Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	**Assistive Technology – ASC and CCG partnership**
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The subject matter of this report deals with the following priorities of the Health and Wellbeing Strategy

- ☒ Priority 1: Early help for vulnerable people
- ☒ Priority 2: Improved identification and support for people with dementia
- ☐ Priority 3: Earlier detection of cancer
- ☐ Priority 4: Tackling obesity
- ☒ Priority 5: Better integrated care for the 'frail elderly' population
- ☐ Priority 6: Better integrated care for vulnerable children
- ☒ Priority 7: Reducing avoidable hospital admissions
- ☒ Priority 8: Improve the quality of services to ensure that patient experience and long-term health outcomes are the best they can be

SUMMARY

Over the past 2 years there has been a significant increase in the use of assistive technologies (AT) by adult social care (ASC) clients in Havering. At the core of every package of AT is a basic telecare alarm and pendant which links the individual to a monitoring service. It is the increased use of this basic package that is delivering the benefits outlined within this report. The benefits indicated so far are significant and are cross sector and have prompted the development of a joint initiative between Health and ASC to extend its use and which the joint team felt should be raised with the HWB board.

RECOMMENDATIONS

The Health and Wellbeing Board is recommended to:

i. Note the benefits of AT
ii. Note that Havering Adult Social Care and Havering CCG are working together in partnership to increase the use of AT and maximise benefits realisation.

REPORT DETAIL

The use of AT

Since 2011 significant work has been undertaken that has resulted in greater use of AT by adult social care clients, underpinned by improved operational efficiency in assessing, referring, providing, installing and monitoring equipment.

The provision of FACS eligible AT now stands at nearly 1,500 individuals, predominantly pendants, with a further 2,500 or more FACS eligible clients under consideration to have AT as part of their care package.

Current funding

AT is currently funded through S256 funding and this will be continued throughout 2013/14 and is committed for part of 2014/15. There is a commitment within the AT board, however, to consider future mainstreamed joint commissioning between health and ASC based on a strong understanding of the benefits provided by AT.

Benefits Analysis

To identify the benefits delivered by AT, two cohorts have been monitored over an extended period of time to provide robust, longitudinal analysis of a number of key measures. This monitoring will continue on a quarterly basis to further improve the robustness of the analysis reported. The cohorts are:

- Cohort A - ASC clients who receive AT and homecare (70 at outset)
- Cohort B - ASC clients who only receive homecare (407 at outset)

The cohorts are not selective other than in respect of either being in receipt of homecare or homecare and AT services. The outcome of this is that the two cohorts are not equal in size but the level of needs should be broadly similar.

The three key benefits measures are:

- Benefits Measure 1: General impact on hospital admissions as indicated in ASC systems[1]
- Benefits Measure 2: Reductions in admissions due to falls from health data[2]
- Benefits Measure 3: Impact on admission to residential/nursing care from ASC data

These benefits measures extend beyond the organisational boundaries of the Council and show that the use of AT is having a positive impact across the measured benefit areas:

[1] Benefits measure 1 uses data from the ASC AIS system where a "section 2" notice is issue by Health to ASC indicating that an ASC client has been admitted to hospital.

[2] Data has been supplied from Health systems by CCG analysts from the BHR CSU team on the number of Havering residents aged over 65 who over a specified period have been admitted to hospital and the reason for admission has been recorded as a fall.

- **Benefits measure 1 - General impact on hospital admissions (ASC data)**

Cohort A, (AT and homecare) is less likely to be admitted to hospital than cohort B (homecare only) after a period of 18 months by a margin of 25.02% (see figure 1 appendix 1). This indicates that the application of AT will have a beneficial impact on reducing hospital admissions. To validate this there should be an actual impact on hospital admissions. Benefits measure 2 (below) uses health data to quantify this impact.

- **Benefits measure 2 - Reductions in admissions due to falls (Health data)**

Having used ASC data to evidence the apparent decline in hospital admissions health data relating to admissions due to falls has been analysed. This indicates that there is a correlation between the increased number of pendants in the community and a reduction in hospital admissions due to falls of 44% in 2013 compared to 2011 – which would convert to an estimated annual saving of £2.24M[3] – or if attributing 50% of this to AT then £ 1.12M (see figure 2 in appendix 1).

- **Benefits measure 3 - Impact on admission to residential/nursing care**

Cohort A (AT and homecare) are less likely to be admitted into residential or nursing care by a margin of 5.9% than cohort B (homecare only) see figure 3 in appendix 1.

Cohort A also demonstrates that of those who are admitted there is significant delay in the elapsed time from when they start to receive services until admitted of at least 3 months but this is likely to be significantly longer.

A delay of 3 months in the start of a typical residential care package costing £25,000 indicates a gross benefit of £6,250. However, the average cost of domiciliary care prior to admittance to residential care is £12,500 or £3,125 per quarter. The net saving is therefore £3,125 per person (£6,250 less £3,125). If these numbers are factored up, with approximate numbers entering residential care of 300 per year, the projected minimum annual saving would be £937,500.

This analysis is based on the best possible information but recognises that greater numbers in cohorts would provide greater assurance of impact. It is therefore within on-going plans to keep monitoring benefits and expand numbers where possible.

Quality of life

In January 2013 a survey was conducted for recipients of AT and their carers.

- 194 surveys were sent to AT service users with a response rate of 35.57% (69 service users)
- 80 surveys were sent to carers of AT service users with a response rate of 36.25% (29 carers)

The survey asked a series of questions focussed on general feelings of wellbeing and safety, levels of help and support and incidents of admission to hospital (see appendix 2).

[3] Abayomi-Lee, F. (2012). Havering Falls Prevention and Bone Health Strategy Implementation Report. Havering: Public Health.

Generally the responses were extremely positive from both carers and users. Observations include:

- In regard to questions around feelings of well-being, 80% - 90% of users and carers agreed that people generally 'feel better' with the AT in place
- Between 50% and 60% of respondents agreed that AT prevents escalation to hospital or residential care
- There is a general similarity of response between users and carers

In light of the more tangible benefits outlined in this report, the survey has been included to indicate the sense of well-being imparted by the AT and the support service behind it. It provides some explanation, by explicit answers and by the implied 'feel good', why some of the benefits identified are being delivered.

IMPLICATIONS AND RISKS

There are no implications or risks arising from the Board noting this report at this time.

BACKGROUND PAPERS

None.

Appendix 1 - AT Benefits Measures.

Benefits measure 1 - General impact on hospital admissions (ASC data)

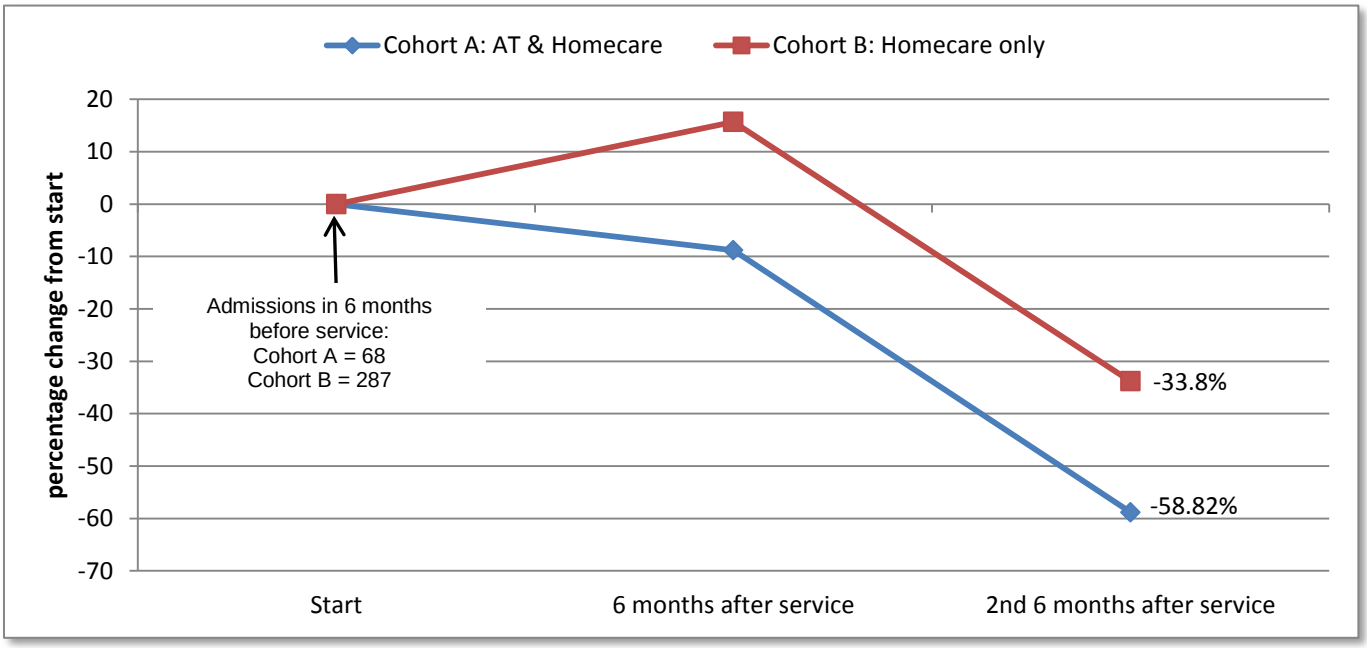

Figure 1: Percentage of cohorts admitted to hospital

Benefits Measure 2: Reductions in admissions due to falls

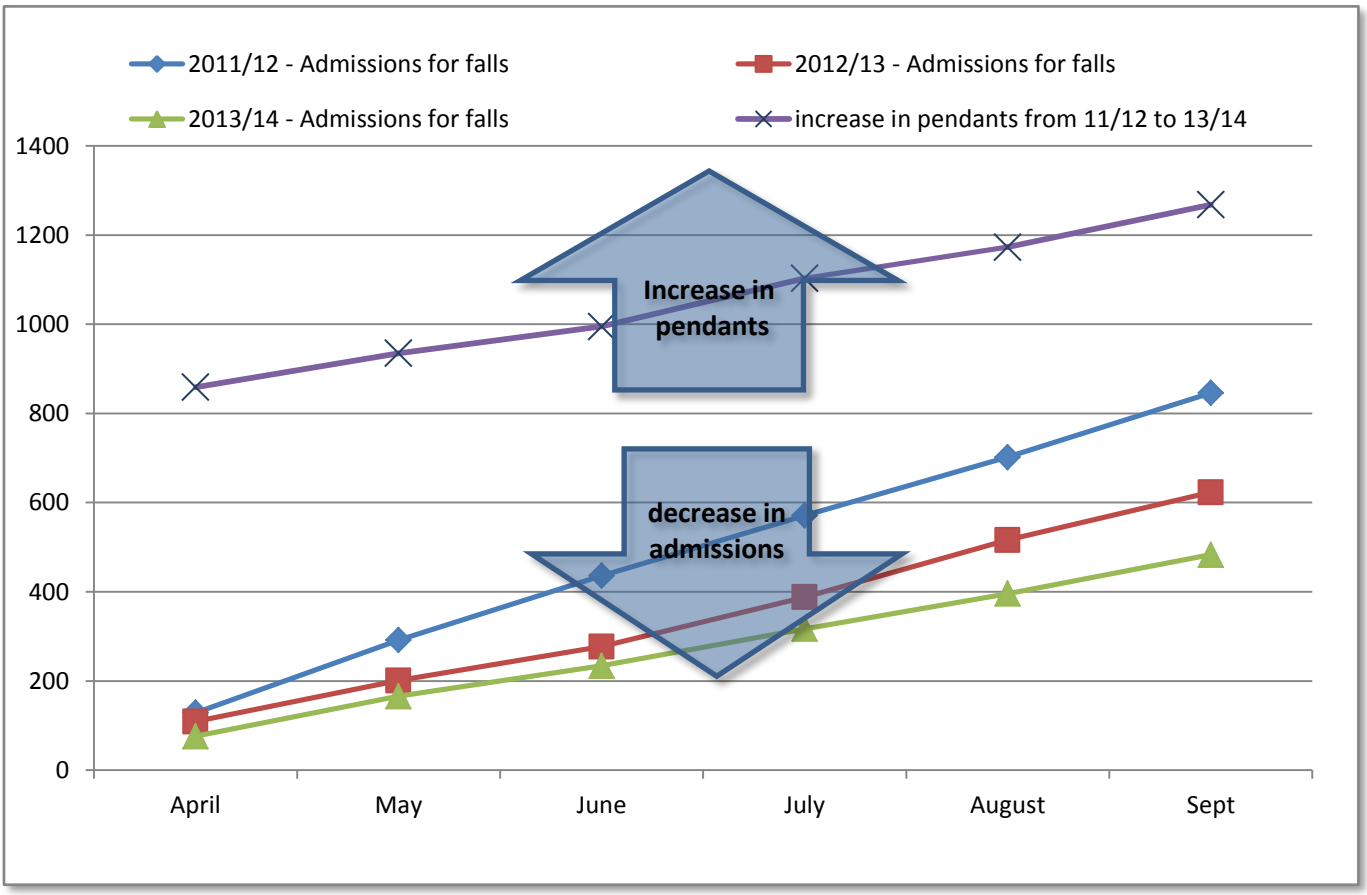

Figure 2: Correlation between hospital admissions due to falls and increased number of pendants in the community

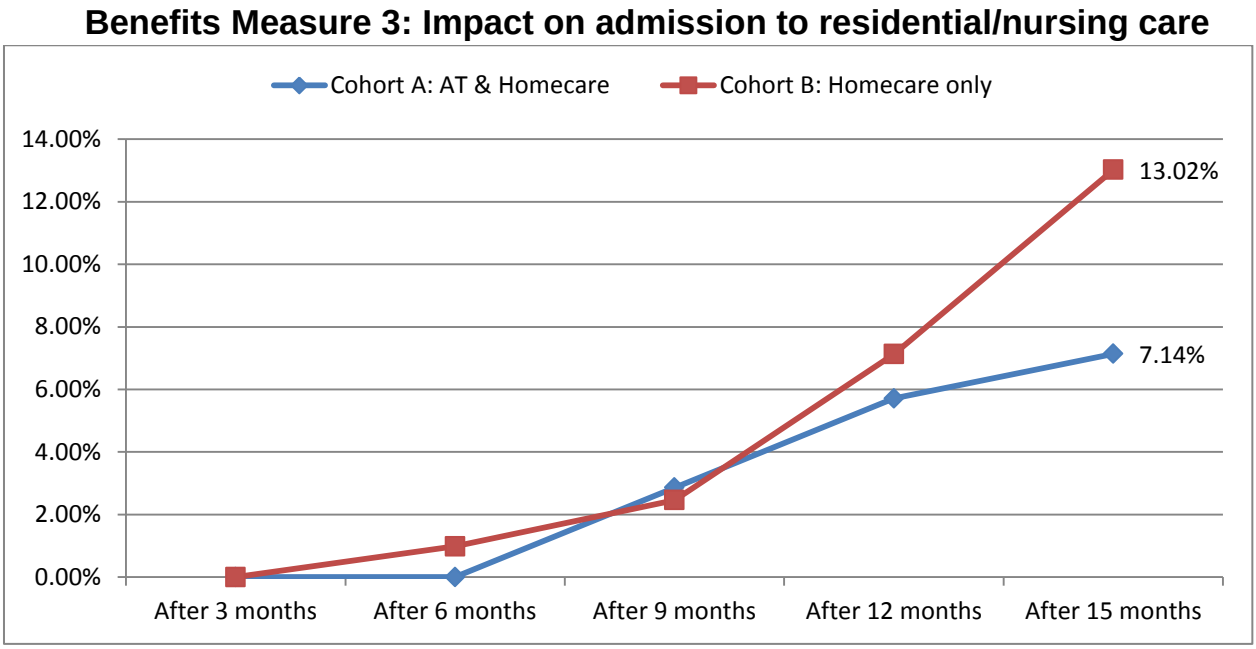

Figure 3: Impact of AT on admission to residential/nursing care

Appendix 2 – AT Users & Carers Survey

Key: Service user response / Carer response		Strongly agreed or agreed		Strongly disagreed or disagreed	
No.	**Question**	**Service Users**	**Carers**	**Service Users**	**Carers**
1.	I am more secure knowing that someone would respond in an emergency	97%		1.59%	
	The person feels more secure because they know that someone will respond in an emergency		96%		
2.	I feel safer in my own home	95%		1.56%	
	The person being cared for feels safer in their own home		93%		
3.	I am being helped to remain independent in my own home	89%			
	The person being cared for is being helped to remain independent in their own home		93%		
4.	I feel more confident being on my own	84%		3.17%	
	The person being cared for is more confident to be on their own		82%		3.57%
5.	It has prevented me having to go to hospital (or reduced the risk of it happening)	65 %		3.17%	
	The person being cared for has been prevented from having to go to hospital (or the risk of it happening has been reduced)		62%		3.45%
6.	The amount of help I need from others has reduced	61%		14.06%	
	The person being cared for needs less help from others		52%		10.35%
7.	HTC's response prevented me from calling emergency services	52%		10.81%	
	HTC's response prevented the calling of emergency services (Ambulance, Police or Fire Brigade)		55%		10.00%
8.	I am more able to manage my medication on my own	52%		9.68%	
	I feel that the person I care for is more able to manage their medication on their own		42%		16.67%
9.	HTC's response prevented a stay in hospital	45%		4.55%	
	Havering Telecare Centre's response prevented a stay in hospital		40%		5.00%
	Only asked of carers:				
10.	I feel that the person I care for is less likely to need to move to a residential home		59%		7.4%

To be noted:

- The percentages not adding up to 100 are accounted for by responses of 'neither agree nor disagree' or 'don't know'.
- Analysis of response between those with pendants only or enhanced AT showed no significant difference.