Is there a clearer role for electronic assistive technology and telecare in adult social care?

Telecare is seen by many as a way for local authorities to address rising demand with shrinking resources, and as a substitute for personal care.

Only a fraction of the potential of assistive technology has been exploited. Data could be used to identify loneliness, for example.

Local authorities need to consider if different professional groups have the full breadth of skills and experience needed to optimise telecare use.

More investment in training might help better equip telecare assessors with the skills to enable recipients to get the best out of telecare.

School for Social Care Research

SOCIAL CARE WORKFORCE RESEARCH UNIT

BACKGROUND

Telecare devices aim to help older people by compensating for disabilities or impairments. It is claimed to support the independence of people using it, reduce unpaid carer workload and save councils and the NHS money by preventing unnecessary hospitalisation or moves to care homes.

Early studies, based mostly on small scale projects, invariably suggested positive outcomes. These, and lobbying by the AT/telecare industry led the Department of Health and Social Care (DHSC) to provide an £80 million Preventive Technology Grant to support rapid upscaling of telecare use. Guidance was also published, and the DHSC also funded a large scale clinical trial of telecare's impact, which became known as the 'Whole System Demonstrator' project. This found no evidence that telecare improved outcomes for users. Despite these findings, local authorities (LAs) continue to invest in telecare; notably in a continuing context of financial austerity.

STAND-ALONE or ELECTRONIC ASSISTIVE TECHNOLOGY (AT) refers to types of devices not linked to a remotely sited call centre

TELECARE refers to types of devices that are linked to a remotely sited call centre.

In this summary, reference made to 'telecare' is for both types unless specifically referring to AT alone.

TELECARE USERS refers to individual adults; **CARERS** refers to family and friends.

The UTOPIA (Using Telecare for Older People In Adult Social Care)) study was intended to provide a better understanding of:

- What strategic aims telecare is intended to serve for older people and what local evidence is being collected to enable LAs to assess if these are being achieved;
- How telecare is deployed;
- To describe what data is being collected to enable LAs to monitor if intended strategic aims are being met.

Methods

The study took place between April 2016 and May 2017 and used a three stage, mixed-method design: (1) interviews with telecare lead managers in a representative sample of 25 LAs, (2) additional interviews with five to six key stakeholders from four of the 25 sites, chosen to offer a cross section of different approaches to AT/telecare implementation, and (3) an online survey of all English LAs. This achieved an overall response rate of 75%. Qualitative data from interviews were transcribed and analysed using NVIVO and survey data used SPSS.

FINDINGS

WHAT STRATEGIC AIM IS AT/TELECARE INTENDED TO SERVE FOR OLDER PEOPLE?

The study's online survey conducted in 2016–17 found four overriding strategic aims:

- to delay or reduce the need for care (97%);
- to enhance quality of life (90%);
- to safeguard (85%); and
- to prevent carer breakdown (84%).

Qualitative data collected in 2016 from telecare manager interviews largely confirmed these priorities. The survey found that in most LAs, any telecare strategies were usually unilateral: only 24% said their strategy had been produced collaboratively with NHS or other health partners.

HOW IS AT/TELECARE DEPLOYED?

Survey respondents felt telecare 'fits in' operationally with other forms of care and support by being available alongside social care (77%), to support reablement (77%) and for self-funders (75%).

Many said it could be offered to people ineligible for publicly-funded social care (although the survey could not establish if this was as a direct service or 'signposting' to enable private arrangements to be made) and 47% said their LA used telecare as a substitute for personal care.

It is usually deployed to manage risks to independent living, by enabling users to call for help if needed, or by using 'passive' technology to monitor changes to routines or patterns of

Note: the online survey percentages use the total sample size (all 152 LAs) as the denominator, not the number of responding LAs, unless questions required multiple responses.

behaviour. Carer support is envisaged by using telecare to offer reassurance and support via remote monitoring.

The assessment process

The survey found that LAs do not see telecare assessment as especially problematic, but variation in practice and outcome was reported which may have impacted on effectiveness.

Although in most LAs telecare assessments are seen as wide in scope, they are conducted by a range of community professionals, including social workers, care managers, occupational therapists, or specialist telecare workers.

Some interviewees said telecare assessments are mostly integrated within wider assessments of need, and others that they are separate. Some interviewees felt integrated

assessments enabled matching of needs with telecare in one step, others that not all social care professionals were competent at assessing for telecare: either overlooking or 'over-prescribing' it.

A formal assessment for telecare before installation is 'always' done in 16% of LAs, in 20% 'usually with some exceptions', and in 16% it is not (4% were not sure, 18% did not answer the question and 25% were 'non-respondent' councils). Reasons for non-assessment include the need for speedy discharge from hospital or because the person is self-funding.

Only 9% said assessors can 'always' observe how older recipients interact with their environment (34% said this is 'usually' and 9% that it is 'sometimes' possible). Assessments are also completed in a range of different

settings, including telephone (39%), hospital (51%) or reablement settings (45%).

Reviews

The survey found that most LAs carry out reviews annually. Just under half carry out equipment checks annually. Over a third rely on users or relatives to tell them if devices are malfunctioning; or that they are responsible for basic maintenance.

Reviews are usually done by telephone and often seemed to focus on the technology, not the needs of the telecare user.

Installation of AT/telecare

Interviewees described three different installation arrangements: in-house, 'arm's length' (e.g. a local organisation funded by the LA) or contracted out –

often to a supplier or manufacturer. Several mentioned plans to increase self-installation by users and family carers of AT/telecare equipment. The survey found that specialist telecare workers are the most likely group to install and maintain equipment, followed by telecare manufacturers and suppliers.

Responding to alarm signals generated by AT/telecare devices

Relatives are the most likely group to respond to call centre alerts. Most LAs offer a 24/7, mobile response service. Several said triage involved contacting a nominated family member first before sending out LA responders. In over a quarter of LAs (usually Shire counties) the response is provided exclusively by family members. In these LAs, if no family member can be identified as a responder, no telecare service is provided.

Telecare removal

Excluding death or moving into a care home, the most frequently cited reason for telecare removal is changes in need so telecare is either no longer needed or helpful (56%). Other reasons are concerns about rental charges (37%); and because the user 'just can't get on with it' (33%).

Availability of devices, diversity of manufacturers and suppliers

Most interviewees said their LA purchase most telecare from one or two manufacturers, though others said they use 'framework' or 'spot purchase' arrangements.

Survey findings confirmed this: five telecare suppliers predominate, one of which is by far the most frequently used. Six types of device are most commonly used: pendant and smoke alarms, fall detectors, bed/chair occupancy and door exit sensors.

Person-centeredness of AT/telecare assessments and services

The survey found over a third feel their LA's telecare service is 'person-centred' and over a fifth that it is partly person-centred and partly service driven.

Interviewees referred to a range of defining characteristics of telecare 'person-centredness': the absence of standardised AT/telecare packages; prescription of AT/telecare according to specific needs; and the ability to offer bespoke and state-of-the-art AT/telecare when needed.

Training

The survey found 47% of LAs provide training to telecare assessors. This is most frequently delivered by an AT/telecare manufacturer. In only five LAs is training accredited, in only six could it lead to a formal qualification and in almost a quarter it took only ½–1 working day to complete.

Advice and information

22% said that people can self-assess for telecare in their LA, and 24% that they can offer advice to self-funders and Direct Payment users.

WHAT EVIDENCE IS BEING COLLECTED TO ENABLE LAS TO MONITOR IF THEIR INTENDED STRATEGIC AIMS ARE BEING MET?

LAs collect a range of performance data, including numbers of installed devices and people receiving AT/telecare. Data on impact and outcomes are also collected by most LAs.

Some also aim to provide evidence of savings and cost effectiveness, referred to as: 'hypothecated savings': e.g. the cost of alternative services to telecare. Not all LAs make use of call centre data to profile telecare users to enable better targeting of support.

TYPES OF DEVICES

Assistive technology and telecare devices include a wide range of products.

They help to make life easier and compensate for disabilities or impairments. It is claimed they support independence, reduce family workload and save money by preventing unnecessary hospital stays or more expensive care.

They can be 'active' and require user activation (usually a button to press) or, like most environmental sensors, 'passive' and require no user input to work.

They include smoke alarms that are purchased in many High Street stores, and pendant or wrist alarms that have been very widely used for several years.

They can be simple 'plug and play' devices like electronic calendar clocks (which can play an important role in keeping someone living with dementia oriented in time), to devices that require skilled installation such as gas switch off equipment (temporarily disconnects the supply to an unlit device from which gas is escaping).

They can, like fall detectors, personal alarms and environmental sensors, be linked to a call centre. They can be simple 'stand-alone' technologies which are not linked, such as electronic medication dispensers.

IMPLICATIONS FOR PRACTICE

Telecare as a substitute for personal care: Telecare is seen by many as a way for LAs to address rising demand with shrinking resources. Using it in this way may be problematic because of the potential to compound social isolation and loneliness. Savings may be made – though not necessarily always to the LA – by using telecare to prevent a move into care, or hospital, but the latter will require close collaboration between LAs and NHS to demonstrate cost effectiveness and realise savings.

Strategic focus on risk management and safety: LAs envisage telecare as enabling people to live independently and safely. This only exploits a fraction of the potential of AT/telecare. For example, almost none used telecare to identify and address loneliness. Many 'false alarms' made to call centres may arise from a need for human contact and this should be recognised rather than seen as an inappropriate use of a device.

Impact on family members: Though family carers could benefit significantly from telecare, it can also add to their workload. Effective triage of calls and alarm signals at call centres may help prevent carers feeling overwhelmed.

Assessments: LAs encourage practitioners to take a holistic approach to assessing need, but need to consider if different professional groups have the full breadth of skills and experience needed to optimise telecare use. Telecare specialists, for example, may know what technology is available, strengths and limitations and how to install it, but lack insight into the ways older people interact with their socio-physical environment: both will have an important impact on telecare's usefulness, acceptability and perceived value. Lack of access to specific devices will also affect the ability to match technology with the priorities and needs of the user and family responder.

Training: Training by manufacturers may mean this is focused more on devices than wider issues of practice and use. Though training is available to support telecare workers this seems superficial in many LAs. Given the level of investment made in telecare, exploration of training effectiveness and more investment in training might help better equip assessors – regardless of professional background – with the skills to enable recipients (and the LA) to get the best out of telecare.

Some of the reasons suggested for telecare removal suggest potential shortcomings in the assessment process through poor matching of device with need, low involvement by the user in decisions about acceptability and what to install and/or a limited range of devices from which to choose.

COMMENT

Skills for Care welcomes this study of the use of telecare in local authorities. The online survey carried out by the research team found the use of telecare to reduce the need for care and support was confirmed by respondents (97% agreed) as was its role in enhancing the quality of life for people who need care and support (90%).

Diane Buddery
Skills for Care

However, the report also found that skill deficits amongst professional staff responsible for assessing for telecare and lack of staff with the right skills to install telecare were cited by commissioners and senior managers as barriers to better use of telecare. Those assessing for telecare are given short (mostly half- to one-day) training, in the majority of cases either by the manufacturer or by peers. Almost none of this training led to a qualification or accreditation of any sort.

While this study demonstrates wide agreement about the many positive aspects of telecare, it poses questions about why this is not mirrored by sufficient investment or development of skilled staff, who can maximise imaginative and knowledgeable solutions from a wide range of suppliers to meet need.

Skills for Care urges all local authorities to consider the findings from this report. Skills for Care will continue to work with partner organisations to promote learning and skills for those involves in telecare provision.

FULL REPORT

The full report of the study is available at:
https://kclpure.kcl.ac.uk/portal/files/87498580/ Utopia_project_report.pdf.

School for Social Care Research

The School for Social Care Research was set up by the National Institute for Health Research (NIHR) to develop and improve the evidence base for adult social care practice in England in 2009. It conducts and commissions high-quality research.

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