard that these had not yet been applied as some IT issues were still outstanding arising from the implementation of the new Integrated Adult Social Care system (IAS), i.e. electronic ordering and staff training, and also some staff recruitment matters.
- *Developing technology* – It was acknowledged that telecare and telehealth was a rapidly moving area. There was a standard list of equipment but other items can be provided where this would address assessed need. The Committee agreed that for any assistive technology to work effectively, it was essential that any equipment provided must be compatible with the monitoring equipment.
- *Telehealth* – It was noted that a pilot focussed on dermatology, i.e. skin cancer, based at one GP practice in the north of the borough was currently being explored by NHS Hillingdon. The benefits of establishing further pilots intended to assist in keeping people with chronic obstructive pulmonary disease (COPD) or diabetes in their own home would be explored over the next year.

1. *Publicity* – Officers explained that publicity materials were currently being developed to be distributed to users and their carers and also to assist professionals. The Committee agreed that good quality information and signposting needed to be provided for both carers and service users to enable then to understand their AT options to assist them to make informed choices to address their needs**.**

- *Rebranding of Careline* – Discussions were taking place about the rebranding of Careline to emphasise its new role as a telecare service.

**Demonstration of Telecare Technologies.**

In addition to hearing from officers, the Older People's Housing Services Operations Manager provided the Committee with a practical demonstration of some of the key telecare technologies. We were shown how programmable pill dispensers, bogus caller alarm systems, tilt detectors and armchair sensors worked and discussed the applications for wandering sensors which were linked to both door sensors and global positioning systems.

The demonstration prompted a series of questions which included:

- The sensitivity and radius of wandering systems and whether these could be customised to react to particular types of medical condition.
- Whether wandering systems might have other applications such as assisting clients with some mental health conditions.
- Whether or not the council (in all cases) would be the first point of contact with the user, if an alarm had been triggered.

- Whether some of the tracking technology was susceptible to dead spots (when the sensors would not work) similar to problems associated with mobile phone usage and if so what mitigating action could be taken?

Key points of the responses and the subsequent discussions included:

- Whether rebranding Careline was strictly necessary and the possibility that if this was done, it might confuse elderly users. Members suggested that before any rebranding took place, a strong business case for this would need to be presented by officers.
- The re-enablement service currently had a 23% success rate. It was noted that officers would be using a combination of occupational therapy and telecare to improve this success rate.
- The plans in place to deliver assistive technology. Officers explained that this was not just about demand and it was anticipated that using new technology would have staff resource implications.
- Other important issues raised by the Committee included the need for officers to investigate self-funding patterns, anticipated demand and ways of marketing the re-enablement service.
- In relation to the performance indicators mentioned at the meeting, Members agreed that it was essential to track the numbers of referrals back to hospital (through the PCT) and usage patterns so the Council could establish whether the service paid for itself.
- The Committee concluded that a number of further perfomance indicators need to be monitored. These included serviceability, maintenance, reliability and feedback from users.
- Members agreed that it was essential to track the cost of the service in relation to the 2 levels of service (bronze and silver) and it was important that users understood that this differentiation was based on need and not cost.

Our October meeting was attended by Martin Scarfe, London Borough of Newham, Simon Jennings, NHS Hillingdon and Chris Commerford, Age UK. This meeting looked at partnership working and highlighted the type of challenges the Directorate would be facing in the future to deliver excellent services for people with long term health problems.

Mr Scarfe provided a presentation on the development of telecare / telehealth and the Whole System Demonstrator (WSD) Trial currently underway in the London Borough of Newham. The following points were noted:

**Whole System Demonstrator (WSD)**
The Newham Whole System Demonstrator (WSD) Trial was a two-year research project funded by the Department of Health. Its aim was to establish a national business case to measure the benefits of assistive technology in the homes of persons with long-term health and social care needs. Newham's PCT were successfully selected to become one of three sites to take part in the trial – the other two were Kent and Cornwall (making this the largest telecare trial anywhere in the world).

**Newham WSD Trial**
As well as provide a business case for assistive technology, the WSD trial in Newham was a response to the needs of an ageing population and the implications this would have for the future of health and social services. The Committee were informed that the business objectives of the trial were to reduce:

- emergency hospital bed days and admissions;
- accident and emergency attendances;
- numbers admitted to residential care and nursing homes;
- financial and staffing pressures in the region.

and the clinical/social objectives of the trial were to:

- promote users long-term health and independence;
- improve quality of life of user's and carers;
- improve working lives of health/social care workers

We heard that more than 1,500 people located across the borough were involved in the Newham trial and participants were identified through patients' General Practioner (GP) and social care records. In terms of the methodology employed, Mr Scarfe explained that the trial focused on two main patient/user groups which included:

1. Telecare patients with: a social care need, physical disability, frail and elderly, risk of hospital admission or falls and

2. TeleHealth patients with: Chronic heart disease (chf), Chronic obstructive pulmonary disease (COPD) , Type 2 diabetes and Previous hospital admissions.

The technologies used in the trial included:

- (Telecare) a combination of alarms, sensors and other response equipment (working 24/7) so that a call for help could be raised in case of an emergency. However, it was important to note that this was not intended to replace human contact. This echoed one of the Committee's key concerns which they highlighted throughout the review.
- (Telehealth) providing daily care management and an early warning should readings go outside normal parameters. Telehealth also allowed early intervention e.g. change of medication and onward referrals to be made.

**Successes of the Newham WSD Trial**

Although the Newham WSD trial was not due to finish until May 2011, the Committee heard that there had been a number of notable successes. These included the positive reaction the trial had received from the medical community. Mr Scarfe explained that (in Newham) the majority of GP's had endorsed and signed up to the trial and so far, no negative feedback had been received. We also heard that in broader terms, positive outcomes had included:

- Greater stakeholder engagement
- Positive clinical outcomes
- Extensive collaboration between the WSD call centre and external health and social care professionals.
- Very positive feedback had also been received from users and professionals.

**Partnership Working**

The Committee heard that one of the important reasons for the success so far had been the partnership working between the Council and PCT. Members were keen to ensure this relationship was emulated in Hillingdon. Referring to the structures in place in Newham, Mr Scarfe explained that at present, telehealth and telecare were separate stand-alone services, but the intention in Newham was to integrate these services in the future. In overall terms, the Committee heard that 9 separate datasets would need to be analysed to measure how successful the WSD trial had been and it was anticipated that this task would take about 6 months. However, early results had been encouraging.

**Funding**
Mr Scarfe explained that in relation to funding streams, telecare (in Newham) had been maintained by capital funding whereas Department of Health funding had supported the WSD. We heard that in relation to the future, it was anticipated that telecare would be funded by top slicing of Adults budgets and telehealth would be supported by a mixture of Commissioning intentions and Staffing efficiencies. In his view, for services to be successful, further investment would be necessary and more would need to be done to integrate Health and Social Care services providing a joined up service, directed and controlled through a control centre.

**Good Practice**
The Committee heard that for assistive technology to be implemented successfully a number of conditions would need to be in place. These included:

- Assessments for Telecare and Telehealth.
- Care Pathways
- Control Centre (accredited) – allowing for huge financial savings to be made at 3 or 4 control centres across London.
- Monitoring
- Response Protocols
- Reports
- Survey
- Risk (Combined Model)

In addition to the early results from the Newham WSD trial, we heard that a number of common learning points had emerged from the three WSD trials taking place across the country. These were:

**Key learning points about installation, monitoring and response when working at scale**

- The level of planning and basic project/programme management involved is really significant when working at scale and at speed.
- It is important to plan installations and work closely with the supplier/install team. There needs to be flexibility in these arrangements.
- Demand management is important – people have come on and off the trial in spikes, so the demand is not even. This affects resourcing and staffing arrangements.
- Don't underestimate the technical and logistical issues – eg, power sockets and telephone line in the home, availability of broadband (for instance, Newham has an eight-day turnaround for connections for their telehealth service).

- There is a need for flexibility in arranging assessments and installations, including out-of-hours service, as people can have active and busy lives even though they have high levels of need.

- Communications are important for staff and service users – eg, setting expectations, booking visits.

**Early lessons for integrated working from across the three sites**

- Senior commitment is necessary.
- Data sharing and handover are important – initially, we underestimated the time for setting up data sharing agreements and ensuring the slick handover of responsibility from one organisation to another.
- Pockets of excellence may not spread across a large local authority area – it is important to work towards high standards.
- The WSD programme is recognised by the sites as a vehicle for more integrated working.
- There are differences in culture, motivation and performance metrics between organisations (including the private sector and the third sector).

- A common goal is needed

**Learning points about working with suppliers, third sector and independent organizations and the role of housing services**

- Many of the participants were already working with earlier telecare and telehealth programmes in the sites at a smaller scale. Some organisations were new.
- It is important to work with housing services and the third sector – many organisations are already providing services that should be part of a total care package.
- It is important to ensure flexibility and that contracts and service level agreements are in place.
- Governance must be in place to handle sensitive personal information.

- It is important to work with voluntary organisations to raise awareness and set up user forums – to hear the user voice and allow people to share their experiences

Simon Jennings, Chief Information Officer, NHS Hillingdon provided his views on telecare and telehealth. The following points were noted:

Members heard that overall, London had been slow to engage with telecare. Referring to recent developments in Hillingdon, he explained that NHS Hillingdon had looked at redesigning the dementia pathway (the whole system of dementia care) and were exploring the ways in which telecare (through early intervention) could play a greater role in the preventative agenda. In addition we were informed that by using data from social services, hospitals and GP's, NHS Hillingdon were looking at the BUPA models to see what it could do differently in the future.

The intention was for the BUPA models to be used to evaluate 3 models of care for inclusion in the improved Pathway. These models were:

a) Telecare deployment –working jointly with the Borough
b) Introducing a Mental Health Liaison at Accident and Emergency and
c) Intermediate care which is a combined operation with community and social service.

It was anticipated that the conclusions and recommendations arising from this modeling would be published in December 2010.

Further work conducted by NHS Hillingdon included a Dermatology pilot which had been approved and would involve 18 General Practitioners from 18th October 2010. Members noted that the programme involved GP's using a Teledermatology service to assess patient conditions, through transmission and clinical assessment of images of the condition.

Members heard that indications had shown that there were clear efficiencies from the process change, which resulted in reduced diagnostic time for patients, and at a lower cost. It was noted that the business case anticipates a £28,500 recurrent saving in referral costs for the pilot, which is £198,700 recurrent saving for a full Hillingdon deployment.

Chris Commerford, from Age UK provided her views on telecare and telehealth. The following points were noted:

- Telecare could offer choice and independence to users and increase the confidence of those people living at home.
- The role played by Careline was supported as it offered a strong local service.
- While it was acknowledged that telecare had many advantages it was important that it complemented social contact rather than replaced it.

- It would be useful to offer people being discharged from hospital free telecare services for 6 weeks to help them remain independent and establish whether they wished to purchase these services (telecare and telehealth) in the long term.

Key points of the responses and the subsequent discussions included:

- With reference to the WSD trial in Newham, it was noted that as most GP's had entered the trial and GP's had controlled the funding, there had not been a postcode lottery and there had been a commonality of response.
- Members were encouraged to learn that nursing had not suffered as a result of the introduction of telehealth and had benefited from systems providing more information in real time so that preventative care could be provided.
- With reference to the telecare response service in Newham. Of 2,500 people receiving telecare services, there had been 10,000 alerts in the first 6 months, of which 50 % had been false alarms. Of these 5,000 alerts, 700 had generated either an emergency or in-house response. Making a judgement as to whether or not this was cost effective, would be dependent on the specific needs of service users.
- The number of control centres across a given area, co-ordinating telecare and telehealth services was crucial. As the complexity and demand for services would vary from area to area a one size fits all approach could not be taken. Control Centres could be used to provide numerous additional services such as out of hours social work and repairs management and therefore there would be scope to introduce higher charges for higher levels of response.
- In relation to call centres, it was noted that NHS Hillingdon was currently looking at commercial sector business models with a view to moving away from small local call centres to larger more centralised services.
- Members agreed that long term demographic change meant that telecare and telehealth was an emerging marketplace and there was considerable scope for services to be developed so that long distance care could be provided for elderly relatives.
- Members agreed that providing telecare for a limited period after hospital discharge was a good idea.
- That Officers be requested to investigate providing an all councillor seminar on telecare / telehealth and for this to include a demonstration of telecare equipment.

At our final meeting, the Committee examined the resource implications of different proposed assistive technology delivery models, e.g. social enterprise schemes and the income generation opportunities.

**Proposed Model of Service Provision**
At the beginning of the meeting, officers reminded the Committee that the purpose of telecare was to:

- contribute to Hillingdon residents to remain independent in their own homes for as long as possible; and
- prevent avoidable admission or readmission to hospital.

Officers explained that it was for these reasons the intention was to develop a menu of options that would provide flexibility for residents and their families while at the same time address the anxiety that some older people might have about the use of technology by introducing technology in a phased way. We heard it was proposed that the menu comprise of the following four levels of service:

1. ***Level 1*** – this is the standard service comprising of button and box, smoke detector and bogus caller alarm.
2. ***Level 2*** – the standard service but with access to a mobile response service
3. ***Level 3*** - the standard service but access to a range of detectors and/or sensors appropriate to their assessed need.
4. ***Level 4*** –a full range of telecare sensors and detectors to address their needs, including safer wandering equipment, and also the Mobile Response Service.

Residents who did not satisfy the Council's eligibility criteria would have the option of purchasing telecare equipment over and above the standard package as well as having access to the Mobile Response Service. We thought this offer might prove attractive for families to purchase for their parents, especially if they lived away from the area.

**Charging Policy**
We heard that at present there was a flat rate charge of £1.13 per week. To access telecare services it was proposed that:

a) for clients in receipt of social care the allowable expense of £1.13 per week is applied to all levels of service
b) for clients NOT in receipt of social care the full charge of £1.13, £2.50, £5.00 or £8.00 a week is applied according to the level of service provided

**Mobile Response Service**
Officers explained that the mobile response service would be available 24/7 and would be provided jointly by the in-house Home Care Team and Careline. We heard that by including this function within the role of the in-house Homecare Team, would ensure access to personal care should this be required and would represent a part of its transition to become a reablement service. This proposal also reflected the increasing prominence of reablement as a means of maximising independence and reducing avoidable demands on community care and health services. We were encouraged at the prospect that Careline's role in the provision of the response service would ensure that there were two officers able to attend out of hours call outs at residents' homes in accordance with the council's lone working policy.

**Telecare Service Costs**

Table 1 identifies proposed budget for the new telecare service for 2011/12.

| **Table 1: Telecare Proposed Budget** | |
|---|---|
| Installer | 13,500 |
| Home Carers On-Call | 16,000 |
| Home Carers Hours | 23,300 |
| Other Costs | 3,000 |
| Equipment | 152,300 |
| Gross Cost | 208,100 |
| | |
| Income | -93,600 |
| | |
| Net Budget | 114,500 |

**Funding Telecare**
From the evidence the Committee had considered so far, it was clear that if assistive technology (telecare and telehealth) was implemented successfully there were clear benefits for residents. The crux of review focused on how telecare could be funded. We heard that the intention was for there to be separate financial arrangements in 2010/11 for Careline. We learnt that at present, Careline was funded by a combination of Housing Revenue Account (HRA) and General Fund but from 2011/12 the intention would be to bring the Careline and telecare budgets together as part of a unified service. From the modelling work conducted so far, officers explained that *it was anticipated that the telecare service would be funded from the avoidance of expensive Residential or Nursing placements, with the costs of the home care staff being funded from the current homecare budget.* The telecare service would be incorporated into the wider reablement service within Adult Social Care, Heath and Housing.

Table 2 sets out the combined budget for the service.

| Table 2 - Telecare Service Proposed Budget | | | |
|---|---|---|---|
| | **Careline Current Budget** | **Telecare Proposed Budget** | **Total Proposed Budget** |
| HRA | 467,000 | 0 | 467,000 |
| General Fund | 254,000 | 208,100 | 462,100 |
| **Gross Cost** | **721,000** | **208,100** | **929,100** |
| | | | |
| Client Contribution | -245,000 | -93,600 | -338,600 |
| Supporting People | -75,000 | 0 | -75,000 |
| **Income** | **-320,000** | **-93,600** | **-413,600** |
| | | | |
| **Net Budget** | **401,000** | **114,500** | **515,500** |

Table 3 sets out the anticipated savings from the telecare service:

| Table 3: Estimated Saving from Telecare Service | | | |
|---|---|---|---|
| **Year** | **2011/12** | **2012/13** | **2013/14** |
| Cost Avoidance of Residential/Nursing Care | | | |
| Number of Service Users | 22 | 32 | 45 |
| Estimated Cost Reduction per client per annum | 5,882 | 5,882 | 5,882 |
| | | | |
| Annual Cost Avoidance | 129,406 | 188,227 | 264,694 |
| Existing Homecare Staff Budget | 42,300 | 42,300 | 42,300 |
| Total Budget Available | 171,706 | 230,527 | 306,994 |
| | | | |
| Cost of Proposed Service | 114,500 | 114,500 | 114,500 |
| | | | |
| Saving | 57,206 | 116,027 | 192,494 |

**Cost Avoidance**
Mindful of the current economic climate and the pressures on all service budgets, a key aspect of our review was to look at the financial basis of telecare, how savings might be realised and how cost benefits could be illustrated. In broad terms, officers suggested that savings could be made in the following ways:

1. where the cost of supporting a resident at home was less than that of residential care after taking the cost of domiciliary care and any other community care service into consideration.
2. by reducing the scale of a domiciliary care package, e.g. through the provision of medicine dispensers.
3. saving money to the health economy through the prevention of a hospital admission or readmission.

However, officers pointed out that as assistive technology was a relatively recent development, this meant that empirical data relating to its impact was not readily available. However, we heard that there was a growing body of both qualitative and quantative evidence which suggested telecare could make a valuable contribution to older people to live independently.

Officers explained that strong results about potential cost savings were expected from the Whole Systems Demonstrator (WSD) pilot which was due to publish its results in March 2011. In the meantime, Officers referred to a number of case studies (listed below) which had already shown that telecare was cost effective for Local Authorities. The Use of Resources study by the Department of Health and compelling evidence had been provided by the North Yorkshire Pilot about how cost savings could be made.

**North Yorkshire County Council**
The Committee heard that costs had been reduced significantly at North Yorkshire County Council (NYCC) which was regarded as a national leader in the use of telecare and had invested heavily in this approach since 2005. During 2009, NYCC had analysed a sample of 122 new telecare users during a two month period and the following results had been identified:

- 48 cases would have been residential, dementia residential or nursing
- 74 cases would have been care at home requiring decreased levels of domiciliary care
- 33% reduction in care costs (annualised analysis = net average efficiency £3,180/person countywide)

**University of Kent based study**
Officers referred to a study by the Personal Social, Services Research Unit (PSSRU) based at the University of Kent which reported that medium need equipment installation costs were £350 to £450 and higher needs ranged from £700 to £900 per week with ongoing running costs of £5 to £10 / week / client

*(when compared with the weekly cost associated with residential care this represented significant savings).*

**Croydon Study**
The Department of Heath publication 'Use of Resources in Adult Social Care', published in October 2009 included a number of case studies. The Croydon study showed how closer working with the PCT could help reduce the number of admissions to residential care.

**Coventry Council**
A case study from Coventry Council evidenced a 2% reduction in their Learning Disability spend; this would equate to an approx £0.5 million saving to the London Borough of Hillingdon.

**The difficulties of providing exact cost figures**
Officers explained that while they understood the Committee required hard figures to evidence their recommendations, these were difficult to provide (and calculate). The WSD pilot included a control group without any Assistive Technology (AT) which would allow direct comparison with the corresponding AT group. Officers believed this to be the first such in depth study that would give hard evidence of the cost / benefits of AT. The Committee heard that after telecare installation and running costs had been taken into account, savings could be made after the equivalent of providing 2 weeks residential care.

**Health Benefits of Telecare**
To illustrate how costs might be saved officers highlighted how telecare had a considerable role in preventing avoidable hospital attendance and admission. Officers used the example of falls which the Committee was aware were a major cause of injury for older people that could lead to a loss of confidence and a progression towards decreasing levels of independence. Whilst it was acknolwledged that telecare could not stop this from happening, it could help to prevent it, e.g. as a result of a bed sensor triggering a light to come on if an older person gets out of bed at night. The Committee appreciated how savings might be made when officers explained that in this particular scenario, the estimated cost within an acute setting of addressing the needs of an older person with a hip fracture could be in excess of £10k.

**Service Options**
Officer explained that there were a range of options we could consider concerning the following aspects of the telecare service:

a. equipment purchase, installation, collection and maintenance
b. Careline monitoring service
c. mobile response service

**a) Equipment purchase, installation, collection and maintenance**
We heard that an alternative option available to the Council would be to join the telecare aspect of the community equipment framework agreement held with Medequip Assistive Technology Ltd following the collaborative commissioning exercise that took place in 2009. One of the reasons for the decision to bring this aspect of the telecare service in-house was that Careline provided the less expensive option. It was noted that if more councils joined the Medequip telecare service the increased bulk discount opportunities would reduce equipment costs. However, there would not be any changes to the installation, collection, maintenance and repair charges.

It was suggested that this was something that the Council would need to keep under review. However, there are other factors that would need to be taken into consideration, such as the potential loss of cohesion that spreading the different functions of the telecare service over more than one provider would have and also the technical difficulties that would arise with having different computer systems. Ensuring compatibility between the telecare technology and the Careline monitoring service would also be a factor that would influence any decision about future provision arrangements.

**b) Careline Monitoring Service**
The Committee heard that the current intention was to develop Careline as the Council's emergency out of hours service covering a range of needs including:

- *electronic call monitoring (ECMS)* - response service for those people identified as being at risk should they not receive a call from their domiciliary care agency. The Careline monitoring function for this service is expected to become operational from January 2011;

- *out of hours repairs* – Council tenants experiencing emergency repairs can contact Careline who have access to on-call repairs staff;

- *emergency heaters* – Careline would make available heaters out of hours to vulnerable people during the winter where they have experienced a heating system breakdown.

And the following options were under consideration:

- *Emergency Housing call out* – this would entail Careline contacting the duty emergency housing officer to assist anyone seeking to make an application under the homelessness legislation out of office hours

- *Duty Social Worker call out* – Careline would seek to contact the duty Social Worker out of hours where there was a resident potentially in need of adult social care, including a safeguarding issue out of hours.

- *Combining all of these functions together in a local service* run by people with local knowledge offers both service efficiencies and potential improvements in customer care through improved responsiveness. It also helps to safeguard the interests of vulnerable residents.

**Alternative Service Delivery options (to an in-house model)**
Officers explained that there were a number of options that the Committee could consider and these were:

***Tunstall call centre***
We heard that Tunstall was one of the main telecare equipment providers in the country and a subsidiary, Tunstall Response Ltd, ran a call centre based in Doncaster which had over 500,000 people linked to it. Officers suggested that the council could explore the option of Tunstall providing the call centre function. We heard that one of the key disadvantages of this option would be the loss of the cohesive approach to out of hours provision and the lack of local knowledge (which the Committee had already suggested was an important factor). For this option to be taken forward, the Committee were informed that installation, collection and maintenance arrangements would need to be in place as well as its own mobile response service.

***Market testing***
An alternative option which the Committee considered was whether the Careline monitoring service and the mobile response service could be market tested. Officers explained that there had been some interest in the possibility of this being developed as a West London Alliance initiative with a view to achieving efficiencies. With this option, the submission of a tender by Careline *could be successful in securing additional income for the council*. However, if Careline was unsuccessful a key potential disadvantage of this approach for Hillingdon would be the potential loss of the coherent approach to out of hours services although this could be mitigated to some extent through the content of the service specification.

***Sell services to other boroughs, housing associations and health economies***
A further option we considered focused on whether the Careline monitoring centre and the mobile response service could be sold to other councils and housing associations. It was noted that Careline already received £35k a year income from 6 housing associations operating in the borough but there was scope for the service to be promoted more rigorously.

***Social enterprise option***
Careline could also be established as a social enterprise. This would enable it to offer services to a wider range of customers and for any profits to be reinvested for the benefit of Hillingdon residents.

***Multi-disciplinary service***

By integrating health professionals with Careline staff, we heard that this could enable it to provide support for people with long-term conditions utilising telehealth equipment. This would need the support of GPs, although the Health White Paper proposals could make participation in such a venture attractive to the Hospital, especially considering the loss of income that they are likely to experience as a result of the 30 day readmission rule which comes into effect in April 2011.

**c) Mobile Response Service**

The scope of the mobile response service could be reduced so that it only operated from 7am to 10pm. This would reduce the operational cost by £42k; however, this was likely to have a detrimental effect on the confidence that residents, their families and professionals both in a health and adult social care environment would have on the effectiveness of telecare supporting vulnerable people to live in the community. As a result this could impact on the success of the drive to reduce the number of people living in institutional care.

Key points of the responses and the subsequent discussions included:

- Officers recognised that residents preferred to live in their own homes for as long as possible and were currently exploring a number of assistive technology options. No final decision had been taken and none of the possible options were set in stone.
- Members asked whether the current premises for Careline were large enough bearing in mind the number of additional services Careline might provide in future. Officers explained that they were currently looking at the appropriateness of the site and investigating a number of options including possibly co-locating the service to the Civic Centre.
- To meet the anticipated demand for the responder service, officers agreed that more staff would be required (especially if a re-ablement service was provided free of charge for 6 weeks after a hospital discharge).
- Members asked about the Tunstall call centre option. In response, officers suggested that a locally managed, local provider was their preferred option.
- Members asked about how the service might respond to confused callers (i.e those suffering from dementia). Officers explained that any service the Authority provided ought to be able to accommodate these types of calls and local knowledge of the client base was an essential part of being able to manage these enquiries as sensitively as possible. Officers agreed that these types of calls would need to be monitored on

a case by case basis but the service would need to be as responsive as possible.

- In response to a query about cost savings, Officers agreed that telecare could not replace personal contact and should be seen as a complementary service which was less intrusive (due to the ability of the user to self monitor and request services).
- With reference to cost savings, members agreed that periodic reviews of costs were required to ensure best value whoever the provider was.
- Members asked about which option offered the best long term security to ensure the continuity of the service. Officers explained that a combination of modelling and research would highlight the best way forward but that future income streams would not be restricted to those services provided to Adult Social Care clients only and providing services to other groups would provide a degree of stability.
- Officers explained that a built in evaluation process had an important role to play whereby positive feedback could be used to sustain the service and Hillingdon was in an advantageous position and could offer added value due to its housing stock.
- Members asked about whether a zero client contribution system could work. In response, officers explained that a universal offer was not affordable at least not in the short term and there would need to be an element of contribution. This, along with other charging options would be explored in more detail within the modelling being undertaken.
- With reference to the cost information provided the course of the review, officers explained that only one company had submitted a tender for the telecare service and these figures were set out in the report.
- From the evidence presented to the Committee, Members agreed that the best way forward lay in a comprehensive in-house model.

**Conclusions / Closing Word**

*To add.*