

Smart technology and community care for older people: innovation in West Lothian, Scotland



By

Alison Bowes and Gillian McColgan

With the assistance of David Bell



**UNIVERSITY OF
STIRLING**



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Foreword

Smart technology at home

Age Concern Scotland warmly welcomes this timely research by the University of Stirling into smart technology at home in West Lothian.

The housing with care innovations in West Lothian, a first in Scotland and the UK, have proposed a radical shift in community care of older people, including a range of smart technology, installed both into people's own homes and also into new homes, flats and cottages.

Smart technology at home is an immensely important step forward in supporting older people to continue to live in their own homes thereby maintaining autonomy and control over their daily lives. It promises increased security and safety for older people, and also enhances services given by support workers whose range of tasks are undertaken according to clients' assessed needs, such as help with housework, showers, personal care tasks and so on.

The research clearly shows how smart technology has been positively received by older people, how they have embraced its benefits and how it has transformed their lives.

Smart technology at home, with its emphasis on innovation, sustaining independent living and individual care planning, supports these key objectives.

It is radical. It is transforming our approach to community care. It has a future.



David Manion
Chief Executive
Age Concern Scotland

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Executive summary

Innovation in West Lothian

West Lothian's new approach to the care and support of older people at home uses telecare, integrating smart technology into a model of care emphasising choice, independence and capacity-building for older people and aiming to support them to remain in their own homes as long as possible. Smart technology is installed in people's own homes and in newly built housing with care complexes.

The initiative was introduced during a time of radical change in policies for the care and support of older people, and is a distinctive and radical response to the challenges of demographic change and service improvement.

The programme has been evaluated over more than three years by the University of Stirling. The evaluation has particularly emphasised the impact of the new model of care on people's quality of life.

Staff responses

- The new model of care caused staff to question their former ways of working, to focus on promoting independence for older people, and to provide 'support' rather than 'care';
- Staff worked in new teams, in which traditional professional boundaries were blurred, and there was more sharing of tasks formerly separate;
- The rewards of the new model of care for staff were significant, despite the challenges they experienced both from the

development of the new model of care and from the blurring of boundaries in the new staff teams;

- The large majority of staff were supportive of the new model and felt that it benefited the older people and improved their quality of life;
- Smart technology was integral to the new ways of working. It presented its own challenges, and one of its key impacts for staff was to catalyse the process of change in ways of supporting older people and working with other staff.

Smart technology at home

- A large group of respondents living at home, both older people and informal carers, reported the positive impact of the smart technology. It was widely seen as supporting safety and security both of the person and the home, and thus as helping people to stay in their own homes;
- Many respondents were reluctant to 'give in' to a need for help and support. This emphasis on independence supports the 'mainstreaming' strategy, and the focus on the equipment being for everyone. Mainstreaming can reduce any stigma that people may feel, by making the technology seem normal;
- Technology is one element of the support received by older people, who also receive support from families, neighbours, communities, formal and informal carers. Family relationships emerged as especially important for providing both general social support and specific care and were often taken for granted.

Housing with care with smart technology

- In housing with care, older people became tenants of new homes with smart technology already installed. Nearly all the tenants were very positive about their new homes, more so after an initial settling-in period;
- Over time, the new developments demonstrated that they delivered choice and independence for the individual, reassurance for informal carers and increasingly an 'ordinary life' for tenants within emerging communities which both built on existing family and community relationships and promoted new ones;
- Housing with care entailed a new model of care promoting independence and emphasising support and capacity-building. This was generally welcomed, but presented a challenge for those who sought a care home model.

Costs

- West Lothian performs very well compared with other Scottish local authorities in its care and support services for older people;
- West Lothian receives and spends a relatively small amount on these services, producing high quality support and care at low cost;
- It has been especially effective in dealing with delayed discharge;
- The new forms of care and support are central to this performance. They offer high quality combined with control of costs.

Conclusions and implications

Comparatively, West Lothian's approach to change is radical rather than step-wise, involving a strategic approach to the use of technology, greater independence, safety and security for clients and peace of mind for informal carers.

The key lessons from the West Lothian experience are:

- Smart technology is effective in a model of care promoting independence, choice and capacity-building and in supporting older people and informal carers;
- For staff, smart technology can be a catalyst in a cultural change regarding service delivery;
- A mainstreaming strategy can offer wider support, reduce the stigma of using services and facilitate additional support if needed;
- Costs can be controlled, ensuring effective use of limited budgets alongside improvements in services.

Chapter One: Introduction

1

Key points

- The West Lothian smart technology initiative was introduced during a time of radical change in policies for the care and support of older people, and is a distinctive response to the challenges of demographic change involving a new and radical approach;
- The new approach uses telecare, integrating smart technology into a model of care emphasising choice, independence and capacity-building for older people and aiming to support them to remain in their own homes as long as possible;
- A radical review of services for older people led West Lothian council to invest in smart technology installations in people's own homes, and the development of new housing with care complexes;
- The programme has been evaluated over more than three years by the University of Stirling. The evaluation has particularly emphasised the impact of the new model of care on people's quality of life.

Introduction

Strategies for providing care and support for older people in the UK have increasingly moved towards an emphasis on independence and choice. Pressures to improve the standards of care and support provided have increased at the same time. The proportion of older people in the population has been increasing, and will continue to do so for decades to come. For care providers, including local

authorities, these policy developments and demographic changes present challenges to find better ways of providing the care and support that people need, within budgetary constraints.

This report examines a radical response to these challenges developed by the local council in West Lothian, Scotland. West Lothian fundamentally reviewed its existing systems for the care and support of older people in the late 1990s-early 2000s, and set out to deliver a modernised model of care and support, using smart technology both within people's existing homes and in newly developed housing with care communities. The result was one of the most innovative schemes using smart technology to support and care for older people anywhere in the world. West Lothian is a key exemplar of the use of telecare, with experience offering valuable lessons for other care providers. As far as we know, no other authority yet approaches this level of innovation and implementation (Wanless 2006).

The University of Stirling was funded by the Health Foundation and the Nuffield Foundation to conduct a three year evaluation of the smart technology programmes. As such, this is the first comprehensive evaluation of a telecare system of this extent (Croucher 2006), and contributes to the real dearth of information about the implementation and effectiveness of telecare (see Poole's 2006 call for evidence). In our report, we focus on the development and impact of the new model of care, with particular emphasis on the experiences of a range of stakeholders, including the Council itself, staff involved in delivering the model of care and the older people themselves and their informal carers who used the service.

This chapter introduces the evaluation report by considering the policy context in which the West Lothian innovations took place, exploring the use of new technology in telecare systems, outlining West Lothian's approach and the development of the programme of innovation and explaining how the evaluation was undertaken.

The policy context – care at home

Since the late 1990s, the Scottish Office (until 1999) and the Scottish Executive (after devolution) has shared with the UK government a commitment to supporting older people to stay in their own homes, receiving any care they may need without moving to hospital or care home settings unless this is absolutely necessary. Along with this commitment, there has been an emphasis on service improvement, particularly through enhanced flexibility – and thus potential to expand choice – and joint working between health, housing and social care services. Whilst the research record has been somewhat critical of some rather slow progress with these aims (e.g. Manthorpe 2004), there is clear evidence that, in Scotland, the balance of care has shifted significantly towards increased provision of care at home (Bell et al 2006). West Lothian's services have increasingly focused on care at home, and the innovative systems have been specifically designed to support this.

One element in joint working has been the development of single shared assessment, whereby instead of experiencing repeated assessment of their needs for care and support as different professionals became involved as was formerly the case, older people would receive one, comprehensive assessment, which would be used by all the professionals involved in their case. Implementation of single shared assessment has been rather slow and patchy in Scotland generally, though the approach was in use in West Lothian from November 2004. The use of single shared assessment reinforces the importance of professionals working together, and the need for effective multi-disciplinary teams.

Joint working between agencies in Scotland involved particularly health and social care services, and is known as 'integrated care' (Petch 2003) This is often contrasted with the approach in England which produced a separate category of 'intermediate care' where health and social services were jointly responsible for looking after older people with care needs. The Scottish approach has been argued to avoid 'artificial' boundaries between health and social

care. In West Lothian, as the boundaries of the local authority and the Health Board were coterminous, bureaucratic obstacles to developing joint working were perhaps fewer than elsewhere.

As part of the policy imperative to improve service quality, the Scottish Commission for the Regulation of Care monitors and inspects care services against twenty one sets of National Care Standards. These include standards for care at home, care homes for older people, housing support services and support services (including e.g. day centre services), all of which are relevant to services for older people. The 'Care Commission', as it is commonly known, is also required to provide information and advice about services and to deal with complaints. The Commission thus acts as a 'watchdog' for services, and sets standards with which providers must comply. In particular, the standards for care homes have provided impetus in many areas for reviews of care home provision. In West Lothian, several of the council's own care homes were found in the 1990s to present problems in meeting the new standards, thus supporting the need for a review of care provision.

Alongside these developments, older people's services have also been affected by the 'Supporting People' initiative, a UK-wide development implemented in Scotland by the Scottish Executive. Supporting People provides funding for people affected by, amongst other things 'ageing or infirmity' to help them remain in their own homes, rather than move to residential care settings. It can also be received by people in 'supported accommodation', such as sheltered housing. Supporting People might be seen as part of a more general move towards considering housing based support and care services, which are gaining in popularity and attracting increasing research attention (cf Bernard et al 2004, Croucher 2006, Valley et al 2006). The focus on housing is reflected in West Lothian's innovations. Furthermore, in West Lothian, 'Supporting People' forms a revenue funding stream for many clients needing housing support.

The charging regime for care and support in older age is distinctive in Scotland, due to the policy of free personal and nursing care, which was introduced following the Scottish Executive's (2000a) response to the Royal Commission on long term care for older people. This policy was not implemented in the rest of the UK. In Scotland, funding to support free personal care is administered by local authorities, which receive a fixed budget to cover the costs, based on calculations of local levels of need according to a Scottish Executive formula¹. In care homes, nursing and personal care are paid for at a standard rate, which has not changed since the introduction of the policy in 2002². In the community, there is no specified funding limit. At the time of implementation in 2002, additional funding was made available to facilitate the process – this was not ring-fenced. Whilst older people in Scotland who are assessed as needing personal care do not pay for it, they continue to contribute on a means-tested basis to the costs of other support, including non-personal care at home and 'hotel' charges in care homes. In West Lothian, the Council had already taken a policy decision to provide free personal care ahead of implementation elsewhere – this obviated some of the financial difficulties that other councils faced following implementation (Bell and Bowes 2006).

One consequence for clients of the introduction of free personal care must be noted – care home residents were no longer allowed to receive Attendance Allowance, a non-means tested benefit from the UK Department of Work and Pensions, which is intended to give support with personal care needs due to disability. In Scotland, older people in residential care do not receive this benefit, as the local authority, through the policy of free personal care, is contributing to the costs of their care. Older people receiving care at home however, continue to be eligible for this benefit, which thus supports the policy emphasis on care at home.

¹ The Grant Aided Expenditure (GAE) formula

² From the introduction of the policy in 2002 to 2006, the rates in care homes are £65 for nursing care and £145 for personal care per week. For care at home, there are no specified limits.

Service development and evaluation increasingly involve consultation with service users. Scottish policy on service improvement has user consultation as a central element. Manthorpe and Watson (2004 – citing Crawford et al 2002) argue that user involvement can have a significantly positive impact on both design and delivery of services. In the case of services for older people, the client population also involves informal carers, though there is a recognised need in recent research to ensure that older people speak for themselves, and that the potential for differences of view between informal carers and those for whom they care must be recognised. Increasingly too, there is recognition that the experiences of front line workers need to be understood (Innes, MacPherson and McCabe 2006), as they make a vital difference to the delivery of services. In our evaluation, all these stakeholders are considered.

In common with other Scottish local authorities therefore, West Lothian has been working in a climate of significant change. Changes had the potential to increase the calls on local authority budgets, to raise clients' expectations, and to demand continuing improvements in services, as well as responses to demographic change. The new approach to care and support aimed to address all these potential issues, and, particularly, to deploy limited resources in the most effective way possible, permitting investment in new areas.

Telecare for older people

In recent years, new electronic technologies capable of supporting older people have enjoyed increasing attention, as they have become more sophisticated and their potential has increased. These technologies include both telecare systems and stand-alone electronic devices. Big claims have been made for them. For example, announcing an £80 million 'Preventative Technology Grant' for local authorities in England, the Department of Health (2005) suggested that telecare might support more older people to remain at home, cut hospital admissions and improve quality of life for

informal carers as well as older people themselves. For government, it could address problems of a diminishing workforce and increased demand for services and also reduce costs. These are indeed radical claims. Yet the evidence base for them remains limited, and evaluations tend to relate to small-scale implementations only (Poole 2006).

Alongside the undoubted beneficial impact of new technologies, some commentators highlight potential problems. These include the potential for telecare to promote medical models of ageing, detracting from recent headway made in promoting socially inclusive models (Fisk 2001:120); the tendency for a focus on risk resulting in new technology becoming a new form of restraint, for example watching a person with dementia for 'risky' behaviour which then precipitates residential care, as they are labelled 'personifications of risk' (Manthorpe 2004:148); and emphasis on surveillance, including electronic monitoring or tagging, potentially carried out without full consent (Fisk 2003:238).

Technological developments over recent years have been rapid, and there is an increasing market for electronic devices which can be used as part of care regimes – their use is commonly referred to as 'telecare'. Telecare is related to 'telemedicine', and the two may be used together. Whilst there is some debate in the literature regarding precise definitions of both (e.g. May 2005), we use the term 'telecare' to refer to electronic systems and/or devices used to support social care. Some devices may be used in people's homes or in care settings as 'stand-alone' items. Examples of these would be electronic clock calendars, which support people with time-orientation difficulties, or devices which can help people manage medication, supporting them to take the correct doses of their medicines at the right times. There is some evidence that such devices can be beneficial for clients as well as service providers (e.g. Woolham 2006).

Other devices are used in connection with a system of alarms

connected to a home alert console, with calls usually routed through a call centre. These devices include items such as smoke alarms, heat sensors, and fall detectors along with movement or lifestyle monitors, such as MIDAS (Modular Intelligent Domiciliary Alarm System – Doughty et al 1999, Fisk 2001). On receiving a call from such a device, a call centre operator uses a protocol normally tailored to the individual to call on an appropriate response to the information received. These ‘smart’ systems – so-called because they can communicate with one another - can also include assistive devices such as door entry systems, window openers and closers, light operators and so on, all of which can be controlled remotely. Many of the devices can operate passively, in that they do not require action by a user to raise an alarm or to carry out an action, such as closing curtains when darkness falls. Others require action by the user, such as pressing a button on a pendant or bracelet to call for assistance. The West Lothian approach uses a telecare system of this type.

By themselves, the devices may be seen as neutral, in that they have potential to be used in a variety of ways, positive or not. However, like all technological innovations, they cannot be considered as ‘purely’ technical, in that they occur within a social context and are stimulated by issues perceived within that context. Baldwin (2006) eloquently argues that all technological devices reflect values, as, for example, precise clocks reflect a value attached to knowing and working by precise times. The values underpinning the West Lothian use of these technologies are considered here in detail, emphasising the importance of understanding technology use within the particular system of care and support concerned.

Much of the evidence about telecare comes from evaluations attached to the development of new technological devices and from mainly small-scale use of these devices in real care situations (for a review see Bowes 2006). The West Lothian case is an important addition to this evidence base, as it is a mainstream approach,

central to the whole model of care and support for older people across an entire local authority, and has been systematically evaluated over a long period of time.

New services in West Lothian

West Lothian faced particular challenges in the late 1990s. The numbers of older people were identified to be increasing especially quickly. Formerly, the local population had been younger, due to the new town development, alongside lower life expectancy resulting from manual occupations. Population ageing of people who had moved to the new town as incomers, and improved health of older people as old industries declined both served to change local demography significantly. Policy dictated a change in the balance of care towards care at home and local care homes were in general old-fashioned and perceived as unlikely to meet the new standards, without extremely costly redevelopment.

A radical rethink of services for older people was needed. The outcome was a decision to develop a new model of care and support which would promote independence and capacity-building and emphasise care at home. The level of care home provision in the area would be significantly reduced. The new approach would use smart technology to its fullest possible potential to support these changes. The programme was given the name 'Opening Doors for Older People' (ODOP).

West Lothian Council's new approach uses smart technology in people's own homes as well as in newly built housing developments specifically designed to deliver a new and innovative model of Housing with Care. Technological innovation, a new approach to housing for older people and new models of care which implement the 'Joint Future' Agenda (Scottish Executive 2000b) are all integral to this approach. In the early phases of the programme, smart technology was available to people with high support needs, but the vision from the start was to make it much more widely available. A key element of the approach was to increase choice for older

people and to move away from the continuum of care whereby, as their needs increased, people would make repeated moves into increasingly intensive care settings. Instead, the approach was to plan the care to be delivered to meet needs where people chose to live, drawing on concepts such as that of the 'lifetime home' (Joseph Rowntree Foundation 1997) and supporting local community living (Godfrey, Townsend and Denby 2004).

The objective of the 'Opening Doors for Older People' initiative was stated by West Lothian Council as:

To provide an innovative form of housing for older people with support needs that will sustain independent living through effective physical design, focused individual care planning and the efficient use of new technologies.

The emphasis from the start on a housing baseline is notable (cf Croucher 2006). ODOP operated within the wider context of a council which was committed to modernisation using new technologies. Operating under the banner of 'Wired West Lothian', the council was involved in the development of a community-portal, giving access to world-wide-web based services. All council services were linked into the electronic network, and people seeking information and service support could gain ready access to them all, either for themselves, or through professionals such as GPs. The objectives of 'Wired West Lothian' included more customer-driven services, easier, 'joined-up' access to services, and the release of resources to invest in service improvements as service access was made more efficient.

The ODOP initiative involved a fundamental shift in the provision of housing and care for older people, with radical movement of investment from residential care homes to people's own homes. Two key developments took place, firstly investment in new accommodation and secondly, and much more extensively, the re-development of services delivered in people's own homes. Care homes also shifted in focus, to accommodate the more frail older people.

Four of the six council-owned residential homes were closed down, as they did not meet new standards and the costs of modernising them would have been considerable. They were replaced by newly built housing with smart technology. By April 2004, four of these new 'Housing with Care' developments had been completed. One of these was occupied in September 2002. The second was completed in May 2003 and the third completed in February 2004. Through joint funding agreed by West Lothian Council and West Lothian NHS Healthcare Trust, a fourth new-build Housing with Care development was completed in April 2004. The Housing with Care complexes were designed to accommodate people with relatively high support needs who could no longer be supported at home. People who lived there were tenants, and therefore continued to have their own homes.

The larger part of the programme involved modifying older people's existing homes by the introduction of smart technology tailored to their particular needs. This was accomplished in three phases:

- During Phase One, as part of the Opening Doors for Older People initiative, Tunstall Telecom Ltd and West Lothian Council entered into a partnership agreement in 1999 to take forward the development of smart technology in the home. Packages of technology were installed into approximately 75 service users' homes. This pilot stage of the work was evaluated by Gillies (2001) and Bowes and McColgan (2002).
- The second phase involved a tendering exercise undertaken in May 2002 which confirmed Tunstall Telecom Ltd as the providers of smart technology in a project which enabled the Council to upgrade its Community Care Alarm Service to the new 'Home Safety Service' by February 2003. This was completed in March 2003 with 1200 households receiving the Home Safety Service. The Home Safety Service was much more advanced than traditional community alarm services. It provided a core package of basic home safety and security.

Alerts from the detectors were transmitted to a 24 hour monitoring call centre where operators were able to identify the service user, what alert had been triggered and the location of the alert. Operators at the call centre used individually tailored protocols to determine the appropriate response to the alert. This might be to call a relative, emergency services or the Health and Care Team (a multidisciplinary team of care and support workers). The basic package could be augmented with additional technology assessed as being required by the Council's Health and Care Team.

- In phase three, the Council aimed to roll out the Home Safety Service to all people aged 60 or over and other vulnerable people living in West Lothian, with the contract being awarded to Tunstall Telecom Ltd. The extension to the service was officially launched in December 2003, marketed across West Lothian and its success was highly dependent on a successful marketing strategy. At the time of writing (May 2006) the Council has approximately 2150³ Home Safety Service users. The idea behind this extensive rollout was to ensure that, as far as possible, every older person's household had smart technology installed, so that if people developed needs for care and support, these could be easily delivered, built on a familiar service platform. Smart technology was to become a taken-for-granted part of people's homes. Later in the report, we refer to this as the 'mainstreaming' strategy.

West Lothian Council itself has stated

'The proposal to replace residential homes with care based in people's individual houses and smart technology is probably one of the most advanced projects in Europe. It will be pioneering new approaches and new systems in patterns of human service delivery combined with the development and integration of technological services. The partners to the project are all

³The total number of packages that has been installed is higher, as there is turnover of about 17 people each month for a range of reasons e.g. clients who have died or moved into a care home.

*committed to evaluating the result of this programme, so that it can assist similar technical developments throughout Scotland*⁴.

Table 1.1 below outlines the various capital resources which funded the three phases of the project. Through a Scottish Executive New Partnership Grant awarded for the Opening Doors for Older People Project, approximately £200,000 was allocated for Phase 1. Further funding of £700,000 was obtained from the Council's capital budget to upgrade and transfer the Community Care Alarm Service to the Home Safety Service. Phase 3 drew on further Scottish Executive funding (Modernising Grant Fund second round), with further monies from West Lothian Council and the local Healthcare Trust. It is important to note that much of this money would have been spent on maintaining or upgrading existing services anyway – the Opening Doors initiative redirected it to the new systems and supported implementation of the new approach. The new model of care therefore used existing resources to a significant extent.

Table 1.1 Funding

| Project Phase | Funding Source | Amount |
|---|--|------------|
| Phase 1 – Pilot of 75 Households | Scottish Executive NHP | £200,000 |
| Phase 2 - transfer of Community Alarm Service | West Lothian Council | £700,000 |
| Phase 3- Roll out of the Home Safety Service | Modernising Grant Fund 2 | £768,750 |
| | West Lothian Council West Lothian (NHS) Healthcare Trust | £392,166 |
| | | £68,000 |
| | TOTAL | £1,228,916 |

Revenue costs for the Home Safety Service are met predominantly from Supporting People Grant funding. This funding source would also have been used to maintain any continuation of a traditional community alarm service in West Lothian, should the change in approach not have taken place.

⁴West Lothian Council (1998) Opening Doors for Older People (submission for funding of a new housing partnership initiative)

Preliminary costs analysis soon suggested that significant cost benefits could be achieved from the new services, when compared to the cost of an institutional care place. Thus:

- the cost of a care home place in West Lothian (February 2005) was calculated by the Council to be £21,840 per annum;
- a Housing with Care tenancy cost £16,400, including a technology package, personal care and housing support; and support in the community, including a technology package and ten hours of care, cost £7,121⁵.

Smart technology at home

Whether they have tenancies in the new Housing with Care developments, or continue to live in their own homes in the community, older people with these support services in West Lothian all have the basic package of technology⁶. This consists of

- A home alert console, which links sensors to the call centre when they are triggered;
- Two passive infra-red (PIR) detectors to monitor activity and potential intruders;
- Two flood detectors, activated by leaking pipes, overflowing baths etc;
- One heat extreme sensor, sensitive to both high and low temperatures;
- One smoke detector.

All the devices are wireless. The home alert console simply plugs into a conventional telephone socket, so the packages can be installed with minimum disruption.

People with care and support needs receive the package following a community care assessment, which looks at their individual needs. In many cases, the basic package is augmented by additional

⁵All these costs are gross costs.

⁶The full range of technology used is listed in Appendix One.

technological devices. These can include further passive alarms, such as a device alerting that the front door has been opened at night or a fall detector, or active devices such as a pendant alarm requiring the user to press a button. Video door entry systems, which show a picture of a caller on the television and allow the front door to be opened remotely, are also added in many cases. There is also scope to add assistive devices such as window openers, bed occupancy monitors, and many others. Furthermore, the system can be connected with lifestyle monitoring systems such as MIDAS (Modular Intelligent Domiciliary Alarm System – Doughty et al 1999, Fisk 2001), which was used in a limited way in the housing with care developments, and health monitoring equipment.

The home alert console is connected to the specialist Call Centre. Operators who receive training in working with older people, including instruction in the principles behind the new model of care, respond to calls according to an individual protocol for each person. The protocol identifies action to be taken in response to calls. Usually, the first step is to ring the older person themselves and check what has happened, if anything. Then, the protocol lists what help should be summoned in each eventuality.

In addition to the technology package, clients may receive hours of formal support and care according to their individually assessed needs. They also have other assistive devices if they need them. Many also have informal carers who make a vital contribution. Thus, whilst the technology supports clients, it is not the only source of support they have. However, some households which have received the technology as part of the mainstreaming rollout to the general older population may only have the technology and no other formal support.

These mainstream households applied to receive the technology following a marketing strategy, which involved advertising in local papers, road-shows in shopping centres, a radio advertising campaign, leaflets and posters circulated to local social work,

housing and council customer information offices, GP surgeries, libraries and so on.

The introduction of the smart technology programme also involved the development of new staff teams, which brought together staff from a range of backgrounds. The new teams were responsible for delivering the new model of care, as well as being involved in implementing the technology itself. The Health and Care team was especially significant – this team delivered the service out in the community, not only providing support for older people, but also installing and maintaining the technology itself.

The research study

The evaluation lasted more than three years (2001-2005). The evaluation team was independent of West Lothian Council, and funding for the work was also independent, coming from the Nuffield Foundation and the Health Foundation. As the evaluation proceeded, the team produced a series of interim reports (Bowes and McColgan 2002, 2003, 2005), which were used by the Council to support the further development of the programme (Kelly 2005). Additionally, the findings of the research were presented at conferences for researchers and professionals by the research team and by Council representatives, to offer lessons to others interested in implementing telecare.

The overall aims of the evaluation were as follows:

- To monitor development of West Lothian Council's 'Opening Doors for Older People' (ODOP) initiative longitudinally, by exploring the experiences and views of stakeholders, older people themselves, carers, care staff, professionals and care planners;
- To examine the implications of the project for the quality of life of older people, especially in terms of maintaining them at home;
- To explore the value for money offered by the project for the user, the local authority and government;

- To compare the care provided and the requirements of service users with those in other forms of care and other forms of supported housing provision;
- To consider the implications of the initiative for all stakeholders;
- To identify best practice for dissemination nationally, whilst also producing early feedback to inform the development of the ODOP project.

To investigate these questions, the following tasks were carried out:

- Interviews with older people receiving the services. These included
 - 44 people who had smart technology packages installed in their own homes, both following comprehensive community care assessments and as part of the roll out of the Home Safety Service.
 - 29 people who moved into two of the new housing with care complexes.
- A questionnaire for people receiving the Home Safety Service. This received 89 responses.
- Interviews with 11 informal carers.
- Interviews with 79 staff from a range of disciplines, including
 - Managerial staff
 - Members of the new Health and Care team
 - Call centre staff
 - Medical personnel including geriatricians, GPs, community nursing staff
 - Social workers
 - Housing staff at managerial and front line levels
 - Occupational therapists

All these staff were involved, directly or indirectly, in delivering the new model of care.

- A study in a comparator local authority, which included
 - Comparison of local statistics on demography and care and support services for older people

- Comparison of a sample of individuals receiving care and support over time
 - A small interview study, to provide qualitative comparisons between the new model in West Lothian and a more traditional approach. This element included 9 staff, 7 clients and 6 informal carers.
- A value for money study, exploring the costs of providing care and support for older people in West Lothian, and comparing these with other Scottish local authorities.

The report

We begin in Chapter Two by exploring the views and experiences of staff involved in delivering the new service, examining the challenges and rewards it presented for them and the impact of smart technology in their working lives. Chapter Three looks at the experiences and views of people who received smart technology installations in their own homes, concentrating on a holistic view of their quality of life and the role of smart technology in enhancing this. Chapter Four then turns to people who had moved to the new housing with care developments, and considers the communities in these complexes, supported by the smart technology in the new model of care. Chapter Five compares West Lothian statistically with Scotland and other local authorities. We explore aspects of the costs of delivering care and support by considering a sample of people in receipt of care packages including smart technology. In conclusion (Chapter Six) we discuss some of the wider lessons of the West Lothian experience for the use of smart technology in the care and support of older people elsewhere.

Chapter Two:

Delivering support with smart technology – staff perspectives

2

Key points

- The new model of care developed in West Lothian caused staff to question their former ways of working, to focus on promoting independence for older people, and to provide ‘support’ rather than ‘care’;
- Staff worked in new teams, in which traditional professional boundaries were blurred, and there was more sharing of tasks formerly separate;
- The rewards of the new model of care for staff were significant, despite the challenges they experienced both from the development of the new model of care and from the blurring of boundaries in the new staff teams;
- The large majority of staff were supportive of the new model and felt that it benefited the older people and improved their quality of life;
- Smart technology was integral to the new ways of working. It presented its own challenges, and one of its key impacts for staff was to catalyse the process of change in ways of supporting older people and working with other staff.

Introduction

A total of 79 staff, from a wide range of backgrounds, were interviewed. They included senior management of the programme, front line staff involved in delivering care and support in people's homes and in the new developments as well as installing the smart technology, team leaders, call centre staff, social workers, community nurses, doctors both hospital and community based, housing staff, occupational therapists and technicians. This wide range emphasises how far-reaching the programme was – all these staff groups were involved in delivering the new model of care, and their work was affected by it in some way. They varied in their degree of involvement in the programme, with some spending all of their time delivering it, and others involved in assessments or referrals or a small aspect of people's care programmes. Many had found their working lives fundamentally changed by the programme, as we will show, with others experiencing challenges to existing ways of working. Twenty four staff were interviewed twice, with intervals of several months between interviews. This allowed us to explore the development of the programme over time from the staff's points of view.

Changing cultures and the new model of care

Early staff interviews took place at a time of rapid change, during the pilot project and the early stages of the rollout of the mainstream service in the community. It was clear that staff were becoming involved in working in new ways and new teams, and that there was evidence of culture change on a wide front as the new model of care evolved. Staff who were involved in the earliest stages had a strong sense of being pioneers in something really new, and communicated a sense of 'ownership' of the initiative. For example, when the first new development was about to open, the team expressed their excitement:

““ *This really is exciting, because you are promoting this living independently.*

““ *I am just keen for it all to happen now – it is quite exciting.*

““ *They [the staff team] are just all so excited and enthused about it, it's wonderful.*

Staff were asked to comment on their day to day work and the rewards they experienced. Overwhelmingly, they expressed their enjoyment of working with people and making a difference to their lives.

““ *I love being out with people in their own homes. I've always had a deep feeling, even before I trained, that people should be able to remain in their own homes and have some independence.*

““ *I really enjoy working with older people. I find it challenging working in the multi-disciplinary environment and I do enjoy that as well. When there are other views it can make you question your own values and it usually strengthens them.*

They spoke of having learned much as the programme was rolled out

““ *Despite feeling under pressure, I do like the buzz. Our manager is a fairly radical thinking manager so there's always change. Newness. Never boring.*

The profound changes brought about by the programme were highlighted, alongside some issues about bringing staff fully on board:

““ *You bring different people in with different levels of knowledge. Different perspectives of how the project operates. I find it personally difficult when people close their minds to it. Money hasn't been an issue on the smart technology side,*

but staffing probably has that we've had very few people being pulled in all directions. But then if there had been more people it wouldn't have been as easy to move it over to mainstream.

Some of the front line staff had been unsure about how to conduct their work in the early months, and described being unclear about where to go for help, who was supervising them, who was responsible for making decisions – however, these issues appear to have been quickly resolved.

It was clear as the programme rolled out that there had been a general cultural change in the ways in which staff expected to work with older people. Some of this was related to the introduction of smart technology, which could be seen as a catalyst for wider change, but it was also related to more general changes in community care policy and practice, with, for example, increasing emphasis on care in the community, and on supporting older people to remain independent and to stay in their own homes. When staff were asked about the main changes they had seen in their work over the years, by far the most frequent comments related to clients' independence. This emphasises that the new programme was developed in the context of a wider shift in approach, as we identified in Chapter One.

““*[There is an] emphasis on partnerships with clients, them taking a lead role and their choice and rights. People are much more aware of what their rights are than 15 years ago.*

Contrasts were frequently drawn with traditional residential care regimes:

““*It's worlds apart from residential care. In the community I deal with people on an individual to individual basis and that has widened the services I come into contact with. Clients are in the comfort of their own home - they don't lose their contacts and identity in the same way as in residential care.*

““*[In residential care] you actually took people’s independence away from them. Whenever they came into residential, you were inclined to start doing everything for them.*

The same staff member highlighted a change which had occurred with the new model, as implemented in housing with care:

““*Through capacity-building and encouragement from staff, we gave a lot of these people back their independence that we had taken from them when they had gone into residential care. It was absolutely fantastic watching them gain that independence again and it was just wonderful watching them being able to do something that you thought that they could not do and it was all our fault because they still could do what we had taken away from them.*

Another added

““*That is where this job is different, you don’t take over. You help and you get them to do it themselves. There is a difference, there’s quite a huge difference.....It was always your instinct to do for people, but now you have to stand back and say I will help you if you can’t do it but if you can do it I am going to let you do it. The more you can do for yourself the better. I can now see that really works.*

This staff member explicitly highlighted a culture change from residential care to housing with care:

““*[It’s] lots to do with the culture of the place you’re working in. It is like - you must have the beds done by this time and must have it done by that time..... I have worked in places where it is a calamity if somebody is not up for half past eight in the morning, so I feel that this is a way forward to enable people. These elderly people are people who have contributed probably 50-60 years in their life to work. They are not children, they are*

individuals. They deserve to be treated like that. It has always been my philosophy to treat people like I want to be treated myself.

She explained that she had been delighted to get the new job, and that the new approach to supporting older people had been a specific attraction.

At a more senior level, a team leader identified a structural change in services which now had to respond to higher expectations:

“*I think that they have for older people a greater range of services to access, and increasingly higher expectations both of ourselves and from the public, in terms of the services to be delivered. So the services have had to be restructured so radically in order to meet the aspirations of the change in the balance of care from institution to the community.*

She went on to draw a comparison with a case in former years of an older person who had moved to residential care simply because there was no provision to prepare evening meals for people living in the community – in her view, that was not an adequate or sensible reason to move.

In speaking about the aims of the programme, most of the staff were aware of what these were, and their answers focused on the model of care as a whole, rather than singling out the smart technology. This was especially so in later interviews, perhaps when the novelty of the introduction of the smart technology had worn off a little. They emphasised the policy imperative of promoting independence for older people, and continued to draw the perceived contrasts between residential care and both care at home and housing with care.

Housing with care was highlighted as a new approach, which altered the way care and support work were done and involved new ways of

working and thinking. For example, the stress on capacity-building and the status of older people as tenants (rather than ‘residents’ as in a care home setting) were significant.

“GM⁷: *Does the housing with care model make any difference to the way staff work and what they do as part of their job?*

R: *I think it does. Rather than doing something for a tenant then you would stand back and think ‘can that tenant actually do this?’ or ‘do they need assistance to do it?’ or ‘do I need to do it for them?’ I think it makes you think, evaluate each activity and what they can do.*

““*You can’t just go and invade them, you know. I mean I wouldn’t like it - somebody just walking in and sitting themselves down. I think we have to give them their space.*

At the level of assessment, there were indications that new thinking was influencing the process, and that the new model of care was influencing the suggested solutions for people’s support needs:

““*I think what we have been trying to achieve is an assessment model which emphasises abilities and strengths as well as needs. I won’t say necessarily that we’ve got there 100 per cent, but that’s what we’re trying to achieve. I think practice has changed. Both in terms of the Housing with Care and in terms of the potential of technology to support people with independence in their own homes. People are thinking more creatively about how somebody might be supported at home. Or move into a different tenancy, a more independent tenancy.*

For clients, staff emphasised that housing with care was positive

““*It sees the person as an individual. Not as another person with dementia, or another person with a disability. It’s person-*

⁷ GM is always the interviewer, R denotes a respondent.

centred, it focuses on the person and really builds on their strengths. I think that's excellent. I've been really impressed with that.

“*I think it does make a difference because they can open up, they can open up to you and they've still got their own, they're in control themselves because it's their own house. It's their tenancy - if they don't want us in they don't need to let us in, we've got to abide by that.*”

As well as culture changes for staff, there was also evidence that clients' cultures were challenged by the new approach. Staff reported that they had supported this process. For example, some clients were not completely clear about the nature of the new service, especially housing with care. Discussing their work with tenants, these staff members noted

“*We are finding some of the tenants that are coming into the complex are a wee bit unsure of what the level of service is they're getting so we're getting a wee bit where they're wanting a lot more done and we're having to explain what type of service it is and what we're expecting of them.*”

“*It works quite well with most people. Some people are still quite set in their ways and when they see a uniform, they see a carer and they think that you are there just to come in and do everything. That is sometimes quite difficult to get through, depending on the type of person that you are working with.*”

There were differences in the support for the model among the various groups of staff. The front line staff were nearly all positive about it.

“*The list is endless with the differences. They have their own house, they have their own front door so at the end of the day they can ask you not to come to their house...they can pick and*

choose what people they want to work with - if there's a member of staff they're not happy with keeping on then that's fair enough. it promotes the choice and independence

Again, the contrast with residential care was made, as the staff member spoke of

“.....being put in a nursing home, in a box basically, and shut in there at nearly eight o'clock at night....they just get them up in the morning and things like that.....It's obviously a production line and it's awful, and the choice and stuff [in the new model] really makes a difference.

A further front-line respondent emphasised the importance of choice:

“I would like to think that it would make a big difference in terms of supporting people at home and moving us out of the mindset of moving people kind of in a kind of stepladder approach until they're in some sort of institutional care. I would like to see it preventing that happening because I don't think that is always the right answer for people. I think that if clients want to stay at home, facilitating that for them is a huge bonus and will improve the quality of their life and also reducing disruption to it.

This group also identified benefits for informal carers:

“Well I think it's going to take a big load off their minds, I think if a son or daughter or some relative or even just a friend had been looking after the person then they are going to benefit from a lot more free time, a lot more nights where they can sleep without worrying.

“You will of course get the odd person who is quite happy for their family to be running themselves ragged and they would still want them to do that, but the biggest majority of people are quite happy that their families can enjoy their own lives.

Among social workers however, there was some criticism of the model, and some appeared to struggle with understanding it. For example, this social worker questioned the continuing role for informal carers:

“ Well it does make a huge difference, because clients’ informal carers are still part of the care package in these units.... The families still have to do laundry and cleaning and so on. So they’re still quite involved. Not able to detach. They’re still having to be involved and that’s them. For some that’s fine, but for others it’s not really that appropriate.

So did this one, who had believed that housing with care was to be similar to a residential care model:

“ I think it’s very difficult for them to know what to expect. We’ve been misleading them because we thought we knew what to expect. And they’ve gone in there and not got it. I had a client who moved in and I got a little letter from the extra care housing people to say did I realise they wouldn’t be doing their laundry, and I was to tell the daughter to do it. The reason I placed the woman there was that the daughter had far too much to do. I was putting in help with laundry where she was. Why would I move her somewhere where there was less help? I made things worse for them. Not better. She’s got to travel to see her mum. When she was living with her mum before. And then when she gets there she’s got to do the laundry. That’s ridiculous.

Similar issues were reflected by management staff at the development when discussing some of those who had been referred to housing with care, who perceived where these misunderstandings were:

“ I think clearly, people referring them had higher expectations and probably expected more out of the tenants and staff, not

just the staff but also the tenant's ability. And perhaps the true information was not presented to us in terms of their care and support needs, you know. We've had a couple of examples of people who have needed a lot of toileting support which wasn't highlighted in the community care assessment or whose dementia is more progressed than had been indicated or... various things which you think, this hasn't just happened in two months – and whether or not that was a deliberate mistake or an error, we don't know.

Work practices and relationships

From the start, the programme aimed to establish new working practices and relationships, with more staff involved in a wider range of tasks, and a reduction in disciplinary boundaries. This process continued as the programme developed. At first, a special team of workers was recruited to take the smart technology initiative forward. They had a dedicated manager, and were closely involved in the consultations around the development and rollout of the programme. As the programme developed, more and more staff were recruited or transferred from other areas– notably residential care – to contribute to the new work.

With the focus on fresh recruitment and new ways of looking at the delivery of care and support, job descriptions moved increasingly away from traditional, disciplinary based ones towards a more generic focus, especially at the front line level. At this level, former nurses, care workers, housing staff, and occupational therapists found themselves sharing tasks and learning new ones. For example, those who became 'housing support workers' based in the new developments explained that their work was focused on maintaining people's independence, listing tasks such as personal care, assistance with housework, providing advice and support, and helping people make medical and other appointments. Front line staff who did most of their work out in the local communities, indicated tasks including assessments for smart technology and installations of smart technology, providing personal care,

rehabilitation, and Rapid Response work, supporting people recently discharged from hospital. Each of these teams was managed by staff with similarly inclusive remits.

The Call Centre staff were, from the start, a key element in the whole programme. They had a specialist remit to deal with clients receiving care and support both within the community and in the new housing with care developments, and received training specifically for these tasks. Each client had an individually assessed response protocol, which Call Centre staff followed when an alarm was raised or a call was made. The first step in response was normally a call to the client concerned to check how they were and what the problem was. The protocols then indicated where any further help should be sought, whether from an informal carer, a doctor, the care staff team, the emergency services and so on. The Call Centre staff were also responsible for monitoring that the equipment was working properly, and that clients made their regular checking-in calls. The call centre facility was initially run by a housing association, contracted by the Council, but later on, the Council brought the services into its own call centre. Statistics were kept from an early stage on the volume of calls and the response times – these demonstrated significant success, with 92 percent of calls answered within thirty seconds during 2003⁸.

The Call Centre staff were particularly enthusiastic about the new way of working. They described cases in which they had had a key role in reassuring clients who, for example, were awaiting help following a fall – ‘you really have to be on the ball’. They also had a more routine role in checking with clients that their equipment was working, and ensuring that people were clear about the technology. They described some initial trepidation among clients about the technology, but had seen people become accustomed to it:

“Most of them are absolutely happy and the families love it because it gives them peace of mind you know. It really does.”

⁸This complied with the standards of the Association of Social Alarm Providers (now renamed the Telecare Services Association).

““ *They’re wary to begin with, but now I think they couldn’t do without it.*

Care assessments were conducted by a range of staff, though long term, comprehensive assessments continued to be carried out principally by social workers, who were thus important in the process of identifying some of the people for whom smart technology at home or housing with care was appropriate. Not all the clients who used the services however, required to have a social work assessment. Some of the housing with care tenants arrived at their assessments via a housing application route, and some of those who used the mainstreamed service were assessed by the community based staff. Referrals to the services came from a variety of sources including health, housing and social work, as well as self-referral.

Other staff involved in the programme included consultant geriatricians – they determined whether people were ready to leave hospital, and referred them for assessments by medical teams including those in day hospitals or specialist facilities such as the stroke unit. Community based health care workers carried out specialist medical support such as wound dressing, palliative care, injections and community based nursing care. Housing Association staff were linked with the programme through their role in managing the properties and tenancies in the new developments. All the staff interviewed reported that they were working with many other staff from different professional backgrounds.

The staff agreed widely that their work had changed in recent times, and much of this change could be related to the new model of care as well as to the policy imperatives lying behind it. In particular, staff spoke of the emphasis on independence of older people, and the need for them to work in ways which supported this. They referred frequently to the need for services to be more flexible and responsive to individual needs.

Rewards and challenges

Team working was a central topic for comment in the staff interviews, and participants identified both positives and negatives. Throughout, there was evidence of changing working relationships and practices, and ways in which these presented both challenges and rewards for staff. The large majority of the staff interviewed were generally positive about their working relationships, particularly so when commenting on their own teams, including the newly constituted and multi-disciplinary teams.

The strengths of working relationships were identified as including good communication (the most frequently mentioned factor), honesty and openness, good knowledge and mutual support, high quality care and flexibility.

““ *There seems to be a tremendous emphasis on the client. Again some people would say that is the way it is supposed to be. With lots of offices it is 5 o'clock and it is time to go and off they go. Whereas in here it is quite the opposite, you know – this needs to be dealt with before I go home. It seems to be across the whole range of staff. It is not anyone in particular.*

““ *We all know we've got our own limits and there's things that we can gain from each other and basically we're all just willing to help, we're looking for the best for that client so if anyone can help at all in any way whether it's guidance or actually physically helping them.*

““ *I think we're very willing to blur the edges and the boundaries. We're very keen to make things work around patients and clients. It doesn't really matter who provides the care, providing it's appropriate and they'll go all out to make that work. There's a lot of coming and going and I suppose at a senior level we see the benefits and we just try and make it work.... So we try very hard to make the staff lose the sort of parochial attitudes [like] 'I'm not doing this because it's not my job'.*

“We’re here for a common purpose, and the common purpose is the client and the service of the client. We speak about the joint futures with the health board and what’s going to happen, but surely it’s for a common aim. Why are we getting hung up about I’m a nurse and you’re a social worker and never the twain shall meet? It’s for the common good.

Staff also identified some problems with working relationships, though these negatives were outweighed by the positives highlighted before. Where difficulties occurred, the most frequently mentioned issue was poor communication. Inter-disciplinary issues were also mentioned, such as lack of mutual understanding and a tendency for some to consider their disciplinary view as the most important. However, such difficulties were infrequent.

Several staff, especially in the early days, felt that the new model of care required staff to learn, to move away from old working practices and to be more appreciative of the aims of the programme. Generally, these challenges were embraced

“It’s a new job, it’s a new post, it’s stressful. And they’ve [team leaders] had stress as well. And we’ve often found that. That’s probably another reason why we all support each other so much, is that we feel we don’t want to keep going to them all the time. When they’re so busy and they’re so stressed. We are all trying to work together to ...make it become a better working environment for everybody. Not to be segregated in any way. To try and pull together more.

“There’s still a lack of understanding about what we do, and what our aims and purposes are, what our system is and how it works. That’s a hard one, because it does change as well, not constantly, but there are ongoing changes. It is quite hard for people to keep up to date. I think we’re guilty as well; we’re not making as much effort as we could to keep people up to date.

Then again, others have to want to come and learn about that too, and that doesn't always happen.

Several staff were unable to identify specific issues – one in particular put a perceived lack of weaknesses down to effective team working:

“ It is probably one of the most difficult things to identify weaknesses. I could not specifically say there were any. I have not noticed anything from a team point of view. We may as individuals all have certain weaknesses or flaws.....There are probably specific weaknesses at a given time but because you are working in a team environment, they are talked through, you can always fall back on another colleague to help you through that particular weakness at that given time.

Managerial staff perceived issues attached to organisational matters such as budgets, with for example, pressure to keep clients in one setting to avoid a call on the budget of an alternative. Also highlighted were some of the issues attached to promoting joint working, for example in this comment on allocating tenancies, in which several agencies were involved:

“ I suppose sometimes you could say it's maybe overly bureaucratic at times, you know the operation of groups although I'm saying that in a general fashion. If for example you've got allocations, if you've got one organisation that assesses applications in line with its policy and then allocates that, it's less bureaucratic than having maybe three organisations meeting to discuss allocations, agree them et cetera and that can maybe, at a practical level, build in delays, so it takes longer to re-let properties because you have to arrange meetings and trying to arrange meetings with different groups can often be difficult.

The impact of smart technology

Most of the staff interviewed had heard about smart technology and knew that it was installed both in people's own homes in the community and in the housing with care developments. Some of our participants had been involved with the programme since its earliest days. Still earlier experience of the potential of smart technology had come from the use of personal alarms in people's homes in community alarm systems. There were several comments about the formerly expensive nature of smart systems, and comments that this had kept them out of reach.

Only one respondent (a social worker) appeared set against smart technology from the start:

“ I felt right from the start there were problems. It was very much alarm orientated. OK. So you know when someone's wet themselves, or left the taps running. What then? They were telling us something was going on, and not providing a means of dealing with it. How does that help a carer if they are already under pressure? To know that while they're picking up the kids from school, granny's wet herself. And she's got to go off and do something about it.

Others had been sceptical at first, but won over. A community care assistant and a housing support worker commented:

“ I thought it wouldn't be [useful], I thought it was a lot of rubbish. It all seemed like fantasy.

“ Well no, it wasn't something that I would have thought of. No, I would never have made the link between it at that point, I don't think, until I came in here and sort of saw it working and in practice and its excellent.

Among medical practitioners, there was also some scepticism about the benefits of technology in relation to telemedicine and

this scepticism appeared to have been generalised to telecare. However, others were more positive, and saw potential benefits in the future:

““ *There could be real positives in terms of independent management of patients, monitoring their own condition and being able to feed that into the system you know in some way. I think there’s potential there but I know it’s a difficult area to get general practitioners and other medics kind of signed up to sometimes. I feel it’s a bit difficult.*

Examples of positive benefits were also noted by medics. For example:

““ *Dementia patients who maybe wander a bit, they can be maintained in their own home community, because if they’re wandering at night somebody knows they’re wandering. Instead of finding them out in the cold and having to treat them for hypothermia, there’s early alerts. So yes, I think in a way it probably stops a lot of the sort of accidental type issues that we would have to deal with, particularly for vulnerable older people.*

One participant had a very personal reason for welcoming the smart technology programme:

““ *I am looking forward to my retirement. I should have retired on Friday but I am staying on another month. I am staying on to the 31st of March but it is such an exciting time for caring for the elderly. I feel it has come too late for me to be involved in it. I am really looking forward to my retirement but I would have loved to have been involved in the new development. That is what I want. It is an exciting time. Can I just say I am glad it has come on board when it has come up to my time?*

Generally, staff felt they had a basic level of knowledge of smart technology, and that this had improved as time went on.

““ Yes, I think I know what it does. I know what it can offer. I know if a client is going to fall, or if I've got somebody that is going to flood their kitchen, I know what's available.

There was evidence of learning among the staff team too, as well as developing ability to communicate effectively with clients about the technology in ways sensitive to their levels of knowledge

““ You don't realise how much you have learnt until other people talk about it or ask. I've got to the stage now that I only explain a few things at a time to the client as it's too much for them. Now I find it easier to explain it and how much information to give clients at a time. We have to explain the package and then how the equipment works.

Staff were involved in innovating within the programme, for example by looking for new items of equipment, and exploring technological approaches:

““ If I have a problem, I would ask now. Even if I didn't know if there was a piece of equipment, I would say, is there a piece of equipment for this now? Because they can just do so much. We have very successfully got a talking doormat just now with a lady who has a tendency to leave her sheltered housing. And I think it's possibly her daughter's voice on it, that says, 'Go back to bed now mum. Don't go out now mum.' And so far it's working quite well.

““ Its moving up a notch. [This alarm is] an excellent piece of equipment - it goes under the bed underneath the mattress so you're laying on this bump and what happens is.....you programme it through and if the person maybe gets up during the night, when they get up, the light will go on and then when they get back into bed it will be another fifteen seconds before the light goes off. So that takes away the fear of people getting up in the dark.

Gaps identified in people's knowledge tended to relate to the more specialised items of equipment, whereas knowledge of the basic smart technology packages was widespread. It was clear that there was a willingness to learn about the technology and a genuine interest in its possibilities and the development of new devices.

“ I have a good knowledge about [the Call Centre] and where they come in and the.....phones. What their uses are. How they respond. MIDAS and that. I know I will get there, I know I will. Practice makes perfect. When I first started using hoists and even washing machines when I worked in residential, I wasn't sure, but you get there in the end if you take your time.

The staff were asked what they felt had been the impact of the smart technology on their clients. They repeatedly used words like 'secure' 'independent' 'reassurance' 'self-confidence' and 'safety', emphasising a generally very positive assessment of the impact of the technology. They made explicit links between the technology and the model of care, emphasising the context in which it was being used.

“ I think it is going to make them secure. It is important that they feel secure in their own homes. You know yourself you have to be secure in your own home.

“ It is going to give them their own independence. It is going to give them independence in the fact that they know....that they can be on their own and have no input whatsoever, but if something happens then they know that we have the technology to help them straight away. Apart from independence, it gives you security as well.

“ I think it has just made clients so much more independent within their own home and in some cases it must have given them a new lease of life.

““I think it has kept people at home. I’m convinced it has kept people at home. I think at home both clients and carers feel safer. And that’s such a big thing. To feel safe.....I genuinely believe that people are able to maintain more independent living skills.

““One of my elderly clients - somebody came to her door and came in and robbed her on Saturday morning. And she got very distressed, and so the installation of smart technology definitely made a difference to her, in that she felt safe in her own home. She could monitor who came and who went. She had immediate contact, press the button and have somebody. I think it actually gives families.....security, peace of mind.

Staff were easily able to identify cases in which the technology had supported people effectively. For example, Call Centre staff noted several cases of flood detectors which had prevented damage to property. A Housing Officer was enthusiastic about several items of equipment

““It’s kept them independent, plus the fact it’s a bit more secure as well, that they know that if they have any accidents or things they can call us on their pendants. Or a couple of them’s had fall detectors as well, and we’ve got a lady with a wandering alarm because she was coming out at night and she was getting lost, so obviously now we know if she is out at night. But the funny thing is, she doesn’t come out now because she knows it’s there.

Support for informal carers was identified by a manager as a significant benefit of technology

““It has taken away anxiety for carers.

And a district nurse had found this to be particularly significant

“Even maybe not the patients as much, but I think their families feel that they’re safer. I’ve had that reaction more often really you know. A lot of the time patients think ‘oh there’s no need for that and I’m fine’, but it’s the relatives that are really much happier with it, can feel that their relatives are safe and things like that.

Frontline staff who were installing technology packages noted that some clients were rather apprehensive about the technology at first. They described how they worked with such people to explain how it operated, and helped them to make their check-in calls and press buttons to open doors and so on . They explained that, with support, people got used to the system, and became content with it as they realised its benefits.

“Most of the clients really like having the smart technology. Oh yes. Most of them. It fazes some of the older people. They get a bit worried by it. But once they see it in place, once it’s installed in their house, they soon realise [the benefits].

“For some of my clients it has made a difference. One client is now so confident, she’s having fewer falls. I have another client who’s blind. Before, her door was left open all the time, her curtains were open all the time. She didn’t know who was coming into her home, now she has the video entry system, the curtain openers and shutters, she thinks it’s great.

Where issues were raised in connection with clients, these focused on whether the clients had fully understood the technology, and given their consent to its use. For example, one of the sceptical social workers raised a question about consent:

“I don’t think they know if they’re wired up or not. Then you start to think, are they consenting? Because it can be quite intrusive. At the same time, if it allows them to stay in their own

home and they wouldn't agree to move into a home, then it's a reasonable compromise. But you wonder how much people have consented.

It is notable that this social worker did not identify their own potential role in ensuring consent at an early stage in the process of assessment and referral. Overall, such comments were far outweighed by those indicating that staff had done their best to ensure that clients were clear about the technology and that they had indeed consented to its installation following clear procedures.

We also explored with staff how the smart technology had affected them and their work. Frontline staff engaged in work with clients explained:

“ Well it will enable me to react quicker to the tenant's needs.

“ We don't have to go around everybody, 'are you ok?' We know what is needed when it is needed. It makes us confident if anything does happen we will know.

In some cases, there had been a perceived issue with false or unclear alarms;

“ Well one night I was up four times, lack of sleep, no-response calls, having to get up for a needless call because they [Call Centre operators] can't make out what the tenant's saying.

Such incidents were however, unusual. In this case, the staff member concerned was apparently unclear that the sleepover service was intended to provide a failsafe in cases where the response needed was in doubt. The failsafe had clearly worked in the incident described.

The Call Centre staff reported that the new West Lothian programme had made their work both busier and more interesting, as they were

dealing more closely with clients. Two had gained particularly useful knowledge from the system:

“ [It has] given a bit of insight into what my own old age might be – not just the technology but working with residents and knowing all the illnesses that you can get now.

“ It has given me some knowledge that I will find useful for my aunt, my father and mother-in-law.

Conclusion

For staff, the new model of care developed in West Lothian had caused questioning of and changes to former ways of working. There was a new focus on promoting independence for older people, and providing ‘support’ rather than ‘care’. Staff saw this as a positive development, in particular because it moved away from old-fashioned residential care regimes. They illustrated a strong sense of respect for the dignity and independence of the older people with whom they worked. The enthusiasm for the new ways of working was sustained throughout the period of the evaluation.

Staff began to work in new teams from the outset. In these teams, traditional professional boundaries were blurred, and there was more sharing of tasks formerly separate. Whilst at the start there were some challenges linked with different professional cultures, and some ‘protection’ of traditional territories, the staff interviewed had generally embraced the positive aspects of the new teams, and welcomed the opportunities to work more closely with others.

The rewards of the new model of care for staff were significant, despite the challenges they experienced both from the development of the new model of care and from the blurring of boundaries in the new staff teams. In particular, participants welcomed the positive impact of the new model of care for older people.

Smart technology was integral to the new ways of working. It presented its own challenges, and one of its key impacts for staff was to catalyse the process of change in ways of supporting older people and working with other staff. The novelty of the technology appeared to have supported staff to consider how they worked more radically, and to make changes which they positively welcomed. Where there had been difficulties with the technology, these had been addressed and overcome, and there was an orientation towards seeking new possibilities for the technology to support older people more effectively.



Chapter Three: Smart technology at home

3

Key points

- A large group of respondents living at home, both older people and informal carers, reported the positive impact of the smart technology. It was widely seen as supporting safety and security both of the person and the home, and thus as helping people to stay in their own homes;
- Many respondents were reluctant to 'give in' to a need for help and support. This emphasis on independence supports the 'mainstreaming' strategy, and the focus on the equipment being for everyone. Mainstreaming can reduce any stigma that people may feel, by making the technology seem normal;
- Technology is one element of the support received by older people, who also receive support from families, neighbours, communities, formal and informal carers. Family relationships emerged as especially important for providing both general social support and specific care and were often taken for granted.

Introduction

Smart technology was installed in more than 2,000 homes throughout West Lothian by the end of the evaluation. In this chapter, we focus on the experiences and views of people who had received the service as part of their community care packages at home, including those who had taken part in the roll-out of the service to all those aged 60 and over. The data include interviews

with 51 people using the service, 7 of whom identified themselves as informal carers, and 89 responses to a postal survey of users of the Home Safety Service conducted in Summer 2004.

Daily life

Services, including smart technology, may become part of people's lives as they age, and it was important to understand these ordinary daily lives. Accordingly, we asked respondents about their typical day, exploring their quality of life, in terms of the pleasures and difficulties they recounted, and their own assessments of their day-to-day activities. Most strikingly, we found marked variation in people's typical days, suggesting the exercise of choice and autonomy. There was an emphasis on variety, choice of activity and the maintenance of independence.

Household chores often structured people's days, and there was evidence that people were keen to keep up with these, engaging in various means of self help to ensure they did so – one respondent described wheeling herself round the room on an office chair, whilst she did her dusting, to lessen the effort involved. Getting up in the night was described by several respondents as regular and frequent. They rose to visit the toilet, to have a cigarette, or to make a cup of tea.

For a minority, the structuring of daily life by the demands of a regime of formal care was significant, in that times for rising, taking meals and retiring to bed depended on when the formal carers came to visit the house. People would prepare for the carers' arrival in the morning, for example by making sure they were out of bed in time. There was a sense here of presenting independence to the visiting carers, taking control by being ready for their arrival. Throughout these interviews, as we will show, the theme of maintaining independence was strong, including among people who had quite intensive care packages.

Routine itself was highly valued by some:

“I stopped going on holiday you know. I just feel better at home. If you're doing anything very much out of the ordinary, it takes me a day or two to come round, you know what I mean.

Punctuating the daily routine, a wide range of outings was described, despite a minority being unable to go out of the house. Sometimes, outings were formally organised, such as visits to a Day Centre, and these would influence people's activities for the whole day. Other more informal outings included trips to the pub to meet friends, and there were also some accounts of informal 'clubs' that people organised for themselves, such as a walking group.

Some people described making particular efforts to go out, to 'keep going'.

“I sometimes just walk up the way, just for the sake of the walk you know, and to keep the legs going.

They expressed determination to have outings, despite difficulties including physical limitations. They would plan outings carefully, and time them to ensure their safety. One woman for example explained that she did not like to go shopping during school holidays:

“I'm frightened I get bumped you know. The children – nothing to do with the children, [but] myself. I don't like being in a crowd.

Several respondents used their cars, and these conferred, unsurprisingly, a considerable degree of freedom to get about, especially if walking was difficult. Generally, people related limiting their driving in terms of distance. Electric scooters also provided some people with mobility which they would not otherwise have enjoyed, and three people mentioned using the Dial-a-bus service, which was highly valued.

Pastimes were also much valued, including writing letters, handicrafts such as sewing, knitting, crochet, reading books, doing puzzles, making preserves, home-baking, board games and electronic games (Playstation was mentioned in one case). Many of these were notably women's activities (though one man enjoyed crochet). Some people retained an interest in gardening, though this was often curtailed by physical limitations.

Watching television was a significant activity for many respondents, though not necessarily universally enjoyed:

“*That daft TV – it would drive you round the bend that. I was thinking of throwing a stone at it!*”

Pastimes which people had enjoyed whilst younger proved more difficult with limitations of mobility and difficulty of travelling. For example, an avid football fan was unable to watch his team play unless his son happened to be visiting from the South of England. A couple similarly described not being able to attend their church or the Bible classes as they had previously done.

For some, there was a sense of loss of activities formerly enjoyed. Several people reflected on things that they used to do, often mentioning favourite holidays. Ill health prevented some former activities:

“*I used to go swimming every Tuesday till I wasn't well..... I'm always thinking I'll go back but I'm always terrified of getting cold.*”

This kind of loss was linked to lack of former companionship, which could change the way some people felt about doing things:

“*My husband was a very keen tennis player....we used to watch Wimbledon and discuss it all ...but now I've no-one to discuss it with... I used to like watching the tennis - I still do, but it's not the same.*”

Informal carers described how much of their own time was taken up with spending time with the person they cared for to the extent that they had to sacrifice doing what they wanted themselves. For instance:

“ You know it’s things that I was into at the time but over the last couple of years, I’ve lost interest in it, you know. You’ve got more on your plate, so you tend to lose interest.

“ I take her out to the Bingo on a Sunday and a Wednesday, that’s the only two nights I’m out.

Their own values and time were often dominated by those of the person they cared for and they sometimes felt they had to make extra efforts to prevent the person overdoing things themselves.

When carers did find time to pursue their own interests, they talked of decline in abilities through illness or impairment of their own. For instance, a retired woman in her 60s who cared for her aunt, loved to garden with her husband, but found that she was now limited in how much she could do because of a leg injury. Another carer of a similar age had enjoyed painting but could no longer do it because of severe back pain.

Throughout the accounts of daily life there was an emphasis on variety, choice of activity and the maintenance of independence, often through ‘keeping going’. These subjective accounts of valued activities and preferences are indicative of how people perceived and attempted to maintain a good quality of life for themselves. There was a sense of valuing and wanting to maintain control, even where former activities had been curtailed, and from these accounts, most people had a generally positive experience of their everyday lives.

Support and care

In their daily lives, respondents received support from a variety of sources, both formal and informal. In many cases, they belonged to couples, families and communities in which support and care were mutual. They discussed their attitudes towards receiving support and how this affected their lives. There was considerable variation among them in terms of their needs and wants for support, and the themes of choice and independence continued to be strong:

“ So maybe other people who may have a different nature from me would be quite happy to have a carer morning and night, but as long as I can do without that I would prefer to....I'm not saying I'm not old now but I don't feel mentally that I need.

“ Can I make that clear right away, that that would be my aim - to be as independent as I could. Now, I couldn't get into a bath ...I have a shower...There is someone there, one of the carers is there. They let me try and do what I can. And they're there to supervise and help as I need.

It was clear that people had negotiated their own 'packages' of support and care, which drew on formal services, on informal support from family, friends and neighbours, and for a few, privately paid support, such as cleaning or gardening.

Much of the support and care was embedded in social relationships. Some of the informal support in particular was often so much taken for granted, and so much embedded in people's ordinary, day to day interactions that they did not readily identify it as such. For example, couples indicated the importance to them of mutual support – often, it was difficult to identify one as 'carer' and the other as 'cared for' as the degree of mutuality in these relationships was very marked. Similarly, family visits were significant for many respondents, many of whom had relatives nearby. Children and grandchildren were particularly popular visitors. In general, people usually preferred family support over support from others and family members were

providing a significant quantity of informal care for this group of respondents. This ranged from co-resident, full time care and support (in four cases) to more general visiting and helping out with tasks such as shopping and gardening.

Some people however, were very conscious of receiving informal support, and worried that they might be asking too much of their families. For example, a woman who was in the habit of going on holiday with her sister's family explained:

“ I feel I'm at the stage where they like walking and I'm not able to walk, and I feel if I go I'm keeping them back.

She thought aloud in the interview about how she would manage for the coming year, perhaps by taking rest days to allow the others to go off without her.

Many people emphasised the importance of good neighbourly relations. They related the enjoyment of being part of a long-standing community, and the support which came from that:

“ When it's nice, I like to be outside and I just potter about in the garden. I take my Zimmer and keep it near me – just potter about like. And I've lived here so long, everybody knows me, so of course when they're passing by, they're shouting to you, speaking to you. And I like that.

Neighbourly help of a material kind was frequently described, and there was a sense of mutuality and community in these accounts. One carer for example, whose husband now needed much support from her, described how in past years, when he had been in better health, he had cooked soup both for the two of them and also for neighbours:

“ Two old ladies used to live here, well God bless them, they're not here now. And they were only up the stair. They always would guarantee to get their soup every day from [him].

More usually, neighbours were keyholders, who would watch the house while a person was away, or check on them in any emergency.

Several respondents had pet animals, which were involved in their daily activities. Dogs as walking companions were highlighted, and in one case, the dog was described as actively supporting a man with dementia:

“*He used to walk the dog a lot, and she knew her way back when he took her out for a walk. And a few of the carers⁹ lived up in the area that he used to walk the dog, and if he was confused, somebody brought him back you know.*”

Neighbourly support and good relations were not however universal. In some cases, people were reluctant to seek help. One man for example, who enjoyed ‘pottering’ in his garden, did not want to get help with grass cutting, in case neighbours felt he did not really deserve it. A couple who had newly moved to an area after a working life abroad described themselves as feeling lonely, and as having few local acquaintances.

Throughout these accounts, there was continued emphasis on people’s desire to be independent and to make their own choices. This frequently involved resisting help, or presenting it as something others had almost obliged them to take. For example, a woman involved in a walking club (who said her current limit for a walk was fourteen miles) had been given a walking pole by her son:

“*He said ‘that’s what you need Mum – not a walking stick, because that’s got the spike at the end’ he said ‘and it’ll go any place and it’ll balance you’. I said they’ll think I’m Bo Peep!*”

So far, she had only used the stick in the house. Another woman had had a bath lift installed, and commented in similar vein:

⁹ Local Authority staff

““I didn't really want it, and my daughters said we would feel better if you had it...I thought folk who had them were really poorly....And I was trying to get away from that image...When they said it would give them peace of mind, it wouldn't have been fair if I hadn't taken it, so I took it. But you see I worked, and I had a superannuation...

Both these women presented their relatives as the prime movers in their acquisitions of these aids, and both clearly resisted the images of older age associated with walking sticks and bath lifts.

The second woman, in referring to her working life, contrasted this positive image with the rather negative experience of being old, and the negative images she associated with the bath lift. The first used the derogatory image of 'Bo Peep' in her objection to the walking pole. These perspectives were echoed by another woman who related the reactions of school children to her electric scooter, and had direct experience of abuse:

““You've no idea the abuse I get when I'm out on that scooter....especially when the school comes out and they're all together. Verbal abuse and oh, terrible it is – I mean not just me, all the old ones.

Further comment on wider attitudes towards older people came from a respondent who had surprised a social worker with a challenge:

““I was seventy six you see. Maybe at seventy six you're not supposed to have your marbles – I have been treated with ageism for some considerable time. I tell [my husband] 'another one, another one who does not think you can use your brain'. They must think you're senile or going into Alzheimer's or something like that, which God forbid.....But I was hearing on the television the other day that ageism has become common. Did you know that?

These comments and experiences are a reminder of the complex dynamics of ageing and ageism which are part of the context of living as an older person in modern communities. As these accounts demonstrate, whilst good family and neighbourly relations are important and highly valued, their positive impact may be tempered by wider processes of social exclusion through ageism.

Most of those interviewed were receiving some level of formal services, usually from the Council, though some were paying privately for services such as cleaning and gardening. Eighteen people were receiving personal and or nursing care and 11 were attending day centres regularly.

Generally, people were positive about the formal services they had received. One respondent used the word 'flabbergasted' three times to emphasise how pleased she had been with the support she had received at home after a hospital stay (most likely this came from the Rapid Response team). Four respondents singled out excellent services they had received from Occupational Therapists. Where people had difficulties, this was often related to individual preferences, suggesting that services could do more to respond to diversity and be less standardised. For example, one man felt that the day centre activities were more geared towards women's interests, others described the frozen meals delivered to the house as 'bland', or the day centre chairs as designed for taller people.

Some respondents had not received the care and support they felt they needed. In some cases, this was clearly due to misunderstanding – for example erroneous perceptions that certain services were alternatives, worries about the costs of services, misunderstandings of the nature of help that could be provided. A small number of people felt they had had bad experiences, such as care workers who were 'in it for the money', repeated changes of social worker, or difficulty in getting information. These cases were very few in number.

These responses illustrate the wide range of sources of support that people received, as well as indicating a range of preferences. Independence and choice were widely valued, and the responses also demonstrate the active role taken by many people in obtaining the care and support they needed. It would indeed be a mistake to view this group of older people merely as the passive recipients of services.

Home and community

As part of the focus on quality of life and in the light of the policy emphasis on encouraging people to remain in their own homes, we explored ideas about what their homes meant to service users, how much they were valued and in what ways. It was also important to be clear about whether quality of life was maintained, improved or compromised by staying at home in situations where changes were taking place, such as increasing intrusion into the home as support needs increased and formal services were increasingly used. In particular, we wanted to explore whether the introduction of technology into people's homes changed their feelings about them.

Many people explained that they had lived in their homes for long periods – a few for more than 70 years - reflecting the history of local communities. Emphasising their desire to remain at home, they talked about the importance of where they lived in relation to having a home and having roots. One person, who had recently returned to her home area, summed up these perspectives:

“*Oh I like living here, I've come back to my roots and I've got everything arranged for my funeral to happen. I've got all the arrangements made....So I'm just waiting on.*

Focusing on the home itself, people spoke about family relationships and memories. Personal possessions were also important and added to valued memories.

“ Well I’ve got a four bedroomed house which I know is big but my husband and I had so many happy years in here and I don’t want to go.

“ Well it’s something that all the family have lived here and my mother and father.

Speaking about the memories attached to the house, this woman added:

“oh yes and nobody takes them away.

Many respondents referred to the freedom to do as they liked which they enjoyed in their own homes. For one respondent, a contrast was drawn with residential care:

“ I used to pass by this home for old people on the bus, and I guarantee you, the bus stopped right outside this home and I used to see the same old people sitting in the same chair you know. I think they must get up out of bed, get washed and fed, then go into that day room and sit in that chair and that, that was their life.

These interviewees emphasised the importance of having one’s own front door, security, privacy and choice, all associated with having one’s own home.

Neighbourly relations could be linked with positive views about home. Many service users talked about their neighbours, explaining that really good neighbourly relations reinforced their wish to stay in their homes. Good neighbours were people who could be called on when help was needed, who would keep a key for the house, call in frequently and pick up bits of shopping. Good neighbours were important for many as a source of support and simply as a means of ensuring an acceptable environment.

“.....to be in control of yourself... be your own person....try not to be needing too many other folk.

A minority of respondents had moved home more recently, often because their former homes had presented difficulties such as stairs, or in order to live closer to family members who might be a source of support, and others were planning to move for similar reasons. Nearly all those who had moved recently or who were planning to move appeared not to see these moves as problematic. Indeed, they generally expressed relief that they had moved or were moving to accommodation that was easier to manage. It is worth noting that most house moves were spoken about as having occurred by choice. They provide evidence of positive choices made to improve quality of life and to promote valued activity and valued relationships.

Where neighbourhood relationships were perceived as problematic, this could seriously affect people's enjoyment of their homes. For example, one long standing resident wished to stay, but felt forced to move by problem neighbours:

““If I get any more bother with them, I'll need to move. I'll need to move because I can't stand it any more.

Two other people who lived alone in flats had had really bad experiences with neighbours. Both talked of younger people moving into their blocks, taking drugs and playing loud music. One reported numerous complaints to the Council about the noise but said that things were slow to improve. The other had been very upset because a young person had died of a drugs overdose in the flat upstairs from her own, and explained that she had become very unsettled by this. Having good or bad neighbours clearly had a huge impact on how people felt about where they lived.

This material emphasises both the attachment to and preference

for their own homes of interviewees, but also the individuality of people's preferences on the one hand and on the other, ways in which environment, including house conditions and neighbourhood, could potentially compromise the exercise of these preferences.

Well-being and quality of life

Good quality of life for these older people came with independence and choice, the enjoyment of their own homes, and a good community around them, including family, friends and neighbours. They valued their families, and good relationships with those around them. Sources of ill-being included separation from families, the loss of partners and difficulties arising from problem neighbours as well as ageism at a wider level.

Well-being could in many cases be compromised by health problems, about which respondents spoke at length. Both the older people themselves and the informal carers had problems, often of a nature which limited their daily activities and, in particular, restricted their mobility. Problems described included arthritis, chronic pain, skeletal problems, strokes, hip replacements, diabetes, asthma, heart problems, cancer, thyroid problems, dementia, angina, inner ear problems, high blood pressure and skin problems. Some men had been injured at work – such as in coal mining - and had lasting long term health difficulties as a result. In the questionnaire responses, the most commonly mentioned health issue was falling and this was also significant among the interviews. Falling was reported most often among people who had come into the formal support system during the more recent phases, and there were indications that it was the experience of a fall which had led them to seek support. In discussing falls, they referred to the feelings of insecurity these engendered.

There is no doubt that health problems negatively affected the quality of life of many respondents in this group. However, there was an emphasis throughout, as we have noted, on 'keeping going', and resisting the problems which ill health could cause. People generally

adopted a philosophical attitude to such problems, and emphasised being reluctant to 'give in'. Again, independence was a central theme, and people sought ways of maintaining this.

The impact of smart technology

Against the background of these accounts of daily life, support and care, we can now consider the impact of the smart technology, which had come into these people's homes. How had it come into their lives, and how had it affected them?

Overall, the impact of the smart technology seems to have been to enhance people's quality of life as they saw it, and to support them in achieving their goals of maintaining independence and control over their own lives as long as possible. All the respondents commented on the technology installed in their homes. All were positive about it, apart from one, who said he knew nothing about the equipment and one who described it as a 'prison warden'.

Reasons for having the smart technology installed often highlighted safety and security. This comment relates to safety for those living alone:

“Why did I decide to have it? Because all over Scotland and England you've read and you're seeing on the TV about somebody that's died at home right. Now, I remember in Glasgow the most recent one, there was one down in Yorkshire, an old lady – anyway, again, how did I find out about this? I think it was a thing that came through the door, so I studied it and I read it and I decided to apply so I applied for it.

Security was discussed particularly in relation to door entry systems. Two service users described how these enabled them to gain some control over what was occurring outside their front doors:

“R: Well they've done that. They've put that alarm system out there, that you press that buzzer to open the door.

GM: *And that rings here, does it?*

R: *That rings here. And they were having a carry on¹⁰ out there ... When they were having a carry on I used to press that, lift that, and hold that to that and I got wise to them. I would just say, could you put me through to the police station please.*

The youths outside who were ‘carrying on’ would be able to hear the ‘call’ to the police through the entry system, and this was enough to send them away.

A similar case:

“R: *The kids have a habit of coming up the ladder¹¹ so you can actually see them and they can’t hear you.*

GM: *So the children just sort of come up and have a wee look do they?*

R: *No, they done it anyway before I got the videos in, but they don’t realise that I can see them even when they’ve not pressed the bell. You can’t hear anything and they can’t hear anything but you can have a look outside, yes.*

GM: *That must be quite reassuring?*

R: *It is. It’s brilliant. It really is.*

In this case, simply being able to see what was happening outside was important.

Further reasons for having smart technology installed were articulated by informal carers, who had obtained reassurance from it. Two described why they felt better with the person they cared for having smart technology in their homes:

““*But she still thinks that she should cook. Then she leaves the gas on. There’s a build up of gas, so she’s now got one of these...It’s a gas detector, and that goes through to the Call*

¹⁰She referred to youths outside creating a disturbance.

¹¹The ramp to the front door.

Centre, and they either get in touch with her next door neighbour or with me.

and

“Well like the smoke detector and things like that, she was really bad. We just actually got, bought her the new cooker - this old cooker, she'd a tendency for, when she was shuffling along, she would bang into the cooker and turn the gas on. So it's quite an upheaval sometimes, the things she does you know, especially on a bad day. She'll maybe sit down and she falls asleep. And it was the Sunday, my two kids they were in here playing with their friends and I happened to come downand the kitchen was full of smoke. She'd left a pan on the stove.

Increased safety and security were linked with maintaining independence and control over one's own life, and hence to quality of life. As with accepting other forms of support, there was some initial reluctance, which a carer described thus:

“I think, well probably to start with it's like using a stick. You don't want to do that. You'll do anything, cling on furniture and what have you rather than use a stick. And this, sitting on your chest [pendant alarm], I think she thought ... But she is wearing it now. We finally got round to ... she has it on all the time. So that's a good thing.

In speaking about the impact of the technology, half of the respondents explained that they had previously experienced falls at home, and saw the technology as being particularly important to safeguard them on future occasions. They described pre-technology experiences such as having been stuck in the bath for three hours, or falling in the bedroom and having to sleep on the floor until help came in the morning. Others had been injured in falls, and had experienced long spells in hospital. This emphasis on falls was strongest for those who had joined the services later on,

when the roll-out to the wider community of older people had begun. It suggests a level of unmet need for support in this respect.

Having had the technology installed, several respondents described how it had been used, giving real examples of its effectiveness. Three instances of fires, caused by leaving things cooking or by 'dozing off' while smoking, had occurred, two floods were reported, and several further falls for which assistance had been required.

“ Since January, I would say it's saved my life three times. It's been used five times, and it's saved my life three times.

This respondent went on to recount an asthma attack, a bad fall and a fire.

Respondents whose alarms had not been activated nevertheless expressed feelings of greater safety and security, not only referring to personal safety, but also to the general security of the house against intruders. For example, they spoke of 'the comfort of knowing there's somebody there', 'peace of mind', and 'tremendous confidence'.

Nearly everyone seemed to be sufficiently clear about how the technology was meant to work, and they described testing the system regularly as required. They were full of praise for the Call Centre staff, particularly noting that they did not mind false alarms, and were friendly and helpful. One man had mentioned to the Call Centre that he was going on holiday, and was very impressed with the response:

“ I said I will be going away for a week, and when I came back in and pressed the button to say I was home, within a few minutes somebody else was on saying have you had a nice holiday...[I've] nothing but praise for them!

Whilst there was a generally positive response to the Call Centre's

approach, a minority appeared nervous of bothering them unnecessarily. There were some suggestions that this feeling might have been linked with a reluctance to accept the equipment on the grounds that this would be an admission of dependency. One respondent for example recounted how she had fallen, been unable to get up, and had been rescued by a ‘social worker’¹² who happened to be visiting about some bathroom alterations:

““And she started telling me all about this [the Home Safety Service], and she says will I apply for it. I says ‘och you’re making me feel awfully old’. She says ‘no, but by the time you maybe need it, it maybe wouldn’t be there’. So they just came and they done it.

Thus, she had agreed to the equipment ‘just in case’. Others explained that they had agreed to the equipment not so much because they felt they needed it, but to put their relatives’ minds at rest:

““I didn’t really want it, and my daughters said we would feel better if you had it.

In general therefore, the impact of the technology had been positive. It had supported people in reinforcing their feelings of safety and security, and it had enabled quick responses in a number of emergencies. People using the service had overcome some initial reluctance to use it by focusing on the ‘just in case’ aspects, and on the wishes of their relatives.

Nevertheless, there were some difficulties and challenges attached to living with smart technology at home, some concerning shortcomings of the technology itself and some, misunderstanding or misuse of the equipment.

¹²This person was a member of one of the new teams – their designation as ‘social worker’ illustrates the persistence of former thinking, as noted earlier.

A limitation of the technology was illustrated by a woman who had fallen in the garden. She related how she had pressed the button on her alarm, the call centre had called, but she was out of range and they could not hear her reply. She had managed to get up, and get into the house where she could be heard, but realised that on another occasion, that might not have been possible. Had the pendant alarm incorporated a means of direct communication with the call centre, this difficulty would not have arisen. This was not the only incident of this kind:

“R: *I've had one fall in the house. I think it was, I tripped in my cover, the bed cover and staggered back, and I've got a wooden chair at the window which goes up you know one that you fold down and I was caught and my body centred round, my head was out and I was caught there and my shoulder, oh my shoulder was terribly sore at the time, but that's the only fall I've had inside.*

GM: *Yeah, but you would be able to call for help now if that happened?*

R: *Aha,*

GM: *Yeah.*

R: *Well I can't, I can't hear that when I'm in the bedroom.*

Again, this comment concerns the set-up of the equipment, whereby the call centre response was only heard through the console. It is important to note that, if she had not responded to the Call Centre, help would have been sent to her. However, for her, the issue was her wish to be able to speak directly with the Call Centre.

The vast majority of those interviewed understood what equipment they had in the house and how it worked. Misunderstanding was illustrated by a few people who thought, for example, that it was not always the quickest way of summoning help. The description below is of an emergency when the client collapsed and the family carer was at hand to call for help. She related:

“ Yeah I find, when you're connecting through it goes de-de-de-de-de, it's dialling and then and it takes a couple of minutes before it actually, before you get somebody. I find it takes, I thought well 999's quicker for me to dial and I'll get somebody straight away. And just said right, I want an ambulance straight away. So I done it myself, although I do test the pendant and stuff you know.

The Call Centre would also have called 999 – this would be normal if a call was needed and the client unable to make it themselves.

Other clients related incidents in which the technology had not worked because it was not being properly used, reflecting further misunderstanding. Two had experienced floods which were not alerted by their flood detectors. Both had occurred for similar reasons. One client explained:

GM: *Tell me - you know you mentioned that you'd had this flood when you'd left the tap running – have you got a flood detector in your kitchen?*

R: *Yes, but I had just swept my floor and I lifted it from the front of the fridge and I put it on the microwave and I hadn't replaced it.*

The flood detectors raised an alarm when they became wet, and needed to be on the floor to detect a flood.

Other examples of misuse include three people who explained that they did not wear their pendants. Several others described false alarms, caused by pressing the button accidentally, or knocking the pendant in some way.

“ I don't wear it when I'm in the house for the simple reason I'm always so afraid that I might just press it accidentally.

The pendant was not designed to operate outside the house, as it communicated within a certain range of the console. Most likely, this woman's difficulty was that she did not want to bother the Call Centre unnecessarily, but it is hard to see what benefit the pendant would be for her if she needed to call for help either inside the house where she was not wearing it, or outside the house, where it would not work.

An issue was raised about paying for the technology, though this was not a widespread concern. It came from people who felt that they had not had cause to use the smart technology to summon help, and had some difficulty seeing the benefit of it against the cost of paying for it. For example:

“ Well I know it's there if I've to use it but otherwise I think it's pretty hopeless really, but I've never had to use it you see.

and

“ R: Because I've got my own house I've got to pay for that and yet I once refused to, but because I've got my own house I've got to pay for it. Mind it is only one sixty a week¹³ but still it doesn't seem fair.

GM: Aha, yes, yeah. Does it give you a bit of peace of mind?

R: It keeps the girls [her daughters] off my back.

Another interviewee, who also had never used the smart technology for an emergency situation, summed up her feelings thus:

“ I think it's wonderful. I don't know how it works. I mean normally when you go into places and they've got these heat sensors or whatever it is on the wall you know you see the lights flashing and whatnot, but you don't see anything here or at least if there is I've never seen it. But I do phone up once a month and check and it is working. I tell them if I'm going to be away

¹³ Charges were discontinued in January 2006.

overnight and all this nonsense. But yeah it's fine and if you read the pamphlet well you can have almost everything, I mean you could have John Wayne coming in and looking after you according to the wee brochure [laughs]. You can have almost anything, things that take photographs of everybody that comes to you, if you want to pay the money¹⁴.

This material illustrates very strongly the importance of understanding how people engaged with the technology. Undoubtedly, it could prove supportive for them, conferring peace of mind, security and safety and supporting an independent lifestyle of choice. The examples of technological limitations, of misunderstandings and misuse, of equivocal responses all show potential for failure to realise this clear potential. They were not, in the case of West Lothian, common, and this is explained by the strategy behind the programme and the way it was delivered, as we discussed in the previous chapter. In West Lothian, the overwhelming response to the technology, as part of the new model of care, was positive.

Conclusions

In this chapter, those who had received the technology packages in their own homes emerged as highly valuing their independence, and as actively working to promote it. They received support from a wide range of sources, including much family support, and, for some, privately purchased support. Their independence was emphasised by their varied preferred lifestyles as well as by the ways in which they gained support, and actively participated in negotiating what they needed. Effective support was achieved often in the face of some obstacles, including the burden on informal carers, the ill health and impairment of both older people and informal carers, and some less than ideal neighbourly relations and wider social attitudes towards older people.

¹⁴ A further potential misunderstanding – actually the charge was unrelated to the quantity of technology used.

In the context of these people's lives, the smart technology packages and the new model of care provided an important element of support, which seemed to tune into people's own wishes and to support both the independence and choice which they valued highly. There were very few negative responses or reported difficulties, involving limitations in operation of the technology or misunderstandings of how it worked.

Chapter Four: Housing with care with smart technology

4

Key points

- In housing with care, older people became tenants of new homes with smart technology already installed. Nearly all the tenants were very positive about their new homes, more so after an initial settling-in period;
- Over time, the new developments demonstrated that they delivered choice and independence for the individual, reassurance for informal carers and increasingly an 'ordinary life' for tenants within emerging communities which both built on existing family and community relationships and promoted new ones;
- Housing with care entailed a new model of care promoting independence and emphasising support and capacity-building. This was generally welcomed, but presented a challenge for those who sought a care home model.

Introduction

The first newly built Housing with Care development opened in September 2002 and the second in May 2003. This chapter explores the experiences and views of tenants who moved in during the early months of the developments. Most were interviewed more than once, over the period August 2002 – March 2004 in the first development and November 2003 – October 2004 in the second.

In total, we interviewed twenty nine tenants and four people who described themselves as informal carers.

The developments

The first complete, newly built housing with care development consisted of 24 cottages built around a courtyard containing a garden area. At the front of the development was a 'hub' area, containing facilities which could be used by the tenants and also by members of the local community.

The facilities included an internet café, a hairdressing shop and a bookable meeting/function room. The staff at the complex were based in the hub, in a small office area. The hub was seen as a means of offering opportunities for the development to be connected with the local community, and to help prevent the tenants becoming cut off from community life as residents of care homes can do.

The flats and cottages were on one level and each contained a lounge, bedroom, bathroom and kitchen, connected by a hallway. They were designed to permit access by people with disabilities, including people using wheelchairs. Each home included the basic smart technology package consisting of the home alert console, two passive infrared (PIR) detectors, an extreme temperature sensor, smoke and flood detectors, a pendant alarm for the tenant, a pull-cord in the bathroom and a door entry system which allowed tenants to see who was at the door and open it remotely. Some tenants also had other devices, depending on their individual needs, which might include fall detectors, window openers and so on. A MIDAS (Modular Intelligent Domiciliary Alarm System – Doughty et al 1999, Fisk 2001) passive monitoring system, capable of monitoring the activities of daily living was also installed in the complex, and piloted, but technological advances in this area meant that this model was never fully adopted. It was a prototype, in the process of development in consultation with the suppliers. That process proved lengthy, partly due to technical difficulties and changes in specifications of equipment.

One of the flats was set aside as a 'flexible flat', used for up to 14 days at a time to provide short breaks for people normally cared for informally. This allowed for assessment and rehabilitation using smart technology or to avoid hospital admission and delayed discharges from hospital, assisted by the Health and Care Team.

The second newly built Housing with Care development opened in May 2003. It included 22 flats and 8 small cottages. The central part of the building, also known as the hub, was arranged as a 'street', with a high, sky-lit roof, a street café, and the amenities including the dining room, hairdresser and a multi-purpose room intended for social events and activities opening off the wide central space. The bungalows were outside, surrounded by gardens, and the flats, on two levels, opened from internal corridors, with a secure entrance at the end of the street. Each flat or bungalow contained the same basic technology package as the first development, with additional items for some tenants, depending on their assessed needs. Staff were on site with an office base adjacent to the 'street'.

The model of the central hub with the facilities and the flats and cottages adjacent was also used in subsequent developments, with each one learning from previous ones. For example, the enclosed and carpeted hub in the first was replaced with hard flooring in the 'street' section of the second, and the café was more open in the second than in the first. These decisions were related to the mainstreaming philosophy, and the perceived need for the developments not to have the appearance of residential care. The corridors in the second development were wide and carpeted, with the doors to people's flats opening from them. One of the tenants felt that these corridors should be hung with pictures – this proved a bone of contention, with some staff in particular feeling that this gave the impression of a care home, rather than a development of private homes.

All the tenants of the housing with care developments, no matter what their care and support needs, were classified as home care

service users. When the first development opened, some tenants moved in who might otherwise have been offered a care home place, and three of these were unable to sustain the independent living promoted in the housing with care model, moving on quickly to care homes. The Council then moved towards offering the tenancies to people who were not in crisis, but who were assessed as having the potential to have their care needs met at home in a tenancy. For all the tenants, the new developments were intended to be homes for life – there was a specific commitment not to require people to move on to care homes as their needs increased, but to continue providing care and support at home.

Daily life

There were clear differences in people's daily lives between the initial settling in period and later on. This was especially the case for the first tenants, who all moved in at about the same time, coming freshly to a new community. In general, the shift was from days primarily punctuated and marked by mealtimes and episodes of support and care towards much more varied and individual activities, including, for many, involvement in the new communities that appeared over time within the developments. In the early days therefore, tenants spoke of getting up, going to bed and meals as punctuation points of the day. One tenant said:

““ *We make our own breakfast.*

Another said:

““ *Then it comes lunch-time and they come for you at a quarter to twelve.*

Another explained mealtime routines:

““ *Dinner is at 12 ... and tea is at five.*

Later on however, tenants spoke of increasing variety of daily

routines. Most people had choice about when to get up and go to bed, though there were some limits to this, as some people needed assistance with going to bed and inevitably relied on staff availability. If meals were taken in the dining room, these were at fixed times, with two sittings each for lunch and evening supper. Everyone had breakfast in their flat or bungalow, and most people made this themselves. People spoke of their own, personal routines, and daily activities of choice. In general, they felt that they did have freedom to do as they pleased, and had retained their independent living. A small number of tenants described having regained some independence formerly lost, especially as the flats and cottages were often more accessible and convenient than their former homes.

The freedom to do as they pleased in their own homes was valued by many tenants. Amongst the activities and routines they mentioned were being able to have a lie down when they felt like it:

“R: *I just get on with it. And if I don't feel too well after we've ate our lunch I just go to my bed and close everything out – so that everybody realises I'm asleep. That helps me. Clears my mind a bit, clears my mind of things that's in it. Sometimes I think 'what is going to happen to me?' and all the rest of it.*

GM: *Do you worry about that?*

R: *Yeah I worry about it.*

Others liked smoking, which they could do in their own flats when they wanted to. It was possible to watch the sport of one's choice all day on television, or to curl up with a book in front of the fire:

“[It's] *homely even at night.....you can put the flame on and be sitting wi' your lights on if you're reading or watching the telly and it's homely.*

There were people who liked their privacy, and appreciated that this was possible in the tenancies:

““ *I keep myself to myself.*

““ *We've been a very private family together all our lives.*

It was possible to be lonely, and there were a few tenants who expressed continuing loneliness, despite the potential company around them. However, this group was a small minority, and in general, respondents suggested that they could find congenial company if they wanted it.

The housing with care developments were located within some of the small town communities spread over the district. Many of those who moved in were long standing members of the surrounding communities, and had local family and friends still close. There were many examples of these relationships and interactions continuing once people had moved into the housing with care developments – for example, one tenant talked of calling on two of her friends ‘up the corridor’. Visitors were frequent for these ‘locals’, and long-standing relationships supported. As tenants, our respondents had the freedom to entertain as they wished in their own homes, to consume alcohol, to smoke, play music, or whatever they wished. There was a sense of ordinary life continuing in the housing with care developments, in ways which the routines of institutional life would not by comparison have allowed. Those people who had previously lived locally to the new developments benefited most from social contacts, as family and friends from outside could visit them.

In the early months of the new developments being tenanted, social interaction between people who had not formerly lived close by one another was limited, and most visitors were those with whom tenants already had relationships. As time went on however, new relationships started to appear, and people made new friends and acquaintances within the developments.

Meals were definitely seen as a time of social contact and one tenant said that she only saw people at meal times. However, another tenant saw this as less than pleasurable because:

“Well everybody is talking through one another.

Early on, with the unfamiliarity of being in their new surroundings, some tenants seemed a little uncertain of what to do in the intervening periods between meals. This tenant's comments are typical:

“It is a long day. They come in and get you up and get you washed, breakfast and then they go away and leave you till lunch-time and it is a long day.

Similar comments suggest expectations:

“I sit around and if there is anything going I go to the wee shows and that.

Another tenant seemed to value the free time:

“If you are lucky you get a visitor or something. Can't expect people to be on your door every day visiting, but sometimes you get somebody. Then they come back for you at quarter to five and that is tea-time. Then they bring you back after that and it is really up to yourself.

The element of freedom to choose is important to the concept of housing with care which aims to promote independence and capacity-building with some support. From an early stage, there was evidence of choices being made in daily routines and activities by tenants – at a very basic level for example, people reported a wide range of favourite television programmes, which they were clearly able to enjoy.

Early on, when people were only just settling into their new homes and were asked about hobbies and pastimes, they talked of physical activities such as gardening, walking and keeping fit; and other

hobbies from their pasts. Many thought they would do these things again. Later on however, people described more activities, both solitary and collective.

Partly, once the settling in process was over, people were able to resume activities formerly enjoyed. However, some of the changes in people's activities were linked with the organised events in the new developments. Once a staff member had been given responsibility for promoting social activities and, particularly, the use of the 'hub' area, many more respondents started to talk about activities that were available, and about joining in with them. There was a variety of options, including church services, outings, sporting activities including carpet bowls, tea dances and bingo, as well as a Tenants Association.

Tenants varied in the extent to which they went out from the developments. Some continued with former activities, including attendance at day centres and regular outings with relatives. Others belonged to clubs and societies which they continued to enjoy. However, from the descriptions given by tenants, it seemed most spent nearly all of their time at home. In many ways, this is not surprising, given that many had mobility difficulties and relied on others to get out and about. There were however almost no reports of people who wanted to get out more than they did.

Support and care

As we previously indicated, housing with care was a new concept for tenants, carers and staff, being based upon promoting independence, capacity-building and supporting tenants rather than caring for them. The way in which tenants adjusted to their new homes appeared to be linked to their expectations and understanding of the concept of housing with care. Four comments taken from tenant interviews illustrate a range of views in the early days of the developments:

““ *There are not many that come in and help me.*

““They are all very helpful. If you ask them any questions they all answer them. With me not knowing the place I will ask them this and that. Go that way and go that way. You feel lost.

““We are being looked after and you are safe enough. What more do you want?

““I was told that I had to be so much independent or I wouldn't get in.

Many tenants and their families appeared to have expected care as it had traditionally been given in residential establishments. This might have accounted for them not knowing what to do in their 'free' time between meals. Against this traditional model, it could appear not enough was being done for them. One tenant and their carers who were interviewed said that they had struggled to come to terms with the fact that not everything was being done for the tenant when they had moved because they needed 'more care'. They said that the tenant was 'not allowed to use the wheelchair'. However, the move did appear to have benefited the tenant, as this comment illustrates:

““[I've] always lived in my own house. Five years I was a prisoner in my own house ... I couldn't do anything ... I am not a prisoner now.

This tenant had gained a new freedom, having given up their wheelchair.

Housing support workers were in the development during daytime hours and at night there was a 'sleepover' support worker on call, whose duties involved responding to calls from the Call Centre as appropriate, not making routine checks on tenants. The assistance from support workers involved a variety of tasks, including doing washing, assisting tenants to get to and from the dining room

at mealtimes if needed, help with housework, showers, getting in and out of bed, dressing and other personal care tasks and using the toilet. Whilst these tasks were completed according to tenants assessed needs, there was flexibility, and staff worked in a responsive way, aimed at maximising tenants' independence, whilst providing the support they needed.

For some tenants, the support they received from staff did not satisfy them. For example, one described how she had moved into the development because she now needed more support than previously but that she felt she was not getting it. She said she did not want her family to have to do more and that was why she had decided to 'come here'. She said she had made her decision and would have to live with it. However, this was a minority view.

For most however, the focus on independence and capacity-building was experienced positively. A tenant described how she had not wanted to move into the development but had been persuaded by her family to do so and had since formed a new view:

“*Oh it's lovely. I didn't want to come at first – I felt strange, but everybody's so nice.*”

This tenant described with great pride how she had cared for her own house and it was only after a period of hospitalisation that she was not able to continue keeping her house to the same standard. She still wanted to keep her independence but realised that she might have further medical emergencies and felt that housing with care would be safer for her. From her point of view, the tenancy meant she could keep her home nice with support when she needed it.

By the time of the second interviews, for most people there appeared to have been positive moves towards capacity-building and greater independence.

For example, one tenant who had been very disorientated and had alerted the call centre during the researcher's visit for her first interview, now entertained her and offered hospitality and warmth during the second interview. Other tenants now did most of their housework and personal hygiene tasks, something they had not done for many years, and were now looking forward to getting a washing machine installed to increase their independence and build on their skills. In one case, a tenant who had previously feared using a shower was being supported to wash herself for the first time in her life, most of which had been spent in institutions. Another, who had moved to housing with care from a care home explained how pleasant it was to be able to make herself a cup of tea whenever she felt like it – this was 'not allowed' in the care home.

Two tenants had now started using the telephone knowing that if somebody rang, the call would be for them – in their previous accommodation, they had shared a telephone with others. Their confidence had grown to such an extent that they now also telephoned family members when they wanted a 'blether'¹⁵.

By the time of these second interviews, visits by support workers had become routine and it was unclear if they were now having to do less because of successful capacity-building, or if what they did for tenants was now so routine that it was taken for granted and no longer mentioned. It was clear that they called on tenants and helped several with housework, but the extent of this and other duties were less clear. There was evidence that some people resisted calling on staff for support. For example, tenants frequently talked of making sure they got up before the 'carers' got to them so that they did not have to be helped.

““ *They've got an awful lot of work to do for the people that are in chairs and needed lifted and bathed, so I do what I can do.*

¹⁵A chat or a gossip.

““ *She comes – but I’m always up sitting in this chair. I’m always up.*

It seems many tenants wanted to show the staff that they could do things for themselves. This resonates with the ethos of capacity-building.

Family relationships were an important source of support for many tenants, especially those who had family living locally. In most cases, particular family members were identified who visited regularly, whereas others remained more detached, and were seldom or never seen. A minority had experienced family rifts and a small number of people had no relatives. These cases emphasise the need not to assume family support to be available.

In many cases, family members and friends were still involved in providing informal care, in terms of support with activities of daily living, including cleaning, shopping, laundry and some aspects of personal care. In one case a resident stated that a relative dealt with all their finances. The move to housing with care had not apparently ended or disrupted informal care relationships – indeed, as in the case of the support at home, carers appeared to be supported by the approach. Interestingly, tenants in housing with care who were keen to emphasise their independence were often reluctant to put us in touch with family carers to participate in the study. Like the clients at home in the community, they retained a reluctance to ‘give in’ to or acknowledge what they saw as dependence on others. In this sense, housing with care was also supporting people’s own preferences.

There was also a certain amount of resistance by tenants to family support because they wanted to enjoy family visits and did not want to be a burden on them:

““ *Well you can’t expect him to be here all the time – they’ve*

got their own freedom haven't they. I don't mind if he doesn't come, he can't always be here.

“*My daughter's in ... she works full-time so I see her on Saturday and we go out for lunch and then a bit of shopping. I used to have Home Help before and we thought we'd arrange it for here so that she didn't always have to be working when she came to see me. I was going to pay, but then the support workers said they'd help out. So they do kitchen and bathroom and the hoovering for me.*

Respondents were keen to discuss issues they had encountered – in this respect, they differed from many respondents in residential care for example who are often reported as being reluctant to express their views, perhaps disempowered by their status and dependent position.

There were some differences between the views of tenants and those of informal carers. Carers tended to be more protective of their relatives, and to worry for example about potential ‘intruders’ in the development, or about privacy in the dining room. Tenants however focused on issues such as their growing appreciation of how the development operated and the reassurance that they could get staff assistance when they needed it. Several joined the tenants association, and commented for example on discussions about heating bills, in which information about power charges by different providers had clearly been shared, and a campaign to change supplier was getting under way.

Home and community

As time went on, there was less talk of mealtimes, and more talk of friendships built within the developments, interaction with the community round about and participation in activities which had been organised in the developments. These included joining a dominoes team, playing carpet bowls, attending afternoon tea dances, taking part in religious services within the development,

or going on theatre outings. It was also clear that community life occasioned a gossip network, and characters as would be found elsewhere, such as an organiser, a good neighbour, a complainer, someone always ready for a chat and so on. Mealtimes continued to be significant for social interaction, with a tenant explaining that this was a time to

““*Catch up with all the news.*

It was clear that for many tenants, social interaction was a significant part of their days and that they valued this. There was a certain amount of grumbling about some activities – such as by a woman who thought dominoes was a waste of time:

““*That's a right old Granny's game!*

This however is indicative of the potential for choice of activity. A small number of tenants were at the forefront of organising social life, including a man who liked to organise games evenings, and a woman who explained that she thought the development needed a women's group:

““*Men have no conversation.*

All tenants in the new developments were in new homes, and had experienced the potential trauma of a house move. Some had moved twice - a care home had been closed, residents had temporarily moved to other accommodation, and then moved into housing with care. Perhaps surprisingly however, even if the moves had been traumatic, people did not present this as a problem. They were overwhelmingly positive about their new homes. Even those who had moved from long-standing previous homes expressed little regret, and there was no indication of lack of choice on their part. This is in marked contrast to the often-reported negative experience of moving into residential care, seen as loss and described by Vesperi (1995:16) as a 'brutally abrupt event'.

There was of course a period of adjustment to the new home, involving physical arrangement of possessions, as well as getting accustomed to moving about the house independently. This was a very individual process, but most people reached the point of being able to say

““ *I feel at home, I do.*

Tenants were individually responsible for furnishing their houses and did so with varying degrees of old and new. They talked of pleasure taken in carpets and furniture, many of them new items recently chosen. They appeared to value even more the photos, trinkets and memories brought with them from their previous homes. One tenant, in particular, took the interviewer around her new home and pointed out items her late husband had bought her, relating where each item had come from, and demonstrating great pride in the association these items held for her. The most talked-about objects were family photographs, which nearly everyone had.

At second interview, respondents appeared well settled, and had their homes set up as they wanted them. People described processes of rearranging the furniture and possessions to get them just right. One tenant had moved from a flat inside the main building to an outside cottage, and this move had suited her very well. She could now leave her front door open for her cat, and though she regretted not having a view, felt very much more independent in this situation. She liked visitors having direct access to her home without having to pass through the hub of the main building. For her, this independence was an important element of having her own home.

A minority of tenants had left housing with care by the time of the second interviews – it appeared that if people were not going to settle, they moved away fairly quickly, generally to residential settings. In the early stages of the programme, those most likely to leave were people who had been moved to housing with care

at a time of crisis, when they were assessed as being 'at risk' of going into residential care. An early decision was made that this was not an appropriate approach, and that housing with care was not an appropriate way of addressing issues of crisis. Later tenants were not therefore in immediate crisis situations, but assessed as potentially needing more care and as likely to benefit from housing with care.

A further group likely to leave were people with dementia, who found it much more difficult to settle after a move and needed more support. This was especially the case in the early months of the first development opening – potential reasons for this were firstly, that the decision about the move had been made too late, and secondly, that when the developments first opened, many tenants would be moving in at the same time, and it was difficult for staff to give extra support to people who needed it. As time went on, there were many examples of people with dementia who did settle into tenancies, and maintained them for a significant period. This is likely to be related to the improved assessment processes, to the 'bedding down' of housing with care as a model, to staff's increasing confidence in their roles, and to the gradual development of a situation in which new tenants would be moving in by stages, rather than in large numbers at one time.

Well-being and quality of life

The generally positive views about the housing with care developments reported so far already indicate the sense of well-being of many of our respondents. This well-being came from being settled in a new, convenient home, with their personal possessions, with the relative freedom in activities of daily living, and the availability of support when it was needed. For many too, retaining independence as far as possible was important – for these people, this was perhaps even more sensitive and valued than for those at home in the community, since they had overall higher support needs. Many had significant impairments, including mobility limitation due

to paralysis following strokes, arthritis, osteoporosis and other conditions. Others recounted that they had memory problems, which made life difficult. It was clear that several of the problems were related to working and living conditions. For men they frequently related to employment in mining.

Despite these often severe problems, respondents gave the impression of not wanting to dwell on them. They appreciated the accessibility of the housing with care developments, which often represented a considerable improvement on their previous homes. As time went on, as we have noted, people's activities settled into patterns they preferred, with many taking advantage of the flexibility offered by housing with care as well as the developing community life within the developments. This is not to say that everyone was perfectly content all of the time – but this would not be the kind of 'ordinary life' that research demonstrates older people want and prefer to continue.

Even those with very severe problems preferred to 'carry on' despite difficulties. For example, one person with a serious degenerative condition explained

“I'm sort of up and down all the time now.

Nevertheless he added

“I love it here.... They're [staff] really good.

He went on to describe the extra support he had received from a specialist association, and from local taxi drivers. He described his enjoyment of the company of other tenants at mealtimes, his appreciation of the freedom he had to choose a late bedtime, and the pleasure he took in watching sport on television, or being taken out to go to the races. Significant elements of this tenant's quality of life can be linked with the model of care and holding the tenancy, rather than living in an institutional setting.

The potential for housing with care to deliver improved quality of life and to sustain independent living was illustrated over time as the health status of respondents deteriorated. There were examples of people who had become ill and gone into hospital who were able to return home to housing with care, in which short periods of intensive support were readily supplied. Although it is not possible to say that in these particular cases people would otherwise have stayed in hospital, it was clear that they departed from the frequent experience of older people unable to leave hospital because of a lack of suitable accommodation to which to return, and furthermore did not leave hospital for residential care, unable to return home following illness. They appear to have benefited from the housing with care model's commitment to maintaining people in their own homes, rather than in hospital or residential care.

The impact of smart technology

Tenants in housing with care had the same basic package of technology as those in the community, and the alarms were linked to the Call Centre in exactly the same way. Even though staff were on the premises during the day and there was a worker on call at night doing a 'sleepover', the staff did not respond directly to alarms – these always went through the Call Centre, which followed the individual protocols in the same way as it did for community-based alarms. If an alarm necessitated a staff visit, there was a key advantage that the staff were nearby, and could respond quickly.

Tenants also had their technology packages augmented with a range of additional devices. Everyone had a door entry system, whereby they could see and speak with their callers on the television before letting them in, which was done remotely. They also had a pull-cord in their bathrooms and a pendant alarm. Others had various additional pieces of equipment such as devices to operate windows and internal doors. In the first housing with care development, a MIDAS system was installed, but this was only being piloted during the period of the evaluation, as previously noted.

Overall, responses to the technology in housing with care were positive. However, it was even more difficult to identify the specific impact of the technology in housing with care, as people had also experienced a move to a new house and the delivery of a new kind of support. The technology was only part of a much broader change in their lives, and its specific impact was thus hard to isolate.

Tenants' comments about technology in housing with care particularly related to the personal alarms and the door entry systems. The lack of reports of the use of flood, smoke and heat detectors in housing with care as compared with the community based model may be related to the improved convenience and safety of the housing with care tenancies.

In general, tenants appeared to have understanding of the technology installed in their homes, though it was clear that in housing with care, it was much less obviously there – it had come as part of the new accommodation, and had not involved a process of installation, with obvious disruption to the home as had been experienced by community based clients. Specific equipment to support particular individual needs was more obvious, but even this attracted rather little attention – it was seen as part of the whole package of support, including the new accommodation that people had moved to, and 'part of the furniture'.

Tenants understood that the technology was a means of calling for help in an emergency and recounted occasions on which they had done so. These included incidences of falls, of feeling unwell, of needing help to move somewhere. There were indications that when people initially moved to housing with care, they were a little uncertain about the alarms, and several reported early problems, such as using the alarms often when they first moved in, or not being clear that the alarms were working properly. In later interviews however, it was more likely that people would say that the technology was taken for granted, or 'just there in the background' and that it did not do anything. They became accustomed to the

technology, and there were fewer accounts of problems with it over time.

The early difficulties are however instructive, and illustrate some general issues about using technology which offer wider lessons.

One set of problems related to the door entry systems and the need for clarity in their use – in time, these became very popular with tenants, but at first, they created considerable confusion. The key issue was that the door buzzers sounded like alarms, and tenants tended to interpret a buzz at the door as an alarm. They would not then answer the door, and visitors would not be able to contact them. When the interviewer arrived, tenants would typically comment:

““ *The alarm went off there and I don't know what it was. It may be the smoke detector.*

Or tenants would comment that they had been to open the door, and there was nobody there, or they had spoken to the interviewer over the phone and had not realised that she was at the door. Over time, this problem diminished, but it does illustrate the need for clarity in the workings of the technology, and its potential to confuse. When the system was working as intended, a typical reaction was

““ *It is very safe because you see who it is and if you don't know the person then you don't need to open the door.*

Further issues attached to the pendant alarms. Several tenants did not wear the alarms whilst in their homes – they would however put them on when they went for their lunch. In some cases it was clear that people had not understood how the alarms worked – that they would need to press the button on the alarm to summon help. In others, people simply did not like wearing an alarm – in these cases perhaps wearing it out to lunch was a demonstration to the staff of ‘good behaviour’, echoing some of the perspectives about

institutional life highlighted earlier. In other cases still, tenants suggested that they had just forgotten about the alarm, perhaps reflecting the increased safety and security that many reported.

Sometimes, people did not have sufficient technological support. For example, the front doors of some of the bungalows were large and heavy (for security reasons), and hard to use if people lacked physical strength, or used mobility aids such as wheelchairs or zimmer frames. Some tenants did not mind asking for help each time they went in and out of their doors:

“Well, there’s always someone ... well the only time that I go out is when I’m having a meal and there’s always someone to open the door for me.

For others however, there was disappointment that several months after moving into their tenancies they were still awaiting modifications to their doors. Two tenants specifically mentioned that this was stopping them from coming in and out of their doors independently. Door-openers were clearly needed in cases such as these. These tenants wanted to get in and out of their houses independently, and saw the potential of technology to enable them to do this. They did not feel they should accept being ‘stuck’ in the house when a ready solution, which did not involve relying on other people, was available.

Conclusions

For people who moved into housing with care, the focus of their responses was on the whole model of care, particularly the housing with care development itself. Tenants had experienced radical change in their lives, not simply the introduction of technology as part of the packages of care and support, but also a move to a new home, with a new pattern of formal and informal support, with smart technology as an element of this whole. It was therefore more difficult for the evaluation to highlight the specific impact of the technology.

Housing with care was popular with those – the large majority – who were able to sustain tenancies. Tenants reported enhanced quality of life, and pride in their new homes. There was clear evidence of the effectiveness of the capacity-building approach, which had not infrequently supported people to resume activity and independence formerly compromised by unsuitable accommodation or traditional residential care regimes.

As time went on, the housing with care developments themselves developed new community relationships, moving closer to the sort of ‘ordinary life’ preferred by older people. This had both positive and negative points – like ‘ordinary life’ – but people from various backgrounds with differing interests and preferences found it congenial.

There was significant evidence that tenants were able to exercise choices and preferences, as the model of care intended. These included choices at home, such as household arrangements, bedtimes, visitors, what to watch on television, as well as wider choices concerning for example, participation in organised activities.

Where difficulties remained for some tenants and their families, these were sometimes linked with a continuing desire for and expectation of more help, and a regime akin to residential care homes. In others, notably the instances of the long-awaited assistance with the doors, they should have been more easily resolved. There remained in addition, a population of people for whom housing with care was clearly not the appropriate way of living, and this was at least partly due to the time at which people were supported to move in. Others, with similar conditions, who had moved into housing with care at an earlier stage in their lives, appeared over the time of the evaluation to have done well.

The focus on the tenants illustrates clearly the importance of considering smart technology within the context of the model of care. The particular approach to housing with care taken in West

Lothian, as we have indicated, emphasised capacity-building; support was organised on the basis of individual protocols rather than institutional imperatives; all calls for support went through a call centre; there was little ‘just in case’ visiting; independence of tenants was actively promoted and supported. The tenants, in speaking about their experiences of housing with care, focused on the whole package and clearly saw the technology as part of this. Whereas for people who had had technology installed in their own homes in the community, this had been a clearly marked event, for the tenants, the technology was there from the beginning, and very much taken for granted – indeed, they were seeking technological solutions to some of the difficulties they faced, such as those with the design of the doors. In expressing their satisfaction with their tenancies, they clearly referred to the whole package of support, and did not single out or highlight the technology. The model of care appealed to a large majority of our respondents. For those who had difficulties and moved on, the problem was not the technology – it was the kind of care and support they needed on a wider front.



Chapter Five: **The costs of social care in West Lothian**

5

By David Bell

Key points

- West Lothian performs very well compared with other Scottish local authorities in its care and support services for older people;
- West Lothian receives and spends a relatively small amount on these services, producing high quality support and care at low cost;
- West Lothian has been especially effective in dealing with delayed discharge;
- The new forms of care and support are central to this performance. They offer high quality combined with control of costs.

Introduction

This chapter analyses the costs of care in West Lothian and considers the effect of the smart technology initiative. It covers four care settings: care homes, sheltered housing, the new housing with care developments and care at home. Characteristics of these care types are described elsewhere in the report. The analysis of care

costs associated with technology is inextricably bound up with the care settings, two of which incorporate smart technology.

In the first part of the analysis, we consider the background demographics of West Lothian in relation to the rest of Scotland and examine West Lothian's comparative performance

West Lothian in context

There is considerable information on care needs and care provision in West Lothian which helps set this analysis in context. This is available mainly from data on social care and local authority finance provided by the Scottish Executive, from the 2001 Census provided by the General Registrar's Office Scotland and from the analysis of local authority performance provided by Audit Scotland. In presenting these data, we compare West Lothian with Scotland as a whole and evaluate how it performs relative to other Scottish local authorities. We also include material on the local Health Board – Lothian Health, which covers not only West Lothian, but also Midlothian, East Lothian and Edinburgh City.

Older population

At the 2001 Census, there were 1.1 million individuals aged 60 and over in Scotland. Among these, 25,800 lived in West Lothian. Those aged 60 and over comprise 16.2 per cent of the West Lothian population, substantially below the Scottish figure of 21.1 per cent. Thus West Lothian has a relatively young population compared with Scotland as a whole. However, the projected rate of increase of the older population in West Lothian is the highest in Scotland. Between 2004 and 2024, those aged 60 and over will increase by 72 per cent in West Lothian, compared with only 39 per cent in Scotland as a whole. This implies that West Lothian will face proportionately greater challenges in its care provision compared with the rest of Scotland in coming decades.

In terms of the availability of resources, the Scottish Executive's estimate of the spending required on older people in West Lothian

(Grant Aided Expenditure¹⁶ or GAE) is £1085 for each person aged over 65. This compares with £1191 for Scotland as a whole and, for example, £1446 in Glasgow City and £1240 in Edinburgh. West Lothian receives the sixth lowest per capita older people's GAE among Scottish local authorities.

Health and informal care

Around 9.5 per cent of the West Lothian population described their health as 'not good' at the 2001 Census. This compared with 10.2 per cent in Scotland as a whole. Thus the self-reported perceptions of health of the West Lothian population appear to be better than in Scotland as a whole. Nevertheless, 9.5 per cent of all adults in West Lothian reported that they provide unpaid care to people with long-term disability, ill-health or problems relating to old age – this is the same proportion as in Scotland as a whole. Whilst these figures relate only to people's own perceptions, they may suggest that West Lothian residents are prepared to provide the same level of informal care as in the rest of Scotland, even though levels of health may be better than elsewhere.

Geriatric care and care homes

Geriatric continuing care costs in Lothian Health Board as a whole in 2005 were £1121 per week, close to the Scottish average which is £1128. In contrast, a neighbouring Health Board, Forth Valley, has one of the cheapest costs for geriatric care - £976 per week. A similar pattern occurs with acute services, which are also heavily used by older people. The cost per acute case in West Lothian is £2159, compared with an average of £2149 in Scotland as a whole. Forth Valley costs are lower at £1956, but this may partly reflect that more complex treatments are allocated to Edinburgh, which is within the Lothian Board area. There have been, as we have described, clear policy drivers to reduce the numbers of hospital beds occupied by people who could be cared for outside hospital, and these figures illustrate the significant costs that may be moderated by such policies.

¹⁶GAE is calculated to reflect local conditions, such as demography and levels of deprivation. It is independent of the approach to care.

West Lothian has a slightly smaller share of care home places than its size would suggest. Whereas Scotland as a whole has 46.4 care home places per 1000 population aged over 65, West Lothian has 7.3 per cent fewer – 43 places per 1000 population aged over 65. In 2004, occupancy rates in West Lothian averaged 94.1 per cent, compared with a Scottish average of 91.1 per cent. The lower share of care home places is quite consistent with the lower number of older people in West Lothian, and also relates to the recent closures of care homes in favour of the new developments, including the newly built complexes as well as increased emphasis on care at home.

Charges for local authority care home places in West Lothian are significantly lower than in the rest of Scotland, whereas there is virtually no difference in the charges for privately provided care home places (See Table 5.1). In contrast, local authority care home charges in other authorities are significantly above the Scottish average. These differences may reflect differences in charging policy between local authorities or varying real costs. However, it is unlikely that there are inherent differences in cost structures between West Lothian and similar authorities. Strong evidence to support this argument comes from the very small differences between the local authorities and indeed Scotland as a whole in respect of private sector care home charges as Table 5.1 shows.

Table 5.1: Care Home Charges 2004 (per week)

| | Local authority | Independent | All |
|---------------------|-----------------|-------------|-----|
| West Lothian | 374 | 420 | 412 |
| Scotland | 459 | 421 | 427 |

Source: Care Home Census Statistical Return - Mar 2003/Mar 2004

These figures suggest that West Lothian's local authority care homes are relatively economical from the client's point of view.

Delayed discharge

One very important aspect of recent policy for older people in Scotland is to reduce the numbers of older people who are staying in hospital too long, because adequate arrangements for care on discharge have not been made. Reductions in delayed discharge attracted additional funding, principally through the Joint Future initiative.

West Lothian's delayed discharge performance has improved dramatically and more significantly than in other areas. In April 2001, there were 48 patients awaiting discharge into care provided by the local authority, 17 of whom had been waiting for longer than six weeks. The mean waiting duration was 63 days. In April 2006, there were only three patients waiting, two of whom had waited longer than six weeks. The mean duration of this very small group was 50 days. Thus, the numbers of those waiting for discharge fell by 88 per cent in West Lothian during this five year period. Over the same period of time the numbers in Scotland as a whole fell from 2469 to 997 – a reduction of 60 per cent.

West Lothian's initial share of the Scottish total of delayed discharges was 1.9 per cent, which is very closely aligned to its share of the over-75 population in Scotland. West Lothian's reduction was dramatically better than most local authorities. Highland was the only other local authority to achieve a comparable reduction. Midlothian, Edinburgh and East Lothian, which all fall within the same health board as West Lothian achieved reductions of 83 per cent, 55 per cent and zero in the numbers waiting for discharge.

Reductions in delayed discharges clearly produce cost savings for the NHS. If West Lothian had only achieved the Scottish rate of reduction in delayed discharges by 2006, it would have required an additional 536 bed nights for this cohort of clients. These 536 bed nights would have cost £85,837. The achievement of such significant time (and resource) savings is likely to be related to the changes

in social care arrangements described in this report, with one key factor being the Rapid Response service, which was integrated with the smart technology programme.

Provision of social care in West Lothian

Historically, the number of care assessments in West Lothian has been above the Scottish average. However, in recent years there has been a sharper increase in assessments in the rest of Scotland than in West Lothian (Table 5.2). West Lothian's less rapid increase implies that costs in this area will also have increased more slowly than elsewhere. These data suggest that nearly a quarter of the West Lothian population aged 65 and over are assessed each year.

Table 5.2: Number of community care assessments or reviews for older people aged 65+ per 1,000 population

| | 2001-2002 | 2002-2003 | 2003-2004 | 2004-05 |
|---------------------|-----------|-----------|-----------|---------|
| West Lothian | 229.2 | 235.5 | 226.0 | 233.5 |
| Scotland | 201.4 | 215.8 | 226.4 | 219.3 |

Source: Audit Scotland Social Work Performance Indicators 2003-04 and 2004-05

The figures suggest that West Lothian has succeeded in controlling levels of assessment, and thus controlling the resources allocated to this activity.

West Lothian's assessment rate of people with dementia exceeds the equivalent rate in Scotland as a whole (Table 5.3). In general, assessment rates associated with dementia are less than one tenth of the overall assessment rate for older people.

Table 5.3: Number of community care assessments or reviews for older people aged 65+ with dementia per 1,000 population

| | 2001-2002 | 2002-2003 | 2003-2004 | 2004-05 |
|---------------------|-----------|-----------|-----------|---------|
| West Lothian | 19.1 | 16.9 | 22.7 | 26.3 |
| Scotland | 17.1 | 18.1 | 18.4 | 17.5 |

Source: Audit Scotland Social Work Performance Indicators 2003-04 and 2004-05

The higher numbers of assessments suggest that more people with dementia are being considered for support, and may also reflect better diagnosis rates.

The number of individuals aged over 65 receiving some community care service in West Lothian is slightly above the Scottish level, (Table 5.4). It is surprising that West Lothian comes so close to the average level of provision, given that the demographics suggest that the share of those aged 65+ in Scotland as a whole is more than 50 per cent above the West Lothian share. Again, the figures suggest delivery of services to more people who need them, including people below the highest levels of dependency.

Table 5.4: Number of people aged 65+ receiving a community care service per 1,000 population.

| | 2001-2002 | 2002-2003 | 2003-2004 | 2004-05 |
|---------------------|-----------|-----------|-----------|---------|
| West Lothian | 253.1 | 269.3 | 254.5 | 283.0 |
| Scotland | 240.6 | 249.9 | 258.6 | 254.4 |

Source: Audit Scotland Social Work Performance Indicators 2003-04 and 2004-05

Provision of services to those with dementia is shown in Table 5.5. In 2004-05 there was a substantial expansion of provision in West Lothian, taking it well above the equivalent rate for Scotland as a whole.

Table 5.5: Number of people with dementia aged 65+ receiving a community care service per 1,000 population

| | 2001-2002 | 2002-2003 | 2003-2004 | 2004-05 |
|---------------------|-----------|-----------|-----------|---------|
| West Lothian | 19.7 | 19.8 | 21.8 | 30.2 |
| Scotland | 19.2 | 20.9 | 22.2 | 22.1 |

Source: Audit Scotland Social Work Performance Indicators 2003-04 and 2004-05

Table 5.6 illustrates spending per head on home and community based services in West Lothian and Scotland between 2001 and 2004¹⁷. West Lothian spends significantly less per head on these services, which consist predominantly of services for older people. Given that the level of service provision for older people in West Lothian is close to, or above, the Scottish average, this suggests that the authority is relatively efficient in the provision of social care. We subsequently return to this argument in more detail.

Table 5.6: Total spending per head of population aged 18+ for home and community based services

| | 2001-2002 | 2002-2003 | 2003-2004 |
|---------------------|-----------|-----------|-----------|
| West Lothian | £109.51 | £131.16 | £179.04 |
| Scotland | £138.78 | £148.87 | £222.42 |

Source: Audit Scotland Social Work Performance Indicators 2003-04

Spending on long-term residential and nursing home care grew more rapidly in West Lothian than Scotland as a whole between 2001 and 2004, as Table 5.7 shows. Nevertheless, in 2004 it was broadly in line with West Lothian's share of the Scottish population aged 65 and over.

Table 5.7: Total expenditure on long-term residential and nursing home care (£m)

| | 2001-2002 | 2002-2003 | 2003-2004 | Growth 2001-2 to 2003-4 |
|---------------------|-----------|-----------|-----------|-------------------------|
| West Lothian | £15.1 | £17.2 | £22.8 | 51% |
| Scotland | £564.0 | £699.5 | £782.9 | 39% |

Source: Audit Scotland Social Work Performance Indicators 2003-04

West Lothian spends a larger, though diminishing, share of its social care budget on residential and nursing home care. Between 2001/02 and 2003/04 the share dropped from 53.6 per cent to 51.3 per cent. In Scotland as a whole, the proportion rose between 2001/02

¹⁷ This series of figures was not continued in 2004-05

and 2003/04 from 52.9 per cent to 54.2 per cent, but then fell dramatically in 2003/04 to 47 per cent¹⁸.

Care staff in residential homes are somewhat more likely to have appropriate qualifications¹⁹ in West Lothian than in Scotland as a whole (Table 5.8). One might expect that this would drive up costs relative to the rest of Scotland, but we have already noted that care costs are relatively low in West Lothian. This suggests a greater ability to attract qualified staff, and that the organisation and delivery of services in West Lothian may compensate for the higher costs of qualified staff.

Table 5.8: Percentage of care staff in residential homes for older people with appropriate qualifications

| | 2003/2004 | 2004/2005 |
|--------------|-----------|-----------|
| West Lothian | 51% | 52% |
| Scotland | 42% | 47% |

Source: Audit Scotland Social Work Performance Indicators 2003-04 and 2004-05

Home care hours are fewer in West Lothian compared with other parts of Scotland (Table 5.9). But a very high proportion of these are devoted to personal care. This suggests that West Lothian has particularly focussed its efforts on clients with higher levels of need.

¹⁸ All figures are from Audit Scotland Social Work Performance Indicators

¹⁹ Scottish Vocational Qualifications

Table 5.9: Home care hours and personal care 2003-04 and 2004-05

| | Total number of homecare hours as a rate per 1,000 population aged 65+ | Number of homecare clients receiving personal care | Percentage of homecare clients receiving personal care |
|---------------------|--|--|--|
| West Lothian | | | |
| 2003-04 | 312.8 | 851 | 84.9% |
| 2004-05 | 298.8 | 948 | 91.0% |
| Scotland | | | |
| 2003-04 | 512.2 | 33,311 | 57.2% |
| 2004-05 | 561.6 | 35,462 | 63.0% |

Source: Audit Scotland Social Work Performance Indicators 2003-04 and 2004-05

Perhaps as a result of this client profile, West Lothian provides a higher proportion of its clients with overnight care than is the case for Scotland as a whole (Table 5.10), though this share fell quite dramatically between 2003-04 and 2004-05. The proportion of clients receiving a home care service at weekends is well above the Scottish average. We suggested earlier that individuals in West Lothian reported themselves just as willing and/or able to provide informal care as is the case for Scotland as a whole. Nevertheless, weekend provision by West Lothian rose sharply in 2004/05, alongside a drop in evening or overnight services. In both cases however, provision of these services remains well above the figure for Scotland, suggesting higher levels of service provision and reinforcing the impression of effective deployment of limited resources.

Table 5.10: Percentage of homecare clients receiving a service by time of delivery

| | Percentage of homecare clients receiving a service during evening/overnight | | Percentage of homecare clients receiving a service at weekends | |
|---------------------|---|---------|--|---------|
| | 2003/2004 | 2004/05 | 2003/2004 | 2004/05 |
| West Lothian | 64.2% | 48.6% | 47.7% | 69.2% |
| Scotland | 24.3% | 27.2% | 48.3% | 53.9% |

Source: Audit Scotland Social Work Performance Indicators 2003-04 and 2004-05

Costs of care and relative performance

Another way of evaluating these indicators is to compare West Lothian's performance when ranked against other Scottish local authorities.

Table 5.11 includes some of the Performance Indicators that we have already discussed as well as some new ones. Alongside is West Lothian's rank compared with the other 32 Scottish local authorities. In the bottom line we indicate that West Lothian came 28th out of the 33 authorities in spend per head on older people: as implied already West Lothian does not spend a large amount per person on older people compared with most other local authorities. This is true whether one ranks spending per head in gross or net terms and is also consistent with the relatively low allocation for older people received by West Lothian from the Scottish Executive.

West Lothian is in clear first place in respect of five indicators – some have to do with care home facilities while others have to do with the flexibility of home care provision. It is also within the first five in another four out of the total of 16 indicators. Thus West Lothian is within the first five Scottish local authorities for one half of all of Audit Scotland's Performance Indicators. The outcome on some other indicators is poorer, but only four are in the "bottom half" of the league. Only one is lower than West Lothian's ranking in terms of spending per head on older people. Thus, while spending per head is relatively low, West Lothian performs remarkably well

– suggesting that it is very effective at deploying its resources towards achieving goals that are congruent with Audit Scotland’s Performance Indicators.

Table 5.11: Ranking of West Lothian using Audit Scotland’s Performance Indicators.

| Performance Indicator | Rank |
|---|-------------|
| Number of community care assessments or reviews for older people aged 65+ per 1,000 population | 9 |
| Number of community care assessments or reviews for older people aged 65+ with dementia per 1,000 population | 5 |
| Number of older people aged 65+ receiving a community care service | 17 |
| Number of older people aged 65+ with dementia receiving a community care service per 1,000 population | 4 |
| Percentage of care staff in residential homes for older people with appropriate qualifications | 17 |
| Percentage of care staff in residential homes for older adults and other adults with appropriate qualifications | 15 |
| Percentage of occupied voluntary sector places for old people that are single rooms | 1 |
| Percentage of occupied private sector places for older people that are single rooms | 13 |
| Percentage of occupied council places for older people that have en suite facilities | 1 |
| Percentage of occupied voluntary sector places for older people that have en suite facilities | 1 |
| Percentage of occupied private sector places for older people that have en suite facilities | 5 |
| Percentage of homecare clients receiving personal care | 1 |
| Percentage of homecare clients receiving a service during evening/overnight | 1 |
| Percentage of homecare clients receiving a service at weekends | 4 |
| Number of nights provided as residential respite care for elderly people as a rate per 1,000 people aged 65+ | 30 |
| Number of hours of respite care provided at home for elderly people as a rate per 1,000 people aged 65+ | 19 |
| Spending Per Person Aged 65+ | 28 |

Source: Audit Scotland Social Work Performance Indicators 2004-05

Costs

We now consider costs at the individual level using data received from West Lothian. As far as possible, we apply the methodology used by Laing (2004). Thus we estimate total living costs for individuals in different care settings. These include their “hotel” costs. These totals are subsequently allocated between the client and the local authority depending on the client’s financial circumstances. In 2004-05, West Lothian paid for 78 per cent of the gross costs of home care within its boundaries²⁰.

We have two sources of information. First we have estimates of weekly costs excluding care produced centrally by West Lothian Council. Second, we have estimates of hours of care provided in each of the care settings produced from a sample of the West Lothian caseload.

The central information on costs is shown in Table 5.12. Care home costs are shown in aggregate since the breakdown within the contracted price is not known to the local authority. The costs of Sheltered Housing and Opening Doors New Build²¹ include a rental charge, to meet housing management related costs. An accommodation cost is also estimated for Opening Doors Dispersed²² to reflect the fact that “hotel” costs associated with the other care settings are included in their costs, even though they are not strictly costs of care.

²⁰Source: Scottish Executive LFR3 Return

²¹In the analysis that follows, we use this term for the new developments

²²We use this term to denote care at home

Table 5.12: Central Information on costs in West Lothian by setting

| Average Weekly Cost (£) | Care Home* | Sheltered Housing | Opening Doors New Build | Opening Doors Dispersed |
|---------------------------|------------|-------------------|-------------------------|-------------------------|
| Accommodation/Rent Cost | | 45 | 51 | 75 ¹ |
| Service Charge | | 32 | 35 | |
| Meals (If provided) | | 42 | 42 | 42 |
| Heating/Fuel | | 5 | 10 | 14 ² |
| Support Cost ³ | | 11 ⁴ | 128 | 7 ⁵ |
| Care Cost | | | 80 ⁶ | |
| TOTAL | 531 | 135 | 346 | 138 |

As at end March 2006

Notes

1. Based on Rent Officer level for one bedroomed property in West Lothian.
2. Based on average WL annual fuel bills of approx £700 per year for a one bedroom house (these depend on house type/location/ construction).
3. These are housing support costs eligible for funding under Supporting People.
4. This includes the warden service and community alarm service.
5. This is the weekly cost of running the basic technology package and its operation, including the Call Centre, staffing, battery replacement and depreciation. It is also included in costs for new build.
6. This figure relates to the personal care element in the job descriptions of the generic staff working in housing with care.

Source: West Lothian Council (Revenues/Fuel Advice/Social Policy)

The Opening Doors New Build estimates attempt to capture all of the costs associated with this form of care provision, including the costs of the smart technology and the on-site staff teams.

To complete the estimates in Table 5.12, we used a sample drawn from the West Lothian social work client base. We now describe the characteristics of this sample.

The sample

While we already have estimates of the costs of care in the Opening Doors New Build setting, we construct estimates of weekly care costs in all settings except care homes from data drawn from a sample of 57 clients in West Lothian. The data was recorded between January 2001 and July 2004 using monthly client records.

Table 5.13 shows the allocation of the sample by care type. These do not include a sample from care homes, since these costs would be consistent across the period. In the other settings, costs can be seen to vary, as care needs change.

Table 5.13 Individuals by Care Type (West Lothian sample)

| Sex | Sheltered housing | | Opening Doors New Build | | Opening Doors Dispersed | | Total |
|--------|-------------------|-----|-------------------------|-----|-------------------------|-----|-------|
| Male | 5 | 14% | 0 | 0% | 14 | 40% | 19 |
| Female | 14 | 27% | 10 | 20% | 14 | 27% | 38 |
| Total | 19 | 22% | 10 | 12% | 28 | 33% | 57 |

There were no significant differences in average age across care settings.

We do not directly observe dependency levels in this sample. However, we can use additional information to estimate dependency levels. For these estimates to be accurate, we need to assume that our sample's dependency levels are similar to those in a different study of older people in West Lothian (Lardner et al. 2004). In this study, individuals were allocated by care type to one of eight SCRUGs²³ categories – A to H. These are allocated to levels of dependency as follows: Low: A and B; Moderate: C, D and E; High: F, G and H.

Applying our sample's distribution of care type to the SCRUGs data gives the implied distribution of dependency category for our

²³Scottish Care Resource Utilisation Groups (Lardner 2004:4).

sample, which is shown in Table 5.14. Most clients are in the low dependency category and this is most particularly the case for sheltered housing and Opening Doors New Build. Those receiving the Opening Doors Dispersed service have the broadest range of dependency so that while the majority of clients are low dependency, there is still a substantial share (19%) of high dependency clients among this group. While these are only estimates of the distribution of dependency by care type, it is important that they be borne in mind when discussing costs, since level of dependency will play an important role in determining the costs associated with individual clients.

Table 5.14 Implied Dependency Level by Form of Care (West Lothian Sample)

| Dependency | Low | Moderate | High |
|-------------------------|-----|----------|------|
| Sheltered housing | 94% | 6% | 0% |
| Opening Doors New Build | 89% | 9% | 2% |
| Opening Doors Dispersed | 56% | 25% | 19% |

We now construct estimates from the sample of weekly care costs associated with each of these settings.

Revenue costs

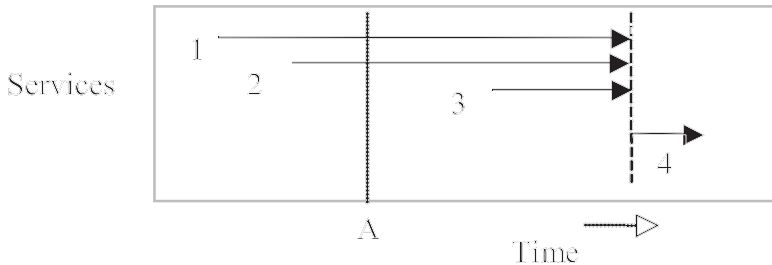
There is an important conceptual issue in interpreting costs data. It is whether to focus on per period or per client costs. Per period costs capture how much care is provided by social work departments each period. Per client costs try to capture the total cost of supplying care to a client. This cost is calculated over the entire period during which the client receives care and may include spells of hospitalisation. The difference between these two types of cost measurement is shown in Figure 5.1.

The West Lothian data on care hours provided show a steady build up of provision as the services provided after the initial assessment are extended. Thus the client whose costs are illustrated in Figure

5.1 is initially assessed as requiring Service 1. Subsequently both Service 2 and Service 3 are added. Then these services are discontinued while the individual receives treatment in hospital (Service 4).

The most common recording period for cost information is weekly. Thus, to ground the discussion in practice, we now substitute “weekly” costs for “per period” costs. The weekly cost of care is the costs of those services which the client is receiving during week A in Figure 5.1. It comprises the total costs of care for the client in that week. So long as there is a distribution of clients at different stages of care at any point in time, the averaged value of such cost snapshots will provide a reasonable estimate of the average weekly cost of providing care.

Figure 5.1: Per Period and Per Client Costs of Care



The total cost of care for services provided to the client is the sum through time of Services 1 to 4, which is captured on the diagram by the costs represented within the whole rectangle. Clearly, this may include services that are provided by different agencies, such as health and social care .

Combining both approaches to costing enables a comparison of the intensity and duration of care provision. High intensity, low duration provision would imply high values for costs in week A, but relatively

low values for the ratio of total cost, to the cost in week A. For low intensity long duration provision, the ratio would be much larger.

Table 5.15 shows the estimated hours of personal and domestic care provided from the sample. The “Total” figure gives the average hours provided to each client during the sample period: the “Weekly” amount averages this over the number of weeks that the care was provided.

Table 5.15: Average Hours of Care Per Client

| | Personal | | Domestic | |
|--------------------------------|----------|--------|----------|--------|
| | Total | Weekly | Total | Weekly |
| Sheltered Housing | 246.5 | 10.3 | 52.9 | 2.4 |
| Opening Doors New Build | 35.0 | 4.1 | 121.2 | 3.9 |
| Opening Doors Dispersed | 653.1 | 15.0 | 179.9 | 3.6 |

Mean weekly costs of provision by care setting are shown in Table 5.16. These are drawn from the individuals in our sample. It is not possible to break these down into personal and domestic care costs since a significant proportion of records simply provide an aggregate cost associated with a combination of domestic and personal hours. We do not quote hourly rates for different types of care, since rates sometimes differed across suppliers. Note that the centrally provided estimate of weekly care costs in Opening Doors New Build (£80) is close to our calculation of the weekly costs (£74), giving increased confidence in both figures.

Table 5.16: Mean Weekly Cost of Care Provision

| | Weekly |
|--------------------------------|--------|
| Sheltered Housing | £123.4 |
| Opening Doors New Build | £74.1 |
| Opening Doors Dispersed | £230.3 |

We add these costs to the data in Table 5.12, having allowed for the effects of inflation by including an 8 per cent increase in weekly

costs over the two year period (this brings our estimate of the weekly care costs of Opening Doors New Build in line with the current central estimate of £80 per week). This gives a set of final estimates for the weekly costs of care in the four settings, which are shown in Table 5.17.

Table 5.17: Final Estimates of Weekly Cost of Care

| Average Weekly Cost | Care Home | Sheltered Housing | Opening Doors New Build | Opening Doors Dispersed |
|-----------------------------|------------|-------------------|-------------------------|-------------------------|
| Accommodation/ Rent Cost | | 45 | 51 | 75 |
| Service Charge | | 32 | 35 | |
| Meals (If provided) | | 42 | 42 | 42 |
| Heating/Fuel | | 5 | 10 | 14 |
| Support Cost | | 11 | 128 | 7 |
| Care Cost | | 133 | 80 | 249 |
| TOTAL | 531 | 268 | 346 | 387 |

In interpreting Table 5.17, it is important to note that, as we have described in the report, these settings are not necessarily alternatives. In particular, one aim of the innovations was to permit ‘ageing in place’, that is, remaining in one’s own lifetime home. The table suggests:

- Weekly costs of the Opening Doors New Build model are around £185 lower than care homes. This corresponds to £9,620 per unit per place per annum, a reduction of £288,600 compared with the costs of an average 30 unit development.
- Opening Doors Dispersed is somewhat more expensive than Opening Doors New Build, but less than Care Homes.

One caveat on these estimates is that with a relatively small sample, estimates of care costs have fairly large uncertainty associated with them. This is partly because these costs are very skewed. Most

clients have fairly low weekly costs, but for a relatively small number, weekly costs can be much larger. Thus, for example, one might argue that care costs in Opening Doors Dispersed have perhaps been overestimated. However, our expectation from Table 5.15 that a small number of clients in this care setting are high dependency suggests that one should be cautious with this line of argument.

It is important to consider the relationship between level of dependency and care costs: one might expect higher dependency would necessarily involve higher cost. However, one has to examine this argument carefully. In a well-functioning care system, individuals will be accommodated in a setting that is at least able to provide the services that are consistent with their level of dependency. This means that costs and dependency are not necessarily closely linked because, for example, when a care setting does not exist e.g. Opening Doors New Build, moderate-dependency individuals may be allocated to care homes. Such care homes may be able to provide more services than the client requires, but a care home setting may be the only safe option that a care manager can recommend. This implies that there are efficiency gains to be made by having forms of care setting that are appropriate to a wide variety of dependency levels. It also raises interesting questions about the longer term for Opening Doors New Build – a care setting which can accommodate changing and increasing needs will clearly be more efficient than a series of ‘stepwise’ alternatives. Opening Doors New Build is designed to work in precisely this fashion, and its long term efficiency gains are likely to be greater.

Conclusions

Our research into the costs of care in West Lothian has shown the following:

- (1) Aggregate indicators of the performance of care provision in West Lothian show that it compares extremely well with other Scottish local authorities

- (2) Compared with other Scottish local authorities, West Lothian is allocated a relatively small amount, and spends a relatively small amount on care for older people. Coupled with (1), this suggests that West Lothian is very efficient compared with other local authorities in producing good care services for older people at low cost.
- (3) Although it may produce upward pressure on the overall care budget for the local authority, in that more people are discharged from hospital sooner, West Lothian's policy for reducing delayed discharge has been more effective than that in Scotland as a whole.
- (4) Part of the explanation for West Lothian's high efficiency is likely to be its provision of new forms of care that are appropriate to client need. Thus, Opening Doors New Build and Opening Doors Dispersed both produce substantial savings compared with care homes and are likely to provide significant overall cost savings.



Chapter Six:

Lessons about smart technology and community care

6

Key points

- Comparatively, West Lothian's approach to change is radical rather than step-wise, involving a strategic approach to the use of technology, greater independence, safety and security for clients and peace of mind for informal carers.
- The key lessons from the West Lothian experience are:
 - Smart technology is effective in a model of care promoting independence, choice and capacity-building and in supporting older people and informal carers;
 - For staff, smart technology can be a catalyst in a cultural change regarding service delivery;
 - A mainstreaming strategy can offer wider support, reduce the stigma of using services and facilitate additional support if needed;
 - Costs can be controlled, ensuring effective use of limited budgets alongside improvements in services.

Introduction

The innovative programme of smart technology and community care in West Lothian involved a radical re-thinking and re-designing of care and support services for older people across a whole local authority. The report has described the new system, and considered its impact for staff, clients and informal carers. This chapter considers the West Lothian programme in comparison with a more conventional approach to community care for older people, identifying its distinctive attributes, and goes on to consider some of the lessons of the West Lothian programme for the provision of services for older people.

West Lothian compared

We examined the views and experiences of a small group of staff, clients and informal carers in the comparator authority to improve our sense of where West Lothian's approach was significantly innovative, and where it followed wider changes in care and support of older people as other authorities were also doing. Whilst the comparison was limited, a number of key differences emerged, which emphasised the innovative aspects of the West Lothian approach.

Firstly, the review of older people's services that West Lothian had conducted was indeed radical – the comparator authority, whilst also reflective about the services provided, amended its models of care more gradually, responding step-wise to policy changes. So, for example, in the comparator authority, staff spoke of 'person-centred' care and the need to respond to individuals, responding to recent policy emphases. They particularly stressed that the care packages they produced were tailored to the individual. They did not see radical changes and challenges as did the west Lothian staff.

Secondly, technology was used in some cases in the comparator authority, and included a community alarm system and individual items of technology. It was interesting to note that the West Lothian approach was seen as standardised by staff in the comparator

authority – an inaccurate portrayal, as we have seen. There was no strategic overview of technology in the comparator authority at the time of interviews. New devices were being used on an ad hoc basis, or in small pilot projects.

Thirdly, clients in the comparator authority described their days as being significantly structured by the timetables of the care regimes. Their care needs were comparable to those of the West Lothian clients, but they did not have the flexibility of timetable that the West Lothian clients enjoyed, being more restricted in, for example, bed times and meal times.

Fourthly, whereas in West Lothian, talk of safety and security was commonplace amongst those receiving a smart technology service, no-one in the comparator authority expressed such feelings, even where they had community alarms or other technological devices. They welcomed the services they received and were broadly content with them, but did not speak of them in the very positive terms we found in West Lothian.

Fifthly, the informal carers in the comparator authority spoke at length of the difficulties of caring. Their time too was structured by formal services, there were difficulties in their relationships with the people for whom they cared and there was a sense that many of them were close to the point of no longer being able to cope. The services did not provide the ‘peace of mind’ that was so prominent in West Lothian.

These comparisons suggest clear qualitative differences in the experience of care and support between West Lothian and a comparator authority. They emphasise that West Lothian’s approach is indeed a departure from others. Notably, the differences identified are only partly about technology. They also relate to the whole model of care, including the underlying philosophy and the delivery of support.

Changing cultures of care and support for older people

The evaluation has emphasised throughout that the West Lothian smart technology programme addressed the whole model of care and support for older people. An alternative approach might have been to use smart technology within an existing model, to support current ways of working. This was not done. We would conclude from the evaluation that the radical re-think of services was important to the success of the programme, in that it promoted a culture change which accelerated the growing emphasis on independence and choice for older people which was already part of the changing policy environment. It was clear that the older ways of working, which staff described in some detail, were simply no longer possible under the new model of care.

Key aspects of the new model of care included the emphasis on capacity-building and the promotion of independence and choice for older people. The emphasis in the aims of the programme was on innovative housing, sustaining independent living, and individual care planning, with new technologies seen as supporting these key aims.

Technology as a catalyst

We suggested in the opening chapter that, on their own, technological devices are neutral, and that their impact will depend on the context in which they are used. In the West Lothian context, it was clear that the impact of the technology was predominantly positive, that it was recognised as making a significant contribution to the well-being of clients and informal carers, and that the model of care was central to the realisation of this potential. That this would not necessarily be the case under a different model of care is illustrated by the comparator case, in which the role of technology was barely recognised by clients. Furthermore, it was suggested by one sceptical member of staff in West Lothian that technology had the theoretical potential to be used in less supportive ways, for example, to monitor people without their consent.

Technology appeared to have acted as a catalyst for change in West Lothian, as well as being an integral part of the new model of care. It encouraged staff to approach their work in new ways, and there were many examples of reflections on the potential of technology to improve support and care.

Independence and choice

Promoting independence and choice for older people are integral to recent policy developments. These principles were fundamental to the West Lothian approach to capacity-building. There was much evidence of success, in that people were being enabled and supported to stay in their own homes, there were many examples of regained capacity and independence, especially in the housing with care complexes. Indeed, there were several cases of people who had moved out of residential care settings into housing with care and thrived.

Increased independence and choice clearly affected the quality of life of those receiving services for the better. There was much evidence of people experiencing increased senses of both personal safety and security, as well as safety and security of their homes. Informal carers found peace of mind.

Two sets of factors were significant in promoting these improvements in quality of life. One was certainly the staff, and their approach to support and capacity-building. The other was the technology, whose effective operation was supported by the staff, including particularly the Call Centre, which emerged as central to the effectiveness of the whole system.

Informal care

Informal carers continue to be central to the provision of support and care for older people. Those in the comparator authority appeared close to burn-out, and reported difficulties in getting support for their caring work. In West Lothian, there was evidence that the new model of care produced peace of mind for carers, and had the

additional consequence of improving informal carers' relationships with those for whom they cared. Whilst we cannot definitively conclude this, the potential for better supported carers to continue with their work for longer periods, and thus continue to play their key role in supporting older people, seems clear. The smart technology had the capacity to produce support for carers which was not formerly possible, and the model of care allowed this potential to be realised. At its simplest, this support meant that carers knew that if anything untoward happened to their relative or friend, they could be alerted immediately, or if their relative or friend was in danger, this would be addressed.

Mainstreaming smart technology

One of the most radical elements of the new strategy in West Lothian was the mainstreaming of smart technology packages for all households aged 60 and over in the local authority area. The idea behind this was to make smart technology a taken-for-granted part of people's houses, and to ensure that everyone had the potential to benefit from it and to have additional services added to it if they needed them. Whilst the service has not yet achieved universal penetration, impressive numbers of older people in West Lothian now have smart technology in their homes, and have the basic level of protection afforded by the core package. The evaluation showed that people without care needs welcomed the safety and security features of the package, and came to take the technology for granted. It emerged that many people were fearful for their own personal safety, for example having experienced falls in the past. Such people were particularly enthusiastic about the smart technology. The continued expansion of the mainstreamed service is anticipated, with the removal of the weekly charge in January 2006.

There was evidence, confirming other research, that some people felt a stigma attached to receiving services – they did not want to acknowledge that they were unable to cope alone, or simply that they were getting older and might need help. The mainstreaming of smart technology appeared to address some of these concerns,

especially where relatives had encouraged its use, for their own peace of mind.

One area in which the mainstreaming strategy may be of particular interest is that of people with dementia. Many people experience undiagnosed memory problems, which may present certain risks, and the smart technology packages provide support against common risks. Also, mainstreaming may prevent some of the stigma attached to dementia (whether diagnosed or not) by making protection against some key risks normal.

Community support and participation

Part of the rationale for promoting community care is that thereby, older people remain part of community life, and continue to live an 'ordinary life' (Godfrey, Townsend and Denby 2004) despite having needs for care and support. There was much evidence in the report that many older people receiving smart technology packages in their own homes felt supported and therefore able to continue living in them. The statistical trends demonstrated a significant shift towards care at home.

One emerging issue concerned the safety and security aspects of the smart technology in communities in which people did not feel safe. There was potential for the smart technology to protect people against undesirable aspects of their neighbourhoods, and we suggested that these problems needed to be addressed through wider community safety initiatives, rather than through protection of older people in their homes.

The housing with care developments were especially interesting in regard to community relationships. Locally based, in closely knit communities, they retained connections with the surrounding communities through existing social ties as well as through the use of the community hubs, though these took some time to develop their full role. In addition, over time the housing with care developments began to become communities themselves, with new

relationships formed, new characters emerging and new gossip networks developing. Thus, people who took up the tenancies not only retained a home of their own, but also gained, or regained, a community life in which they had a choice of how to participate.

Costs and benefits

In some respects, costs savings attached to using smart technology are obvious. For example, if someone falls and assistance comes quickly, a long hospital stay may be averted. Or if there is a small fire, quickly extinguished, personal injury and damage to property are significantly reduced, as compared with a large one. Calculating costs and benefits in monetary terms is difficult, in a context in which demands for higher standards of services are increasing. Nevertheless, we found that West Lothian was performing particularly well in costs terms as compared with other local authorities in Scotland, and demonstrably using its rather limited resources very effectively. This performance can be attributed to the new model of care, incorporating smart technology. We found that both care at home services and the new housing with care developments were producing significant savings as compared with care homes, whilst also being popular with the clients who used them. Our analysis thus illustrates particularly effective deployment of limited resources in West Lothian, and the production of high quality services, appreciated by clients.

Wider lessons

The key lessons of the West Lothian programme for other providers of care and support for older people can now be highlighted. They are:

- A model of care which promotes independence, choice and capacity-building for older people with support needs can benefit significantly from the appropriate integration of smart technology. If technology is introduced without a careful review of the model of care, it may not achieve its full potential;

- Staff involved in delivering the programme experience culture change which may be catalysed by the smart technology;
- Used effectively, smart technology can significantly support older people, bringing safety, security, access to help when needed, as well as independence and control over one's daily life and community participation;
- Informal carers can also benefit from smart technology, through the peace of mind it can confer and some ease in the burden of caring and the worries they may experience. A result of this may be better relationships and longer caring contributions;
- For older people generally, mainstreaming smart technology may reduce the stigma of using services and facilitate enhancement of support if needed;
- This model of care, incorporating smart technology, has demonstrated that the quality of life of older people and informal carers can be improved. Thus, service quality better meets people's needs and is of a higher standard;
- Evidence on the cost-effectiveness of the approach is still at an early stage, but shows positive results. We were able to show that costs were controlled, and that smart technology has illustrated a potential to assist providers in making effective use of limited budgets, whilst still effecting service improvements. In the West Lothian case, objective evidence of performance demonstrates particularly effective provision;
- Throughout, our assessment of the quality and impact of services has been grounded in the views of older people and informal carers themselves. This reflects the policies of user participation in service design and evaluation now central to support and care for older people.

The future

West Lothian is the most developed, largest scale user of telecare in the UK. The authority and the local Health Board are committed to continuing the review of service provision, and developing the model of care and support to include new elements. This process is being taken forward by the local Community Health and Care Partnership, launched on 1st April 2005. This new body, established under the National Health Service Reform (Scotland) Act 2004, is charged with promoting partnership working, service integration, service improvement and innovation. The CHCP is currently developing its plans for the future for telecare and telehealth, building on its rich inheritance of experienced staff and a tested technology platform as discussed in the report.

The CHCP has identified a set of principles to underpin its work on technology applications. These are:

- There must be demonstrable benefits for the service user/patient;
- Developments must be capable of integrating with the current platform, either directly or via the shared information system;
- A cost/benefit analysis should be conducted for innovations;
- Developments should complement the workforce strategy, which involves changing staff roles and new ways of working.

These principles aim to ensure that new technologies are used effectively, where there is evidence of their benefit. Individual pieces of technology can often seem very attractive, but the CHCP recognises the need for careful initial appraisal.

A wide-ranging 'business re-engineering' process is now underway in West Lothian. Systems and processes are being analysed in detail to identify specific pressure areas and gaps which could be

overcome with the assistance of technology. In terms for example of telehealth applications, this process has already identified potential for substantial impact for people with both acute and chronic conditions, such as falling, Chronic Obstructive Pulmonary Disease (COPD) and diabetes. Other potential improvements could be made in areas such as medication management and the development of a more cost effective response to general health enquiries. There are also significant challenges to be addressed, some of which relate to the basic infrastructure of the local health and care system. These include the risk issues attached to managing conditions outside hospital and the development of robust joint performance management systems. However, West Lothian's record of achievement provides a strong basis for these further developments.



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Appendix One:

Smart technology used in Opening Doors for Older People

Specification of core package, additional items and general conditions of usability

Specification of Core Package

| Product | Description |
|---|--|
| Home alert console – Tunstall Lifeline 4000 | <p>This unit provides personal communication, emergency communication, wireless monitoring of a range of sensors. It can transmit data from each sensor automatically by telephone.</p> <p>It provides full duplex speech with a remote party and is capable of being used with a fixed line handset, in hands free mode, and as a reception for a cordless phone.</p> <p>The console is capable of being programmed to enable different responses to different alerts, i.e. it can call different destinations in response to alerts from different sensors and triggers. The calls may all go to the monitoring centre or some may call a neighbour, friend or family carer to identify that the householder is at risk.</p> |
| Personal trigger | <p>These personal radio triggers allow the user to raise an alarm call within the home. These triggers have a simple button operation and provide a range of wearing options.</p> |
| Smoke detector | <p>Smoke detectors operate with a normal alarm signal within the home and have wireless data transfer capabilities to send the alert via the Home Alert Monitor to monitoring centre.</p> |

| | |
|----------------------------|---|
| Flood detector | Flood detectors monitor the bathroom and kitchen floors for water. They trigger an alarm call within the home and send an alert to the monitoring centre. |
| Extreme temperature sensor | These detectors are capable of providing an alert if there is extreme heat, such as from a cooker hob being left on. These detectors can monitor both high and low temperatures in the home so that it can not only detect the risk of fire but also the risk of hypothermia and freezing pipes. The sensor can raise an alarm call in the home and transmit an alert call to the monitoring centre. |
| Passive infrared detectors | Intruder detection is provided by two passive infrared (PIR) detectors which are linked to the Home Alert Console. The detectors can raise an alert within the home or, if there is a reason to avoid alerting the intruder, they can operate silently and transmit the alert to the monitoring centre. The detectors can also be programmed to raise an alert in the event of prolonged periods of inactivity. |

Menu and Specification of Additional Items

| Product | Description |
|-----------------------|---|
| Pull cord | This is an alarm trigger that calls assistance when the cord is pulled. A communication link with the Home Alert Console is opened and this connects the alarm signal to the monitoring service or other designated telephone number. |
| Visual call indicator | This device provides an alternative visual alarm signal for people who have hearing impairment and cannot hear the telephone or other audible alarm. |
| Fall detector | This sensor can be worn by the user and will automatically detect a fall. |
| CO detector | Carbon monoxide detection is similar to smoke detection but this device monitors hazardous levels of carbon monoxide emissions. |

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|---|--|
| Bed occupancy detector* | This device monitors a person's bed occupancy at night and can trigger an alarm via the Home Alert Console according to pre-set exception rules (for example, if a person gets out of bed at night and does not return within a period of (say) 30 minutes. |
| Wandering detector* | This device monitors a person's entry/exit door during a pre-set period when the service user may be at risk. If the sensor is triggered, for example, at 2am in the morning, a carer or the monitoring station would be alerted that the door has been opened. |
| Incontinence sensor* | A sensor which can monitor bed wetting will alert a carer via the Home Alert Console when timely intervention/ support is required. |
| Internet access via TV | A set-top box can be provided to enable internet, email and web access via the user's television. The user operation is via a laptop infra-red linked keyboard. |
| Epilepsy alarm | A sensor for people who may have an epileptic seizure in bed. It detects rapid movements and transmits an alert to a carer or the monitoring station as desired. |
| Video door entry | An entryphone that has video capability, two way conversation between service user and caller and remote control of door lock by service user. The entryphone has a video output and it can be connected to a TV so that the caller's face can be viewed on a larger screen. |
| Infra red and radio frequency controllers | These are programmable controllers for remote control of other appliances and can be used in conjunction with equipment such as door openers/closers, window and curtain operators and lighting controllers, lifts, TV and door entryphones. |
| Remote control of lighting | Lighting can be controlled by means of infrared or wireless remote controllers. |
| Automatic control of lighting | Lighting can be switched automatically by an activator such as when a person gets out of bed at night to light the way to the toilet and then to automatically switch off the lights on return to bed. |

* Work via a telecare interface module

| | |
|--|--|
| <p>Monitor activities of daily living to assess a person at risk</p> | <p>Sensors can be used to determine the time and frequency of certain everyday activities being carried out and software that can analyse the data to determine if a person is at risk. Sensors might record the use of kitchen appliances such as fridge and kettle, bathroom facilities such as toilet flush and other services in the home such as switching of lighting. The information gathered can identify that a person has departed from their regular routine and is at risk or needs assistance.</p> |
| <p>Curtain, window, door openers</p> | <p>Doors, windows and curtains can be opened and closed by remotely controlled actuators.</p> |

West Lothian Council has developed a new approach to the care and support of older people at home using telecare. Smart technology is integrated into a model of care which emphasises choice, independence and capacity-building for older people and aims to support them to remain in their own homes as long as possible. This is the UK's largest telecare implementation to date.

The programme has been evaluated over more than three years by the University of Stirling. This book is the outcome of the evaluation, which considered the views and experiences of stakeholders including clients and staff and examined the cost effectiveness of the programme.

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