

AN ASSESSMENT OF THE DEVELOPMENT OF TELECARE IN SCOTLAND

2006-2010



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Executive Summary

The national Telecare Development Programme (TDP) for Scotland was launched in August 2006 as a policy initiative to drive the adoption of telecare by local social and health care service providers.

Over the period to March 2010, £16.35 million was made available by the Scottish Government under the programme. Of this sum, £2.55 million was used to fund an innovation programme, and meet research and administration costs, while £13.8 million was allocated directly to care partnerships to drive service expansion.

Initial expectations regarding the likely outcomes and efficiencies that a dedicated funding programme would generate over the period to March 2010 were laid out in a telecare business case document, which argued that (initial) TDP funding (of £8.35 million) would generate outcomes and efficiencies worth around £43 million in gross terms by March 2010.

Wider activities to support the establishment of telecare services in Scotland were subsequently detailed in the strategy document '*Seizing the Opportunity*'.

The purpose of this report is to:

- Present data on the growth of telecare through TDP funding, based on quarterly reports submitted by Scottish local care partnerships.
- Provide an assessment of progress against the business case made for TDP funding in Scotland, using the quarterly reports and other available data.
- Provide a broader review of progress against '*Seizing the Opportunity*'.
- Consider more generally the extent to which efforts to promote telecare over the period 2006-10 have led to mainstreamed services across Scotland.

Key Findings

Growth of Telecare Through TDP Funding

Over 29,000 people began a telecare service through TDP funding over the period 2006-2010. Over the whole period around 7,300 subsequently stopped receiving a service.

Over 2,000 people that received a TDP funded service are known to have been diagnosed with dementia, but the true figure is likely to be significantly higher.

Assessment of Progress Against Business Plan Expectations

By 31st March 2010, approximately £10.4 million of TDP funding had been spent by local partnerships, and another £2.6 million as match funding.

Around 1,500 hospital discharges were expedited as a result of TDP funding 2006-10 against a business plan expectation of about 1,800.

At the same time around 6,600 unplanned hospital admissions were avoided against an expectation of around 3,800.

Over 2,650 care home admissions were also avoided against an expectation of 3,025.

By achieving the above outcomes, partnerships saved around:

- 346,000 care home bed days (against an expected 188,000)
- 65,000 hospital bed days through facilitated discharges and unplanned admissions avoided (against an expected 80,000)
- 35,000, nights of sleepover/wakened night care (against an expected 55,000)
- 411,000 home check visits savings were less than anticipated (against an expected 615,000)

Overall, the gross value of TDP funded efficiencies over the period 2006-10 is approximately £48.4 million at current prices; the financial value of gross benefits achieved was fairly close to expectations, given the uncertainties necessarily involved in business planning.

Progress Against the Wider Telecare Strategy 'Seizing the Opportunity'

Much of the focus of the national telecare strategy 2008-10 was about providing guidance and support to care partnerships, and developing the 'infrastructure' necessary to deliver effective telecare services.

Some of the key elements of the broader 2008-10 telecare strategy – targeted (non financial) support to individual partnerships, promotion of the standards agenda, and aspects of the innovation programme – were delivered. However, important aspects of the vision for 2010 have still to be achieved.

The extent to which mainstreaming of telecare has been achieved

The evidence from a self assessment survey suggests that 22% of Scottish partnerships (or 7 partnerships in absolute terms) are now there or almost there in terms of mainstreaming. The bulk of partnerships (63%, or 20 partnerships in total) may be considered to be to a greater or lesser degree solidly on their way. This leaves some 15% (5 partnerships) over which there may still be said to be a serious question mark.



Introduction

The national Telecare Development Programme (TDP) for Scotland was launched in August 2006 as a policy initiative to drive the adoption of telecare by local social and health care service providers (or 'care partnerships')¹. In total, when it comes to an end (which will be in March 2011) TDP funding will have been worth just over £20 million.

Over the period to March 2010, £16.35 million was made available by the Scottish Government under the programme. Of this sum, £2.55 million was used to fund an innovation programme (discussed later), and meet research and administration costs, while £13.8 million was allocated directly to care partnerships to drive service expansion.

Despite the relatively modest scale of the TDP budget, expectations were high concerning its potential to support a more widespread shift in the balance of care from reactive to prevention, and from institutional to community based settings².

In particular the TDP fund was expected to:

- Increase the number of people in receipt of telecare services.
- Reduce the number of avoidable admissions to care homes.
- Reduce the number 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.

Initial expectations regarding the likely outcomes and efficiencies that a dedicated funding programme would generate over the period to March 2010 were laid out in a telecare business case document³, which argued that (initial) TDP funding (of £8.35 million) would generate outcomes and efficiencies worth around £43 million in gross terms by March 2010.

¹ Consistent with previous evaluation reports, the term telecare is used here as it is defined within the Scottish Government (2008) telecare strategy: "Telecare is the remote or enhanced delivery of care services to people in their own home or a community setting by means of telecommunications and computerised services. Telecare usually refers to sensors and alerts which provide continuous, automatic and remote monitoring of care needs, emergencies and lifestyle changes, using information and communication technology (ICT) to trigger human responses, or shut down equipment to prevent hazards".

² For details on the shifting the balance of care agenda see: <http://www.shiftingthebalance.scot.nhs.uk/>

³ The original business case was updated for the Telecare Development Programme Board in late 2007 (JIT, 2007), and it is this later version that is referred to in this report.

Wider activities to support the establishment of telecare services in Scotland were subsequently detailed in a strategy document '*Seizing the Opportunity*', published in May 2008 and covering the period 2008-10 (Scottish Government, 2008).

Seizing the Opportunity established the following overall vision for telecare provision in Scotland 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.

To achieve this vision, the strategy argued the need for:

- Innovation in service delivery arrangements.
- Agreement of a standards framework suitable for telecare providers in Scotland to sign up to, and greater engagement of the Care Commission in regulating telecare service provision.

- Consistent inclusion across Scotland of telecare as a possible solution in the 'single shared assessment' process.
- Development of new training modules for assessors and courses for telecare call handlers, responders and equipment installers.
- Widespread communication of telecare possibilities and opportunities to service users and carers, service funders and providers.
- Development of international partnerships to promote good practice in telecare implementation and innovation.

Report Purpose and Approach

This report presents data on the growth of telecare through Telecare Development Programme (TDP) funding, based on quarterly reports submitted by Scottish local care partnerships. In doing this it incorporates findings from previous studies to show the whole picture over the period 2006-10.

The quarterly monitoring data is then combined with other relevant information in order to compare actual outcomes and efficiencies secured through TDP funding to March 2010 with the expectations set out in the business case prepared to support the first round of TDP funding.

The report then provides a broader assessment of achievements and developments against the framework of the 2008-10 telecare strategy.

Finally, survey and other data are used to assess the extent to which efforts to promote telecare over the period 2006-10 have led to a mainstreamed service across Scotland.



Growth of Telecare Through TDP Funding

Client Numbers and Type of Service

Table 1 shows that over 2009/10 as a whole, 12,635 people were newly recorded as receiving a telecare service. However, over the same period 4,823 people were recorded as having stopped receiving a service, leaving the net growth in telecare service users over the year as 7,812.

Of the 21,215 people who began receiving a telecare service under TDP funding within financial years 2008/9 and 2009/10, some 14.7% had previously been in receipt of some form of telecare assistance. For 2009/10 alone, this figure increases slightly to 15.7%.

It is also worth noting (figure 1) that 6,921 (55%) of the 12,635 assisted in 2009/10 were provided with a basic telecare service; the remaining 5,714 were offered an enhanced telecare service⁴.

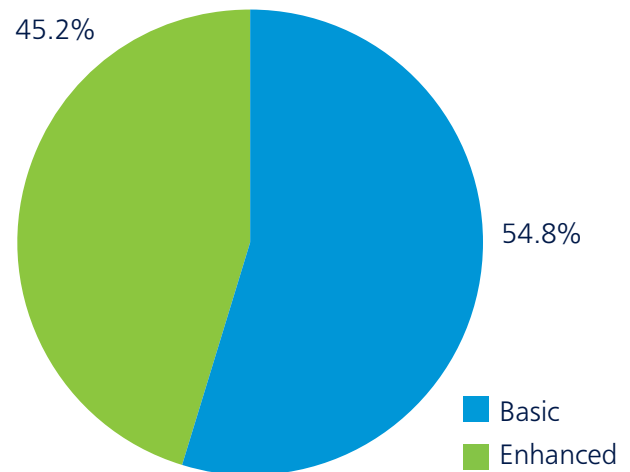
Table 1: TDP Funded Telecare Service Users

	2007-8	2008-9	2009-10	Total
New Clients (gross)	7,902	8,580	12,635	29,117
Stopped receiving a service	679	1,819	4,823	7,321
Net new clients	7,223	6,761	7,812	21,796
Turnover rate (%)	8.6	21.2	38.2	25

Over time the turnover rate (defined as the number of people that stop using a TDP funded telecare service within a year as a proportion of the gross number of new clients within that year) has been increasing. This is perhaps not surprising; as time has passed, increasing numbers of initial beneficiaries of TDP funded telecare would be expected to not require it for a number of reasons. It also indicates that increasing numbers of people have been using recycled equipment.

Looking across the whole period of TDP funding to 31 March 2010, some 29,117 people had been assisted via TDP money, with 21,796 (75%) still in receipt of a service of some kind as at March 2010.

Figure 1: Nature of Service Packages Offered to TDP Clients



⁴ For the purpose of completing quarterly monitoring returns, a basic service was defined as a telecare hub unit together with a pendant and an integrated smoke alarm. An enhanced package was defined as one that goes beyond the basic configuration and includes any other sensors or monitoring equipment.

Client characteristics

Table 2 summarises information on the demographic and care group profiles of those assisted through TDP funding in 2009/10, and compares this with data for previous years.

Table 2: TDP Client Demographic and Care Group Profiles

	2007/8	2008/9	2009/10
Age:			
Less than 16	0.2	0.3	0.3
16-64	9.5	12.4	15.6
65 or more	85.0	86.1	80.5
Unknown	5.3	1.2	3.7
Sex			
Male	32.6	33.9	33.7
Female	62.4	65.3	63.1
Unknown	5.0	0.8	3.2
Ethnicity:			
White	84.5	85.4	84.2
Mixed	-	0.2	0.1
Asian	0.1	0.1	0.1
Black	0	0	0
Other	1.6	0.2	0.1
Unknown	13.8	14.0	15.5
Community Care Group:			
Older	63.1	61.6	58.1
Mental health	2.5	2.3	2.4
Dementia	7.9	9.9	9.2
Physical	18.3	24.3	22.5
Learning disability	2.2	3.1	4.0
Substance misuse	0.5	0.4	0.4
Less than 16	0.2	0.3	0.3
Unknown	5.3	1.9	3.1

Over time the proportion of people receiving telecare that are younger than 65 has been increasing, as has the proportion of people with a learning disability. The proportion recorded as 'older' for community care purposes has decreased a little.

The proportion with dementia also fell slightly in 2009, having risen in the previous year. In total, by 31 March 2010, at least 2,044 people with a diagnosis of dementia had been assisted through the TDP programme, although in practice the number assisted is probably much higher than this.

Reasons partnerships offer telecare

Table 3 summarises the primary reasons partnerships gave through monitoring returns for providing a TDP funded telecare service to people.

Table 3: Recorded Reason for Offering Telecare to New Clients

	2008/9	2009/10
Prevent admission to a care home	10.0	8.4
Prevent/lessen hospital admission risk	17.4	18.9
Facilitate hospital discharge	5.9	8.2
Improve carer piece of mind/respite	23.2	22.0
Meet a low level need	32.6	36.4
Other reason	10.9	6.1
Total	100.0	100.0

Again, there appears to be considerable stability in the reasons partnerships report using to decide whether it is appropriate to provide telecare support. An increase in the proportion of telecare support being offered to facilitate hospital discharge or lessen the risk of hospital admission is evident in the data, and there is a higher emphasis on meeting low level needs⁵, while the proportion of people receiving telecare for a reason other than those specified in the monitoring form has fallen by half since 2008/9.

⁵ We return to this later, in discussing other partnership reported data on the extent to which telecare has been mainstreamed.

Assessment of Progress against Business Case Expectations⁶

Outcomes

Since the inception of the Telecare Development Programme, local care partnerships have been asked to indicate what they expected to deliver locally with TDP funding. Taken together, these expectations of locally generated outcomes and efficiencies formed the basis for business plan estimates of the overall benefits the programme could deliver.

Table 4 summarises partnership achievements in terms of outcome measures for 2009/10 and for the period 2006-2010 as a whole against what the partnerships said they expected to deliver using TDP funding.

Table 4: TDP Outcomes 2006-10

	PARTNERSHIP EXPECTATIONS		PARTNERSHIP ACHIEVEMENTS	
	2009/10	2006-2010	2009/10	2006-2010
Reduction in delayed discharges from hospital	967	1,804	611	1,505
Reduction in the number of unplanned hospital admissions	1,088	3,803	2,793	6,594
Reduction in the number of care home admissions	2,036	3,025	1,190	2,655

Sources: 2006/7 and 2007/8 expectations are from JIT (2007). Expectations for 2008/9 and 2009/10 were provided by JIT from data provided by partnerships. Achievements up to 31 March 2008 are from YHEC (2009c). Achievements for 2008/9 and 2009/10 are from relevant quarterly monitoring returns.

- Expectations on reduction in delayed discharges have been consistently higher than subsequent achievements, which could reflect a lower actual incidence of the problem over time in a number of localities than anticipated.
- Significantly stronger performance in reducing unplanned hospital admissions than initially expected
- Weaker performance against expectations with respect to reduction in the number of care home admissions in 2009/10. However, care home admissions avoided in 2009/10 were still over 25% higher than in the previous year, and performance in this regard across the period 2006-2010 as a whole was closer to expectations.

⁶ The numbers in this and subsequent sections do not reflect quarter 4 monitoring data returned late by one care partnership, and hence are to be treated as slight underestimates of the true position.

Expenditure and efficiencies

Over the year 2009/10, partnerships collectively reported total TDP expenditure of £2.9 million.

This brings total TDP expenditure since the beginning of the programme to £10.4 million⁷ and represents 75% of the £13.8 million TDP funding actually allocated to partnerships over the same period⁸.

In contrast to previous years, 2009/10 TDP funding carried a requirement for match funding. At the outset, some £4.9 million was promised in match funding. Partnership returns indicate that around £2.6 million match funding was actually spent over the course of the year. This is not necessarily inconsistent with initial promises however given carry forward of unspent TDP allocations into 2010/11.

Combining the reported TDP and match funding figures, the TDP programme was responsible for a minimum of £5.5 million expenditure in 2009/10.

In terms of efficiencies secured, Table 5 summarises partnership achievements against efficiency measures for 2009/10 as well as for the period 2006-2010 as a whole, relative to what they anticipated delivering using TDP funding.

Table 5: TDP Outcomes 2006-10

	PARTNERSHIP EXPECTATIONS		PARTNERSHIP ACHIEVEMENTS	
	2009/10	2006-2010	2009/10	2006-2010
Number of hospital bed days saved due to reduction in number of delayed discharges	10,674	45,104	7,013	16,360
Number of hospital bed days saved due to reduction in number of unplanned hospital admissions.	10,922	35,330	23,747	49,033
Reduction in number of care home bed days purchased	43,313	188,099	205,308	346,292
Number of nights sleepover care saved	16,902	55,427	12,895	35,470
Number of home check visits saved	85,778	614,983	50,472	410,685

Sources: 2006/7 and 2007/8 expectations are from supporting spreadsheets to JIT (2007). Expectations for 2008/9 and 2009/10 were provided by JIT from data provided by partnerships. Achievements up to 31 March 2008 are from YHEC (2009c). Achievements for 2008/9 and 2009/10 are from partnership relevant quarterly monitoring returns.

⁷ This includes an upwards adjustment of £92,475 to the expenditure total for 2008/9 reported in Newhaven Research (2009), based on data revisions offered by local partnerships after the 2008/9 progress monitoring report was prepared. More generally, the expenditure figures reported in this paper, including match funding expenditure, should be considered as minimum estimates, as a number of partnerships continue to report difficulties in timeously extracting accurate expenditure data from their corporate finance departments.

⁸ It should be noted that partnerships have been allowed to carry unspent allocations across financial years, including 2010/11.

Table 5 shows that:

- Relative to expectations for both 2009/10 and for the period 2006-10 as a whole, hospital bed day savings achieved due to a reduction in delayed discharges have been quite modest.
- On the other hand, hospital bed day savings achieved due to a reduction in unplanned hospital admissions were considerably higher in both instances.
- The biggest impact has been on care home bed days purchased, where the expectation of around 188,000 saved over the period 2006-10 has been considerably bettered by an actual saving of over 346,000 days.
- Actual nights of sleepover/wakened night care saved and home check visits have both been somewhat below expectations.

Comparing tables 4 and 5, one can also see that:

- The average number of hospital bed days saved per reduced delayed discharge was 11.9
- The average number of hospital bed days saved per unplanned hospital admission avoided was 7.4
- The average number of care home bed days saved per care home admission avoided was 130 (or roughly 18.6 weeks)

Financial Analysis

To give reported 2009/10 efficiencies a money value, we require a 2009/10 price, at partnership level, for:

- A day of in-patient 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. YHEC used locally reported costs for hospital inpatient treatment, care home residency, sleepover care and home check visits wherever possible, and NHS Information Services Division cost book data otherwise⁹.

These prices were then updated to 2008/9 values by adjusting for inflation, with the annual RPIX measure of inflation prepared by the Office for National Statistics used for this purpose (Newhaven, 2009). This procedure was repeated to generate 2009/10 prices¹⁰.

These prices were then applied to the unit efficiency measures reported in table 5. Table 6 summarises the results.

⁹ Cost book data is available here: <http://www.isdscotland.org/isd/797.html> while the YHEC report is available here: <http://www.jitscotland.org.uk/action-areas/telecare-in-scotland/telecare-publications/>

¹⁰ 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.

Table 6: Estimated Value of TDP Funded Efficiencies

	2009/10	2006-2010
Increased speed of discharge from hospital	£2,638,623	£5,694,428
Reduced unplanned hospital admissions	£7,045,743	£14,619,074
Reduced care home admissions	£14,234,324	£22,987,252
Reduced sleepover/wakened nights care	£681,655	£1,790,654
Reduced home check visits	£459,188	£2,634,391
Locally identified efficiencies	-	£301,000
Procurement efficiencies	£187,019	£406,397
TOTAL	£25,246,552	£48,433,196

Sources: 2006-8, YHEC (2009a) table E1; 2008/9 and 2009/10, own calculations based on partnership monitoring returns 2008/9

Table 6 shows that the overall value of financial benefits arising from TDP expenditure in 2009/10 was just over £25.2 million, or more than double the value for the preceding year. In total the estimated financial value of benefits arising as a result of TDP expenditure from the start of the programme in 2006 to end March 2010 was roughly £48.4 million at current prices.

Nearly half of these savings (47.5%) have arisen from avoidance of care home admission. Another 42% derives from preventing unnecessary hospital inpatient stays.

The bulk of the remainder, in the form of reduced sleepover care and home check visits (9.1% of the total), is likely to have mostly benefited local authorities. Just less than 1% of benefits have arisen in the form of procurement savings¹¹.

In overall terms, the original business case anticipated that quantifiable benefits of £43 million would accrue by March 2010. While the estimated total for actual savings is £48.4 million at current prices, the original business case was based on total partnership expenditure of £7.133 million (from within an overall budget of £8.35 million). The £48.4 million achieved is based on actual partnership spend of £10.4 million, or TDP spend and match funding expenditure together of £12.9 million¹².

¹¹ As in the previous monitoring report, the 2009/10 procurement efficiency 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, and adding the actual negotiated savings reported by Partnerships through non PASA procurement arrangements.

¹² Moreover, as has been emphasised in earlier reports, the £48.433 million should be understood as gross benefits; Partnerships may have combined telecare with other service elements to generate these, and this would have to be allowed for in a full cost-benefit analysis. Moreover, not all of the reported savings could be realised in the short term; it is not possible to close half a hospital ward for example. Nonetheless the benefits as measured are real and meaningful.

Progress Against the Wider Telecare Strategy 'Seizing the Opportunity'

Implementation of the national telecare strategy 2008-10 was driven through the work of a Joint Improvement Team (JIT) Management Group, and progress was recorded in a regularly updated programme implementation plan. The 31 March 2010 version of the programme implementation plan records 17 out of 21 major actions noted as completed¹³. In the rest of this section we describe how important elements of the strategy have been taken forward.

Partnership support

The 2008-2010 strategy introduced a change in thinking towards the allocation of TDP funding. Initial allocations in 2006-8 were based on population size in partnership areas relative to Scotland as a whole. In contrast for 2008/9 the strategy offered each partnership assessed to be progressing particularly

well a sum of £200,000, and those deemed to be progressing on an otherwise satisfactory basis £125,000 each. Partnerships were also advised that match funding would be a condition for receiving 2009/10 TDP funding. These adjustments to the allocation process were designed to reward delivery and encourage financial commitment.

Nine partnerships were considered to have made slower progress in developing telecare services to March 2008 than could reasonably have been hoped for, and these partnerships were offered assistance in the form of an externally conducted telecare review, to explore the potential for telecare locally, the nature of barriers to progress, and possible ways to address these barriers. By March 2010 these reviews had been completed, and in some cases further allocations of TDP funding made to the partnerships involved. Moreover, a number of other partnerships concluded that the review process could be locally helpful, and four formally requested a review in 2009/10. However, the review process itself took longer to establish and implement than originally anticipated and proved demanding on the limited time resources available to JIT to manage other aspects of strategy implementation.

¹³ This section of the report draws on TDP Board papers (which are available on the JIT website), unpublished JIT Management Group papers, and discussions with TDP Board and JIT Management Team members.

More generally, the review process identified or confirmed a number of common barriers to the expansion of telecare across Scotland, including:

- Lack of clarity around key local outcomes.
- Limited, inconsistent or poor project management.
- Lacklustre sponsorship/engagement by senior decision makers.
- Lack of buy-in from key stakeholders.
- Limited understanding and skills to implement service redesign.
- Fear of the consequences of “getting it wrong”.

Judging that these issues could become more acute and quick fixes would unravel as partnerships scaled up initial activity into a mainstream approach, JIT used this information to shape the content of additional guidance for partnerships to use (Boddy and Henderson, 2009).

Innovation

The innovation and health/social care convergence agenda laid out in the strategy document also proved demanding on available resources.

Organisationally, over the period of the strategy JIT worked actively with the Scottish Centre for Telehealth (SCT) to establish a common approach to the broader question of ‘telehealthcare’ implementation – a process that is still actively evolving.

More generally, the innovation agenda has involved the following significant initiatives¹⁴ :

- Three home telemonitoring demonstrators in the Lanarkshire, Argyll and Bute and Lothian areas to enhance the community based care of people with long term health conditions.
- Three housing and care demonstrators in the Inverclyde, West Lothian and Highland areas.
- Partnership working with Carers Scotland.
- Three demonstrators to explore the potential role and benefits of using telecare as part of an integrated approach to the prevention and management of falls and fractures in older people.
- Examination of the future of call handling.

The housing demonstrators and to a lesser extent the health demonstrators got off to a slow start. By March 2010 most of these initiatives were established, but there had been very limited progress with the Highland housing demonstrator. The falls management and prevention demonstrators are more recent. At time of writing, it was too early to assess what if anything will emerge from these workstreams that will be of lasting significance.

Partnership work with Carers Scotland has borne more immediate results. Research into the challenges and benefits of telecare for carers led to a national conference in December 2009, and publication of a report of research findings (Jarrod and Yeandle, 2009). Recommendations from the research have informed actions within the Carers Strategy for Scotland (Scottish Government, 2010).

¹⁴ Further small initiatives, such as supporting a project on using software to integrate telecare assessments with other information and link to eCare in West Lothian, were also developed.

With respect to the future of call handling arrangements in Scotland, in summer 2008 research commissioned by JIT reported significant variation across Scottish telecare alarm handling centres, reflecting differences in scale and in the range of applications being offered in different areas (Telecare Think Tank, 2008).

For the future it concluded that:

- Staffing models need to change.
- The quality agenda will demand staff capable of providing more added value services.
- Training will become an increasing issue.
- More specialist roles (such as alarm handler, installer and emergency responder) will emerge.

The report findings were launched at an event in September 2008, and a follow up conference was held in April 2009 to identify what actions had been taken in the intervening period, and what could be done to facilitate the anticipated changes. General consensus supported effort to encourage a greater joining-up in the provision of call handling services and enable greater consistency in call handling standards across local partnerships. However, subsequent development of a purposeful plan of action on modernisation of call handling arrangements is still awaited.

Standards

Over the period of the strategy, a workplan was established to ensure that all aspects of telecare service are delivered to recognised standards.

Initial effort was focused on encouraging and facilitating partnerships to seek accreditation under a recognised framework such as that provided by the Telecare Services Association (TSA). This included work to ensure that a review of accreditation standards being conducted by the TSA would generate a standards framework suitable for application in Scotland. The new TSA standards

framework was launched generally in November 2008, with a subsequent Scottish launch in February 2009. Some 19 partnerships were members of TSA by March 2010, of which 5 had achieved accreditation and another 10 were formally working towards it.

A second strand of activity sought to influence the Care Commission (CC) to register and inspect telecare services, where appropriate; a third to encourage the Social Work Inspection Agency (SWIA) to include telecare services in relevant themed and service inspections in a consistent way, and a fourth strand of activity sought to clarify with the Scottish Social Services Council (SSSC) the position of telecare staff in relation to recommended training standards and registration requirements for staff who work in telecare services

The new TSA standards are being mapped against CC standards, and the Commission has agreed that where TSA regulation covers an area of common interest, and accreditation has been achieved, it will not seek further information at the pre-inspection stage. While this falls short of passporting of accredited services to full registration with the Commission, it is a valuable concession to service providers nonetheless, avoiding repetition and duplication, as well as saving time.

SWIA expressed interested in knowing more about telecare, and what might be reasonable expectations of local partnerships, to better inform their inspections. It was felt that in both performance and themed inspections it might consider asking for information about local telecare services in pre inspection questionnaires and contact was made to explore these possibilities. A written protocol is now in place between JIT and SWIA under which a view of local telecare services is offered to SWIA as part of its pre inspection information collection and preparation activities.

Work is also now underway to explore a common approach to standards/regulation for telehealth in partnership with the Scottish Centre for Telehealth.

Needs assessment

In terms of the single shared assessment (SSA) process, a telecare prompt has been included in the National Minimum Information Standards that guide assessment and care planning for all adults in Scotland. However, as the Scottish Government notes in CCD3/2008¹⁵.

“The standards themselves do not guarantee that every assessment, care plan or review is of good quality; they are a necessary prerequisite towards this goal”.

The evidence we have on the quality of SSA from a telecare perspective is somewhat mixed however, with the generally positive picture found by Sergeant (2010) and discussed below balanced by the somewhat more sceptical nature of recent partnership survey evidence that is also reported on later.

Training

Due to weight of other priorities on available resources, training matters were not initially progressed after the 2008-10 strategy had been adopted. It was recognised by the TDP Board as a key issue to address in 2009/10 however, and a training and education strategy for 2010-12 has now been published.

This new strategy covers community based services only. A phase 2 strategy for acute health sector staff is to be prepared in due course.

The new training strategy notes, amongst other things, that there is no accredited training currently available in Scotland for staff involved in equipment management or call handling. Where training has been provided to date for call handlers, this has for the most part been developed locally or bought in from telehealthcare equipment suppliers.

“
The standards themselves do not guarantee that every assessment, care plan or review is of good quality; they are a necessary prerequisite towards this goal.”
”

¹⁵ <http://www.scotland.gov.uk/Resource/Doc/924/0064534.pdf>

Training for staff that respond to telecare alerts has also, for the most part, been locally developed within partnerships and there is no Scottish Qualifications Authority (SQA) accredited training currently available for this key staff group. Paid response staff are not usually required to have a professional qualification.

A series of practice guides has been developed to support professionals in the use of technology with different user groups, including people with dementia, learning disabilities, physical disabilities and sensory impairment¹⁶.

A model induction programme for call handling staff has also now been developed and made available to all partnerships for local delivery, where appropriate¹⁷.

As 2009/10 drew to a close, exploration of the possibilities for developing interactive training materials was getting underway, and training remains an area of future possible European Union collaboration (see below).

Communication and raising awareness

Considerable work, co-ordinated through an overall TDP Board approved communication plan, has been focused on raising awareness.

One strand of work during 2008/9 involved development of a multi-media toolkit of awareness raising resources. The toolkit includes a DVD introducing telecare and a range of 'digital stories'.

The majority of local partnerships have also developed awareness raising materials and programmes for stakeholders, examples of which can be found in the internet based 'telecare resource bank'¹⁸.

However, it is not clear that all of this activity has been equally effective to date. Henderson (2010) notes that partnerships continue to report an apparent lack of awareness of the potential of telecare amongst carers as well as amongst health and social care professionals.

International collaboration

Over the past two years, Scottish telecare activity has proved of considerable interest to European governments and organisations, in particular to potential collaborators in Norway, Italy, Germany and the Republic of Ireland. In part this has been the result of independent reports on UK progress with respect to the introduction of telecare services (for example, Empirica/WRC, 2008).

Active interest has been shown in applying for EU funding on a collaborative basis to progress telecare in Scotland, but this has been effectively stymied to date by the comparatively short lead in times for preparing applications, and the up front and ongoing management costs associated with making winning bids.

An EU application was submitted in February 2010 however, following an approach from the Work Research Centre in Dublin involving a proposal around knowledge transfer/training. The outcome of this application is not yet known, and others may be made in due course.

¹⁶ <http://www.dementiashop.co.uk/?q=catalog/21/telecare>

¹⁷ <http://www.jitscotland.org.uk/downloads/1252573256-Telecare%20-%20Introduction%20Programme%20for%20Call%20Handlers.doc>

¹⁸ Telecare Resource Bank – <http://www.jitscotland.org.uk/toolkits/implementing-telecare-an-action-guide/telecare-project-tools-and-references/telecare-resource-bank/>

The Extent to which Mainstreaming of Telecare Been Achieved

An important measure of success to date is the extent to which TDP funding and wider actions under the telecare strategy have served to embed telecare securely in local service structures. Two recent sources of information provide direct evidence on this.

The Sergeant Review

The first is a report by Sergeant (2010), who undertook a review of national and local telecare developments, and planned activity, as at September 2009.

Of the 32 care partnerships in Scotland, 31 returned a questionnaire as part of this review, providing a comprehensive picture of service provision across Scotland at that time.

The Sergeant review concluded:

- All partnerships were making efforts to move telecare services from a project basis to mainstream provision.
- Many partnerships were progressing effectively with integration of telecare into day to day local service options.
- There is a clear commitment in strategic partnership documentation to integrating telecare into wider service provision over the coming five years.

According to Sergeant, 94% of partnerships are now using SSA as the principal route for access to telecare services. Adaptation of the SSA process to facilitate this was reported by many partnerships, with one requiring staff to rationalise not using telecare. 35% of partnerships also reported use of lifestyle monitoring systems as a means of supporting the assessment process.

More generally:

- All partnerships said they were providing telecare services to older people and those with a diagnosis of dementia. A number of partnerships also said they were trialling the use of GPS tracking systems for supporting older people with early stage dementia
- Over the first three years of the TDP all partnerships explored use of telecare to support a wider range of user groups, with these services becoming part of day to day service delivery within a number of areas
- Almost all partnerships said they were making telecare services available to people with learning disabilities, including the use of telecare in service redesign of group home living, and in supporting the development of daily living skills such as self travelling and activity scheduling

Providing home based health monitoring was also a focus for 19 partnerships during 2009-10. This included use of:

- Medication dispensers in four areas.
- Falls management programmes in five areas.
- Chronic Obstructive Pulmonary Disease (COPD) pilot projects in six areas.
- Home pod units for complex health needs in one area.
- Diabetes monitoring using mobile phone technology in one area.

In addition, 10 partnerships anticipated involvement in further telehealthcare projects during 2010/11.

However, partnerships also reported that a number of local issues were impeding the mainstreaming of telecare and telehealth services, including:

- Lack of equipment 'interoperability'.
- Problems with supplier relationships and with equipment reliability.
- Infrastructure gaps.
- Difficulties with respect to recruitment and training.

Other issues reported were:

- Lack of engagement amongst 'stakeholders' in the implementation process. 90% of partnerships indicated that this continued to pose problems, including with respect to shared vision and ownership of programmes.
- Limited commitment to telecare from senior management as a continuing problem.

- Difficulties in understanding the role of telecare in wider agendas including shifting the balance of care, enablement, management of long-term conditions and reshaping care for older people.
- Additional pressure on homecare services from the implementation of telecare, with no appropriate compensating resource adjustment being made.
- Linked to the two preceding points, a need for a more innovative approach to resource management.
- Largely undeveloped local performance management systems.

Partnership views on the extent to which telecare has been mainstreamed

The second source of evidence is a further survey of partnerships conducted in March 2010 to explore their views more directly on the extent to which a mainstreamed telecare service had been established in their areas.

The timing of the survey was chosen to coincide with the end of the telecare strategy and business case period, and 31 partnerships returned a completed survey form on the understanding that individual returns would be reported on an anonymous basis.

The following discussion of survey findings also includes unattributed comments that were offered by survey respondents in response to open ended questions.

Not surprisingly (figure 2), the survey found that in most parts of Scotland social care is the lead partner in telecare service provision. In 16% of cases (5 areas), health and social care are reported as in joint lead.

Figure 2: Lead partner in telecare delivery (%)

In terms of local area service targeting, the people most partnerships said they have to date been targeting telecare towards are typically those at some considerable risk (figure 3). This appears to be the case regardless of which partner agency takes the lead.

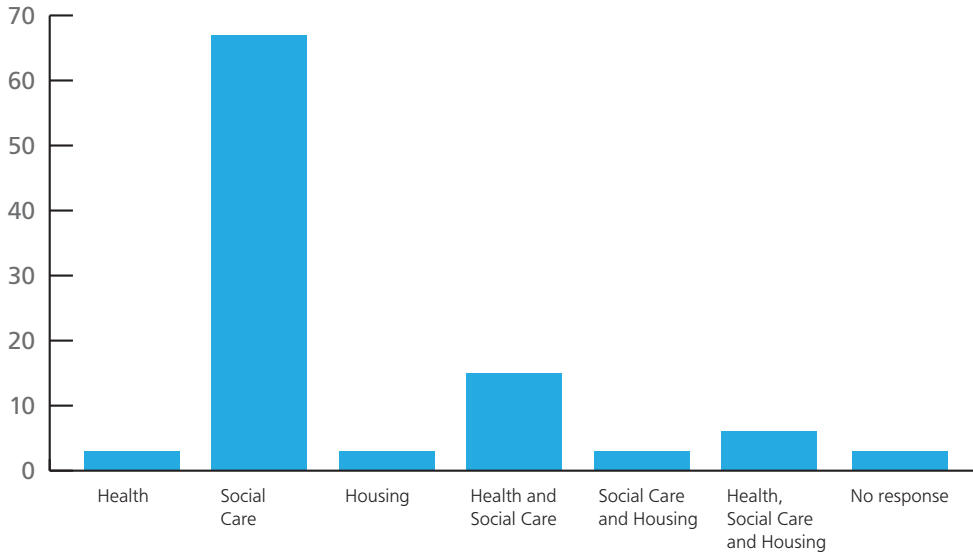
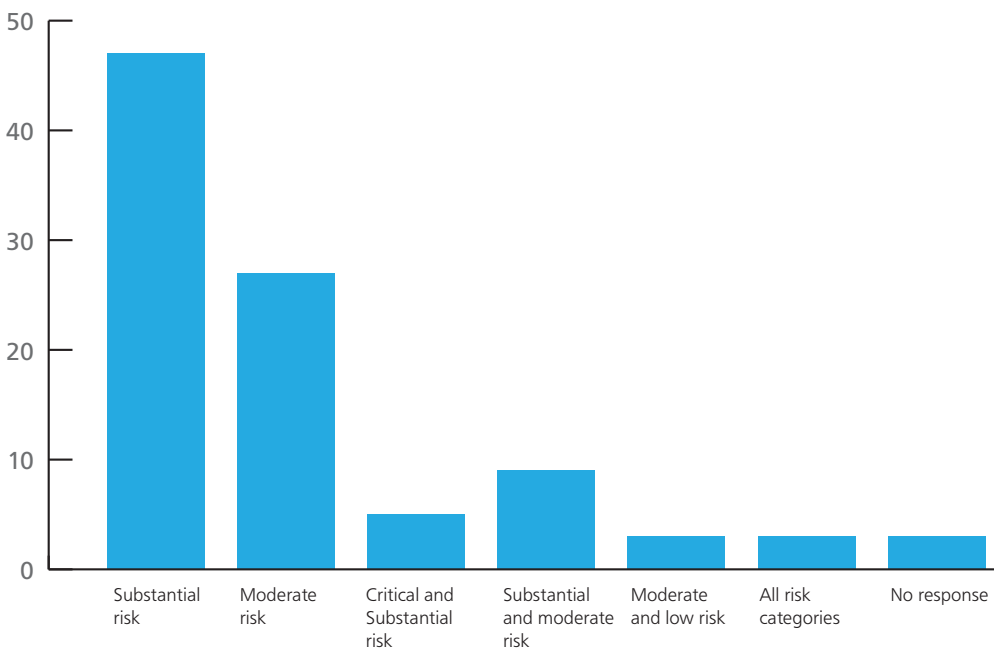


Figure 3: Major client risk category focus of telecare delivery (%)

However this finding seems a little at odds with the fact that, as seen earlier, telecare has been reported through the quarterly monitoring returns to be meeting a low level need in around a third of cases¹⁹.



¹⁹ The actual wording of the question asked here was "What is the major focus of telecare service provision in your local care partnership area?" It is perhaps possible that 'major' was in this instance interpreted by some respondents as 'most important' rather than 'most numerous'.

More generally, not all of those returning a questionnaire necessarily agreed that a policy focus on high risk clients was appropriate.

“There is a genuine commitment to the continued growth of a telecare service as a means of ‘shifting the balance of care’. The original concept of this being a freely available preventative service seems to be becoming somewhat diluted as once again it is being targeted at the high need, high risk end. While this is obviously a significant area of service provision, my hope is that we will be able to come back to a more pro-actively preventative provision once things settle down. In times of financial difficulty, it requires a leap of faith to invest in a preventative approach which may not reap recognisable rewards immediately”.

In terms of bedding telecare services firmly into a wider portfolio of service activities, about half (47%) of local partnerships said that a strategic assessment of future need for telecare service provision in their areas had been conducted; 28% said one had not been undertaken and a further 22% did not know.

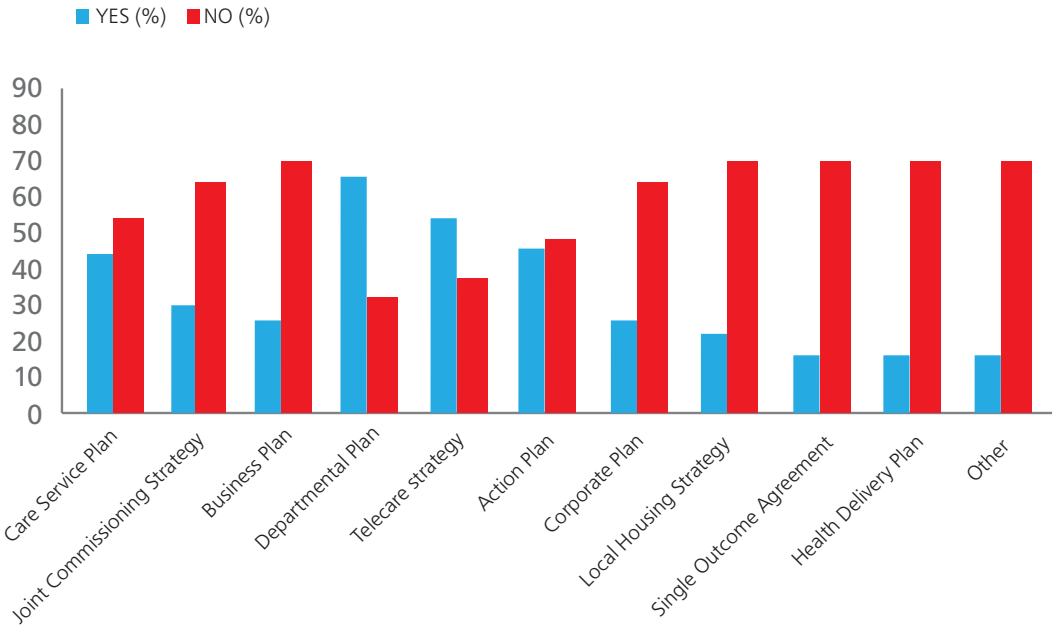
More generally, in slight contrast to the findings of Sergeant (2010), the incorporation of future telecare service provision considerations within key partnership strategic and operational documents appears to vary greatly (figure 4).

Two thirds of partnerships have telecare embedded in the departmental plan of one or more of the organisations involved in local partnerships, and almost 60% of local partnerships now have a telecare strategy document of some kind. The presence of telecare is less obvious however at the level of joint commissioning strategies, business plans, corporate plans, single outcome agreements and health delivery plans.

“

There is a genuine commitment to the continued growth of a telecare service as a means of ‘shifting the balance of care.’”

Figure 4: Inclusion of telecare in planning documents (%)



“To continue to provide this much needed telecare service we are seeking to ensure that some core funding is provided from Health/Council for future years. In the existing financial climate it is a real challenge”.

“We continue to have an increase in expenditure on our mainstream budgets as a result of greater knowledge throughout the partnership as a consequence of staff and service users visiting the demonstration flats”.

“The Telecare Manager has also written a telecare strategy 2010 to 2014 which includes a detailed action plan for each year. This strategy document along with a committee report was presented to the Social Work and Health Committee on 20th January 2010. It was agreed at committee and mainstream funding was agreed”.

“There is an intention to use service redesign and resource release from NHS to invest in telecare services post TDP”.

“To continue to provide this much needed telecare service we are seeking to ensure that some core funding is provided from Health/Council for future years.”

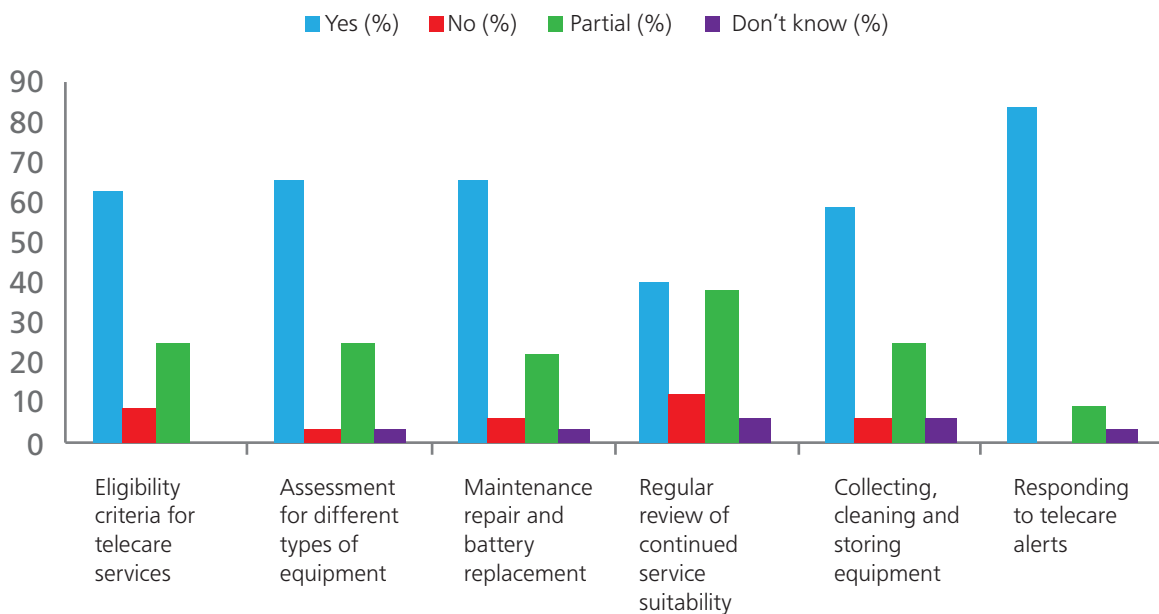
Nonetheless, some 63% of partnerships report that ongoing core capital funding is in place for future telecare service provision and 78% said that this is the case for ongoing core revenue funding. Moreover, 78% of partnerships advised that there was planned investment in telecare equipment acquisition in their areas, 53% that there was planned investment in call centre capacity and 63% that there was planned investment in response services.

The principal funding source for these investments was reported as local authorities. In 66% of partnership areas, local authorities expect to shoulder these investments alone; local authorities anticipate co-funding from the health sector in a further 16% of areas, and in a further 6% of areas a wider consortium funding arrangement is in place.

Figure 5 shows that, in terms of the establishment of agreed protocols and processes for service delivery, partnerships report that considerable progress on mainstreaming has been made. In particular, partnerships reported that clear eligibility criteria for receiving a telecare service, assessment processes, and protocols for maintenance and recycling of equipment and delivery of response services are well established.

However, partnerships were also asked to indicate, on a scale of 1-10 where 1 = 'not started' and 10 = 'completed', the extent to which they had embedded telecare into various key processes and services. The results (table 7) show a more mixed picture, with less progress than might have been hoped for on integrating telecare services into wider community equipment services, overall approaches to managing long term conditions and dementia, and budget setting processes.

Figure 5: Whether partnership has defined processes/protocols (%)



“
Clearer direction required
so that telecare is part
of the Single Shared
Assessment process.”

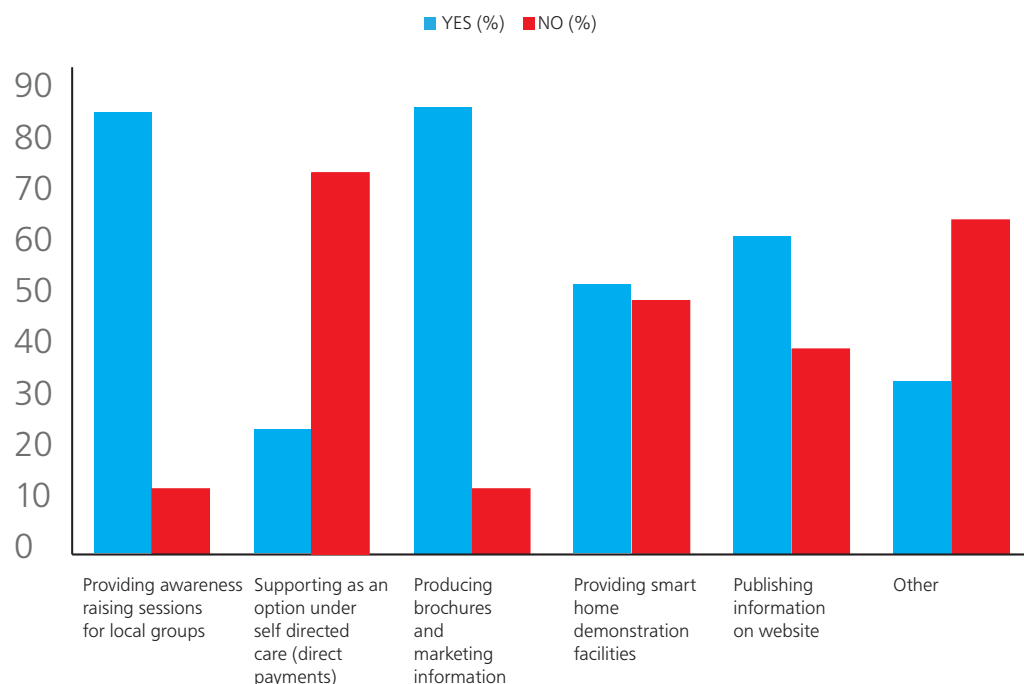
With respect to other dimensions of mainstreaming:

- Some 16% of partnerships confirmed they are now accredited to recognised telecare standards; a further 31% said they are actively seeking such accreditation, while 50% said they are registered with the Care Commission for elements of the telecare service provided.
- Exactly half of the local care partnerships in Scotland said they now have a permanent telecare manager post.
- Nearly three quarters (72%) said they undertake local monitoring of telecare service provision, but only 56% of partnerships said that the data collected as part of their telecare service is integrated in some way into shared information systems.

More generally, partnerships reported themselves as being engaged to varying extents in a wide range of activities to promote the uptake of telecare services in their localities (figure 6).

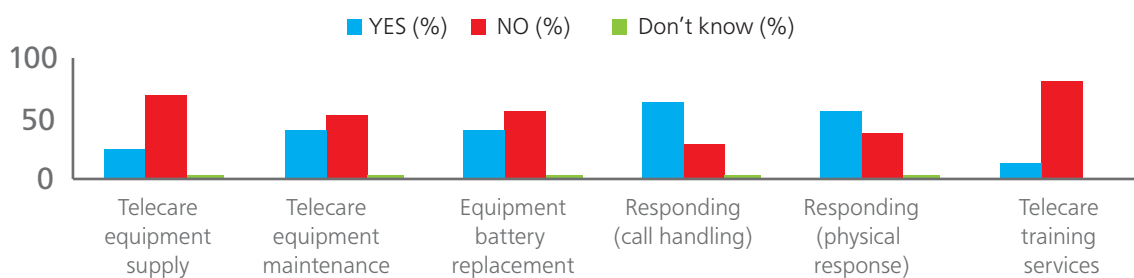
The most popular types of activity are providing local awareness raising sessions and preparation of marketing information, with over 80% of partnerships engaged in these types of activity. In addition, half of the local partnerships have developed demonstration facilities and nearly 60% are putting service information on their websites. Much smaller numbers have been promoting telecare as an option under self directed support arrangements however.

Figure 6: Partnership engagement in promotional activities (%)



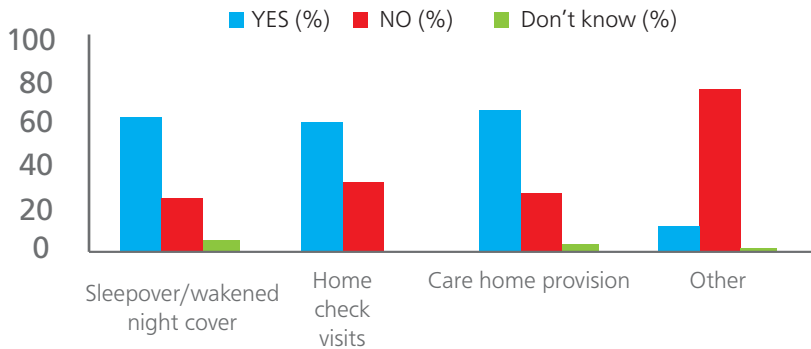
Other than for response services, comparatively few partnership telecare services are currently predicated on formal long term (2-5 year) contractual arrangements (figure 7). The percentages saying they had such arrangements in place varied from 16% for telecare training services and 25% for equipment supply up to 63% for call handling services.

Figure 7: Partnership involvement in 2-5 year contractual arrangements (%)



Importantly, quite high numbers of partnerships said that other types of service were being phased out or reduced locally as part of the development of a telecare service (figure 8). Some 66% of partnerships said they were phasing out or reducing sleepover or wakened nights cover, 63% were doing the same with respect to care home provision, and 60% of partnerships said they were phasing out or reducing home check visits.

Figure 8: Whether other services are being reduced by partnerships (%)



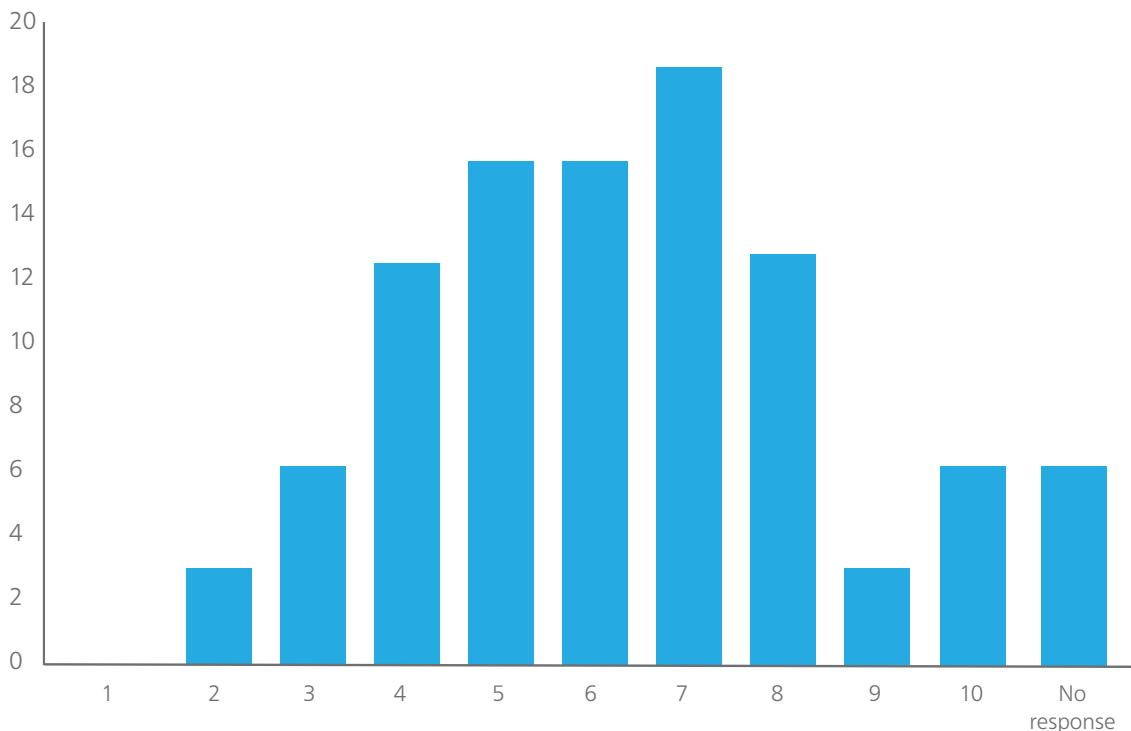
Finally, partnerships were asked to assess where, in the round, they believe they are in respect of mainstreaming telecare. Once again, they were asked to score this on a scale of 1 (not yet started) to 10 (completed) (figure 9).

Taking a score of 3 or less as evidence of a very immature service, and of 8+ as evidence of one that is well progressed towards full main streaming, the results suggest that 22% of Scottish partnerships (or 7 partnerships in absolute terms) are now there or almost there in terms of mainstreaming. The bulk of partnerships (63%, or 20 partnerships in total) with a score of between 4 and 7 may be considered to be to a greater or lesser degree on their way.

This leaves some 15% (5 partnerships) over which there may be said to be a serious question mark.

Partnerships were also asked whether they thought their local telecare services would grow, stay the same, or reduce, once TDP funding support came to an end. In response to this question, 66% of partnerships said that their local telecare services would grow, and 13% that they would stay the same, with 9% saying they did not know. These numbers are also consistent with the view that the bulk of partnerships are well on the path to having a fully mainstreamed telecare service.

Figure 9: Extent to which partnerships believe telecare is mainstreamed (%)



“B Grade nurses and Home from Hospital Team are now using alarms where actual visits can be avoided, thus increasing capacity”.

“Things are improving slowly in terms of cultural shifts etc”.

“The joint cohesive approach required to drive this area is still at infancy stage”.

“We estimate that there has been a 15% increase in take up of peripheral equipment. We ascribe this to heightened awareness from staff and service users to the benefits of the technology. This increase in demand has been met from our mainstream budgets (basic community alarm and peripheral budget)”.

“Local aspiration is to manage change of practices through personalisation and examining other ways of care management, maximising use of telecare. However as with all change, staff hesitation or reluctance may mean progress is not at the pace we might want”.

“Our approach is evolving and our revised focus on an evaluation based programme will result in rigorous local monitoring”.

“Continuous promotion of this service will be an ongoing requirement for a significant period of time. The cultural shift required within Health and Social Services as well as within our client group, is far from achieved currently”.

This should not however be taken to mean there is not still much to do to support the development of telecare services further in Scotland.

“
Things are
improving slowly
in terms of cultural
shifts etc.”





Conclusions

The overall assessment of progress to March 2010 ultimately comes down to the answers we can give to the following questions:

- Did TDP funding accelerate the development of telecare in Scotland?
- Did the TDP programme deliver the gross benefits anticipated in the business case?
- Was the overall vision offered in the telecare strategy achieved?
- Finally, and more specifically, has telecare become part of mainstream service provision?

The answer to the first question is that over 29,000 people enjoyed a service during the period 2006-10 that they were extremely unlikely to have received without TDP funding.

On the second question, not all of the specific outcomes and efficiencies anticipated in the initial business case were subsequently realised, but there was over achievement in some important regards, and the overall financial value of gross benefits achieved was impressively close to expectations, given the uncertainties any projection exercise has to encompass.

On the third question, much of the focus of the national telecare strategy 2008-10 was about providing guidance and support to care partnerships, and developing the 'infrastructure' necessary to deliver effective telecare services. Some of the key elements of the strategy – targeted (non financial) support to individual partnerships, promotion of the standards agenda, and aspects of the innovation programme – have been achieved. However, important aspects of the vision for 2010 have still to be secured:

- Telecare is much more widely understood and appreciated than it was, but not to the extent the vision anticipated.
- Some progress has been made on integrating health and care service working arrangements, but local partnership feedback testifies to enduring issues.
- The housing role in telecare service provision remains to be fully developed.
- All local partnerships have established telecare services to a degree, but again not to the full extent the vision anticipated.

This last point bears directly upon the final question. Ultimately the core telecare policy objective 2006-10 was, in effect, to ensure that telecare is mainstreamed in Scotland as a way of cost effectively supporting a shift in the balance of care.

The evidence on this from partnerships themselves supports the conclusion that considerable but not complete progress has been made in this regard.

A number of partnerships have all but made the transition to a fully mainstreamed service, while others are much further down that road than they were even a year ago. The removal of TDP funding, now extended for a further but final year for 2010/11, will not in the great majority of instances lead to partnerships running telecare service provision down; with nearly 80% of partnerships saying that local telecare services will not diminish once TDP funding is withdrawn, the TDP pump priming exercise therefore appears to have been successful.

There remains a small (and diminishing) rump of partnerships that have still not given the telecare agenda much priority; as time passes, and if they do not take steps to address the issue, they are likely to increasingly stand out as out of touch with good practice in service delivery and the achievement of value for money.

In sum therefore, a great deal has been achieved in a short space of time. Most local partnerships in Scotland are on the way to delivering telecare as a mainstream service, there are recognised and accepted standards for this service, and increasing awareness of the power of telecare to transform lives as well as working practices²⁰.

²⁰ Partnerships regularly provide examples of the transformational impact telecare can have on people's lives through their quarterly monitoring reports, and some of these have been included in this report as an appendix.

Appendix: Transforming Lives: Partnership Reported Case Studies

Mrs S

S is a 92-year-old lady who lives in North Ayrshire. S sustained a fall and as a consequence had become very weak. She was very dependent on her daughter to do most things for her and was admitted to an intermediate care centre. Whilst there a physiotherapist assessment confirmed weakness in her lower limbs and reduced balance, making S prone to falls. S spent approximately 10 weeks at the intermediate care centre before going home, during which time she received regular physiotherapy and was supported by staff to regain a degree of independence.

In preparation for discharge a care manager discussed the case with the Telecare Co-ordinator who advised that a bed occupancy sensor and a fall detector could be installed, but initially had some reservations with regards to the suitability of the fall detector, believing that S might not be able to adapt to wearing the device. However, both S and her daughter wished to pursue the option.

The equipment was installed on the day S was discharged home. There were some teething problems but, despite the initial reservations of the Telecare Co-ordinator with regards to the fall detector, S managed very well. In the mornings, a home carer assisted S with her personal care and with positioning her fall detector.

S's daughter is aware that her mum is frail and still at risk of falling, but now sleeps better at night knowing that if her mum does fall, staff will be alerted and will respond quickly. She feels that she can now spend quality time with her Mum.

This equipment has supported S's independence and enhanced the quality of her life without placing any restrictions on her lifestyle. Although S continues to experience some falls, she is able to continue living at home. Early intervention enabled S to become accustomed to the equipment. Habits have been established that have lasted. It has also improved her daughter's quality of life, giving her piece of mind and helping to reduce the anxiety that she had previously experienced.



Mr F

Mr F is a 60 year old man with Korsakoff's syndrome resulting in confusion and wandering at night. He also has severe memory loss. Due to his condition, and to allow him to remain at home, he had a 24 hour care package to support him. A telecare package was installed, including smoke and heat sensors and a property exit sensor. Since the installation of the equipment Mr F has not required overnight care. His brother lives close by and if any of the sensors are activated he is able to attend within a short time.





Mrs B

Mrs B is a 79 year old lady who, lives alone and has advanced dementia. She has a very stringent routine that has assisted in maintaining her in her own home. Her son visits every morning on his way to work and her daughter spends most of the day with her. However, her family initially struggled to cope with a need for evening visits after an incident when Mrs B lay on the floor all night, until found the following morning. Two years ago Mrs B had received an initial package of telecare support that included smoke and heat detectors. After her fall, her family contacted the telecare service to see if there was any additional equipment that could assist. Home monitoring equipment was then installed, allowing members of her family to use the internet each evening to ensure that she is in bed.

Mrs J

Mrs J is a 90 year old lady who received a community alarm service in March 2007. In December 2008 she became unwell and was admitted to hospital in a confused state. She was treated for a urinary tract infection and although fit enough to be discharged from hospital she was admitted to a local nursing home for a period of respite. Mrs J made a good recovery but it was felt she would not cope if she returned home so permanent residency was sought. In May 2009 a 6 week review meeting took place that established Mrs J was not settling in the nursing home and wished to return to her own home. Her family were supportive and willing to act as responders should a door alarm be activated. This alarm was fitted, together with smoke and gas alarms and Mrs J returned home for a 4 week trial period at the beginning of June 2009. To date there have been no activations from the equipment and Mrs J has settled back into her home.





Mrs W

Mrs W is an elderly lady with severe dementia who wished to remain at home. Her son who is her main carer supported this wish but was concerned about his mother's activity during the night. Home activity monitoring equipment was installed to allow a professional assessment of the situation. Her son also requested that he be able to access monitoring data and this was arranged. The equipment picked up a pattern of movement in the middle of the night. It also showed that she opened her door sometimes during the night she wasn't leaving the house. As a result a door contact was fitted, linked to her son's mobile phone. Mrs W's son has been reassured that his mother is not at risk and he is happy for her to continue living in her home with support. Because the monitoring equipment is unobtrusive there has been no disruption for Mrs W, and the information gathered has allowed her social worker to introduce changes to her care package that enhance the support she receives.

Mr E

Mr E is 79 and has dementia. He lives alone with the support of his daughters and attends a local day centre. He started to have falls in his home but was not able to use his community alarm to call for help. His daughters were very concerned at the risk of further falls and worried that he was possibly increasing this risk by getting up in the night. A telecare 'memo-minder' (a device which plays pre-recorded messages when it senses movement) was installed with a message from his daughter telling him to go back to bed, but this made him think she was in the house and go looking for her, so it was removed.

Lifestyle monitoring was suggested to Mr E and his daughter and they were keen to try it. Mr E's records showed a great deal of night time activity in and out of the bathroom, bedroom and kitchen as well as around the front door.

Mr E's daughter took copies of these reports to her father's next consultation with his Geriatrician and this information enabled the Consultant to prescribe medication to reduce anxiety and give Mr E a good night's sleep. Within a few days Mr E's night time activity was reduced to a couple of bathroom visits. He was still going to the front door a great deal during the day – 128 occasions on one day – so the Consultant, who had been planning to reduce his dose, increased the medication.

Mr E suffered a major stroke in March; the lifestyle monitoring system detected lack of movement in the morning and activated a red alert.



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