Agenda Item No: 7

DELIVERING BETTER OUTCOMES THROUGH TECHNOLOGY ENABLED CARE

To:	**Adults Committee**
Meeting Date:	**12th October 2017**
From:	**Will Patten, Service Director, Commissioning**
Electoral division(s):	***All***
Forward Plan ref:	*Key decision:* **No**
Purpose:	**To report on the work of the Assistive Technology Telehealthcare Team and the Double-Up Project to demonstrate the positive outcomes and challenges of providing technology enabled care.**
Recommendation:	**It is recommended that the Committee review and comment on the work of both teams and their progress to date.**

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1. BACKGROUND

1.1 Care technology, whether that is defined as assistive technology, telecare, telehealth, tele-monitoring, daily living equipment or all of the above, when appropriately deployed, has a growing track record of delivering high quality care whilst reducing the cost of other types of care provision. This report demonstrates how best practice is being used across Cambridgeshire to deliver higher standards of care sustainably, at a lower cost, and delivering better outcomes for people in terms of health and wellbeing.

1.2 The report focusses on two key areas of work. Firstly, the Assistive Technology Telehealthcare (ATT) Team and secondly the Double-Up Team. Both of these services are responsible for delivering solutions that have technology at their heart and are an essential part of the health & wellbeing, transformation and prevention agendas.
For each of these services the report will explain:

- The background to the service and its aims
- How the service is commissioned
- How the service works from assessment of people, through provision of services, to review and evaluation
- How the service delivers outcomes for service users and carers
- The future development plans for the service and some of the challenges that these might entail

2. ASSISTIVE TECHNOLOGY TELEHEALTHCARE (ATT) TEAM

2.1 Background

Assistive Technology is an umbrella term for any device or system that allows individuals to perform tasks they would otherwise be unable to do, or increases the ease with which they are able to complete those tasks. In Cambridgeshire, the term 'assistive technology' tends to be used when referring to the sub-range of electronic technology which broadly falls into two categories – Telecare and Telehealth. These are defined in more detail at paragraph 2.3. The Assistive Technology service was founded in 2002 with a small amount of funding allocated to mental health services. It was boosted in 2004 with the Preventative Technologies Grant (PTG) and the allocation for Cambridgeshire was £800K over two years. Ongoing investment in the service was secured through mainstream budgets from 2006 and has enabled ATT to grow into the service it is today. Some local authorities chose to use the PTG to simply enhance their community alarm (Lifeline) services. In some places, this led to large amounts of equipment being purchased which were never actually deployed. Cambridgeshire chose to retain an in-house bespoke service so that people could be given more choice and control and the team could build solutions around people's individual needs. This approach and ethos is maintained in the current service.
The team consists of:

- Manager
- Senior Practitioner
- 5 Technologists
- 1 Technician
- 2 administrators

They are a countywide team, employed by the County Council, and operate out of Amundsen House in St Ives. The team provides a service to people of all ages and across all service user groups, including children, although most of their work is with adults.

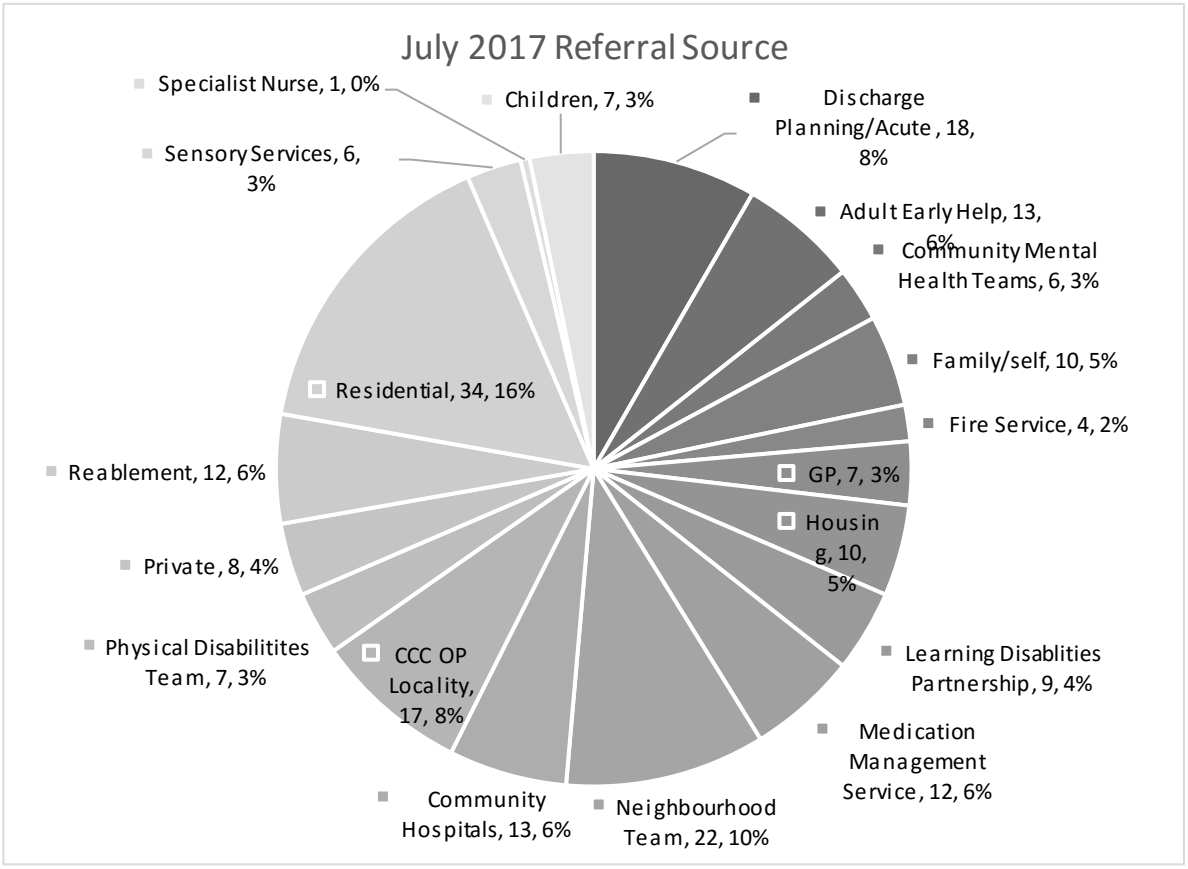
2.2 Commissioning

ATT is commissioned via a Section 75 Agreement with the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG). It is a wholly integrated service responsible for delivering both health and social care outcomes. The budget for 2017-18 is £585K which consists of £345K from the County Council and £240K from the CCG. The budget covers both staffing and equipment costs. In addition to the baseline budget, the service has secured Transformation funding for 2017-18 totalling £110K to roll out the use of the *Just Checking Assessment Tool* (see paragraph 2.5) as well as facilitating the completion of a workforce development programme and to support other areas of innovation and service improvement across the county.
An additional £77K is contributed to the service annually by NHS England, via the CCG, to fund Environmental Control Systems (ECS) – see paragraph 2.4.
The service expects to end the year on a break even position but there is a risk there may be a slight cost pressure, particularly in the ECS service.

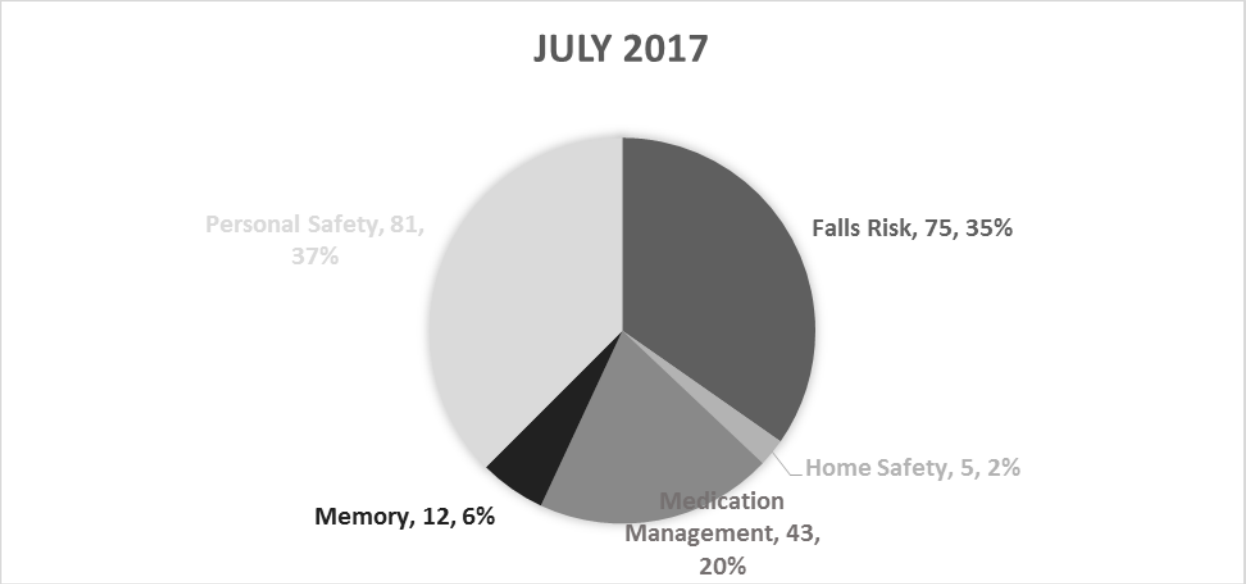
The diagram below summarises how the budget is allocated:

2.3 Referrals, Assessment and Service Provision

The team receives between 200 and 250 referrals a month. These originate from many different sources as can be seen from the diagram for July below.



People are referred to the service for many different reasons but the referrals generally fall into five main categories The referral pattern for July 2017 demonstrates the typical range of referrals received.



Following receipt of a referral, the team will allocate the case to the most appropriate member of the team, depending on the complexity of the case. Some people might just need a brief telephone assessment whilst others will require more extensive involvement and a number of home visits to try out different pieces of technology in order to find the best one to meet a person's needs. This assessment will always need to take into account the needs of the person's carers as they are often the people who benefit greatly in terms of peace of mind, as is shown in the comments at the end of Appendix A.

Once the most appropriate piece of technology has been identified, this may be issued directly from the team, or requisitioned through the Integrated Community Equipment Service operated by NRS Healthcare. People also have the option of Direct Payment or private purchase and the team can signpost people who wish to buy equipment privately.

There are a number of different types of assistive technology, all of which are available from Cambridgeshire's service, following an assessment of need:

- *Standalone technology* consists of individual pieces of electronic equipment that enhance a service user's independence by prompting or reminding them. Alerts are not sent to either a carer or monitoring call centre. Such items include medication reminders and task prompt devices

- *Standalone Telecare* sensors and detectors are not connected to a monitoring call centre but are programmed to link to pagers or mobile phones carried by a carer – often a family member. Such equipment includes bed and chair leaving alarms, fall detectors, epilepsy monitors and GPS tracking devices

- *Connected Telecare* equipment includes wired and wireless sensors and detectors that are programmed through a base unit telephone or call system to alert monitoring call centres – *Lifelines* are an example of these. The call centre then tries to contact nominated key holders or emergency services. The variety of sensors and detectors are similar to the standalone range. There is normally a small weekly charge for the services of the call centre but this may be subsidised

via the local authority housing services or can be subscribed to privately

- *Telehealth* equipment enables people to take their own readings of their 'vital signs' such as blood pressure, blood sugar, temperature, weight etc. These readings can then be transmitted to a monitoring centre where they are read by a clinician who can instigate a response if the readings fall outside set parameters

- *Environmental Control Systems (ECS)* are devices which assist people who have severe physical impairments enabling them to control their surroundings – for example, controlling heating, remotely answering a door intercom / releasing a door to allow carers in, opening and closing curtains, switching lights on and off. The devices can be controlled by switches that respond to even the slightest movement – eg an eye blink might be used by someone who might be, in all other respects, completely paralysed. Funding for these systems has been controlled centrally for many years – first through Health Authorities and now via NHS England. Cambridgeshire are keen to align their ECS offer with the rest of the ATT service but the baseline funding for ECS is extremely small (only £77K per year to cover new installations and ongoing maintenance) so this has to be carefully managed.

2.4 Delivering outcomes with Assistive Technology

Outcomes are measured in terms of improvements in **health and wellbeing**, as well as in financial terms:

- The team recently installed an ECS for a young man with a progressive brain tumour who had no control over anything in his environment. By the provision of an ECS he is now able to control his TV and gain computer access which has completely transformed his life, and that of his carer

- An automated dossett box prevents a person becoming unwell by prompting them to take medication and may avoid them needing a formal carer for this

- An epilepsy alarm alerts a carer to the need to administer medication or offer physical interventions when a person is having a seizure and can avoid the need for a waking night support package of surveillance

- A bed / chair leaving alarm alerts a carer to the fact that a person may need help when mobilising and help to prevent falls

- A direct payment may be offered to a carer so that they can access the benefits of a pager through their smart phone, rather than having to carry a separate pager system

In terms of caseload, waiting times are kept to a minimum (currently between one and two weeks) and the team have around 80 open cases at any one time that they are actively working on. There are around 2000 open cases at any one time – these are cases that require ongoing support or an annual telephone review. This compares favourably with the national average of 2345 based on data from the Good Governance Institute (GGI).

It has not been possible to include, in this report, any specific comparative data with other local authorities as the models of service delivery vary enormously from one area to another and reporting is not consistent across those different areas. Central Government no longer ask for statutory returns in relation to how people are supported with assistive technology. However, the Telecare Services Association (TSA), a national organisation who support AT services, recommend measuring the percentage of people in receipt of a community care package that includes AT and suggest that local authorities aim for 50%.

Regarding outcomes in terms of **Financial Savings** the team have, based on first quarter data of their mainstream work, delivered circa £204K worth of domiciliary care savings (full year effect).

In addition to this, they have also demonstrated specific savings in relation to the deployment of the *Just Checking Assessment Tool (JCAT).* JCAT is a system deployed to provide information about how a person is managing at home – for example, how often the person is moving around their home, how often they are boiling the kettle, how often they go to the bathroom etc. Such tools are commonly used to provide information to help inform what level of care package someone might need. There are no cameras or microphones, just simple motion sensors that create an easy to read activity chart detailing the person's movements, both day and night. Motion sensors are placed around the property and a controller with a multi-network SIM is plugged into the mains. The data gathered from 13 cases, where the JCAT was used, shows that the social care teams have been able to commission care packages consisting of fewer hours of care than was originally expected. The impact of JCAT on these 13 cases is summarised in the table below:

Care Avoided	**Saving (full year effect)**	**Clients**
Considering 24hr package	149,322	7
Increase in formal care package-day	8,265	3
Increase in formal care package-night	7,923	3
Total	**£165,510**	**13**

The service has been allocated £110K from this year's Transformation funding in order to enhance the assessment element of the service through more use of the JCAT. As well as the JCAT units, the Transformation Fund has also enabled the team to invest in an additional technologist and a technician on a two-year fixed term basis. The outcomes from this investment will be reported throughout 2017-18.

2.5 <u>Service Developments</u>

There are a number of areas of service development for the AT service. Some of these are already underway, whilst others are still in the planning stage and may present the service with a number of challenges, which are also explained:

- *Training Programmes*

  The service has recently reviewed and changed the training programmes that it offers. Previously, the service offered a half-day Awareness Raising session and then a more extensive Trusted Assessor training. The Trusted Assessor training proved to be too resource intensive and did not deliver the expertise in the work force that we had anticipated which led to those regarding themselves as "Trusted Assessors" making inadequate referrals for equipment and then the work would have to be reassessed. The new one-day course, which is run on a rolling monthly programme, is called *"Think ATT"*. It aims to train people from across health and social care organisations (including the voluntary sector) to be confident in considering ATT interventions as part of their practice so that they can identify appropriate solutions for people. By doing this, their referrals to the ATT Team are more prescriptive and accompanied by a "Trusted Assessment". This avoids the client having to have too many different interventions from different personnel. During the first quarter of 2017-18, 38% of all referrals to the team were completed to a standard whereby an AT solution could be deployed without any further assessment. The team are very pleased with this early success and expect this impact to grow in the coming months.

- *Transformation Funding – Phase Two – Enhanced Response Service*

  This service will be developed in order to provide a response service for people who do not have family, friends or neighbours able to be a contact for the call centres should an alert be raised. The lack of this results in unnecessary costs to public services:

  - Calls to the ambulance service for people who need attention but do not actually need an ambulance (the ambulance service considers such calls as low priority so there is often a delay in the person receiving help)

  - The deployment of very costly overnight support (sleep-in or waking night support) for people with learning disabilities

  - Decisions to recommend costly residential / nursing care for older people because they are considered to be too much risk overnight without quick response support being on-hand

  This enhanced response service will be delivered through the Reablement teams and will be rolled out across the county during 2017-18

- *Learning Disability Initiative*

  The Learning Disability Partnership (LDP) have recently terminated the use of an external consultant for their ATT assessments so that they can be undertaken by our own ATT Team. The savings target for this initiative is £214K for 2017-18 and the team anticipate being able to deliver on this. However, it is comparatively early days for this project and at the time of writing this report (August '17) the savings are estimated based on anticipated outcomes rather than cashed savings

- *Telecare Enabled Discharge*
  This is in the early stages of development but will aim to support people being discharged from hospital through the provision of a telecare discharge package. This will consist of a lifeline, keysafe and telecare devices alongside the Enhanced Response Service. This could also be supported by a *Just Checking Assessment Tool* for those people where there are concerns about their ability to manage at home alone or where more assessment of the full situation at home is required

- *Re-branding*
  The Manager and Commissioner of the ATT service have attended a number of conferences, seminars and exhibitions in recent months where it has become clear that the term 'Assistive Technology' is being phased out, in favour of Technology Enabled Care'. It should be acknowledged that the very long name of Cambridgeshire's team is not user friendly nor easily understood by local service users and carers. Commissioners and operational managers are therefore considering a re-branding during 2018, by possibly changing the name of the team to the Technology Enabled Care (TEC) Team. It is felt that this would be more catchy', meaningful and more easily understood by the general public and comments are welcomed on this

- *UK Telehealthcare Market Place Event*
  UK Telehealthcare are a national organisation who support health and care professionals and providers to deliver the widest possible choice of Technology Enabled Care services. We are actively working with them to deliver a Market Place event in March 2018, probably at The Burgess Hall in St Ives. This event will be widely publicised and will offer the opportunity for commissioners, service providers and others to network and exchange information on best practice, new products and national developments

- *Understanding the Evidence Base*
  As has already been mentioned, central government no longer requires statutory returns, or Key Performance Indicators (KPIs), as it did in the past. Reporting is now more outcomes focussed but defining specific outcomes measures can be problematic. Research evidence around the use of ATT has tended to be manufacturer or industry led and often the findings are over stated or out of date by the time the studies are published. Cambridgeshire's ATT service were involved in a comprehensive independent evaluation between September 2012 and March 2016 led by The Institute for Health Research, University of Bedfordshire. The study sample included all people referred to Cambridgeshire's ATT service, who were followed up for a year and methods used were both qualitative and quantitative. The key finding was that ATT reduced the number of face to face contacts with GPs by 20% but increased the number of telephone contacts with community health staff by 40% demonstrating a more cost effective whole-system service delivery. There was no significant impact on utilisation of acute hospital services. There were substantial benefits for both health and social care for people with telecare in the numbers of responses made by family members and nominated key holders. Overall, the qualitative feedback was very positive and has helped the ATT service to refine their processes to increase the

acceptance and compliance with using technology. The team are now one of the sites participating in the ATTILA national research project which is looking at whether assistive technology interventions can safely extend the time that people with dementia can continue to live independently in their own homes, and whether this is cost effective. The study is expected to publish a report during 2018

- *Community Lifeline Provision in Cambridgeshire*
  The number of different community alarm providers and control centres covering Cambridgeshire makes provision of technologies from the ATT Team extremely complex. The team currently have to work with six different community alarm providers on a regular basis, all of whom have different protocols and ranges of equipment and some of whom are more willing to engage with the team than others. Some of this complexity is due to the differing approaches taken by the different district councils and the team would welcome the opportunity to explore the possibility of there being a more joined up approach to this across the county. There is evidence that other two tier authorities have managed to achieve some success when presented with similar situations

- *Working with Peterborough City Council (PCC)*
  The AT service in Peterborough currently operates a different model to the Cambridgeshire service. PCC did not use its original Preventative Technology Grant allocation in the same way as Cambridgeshire did and the service has evolved differently and lacked year on year investment. Commissioners in PCC have recently commissioned a wide ranging review of AT services which is being undertaken by a consultant from the Telecare Services Association. At the time of writing this report, the review is still ongoing and is due to report end of September / early October. Cambridgeshire colleagues have been interviewed as part of the review and, without wishing to pre-empt the outcome of the review, it is expected that the two services will work much more closely together in the future so that the two service models are more aligned

- *The Integrated Community Equipment Service (ICES)*
  The ATT service requisitions their equipment from NRS Healthcare who are the ICES contracted provider. The complexity of Cambridgeshire's ATT service, mostly as the result of the community alarm issue summarised above, means that it has taken over a year for NRS to fully appreciate the needs of the service and has led to some performance issues which have had to be closely monitored and managed by commissioners. At the time of writing this report (August '17) performance has begun to improve but will continue to be closely monitored. ICES is jointly commissioned by CCC and PCC but with separate Section 75 Agreements and pooled budgets with the CCG. It has recently been agreed that this situation should be reviewed with a view to having a Lead Commissioner operating on behalf of both local authorities with one Section 75 Agreement and pooled budget. A review and options appraisal will be undertaken in the next few months

- *Technological advances*
  The provision of any technology based solution has to be mindful of the impact of the development of advancing technologies in an era where the latest gadget can soon become obsolete and overtaken by ever more advanced equipment. This is a particular issue for AT equipment where services have to be careful with stock control and avoid ending up with shelves full of yesterday's 'kit'. We feel this is well managed in Cambridgeshire but cannot afford to be complacent and must continue to strive to provide services that offer the best value for money as well as being the best way of meeting people's needs.

3. THE DOUBLE-UP TEAM

3.1 Background

The Double-Up Team are responsible for undertaking reviews and assessments of people who are in receipt of, or likely to need, care packages that consist of two carers because of the person's moving and handling needs, which often involve the use of hoists. The service users who they work with include some of the most dependent people in our community who have a range of long term disabilities and complex needs. The service users are very often full time wheelchair users or have extremely limited mobility and need assistance with all aspects of their personal care including transfers – ie hoisting from bed to chair, chair to toilet etc. The support they receive from formal and informal carers enables them to remain living as independently as possible in the home of their choice. The team's reviews are undertaken to see whether it is possible to reduce care packages so that people only need the support of one carer for some, or all, of their calls.

It is acknowledged that the name 'Double-Up Team' may seem a misnomer when it is single handed care that is being promoted. However, the term 'double-up' is widely used across the social care system in Cambridgeshire when referring to domiciliary care packages that involve the attendance of two carers. Local stakeholders immediately understood this term and so the name has stuck!

3.2 Commissioning

The Double-Up Team was set up nearly four years ago as a 'spend to save' initiative. This was based on evidence from other local authorities, primarily Suffolk County Council who had demonstrated positive outcomes through the deployment of Occupational Therapists (OTs) to undertake detailed reviews of service users resulting in the promotion of single-handed care through the provision of better moving and handling equipment and expert advice regarding moving and handling techniques. In Cambridgeshire, a business case was agreed in September 2013 and two members of the team started work that December. It was decided to set up the service in-house, rather than commissioning from elsewhere, so that there was full control over the project and so that social care outcomes could be closely and accurately monitored and easily reported.

The team now consists of a Lead OT Practitioner, two senior OTs and two OT Technicians. The baseline staffing budget for the team is £160K. The equipment that may be prescribed following review is funded through the Integrated Community Equipment Service pooled budget and expenditure is tracked on a monthly basis. The average monthly spend on equipment by the Double-Up Team is £6K.

The service has recently received additional investment of £90K from the Transformation Fund which is being used to focus on assessments of service users with learning disability who also have complex moving and handling needs, and to enhance the service's offer within the care home sector (see section 3.4).

3.3 Referrals, Assessment and Service Provision

The team receive their referrals from a variety of different sources but mainly from the care managers and social workers in the social care locality teams, across adults and children's services. They also work closely with colleagues in the acute trusts and the discharge planning teams so that "four times a day double-up" is not the default package for patients with complex needs being discharged from hospital. Similarly, they also work closely with the Reablement Teams so that the people who may need double-up care, when they first go home from hospital, can be reviewed at the earliest opportunity with a view to progressing to a single-handed care package if possible. It is also important for them to work closely with their OT colleagues in the Cambridgeshire & Peterborough NHS Foundation Trust (CPFT) so that there is shared learning for all.

The OTs ensure that they undertake the assessment of service users when the domiciliary care staff are present so that they can observe the moving and handling techniques and assess exactly what personal care tasks require two people. As double-up calls are often early in the morning or late in the evening, that team work flexibly to be able to carry out these visits at the most appropriate time. They involve the service user and their family carer as much as possible to ensure that they understand the purpose of this assessment and the case studies at appendix A demonstrate just some of the positive outcomes from this work and some of the comments that have been received from service users and their carers.

Following the assessment, the OTs may feel that the double-up care package is appropriate in order to manage the risks associated with moving and handling. Alternatively, they may continue to visit the service user a number of times and try out various different items of equipment in order to facilitate single-handed care. The equipment is requisitioned from the Integrated Community Equipment Service in the same way as it is for the Assistive Technology. The advances in technology in this sector are not as fast moving as those mentioned in relation to telecare equipment, however it is important for commissioners and therapists to keep up to date. This is achieved through attendance at conferences and exhibitions and by inviting manufacturers and suppliers to organise local demonstrations of equipment. Appendix A illustrates some of the items that are now routinely issued to service users with complex moving and handling needs in the community.

Once new equipment is in place, the OT Technicians undertake follow-up visits to ensure the new equipment is working well for all concerned. Once all parties are happy with the new equipment the team close their involvement in the case. Case records are entered on AIS and also on CPFT's *SystmOne* recording system so that CPFT therapists are aware of the Double-Up Team's involvement.

Once the OTs in the Double-Up Team have completed their review and provided what equipment might be required, they liaise with the locality social care teams to recommend what changes can be made to the care package. Savings, in terms of reduced domiciliary care costs, are not recorded until the team have confirmation from

the social care team that the revised care package is in place. This has been an essential element of the project so that savings are actual, and not assumed.

Working with the Domiciliary Care Providers
This was one of the major challenges for the Double-Up project due to some outdated moving and handling approaches taken by providers. At the beginning of the project, most of the providers challenged the idea of single handed care citing policies that stated two carers should always be present when a client is being hoisted. Fortunately, the early days of the Double-Up project coincided with the publication of a research paper, *"IT TAKES TWO? Exploring the Manual Handling Myth"* (HFH Consulting, Experts in Care, 2014). This paper helped to dispel the myths around always needing two carers to hoist someone and promoted the fundamental importance of detailed risk assessment being at the heart of every assessment, rather than having blanket approaches. The team have managed to build positive working relationships and the providers are now much more aware of the extensive range of moving and handling equipment on the market and the Double-Up Team ensure that the providers' moving and handling training programmes include training on the newer items of equipment that their care staff are likely to experience using in the community.
The team have also built a strong link with *Prism Medical*, one of the national suppliers of moving and handling equipment, and coordinate regular joint demonstration sessions at the NRS equipment depot in Huntingdon where care staff have a chance to practice using different pieces of equipment they will see, and need to use, in the community. These sessions are well attended and feedback has been very positive.

Prevention Cases and Avoided Costs
As well as undertaking reviews of people with existing double-up packages of care, the team also accept referrals where double-up care may be prevented. These referrals often originate from the domiciliary care providers themselves when they are beginning to struggle with the moving and handling needs of service users. In the past, it is likely that these cases would have been increased to double-up care with little, if any, OT re-assessment. This prevention work now constitutes over 50% of the work of the team and savings are calculated in terms of avoided costs.

3.4 <u>Outcomes</u>

The outcomes of the Double-Up Team's work are not just measured in financial terms but in the impact that the changed care package has on people's lives and their well-being. This is clearly demonstrated in the case studies at Appendix A. The following points summarise the key outcomes from the team's work so far:

- ✓ Improved quality of life, dignity and well-being for service users and their family carers
- ✓ Promotion of as much independence, choice and control as possible for people, who, otherwise, have very complex needs and are dependent on others for most of their support
- ✓ 45% of service users report to be able to do more for themselves following the team's intervention and provision of alternative equipment
- ✓ 46% of service users report that their pain or discomfort has been reduced as the

result of using alternative equipment

- ✓ Only 30% of reduced or prevented care packages involve the issuing of additional and/or alternative items of equipment. The remaining packages can be reduced or prevented purely through close working with the domiciliary carers, provision of good information and advice and demonstration of moving and handling equipment that is already in situ

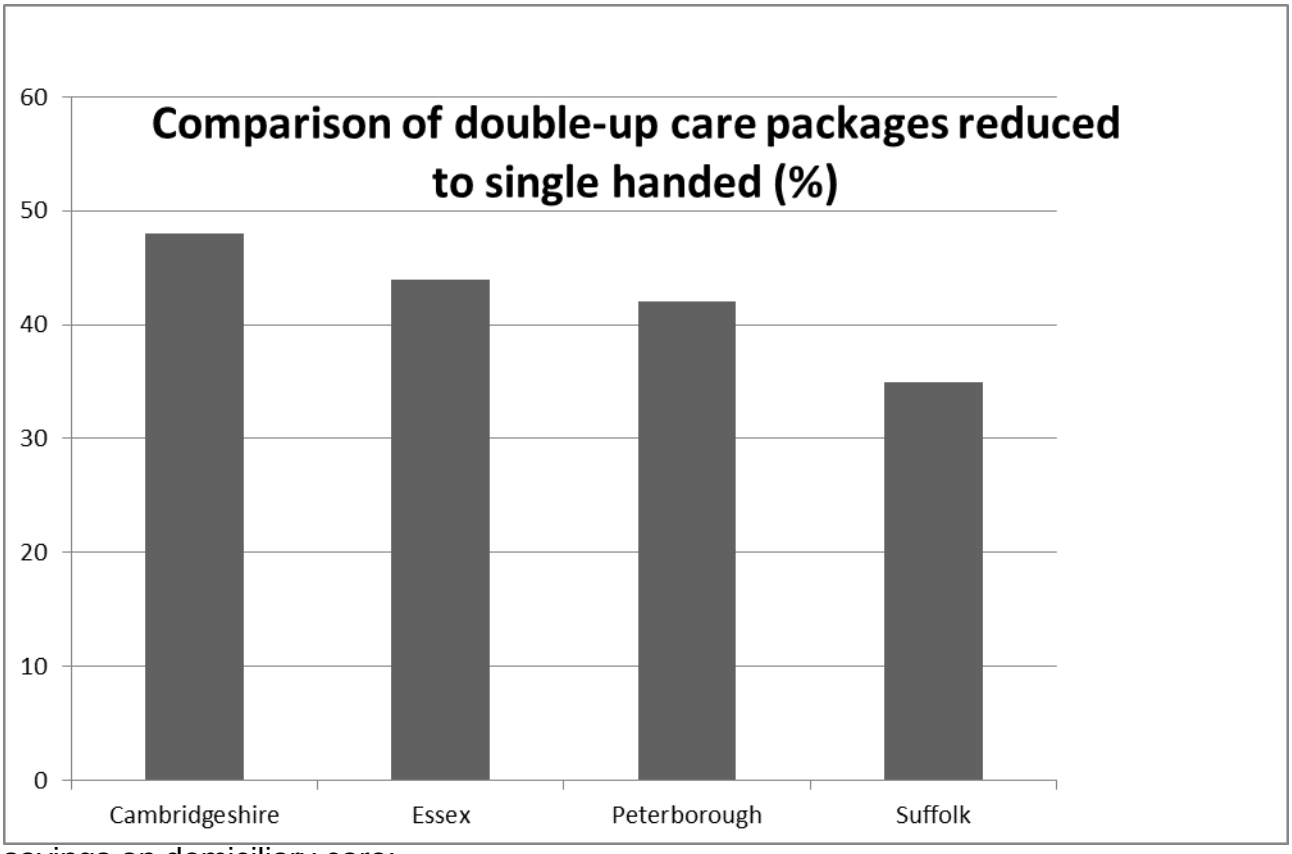
- ✓ Particular success in situations where people have a 24hour live-in carer and were previously having to have a second carer for some personal care calls. Most of these no longer need the second carer

- ✓ At the beginning of the project in 2014, there were 388 service users who were in receipt of a double-up package of care. There are now around 300 (the Double-Up Team cannot take credit for all of this reduction as it is also due to the impact of the Transforming Lives agenda and the changes in approach by the social care teams)

- ✓ On average, each review requires three visits before a decision is made as to whether a care package can be reduced. It should not be assumed that one review equals one OT visit

- ✓ The team have produced a full report on their work entitled *"Why wouldn't we do this?"* which has received interest from many other local authorities, and the Manager of the team has spoken at a number of national conferences and seminars which have been well received

Following the early successes achieved by the team, learning was shared with OT colleagues in PCC who now have their own single-handed care project which has begun to deliver a similar level of savings and other outcomes. The team continue to work closely with Peterborough colleagues to continue that shared learning.
In terms of the percentage of care packages reduced from double-up to single-handed, the graph below demonstrates Cambridgeshire's outcomes when compared to some other local authorities:



savings on domiciliary care:

Year	Number of reviews undertaken	Domiciliary Care Savings, including avoided costs	Equipment Spend
2014/15	101	£671K (full year effect)	£16K
2015/16	185	£1.1m (full year effect)	£70K
2016/17	243	£1.3m (full year effect)	£73K
2017/18 (up to 31/8/17)	135(to date)	£594K (full year effect to date)	£37K (to date)

For 2017-18 the team has received additional investment of £90K from the **Transformation Fund** to deliver savings in two specific areas:

- *Learning Disability.* Reviews are undertaken of service users who have both learning and physical disability with high levels of need, often involving complex moving and handling. Many of the service users live in Supported Living Environments where there may be tenants with a variety of different needs. This presents a unique challenge in determining what levels of care each tenant requires and how to record savings in care costs within a supported living scheme. However, the work has begun to demonstrate savings (see below). It should be acknowledged that service users supported by the LDP may have

double-up care packages for other reasons – e.g. challenging behaviour, which the Double-Up Team cannot assist with

- *Care Home Initiative.* Since the beginning of the Double-up Project, the team have occasionally undertaken reviews of people who have been placed in care homes for respite care (see case study 'Ron' at Appendix A). This has exposed the team to the moving and handling techniques and equipment used in the care home setting and, unfortunately, they have observed some poor practice in a number of establishments. The Care Home Initiative is intended to facilitate a proactive approach within care homes towards improvements in moving and handling and to work closely with the CCG's Care Home Support Team who are leading on a number of quality improvements. The Double-Up Team are also linking in with the Complex Cases Panel to pick up referrals where service users might be able to be maintained and supported at home rather than having to move into a residential home and also in cases where people might be able to stay in a residential home rather than having to move into a nursing home. A person's moving and handling needs are often the reason for these moves. The team have begun to make an impact in this work but it is slow and savings will not be achieved in the same way as they are in domiciliary care.

The savings relating to Transformation Fund investment (LD & Care Home reviews) are currently standing at £59K against a 2017-18 target of £250K. It is likely that this target will not be achieved by the end of the year but the team will continue to bring savings in the mainstream domiciliary care sector as demonstrated in the previous table. Some of the achievements within the Care Home project are expected to be more qualitative and preventative rather than delivering hard financial savings – for example, by implementing better moving and handling practice it is likely there will be benefits in terms of falls prevention, prevention of pressure ulcers, prevention of admission to hospital and reduced injuries to care home staff through the use of correct moving and handling techniques. Evidence of these benefits is more difficult to capture and quantify but processes are being developed for this.

3.5 <u>Service Developments</u>

There are a number of other areas of work that the Double-Up Team will be working on in the coming months. These include:

- *Reviews of Children in receipt of Double-Up Care*
  The team have had some early success with a few children and young people in receipt of double-up care. The volume of cases is very small compared to the number of adults' cases and the savings in relation to this work have yet to be confirmed. However, the team's expertise has been welcomed by colleagues in children's services and there has been shared learning for all

- *Working with the Neighbourhood Cares Project*
  The leads for both the Double-Up Team and the Neighbourhood Cares project have had some early exploratory discussions regarding how the team might be able to offer double-up care reviews to people in the pilot sites. It should be acknowledged that whilst the County Council are aware of the number of service users in receipt of double-up care commissioned by our social care teams, there are many people living in the community who fund their own care packages and

may well benefit from similar interventions. By getting involved with these people at an early stage, it is likely that this could delay people's need for statutorily funded care. There will also be people in the pilot sites who would benefit from information and advice on the use and benefits of assistive technology telecare devices, and discussions have also begun around how best to deliver this

- *NHS Continuing Health Care (CHC)*
  The CCG have recently commissioned the Double-Up Team to undertake reviews of their patients who are in receipt of double-up care packages in order to deliver some savings in terms of NHS CHC costs. This has been agreed via a formal Section 256 Agreement and the CCG are funding a 0.5fte OT post to cover this work. This initiative commenced on 1/8/2017 so it is early days to provide any report on outcomes or savings. It should be noted that the CCG are invoiced for any special (non-stock) equipment that is requisitioned for CHC patients and this is funded in addition to the part-time OT post.

4. SUMMARY

4.1 Both the ATT Team and the Double-Up Team are delivering solutions for people that mean they remain as independent as possible and are able to exercise choice and control over their lives. The teams are supported to take positive and acknowledged risks for their service users in order to provide less intrusive and less expensive forms of care. Technology enabled care services can make a significant contribution to delivering great outcomes for people, as well as cost savings. It is vital to involve all stakeholders in the development of these services and it is hoped that this report has demonstrated how this is being achieved in Cambridgeshire. These stakeholders are essential partners in co-creating services that realise the potential of technology and deliver the dignity and control that people want.

5. ALIGNMENT WITH CORPORATE PRIORITIES

5.1 Developing the local economy for the benefit of all

There are no significant implications for this priority.

5.2 Helping people live healthy and independent lives

The whole paper aligns with this strategic priority and is evidenced in the case studies at Appendix A

5.3 Supporting and protecting vulnerable people

The whole paper aligns with this strategic priority

6. SIGNIFICANT IMPLICATIONS

6.1 Resource Implications

There are resource implications referred to throughout the paper with clear statement of outcomes in terms of financial benefits for both Assistive Technology Telehealthcare

and single-handed care. Both services are delivering evidence based practice and value for money

6.2 **Procurement/Contractual/Council Contract Procedure Rules Implications**

There are no significant implications in relation to this.

6.3 **Statutory, Legal and Risk Implications**

All the work undertaken by both services has to meet the statutory obligations in The Care Act 2014 and other relevant legislation.

6.4 **Equality and Diversity Implications**

Both services are available across all communities, all service user groups and all age groups.

6.5 **Engagement and Communications Implications**

Individual changes to care packages are discussed at length with service users, family carers and formal carers.

6.6 **Localism and Local Member Involvement**

Members have always been supportive of the use of assistive technologies in the delivery of care and will need to be aware of the fast moving and changing nature of these types of provision which will impact on individuals.

6.7 **Public Health Implications**

There are no significant implications within the category

Implications	Officer Clearance
Have the resource implications been cleared by Finance?	Yes - Tom Kelly, Head of Finance
Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by Finance?	n/a
Has the impact on statutory, legal and risk implications been cleared by LGSS Law?	n/a
Have the equality and diversity implications been cleared by your Service Contact?	n/a
Have any engagement and communication implications been cleared by Communications?	n/a – no new implications. These were handled by the consultation on the new policy framework and Transforming Lives model
Have any localism and Local Member involvement issues been cleared by your Service Contact?	n/a
Have any Public Health implications been cleared by Public Health	n/a

Source Documents	Location
• *Technology Services Association (TSA) Quality Standards Framework* (TSA, 2017) • *IT TAKES TWO? Exploring the Manual Handling Myth* (hfh Consulting, Experts in Care, 2014)	Room 015, Shire Hall, Cambridge

Appendix A

Case Studies, Equipment and Feedback from Service Users

(names have been changed in all case studies)

Case study – Peter

Peter was a 72 year old gentleman with multiple sclerosis who lived with his wife in their own bungalow. Peter had been in receipt of a double-up care package for ten years. He was a full-time wheelchair user but on "good days" was able to take some weight during transfers with a rota-stand, but on bad days he would stay in bed as he didn't like to be hoisted – Peter was a large gentleman and felt that manoeuvring him in a mobile hoist put too much strain on the carers, and he found the hoist uncomfortable.

Following the Double-Up OT assessment, his rota-stand was replaced with a Molift Raiser and he accepted a gantry hoist and Glove sling. His transfers can now be managed by one carer and he can get out of bed even on a bad day which means he no longer gets so depressed, and it relieves the pressure on his wife.

Peter said "…it has changed my life…and the carer talks to me now…rather than to the other carer!"

Number of annual care hours saved: 728

Financial savings on annual domiciliary care costs: £10,900

Equipment spend: £2,000

Assisting someone to stand with a Molift Raiser

Profiling bed and gantry

Case Study - Penny

Penny was 44 and lived in her own bungalow with a live-in carer. Penny had a long term neurological condition and needed assistance with all aspects of her personal care and domestic tasks. She, and her carer, enjoyed going out to the theatre and visits to local pubs but were restricted in how long they could be out as Penny needed two carers to transfer her. They often had to return home at specific times in order to meet a second carer to assist the live-in carer with Penny's transfers and personal care.

As a result of the Double-Up OT review, Penny was issued with a 4-way glide Bed Management System, a wedge and an Airflow Glove 'in situ' sling. The provision of these items meant that the live-in carer could safely turn Penny in bed by herself, without causing any drag or sheer, which meant that her risk of developing pressure sores was reduced. It also enabled the carer to fit the sling single-handedly.

The live-in carer now manages all Penny's care and Penny can choose when she wants to be transferred and has more flexibility in being able to get out and about.

Penny said "This has transformed my life in so many ways…it has given me my life back…"

Number of annual care hours saved: 1095

Financial savings on annual domiciliary care costs: £16,400

Equipment spend: £542

Case Study – Ron

Ron, a 77 year old gentleman who lived with his daughter, had to go into respite care when his daughter was unwell. The period of respite was initially for two weeks, but was extended to two months as his daughter remained unwell. Prior to his respite placement in a residential home, Ron had been independently mobile in a self-propelling wheelchair, and his daughter assisted him with transfers, using an Oxford Journey Stand Aid with standard sling.

The residential home insisted on hoisting Ron, with two carers. He therefore lost what little function he had in managing to transfer with the assistance of one person. Consequently, when his daughter was ready to have him home, the care home recommended that he needed "two to hoist" for all transfers.

This delayed his discharge from respite care much to Ron, and his daughter's, frustration.

The OT reviewed Ron while he was in the care home and recommended a transport sling for use with the stand-aid. Ron eventually returned home and his daughter continued to be able to transfer him albeit with a transport sling, rather than the standard sling they had previously used.

Had the appropriate equipment and techniques been used in the care home, Ron would have maintained what little independence he had and his discharge from respite would not have been delayed and would have avoided the additional costs incurred.

Transfers using a standing hoist…and….Four-way-glide bed management system

"The new hoist has changed my life, I now have the controls so that I can be in control…single care has enabled me to change agencies and get more suitable times…everything now is great!"

"…(the OT) was able to do what the hospital didn't offer, to go out, actually listen and take an interest, and see mum as a person and give her the chance to recover at home"

"…I sleep better at night knowing (husband) is safe and comfortable"

'We started with the key finders and that was like a god send it was a blessing, all these things have been really helpful. You don't see the frustration in her…she used to get quite tearful sometimes with things because I think she was beginning to realize that you know things weren't quite right really so yeah no definitely really useful'
(Cathy, daughter, 'informal carer', Telecare standalone)

'I don't think any of us appreciated mum's illness really. I suppose it is one of the illnesses we thought would never happen and all of a sudden it all seems to move forward quite quickly and its acceptance that your mother needs help'
(Sarah, daughter, Telecare standalone, informal carer)

'Knowing that she's got the bed detector and the fall detector, it's a lot more off my mind if you now what I mean, because with the fall detector you know, I know if she falls they'll phone up and then they'll phone me and then they'll get an ambulance you know, they always tell me if she's fallen. Its helped me a hell of a lot because its more peace of mind isn't it, hell of a peace of mind, I know that she's safe to a certain extent.
(Pamela, daughter, 'informal carer', telecare standalone)

'Have you ever got up at 2 or 3 o'clock in the morning cleaning up pee and poo off the floor! As soon as I hear that alarm go off I am out of bed quick so I can save myself a lot of work, it just helps, and I need a lot of help'
(Aubrey, Husband)

'I mean if you're in the garden for example and you have to keep coming in every ten minutes, are you ok, are you ok, and that (the equipment) has changed it because that way I can maybe stay out 20 minutes and in that time or maybe a bit more and in that time if he needs me he just pushes the button'
(Madeline, Wife)