

Monitoring Telecare Progress



May 2009

Executive Summary

- This report provides evidence of progress against the telecare business plan, and in broader terms, against the telecare strategy 2008-10.
- By 31 March 2009, approximately £7.347 million of Telecare Development Programme (TDP) funding had been spent out of a total of £10.326 million allocated to local partnerships. This is about 71% overall.
- Of the money spent, some £5.702 million was from money allocated in 2006-8 (83% of the total £6.832 allocated in this period) and £1.645 million (47%) from £3.494 million allocated in 2008/9.
- Over 16,000 clients have been reported as beginning a telecare service since the start of 2007/8 – 7,902 in the 2007/8 itself and 8,580 in 2008/9. In that time almost 2,500 subsequently stopped receiving a service.
- Nearly 1,500 clients so far have been recorded as having been diagnosed with dementia. However, the true number could be significantly higher.
- The most frequent primary reason reported by partnerships for providing a telecare service to new clients in 2008/9, equating to around a third of all cases, was to meet a low level need. In some 23% of cases the primary reason was to improve carer piece of mind. In a further 23% of cases, the primary reason was to prevent or lessen the risk of hospital admission, or to expedite discharge. Prevention of admission to a care home was the primary reason for providing a telecare service in some 10% of cases.
- Overall the evidence indicates a significant increase in 2008/9 in the numbers able to maintain themselves at home as a result of telecare service provision. The quarterly average of 7,849 for 2008/9 also masks a rising trend in quarterly totals (from 7,289 in the first quarter to 8,721 in the fourth quarter). Moreover, positive numbers of people able to maintain themselves independently were reported in 31 partnership areas in the fourth quarter of 2008/9 (as against 25 in the first quarter).
- Other outcomes reported for 2008/9 are 377 cases of expedited hospital discharge, 2,581 unplanned hospital admissions avoided and 947 care home admissions avoided.
- With respect to efficiencies, partnerships collectively secured more care home bed day savings in 2008/9 than they initially anticipated, but there were considerable shortfalls in some other areas – notably home check visits saved, and to a lesser extent with respect to hospital bed days saved and to night care arrangements.

- Overall, the estimated value of TDP funded efficiencies for 2008/9 is £12.035 million. This compares with the estimate for 2006-8 of £11.151 million. In total therefore, benefits of £23.186 million had been generated by 31 March 2009 under TDP funding. £14.429 million can be ascribed to 2006-8 TDP funded activity, and the remaining £8.757 million from spending under 2008/9 allocations.
- These numbers should continue to be treated as indicative, and a caveat regarding the possible implications of telecare service provision in generating additional service costs should also continue to be borne in mind. The Scottish Government has now commissioned work to investigate the wider cost implications of telecare service provision.
- Case study evidence continues to testify to the transformational potential of telecare for the quality of life of both clients and their carers.
- A significant number of partnerships continue to report impediments to the adoption of telecare as a mainstream element of community care service provision. Only a small number of partnerships have so far achieved telecare mainstreaming. While about half of the partnerships in Scotland are probably on their way to joining this minority, a significant number continue to see telecare as peripheral or pilot based activity.
- It is unlikely that all aspects of the vision for telecare in 2010 articulated in the telecare strategy published by the Scottish Government in 2008 will be fully met, but telecare is on the agenda across Scotland, and 2008/9 was a year of consolidation of earlier progress.

Introduction

The national Telecare Development Programme (TDP) for Scotland was launched in August 2006. This report provides evidence of progress against the telecare business plan, as updated for the Telecare Development Programme Board in late 2007 (JIT, 2007).

The initial aim of the programme was to help an additional 19,000 people to live at home for longer with safety and security and thereby provide a foundation on which telecare systems could become an integral part of community care services across Scotland.

Specific objectives of the programme were recorded as to:

- Reduce the number of avoidable admissions to care homes, and of unplanned admissions and readmissions to hospital.
- Reduce the need for other more expensive forms of intervention.
- Reduce the pressure on informal carers.
- Improve the quality of life of health and care service users - mainly older people, but also others with physical disabilities, learning disabilities or long term medical conditions.

Based on data supplied by the 32 local partnerships across Scotland in receipt of TDP funding, the 2007 business plan update reported that the TDP programme would lead to a range of desirable service changes and care outcomes. While some of the expected outcomes were qualitative in nature, others were quantified as benefits worth around £43 million. Appendix 1 provides summary tables for the outcomes and efficiencies anticipated in the telecare business plan.

Originally, TDP funding was expected to run across financial years 2006/7 and 2007/8. The York Health Economics Consortium (YHEC) was commissioned to evaluate the programme. YHEC based its financial analysis on data provided by local partnerships through a quarterly monitoring exercise. Results published in February 2009 (YHEC, 2009a, 2009b) indicated that the programme had taken longer to get off the ground than had been originally hoped, and by 31 March 2008 only £3.919 million had been spent collectively by partnerships. However, monetary benefits of some £11.151 million had been recorded, and YHEC concluded this was in line with anticipated programme impact over this time period (YHEC, 2009a). Appendix 2 summarises the key YHEC findings on outcomes, efficiencies and financial benefits to end March 2008.

In both of the financial years over which the TDP was initially expected to run, partnerships had been informed that 'slippage' of expenditure into the subsequent financial year would be permissible (subject to other local financial regulation requirements being met). In March 2008 the Scottish Government also announced a further round of TDP funding, for the two financial years 2008/9 and 2009/10.

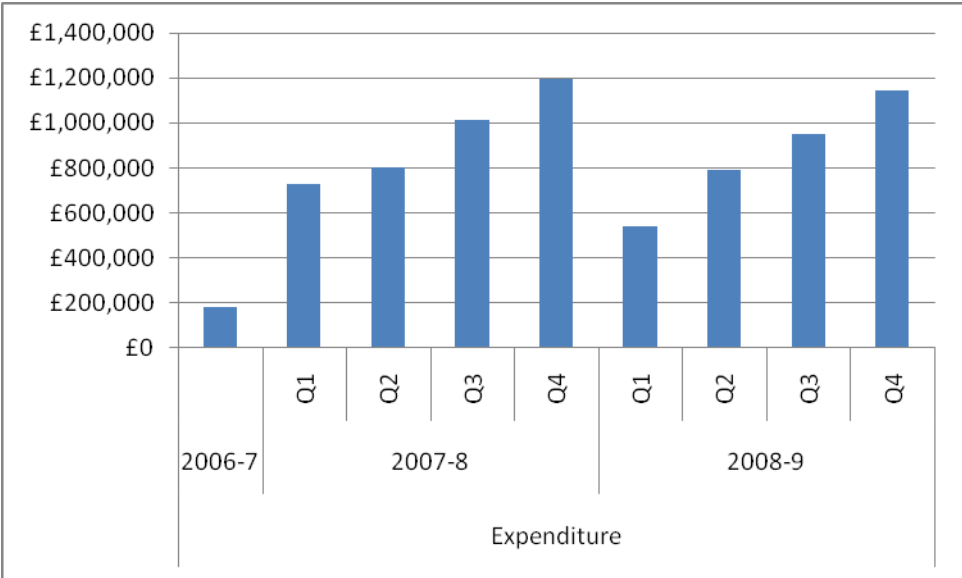
The Scottish Government decided to continue monitoring programme related activity on an amended basis over 2008/9 and 2009/10. The original YHEC monitoring form was simplified and updated for this purpose. The findings in this report reflect the

additional information provided by the four quarterly reports supplied by partnerships over financial year 2008/9 using the updated form.

Expenditure Patterns to 31 March 2009

Figure 1 shows total TDP partnership funding reported as actually spent by partnerships. The first column relates to 2006/7 as a whole and confirms the slow start to the programme overall. Subsequent columns represent individual quarters.

Figure 1: TDP Quarterly Expenditure Totals 2006-9



Sources: YHEC 2009c; Partnership monitoring returns 2008/9

Spending across financial years 2007/8 and 2008/9 shows a strong cyclical pattern.

For the 3 financial years as a whole, the totals are: £180,880 (2006/7), £3.738 million (2007/8) and £3.428 million (2008/9). It is somewhat surprising that 2008/9 shows lower overall expenditure than 2007/8 (in total, and by quarter) both because it was hoped partnerships would ‘kick on’ from the slow start, and because funding in 2008/9 was slanted towards partnerships that showed most evidence of embracing the telecare agenda. It is not clear what factors account for this.

By 31 March 2009 total expenditure by the partnerships was reported as £7.347 million against an allocated total of £10.326 million. 15 partnerships had not spent their total 2006-8 allocation. At individual partnership level, some had spent all or a significant part of 2008/9 funding while others are currently still using earlier allocations.

Two partnerships reported no TDP expenditure during 2008/9, while 5 reported having spent more than initially allocated (to a collective total of almost £178,000). It is likely these findings reflect some underlying weaknesses in financial reporting –

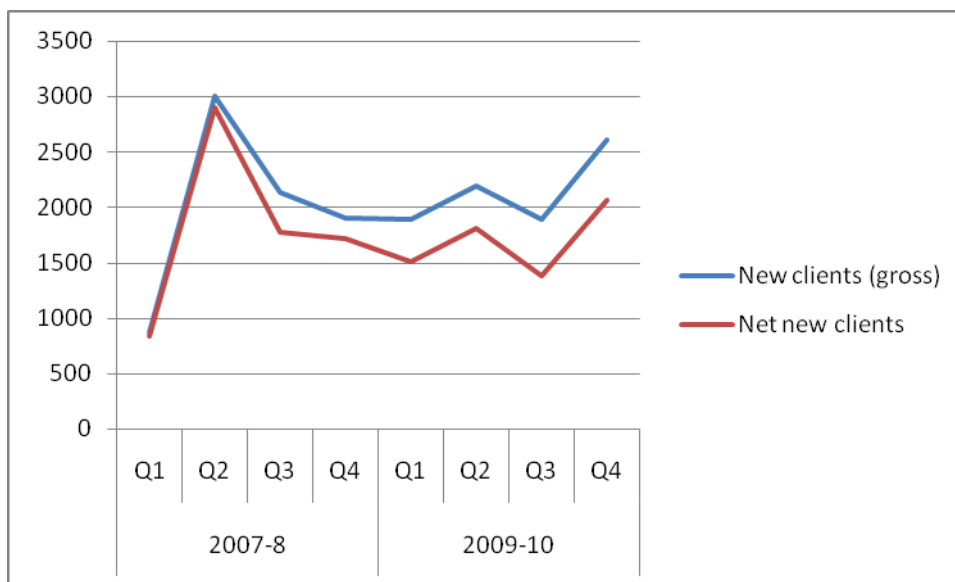
either difficulty in isolating TDP expenditure from other service activity, or problems in extracting financial information within the timescales expected for quarterly reporting.

An important implication of the time profile of expenditure reported is that much of the benefits identified in 2008/9 actually relate to phase 1 funding. This is explored in more detail below.

New TDP funded client numbers.

Figure 2 shows both the total number of new clients funded in Scotland by quarter under the TDP (in blue), and the number of new clients per quarter minus those whose service was for whatever reason terminated (in red). As would be expected, the numbers terminating service within a quarter are rising over time, and the gap between the lines is therefore increasing.

Figure 2: New Clients (net and gross) under TDP funding



Sources: YHEC 2009c; Partnership monitoring returns 2008/9

In total:

- 16,482 clients have been reported as beginning a telecare service since the start of 2007/8 – 7902 in the first year and 8580 in 2008/9.
- 2,498 clients, having started receiving telecare support under TDP, have subsequently stopped receiving the service. Again this can be broken down as 679 in 2007/8 and 1,819 in 2008/9.
- The numbers per quarter stopping receiving a service increased in every quarter except Q4 2007/8, and in Q4 2008/9 reached 553, which was the largest total for a single quarter.

The modest overall increase in gross new client numbers in 2008/9 over 2007/8 is consistent with the lower aggregate spend previously noted, as equipment released by those no longer receiving a telecare service will be being recycled.

Client Characteristics

Over the two full years for which we have data, it can also be reported that 1,463 clients were recorded as diagnosed with dementia. It is probable that this is an absolute minimum, and the true number could be significantly higher, but we have no way of confirming this. Table 1 summarises other demographic and care group information.

Table 1: TDP Client Demographic and Care Group Profiles

	2007/8	2008/9
Age:		
Less than 16	0.2	0.3
16-64	9.5	12.4
65 or more	85.0	86.1
Unknown	5.3	1.2
Sex		
Male	32.6	33.9
Female	62.4	65.3
Unknown	5.0	0.8
Ethnicity:		
White	84.5	85.4
Mixed	-	0.2
Asian	0.1	0.1
Black	0	0
Other	1.6	0.2
Unknown	13.8	14.0
Community Care Group:		
Older	63.1	61.6
Mental health	2.5	2.3
Dementia	7.9	9.9
Physical	18.3	24.3
Learning disability	2.2	3.1
Substance misuse	0.5	0.4
Less than 16	0.2	0.3
Unknown	5.3	1.9

Sources: YHEC 2009a; Partnership monitoring returns 2008/9

Unsurprisingly, there is for the most part considerable stability in the proportions of clients within different categories over time. The biggest general adjustment involves a consistent reduction in the proportion of unknowns provided across categories

(except with regards to ethnicity), suggesting that partnership monitoring arrangements have been generally improving over time.

Reasons for Offering Telecare

One of the consequences of amending the YHEC monitoring form for 2008/9 was that the reasons partnerships record for providing TDP funded telecare services to new clients changed somewhat. It is therefore not possible to offer a simple comparison with 2007/8 results from YHEC. Table 2 summarises the primary reasons partnerships reported for offering a TDP funded telecare service provision. (As a number of partnerships chose to report co-equal primary reasons in a number of instances, the totals recorded in table 2 exceed the actual number of new clients in 2008/9 by around 10%).

Table 2: Recorded Reason for Offering Telecare to New Clients

	Q1	Q2	Q3	Q4	Total
Prevent admission to a care home	153	263	224	307	947
Prevent/lessen hospital admission risk	310	460	366	511	1,647
Facilitate hospital discharge	85	150	142	180	557
Improve carer piece of mind/respice	414	567	481	732	2,194
Meet a low level need	753	696	603	1,033	3,085
Other reason	348	194	171	318	1,031

Source: Partnership monitoring returns 2008/9

Interestingly, the most frequent primary reason reported by partnerships, equating to around a third of all cases, involved meeting a low level need. The next most frequent (23%) involved improving carer piece of mind.

In some 23% of cases the primary reason was to prevent or lessen the risk of hospital admission, or to expedite discharge. Prevention of admission to a care home was the primary reason for providing a telecare service in some 10% of cases.

Partnerships recorded a range of other primary reasons also. In addition, a significant number of partnerships reported that there were also secondary reasons for providing telecare in many (and in some instances all) cases (see box).

Outcomes 2008/9

Table 3 summarises partnership achievements against outcome measures for 2008/9 against what the partnerships expected to deliver using TDP funding. The table also summarises outcome achievements over the period 2006-8 for comparison.

Box 1: Other Primary and secondary reasons for providing Telecare

“To provide greater autonomy for all high level need service users”

“All were issued to minimise risk”

“To manage risks, e.g. gas, fire”

“To reduce dependency on paid support”

“All to maintain client safety at home without the need for an increased care package”

“We also felt that the main longer term benefit is keeping people out of long term care”

“Increased independence by providing a simple method of communication to use while away from home”

“To support the assessment process”

“To assist user to return to work”

Source: Partnership monitoring returns 2008/9

Table 3: TDP Outcomes 2006-9

	Partnership Expectations		Partnership Achievements	
	2006-8	2008/9	2006-8	2008/9
Reduction in delayed discharges from hospital	437	400	517	377
Reduction in the number of unplanned hospital admissions	1,704	1,011	1,220	2,581
Reduction in the number of care home admissions	391	598	518	947
Number of persons able to maintain themselves at home through receipt of a telecare service	3,848	3,463	5,513	7,849*

Sources: 2006/7 and 2007/8 expectations are from JIT (2007). Expectations for 2008/9 were provided by JIT from data provided by partnerships. Achievements up to 31 March 2008 are from YHEC (2009c). Achievements for 2008/9 are from quarterly monitoring returns.

*Figure for 2008/9 is a quarterly average across the year.

Table 3 shows:

- On 3 out of 4 outcome measures (the exception being reduction in the number of care home admissions) expectations for 2008/9 were lower than for 2006-8.
- However, on 3 out of 4 measures achievement increased (the exception being reduction in delayed discharges)

Overall the evidence indicates a significant increase in the numbers able to maintain themselves at home as a result of telecare service provision. The quarterly average masks a rising trend in quarterly totals (from 7,289 in the first quarter of 2008/9 to 8,721 in the fourth quarter). Moreover, positive numbers of people able to maintain themselves independently were reported in 31 partnership areas in the fourth quarter (as against 25 in the first).

Table 3 also shows significant increases in the numbers of avoided emergency hospital admissions (+112%) and a near doubling of care home admissions avoided (+83%).

Efficiencies 2008/9

Table 4 summarises partnership achievements against efficiency measures for 2008/9 relative to what the partnerships expected to deliver using TDP funding. The table also summarises outcome expectations and achievements over the period 2006-8 for comparison.

Table 4: TDP Generated Efficiencies 2008/9

	Partnership Expectations		Partnership Achievements	
	2006-8	2008/9 ^a	2006-8	2008/9
Number of hospital bed days saved due to reduction in number of delayed discharges	24,793	9,637	5,668	3,679
Number of hospital bed days saved due to reduction in number of unplanned hospital admissions.	14,880 ^b	9,528	13,870	11,416
Reduction in number of care home bed days purchased	76,535	68,251	61,993	78,991
Number of nights sleepover care saved	12,798 ^c	25,727	11,707	10,868
Number of home check visits saved	261,506	267,699	314,463	45,750

Sources: 2006/7 and 2007/8 expectations are from supporting spreadsheets to JIT (2007) – but see footnote b. Expectations for 2008/9 were provided by JIT from data provided by partnerships. Achievements up to 31 March 2008 are from YHEC (2009c). Achievements for 2008/9 are from partnership quarterly monitoring returns.

^a The numbers in this column are from 2008/9 submissions rather than the 2007 business plan as reported in table A1.2 in Appendix 1.

^b Figure as reported in YHEC (2009c) table A9.

^c Figure reported as 12,876 in YHEC (2009b).

Table 4 shows that partnerships collectively secured more care home bed day savings in 2008/9 than they initially anticipated, but that there were considerable reductions in some other areas – notably home check visits saved, and to a lesser extent with respect to hospital bed days saved and to night care arrangements.

Comparing tables 3 and 4, it is evident that in a number of instances an increase in the number of positive outcomes has been associated with a fall in the associated aggregate efficiency measure, indicating that the unit savings have reduced over time. Thus:

- The number of hospital bed days saved per reduced delayed discharge fell from 11 days (5,668/517) to 9.8 (3,679/377).
- The number of hospital bed days saved per unplanned hospital admission avoided fell from 11.4 days (13,870/1,220) to 4.4 (11,416/2,581).
- The number of care home bed days saved per care home admission avoided fell from 120 days (61,993/518) to 83 (78,991/947).

Financial Value of 2008/9 Efficiencies

To give reported 2008/9 efficiencies a money value, we require a 2008/9 price, at partnership level, for:

- A day of hospital care
- A week of care home living
- A night of sleepover and/or wakened night care
- A home check visit

The values generated by YHEC for 2007/8 were taken as the starting point. These prices were then updated to 2008/9 values by adjusting for inflation. The annual RPIX measure of inflation prepared by the Office for National Statistics was used for this purpose. At end February 2009 RPIX was 2.5%¹.

These prices were then applied to the unit efficiency measures reported in table 4. Table 5 summarises the results. It shows that the overall value of financial benefits arising from TDP expenditure in 2008/9 was just over £12.035 million. This is around 8% higher than YHEC found for 2006-8.

The composition of this total also differs from that provided by YHEC. In particular,

- The aggregate value of hospital days avoided through faster discharge, reductions in sleepover/wakened night care, and home check visits rendered unnecessary are all lower in 2008/9 than in 2006-8.

¹ <http://www.statistics.gov.uk/cci/nugget.asp?ID=19> . RPIX is a measure of UK inflation equivalent to all items in the Retail Price Index (RPI) excluding mortgage interest payments, and is commonly referred to as the underlying rate of inflation.

- The value of care home admissions avoided has increased significantly from just under £3.422 million to just over £5.331 million. In 2008/9 this represented about 44% of total measured benefits, up from around 31% in 2006-8.
- The aggregate value of hospital days where unplanned admission has been avoided increased from just over £3.343 million to just under £4.230 million, despite the overall number of days falling between 2006-8 and 2008/9 (see table 4). There is both a general adjustment (for inflation) and, more importantly, a compositional adjustment underlying this. Thus, some partnerships in areas where hospitalisation is relatively more expensive were more successful in 2008/9 (relative to 2006-8) in using telecare to prevent emergency admissions; conversely some other partnerships reporting a fall in the number of days related to admissions avoided were in areas where hospitalisation is comparatively less expensive.
- Table 5 does not include a value for local efficiencies in 2008/9 as none were reported. This may just be a consequence of the changes made in the monitoring form that partnerships were asked to return. However, it was possible to derive an estimate of procurement efficiencies for 2008/9, whereas none were reported by YHEC for 2006-8. The 2008/9 figure was derived by applying the PASA reported average savings rate on open market equipment purchase (14%) to the amount of TDP funding unambiguously reported as spent via PASA (£1.370 million) and adding the actual negotiated savings reported by partnerships through non PASA procurement arrangements.

Table 5: Estimated Value of TDP Funded Efficiencies

	2006-8	2008/9
Increased speed of discharge from hospital	£1,731,944	£1,323,861
Reduced unplanned hospital admissions	£3,343,467	£4,229,864
Reduced care home admissions	£3,421,621	£5,331,307
Reduced sleepover/wakened nights care	£557,119	£551,880
Reduced home check visits	£1,796,039	£379,164
Locally identified efficiencies	£301,000	-
Procurement efficiencies	-	£219,378
TOTAL	£11,151,190	£12,035,454

Sources: 2006-8, YHEC (2009a) table E1; 2008/9, own calculations based on partnership monitoring returns 2008/9

Transforming Lives: Evidence of Telecare Impact

As part of the monitoring process, a number of partnerships have provided examples of how telecare has affected those receiving TDP funded services. Some have provided direct client testimonials or summarised the findings from locally conducted survey work:

“At 87 this has given me a real sense of security!”

"I no longer worry about leaving my disabled husband at home."

We have recently surveyed over 200 service users. We received a very good response. 92% of service users said that they felt safer because of their equipment. 76% said they felt more independent because of their equipment, 79% said they felt less anxious and stressed because of their equipment. 89% said that their family is less worried about them because of their equipment. One service user reported that it had possibly saved her life after suffering from a heart attack.

More commonly, partnerships have provided case study examples of the impacts telecare is having. The box below provides an example, with others given in Appendix 3.

Mrs. M is 84. She is a widow and has dementia. She lives alone, but has two sons who live close by. She regularly becomes disorientated with respect to time and place, and often leaves her house in the early hours of the morning to go to the shops, despite the fact that they are not open.

Mrs. M attends day care 4 days per week, has a nightly 'bed round' visit and 2 visits per week for bathing. Although she receives the Meals at Home service, and a visit from a home carer to help her reheat her main meal, she often tries to cook food in her microwave without assistance. Her family believe that this is a significant fire risk.

Mrs. M has always told her sons that she would like to remain living in her own home, for as long as possible. They would like to uphold her wishes for as long as possible and were keen to have a telecare package installed to help to address the identified risks to prevent admission to residential care.

A telecare package was installed comprising:

- Lifeline 400 with Gem body transmitter on a wrist strap.
- Property exit sensors fitted on back and front doors of the house, programmed to monitor the door from 8pm to 7am. If either door sensor is activated during the night and Mrs M. does not come back into her home within 10 minutes the Lifeline will call the call monitoring centre. The call monitoring centre will call one of her 2 sons to attend.
- Smoke detectors in hallways and temperature extremes sensor in the kitchen.

Set up costs were £825, with annual recurring costs (including monitoring and maintenance costs plus continuing Care at Home and day care services) of £11,756.

Mrs. M's sons have reported that they are now reassured. She has remained living at home for a year since the installation of her telecare package. Before her telecare package was installed, her family was giving serious consideration to arranging for her to move into permanent residential care because they were so concerned about her health and safety. They are now of the view that her telecare package, along with regular home care support, has enabled her to remain at home for this time. The alternative annual cost of residential care is £27,664.

Evidence of Telecare Mainstreaming

As noted in the introduction, the underlying intention of TDP funding is to support the mainstreaming of telecare as part of overall community care service provision. Is mainstreaming happening?

Commentaries received from partnerships within quarterly progress reports provide evidence that the process of mainstreaming telecare service provision is taking place in a number of partnership areas at present:

"We have agreement to expand the coverage of the existing doorstoppers' initiative to a further 90 clients and to introduce a new telecare aided element of the project to a further 30 clients. These will be operational 3rd or 4th quarters of this reporting year".

"TDP funded activity is enabling mainstream social work services to redesign care packages and free up resources for redistribution".

"With the acceptance of new project specific criteria we have now been able to offer telecare to local service users who would not fall within eligibility criteria for council social services (thus achieving our dream of offering preventative care)".

"We are pleased to report that the appointment of a dedicated assessor has to date dovetailed well with existing care managers continuing to assess their own clients needs for Telecare. This is enabling a region-wide service to be provided for people who might otherwise not have been reached".

"Telecare installations have moved beyond the initial project and are now available for all service user groups within adult social care".

"Discussions are underway with training staff to have telecare as part of staff induction processes".

"The project has continued to provide telecare demonstration sites for staff across agencies and disciplines. Telecare demonstration facilities have been extended to provide a fourth facility within a day hospital setting for older people with mental illness. This facility provides an enhanced service for people with dementia, their families and carers. It will provide greater support to the assessment processes for the suitability of telecare as a mechanism for supporting the independence of people with dementia".

"Consideration has been given to the pressures arising from the growth of the uptake of telecare services and the actions needed to ensure the effective and efficient operation of these services. In response, two additional posts have been created to support the continued development and effective operation of telecare services. These posts have wide remits including installation, maintenance and routine visits to service users".

“TDP funding was used to employ a dedicated Project Development Officer allowing in depth work to be undertaken in the planning and development of the emerging service, thus ensuring sound foundations on which to build. Research, through consultation with numerous organisations plus lengthy negotiations around the procurement process, gives us confidence that a robust, sustainable service is being created. Telecare is developing alongside a rapid response service and the provision of intermediate care beds, part of an overall reprovisioning of community care services”.

“Negotiations for the purchase of a significant amount of telecare equipment were made possible by the provision of capital funding (of £929,000) from the Housing Revenue Account. Housing has also provided the property, at no direct cost to the Social Work Department for a ‘smart house’. Major investment has also taken place in the building of 10 properties adjoining a newly completed care home. They will provide selected clients with fairly intensive support packages, which will include telecare. The capital investment alone in these 10 properties is £1,237,000. Essential to the success of telecare is a responder service, which is to be provided by the newly created rapid response team. This is a joint health and social work venture with financial commitments for staffing alone in 2008/09 of £218,000 (£80,500 of which is from health)”.

“It is essential that we are able to offer a quality service to ensure the safety and independence of service users in their own homes by implementing the use of telecare devices. These range from basic to enhanced solutions. We must be competent to assess, refer, install and respond to bespoke telecare solutions. Some of these packages will include property exit sensors, bed occupancy sensors with X10 options and virtual bed occupancy sensors. We therefore require to develop the infrastructure to support these technologies. The work for this is ongoing and includes

- Developing business plans for the referral process.*
- Working in conjunction with the monitoring station to develop agreed protocols for telecare responses.*
- Purchasing training from telecare suppliers in order to develop in house training for both assessment and installation.*

All of the above is as per the Scottish Government’s expectations as outlined in ‘Seizing the Opportunity strategy 2008-2010”

“Works have been commenced, starting in the last week of October 2008, to provide telecare to all enclosed sheltered housing complexes by the end of March 2009, totaling 216 dwellings”.

“Telecare installations were commenced as part of routine service provision for any new community alarm clients on 3 November 2008. The council housing repairs team is undertaking the installations”.

“Due to the continued success of the telecare project the need to continue the specialised post of Telecare Assessor has been clearly identified. On 5th August 2008 the post of Telecare Assessor was evaluated by Social Work and has been extended to December 2009. Telecare will provide a solution to the growing elderly population and maintain service users in their home environment”.

“Due to the increased demand of the telecare service, the community alarm service has been expanded to support it. 6 additional responder posts have been created and an extra vehicle acquired to accommodate the increase in call volume”.

“Much time has been spent getting policies and procedures finalised and these are now in the final stages”.

“Significant amount of time has been invested during this quarter in strategic planning”.

“Awareness raising activities have now reached a total of over 1,700 health & social care workers and over 750 members of the public (older people, carers, etc.)”.

“Work on improving and speeding up the installation process has commenced”.

A smaller number of partnerships also report specific innovations that they have been exploring:

“TDP funding has led to the active involvement of General Practitioners in the overall programme”.

“Discussions are currently under way with local pharmacy services to establish the role that telecare linked pill dispensers can play in supporting people to live at home. There are considerable barriers associated with the introduction of such a service and work is currently under way to consider the cost effectiveness and efficiency of using this form of support”.

However, a significant number of partnerships report the continuation of pretty fundamental problems. Specifically:

Lack of professional buy-in and absence of cross service cohesion

“A key issue is developing buy-in and engagement with telecare by staff. Continual awareness raising and training is crucial. Engagement by housing services particularly requires development”.

“Health colleagues were unaware of where responsibility within the organisation sat for E-care. It has taken 4 months to identify the person and this was through health contacting Tunstall for information”.

“In fairness local health staff are keen to progress this, but will not do so without director led approval. Local authorities are happier to engage and take lead responsibility at a lower level of the organisation”.

“Alert control and responders belong to different departments”.

More co-ordination is needed between control centre (housing), homecare (responders) and fieldwork staff (assessors)”.

“Lead assessors/professional carers are not working in unison. Telecare needs to be part of a single shared assessment!”

“Lack of telecare referrals”.

“Telecare is dependent on various departments. It is taking a considerable time to approve changes in these departments to accommodate telecare”.

“A change in management structure has resulted in the Community Alarm Team being led by a different service manager. Although telecare implementation has continued as planned, decision making proved more difficult during the change in management structure. The new management structure is now formally in place”.

Specific issues with regard to the assessment process

“There are difficulties in obtaining sufficient interest from front-line care managers and occupational therapists to take on assessment and care planning/procurement”.

“A significant amount of OT time is being spent on re-assessment, following up incomplete installations, and maintenance. Additional OT time given to telecare is becoming insufficient. Increased assessment time is needed and backfill to OT service is required. Awareness raising is beginning to impact on referral rates”.

“There is poor awareness of availability and non-inclusion in the SSA process”.

“An increase in cases across the whole of the Older People's Service in Social Work has created a bottleneck at assessment. This is being addressed through the implementation of a "fast track" referral process for Telecare”.

Lack of dedicated staff and workforce capacity:

“The main barrier currently is difficulty recruiting to a Project Manager post, which has had to be readvertised. This process has been subject to delay outwith the project's control”.

“There are issues where staffing requirements previously uncosted may have been identified. This has required negotiation between partners to resolve such issues”.

“Generally, there are issues around workforce capacity to take forward and oversee specific initiatives. These include need for dedicated project management to coordinate the operational and technical requirements”.

“Staffing capacity continues to be a major issue for our partnership in embedding a wider application of telecare. One specific initiative is yet to start, the delay being mostly due to lack of staffing capacity”.

“Capacity within the Care at Home Service has been temporarily addressed but is likely to emerge again as a risk in the near future as (if!) the referral rate rises following the next wave of assessors training”.

“Still waiting to fill project manager post”.

“Loss of in-house Telecare Development Manager”.

“Lack of dedicated staff time to develop service”.

“During this quarter, the Council Social Work department faced a massive overspend and had to implement restrictions to services. This has impacted on throughput for assessment and service allocation despite having a dedicated assessor and project specific criteria being applied for non-mainstream Social Work service allocations. It has also led to a perception that embedding of telecare would be difficult with such strains on core services (no matched funding was proposed by Social Work for 2009-2010). Since April however, discussions have taken place with the Director of Social Work and new ways of working are being explored. Additionally for 8 weeks one of the 2 technicians has been on sick leave causing slight delays in installations”.

“Because of the absence through serious illness of the Technical Instructor, it has not been possible to initiate any new developments in relation to the use of assistive technology”.

“The main referring agents are indicating that they have a very limited capacity to undertake reviews”.

Service Charging

“Cost of the service to users is a barrier to people taking it up”.

“Charging remains a barrier to wider scale deployment of telecare. Many more clients would be willing to take the service if we reduced charges and abolished our two tier charging policy”.

Specific issues with respect to responder services

“Lack of 24 hour local response service means that police are being called inappropriately and they have raised it as an issue at CPP management committee. Plans are being developed to address the response issues but there are cost implications for partners”.

“While progress has been excellent with the addition of a dedicated assessor, there is concern that current Social Work budget limitations might restrict allocation of responder service where a vulnerable client has no key holders available”.

“Rural setting challenges and lack of responders”.

General lack of funding (and awareness of funding implications) to facilitate mainstreaming

“We have delivered over 150 packages this year to date from our mainstream telecare budget. This 75% increase has been as a direct result of the mainstream framework building the project manager and telecare assessor have carried out. However we need to review all proposed expenditure and this might limit the excellent mainstream telecare service we have developed over the last 18 months. By promoting and raising the profile of telecare services we have established a robust mainstream service with 300 mainstream telecare packages but this has put severe financial pressure on our mainstream telecare budget”.

“Trying to predict the impact that having a growing number of telecare packages installed has on the demand placed upon response service and judging the staffing and resource implications that this will have over the implementation of telecare across the area is a problem”.

“There is an issue in predicting the impact ongoing installations of telecare packages will have on staffing resource. There is also concern as to how we will be able to sustain installations to continue once funding from JIT ceases and we are trying to identify exact efficiencies created by having telecare packages in place”.

“Telecare within our partnership continues to be based on the funding being received from JIT. Our partnership has still not shown any signs of funding telecare through mainstream funding to date”.

“The telecare programme cannot be attributed alone to maintaining people at home in their communities. There is also a requirement for these people to receive extensive home care packages, day care, continued respite etc.

While the monitoring returns show efficiencies made from the reduction of hospital and long term care admissions, any savings from these would have to be distributed amongst the various services that are involved in maintaining service users in the community. There is also the issue of fixed costs within care homes and hospitals, which makes it difficult to release efficiency savings for some time as this would involve the closure of homes, hospital beds etc”.

“We have developed excellent partnership working over the last 2 years resulting in partner funding - however major concerns have been raised about funding increases in future years due to looming budget issues for years 2010-11 and 2011-12 - real concerns that the progress will stall in these years”.

Assessment

In this section, we consider three issues:

- Robustness of the information used in this report.
- Interpretation of benefits calculations.
- Overall progress in mainstreaming telecare.

Robustness of Information

The YHEC evaluation of TDP up to 31 March 2008 considered the appropriateness of different methods for measuring the impact of TDP funding (YHEC, 2009a). YHEC rejected the validity of randomised control trialling (RCT) and ‘before and after’ approaches for assessing TDP funding impact, and developed a monitoring framework to generate the key information required. As the YHEC report notes, the approach adopted, and continued here, is subjective, albeit based on local professional knowledge.

Much of the content of the monitoring form used in 2008/9 involved a straightforward continuation of questions asked for the YHEC study. The primary aim of amending the YHEC form was to simplify the data collection exercise in light of feedback that the original was considered fairly onerous by a number of partnerships. However, and despite circulation of new guidance with the amended form, inspection of trends in quarterly returns confirms that some partnerships have continued to face difficulties responding to a small number of questions. Where necessary, issues of interpretation and meaning in responses received have been clarified through cross checking of responses across questions and by means of direct contact.

In overall terms, we are satisfied that partnerships have completed monitoring forms diligently. Nonetheless, the YHEC caution re subjectivity of responses remains valid.

Interpretation of Benefits Calculations

More generally, the point made by YHEC that, in situations where RCT is unsuitable, establishment of counterfactual outcomes is intrinsically difficult and findings are best

interpreted as indicative, continues to hold good. That said, the data provided suggests that by 31 March 2009 some £23.186 million worth of benefits had arisen from TDP funding, as against business plan estimates of £28 million (see JIT 2007, table 7). Comparing the profile of efficiency effects in table 4 above with that in table A1.2 (Appendix 1), it appears that the anticipated impact on care home bed day and sleepover/wakened nights care provision has been roughly as anticipated, while expectations on home check visit reductions and procurement savings were somewhat optimistic.

There are two further issues to address.

The first issue is how to allocate measured total benefits (that is both those arising in 2008/9 and those previously identified by YHEC) between the initial funding committed for 2006-8, and subsequent funding made available for 2008/9. This is required in order to directly compare outcomes with business plan projections. As noted earlier, carry forward of 2006-8 funding into 2008/9 was deemed permissible.

Looking at expenditure patterns by local partnership, we have calculated that £5.702 million of the total allocation of £7.347million for 2006-8 had been spent by 31 March 2009. To associate benefits to this spending, we have used the following approach:

- Where a partnership has spent less than or equal to the whole of funding allocated for 2006-8, all reported benefits have been treated as arising from 2006-8 funding.
- Where a partnership has spent more than the 2006-8 allocation, benefits have been split according to the proportion of total spend that 2006-8 funding represents. For example, if a partnership had spent twice as much by 31 March 2009 as was allocated for 2006-8, the total benefits arising have been split 50:50 between 2006-8 and subsequent TDP funding.

On this basis:

- As noted above, total benefits to date, as given by YHEC estimates plus those arising subsequently in 2008/9 are worth £23.186 million (table 5). These have been generated by a total TDP spend of £7.347 million.
- Some £14.429 million of these benefits can be said to have been generated by initial (2006-8) TDP funding, where of a total of £6.832 million actually allocated, some £5.702 million (83%) has been spent.
- Further expenditure of £1.645 million of 2008/9 TDP funding has generated an additional £8.757 million of benefit.

The second issue is to re-emphasise the further caveat raised in the YHEC evaluation report, and by a number of local partnerships through their monitoring returns, that the benefits measured above must be understood in the context that telecare service provision frequently makes sense only as part of a broader service package (as the case study above demonstrates). Therefore, while the results reported above are good news, they do not tell the whole story. Newhaven Research

has recently begun work with two local partnerships to identify the wider cost implications of telecare service provision, which will go some way towards closing this information gap.

Overall Progress in Mainstreaming Telecare

Earlier we posed the question, is telecare mainstreaming happening? Over time, engagement with the Scottish Government on the telecare agenda has grown to the point where all local partnerships in Scotland have some active involvement in telecare service provision, but that in itself is not evidence of mainstreaming. While it is not possible with available evidence to answer this question definitively, on the basis of monitoring returns and discussions with officers in a number of partnership areas, our considered view is that:

- A small number of partnerships (possibly 4) have reached a point where it may be said telecare is fully integrated within overall community care service provision arrangements.
- About half (maybe 14) partnerships, while still struggling with fairly significant impediments, may be said to be solidly on the way to having telecare as an element of mainstream service provision.
- The remaining partnerships are, to greater or lesser degrees, happy to participate in telecare as a pilot exercise that opens a door to additional funding, but have yet to make the leap or be convinced that telecare has a central future role in their areas.

Conclusions

The Telecare Development Programme has now been running for two and a half years. After a slow start, activity under the programme really began to be seen in 2007/8. The subsequent financial year, 2008/9, has been one of consolidation of beginnings. Some partnerships have still to fully expend funding initially made available for use by 31 March 2008. Others have taken major strides towards embedding telecare within overall community care service provision. The majority are still either working through a phase of seeing telecare as pilot activity, or taking the first tentative steps towards mainstreaming.

The Scottish telecare strategy (Scottish Government, 2008) articulates a vision that by 2010:

- Telecare will be widely understood and accepted by service users, carers and health and care professionals alike. Local political leaders will appreciate what telecare can do for their constituents and actively promote its use.
- All 32 local care partnerships will be actively engaged in implementing telecare based services to meet service user needs, and telecare will have been fully incorporated into assessment and service delivery processes.

- There will be a more effective working arrangement between health and care services at local level, with the boundaries between these services becoming less rigid as the technology helps to redefine roles and options.
- Social housing providers will be active partners in the implementation of effective care solutions based on telecare, and local authority private sector housing strategies will actively promote telecare solutions for vulnerable people in private accommodation.

While there has been undoubted progress towards some of these objectives, it is unlikely on available evidence that they will all be fully met within a year. Telecare is on the agenda across Scotland, and this is a significant achievement, but continued effort will be required to win hearts and minds, and to secure a widespread view of telecare as a staple form of provision rather than as something rather novel and with a peripheral role to play.

Appendix 1: TDP Business Plan Outcomes and Efficiencies

Table A1.1: Anticipated Programme Outcomes 2006/7 – 2007/8

National Outcomes	
1. Reduce the number of delayed discharges from hospital	437
2. Reduce the number of unplanned hospital admissions for community care based clients	1,704
3. Remove the need for care home admissions for community care based clients	391
4. Increase the number of persons able to maintain themselves at home through receipt of a telecare service (with support)	3,848
TOTALS	6,380

Source: Joint Improvement team (2007) Table 4

Table A1.2: Quantified Anticipated Core Efficiencies from TDP

Annual Efficiency Effects*	2007/8	2008/9	2009/10
Number of hospital bed days saved from people ready for discharge	24,793	10,360	11,399
Number of care home bed days saved	76,535	75,629	72,687
Number of nights sleepover care saved	12,798	15,847	17,437
Number of home check visits saved	261,506	320,282	323,526
Value of procurement savings made	£968,174	£432,383	£427,776

Source: Joint Improvement team (2007) Table 5

*Although based on returns from 32 partnerships, some partnerships had only been able to provide numbers for 2007/8

Appendix 2: Aggregate Progress to 31 March 2008

Table B2.1: Assessed progress against Outcomes and Efficiencies

	Target for 2007/08	Progress against target (to end Q4 including YHEC estimates)	Percentage
Outcomes			
Reduction in delayed discharges from hospital	437	517	118.3%
Reduction in number of unplanned hospital admissions	1,704	1,220	71.6%
Reduction in number of care home admissions	391	518	132.5%
Number of persons able to maintain themselves at home through receipt of a telecare service (with support)	3,848	5,513	143.3%
Total	6,380	7,768	121.8%
Efficiencies			
Number of hospital bed days saved due to reduction in number of delayed discharges	24,793	5,668	22.9%
Number of hospital bed days saved due to reduction in number of unplanned hospital admissions.	15,111	13,870	91.8%
Reduction in number of care home bed days purchased	76,535	61,993	81.0%
Number of nights sleepover care saved	12,876	11,707	90.9%
Number of home check visits saved	261,506	314,463	120.3%
Total	390,821	407,701	104.3%

Source: YHEC (2009b) Table G1

Table B2.2: Financial value of TDP funded Efficiencies

	Estimated monetary saving (£)	Per cent of monetary saving (%)
Increased speed of discharge from hospital	£1,731,944	15.5%
Reduced unplanned hospital admissions	£3,343,467	30.0%
Reduced care home admissions	£3,421,621	30.7%
Reduced nights of sleepover care purchased	£557,119	5.0%
Reduced home check visits	£1,796,039	16.1%
Locally identified efficiencies, namely reduced waking nights	£301,000	2.7%
TOTAL	£11,151,190	100.0%

Source: YHEC (2009b) Table E1

Appendix 3: Additional Case Study Evidence of Telecare Impacts

Case study 1:

One homeless service user has been able to move from supported accommodation to independent living due to the support of telecare. His medical condition makes him vulnerable and he can now readily access emergency services, which on one occasion has saved his life.

Case study 2:

Something as simple as a chair sensor for a client (a retired farmer with severe dementia) has enabled him to sit at ease in his armchair in his lounge watching his beloved fields/farm animals/goings on. This has settled him after being confined to bed, and means his quality of life is greatly enhanced and his relatives are assured of his safety with responsive services to hand.

Case study 3:

One client with Downs Syndrome has managed to move alone into her own tenancy with reassurance provided to an aging parent that help can easily be called for.

Case study 4:

A fall detector and wearing a pendant has provided full cover to a young adult whose parent has to regularly respond to her sudden onset epileptic seizures. The presence of the pendant enables the parent to both call for help without leaving the client, and administer first aid.

Case study 5:

A lady with dementia was in hospital. She lives with her elderly husband and has a history of night time walking. This lady was unlikely to return home due to lack of management of the walking issue. We provided a wander alert linked to an onsite carer pager. This allows her husband to be awoken via a pager and a gradual light. He can in turn get to the front door and street to support his wife to return home. This was a direct alternative to long-term care and we are hoping to trial a GPS locator system to further increase this lady's support.

Case study 6:

Mrs H is 84. She lives in a local authority tenancy. Although not diagnosed with dementia, Mrs H has poor short-term memory and presents as confused at times. She is supported at home by Home Care and until recently only had a dispersed alarm and pendant as part of her support package.

Although Home Care are providing meals for her, it was noted by them on several occasions that Mrs H continued to cook for herself, and there was evidence of burnt pots and food and at times the cooker was left switched on. Both the cooker and fire are powered by gas.

A Mobile Warden response service was arranged for Mrs H, as she had no local contacts able to respond to passive alarm equipment, and smoke and gas alarms have been installed. She retains her pendant so she can call for help in any other emergency situation. When activated, the smoke and gas alarms register at a control centre, where specific instructions are in place to contact the emergency services to attend.

The installation of the passive alarm equipment has enabled Mrs H to continue to cook if she chooses and has removed the necessity to install a cooker isolator switch.

Case Study 7:

Ms J is 19. She has a mild learning disability, and lives with her parents, although she hopes to move into her own tenancy in the near future.

Ms J suffers from epilepsy and has a history of falls. Her parents were concerned about her having a nocturnal seizure during the night and them being unaware of it. They had resorted to using a baby monitor during the night, which left Ms J with very little privacy.

As Ms J is working towards independent living, her parents were keen to see if telecare equipment could be used to support her more effectively and discreetly during the night. A telecare package was installed comprising:

- A fall detector for wearing during the day.
- An epilepsy sensor to detect nocturnal seizures, linked to a telecare base unit in her parent's bedroom to alert them during the night.

Ms J has reported that her telecare package has given her a lot more privacy, and is really pleased that she doesn't have to have a baby monitor in her room any more. She also feels more independent because her parents are happy to leave her alone in the house now.

Her parents have indicated that the telecare package has had a dramatic impact on their lives, providing them all with more freedom and choice.

Prior to having her telecare package installed, Ms J was regularly admitted to hospital on an emergency basis for treatment of injuries associated with her epileptic fits. Since having her telecare equipment installed 8 months ago, Ms J has only had to be taken to hospital once for treatment for a minor head wound. On all other occasions, either her epilepsy sensor or Ms J herself has been able to alert her parents when she has felt a seizure coming on.

Case Study 8:

A year ago, a client's son approached us. He was increasingly concerned for his mother's safety, due to her dementia and associated wandering. There was a real possibility of residential care being required. Instead, we installed door exit monitors

while the son provided a GPS enabled mobile phone (placed in the client's handbag). While the operation of the equipment has meant considerable input from our control room operators and the client's family, the outcome has been positive. One year later, this lady is still living independently in her own home.

Case Study 9:

Mrs W is an 80-year-old lady. She experienced a period of illness, which resulted in decreased mobility, and a loss of confidence, and was admitted to an intermediate care facility for rehabilitation. The staff had concerns with regards to her safety and a risk of her falling when she returned home. She had a bed occupancy sensor fitted, which was configured to work in conjunction with her bedside light. She was also supplied with a fall detector. Both Mrs W and her daughter reported that having these devices assisted in rebuilding her confidence. Mrs W felt after a few months that she did not want to use the fall detector any more, as she no longer required it.

Case Study 10:

Mrs M was a very independent person and lived on her own. She began to experience memory impairment, and dementia was diagnosed. Her daughter supported her to remain in her own home, but as Mrs M's health declined, she sought advice from social services. It came to light during assessment that Mrs M had on more than one occasion wandered during the night, but had been assisted to return home safely by a neighbour. Her daughter had become very anxious about these incidents.

Fortunately the worker involved in the case had a sound knowledge of telecare, and advised Mrs M and her daughter about the use of property exit sensors. With their agreement the sensors were fitted and Mrs M was able to continue living at home. Her daughter became less anxious, knowing that she would be alerted if her mum went outside at night. The quality of both their lives was enhanced. Gradually Mrs M accepted some assistance with personal tasks from home care services. Her health deteriorated further and she moved into a care home some 6 months later.

Case Study 11:

Mrs F is 85. She was admitted to hospital due to a recent illness. During the discharge process it became apparent that Mrs F was forgetful, and she was diagnosed with dementia.

Her family informed staff that she had a history of sleepless nights and were worried that she may wander outside of her home during the night. There were other concerns regarding her safety, which included a risk of fire, as Mrs F is a heavy smoker. After discussion and agreement with Mrs F and her family, smoke detectors, temperature extreme sensors and a property exit sensor were installed in her home.

Mrs F was discharged home and her family continue to be involved in her care but report that worry and stress had been greatly reduced. There have been a few false activations of equipment by family when leaving her home at night, but they informed staff that this provided added reassurance that the equipment works.

Case Study 12:

Mr M has a learning disability. He works in supported employment as a litter picker. The job involves learning new routes through housing estates that are unfamiliar to him. He was having difficulty managing time spent on individual streets and also remembering the routes.

A Personal Digital Assistant (PDA) was provided for Mr M. This equipment provides a task-scheduling programme and also photographs of the streets and routes for helping to manage Mr M's daily work tasks. Training on how to use the PDA was provided for Mr M and his job coach.

The PDA is enabling Mr M to carry out his job more independently. It is also assisting him to expand his work responsibilities by increasing his ability to learn more routes. It has helped with his time management and reduced his reliance on his job coach. His family also report increased self-confidence in relation to his work.

Case Study 13:

Mrs F is 44. She suffers from dementia, and was admitted to hospital in June 2008 after being found wandering in the street, unable to say who she was or where she lived. She was discharged from hospital in December 2008 once a telecare package, involving door contacts, a key safe, a smoke detector, a heat sensor, and flood detectors was provided in her home. Mrs F is now living independently and safely within the community once more.

Case Study 14:

We can report two incidences of telecare smoke alarms being activated. One resulted in the fire service attending a service user's home where a fire had taken hold and required him to be lifted out of his home by the fire service and the fire brought under control. The other was an elderly service user suffering from dementia that had left a pan on her cooker before falling asleep, again the fire service were called to attend and made the situation safe. These two examples highlight the effectiveness of telecare despite the limited number of packages we have in place presently.

Case Study 15:

The client is a 90 year old frail gentleman living alone. He has Parkinson's disease resulting in poor mobility and a stooped posture. He uses a Zimmer frame with 1:1 support for mobilising. He can be forgetful at times and will try and walk without support or his mobility aids. He is unable to manage the stairs and has to sleep in the sitting room. He uses a commode beside his bed. The client does not appear to have insight into his rapidly deteriorating health and the need to wait for assistance when mobilising. He is trying very hard to maintain his independence which increases the level of risk when he is alone at home, specifically during the night, when he will try to use the commode independently, resulting in increasing falls.

The client is high priority for a residential placement. Crossroads care has been increased to supplement his attendance at a day centre. His family decided to provide sleep in cover in conjunction with a nocturnal bed monitor installed on 25th October 2008. The alarm was placed in an upstairs bedroom to notify the carer if he exits bed during the night.

Feedback from the family indicates that the alarm has been very beneficial in providing reassurance. They no longer lie awake listening for him. Unfortunately the alarm was discontinued after one week due to the client realising that family members were on site, and he vacated the bed much more frequently seeking social contact. His family felt this was unsustainable for them and withdrew from sleeping in. Two night support visits are now in place.

Case Study 16:

Telecare equipment has been provided to a young woman who has epilepsy and a 2 year old child. She has a history of falling down the stairs. She can now be left alone with the child and feels greatly reassured.

Case study 17:

Within a few days of installation in a client's home, lifestyle monitoring equipment was clearly showing that she is spending most of her time, by day and night, in the lounge. This raised the question as to whether she is actually going to bed at all and her social worker has been informed.

The equipment also recorded that she had opened her front door on a number of occasions close to midnight and during the very early hours of the morning. This was reported to her GP by the family, resulting in the early detection of a urinary tract infection, for which she was given treatment.

It is now planned to consider whether the use of additional telecare sensors would be appropriate at this time (risks associated with the demonstrated behaviours appear to be minimal and managing the response during the night may be difficult for the family). A door open alert or property exit alarm or bed occupancy sensor could potentially help keep the client more safely at home.

The family feel the lifestyle monitoring equipment has given them an objective insight into their mother's living pattern when she is alone in her home. They have found this very reassuring (she has been awaiting a place in a residential home for over a year) and proactive in managing any deterioration in her condition.

Officers have now concluded lifestyle monitoring equipment will undoubtedly have a cost effective impact on care arrangements and long term placements and have strongly recommended that the partnership invest in this equipment as a helpful assessment tool for Occupational Therapy and Social Work practice teams to use for promoting independence and safety.

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