Is there a clearer role for telecare in adult social care in England that will deliver better outcomes for older people?

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Structure of presentation

• Background
• Definitions
• History & policy development
• The Whole System Demonstrator project
• Telecare as a new policy problem
• Findings from some recent unpublished research
• Conclusions
Definitions

Assistive Technology
‘any item, piece of equipment, product or system, whether acquired commercially, off the shelf, modified or customised, that is used to increase, maintain, or improve functional capabilities of individuals with cognitive, physical or communication difficulties’


Telecare
‘the use if communications technology to provide health and social care directly to the user/patient. This excludes the exchange of information solely between professionals, generally for diagnosis and referral’


Purpose
• To reduce the risk of adverse events
• To monitor individuals (vital signs, falls, flood, etc)
• Physical assistive technologies to aid mobility
• Information and advice & to support medication & self care
• To support independent living

Knapp et al. (2015) unpublished

Functions
• To remind or to prompt
• To support communication
• To support meaningful use of leisure time
• To promote comfort and well-being
• To help keep people safe

AT Dementia website www.atdementia.org.uk
Definitions in practice: a quick example

• The Problem:
  o **Forgets to light gas cooker after turning it on.**
  o **Risk of suffocation or explosion**
  o **High level of concern from neighbours and relatives**

• The Solutions?
  o **Admission into care**
  o **Substitute gas for electric or microwave**
  o **Disconnect cooker**
  o **Use technology to manage risks**
History & policy development since 1998:

1. Use of telecare in England & Wales emerged from use of social alarm technologies in 1960s & 70s (Fisk 2003).
2. Because social alarm technology had to be user activated it was widely believed that telecare per se was only useful for ‘cognitively able’ people.
3. Focus was on the people with CI who were unable to use the technology rather than limitations of the technology itself.
4. Electronic AT was used for people with severe physical disabilities – expensive but supported independence of some people.
5. 3 factors changed this prevalent view
   - New technology & technological progress – especially ‘passive’ technologies.
   - Demography and service pressures
   - Person-centred approaches to telecare – especially in mainland Europe (Bjorneby et al. 1998) and in the UK (Marshall et al. 2000) in relation to dementia care.
History & Policy development since 1998: research evidence: early projects and studies

- Falkirk Mobile Community Alarm service
- Northampton Safe at Home Project
- Adre ‘n’ Saff (Anglesey)
- Croydon Aztec Project
- Kent
- Edinvar Housing Association
- Gloucester smart home

Comparisons of care packages provided to Safe at Home service users and the Essex group at the start and end of the fieldwork period
History & policy development since 1998

1. Politicians, policymakers, civil servants and (one or two) manufacturers became interested.

2. Several policy strands – housing, social care, community equipment & health. Telecare = a way to achieve key NHS & housing priorities & solution to demographic pressures.

3. Policy development
   • 1998 NHS Information strategy: telecare to support the supervision of vulnerable people in their own homes.
   • 1999 Royal Commission - future of telecare with housing but seen as very futuristic
   • 2000 NHS plan: community equipment services seen as key providers of telecare.
   • ICES created in 2001 to integrate community equipment services
   • DH also sets up Telecare Advisory Group (2003)
History & policy development since 1998

- 2002 House of Commons Select Committee – berates care providers for not taking up telecare
- 2005 House of Lords Science & Technology Committee blames industry for not investing in telecare...

All this policy thinking and nothing really happening: how hard can it be to develop local telecare services?
Difficulties in implementation of telecare: formidable barriers and a lack of an infrastructure at a local level to support widespread use:

• Not something that naturally ‘belonged’ to any existing public sector agency – no one sector had all the expertise.
• Local agencies don’t always work well together
• Telecare seen as ‘big brother’ - superficial thinking but resistance
• Big gaps in expertise
  o who assesses for,
  o who decides what telecare,
  o who installs,
  o who responds
  o who pays
  o who realises the savings that can be made
• Best practice: re-engineering services to exploit benefits of telecare rather than trying to fit them in to existing service configurations

So what did the Government do?
History & policy development since 1998

1. Green Paper (2005) more general mood music about technology being useful – but not just for frail older people - and in ‘unlocking resources’ as well as helping people remain independent.

2. 2005 – willing the means rather than just the ends: the Preventive Technology Grant. 80m over 3 years for all English local authorities.
   • To pump prime and stimulate demand
   • Good for industry which was seen as needing help
   • Came with strings: PIs which encouraged local authorities to get telecare and electronic assistive technologies into homes of as many older people as possible.

3. Recognised the need for better research: commissioning the WSD.
History & policy development since 1998

Austerity
Telecare as prophylactic and panacea?
• ASCD budgets not protected
• Cuts of between 25-40% since 2009
• No end to austerity and reduced public sector spending
• Telecare seen as a less expensive way of meeting needs
  o Signposting of non-eligible people
  o Service of ‘first resort’ - before care or as a substitute for care
  o To keep people out of hospital
  o To facilitate early discharge
  o To prevent/delay admission into care
Summary

- Governments have seen a key role for assistive technology for two decades.
- Implementation has been difficult because of formidable barriers & lack of an infrastructure at a local level to support the widespread use.
- Much work was done by ICES (and then CSIP) to promote the wider use of assistive technology and telecare.
- After a false start, the Government willed the means as well as visioning the future for telecare with the PTG and PIs.
- The Government commissioned the WSD to fill the gap in evidence for impact and effectiveness.
- Public sector austerity has led to a renewed interest in telecare as a cost effective way of providing help to people needing adult social care.
The Whole System Demonstrator project (WSD)

Largest clinical trial of telecare and telehealth in the world.

• Robust RCT design.
• Large samples, reliable & generalisable findings.

Data on wide range of outcomes collected over a 12 month period to determine if telecare made a difference.

• Trial cost = approx. 4m.
• Based around 3 ‘demonstrator sites’: Cornwall, Newham & Kent.
• 5,806 randomly assigned to telecare intervention group or control (2,903 each) from 217 general practices.
WSD findings

Some, fairly limited evidence of positive impact of telehealth applications

No evidence for that telecare made a difference

Steventon et al. (2013) compared outcomes for telecare users with a controlled, randomised group people who received no telecare.

None of the measured outcomes were statistically significant

‘In this trial, telecare did not significantly alter rates of health or social care service use or mortality over 12 months’

Steventon et al. (2013 p.6)

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Control (n=1, 236)</th>
<th>Intervention (n=1,190)</th>
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<tbody>
<tr>
<td>Admission proportion (%)</td>
<td>49.2</td>
<td>46.8</td>
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<tr>
<td>Mortality (%)</td>
<td>8.9</td>
<td>8.7</td>
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<tr>
<td>Emergency hospital admission per head</td>
<td>0.57</td>
<td>0.65</td>
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<tr>
<td>Elective hospital admission per head</td>
<td>0.41</td>
<td>0.38</td>
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<tr>
<td>Outpatient attendance per head</td>
<td>3.80</td>
<td>3.92</td>
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<td>A&amp;E visits per head</td>
<td>0.70</td>
<td>0.72</td>
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<td>Falls admissions per head</td>
<td>0.11</td>
<td>0.14</td>
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<tr>
<td>Hospital bed days per head</td>
<td>8.48</td>
<td>8.65</td>
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<tr>
<td>GP contacts per head</td>
<td>6.63</td>
<td>6.72</td>
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<td>Practice nurse contacts per head</td>
<td>3.21</td>
<td>2.80</td>
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<tr>
<td>Proportion admitted into permanent residential care (%)</td>
<td>3.2</td>
<td>3.1</td>
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<td>Domiciliary care weeks per head</td>
<td>15.36</td>
<td>15.41</td>
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<td>Hospital tariff costs per head</td>
<td>2,604</td>
<td>2,846</td>
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<tr>
<td>GP surgery costs per head</td>
<td>315</td>
<td>305</td>
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<tr>
<td>Social care costs per head</td>
<td>4,287</td>
<td>4,210</td>
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Telecare: a new policy problem?

WSD findings = problems for:

• The Government: current policies support the development of service provision offering no advantages over traditional care & support
• Local authorities, some of which have invested v. large sums at a time of unrelenting budgets cuts
• Telecare manufacturers: ability to offer shareholder dividends jeopardised if care industry dis-invests.
• Telecare ‘pioneers’ and early evaluators whose results were very positive

Investment case studies:

• Birmingham, (14m) North Yorkshire, (3.5m?) Hertfordshire, (5m?) Manchester & Newcastle
• ADASS response to Better Care technology Survey (2014)

‘This is an important survey which...will support members to generate further momentum in realising the potential for assistive technology....We hope our investment in resources to support members with their telecare service development can now be focused in the areas that make the most difference’

(Dave Pearson, ADASS President 2014)
Findings from recent unpublished research

<table>
<thead>
<tr>
<th>Study led by Knapp in 2015.</th>
<th>Reflections on:</th>
</tr>
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<tbody>
<tr>
<td>Interviews with 18 experts in the field of telecare, gerontology &amp; dementia</td>
<td>• Existing telecare practices in ASCDs.</td>
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<tr>
<td>• Senior, academics (social work &amp; occupational therapy);</td>
<td>• Expert views on telecare assessment: the ideal &amp; the reality.</td>
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<td>• Consultant practitioners;</td>
<td>• Impacts on users, carers and ASCDs.</td>
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<td>• Consultant psycho-geriatrician;</td>
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<td>• Local authority commissioning managers;</td>
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<td>• Telecare supplier organisation staff.</td>
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Findings from recent unpublished research

Existing telecare practice: poor matching of need to technology in many ASCDs?
• Telecare assessment & deployment seen as separate: not integrated in many ASCDs
• Telecare assessors don’t always have all the skills needed
• ‘Prescriptive’ referrals
• Commissioning decisions restrict the availability of technologies that could help
• Quality of information to non-eligible people about telecare poor in many places
• Technology led rather than person centred

Care managers and carers not always supportive of telecare:
• Substitute for social care
• Threat to job security

Telecare assessors need to know about (a) telecare (b) the needs of the person to be using it (c) their capacity to use what’s provided (d) how they interact with the social and spatial environment
Practitioners sometimes refer for specific items of telecare = often a simplistic understanding of a person’s needs: someone who falls may or may not need a falls detector.
‘We don’t do that, have this instead’

Information not perceived to be widely available, often not very specific, often provided by manufacturers
Findings from recent unpublished research

- The point is that it’s not the technology – it’s what you do with it that counts. (Thanks to Stephen Wey, Senior Lecturer in Occupational Therapy, York St. John University, for this slide).
Findings from recent unpublished research

Telecare assessment: the ideal & the reality

- Focus: start with the person not the technology
- Style: home assessments, self assessments
- Content: person’s needs and goals, how they interact with their environment.
- Who should assess: telecare assessments should be fully integrated
- Who should be involved in assessments: carers and joint assessments

Limited range of telecare availability, telecare as a prophylactic, fitting people and person centered approaches: need to consider wider impact of telecare

Telecare assessments sometimes not done at all, sometimes a response to prescriptive referrals, not always done in the user’s home. Non eligible users don’t always get the right information & guidance to help them choose what they need

Much telecare provision narrowly focused on managing risk. Could be used to support activity and social contact. People who assess for telecare need to have practice as well as technical skills

Unpaid carers are usually the first responders and ensure that the telecare keeps working (charging batteries etc.)
Findings from an as yet unpublished study: (a) views re. impact on older people

Positive impacts
- Potentially effective at managing risks in the home
- Potentially effective at supporting independence & social contact (but not exploited)
- Benefits sometimes straightforward, but sometimes serendipitous

Negative impacts
- Overweening focus on risk management
- Where devices aren’t configured correctly
- User activation for people with CI
- Potentially, ethical issues to be worked through
- Savings made through use as a substitute for social care – not delayed institutionalisation
Findings from an as yet unpublished study: (b) views re. impact on unpaid carers

<table>
<thead>
<tr>
<th>Positive impacts</th>
<th>Negative impacts</th>
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<td>Carers often more enthusiastic – esp. if caring for someone with dementia</td>
<td>Invisible extra work</td>
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<td>Can provide a breathing space/good nights sleep</td>
<td>Responding to false alarms</td>
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<td></td>
<td>Can raise as well as lower anxiety levels in some situations</td>
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Findings from an as yet unpublished study: (c) views re. impact on adult social care departments

Positive impacts
- Potential savings to ASCD budgets
- Can enhance independence of recipients and unpaid carers thereby reducing demand for services.

Negative impacts
- Won’t deliver anticipated savings
- Challenges existing structures: best use means changing local infrastructures
- Investment in skills needed
- Use of telecare company staff to assess for and deploy telecare can address capacity but may lead to technology led rather than person centred focus.
Conclusions

• Best evidence suggests telecare isn’t effective
• We don’t really know why it’s not working
• In transitions from projects to services, something may have been lost
• It is reasonable to think that this ‘something’ may be attention to assessment quality
• Matching needs to technology is difficult
• Telecare policies focus on maximising use - not careful matching with need
• In some places assessment activity may be fragmented, superficial and technology led rather than person-centred
• More research is needed to map adult social care practice and to develop and deliver good quality telecare services


Knapp et al. (2015) unpublished


Royal Commission on Long Term Care (1999) *With Respect to Old Age: Long term care – rights and Responsibilities* (Cm4192-1 London, the Stationery Office


