Inverclyde council

AGENDA ITEM NO: 12

Report To:	**Health and Social Care Committee**	**Date: 26 August 2010**
Report By:	**Robert Murphy Corporate Director Inverclyde Community Health & Care Partnership**	**Report No: SW/25/10/GMcC/JH**
Contact Officer:	**Barbara Billings Head of Community Care & Strategy**	**Contact No: 01475 714015**
Subject:	**Telecare Development Programme**	

1.0 PURPOSE

1.1 To update Members on the progress and future plans for the Telecare Development Programme in Inverclyde.

2.0 SUMMARY

2.1 Since 2006, partnerships across Scotland have been invited to take part in the National roll out of the Telecare Development Programme. This process involves annual reporting on the success of the programme and bidding for additional funding to support further development of the programme.

2.2 The overall objective of the National programme is to support more people to live as independent lives as possible, with safety and security, by promoting the use of telecare in Scotland through the provision of a development fund and associated services.

2.3 Allocations to local partnerships have, in recent years, been conditional on the partnership committing match funding of an equal or greater amount in either funding or kind. The funding made available is non recurring capital, and partnerships are aware that the funding will cease in 2011.

2.4 Partnerships therefore require to put in place arrangements over this next year to ensure local services are robust and sustainable, and that they can play an effective role in supporting future strategic service redesign.

2.5 The 2010-2011 additional allocation is to enable Scotland to further build on the achievements to date in developing telecare as a mechanism for;

- shifting the balance of care,
- improving outcomes for service users and carers
- supporting the delivery of Single Outcome Agreement/HEAT.

2.6 As at 31 March 2010, there were 1857 service users in receipt of a telecare service. 70 people aged between 16 & 64 years were introduced to the service between 2009/2010, with a further 510 aged 65 years and over.

2.7 In April 2010, the Minister for Public Health announced a further £4m funding for the national Telecare Development Programme with an indicative allocation for the Inverclyde Partnership of £120,000.

2.8 The funding should be used by local partnerships to broaden their current platform of telecare services and robustly embed these developments within mainstream care. In addition, a move towards 'telehealthcare' would be encouraged, particularly around the areas of Falls Prevention and the better management of Long Term Conditions.

2.9 £50,000 of match funding has been identified through the political priority process from Inverclyde Council for the second consecutive year.

2.10 A bid was developed and submitted on behalf of the partnership outlining future work-streams and match funding proposals. Copy of the partnership bid attached. Appendix 1

2.11 The Inverclyde Partnership has, as part of the bid, confirmed that it will continue to:

- Outline the steps they will take to further embed telecare within their mainstream processes;
- Commit to providing an integrated health and social care solution where this is appropriate to best meet service user needs;
- Confirm that the TDP funding will be increasingly targeted towards people who have a long term condition and/or an elevated risk of emergency admission to hospital (including falls prevention and management, medication prompting, dementia care);
- Confirm they will actively engage in the Telehealthcare strategy development process to ensure that this is supportive and reflective of experience 'on the ground'; and
- Commit they will continue to participate in the independent evaluation of the programme to evidence ongoing progress and enable partnerships to report back effectively on achievements.

2.12 In June 2010 an offer of £120,000 grant funding was offered to the Inverclyde Partnership for further development of the telecare/telehealth programme.

3.0 RECOMMENDATION

3.1 The Committee is asked to note the progress, and to support and promote further mainstreaming of telecare/telehealth at a local partnership level, within the policy context of shifting the balance of care, supporting carers and supporting the delivery of the Single Outcome Agreement.

Robert Murphy
Corporate Director
Inverclyde Community Health & Care Partnership

4.0 BACKGROUND

4.1 The telecare programme in Inverclyde is now well established following a substantial education and awareness programme delivered to a range of potential service users, carers, assessment and medical staff.

4.2 A robust information gathering system has been developed to meet the reporting requirements of the National Programme.

4.3 **Telecare**

The outcomes achieved for the period April 2009-March 2010 include the following:

- Number of unplanned hospital admissions avoided – 157
  - The number of bed days saved 6072
- Prevention of admission to care home - 90
  - The number of bed days saved -3722
- Maintaining people to live independently at home - 344
- Number of sleepover nights saved - 259
- Number of home check visits saved – 1076
- Number of carers supported - 441

4.4 A range of care groups have benefited from the service including:

Care Group	Number of people receiving service as at 31st March 2010	New people to the service from April 2009 to March 2010
Older People	1486	438
Mental Health	9	5
Dementia	168	62
Physical Disability	130	50
Learning Disability	46	19
Substance Misuse	18	6
Total	**1857**	**580**

4.5 **Telehealth**

Throughout 2009/10, a telehealth service has been developed to support patients with Chronic Obstructive Pulmonary Disease (COPD) to live more independent lives in the community, to have better control over their long term condition and to reduce hospital admissions for these people. Service was introduced in August 2009.

4.6 Ten individuals were identified through GP information systems who had a long term condition of COPD and were at risk of being admitted to hospital. These people were supplied with equipment to provide remote healthcare support where information is able to be monitored by a multidisciplinary team of healthcare staff.

4.7 In the event of identified early warning signs being triggered, support of a Respiratory Clinical Nurse Specialist would be made available to the patient, providing early intervention and at times prevention of hospital admission.

4.8 Equipment was purchased and installed through the local telecare programme, with training and ongoing monitoring of the equipment being commissioned from the equipment provider.

4.9 Interim clinical results have identified a reduction in 10 hospital admissions and also a reduction in the number of home visits by GPs.

4.10 Excellent feedback from carers and users of the service has been gathered through patient satisfaction questionnaires.

4.11 An interim performance report is currently being written with publication including a cost benefit analysis being due by the end of August 2010.

4.12 The bid for funding for 2010/2011 was developed to meet the following objectives:

- to broaden the current platform of local telecare services, and robustly embed these developments within mainstream care, administrative and financial management systems (e.g. assessment/care management/review processes, robust asset management/joint store arrangements);
- to integrate health and social care solutions where this is appropriate to best meet service user needs; and
- to increasingly target TDP funding towards people who have a long term condition and/or an elevated risk of emergency admission to hospital (including falls prevention and management, medication prompting, dementia care).

5.0 PROPOSALS

5.1 A key element of the overall telecare programme for next year is to integrate telecare further within mainstream community care service provision based on the recognition that it can have a significant impact on the ability to promote independence and provide reassurance to people living in their own homes.

5.2 Local partnerships have been asked to give consideration as to how telecare can be further integrated into mainstream service provision so that a sustainable service is available when the additional funding ceases, and this will be considered through the wider review of care at home services.

5.3 The Inverclyde Partnership has achieved success in a range of areas for development of telehealth care and continues to develop systems that will ensure the widest use of telehealth care equipment and also the support and response services from both NHS and Local Authority.

5.4 One of the key success areas has been in the fact that local staff are linked to the joint equipment store and the community alarm response team are able to install most pieces of equipment themselves.

5.5 This has facilitated joint working with other organisations such as Strathclyde Fire and Rescue. The Telecare Coordinator provides input to team meetings with the fire brigade staff to widen their understanding of the equipment. This is reciprocated by local advice being made available in individual situations with fire brigade officers giving advice on positioning of smoke and heat detectors.

5.6 Identified areas for development of telecare for 2010/11 include the following:

- Falls prevention
  - Provision of falls monitors
  - Early identification of people at risk of falling
  - Supporting care homes to reduce falls
- Older adults with mental health problems
  - Assessing the risks of people remaining in their own homes
  - Supporting people on hospital discharge
- Learning disability
  - Making better use of overnight support to a number of people in the community

- Community safety
  - Providing support to older people who feel at risk due to anti-social behaviour
  - Supporting young people in their first tenancies
- Hospital discharge
  - Additional training to hospital staff to highlight benefits of telecare on discharge
  - Supporting rehabilitation on discharge by reducing the risk to people in the early period following discharge
  - Enabling older people to exercise their choice to return home as opposed to being admitted to a care home

5.9 Identified areas for development of telehealth for 2010/11 include support to people with the following long term conditions:

- Multiple Sclerosis
  - Facilitating independence through a wide range of equipment in the home
  - Reducing risk as the condition deteriorates
- COPD
  - Continuation of service with the existing patients
  - increasing the cohort of people receiving the service
  - supporting families and carers
- Diabetes Type 2
  - Use of remote healthcare support
  - Early identification of tissue deterioration
  - Reduction in outpatient visits
  - Improved self management of wounds
  - Joint working with podiatrists, diabetes nurse specialist and hospital consultants

5.10 £50,000 of match funding has been identified through the political priority process from Inverclyde Council for the second consecutive year.

5.11 Additional match funding has been identified through a range of different service areas, with the majority of it being “in kind”, where existing services either currently provide additional response services, or where an element of redesign will enable them to contribute to supporting the telecare/telehealth development across the Inverclyde partnership.

6.0 IMPLICATIONS

6.1 Legal:

6.2 Finance:

Cost Centre	Budget Heading	Budget Year	Proposed Spend this Report	Virement From	Other Comments
02035	Various	2009/11	£170,000		Inverclyde Council political priorities

6.3 Personnel:

6.4 Equalities:

7.0 CONSULTATION

7.1 A NHS Patient Involvement Facilitator is currently supporting the evaluation of the COPD development and the information gathered will be included in the performance report being currently drafted.

8.0 LIST OF BACKGROUND PAPERS

8.1 Appendix 1 - Inverclyde Partnership bid for funding 2010/2011

Appendix One

TELECARE DEVELOPMENT PROGRAMME

STATEMENT OF INTENT/FUNDING ALLOCATIONS 2010/11

1. INITIAL FUNDING ALLOCATION 2010/11

Partnerships are offered an initial funding allocation of **£120,000** in 2010/11. The receipt of this allocation is dependent on partnerships confirming a match funded contribution for the expansion of their local telecare development programme.

2. PARTNERSHIP RESPONSE TO OFFER OF FUNDING

Please **delete** whichever of the following statements do not apply;

I can confirm that the INVERCLYDE partnership;

- Wish to accept the initial funding allocation of £120,000 and agree to provide match funding of £120,000 to progress our local telehealthcare development programme (Please now complete sections 3,4,5, 6 & 7).

- Wish to accept the initial funding allocation of £120,000 and agree to provide match funding greater than £120,000 to progress our local telehealthcare development programme.

THE FOLLOWING SECTIONS 3, 4, 5, 6 TO BE COMPLETED ONLY BY PARTNERSHIPS WISHING TO ACCEPT AN ALLOCATION OF FUNDING IN 2010/11

3. STATEMENT OF INTENT

Please provide a short statement of how you intend to use the allocation and the partnership's match funding to order to achieve the following objectives;

- *to broaden the current platform of local telecare services, and robustly embed these developments within mainstream care, administrative and financial management systems (e.g. assessment/care management/review processes, robust asset management/joint store arrangements).*
- *to integrate health and social care solutions where this is appropriate to best meet service user needs.*
- *to increasingly target TDP funding towards people who have a long term condition and/or an elevated risk of emergency admission to hospital (including falls prevention and management, medication prompting, dementia care).*

The Inverclyde Partnership has achieved success in a range of areas for development of telehealth care and continues to develop systems that will ensure the widest use of telehealth care equipment and also the support and response services from both NHS and Local Authority.

Partnership working
One of the key success areas has been in the fact that local staff are linked to the joint equipment store and the community alarm response team are able to install most pieces of equipment themselves.

This has facilitated joint working with other organisations such as Strathclyde Fire Brigade. In April 2010, the Telecare Coordinator will provide input to team meetings with the fire brigade staff to widen their understanding of the equipment and the joint working that needs to be developed. This is resulting in local advice being made available in individual situations with fire brigade officers giving advice on positioning of smoke and heat detectors. They are also able to offer additional equipment such as fire proof bedding in certain circumstances. This is becoming an area of really positive joint working with safer and more effective outcomes for the recipients.

Falls prevention
Falls prevention will be tackled through a number of sources, with the Community Rehabilitation team piloting a measurement scale which identifies likelihood of falling. This will be rolled out to other community early intervention teams for wider use throughout 2010/2011. Scorings that identify risk will be referred back to the telecare coordinator for provision of appropriate equipment such as bed exit monitors and fall detectors.

Falls will also be logged through the call response system for community alarms, with additional assessment and support being provided through the Falls Project.

Fall detector equipment will also be loaned to care homes for limited periods in line with the agreed protocols for loan of equipment.

Long term conditions
Children
Work has begun to look at stand alone equipment for use with children with special needs to provide support to carers and parents. The work will be led by the Paediatric Occupational Therapist.
Work ia also underway to draw information from the SPARRA data, with 16 children under the age of 14 being identified as having a greater than 50% risk of hospital admission over the coming 12 month period. Greater detail is being sought about any commonalities and possible support mechanisms where telehealthcare could reduce the likelihood of re-admission.

Multiple Sclerosis
A new post with partial funding from the Multiple Schlerosis Society is being established. Inverclyde has a high incidence of MS and a specialist worker will provide support to clients and families, with a key part of this role being to facilitate independence and minimise risk. Individual assessment and provision of telecare and other equipment will be an important element of this support.

COPD
Telehealth products have supported people with COPD over the past year. A report on the outcomes has been produced and hospital admissions have redcued from 16 in the previous period to 4 in the most recent period. This work will continue through 2010-2011 with additional equipment being purchased for use when families/carers are going on holiday.
Installation of smoke detectors to all patients who use oxygen at home has also been identifided as a priority.

Diabetes Type 2
Discussions are underway with the Clinical Director, Rehabilitation and Enablement Manager and relevant clinicians in acute services to explore the possible role of telehealthcare in preventing hospital readmissions for people with type II diabetes who require tissue care and have compromised circulation that may lead to ulceration in feet or legs. The expectation is that people will have had one hospital admission and will have received guidance on self management of the wound and dressings, but telehealth equipment would be used to detect changes in readings such as blood sugar levels indicating possible infection. The development will be supported by the specialist community team including podietary and diabetic nurse.

Mental Health
Bed numbers for Older Adults with Mental Health problems continue to reduce, with hospital closure due for 2011.
A degree of mistrust continues by hospital staff and carers on the ability of technology to provide safety for people being discharged to the community. Work will take place through the day hospital redesign to introduce and trial equipment for people with dementia. This work will be led by identified Occupational Therapists and the Charge Nurse for the Day Hospital who will act as telecare "champions".
The main target will be to support people on hospital discharge where previously care home admission would have been the automatic choice.
The use of "Just Checking" equipment will also be introduced as part of the assessment process where carers are concerned about the activity of the older person during the night and to determine the real risks and also the most appropriate equipment to be supplied longer term.

Learning Disability
Changes to care provision in community services supporting people with learning disability are taking place, giving rise to opportunities to reconsider overnight support using telecare to enable staff to cover more than one or two clients and make better use of resources. This will enable services to be provided in scatter flats, facilitating more independent living across the community without costs being prohibitive by provision of one to one overnight cover. The response service will come form learning disability staffing as opposed to community alarm staff.

Housing Demonstrator
The Housing Demonstrator work with RSLs has identified areas for further development where older people do not feel safe in their tenancies due to Anti Social behaviour, and also where young people who have come through are in their first tenencies. The response services will link back to homelessness teams and community warden services. These developments should make people feel safer and also support them to maintain tenencies.

Hospital discharge
Additional input and training will continue with discharge staff and ward staff to highlight the possible benefits of telecare and the need for appropriate referrals being made prior to discharge.
This will be facilitated through the discharge protocol training and ongoing SSA training.
A review of rehabilitation teams for older people and a review of homecare services will be completed this year and the outcome will ensure the changing services will focus on short term re-ablement. Telecare will become an integral part of this service, reducing risk and proving a feeling of safety for people who have recently returned home from hospital and are in the process of finding out what they can and cannot manage at home.

4. BREAKDOWN OF FUNDING CONTRIBUTIONS

Please summarise below the anticipated budgets for 2010/11.

Summary use of TDP Funds	Anticipated amount (£)	Summary use of Partnership Match Funding	Anticipated amount (£)
Purchase of COPD additional equipment	£5,000	Training for use of falls scoring	£5,000
Purchase of telehealth monitoring equipment for diabetes	£10,000	Planning input to support interegation of SPARRA data	£15,000
Additional equipment purchase	£60,000	Input by COPD nurse specialist to monitor and provide additional visits	£16,000
Purchase of "just checking" equipment	£15,000	Packages to support early discharge	£70,000
Additional response staff	£15,000	Telecare coordinator and additional OT input for training, awareness raising. Political priority funding	£50,000
Additional input and training by podiatrist and Diabetes nurse specialist	£15,000	Evaluation of diabetes telehealth development.	£4,000
	£120,000		£160,000

5. CONFIRMATION OF ONGOING PARTICIPATION IN NATIONAL EVALUATION

I confirm that this Local Partnership will continue to participate in the ongoing evaluation of the national Telecare Development Programme, and will continue to submit the ongoing quarterly evaluation returns.

YES

Comments:

6. ENGAGEMENT IN THE TELEHEALTHCARE STRATEGY DEVELOPMENT PROCESS

I confirm that this Local Partnership will actively engage with the Telehealthcare strategy development process to ensure that this is reflective of experience 'on the ground'.

YES

Comments:

7. ANTICIPATED IMPACT OF ADDITIONAL FUNDING ON OUTCOMES & EFFICIENCIES

It remains important to continue to evidence the impact of the programme at a national level. To ensure the additional funding can be identified in a manner consistent with the previous 4 years programme, partnerships are asked to complete the following table. The contents will be used by JIT to monitor progress and make the case for further adoption of telehealthcare services. Progress will continue to be monitored via a quarterly return in2010/11. As match funding is required, partnerships are asked to make an estimate of the extent to which the TDP funding has contributed to any local outcomes, and include the proportion of this below (e.g. if 50% of funding from TDP has contributed to an outcome for 6 people = an assumption of 3 could be made). If in doubt, reference should be made to the Telecare Monitoring Form Guidance Notes.

OUTCOMES & EFFICIENCIES	2010/11
Outcome: How many prevented delayed discharges do you estimate can be assisted by TDP funded telecare?	60
Efficiency: How many hospital bed days do you estimate this may save?	180
Outcome: How many unplanned hospital admissions for community based clients do you estimate can be avoided due to TDP funded telecare?	200
Efficiency: How many hospital bed days do you estimate this may save?	10,000
Outcome: How many otherwise required care home admissions do you estimate can be avoided due to TDP funded telecare?	100
Efficiency: How many additional care home bed days do you estimate that otherwise it would have been appropriate to purchase?	4250
Outcomes: How many people do you estimate as able to maintain themselves independently due at least in part to TDP funded telecare?	550
Efficiency: Number of nights of sleepover care saved	2,000
Efficiency: Number of home check visits which will be made unnecessary as a result of TDP funded telecare	7,000
Efficiency: Anticipated value of procurement savings made	Unable to calculate

8. NUMBER OF SERVICE USERS RECEIVING TELECARE SERVICES

To enable us to continue to assess progress on the Telecare Development Programme, please advise of the number of people in receipt of telecare in your partnership area as at 31st December 2010. *Note: Where there is more than one person in a household and more than one require the service, the total number of service users should be counted.*

As at 31st December 2010, I can confirm there were ……1819……(insert number) of service users in receipt of a telecare service.

SIGNED (on behalf of the INVERCLYDE Partnership) Gillian McCready..

PRINT NAME…GILLIAN McCREADY……

JOB TITLE …Service Manager, Older people and Physical Disability.....

CONTACT DETAILS (TEL/E-MAIL) 01475 714079 gillian.mccready@inverclyde.gov.uk

DATE……9th April 2010…….....

Please return completed form to **Moira Mackenzie**, Telecare Programme Manager, Joint Improvement Team, Area 3ER, St Andrews House, Regent Road, Edinburgh EH1 3DG **by 9th April 2010.** (E-mail: moira.mackenzie@scotland.gsi.gov.uk

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