MAY 2009

Telecare and Telehealth in action

telecare services association

Our mission is to unlock the potential of telecare and telehealth in the UK.

Designed by Blue Sky Commercial Art 0208 650 0220





Contents

Case Studies

A shared vision and commitment to the transformation of adult social care.

Phil Hope MP

Minister of State for Care Services

Foreword

There are major changes happening in our society driving increased demands for adult social care. We have an ageing population, people with disabilities living longer and fuller lives, higher expectations about what services should deliver, and technological changes. The challenges this represents to social care services cannot be underestimated, but we have clear evidence that telecare services can play a key role in supporting people to live safely and comfortably in their own surroundings.

Putting People First; a shared vision and commitment to the transformation of adult social care, first announced in 2007, recognises and underpins a holistic approach to service provision. It works across the boundaries of social care with housing, benefits, leisure and transport and health, and with partners from independent, voluntary and community organisations to ensure a strategic balance of investment in local services. We know that most people prefer to live independently at home. Initiatives such as personal budgets help to increase people's independence and allow them choice and control over their services. Personalised services are centred around their needs ensuring that each person is seen and treated as an individual, getting away from the 'one size fits all' approach.

For many older people, and people with disabilities, better outcomes from care depend on health and social care services working well together. Over the next few years, councils are expected to have made full use of the additional funding available through the Social Care Reform Grant and will be making significant steps towards transforming their adult social care services. It is also expected that the majority will have most of the core components of a personalised system in place and be investing in early intervention.

In February this year we announced the first national Dementia Strategy, Living Well with Dementia. This landmark document sets out initiatives to increase awareness of dementia, ensure early diagnosis and treatment, and radically improve the quality of care that people with the condition receive. We know that there are currently around 700,000 people in the UK living with dementia and this number is expected to double within the next thirty years. The potential impact that assistive technology may have in helping the support services and individuals living with dementia is only just being recognised. This has huge potential to enable more people with dementia to live independently. The National Dementia Strategy makes clear that local commissioners of services should consider the provision of assistive technology and telecare to prolong independent living and delay reliance on more intensive services.

There are already some excellent examples of how telecare technology is providing safety and freedom of movement for people living with dementia. For example, where a telecare smoke alarm has saved a person's life, or where sensor and detector equipment have allowed the carer more freedom, knowing that they will be alerted to any potential problems before it reaches a crisis. These and other examples are proof of the difference that where telecare is correctly provided the impact upon people's lives can be tremendously empowering.

Following the roll out of the Preventative Technology Grant, many local authorities continue to successfully establish telecare and telehealth operations and are committed to extending the use of technology in delivering 21st century social care solutions for their populations. There are over 300 telecare services provided in England by local authorities, housing associations, independent, voluntary and third sector organisations as well as commercial providers. There are also an estimated 1.5 million telecare installations that are currently benefiting tenants, service users, carers and their families.

This Government believes that more complex telecare solutions, in conjunction with appropriate telehealth, may provide support to enable a wide range of people to live independently at home for longer. However, more robust evidence is required and through the £31 million Whole System Demonstrator Programme, the Government is currently testing the potential of innovative technologies in supporting care for those with complex health and social care needs. Evaluation of the Whole System Demonstrator programme will enable us to assess how these technologies can promote individuals' long-term well-being and independence, improve the working lives of staff and be cost and clinically effective.

I am delighted to be invited to contribute to the Telecare Services Association Annual Report as it allows me the oportunity to emphasise the importance of telecare and telehealth in the delivery of person centred social care. This report brings together the vision, commitment and intiatives that allow people to have the opportunity to live with independence and dignity within the comfort and safety of their own surroundings. It also serves to inspire localities to look again at the advantages and include telecare and telehealth solutions when planning positive services for the future of their populations.

Those people (patients, clients, service users, citizens) have long lamented the lack of flexibility that too often results from the perpetuation of professional ‘silos’. Those silos were and remain a nonsense.

Dr Malcolm J. Fisk

Chair

Telecare Services Association

It has been another successful year for the TSA. This success is, perhaps, best marked by the extent to which members (both in the service and supply sectors) have been building on their telecare work to grasp the opportunity of telehealth. The context is one where there are many changes that are demanded by service reforms. One aspect of these changes is the blurring of the boundary between health and social care.

Putting new service frameworks in place, however, isn’t easy. Many people from healthcare backgrounds are challenged by the less clinically framed service approaches that TSA members are delivering in people’s homes. Many people from social care (including housing) backgrounds are concerned that their important contributions should be recognised, harnessed and developed within new services.

The ‘new ways’ don’t, of course, just make sense in relation to service management and delivery. They make sense from the perspective of millions of vulnerable people. Those people (patients, clients, service users, citizens) have long lamented the lack of flexibility that too often results from the perpetuation of professional ‘silos’. Those silos were and remain a nonsense. And the TSA, by promoting telecare and telehealth, remains steadfast in its wish to see those silos relegated to a footnote in the history of service change.

But we must pause, for a moment, and consider the fact that, because more vulnerable people are being supported at home, we must take more account of that ‘vulnerability’ – whether it stems from illness, frailty, physical or sensory impairments. This means that while we earnestly want to support people in maintaining their independence, we must also give more attention to their protection. Such issues underpinned the review of our Code of Practice for telecare.

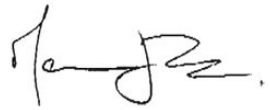
Developing a new Code, launched at our Annual Conference, was not easy. In getting to this point, we had consulted widely and engaged key people from practice, policy and academic bodies throughout the United Kingdom – including the devolved governments. Thanks to their help and enthusiasm, we now have a flagship Code that sets the necessary standards and affords vulnerable people the protection that is so much needed. The new Code also sets a service context that is determinedly designed to promote engagement with, and the empowerment of, people who use telecare services.

In the coming year, there will be well over 100 services that decide to transfer to the new Code, seeking accreditation in relation to those aspects of telecare service provision that they deliver. Already the signs are that the new Code is readily understood and is pitched at the right level. We certainly see it as the benchmark against which all telecare services need to be measured and as delivering that crucial safeguard that government bodies and service commissioners have been calling for.

We must note, though, that the services the Code underpins have considerable implications for healthcare. Telecare technologies, after all, facilitate responses in relation to falls or seizures; can monitor activity; assist people in the recording and sharing of vital signs measures; or can support medication compliance. Social care, as well as health staff are, therefore, contributing to some healthcare and clinical agendas that respond to key government targets. Not to put too fine a point on it, telecare services not only meet many people’s needs and aspirations but also contribute to substantial savings in public spending on health and social care. Following from this, we see an urgent need to develop a complementary Code of Practice for telehealth. The TSA will be actively engaged in this development.

With regard to other markers of progress during the year, we have welcomed two new Board Members, Drs Russell Jones and Nicholas Robinson, to support us in our work. They have already been crucial to shaping TSA’s strategic approach to telehealth. We must also note the great success of our Annual Conference in Brighton. This attracted nearly 650 participants and a record 37 exhibitors. Their positive feedback pointed to our being on the right track in seizing the agenda that brings telecare and telehealth together. We will build on this.

Finally, in this overview, I must pay tribute to the hard work of the TSA team (both fellow board members and staff) and to the endeavours of all TSA members. The barriers to service change are considerable and it is really heartening to be part of a community whose good will, imagination and expertise is matched by their endeavour to overcome these. They are truly demonstrating the efficacy of ‘Telecare in Action’. With such qualities on board, I have no doubt that we will make further progress in 2009/10 towards harnessing both telecare and telehealth technologies to deliver the new, and more flexible, service frameworks that vulnerable people want.



Telecare Code of Practice Matrix

	PROCESS MODULES									
		ACCREDITED SERVICES								
		In development	*Released mid 2009*		*Released January 2009*				*In development*	
	SUPPORT & ADVICE	REFERRAL	PROFILING		SERVICE SET UP		MONITORING	RESPONSE	RE-EVALUATION	
STANDARDS MODULES		Referral/ Enquiry	Service User Profiling	Telecare Plan	Service Tailoring	Installation			Escalation/ Pathways	Re-evaluation
Safeguarding	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Governance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Staff & Training	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Privacy & Data Protection	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Partnership Working	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Service User Communication	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Managing access to/ working in SU's home			✓			✓	✓	✓	✓	✓
Technology Management						✓	✓	✓		
Business Continuity						✓	✓	✓		
Planning and Development of TSC							✓			
Legislation (inc Health & Safety)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Performance Management & KPIs		✓	✓			✓	✓	✓		✓
(Nation State Variants)										

SU = Service User TSC = Telecare Service Centre KPI = Key Performance Indicator

Paul Gee

Chief Executive,

Telecare Services Association

The moment of truth for service users

Telecare and telehealth are now moving rapidly from the margins to the mainstream of health and social care in Britain. Arguably the UK has a real lead in deploying these services allowing users to receive care and support in their own home. The rest of the world may have the technology but the UK really understands how to integrate it!

Yet, as the various service delivery models develop, the missing ingredient remains quality assurance. Increasingly, telecare is positioned as a life-critical service and so some form of 'guarantee' that it will deliver when needed – at the moment of truth for the service user – is essential.

McKinsey and Co have a very relevant definition of the Moment of Truth, they claim that:

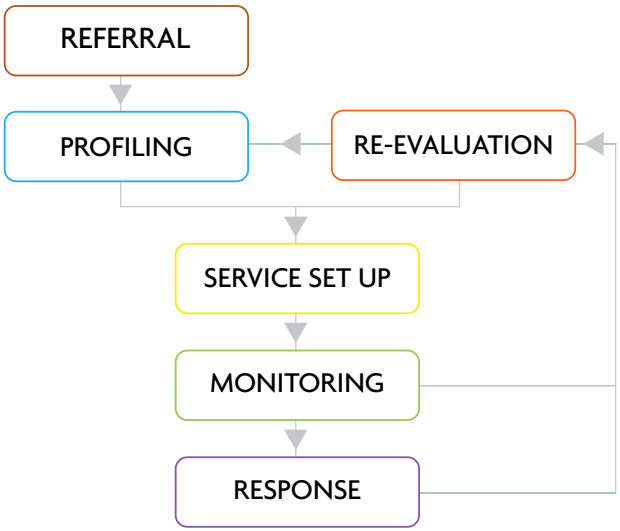
The key to frontline performance is the consistent handling of moments of truth – those few interactions where customers have an unusual amount of emotional energy invested in the outcome.

This was never more true than for service users of telecare – and will be for telehealth too. When their moment arrives, the service has to deliver. Providers have made 'promises' and users, their friends, family and carers, have placed their trust in the service. As a consequence, robust standards need to be in place to ensure that the promise is delivered. When that moment of truth arrives.

So reassurance for service users and commissioners is not optional, it is essential. Hence, the R2R (Referral to Response) model has been developed by TSA based on a close understanding of exactly how the generic components of any service work together. And throughout the model, critical touch points where quality standards are needed have been identified. The result is a clear and concise matrix (see facing page) that establishes a structure for service standards in telecare.

This In Action report is positioned to share with you some strategies, secrets and solutions that may help you accelerate your own thinking around telecare and telehealth.

R2R Referral to Response Model



The Association would like to thank publicly those who have taken the time to describe their learning. TSA is delighted to have again co-ordinated, published and distributed this Report, the demand for which grows year on year.

Throughout this document, TSA is proud to be able to capture the real sentiments of service users and their carers. This Report aims to play a part in helping to realise the potential of telecare and telehealth so that all those who could benefit from such services, do so.

And finally, be aware that the creative treatment of this report is deliberate. For the vast majority of people who these services support – and for many millions like them – their personal centre of excellence is their own home. They have probably lived there for some considerable time and would prefer – overwhelmingly – to have their health and social care centred around it.

Telecare and telehealth services can help make their wish a reality.

Stephen Johnson

Deputy Director, Long-Term Conditions,
Department of Health

The need for innovation

The need to find innovative solutions to address the challenges faced by an ageing population is widely understood. Over fifteen million people, or almost one in three of the population, in England suffer from a long-term condition. Three out of every five people aged over 60 in England suffer from a long-term condition. Due to the ageing population, the number of people in England with a long-term condition is set to rise over the next 25 years.

Importantly people with long-term conditions are very intensive users of health care services. Those with long-term conditions account for 31% of the population but use 52% of all GP appointments and 65% of all outpatient appointments. In addition to the personal tragedy involved, the UK economy stands to lose £16 billion over the next 10 years through premature deaths due to heart disease, stroke and diabetes alone.

Whole System Demonstrators

For this reason the DH has invested in the Whole System Demonstrators (WSDs) which you will be aware of from previous updates in this report. The WSDs are essential to close the evidence gaps that are apparent to most of you. In Kent, Cornwall and Newham the WSD teams are busy recruiting thousands of service users to the trial. The challenge they face is one of introducing a brand new service, at scale, crossing multiple organisational boundaries in a compressed timeframe. Needless to say there have been obstacles to overcome, and the learning from these experiences will help us shape any potential future roll out strategy. Indeed the WSD Action Network has been established to share some of these lessons and to generate new materials to ease the burden of implementation for others.

The lessons learned from the WSD programme to date fall into two camps. Firstly, there are those about how to run a large-scale randomised control trial (RCT). Secondly, there are lessons about introducing a new service at pace and scale.

The lessons we are learning about running an RCT are heavily focused on how we gain and maintain professional and individual sign-up to the trial. There are also lessons about how we define and gather the data we need in order to robustly evaluate the impact of an intervention.

The GP Practice is the unit of randomisation for the trial and hence we need practices to agree to take part in the trial. The need for continual and active engagement of practice staff and their associated community nurses is clear. We have also placed support staff in practices that require it to ease the burden of confirming eligibility and contacting individuals by letter.

From a social care perspective, we have asked care staff to review their records to case find. We have also engaged with the 3rd sector and support groups to find eligible people. We are using memory clinics, falls clinics and analysis of individual budgets and carer support to help find eligible people.

We have also had to spend considerable time ensuring the quality of data and cross referencing data across social care, community, primary, urgent/emergency and acute systems to plug gaps and ensure common identifiers such as the NHS number.

We have analysed every step of the process for drop out rates and compared them across the three sites in order to identify best practice. It is apparent that the key issues faced by each site are at different stages in the process.

We have also revised our submission to the research ethics committee to reflect that we need to share more information with potential participants about the technology to help them decide whether to partake in the study. We also needed to take into account the fact that we are finding relatively few people who meet the eligibility criteria we have set in order for them to be provided with telehealth and telecare. This is something that seems to be mimicked by members of the WSDAN learning set.

The way in which we roll out the service is heavily influenced by the ethics of the trial. For example, the ethical guidance does not allow the telecare and telehealth services to be advertised which they would be if they were being rolled out as a mainstream service. Similarly, the trial requires people to opt in whereas, in a mainstream service, it may well be that people have to opt out.

Overcoming barriers

Barriers occur at three different levels: service user level, provider level and system level. The barriers at service user level are being examined in detail but seem to relate to demographic variables, social support levels, health beliefs and perceived illness, trust issues and personal practices. The barriers at provider level seem mostly related to capacity, skills and attitudes whilst the barriers at system level relate to practices that inhibit joint working and information sharing. All of these barriers need to be overcome to realise truly integrated health and social care working.

Care planning and telehealth/telecare

What is important to stress about the demonstrators is the Whole Systems approach being taken, and how the work on the sites aims to echo the policy that has emerged from the DH on long-term conditions management and adult social care.

We recently published a document entitled 'Commissioning Personalised Care Planning – A guide for commissioners'. The principles documented in this guidance should be close to the heart of all those commissioning and providing telehealth and telecare services. The document aims to provide commissioners of health and social care services with the information and support they need in order to fulfil their obligation to embed personalised care planning in their localities. The commitment is that 'Over the next two years, every one of the 15 million people with one or more long-term conditions should be offered a personalised care plan, developed, agreed and regularly reviewed with a named lead professional from among the team of staff who help manage their care.'

Personalised and integrated care planning is essentially about addressing an individual's full range of needs taking into account their health, personal, family, social, economic, educational, mental health, ethnic and cultural background and circumstances. It recognises that there are other issues in addition to medical needs that can affect a person's total health and well-being. It is therefore a holistic process, seeing the person as an individual with a strong focus on helping people together with their carers to achieve the outcomes they want for themselves. We believe that telecare and telehealth can help deliver outcomes that many would wish to see embedded in their care plans.

Integrated, tailored services

Telehealth and telecare, when integrated into wider services, help promote a more planned, proactive approach to health and social care services. For example, the vast majority of advanced telecare and telehealth services are carefully tailored to the needs of the individual and their carers. In reality, a properly co-designed and integrated telehealth or telecare service goes a long way to embedding the personalisation of care and services and hence 'adding life to years'.

By providing individuals with greater information about their condition through telehealth, we are promoting better health through information and self care. Whilst we recognise that not everyone will wish to use the more advanced features of some telehealth systems, our experience to date on the WSD programme has illustrated that timely information can help people change behaviours. We have even seen some of the WSD team members change their habits as a result of having access to the telehealth technology. For example, some of the team have given up smoking.

Changing the lives of carers

We also recognise that telehealth and telecare have the potential to change the lives of carers as well as those who are cared for. In this way we hope the appropriate use of the technologies can promote independence and achievement of other goals such as returning to work.

Personalised care planning underpins excellent management of long-term conditions and end of life care, and completely supports the key themes described in Department of Health publications such as 'Commissioning for Health and Well-being', our vision for 'World Class Commissioning, Putting People First' and 'High Quality Care for All'. These themes include:

- more individualised services;
- more focus on prevention of disease and complications;
- greater choice – including supporting people to make healthier and more informed choices;
- reducing health inequalities; and
- providing care closer to home.

It is no coincidence that these are also the themes that form the focus of the Whole System Demonstrator programme and that we hope are going to be enabled by telehealth and telecare technologies.

Continued on the following page

CASE STUDY 01

WITNESS PROTECTION

Invicta Telecare

Residents gain the confidence to give evidence in court

Residents had been living with intimidation and fear for the past two years enduring intolerable abusive behaviour, suffering damage to property and being shot at with an air rifle by a neighbour. The local community had to put up with what must have seemed, at times, constant anti-social behaviour adversely affecting their quality of life.

To secure an Outright Possession Order to remove the culprit, Russet Homes and the police needed witnesses to provide vital evidence. Two Russet Homes tenants and one owner-occupier were prepared to speak out in court but obviously felt extremely vulnerable.

Steve Davies, Invicta Telecare's managing director said: "Complaining about a problem neighbour isn't too difficult but stepping forward to give evidence in court however is a completely different kettle of fish."

"The police were unable to provide round the clock protection and the witnesses were understandably concerned for their own safety and petrified of being attacked in their home, especially as the case was expected to last anything up to 18 months. Knowing we had considerable experience in this field and provided this kind of service as an integral element in our mission to improve Life Chances for individuals, Invicta was consulted. We immediately offered to fit an alarm unit in the witnesses' home on the same day, linking them directly to our 24/7 monitoring centre. Of course all our calls are voice recorded so could be used to provide further evidence in court."

This meant if a witness or member of their family experienced any harassment or threats, they could press the alarm and instantly receive assistance from a trained telecare operator. The operator has access to computerised information about the witness protection case and a dedicated telephone line to the police.

One of the witnesses told Russet Homes:

"I felt traumatised by this neighbour's behaviour. He made my life a nightmare, so just knowing the alarm was close to hand if I needed help gave me comfort and the re-assurance to go ahead and stand up in court."

Continued from previous page

'Your Health, Your Way' and telehealth/telecare

'Your Health, Your Way – a guide to long-term conditions and self care' provides a real opportunity to empower and support people with a long-term condition. 'Your Health, Your Way' will enable people to understand and exercise their choice around support for self care, so they can take an active role in decisions about their care, enabling them to control their condition better and ultimately improve their quality of life. Your Health, Your Way will help contribute to effective care planning, shared decision-making, and informed choice and indirectly it should help drive demand for self care services.

NHS Choices is the first and main channel for Your Health, Your Way. The DH is making progress to ensure that the Your Health, Your Way initiative is made available to people through other channels and that it is accessible to those who have the greatest need, lowest health literacy and lowest health engagement to ensure it does not increase health inequalties.

It should be noted that this is not new policy – 'Supporting People with Long-term Conditions to Self Care: A guide to developing local strategies and good practice' was published in February 2006 just after the Our Health, Our Care, Our Say White Paper committed DH to embedding the principles of support for self care in the workforce. The Common Core Principles to Support Self Care were published in May 2008. What Your Health, Your Way does is to put a public face on the existing policy which we hope will provide the 'push' from the public for more and better choice around support for self care. There are examples where self-care support is an integral part of existing care pathways but this is not replicated around the country.

Supporting self-care

Your Health, Your Way was launched on NHS Choices in November 2008 and provides generic (non-condition specific) information on the type of self-care support that should be available locally, and information on what to do if the support is not available. If an individual is not offered self-care support or is dissatisfied with the range of options available locally, they have the right to raise a concern or make a complaint through the new NHS Complaints procedure, which will be introduced in April 2009. It is envisaged that the website will be supported by information at a local level giving specific details of the self-care options available in that region. Recent guidance on the publication of Your Guide to Local Services, states that PCTs should include in this details of services to support self-care as set out in Your Health, Your Way.

Self-care support services should cover five key areas:

- skills training;
- information;
- technology and equipment;
- to support networks; and
- healthy lifestyle choices.

For each of these areas, Your Health, Your Way gives information about what choices a person might expect and how to pursue them further as part of a discussion about care planning. It is likely that, following the wider public launch of Your Health, Your Way in April 2009, there will be an increase in demand for some of the interventions, such as self care training and information, associated with each of these aspects.

Another key element of the Long-Term Conditions Policy that I oversee is the 'Your Health, Your Way – a guide to long-term conditions and self care'. This guide, published by NHS Choices, sets out the support patients with long-term conditions can expect from April 2009.

The launch is only the first step. From April 2009, people with long-term conditions should expect, locally, specific information to be provided through NHS Choices and other formats to help people exercise their choice around support for self care. We would therefore expect the localities that provide telecare and telehealth to document this. We are currently drafting content on telehealth and telecare that will provide the link to local content.

This is not new policy. 'Your Health, Your Way – a guide to long-term conditions and self care' provides an opportunity to draw together all the strands of work/information that are already out there. It is a generic product (applicable to all conditions), and covers the four pillars of existing DH policy on support for self care (information, tools, skills and support networks) together with healthy lifestyle choices. Assistive technology is increasingly being recognised as one of the key tools for delivering our vision.

In addition, and to support local delivery of services and information to support self-care, we expect to produce guidance for the Workforce, Commissioners and the Third Sector in the first half of 2009.

Conclusions

In summary, we are constantly learning from the WSD programme and this learning is helping us shape new policy. We await the outcome of the WSD evaluation but in the meantime it is encouraging to see so many organisations gaining experience of these technologies, albeit mostly on a small scale. Telehealth and telecare have the potential to help deliver many of our policy goals such as delivering care closer to home, providing greater choice, enabling self-care and ensuring personalisation. It is through the efforts of organisations such as the TSA, and centrally funded initiatives such as the WSD programme, that the true value of these interventions will be realised.

We also recognise that telehealth and telecare have the potential to change the lives of carers as well as those who are cared for. In this way we hope the appropriate use of the technologies can promote independence and achievement of other goals such as returning to work.

Moira Mackenzie

Telecare Programme Manager

Telecare in Scotland – seizing the opportunity

Scotland's Government is committed to seeing telecare widely adopted as a central element in the way local service providers meet the needs of people. In many respects, the situation has been transformed over the last few years with an increasing number of local care partnerships in Scotland introducing and expanding telecare services. However, it would be fair to say that there is still a long way to go before telecare could generally be considered part of mainstream service provision in Scotland. Achieving this is the challenge before us, and the opportunity we must seize. How do we best do this? Well, as Bob Marley rightly said, "If you know your history, then you will know where you are coming from". Understanding progress so far at national and local level, and what has facilitated or held back the implementation of telecare in different parts of the country, is the key to moving on. All obvious and logical stuff, you might think, but often easier said than done. From the outset of the Telecare Development Programme in 2006, the importance of monitoring and evaluating progress was accepted. But monitoring had to be achieved in a context where the local partnerships involved in delivering telecare had little prior experience of a need to measure the impact of their activities; baseline information was scarce and data capture mechanisms had to be developed. Beyond this, it had to be recognised than when conducting evaluation there are many ways to skin a cat and seldom is there universal agreement on which is best.

Institutional care to community care

Acknowledging these difficulties, we commissioned an independent evaluation of our Telecare Development Programme from the York Health Economics Consortium at York University. This tracked progress against high level outcomes we considered indicative of a shift from institutional care models to community based care as influenced by the use of telecare. The approach YHEC adopted struck a pragmatic balance between securing the data needed to evaluate the national Telecare Development Programme, and ensuring that the research work did not impede local partnerships getting on with the actual business of implementation. The chosen approach to evaluation, the core of which involved partnership self-reporting of local impacts against nationally specified outcomes and efficiencies, meant that some of the inputs to the evaluation were inevitably subjective. But it is important to acknowledge also that they were based on expert opinion from practitioners working at a local level, who not only knew their individual health and care system, but were familiar with the likely service outcomes for individuals should telecare not have been an option. Moreover, the evaluation exercise also involved case study work and the collection of information relating to how specific telecare initiatives have been embedded in different local service contexts. So the YHEC study findings on the impacts of the Telecare Development Programme up to March 2008 have been invaluable to us, not just in demonstrating significant progress against the high level outcomes sought, but by also informing our understanding of a broad range of wider service delivery issues The YHEC report has now been published and, along with appendices, can be downloaded from the Joint Improvement Team website (www.jitscotland.org.uk).

Shift in the balance of care

The YHEC study has confirmed that telecare can be used to help drive a shift in the balance of care from institutional to residential settings. What is more, it can often meet the aspirations of service users better than other approaches to service provision and can have significant impacts on the need for unplanned admissions into and speed of discharge from hospital. For those working within the telecare environment for some time, these findings may be unsurprising and they reiterate many of the conclusions from earlier local studies. However, it is reassuring to find that telecare has the potential to have highly significant impacts on our overall health, care and housing system across widely differing local service provision structures, and that the same enablers and barriers exist when telecare implementation is scaled up on a country wide basis. The YHEC evaluation exercise also provided more clarity around why some approaches struggle whilst others facilitate more rapid progress. Based on the YHEC study, it seems fair to conclude that:

- Generally it takes 18-24 months from the introduction of a telecare service to a 'steady state' position where telecare is fully embedded within the broader context of local service provision.
- It tends to take longer when a partnership is undertaking a completely new initiative rather than an enhancement to an existing scheme, or is trying to move more than one initiative forward at the same time.
- It takes time also to develop suitable local impact monitoring arrangements, but doing so can assist local service related, business planning activity.

The YHEC study also established that genuine and mature partnership working towards telecare implementation is not yet the norm in many areas. More positively, it showed that some things clearly make telecare implementation easier – for example, having a project manager with protected time for the task, having senior champions for telecare, and having a clear initial focus on one or a small number of initiatives. Moreover, initiatives that have an immediate focus on rolling out telecare services to significant numbers can help to give telecare a high profile locally, and are generally more successful in 'spreading the word' and raising awareness quickly with a wide range of stakeholders. It also helps to promote telecare uptake if those who need to be involved can physically see and touch telecare equipment by means of smart demonstrator homes, displays at joint equipment stores and so on. In sum, the YHEC evaluation has confirmed that, nationally, we are moving in the right direction by backing telecare and that it provides a better understanding of how to help local partnerships mainstream telecare services faster and more effectively. It also showed the Telecare Development Programme 2006-8 made a promising start on achieving our ultimate aim of ensuring telecare is an integral part of community care services across Scotland. So what next?

Mainstream telecare approach

Our challenge now is to continue with implementation, and to accelerate and expand adoption of a mainstream telecare approach across all local partnerships. From a service user, carer and indeed provider perspective, success will undoubtedly depend on continuing to make an appropriate case at national level but perhaps more importantly, it depends on building confidence at a local level – not just in the telecare technology itself but in the assessment and care planning process and in responder services. If more people are to be supported and maintained at home, they and their carers and service providers need to feel absolutely confident that if something goes wrong, there will be a timely and appropriate response to meet their needs. These requirements and themes are central to the telecare strategy we published in summer 2008 (which can also be downloaded from the JIT website). That strategy outlines a number of key actions that we will undertake by 2010 to ensure telecare achieves a 'steady state' across Scotland, including:

- Funding the further adoption and extension of telecare services locally. The Telecare Development Programme for 2009/10 formally requires for the first time that local partnerships match fund any money provided by central government for their local telecare programmes. This will harness additional resources and secure wider and faster rollout.
- Supporting the development of suitable training opportunities for those involved in assessing the need for telecare and in responding to emergency situations that telecare equipment identifies.
- Encouraging local partnerships to achieve recognised standards across all elements of telecare service provision.
- Increasing the awareness of service providers, service users and their carers of the benefits and potential of telecare to enhance their quality of life.
- Supporting further innovation in service delivery, including the integration of telecare and telehealth service delivery where appropriate.
- Exploring opportunities to learn from and engage in telecare and telehealth initiatives both in other parts of the UK, and across the European Union as a whole.

We are also looking at identifying ways to secure greater engagement from housing providers in the active delivery of telecare services, as to date local telecare initiatives have relied more on the enthusiasm of health and social care providers than their housing partners. And finally, we will continue the battle for hearts and minds. We will continue to promote telecare wherever possible, and we will conduct further telecare monitoring and research. In particular, we will continue to explore the financial implications of telecare for service providers and their partners and the ongoing telecare evaluation work in England, Wales and Northern Ireland will add further to our understanding of the financial impacts of telecare and telehealth on service delivery. The evidence is strong that telecare unambiguously enhances the quality of life for service users and their carers and in Scotland we want to acknowledge and respond to this to the fullest extent possible. We believe our current telecare strategy will allow us to do this, and expect that the actions outlined above will give a further significant push to the mainstreaming of telecare in Scotland.

CASE STUDY 02

INDEPENDENT LIVING AND TELEHEALTH

Stockton-on-Tees Borough Council

Telecare mainstreamed in child and adult services.

Stockton-on-Tees Borough Council has mainstreamed its use of telecare across child and adult services to further improve health and social care delivery following an excellent evaluation that showed an estimated net saving of over £220,000.

The decision to mainstream telecare across Stockton was taken as a result of a successful project that began in 2006 using funding from the Preventative Technology Grant.

Results showed that 80% of all telecare installations have already or will result in reducing residential and nursing care home admissions, and also demonstrated that there had been a significant reduction in hospital A&E attendance and ambulance call-outs.

Stockton's 200th telecare service user and an example of someone whose quality of life has been improved as a result of telecare is L.

Only three years old, L suffers from seizure-like episodes, a condition she was born with as one of her heart's pumping chambers is missing.

An epilepsy sensor placed in L's bed detects any seizures and immediately raises an alarm to alert her mother and the monitoring centre, so that rapid support can be provided.

L has been able to sleep in her own room for the first time in her life.

The telecare equipment has given L's parents invaluable reassurance and peace of mind, according to L's mum: "I can sleep better knowing that I will be alerted if L is in trouble. The equipment will give us and the doctors information on the regularity and severity of her seizures as well as ensuring we can get her medical attention."

The solutions introduced in Stockton-on-Tees provide round-the-clock, preventative support and keep service users healthy, safe and in control in their own homes, thereby reducing avoidable emergency hospital admissions and the need for residential care.

Eddie Ritson

Programme Director, Connected Health Strategy,
European Centre for Connected Health

Social care technologies supporting strategic change

Virtually every aspect of our daily lives today is touched by technology in some way – whether this is in our homes, in our wider communities or in our working lives. Technology has transformed business processes and how we interact with service providers, and indeed our social networks and our families. Mobile phones, texting, e-mail and the use of the Internet for entertainment, commercial transactions and information downloads are all part of our daily lives. The speed and nature of change has been marked, and we are now very much living in an 'Information Society.'

Almost every aspect of our Health and Social Care systems are dependent upon new technologies yet, in Northern Ireland, we believe significant opportunities exist to further exploit such technologies to improve the quality, safety and efficiency of service provision.

Looking to the future, our health and social care system faces some very considerable challenges associated with:

- The changing demographics of our population which is growing older.
- The ability of the service to recruit and retain sufficient staff to support increasing demand.
- The changing nature of society itself which contributes to additional pressures on the provision of health and social care services, particularly those associated with maintaining independent living.
- Restrictions on the financial resources available to deliver health and social care services.
- Changing patterns of disease with lifestyle factors such as diet, lack of exercise, alcohol consumption, smoking and stress contributing to increases in the incidence of disease, particularly chronic disease.
- Trends in the delivery of medicine which are increasingly pointing towards the delivery of specialist services in centres serving large populations supported by more services being delivered in community and primary care sectors. These trends require more advanced professional networks.
- Changes in people's expectations with those who use our services increasingly wanting easier and more equal access to high-quality, best-practice and responsive care delivered as close as possible to where they live and work.

Strategic effort

Together, these challenges point towards a significant increase in demand for our health and social care services, highlighting the need for a strategic and concerted effort on:

1. Promoting health and well-being and supporting individuals to change life styles and take greater responsibility for managing their own conditions;
2. Helping individuals and their carers to sustain their ability to live independently in their own homes for as long as possible;
3. The development of early intervention strategies to reduce future demands, promoting and securing community alternatives to hospital admissions;
4. Supporting professional and multi-disciplinary networks so that those involved in the care of an individual have consistent access to robust communication systems and all relevant information; and
5. Better managing the risks associated with care delivery, helping to ensure better outcomes and reductions in adverse incidents, and enhancing patient concordance with medication treatment.

We believe that connected health and social care technologies have a critical role in enabling and supporting strategic change in each of the five areas above. We are working to develop a strategy that will set out our plans for connected health and social care and we anticipate that this will be published during 2009.

Exploiting technological solutions

In Northern Ireland, under the guise of the European Centre for Connected Health, we are continuing to progress the exploitation of such technological solutions through the design, procurement and implementation of a region-wide, end-to-end, remote telemonitoring service which will, by 2011, ensure that the care given to 5,000 people with chronic disease is supported by the provision of a daily remote monitoring service. Our plan is to complete the procurement of this service during 2009 and for the service to commence early in 2010.

This service will support the skills and commitment of our doctors, nurses, social workers and other professionals by making sure that they have access to the tools they need to offer better and more targeted care. Crucially, a core objective of the service is to support individuals and carers in the management of their conditions and to help them to live as independently as possible.

We are committed to modernising the delivery of our health and social care services and there is no doubt that improving the use of technology will be a key component in achieving this and in supporting our professionals to provide better care.

You can follow our progress in Northern Ireland by visiting our website www.eu-cch.org

In Northern Ireland, we are continuing to progress the exploitation of such technological solutions through the design, procurement and implementation of a region-wide, end-to-end, remote telemonitoring service...

CASE STUDY 03

TELEHEALTH AND HEALTH EDUCATION

t+ Medical Disease Management Systems
Diabetes sufferer helped by holistic health-care approach

Summary
This case demonstrates the importance and benefits of providing continued education to patients and their family. This education may not be directly related to their diabetes, but has a direct impact on the patient's health and well-being.

It also shows how effective the t+ Medical system can be, when the NHS clinic DSNs (Diabetes Specialist Nurse) and the t+ DSNs work together to manage patients holistically.

21st July 2008
Patient has type 2 diabetes. He has a manual job with a lot of physical activity. He does not break for lunch; he eats his sandwiches on the go.

7th August 2008
Patient having hyper. On talking to wife it transpires it is because patient is eating cakes! Education given to patient's wife re. the importance of having a good diet.

15th August 2008
Patient has a hypo night before and again in the morning. Education given to patient's wife re. the importance of not driving for 45 minutes after a hypo has been treated. He relies on his car for his job, so wife is informed that if police catch him driving with a hypo, they will take his license from him.

19th August 2008
NHS Dietician advises patient to eat carbohydrate. As a result the patient starts to experience more hypos. Patient's wife is advised that patient should go back to eating slightly more at lunch time and to have a snack before the drive home from work to prevent afternoon hypos.

6th October 2008
Patient not happy with insulin regime. The t+ nurses provided additional advice over the telephone prior to his NHS clinic appointment, to help ensure he gets the most from this appointment.

18th October 2008
Educational call given. On discussion with patient's wife it becomes apparent that patient has not been seen by podiatrist since diagnosis, and had been 'digging' a verruca out of his foot with a pen knife! The t+ Medical nurses immediately informed the Southampton DSN. The patient was immediately referred to podiatrist.

James Barlow and Jane Hendy

Tanaka Business School
Imperial College London

Looking ahead – the next generation of telecare

The momentum for telecare and telemedicine is growing. Its potential benefits are increasingly recognised in health policy around the world. The US has approved the Medicare Telehealth Enhancement Act to stimulate provision of telecare services. The European Commission has called on member states to deploy 'newly innovated' e-health technologies, including remote monitoring. And the potential market for services and technologies is worth an estimated $5.6 billion in the US alone.

Progress towards mainstreaming telecare is also gaining momentum. With all this new activity, it is perhaps useful to take a step forward into the future and ask what the next generation of technologies might offer over the next 10-15 years.

A range of technologies, systems and services are in the pipeline and aim to promote what is sometimes called 'assisted living'. Their goal is to maintain people's independence and move from a reactive to a preventative care model.

Curing to caring

Currently telecare services tend to be small scale, 'one-size fits all' and reactive – a response is triggered after an alert or request for information is made. They are also likely to be stand-alone services, with little or no integration with the care system as a whole. Shifting the emphasis of healthcare from curing to caring involves both preventing illness and predicting when an existing condition is worsening so that more timely pre-emptive action can be taken. The next generation of telecare will need to be widely deployed, much more personalised and fully integrated with the care system to allow a fundamental shift in care practice.

So what technologies and services are on the horizon – and how might they help address the care needs of the population into the 2020s? Drawing on work we carried out for the Assisted Living Innovation Platform, we can identify five important telecare-related needs.

Reducing isolation – promoting social contact and allowing more direct access to carers will be just as important tomorrow as it is today. Information and communications technology will help to create peer support and expert patient groups, allowing much more interaction and access to named carers than is the case today.

Encouraging activity – it is important to give people a reason to leave their home, to reduce social exclusion and encourage exercise. Any services an individual needs should therefore be available **anytime and anywhere**. As well as improvements in the ability to deliver services across all communication channels – phone, Internet, TV – technological innovations will greatly improve people's ability to navigate around urban environments.

Self-care awareness – Governments will increasingly want to promote a health aware culture where individuals are supported and motivated to care for themselves. Generalised, relatively unfocused **behavioural change** programmes of the present will give way to much more targeted and interactive health promotion, involving individual care plans and performance measurement. Innovation is likely to focus on improving how individuals visualise and receive feedback on changes in their condition.

Predictive monitoring – much of the effort in telecare has been on providing timely and rapid response to changes in an individual's clinical or social condition. Over the next decade or so, attention is likely to turn from monitoring the individual's safety and simple vital signs towards more predictive monitoring of key genetic, vital sign and behavioural markers, and eventually lifestyle monitoring.

Enhanced therapeutic regimens – whether physical, cognitive or pharmaceutical – will also be a focus for innovation. The aim here is to provide support for individuals and their carers, and better feedback on the effectiveness of therapies. This includes compliance with medication and other therapies and improved feedback on pain management. Remote medication adjustment via implantable devices may also be on the horizon.

Integrating assisted living

Whether these developments establish themselves as part of mainstream care practice is not only dependent on the future direction of government policy, but also on technological and social factors. Technical challenges over the integration and interoperability of systems remain to be addressed. But even more fundamental are the social challenges. New products and services must address simplicity and ease of use, and be non-stigmatising. This will require far more user input at the initial design stages than has been the case so far. Both the public and care professionals will have to have trust and confidence in the new technologies. Designers will need to emphasise security and confidentiality, and system and device reliability. Ethical concerns over issues such as the provenance of data and informed consent will need to be better understood and addressed. And everyone will need educating to better understand how assisted living can be integrated into existing care practices.

The next generation of telecare will need to be widely deployed, much more personalised and fully integrated with the care system to allow a fundamental shift in care practice.

CASE STUDY 04

INDEPENDENT LIVING

Sovereign Housing Group

Even when the batteries go flat, the device lets the Careline centre know...

Sovereign Careline is designed to support older and vulnerable people living in their own homes, allowing them greater independence and preventing them from having to move into residential care.

The Sovereign Careline offers support to those that need it most. This support could be simply talking to and reassuring the customer, calling a neighbour, relative, social worker or, when required, calling the emergency services.

The Careline also incorporates high technology monitoring and communication devices all at the touch of a button. It allows people to feel more safe and secure by simply wearing a small alarm which fits comfortably around the neck.

Mrs A from Hermitage has been using a care alarm for six years and told Sovereign Housing Group exactly how it has improved her life. She noted,

"My care alarm makes me feel safe, as well as putting my family at ease at the same time. Most of all, it allows me the independence I want as well as having the security should I need it."

The device is so inconspicuous that Mrs A felt happy to even wear it to bed. She continued,

"I used to wear the alarm when I went to bed but stopped doing this after accidentally calling the Careline in the middle of the night. Although I don't wear it at night anymore, I still have it nearby, which is comforting."

The Careline device has never let her down or stopped working and operates on a warning system. As Mrs A explains,

"When the batteries go flat, it automatically rings through to the Careline to let them know, but my batteries have lasted for five years."

My care alarm makes me feel safe, as well as putting my family at ease at the same time. Most of all, it allows me the independence I want as well as having the security should I need it.

Over 1,000 volunteer caseworkers provide client assessments – similar to those an occupational therapist would perform – to consider if any assistive living aids might be required to support the legionnaire with every day life.

CASE STUDY 05

INDEPENDENT LIVING

The Royal British Legion empowers vulnerable ex-service personnel to live independently...

The Royal British Legion provides financial, social and emotional support to millions who have served and are currently serving in the Armed Forces. Along with their dependants, nearly 10.5 million people are eligible for this support. Cirrus, a telecare service provider, works in partnership with the Legion providing innovative technology that supports the needs of the legionnaires who may require additional peace of mind to live independently. For at least three years, members of the Royal British Legion will be provided with an emergency call unit and monitoring services.

The emergency call unit comprises a discreet speech module plugged into the telephone socket and a pendant style button worn about the body of the user either on the wrist, belt clip or on a necklace. The unit, unlike similar products available, does not need to be plugged into the mains power which makes for hassle free installation also eliminating the need for dangerous cables that may become a trip hazard. In the event of a power cut, the unit is not affected in the way other mains powered alarms would be, offering further peace of mind.

When activated by the user in the event of emergency or incident, a connection is made with the monitoring centre.

The monitoring centre is one of the largest and most established in Europe, currently handling over 120,000 connections, receiving around 3,000 - 4,000 calls a day, of which approximately 84 are classified as emergency situations.

Staff are sympathetic and caring, taking great pride in their roles. The operators work on a shift rota of five or six people, throughout the day and night to ensure that there is always enough cover to deal with routine calls as well as the emergencies.

If ever a user subsequently requires additional support, they know that a full range of telecare devices is available including sensors that monitor movement and others that warn of abnormal environmental conditions – such as low temperature. The sensors are compatible with the emergency call unit and are monitored at no extra cost.

Over 1,000 volunteer caseworkers provide client assessments – similar to those an occupational therapist would perform – to consider if any assistive living aids might be required to support the legionnaire with every day life. The RBL funds the purchase and pays for the first year's monitoring costs.

The RBL state that their legionnaires know that if they require support – now or in the future – the Legion is always on active duty for them.

CASE STUDY 06

DEMENTIA

Falkirk Mobile Emergency Care

Passive alarm system takes the pressure off dementia sufferer's wife

Mr C is a 64 year old man who lives at home with his wife. He receives support from the Joint Dementia Initiative as part of a care package to help maintain him at home. Mr C suffers from early onset dementia and epilepsy.

Mr C was referred to the Falkirk Mobile Emergency Care Service for a smoke alarm and gas alarm which would automatically trigger to the MECS Control Centre as Mr C still liked to cook for himself and had left the gas cooker on and unlit on a number of occasions. Mr C takes absences as a result of his epilepsy and the family were concerned he could drop a lit cigarette during one of these absences. Mr C also suffers from grand mal seizures and after discussion it was agreed that a tilt monitor and bed monitor would also be installed.

The tilt monitor is used for periods where Mr C is left alone in the house and wardens are the first responders to this device. The tilt monitor can also be used as a pendant by Mr C should he require help in an emergency.

Mrs C is very capable in dealing with her husband's grand mal seizures. A specific response pattern was worked out with the MECS Assessor so that the MECS wardens would only need to assist if Mrs C was unavailable when the monitor triggered or if she requested assistance from wardens via the Control centre.

The MECS Assessor carried out a review of all equipment installed for Mr C. Mrs C reported that as her husband does not sleep in the same room so it was difficult for her to know when seizures were taking place during the night without the bed monitor being in place. Mrs C reported that the bed monitor was working well for her and the response pattern put in place allowed her to be in control and manage Mr C's seizures herself. At the same time, the telecare package gave her the knowledge that, should she not be at home, the wardens can assist with Mr C during a seizure. The bed monitor allows Mrs C to rest knowing that should Mr C go into seizure then she will be alerted to deal with this.

Mr C takes absences as a result of his epilepsy and the family were concerned he could drop a lit cigarette during one of these absences.

The balance of being in her own flat and going to the day centre has made her far more settled than she ever was in 24 hour care.

CASE STUDY 07

DEMENTIA

Gateshead Care Call, Just Checking

Living with dementia

Mrs P lived with her husband in an extra care scheme when she was diagnosed with vascular dementia. She started to have hallucinations and became aggressive towards care staff and family. She was placed in 24 hour respite care for specialist assessment and medication management. Mrs P's husband passed away while she was in care and the plan to discharge her was changed.

She did not thrive in care. When Mrs P was actively hallucinating, she was unable to manage her own behaviour and often had to be guided away for time out by staff. Her family was concerned that with too few meaningful activities to stimulate her she would deteriorate, slow down and rely heavily on staff. Mrs P has a supportive family who wanted to try to get her home, and the Care Call team suggested using Just Checking as part of the care plan.

Getting Mrs P home after five months in respite care involved in-depth team planning between the community matron, psychiatrist, day care staff, home care staff, social worker, Care Call and the family. Mrs P had not lived alone before. The assumption was that she might not manage at home, that she might become too distressed and leave the flat to look for others. While the family planned to be at the flat for much of the day, they were nervous about what would happen at night. A door exit alert was installed as well as Just Checking.

Within days of being home Mrs P improved. She was able to fill her time in her own flat and activity charts showed that night time was less of a problem than anticipated and she has not tried to go out.

During a week when Mrs P did not sleep well, extra care staff heard her moving around in the early hours but were able to use Just Checking to satisfy themselves that she was fine. The family could also see when she had a disturbed night and were able to explain the increased confusion or delusions which usually followed.

Day centre staff reported Mrs P being able to manage her own behaviour and noted that if she was hallucinating she would take herself away from group. The social worker felt that Just Checking was invaluable for this complex case. The balance of being in her own flat and going to the day centre has made her far more settled than she ever was in 24 hour care.

The Just Checking system monitors a person in their home, and provides a chart of activity via the Internet. Small, wireless sensors in the key rooms of the house are triggered as a person moves around their home, data is gathered and sent via an integral mobile phone to the Just Checking web-server.

CASE STUDY 08

LEARNING DIFFICULTIES

Walsall Council

Sensor makes younger brother's life easier

J is a 22 year old who suffers with epilepsy and severe learning disabilities. He lives with his Mum, Dad and younger brother.

The epileptic fits that he has during the night are quite severe and can cause him to stop breathing. Because of this, he has always slept in the same bedroom as either his Mum and Dad when he was younger, and now his brother.

His brother is eighteen and, like all young lads, would naturally like a bit of independence, a room of his own and the chance to bring girls or friends back.

This was a difficult situation for J's Mum and Dad as they wanted to give their younger son some independence. But it was impractical to have J sleep in the same room as them, due to the lack of space and obviously their privacy. The only way they could think of monitoring J's fits and giving their younger son some freedom was to take it in turns to sleep in the third bedroom with J.

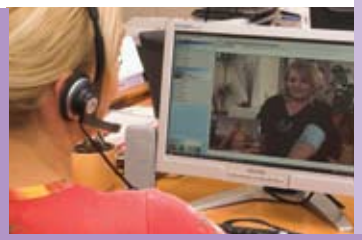
Although they didn't mind doing this, it caused a bit of stress in the parents' relationship.

An epilepsy sensor has been the ideal solution as it has allowed J's brother to be in a room of his own, his Mum and Dad are together in their bedroom, J has some privacy too, and if he does have a fit, the alarm signal goes straight through to his Mum and Dad on their mobile so he has an instant response.

The sensor has made a really big difference to the quality of all of their lives, whilst ensuring J is safe and well through the night.

The sensor has made a really big difference to the quality of all of their lives, whilst ensuring J is safe and well through the night.

The function of the monitoring centre can now be extended to include pro-active and regular monitoring of the client but with the added benefit of each party being able to see as well as talk to each other.



CASE STUDY 9

BOGUS CALLERS

Oldham Council

Oldham Council uses broadband to improve its services to clients.

Oldham's People, Communities and Society Directorate showed their creative flair by introducing the benefits of I.P. based technology into the community. Evidence based reports identified a particular community was vulnerable to bogus callers and burglary. Many residents in the area living on their own were susceptible to unwanted callers and experienced a feeling of isolation.

Working with their partners, Chubb Community Care, a project is currently being tested that will allow the person living alone to seek help when the doorbell rings.

An I.P camera fitted in the porch is linked to a broadband connection that the monitoring centre can activate from their workstation. If the client doubts whether they should open the door to the caller, they simply press the bogus caller button. The monitoring centre recognises the activation, opens up the speech channel on the dispersed alarm and helps the client make a choice to let the visitor gain entry or not. Whilst the features of the bogus caller are well known throughout the telecare fraternity, the ability for the control room to view the caller through an I.P. camera in the porch is quite new. The image of the caller can be snapshot and used as evidence in court if required.

The project also identified a number of clients with a certain medical condition and linked them to their local GP's surgery. This link will transmit information electronically as well as facilitate face-to-face contact between client and GP; the aim being to reduce hospital admissions and keep people in their own homes.

On-line video

Another feature of the project is the installation of video over broadband, using the client's television as the platform to transmit and receive live video connections between the client and the carer, whether nurse, social worker, G.P. or even a friend or relative.

The function of the monitoring centre can now be extended to include pro-active and regular monitoring of the client but with the added benefit of each party being able to see as well as talk to each other.

The Villages Housing Association whose properties are being used, or First Choice Home's Oldham who run the 24/7 Helpline response centre, will have the ability to act as an agnostic hub through which broadband video can be operated in a control room environment.

CASE STUDY 10

COGNITIVE IMPAIRMENT

North Somerset Council and Avon and Wiltshire, Mental Health Partnership NHS Trust

Mrs X is a 73 year old lady who is cognitively impaired due to a severe stroke. She lives with her husband in their own large isolated detached house. She is only able to mobilise with supervision as she is very unsteady and at high risk of falls. She has no insight or understanding of these risks and attempts to move from her chair and/or bed unsupervised.

A referral was made to the telecare service for advice about the possible installation of a sensor mat which would alert her husband if she moves from her bed or chair, so enabling him to move about more freely inside and outside the house. At the assessment, her husband stated that he is managing the home and garden by grasping opportunities to move about whilst his wife is settled and regularly goes back to check on her, either within the house or through the window from outside.

The occupational therapist initially considered use of a sensor mat with a pager, but this was not successful due to the distance the signal needed to be transmitted. It was also felt that there should be a robust system in place to cover risks in case her husband was unable to respond to an alarm call for any reason. Her husband agreed to the installation of a community dispersed alarm, and bed and chair occupancy sensors were linked to the system. The sensors are set to operate at any time during the day and night, and the call centre has been instructed to ring her husband on his mobile phone if the alarm is activated. If the call centre gets no response from her husband, or he himself activates the pendant alarm, they have other numbers to ring to summon assistance.

This system has given her husband huge relief in his caring role as he now feels able to go about daily tasks around the home knowing that he will be alerted if his wife attempts to mobilise unsupervised.

Professor Russell Jones

Senior Partner, Chorleywood Health Centre
Associate Chair, Department of Information Systems and Computing, Brunel University

Telehealth for general practice

Change is inevitable. It is good or bad. It is said that a third of us always view it as bad and resist and a third are cavalier and embrace change despite the risks. The remainder move eventually and at best are reflective and pragmatic and at their worst follow the socio-political fashion of the moment. Hopefully, all of us are realists and as clinicians put our patients first.

General practice has changed in thirty years from a largely reactive primary healthcare service to one that is proactive and organised to deliver case finding, screening, immunisation and the care of chronic illness. How did this come about? I suggest that it happened for two reasons. General practice adopted this evolving clinical role as their own without any central dictat or contracted funding because doctors were seeking a role after a decline in their importance in caring for infectious diseases.

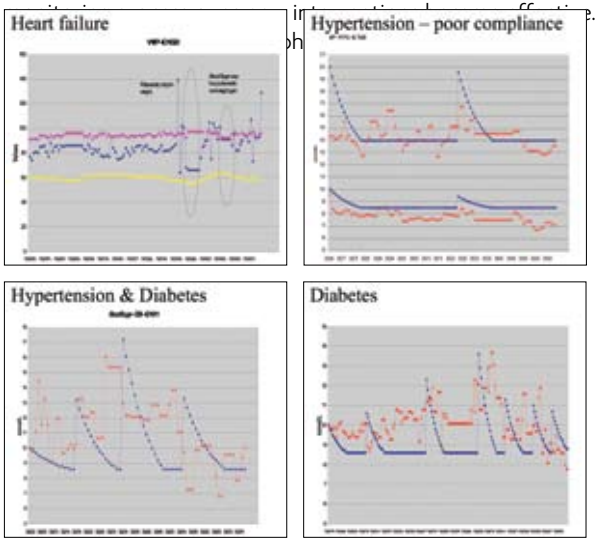
Doctors recognised also that computers made possible the managing of large quantities of clinical information and its transfer to both patient and clinician. Systems supporting screening, case finding, disease registers, immunisation, and disease clinics existed long before Quality and Outcomes framework (QOF) and the new General Medical Services (nGMS) contract and the 'greedy doctor'. The use of the electronic record in general practice developed through the eighties and by 1990 when the first small NHS funding appeared, approximately 94% of general practice used a computer and approximately 60% used the electronic patient record in a consultation. It is an example of general practice at its best that a decade later practice computing is fully funded and the ambition to establish a communicating 'spine' is close to becoming a reality. How much further on could we all be if the rest of the NHS 'family' had developed with similar energy and vision during the last twenty years. Could risk aversion be the basis of this unbalanced growth in clinical IT? And again, can risk aversion be the root-cause for the slow evolution of clinical IT into e-health and the widespread use of both telecare and telehealth?

Barriers to telemedicine

Our experience at Chorleywood Health Centre is that even when risk is defined and resolved there are still significant barriers to successful telemedicine. Silo thinking and reorganisation leads to: staff withdrawal from remote patient monitoring – 'its not their job'; the switching off of telephone lines supporting tele-consultations across the clinical divides – 'just waiting list short cuts'; and the absence of tariffs in primary care that prevents a useful comparison of clinical services in a local health economy – the fourth year of a financial freeze for general practice. Despite these rather gloomy happenings, the power of telemedicine to make a difference for patients drives it forward.

62% of the patients selected from the practice chronic disease registers and monitored remotely needed clinical intervention. The more ill the patient, the greater was the impact. Surprised by the degree of clinical need amongst these patients, the practice established routine case conferences to consider the data and review the electronic patient record.

Data was prepared graphically and limits imposed that followed the outcome range from therapy defined in the Map of Medicine. Variations in these limits were allowed to prevent unnecessary concern as patients became used to the



The power to effect change

I will not go into the detail of the data or the clinical stories but shall state that the data had a profound effect on clinical decision-making and patient care. The clinical team was taken aback by the power of the data to effect change in their way of working; it proved hard to ignore poor treatment outcomes. It imposed a level of clinical responsibility not experienced before and engendered interest in other clinicians involved in the patient's care – one physician requested the latest data for each clinical review.

This was achieved without any direct NHS funding. The PCT reorganisation decimated the primary care clinical team that delivered the innovation despite criticism mounted by some at NHS head office. As in the eighties and nineties, general practice will develop with others this exciting opportunity to improve patient care and will do so despite the often soggy blanket of health care bureaucracy, and perhaps, much to its surprise.

It is an example of general practice at its best that a decade later practice computing is fully funded and the ambition to establish a communicating 'spine' is close to becoming a reality.

Dr. Nicholas Robinson

Associate Clinical Director for Long Term Conditions and Telecare, NHS Direct

Telehealth

A unique service offering a personalised, structured telehealth programme

Birmingham OwnHealth is the first care management service of its kind in the UK, delivered in partnership by Birmingham East and North Primary Care Trust (BEN PCT), Pfizer Health Solutions and NHS Direct. The service is available across four PCTs in and around the Birmingham area. This unique service offers a personalised, structured programme of care managed support for people in Birmingham with coronary heart disease (CHD), heart failure, Chronic Obstructive Pulmonary Disorder and/or diabetes. We are also currently developing other services to support people who have had a stroke, elderly people needing more support and people at risk of developing cardiovascular disease (CVD).

Delivered over the phone by a team of care managers – fully trained and experienced nurses employed by NHS Direct – the service is designed to build and maintain ongoing relationships with enrolled members, thus providing motivation, support and knowledge to encourage people to take actions to improve their health and get the best health outcomes from treatment programmes already recommended by their GP and/or healthcare professional. Evidence shows that when people are empowered to take control of their own health and helped to engage more effectively with healthcare services, their overall health, quality of life and satisfaction levels all improve.

Reaching across communities

Birmingham OwnHealth is a multi-lingual service, offering direct services in English, Punjabi, Urdu and Hindi. It aims to reach across Birmingham's diverse ethnic communities to improve health and wellbeing and reduce inequalities.

People who may benefit from Birmingham OwnHealth are referred to the service and invited to enrol as a member by their GP. Once enrolled in the service, people will receive structured and personalised support over the telephone from a dedicated care manager who will help individuals to achieve the best health outcomes from the treatment programmes already agreed between that person and their GP and/or healthcare professional. The care manager helps individuals to:

- better understand their own medical condition;
- acquire skills and knowledge and make positive lifestyle changes which can benefit their condition and overall health;
- correctly follow treatment programmes as prescribed by their GP and/or other healthcare professionals; and
- understand how to engage and use local NHS services more appropriately and effectively.

Birmingham OwnHealth currently provides support for people with CHD, heart failure, type 1 and type 2 diabetes and/or Chronic Respiratory Disease (COPD). Services are also being developed for people who have had a stroke, people who are at risk of developing CVD and elderly patients needing more support.

For selected long-term medical conditions (e.g. heart disease or diabetes), changes in a person's behaviour and lifestyle (e.g. diet, exercise, getting regular health checks, etc) can make a significant impact on controlling their condition, slowing potential deterioration, reducing the risk of complications and ultimately helping them to stay as healthy as possible.

Care managers give personalised guidance and support over the telephone, building ongoing relationships with people and providing motivation, skills and knowledge to help encourage people to take actions to improve their own health.

One-to-one relationships

Care managers build one-to-one relationships with individuals, calling people at mutually agreed times, as often as needed. GPs and other healthcare professionals can encourage people to call their care manager if they need extra support/have specific queries on their condition on those occasions when a visit to their GP is not essential.

Under Birmingham OwnHealth, the relationship between an enrolled person and their GP and/or other healthcare professionals continues to have primacy in identifying and agreeing the programme of treatment each person needs.

Care managers support and build on the professional care already provided, enhancing the relationships and improving the interactions people have with their GPs and/or other healthcare professionals.

GPs and/or other healthcare professionals can also encourage individuals enrolled in the Birmingham OwnHealth programme to call their care manager for extra support and for help and advice on their condition when a visit to the GP is not essential.

Care manager's role

Each care manager is dedicated to specific GP practices participating in Birmingham OwnHealth. Part of the care manager's role is to work closely and build relationships with the clinicians and healthcare professionals in order to ensure they can best support and complement the work of the local primary healthcare team and together achieve the best health outcomes for individuals.

Care management/disease management is proactive, structured and systematic support, encouragement and help for individuals with those long-term medical conditions where changes in a person's lifestyle or behaviours can lead to significant benefits for the individual, and positively impact on healthcare services and resources.

Care management helps individuals to learn and understand the importance of eight key care priorities:

- How and when to call the doctor;
- About their conditions and set goals;
- To take their medicines correctly;
- To get recommended tests and services;
- To act to keep the condition well controlled;
- To make lifestyle changes and reduce risks;
- How to build on strengths and overcome obstacles; and
- To follow up with specialists and appointments.

Services based on these principles strengthen the quality and value of a person's relationship with their GP and/or local healthcare professionals. People become well-informed, motivated and progressively more independent in the management of their own health.

The quality and value of a person's relationship with their GP and/or local healthcare professionals is also strengthened and becomes more effective. People become well-informed, motivated and progressively more independent in the management of their own health and understand how to engage with and use their local healthcare services more effectively.

Increased levels of self-care positively contribute towards improving the health and wellness of individuals and UK population. It also plays a role in addressing the ever-growing burden on healthcare services and resources, helping the NHS evolve from a reactive sickness service towards a patient-centred one which encourages people to play a greater role in staying healthy.

Widening the reach

NHS Direct are, in conjunction with other partners, working together to deliver assistance to people living with long-term health conditions in other areas in England. A project, working together with SE Essex PCT, has been set up to deliver Telemonitoring for one hundred patients suffering with COPD. NHS Direct is the prime contractor assisting SE Essex PCT to support home monitoring using Docobo Home Health Hubs. The service will prevent acute admissions to hospitals and in addition will support patients once discharged from hospital after treatment. Patients are therefore able to remain in their own homes while being supported by their local nurses and social services departments.

The service also aims to improve the manner in which staff can prioritise their own workload through the effective use of patient data and information. In addition, travel costs are reduced as patient's visits become more targeted.

Close working with local nurses and patient representatives has resulted in the creation of a service which is tailored to their needs. The service has been delivered and fully implemented within four months and is currently taking its initial patients.

Evidence shows that when people are empowered to take control of their own health and helped to engage more effectively with healthcare services, their overall health, quality of life and satisfaction levels all improve.

THE NATIONAL TELECARE & TELEHEALTH CONFERENCE 2008

Change the way you see telecare and telehealth today

More than 640 – a 30% increase over 2007 – attended the National Telecare and Telehealth Conference in Brighton in November, making it the single, largest gathering of industry professionals in the UK in 2008. Three days, nine keynote speakers, 22 workshops...

It was a conference with a fast moving programme and a stimulating exhibition zone.

Delegates represented the breadth of service providers, commissioners, healthcare professionals, academics and sensor and software suppliers. The Conference theme set out to change the way delegates saw telecare and telehealth.

The extensive workshop menu – 22 in all – offered delegates the opportunity to personalise their Conference choosing sessions across the Depth, Strategic and Operational spectrum.

Thirty seven exhibitors, ranging from global brands to boutique manufacturers, created a market atmosphere. More than 20 new products and services were launched at the event – many with the help of Jon Bentley (guest speaker from Channel Five's The Gadget Show).

Following the Networking Dinner, 26 members collected their Code of Practice award – organisations that had achieved accreditation for the first time as well as those that had successfully maintained standards in the intensive three yearly audit.

'Just wanted to say thank you for a brilliant conference. As a presenter and not a member of the TSA I felt very welcomed and looked after at the event, it was lovely and makes such a change from other conferences I have presented at. I enjoyed the sessions I attended and found the last speaker Chris Moon truly motivating and inspiring. Thank you for inviting me. I shall definitely be attending in the future.'

Dr Gillian Ward, Senior Lecturer, Coventry University

Conference Keynote Speakers

Jon Bentley

Presenter of the Gadget Show, Channel Five

Jon looked back to the Star Trek era and identified which technologies had subsequently made it through to market and become a reality. He also helped launch a number of new products and services in the Exhibition Zone.

Mark Treleaven

Healthcare Industry Marketing Manager, Microsoft UK

Mark gave a glimpse of the future (not too distant) focusing on the consumer and how technology would be able to help individuals better manage their own health condition.

Dr. Simon Roberts

Intel Digital Health Group

Captivated the audience with a presentation on **Telecare – thinking beyond the box**. Looking for insights and opportunities in unlikely places.

Jo Wright

Vice President Business Solutions, Incubation and Innovation, BT Global Services

Spoke on **Private sector: friend or foe?** How chronic disease is the biggest challenge to health and society this century... and the solutions required.

Julie Jones

Chief Executive, Social Care Institute for Excellence

Gave an insightful presentation on **Innovation in social care practice** and how the SCIE supports innovation in service delivery.

Tim Ellis

Whole System Demonstrator Programme Manager, Department of Health

The title of this talk was **Demonstrator Sites – key programme learnings so far**. Included an outline of the Whole System Demonstrator programme and evaluation of its process implications.

Barbara Stuttle CBE

National Clinical Lead Nursing & Midwifery – Connecting For Health and Director of Quality & Nursing – NHS South West Essex

Benefiting patients using telecare and telehealth raised practical and philosophical issues of why we are here, independence and choice, self-care and prevention and living our lives.

Jim Thomas

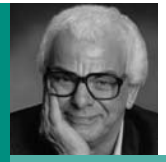
Programme Head, New Types of Worker, New Types of Working. Skills for care.

A far-sighted look at 22nd century social care workers including the changing roles of people who use services and family carers, cross sector working and delivering new models of support.

Wayne Elliott

Head of Health Forecasting, Met Office

And now we go over to the Met Office for the latest health forecast... an enlightening presentation on how the seasons and weather affect health and how this data can be used to support those whose health condition makes them more vulnerable.



Barry Cryer

Comedian, writer and broadcaster

Legendary comedian and gag writer to the stars entertained guests at the Gala Dinner and spoke about his career, his contacts and fond memories of the stage, TV and radio... for many, the highlight of the Conference.

Chris Moon

Surprise motivational guest

During his presentation, Chris Moon, a landmine against-the-odds survivor gave an inspiring talk focusing on his personal mantra to challenge the concept of limitation.

Marian Preece

Operations Manager, Telecare Services Association

TSA OPERATIONAL REVIEW

2008 was another year when the Association expanded in influence and stature with sustained growth in the membership and the level of Code of Practice accreditations.

The highlight had to be the very successful Annual Conference with record attendance, compelling presentations and excellent, interactive workshops. This event also saw the launch of the 2009 Telecare Code of Practice, itself the result of the most comprehensive consultation exercise ever undertaken by TSA. National Government (primarily the Department of Health), devolved Administrations, together with TSA directors and members were all involved in shaping the Code's modular framework and the standards set.

Representing Members

TSA continued to invest considerable time and effort representing the interests of the membership at Government level and through its relationships with key strategic groups including:

- **Department of Health's TAN (Telecare Advisory Network)** – TSA is a founder member of the TAN. The main aim of this body is to provide the Department of Health with a coordination and oversight group for policy and service development, mainstreaming, research and practical application of telecare and telehealth in England.
- **Assisted Living Innovation Platform (ALIP)** – TSA was invited to join a steering group for the Technology Strategy Board ALIP project – its aim to make significant advances in the technology needed to enable people, who suffer from chronic long-term conditions, to live independently.
- **Care Services Improvement Partnership (CSIP)** – since its launch in 2005, TSA has maintained a close relationship with CSIP supporting a range of initiatives that underpin the development of health and social care services.
- **National Telecare Programme Board, Scottish Government** – holds primary responsibility for the strategic development of the National Telecare Programme in Scotland. The Board advises and supports senior officers in the management of the Telecare Development Fund.
- **Telecare Programme, Welsh Assembly Government** – TSA has been involved in the Supporting People Programme that provides vulnerable people with a more stable environment which in turn improves their quality of life and degree of independence.
- **NHS Purchasing And Supply Agency** – TSA's relationship with PASA has helped ensure that the procurement framework delivers the best possible value for money for purchasers of telecare-related goods and services.
- **CFOA** – during the year, TSA worked closely with the Chief Fire Officers' Association (CFOA) culminating in the September launch of the revised CFOA Policy for the Reduction of False Alarms and Unwanted Fire Signals.
- **Other key contacts** –close contact was maintained with Government and other organisations that impact and influence the telecare space, including key individuals in BERR (Business, Enterprise & Regulatory Reform), the Technology Strategy Board, Connecting for Health, FAST (Foundation for Assistive Technology), Counsel & Care, SEHTA (South East Health Technologies Alliance) and Medilink in the UK; and Med-e-Tel and W.TDM in Europe.

Promoting the Industry

During 2008, TSA continued to raise the industry profile by participating in high profile events across the UK and overseas. Here is just a selection:

- Ivan Lewis, Parliamentary Under-Secretary of State for Care Services wrote the Foreword to the 2008 Annual Report
- International Conference of Policy and Service Delivery Model for Telecare in Taipei – the invitation to attend came from the British Trade and Cultural Office in Taiwan. Gerry Allmark attended.
- Invitation to join steering group of SMART 2 project – Self Management supported by Assistive, Rehabilitation and Telecare Technologies. The project focused on three conditions: stroke, chronic pain and heart failure with the aim to produce a 'toolkit' of software and sensors to help people assess how best to manage their condition.

- Joint badge and presentation invitation at Laing & Buisson Telecare and Homecare Conference
- Vice Chair attended W.DTM study tour Spain
- Ethical Issues in the Delivery of Telecare and Telehealth Services at Med-e-Tel
- Invitation to present to Mobile and Wireless Healthcare conference.
- 'Telecare and Epilepsy Conference – Enabling People with Long-Term Conditions'
- 'The Developing Role of Telecare and Telehealth for People with Neurological Conditions', College of Occupational Therapists Conference, Newcastle.
- 'Telecare and Telehealth within Social Care Strategies' at Wireless and Digital Cities 3rd Annual European Congress, Barcelona.

Membership

Growth in membership has to be our central goal. 2008 did not disappoint.

Membership Category	2005	2006	2007	2008
Service Providers with Alarm Receiving Centres	214	223	222	227
Service Providers without Alarm Receiving Centres	36	38	46	51
Supply Sector	23	27	31	38
Related Professional Interest	–	3	8	14
TOTAL	**273**	**291**	**307**	**330**

Launch of Premium Membership

Premium Membership was launched in December 2007 for those member organisations (whether Full or Associate) that are TSA accredited in all the services they deliver. Premium Membership stands at 62; this group has a strategic focus along with additional membership benefits and plans to meet two or three times a year.

Code of Practice

During 2008, service provider accreditation saw strong growth:

Code of Practice	2005	2006	2007	2008
Telecare Calls Handling Operational Requirements	48	62	82	105
Telecare Installation Operational Requirements	17	36	59	80
Mobile Response Operational Requirements	1	15	32	44

In all, some 114 service provider members have one or more levels of accreditation.

Code of Practice Review

2008 saw further building blocks put in place for the future development of the Code of Practice. These included:

- A fundamental and grass roots review of the structure of the Code including a detailed reassessment of and upgrading of Key Performance Indicators. The resulting standards will be published early in 2009.
- Major consultation with external stakeholders, including the Scotland Telecare Programme Board, the Welsh Assembly Government, Department of Health, Supporting People and the broad representation through the Code of Practice Management Board.
- The adoption of an easily assimilated modular format.
- Launch of the Code of Practice Matrix based on the TSA R2R (Referral to Response) Model.
- Recognition by the Scotland Telecare Programme Board of the importance of telecare service quality and their wish to facilitate health and care partnerships in achieving Code accreditation.

Member Forums Programme

Each year, eight Member Forum events are organised across the UK providing an opportunity for members to meet, network, share best practice and influence the work of the Association. 2008 saw attendance exceed 300 – a clear demonstration of the health and vibrancy of the TSA network.

TSA Website – www.telecare.org.uk

During 2008, the TSA website was refreshed and revitalised. It now brings together a rich source of information for members and other telecare professionals. A new area for 'consumers' – service users and their carers – was created and will be developed further.

Annual General Meeting and Spring Conference

Attendance figures show the popularity of this important event.

Year	Delegates	Member Organisations
2006	88	56
2007	90	53
2008	94	53

Following the 2008 AGM, workshops on the Code of Practice and the BT 21CN project were popular with members. Seven organisations also received their Code of Practice award.

21 CN

TSA continued to work with the Supply Sector and BT during 2008 in order to prepare for the introduction of the 21CN network throughout the UK. Good progress has been made across all key issues.

- Most significantly, the first stages of the South Wales Pathfinder programme have been uneventful, free of any social care issues much to the credit of the Telecare Service Providers who have planned and managed the events.
- TSA facilitated the development of a new standard BS8521 which was designed to overcome many of the technical protocol communication issues. It has now been through the process of public consultation and is expected to be formally adopted by BSI and published in mid-2009. Suppliers are already developing equipment compliant with the new standard which is expected to appear on the market very soon after the standard is published and well before the wider 21CN roll out by BT across the UK.
- Engagement with wider stakeholders has been further improved. Both OFCOM and NHS have provided both representation to the TSA Supply Sector meetings and support during the year by facilitating access to other telecommunications providers and technical architects.
- Suppliers are already planning their service provision in an environment where telecommunications travel over a digital fibre and the conventional 'copper pair' phone services are not accessible. TSA has been invited to support the Suppliers in developing their approach to both the challenges and the opportunities that this technology change offers.

The challenge for 2009 will be to ensure that the experience of the 21CN pathfinder in South Wales is communicated to the wider membership and that they too are adequately prepared for the full switchover programme commencing in 2010. Outside of the South Wales region there still remains a large residue of equipment which will need to be modified or replaced before the 21CN Switchover.

2008 Annual Report – Telcare and Telehealth Centres of Excellence

TSA invited contributions from strategic thinkers in the telecare and telehealth market. Six thousand copies of the 2008 Annual Report were distributed locally by members to their key contacts and centrally to policy leads and Governmental decision-makers.

TSA continues to experience circa 250 downloads per month of the Annual Report from the website, further underscoring the need for this form of independent, corporate literature. The Annual Report has proven to be a valuable and effective tool for lobbying and communicating the telecare and telehealth message.

Membership Service Centre Relocation

During the Summer of 2008, TSA relocated its office from Chatham to Wilmslow. The upgraded environment allows for an enlarged staff team to provide better support to members. The new role of Communications Development Manager helped improve the quality and reach of the Association's key messages.

TSA Board Structure

The TSA Board is the principal policy and decision-making body of the Association, a company limited by guarantee. All members of the Board serve as directors of the Company and are bound by Company Law to make all decision in the best interests of the Association. Other than the Chief Executive, members of the Board serve in a voluntary, non-executive capacity.

During 2008 the following individuals served on the Association's Board:

Name	Representing
Malcolm Fisk, Chair	Supply Sector
Fran Taberner, Vice Chair	England
David Foster, Treasurer	Supply Sector
Jon Lowe	Supply Sector
Kevin McSorley	Northern Ireland
Val Parsons	Wales
Gerry Allmark	England
Nicholas Robinson (appointed 1st December 2008)	Co-opted
Alan Clark (appointed 23rd January 2008)	Co-opted
Chris Smith, Treasurer (resigned 12th February 2008)	England
Aileen Stewart (resigned 1st November 2008)	Scotland
Paul Gee, Chief Executive	





Code of Practice Accredited Service Providers

Part One: Telecare Calls Handling – the planning, management and operation of Telecare Response Centres. Part Two: Telecare Installation – the planning, management and installation of telecare equipment in the homes of service users. Part Three: Mobile Response – the planning, management and delivery of planned and/or emergency mobile response services. A TSA Premium Member has secured accreditation in all services provided by their organisations.

tsa
Premium Member
Code compliant in all services provided

ORGANISATION	PARTS			
	1	2	3	
Aid Call Ltd (Age Concern)	Yes	Yes		Premium
Ashfield Homes Ltd	Yes	Yes	Yes	Premium
Ashford Borough Council	Yes	Yes		
Aspire Housing Ltd	Yes			
Barnsley MBC	Yes	Yes	Yes	Premium
Basildon Careline	Yes	Yes		
Bield Housing Association	Yes	Yes		Premium
Blyth Valley Borough Council	Yes	Yes	Yes	Premium
Bolton at Home	Yes			
Boston Mayflower Ltd	Yes	Yes	Yes	Premium
Bracknell Forest Council	Yes	Yes		
Brighton & Hove City Council	Yes	Yes		Premium
Bristol City Council	Yes			
Bromsgrove District Council	Yes	Yes		Premium
Broxbourne (Borough of)	Yes	Yes	Yes	Premium
Caerphilly County Borough Council	Yes	Yes		Premium
Call 24 Hour Ltd	Yes	Yes		
Cannock Chase District Council	Yes	Yes		Premium
Carlisle Housing Association	Yes	Yes	Yes	Premium
Carmarthenshire County Council	Yes			
Casa Lifeline East Sussex		Yes	Yes	Premium
Cheshire Peaks & Plains Housing Trust	Yes	Yes	Yes	Premium
Chester & District Housing Trust Ltd	Yes	Yes	Yes	Premium
Chesterfield Borough Council	Yes	Yes		
Chichester District Council	Yes	Yes	Yes	Premium
Cirrus Careline Ltd	Yes			
Coast and Country Housing	Yes	Yes	Yes	Premium
Community Gateway Association	Yes			
Community Housing Group, The	Yes	Yes		Premium
Conwy County Borough Council	Yes			
Cross Keys Homes	Yes	Yes	Yes	Premium
Derby City Council	Yes	Yes	Yes	Premium
Derwentside Careline		Yes	Yes	Premium
Dudley Metropolitan Borough Council	Yes	Yes	Yes	Premium
Durham City Council	Yes	Yes	Yes	Premium
Eldercare (Newchurch Housing Ltd)	Yes		Yes	
Enfield (LB of)	Yes	Yes	Yes	Premium
Flagship Housing Group Ltd	Yes	Yes		Premium

ORGANISATION	PARTS			
	1	2	3	
Fold Housing Association	Yes	Yes		Premium
Forest of Dean District Council	Yes			
Guildford Borough Council	Yes	Yes		
Hanover (Scotland) H.A.	Yes	Yes		
Hanover Housing Association	Yes			Premium
Hanover in Hackney Housing Association			Yes	
Harlow District Council	Yes	Yes		
Herefordshire Housing Limited	Yes			
High Peak Community Housing	Yes	Yes	Yes	Premium
Housing Connections Partnership	Yes			
Housing Pendle Ltd	Yes	Yes	Yes	Premium
Invicta Telecare Ltd	Yes	Yes	Yes	Premium
Johnnie Johnson Housing	Yes			
Kirklees Council	Yes			
Lambeth (LB of)	Yes	Yes	Yes	Premium
Lewisham (LB of)	Yes	Yes		
LHA/ASRA	Yes	Yes	Yes	Premium
Magna Careline Ltd	Yes	Yes		
Manchester City Council	Yes			
Mansfield District Council	Yes	Yes		
Merton (LB of)	Yes			
Mid Essex Primary Care Trust	Yes	Yes		
Milton Keynes Council	Yes	Yes		
Mole Valley District Council	Yes			
New Progress Housing Association	Yes	Yes		
North East Lincolnshire Carelink	Yes	Yes		Premium
North Hertfordshire District Council	Yes			
North Lanarkshire Council	Yes	Yes	Yes	Premium
North Somerset Council	Yes	Yes	Yes	Premium
Northampton Borough Council	Yes	Yes		Premium
Nottingham City Homes	Yes	Yes	Yes	Premium
Orbit Group Ltd	Yes	Yes		Premium
Places for People Group	Yes			
Plus Dane Group		Yes	Yes	Premium
Poole Borough of	Yes	Yes	Yes	Premium
Purbeck Housing Trust	Yes	Yes		
Redbridge (LB of)	Yes	Yes		Premium
Redditch Borough Council	Yes	Yes		

ORGANISATION	PARTS			
	1	2	3	
Renfrewshire Council		Yes	Yes	
Richmond-Upon-Thames LB of	Yes			
Ridgeway Community Housing Association		Yes		Premium
Riverside Group	Yes			
Rotherham Metropolitan Borough Council	Yes	Yes		
Salisbury District Council	Yes	Yes		Premium
Sandwell Homes Ltd	Yes	Yes	Yes	Premium
Sedgefield Borough Council	Yes	Yes	Yes	Premium
Sedgemoor District Council	Yes	Yes	Yes	Premium
Selwood Housing Society Ltd		Yes	Yes	Premium
Sentinel Housing Group	Yes			
Severnside Housing	Yes	Yes		
Shepway District Council	Yes	Yes		Premium
South Derbyshire District Council	Yes	Yes	Yes	Premium
Southampton City Council	Yes	Yes	Yes	Premium
Sovereign Housing Association	Yes	Yes		Premium
Stockton On Tees Borough Council	Yes			
Sunderland (City of)	Yes	Yes	Yes	Premium
Tamworth Borough Council	Yes			
Taunton Deane Borough Council	Yes	Yes	Yes	Premium
Testway Housing Ltd		Yes	Yes	Premium
Three Valleys Housing Ltd	Yes			
Torbay NHS Care Trust	Yes	Yes		Premium
Trent & Dove Housing Ltd	Yes			
Tunstall Response Ltd	Yes			
VNC Lifeline Ltd	Yes	Yes		Premium
Wales & West Housing Association	Yes			
Walsall Community Alarm Service	Yes			
Warwick District Council	Yes	Yes	Yes	Premium
Wealden and Eastbourne Lifeline	Yes			
Weaver Vale Housing Trust	Yes	Yes	Yes	Premium
West Lancashire District Council	Yes	Yes	Yes	Premium
West Lothian Council	Yes			
Wirral Partnership Homes Ltd	Yes			
Worcestershire TeleCare	Yes	Yes		Premium
Worthing Homes		Yes	Yes	Premium
Wrexham CBC	Yes			
Your Homes Newcastle	Yes	Yes	Yes	Premium

tsa
telecare services association

Telecare Services Association
Membership Services Centre, Suite 8 Wilmslow House Grove Way Wilmslow Cheshire SK9 5AG
Telephone: 01625 520320 www.telecare.org.uk