WARRINGTON INTEGRATED ASSISTIVE TECHNOLOGY STRATEGY

FOR ADULT HEALTH & SOCIAL CARE

Final
January 2011

Produced & written by Choose Independence on behalf of Warrington Borough Council & NHS Warrington

Warrington Integrated Assistive Technology Strategy – Executive Summary

The following is a summary of recommendations for ensuring that AT/Telecare is fully integrated across Warrington and that the benefits that AT/ Telecare brings is fully realised.

As requested by the AT Project Board this executive summary gives timeframes for implementation and priorities in what issues should be tackled first,

Priority 1 – immediate – within the next 3 months
Priority 2 – within the next 3- 12 months
Priority 3 – 12 months onwards

Telecare Infrastructure

The AT/Telecare infrastructure within Warrington needs to be strengthened in order to achieve the wider AT and Telecare vision that the Council and its partners have.

Carecall
Carecall is already implementing best practice in areas of Telecare and has good integration and links with mainstreamed services.

Examples of this good practice are:

- the links Carecall has with Care First
- the use of the tailored AT / Telecare assessment tool
- 1 whole time equivalent staff member, of which approx 20% of her time dedicated to supporting the implementation and awareness raising of Telecare within the Council and externally.

However dispersed Telecare (*AT/Telecare in individual's homes*) still needs to be fully mainstreamed and implemented across all the councils' and its partners' services.

To underpin the further development of a mainstream AT and Telecare service the Councils' monitoring centre Carecall should put some further building blocks in place, namely:

Priority 1 – immediate
Monitoring Centre Software upgrade – Provide a range of Telecare services including Proactive calling from the monitoring centre.

The monitoring centre software should be replaced as an urgent priority to ensure Carecall:

- can offer a wider range of connected Telecare products and services, the software should:
    - be interoperable with a range of Telecare (and 'Telehealth ready' products not just the Telecare market leader.
    - support ***automated*** pro-active calling i.e for medication promoting which uses technology alone
    - be able to produce a range of reports including ones to Care Managers as part of their reviews on named individuals and against specific KPI's

Centre of Excellence
Carecall already is the centre of excellence within Warrington with regard to AT/Telecare, so any queries about Telecare or AT equipment should be directed to Carecall. (A specific phone number/e-mail address could be advertised).

Any queries about what equipment may help in specific circumstances should be directed and answered by Carecall who should continually keep themselves up to date of what AT and Telecare products are on the market and could keep a small range of sample products. This should be led by the Carecall AT Officer currently in place. This should also feed into the procurement of a wider range of equipment as explored below.

Priority 2 – within the next 3-12 months
TSA accreditation - In order to demonstrate that Carecall delivers a guaranteed quality service to its service users it is recommended that Carecall gains the recognised Telecare industry quality standard.

Whilst there is cost attached to this accreditation it should be seen as investment which in turn could ensure securing additional revenue as Carecall would be able to tender for additional monitoring work once this accreditation has been achieved.

Priority 3 – 12 months onwards
Expansion of service - TSA's[1] view is that a monitoring centre of less than 10,000 connections is unviable. In order to secure the ongoing future of Carecall, once TSA accreditation has been secured the centre should explore additional revenue opportunities such as tendering for contracts in the local

[1] Telecare Services Association

area. It is recognised that the monitoring centre market is in major flux at present with monitoring centres consolidating or closing, it is recommended that Carecall take advantage of this market change.

Priority 2 –within the next 3-12 months
AT/Telecare range
The range of AT and Telecare products available in Warrington should be extended significantly to ensure Warrington fully reaps the benefits of AT/Telecare and Telehealth.

It is recommended that lifestyle monitoring is used for a much wider range of clients than currently as a tool for assessment.

As above Carecall should be the experts in understanding what products are available and how their use can hold a virtual 'Warrington catalogue' this also need to link with the self funded Web-site information.

AT/ Telecare resource folders/information folders should be available for practitioners to support their assessment of needs/risk and the relevant solution (s).

Telehealth should be established to support people with long-term conditions in conjunction with local clinicians. It is suggested that an initial first phase service should be instigated for people with COPD.

Priority 2 –within the next 3-12 months
Response Service
It is recommended that a formal response service be established through the reconfiguration of existing resources as a matter of urgency.

Telecare can support service users with higher needs to live independently in the community than was previously possible without technology. Telecare users will also often have up to 8-10 sensors whereas previously they had a single home hub unit and pendant.

This will result in:

- more alarms in the monitoring centre being received; meaning Carecall staffing may need to be revised to meet the additional workload.

- an increased need for a formal response service, as without this additional alarms will result in increased 999 ambulance calls; this may in turn lead to increased emergency hospital admissions.

It is therefore recommended that a formal response service specification and contract is put into place - 1 of 2 options could be explored.

i) Contract to an external agency – Domiciliary care, existing Telecare or housing response or contracted out re-ablement service.

ii) reconfiguration of existing services with some additional resource by extending the remit of existing in house services to cover Telecare response such as Intermediate care as part of admission avoidance services.

Priority 2 –within the next 3-12 months

Contracts

There should be a range of Telecare, AT Telecare monitoring and monitoring software specifications developed and robust contracts/SLA's put into place based on demand and capacity and within available resources to cover:

- monitoring
- installation, planned maintenance, asset management and tracking of Telecare equipment (see specification as previously supplied)
- source and supply using either the Northern Housing Consortium or Telecare /health Buying Solution framework
- physical response service as above

Priority 1 – immediate

Performance Framework

Performance targets and a key performance indicator framework which measures outcomes to be achieved should be implemented; this will also support/ inform future business planning.

Each of the contracts should have relevant performance targets reported on and monitored by the AT Steering Board monthly, this includes Carecall performance reporting.

The KPI reporting should include for example:

Installation

- types of needs identified, the AT / Telecare prescribed against needs/risks
- number of installation requested,
- number achieved within contract timescales and reasons why timescales could not be met

Planned maintained

- number of planned install visits required/ achieved
- number of units etc replaced

- number of batteries replaced

Monitoring and Response
As per appendix 3.

Self funders
- Number of self funders requesting service
- Route to self funding service i.e via web-site, via practitioners
- Self funding numbers/by package

Organisation Structure

Priority 1 – immediate
Organisation Structure - The AT Steering Board should continue to oversee the progress of the implementation of the strategy.

Priority 2 –within the next 3-12 months
Specialist Practitioner - A new post should be created which acts as a specialist practitioner/AT/Telecare change agent (?Band 7/8) for Telecare across all of Warrington, reporting to the Steering Board the post holder should be responsible for delivering the changes recommended in this Telecare strategy.

The current AT officer based in Carecall should report to this post. The new post could be a 'short term' change agent to ensure Telecare is fully embedded in practice and acts as a catalyst of change.

Embedding Practice / Change
Priority 1 – immediate
Pathway Development
In order to embed AT/Telecare into mainstreamed practice work need to be undertaken on an open access pathway(s) that ensures:

- AT/Telecare is an 'opt out' service i.e all service users/ clients should be considered for AT/ Telecare to support them/ their carers in the community unless there are clear reasons not too.

- appropriate and pertinent triggers are included within all assessment documentation including any self-assessment completed by individuals
.
- health and social care staff identify the potential for AT through the assessment process.

- ***there is one clear*** point for all to access AT/Telecare (whether funded, self funded via personalisation or from other partners such as health) which dovetails into existing pathways across health and social care.

- there are agreed mechanisms for the monitoring centre to refer into the Falls Service (this work has already started).

- AT/Telecare is able to be used to support individuals and their carers in emergency situations, particularly to support hospital discharge and admission avoidance.

- AT/Telecare as an integral part of intermediate Care/re-ablement falls, stroke, dementia pathways.

- AT/Telecare is offered to the widest possible user groups not just the elderly.

- AT/Telecare is a reviewable service.

Priority 3 – 12 months onwards
Residential properties
All new build residential properties should be AT/Telecare enabled.

Priority 2 –within the next 3-12 months
Data - Joint Protocols/ Data sharing agreements should be put into place across the Council and its partner agencies so that information about Telecare users and their needs/ risks can be shared as appropriate. Carecall needs to ensure its document is adjusted to support this.

Care Managers should use the information generated by the monitoring centre and the information put on Carefirst as part of their case reviews. Care Managers should request individualised Carecall reports as part of their review on any relevant calls outs to inform their review of the service users risks/needs.

Priority 1 – immediate
Raising awareness external - The WBC website must offer AT/Telecare to individuals with personalised budgets and link with the pathways as described above.

The WBC web-portal must have up to date information about AT/Telecare on it. It should provide access to an on-line self-assessment and ensure that this self-assessment contains the right triggers to indicate the potential for AT/Telecare.

It is planned that the web-portal will go-live in early 2011.

Raising awareness internal/external – It is recommended that through training and awareness raising, with particular reference to assessment risk management and support planning, a change in culture can be achieved.

Raising awareness internal/external – Rebranding of 'Community Alarm' and 'Telecare' into one service. This is in line with the current market direction.

Carecall should undergo a re-branding exercise to emphasise that it will be offering a wider range of services, namely Telecare and AT. A suggestion is to change its name to '*Warrington Telecare'.* This name change should be undertaken as part of an ongoing raising awareness and communication strategy with regard to AT/ Telecare/Telehealth and its associated benefits.

The raising of awareness of AT/Telecare internally and externally should also be undertaken by:

- Regular market place and speaker events such as the Summer AT/Telecare event at The Gateway, which is open to partners such as health, third sector and carer representatives should be held, this should include examples of local case studies from local teams.

- Development of the provision of neighbourhood based AT demonstration facilities which can be used for demonstrating to potential users and carers.

- Regular Warrington AT/Telecare newsletter.

- Putting in 'an introduction to AT/telecare presentation/talk' into the Council's induction staff training.

Priority 2 –within the next 3-12 months
Raising awareness internal/Champions - Extension of the AT/Telecare Champion programme to ensure each relevant team within the Council has a AT/Telecare champion. These should be developed to meet the competency framework as described below.

There should be monthly Champion meetings with the Specialist Practitioner and the Carecall AT officer in order that the Champions are kept up to date and that their support is harnessed to support embedding AT/Telecare into practice.

Priority 2 –within the next 3-12 months
Raising awareness internal/Training
The Department of Health is currently developing a Telecare competency framework, it is recommended that this is used to develop/ commission a range of training. A full learning needs gap analysis should be mapped against this prior to the delivery and design of an AT/Telecare training programme.

The AT/Training programme should:

- Train staff from a range of organisations to increase cost efficiencies and ensure there are consistent AT/Telecare messages.

- Cover risk assessment, needs and practical case studies not just cover the technology.

- Train Funding Staff in AT/Telecare assessment from across the council to the competency level relevant to their role.

- Train brokers from the third sector to support people with AT purchasing.
- Develop Trusted assessors in other organisations e.g. community nursing.

Priority 1 – immediate
Funding - It is recommended that:

- a fully costed model for delivering AT/Telecare is developed to meet both eligible and non-eligible needs, paying particular attention to the preventative agenda

- existing care / support budgets are used to commission Telecare and AT

- the funding for individuals who are eligible to receive services under Fair Access to Care Services (FACS) and for whom AT/Telecare is suitable then the funding will be integral to the person's personalised budget. Where a person is not eligible for services when checked against FACS then the service, which is likely to be a basic one consisting of the hub and pendant, is paid from a grant given by WBC.

2. Introduction

The purpose of this strategy is to develop the vision for Assistive Technology in Warrington for the next 3 -5 years, building on existing services and aspirations. The strategy will outline key recommendations for the successful development of an integrated Assistive Technology service which will support individuals to be independent and remain safely at home for longer.

3. Choose Independence

Choose Independence (CI) have been contracted by Warrington to develop its first AT strategy. CI is an independent telecare and telehealth Consultancy dedicated to bringing independent telecare and telehealth solutions to the marketplace and enhancing the quality of life of individuals.

CI was established in 2005 and has a proven track record of being able to deliver a wide range of tailored consultancy and training services in the fields of telecare and telehealth.

In developing this strategy a number of source documents have been used for reference, namely:

- The CSED Optimum Delivery Tool[2]
- The Telecare Service Association Code of Practice
- Labour and Coalition Government Policies and the recent White Paper
- Local Warrington Strategies
- Other relevant documents

[2] www.**csed**.dh.gov.uk/

In addition a total of 47 interviews were undertaken with Key Stakeholders and 3 focus groups.

4. Vision

The central aim of this strategy is to significantly increase awareness and broaden the use of Assistive Technology so that it becomes a mainstreamed activity within health and social care services in Warrington. These are practical objectives which are reflected in the strategy and action plan.

Over the medium to longer term, it is intended that Assistive Technology will be ***integrated into each health and social care professionals*** 'toolkit' so that the equipment and terminology are as widely recognised as burglar alarms and stand alone smoke detectors and AT is integrated into as many care and health pathways as possible. Warrington residents will be using a wide range of technologies in a variety of settings which maximise their independence and improve their quality of life.

Where access to Assistive Technology is currently through Warrington Borough Council, in a few years time, in line with the Transforming Adult Social Care agenda, information and provision will be readily available through partner agencies to support people with different financial circumstances at different stages of need.

This is Warrington's first integrated Assistive Technology strategy. Building on the service already available within Warrington Borough Council, it provides a foundation which moves away from institutional commissioning and firmly into person-centred support and self-directed care. It is written against a backdrop of fundamental change in the delivery of health and social care services; through the advent of Transforming Social Care, GP commissioning and Putting People First.

These policies signal a major shift in the way in which services will be provided in future years and the strategy outlines the way in which health and social

services in Warrington will use Assistive Technology to respond to that agenda in order to prolong people's independence and enable them to live within the community.

Assistive Technology will help to deliver the outcomes set out in the Warrington Self-Care Strategy and will inform and be informed by local commissioning strategies for older people, disabled people and people with mental health difficulties.

Results of Interviews and Recommendations

Assistive Technology in Warrington

The utilisation of Assistive Technology is currently being delivered through the existing Warrington Borough Council Community Alarm Service and has successfully 'piloted' the use of Assistive technology with a large number of Older People with Support needs who reside in their own accommodation.

Implementing AT - Infrastructure

As seen in the feedback from the Telecare Strategy day held in July there is a urgent need to increase the profile of AT across Warrington and its partners if AT is to support a wide range of users..

It is recommended that:

- The newly developed service is re-branded as ***Warrington Telecare.***
- The AT Steering Board should continue to oversee the implementation of the strategy.
- A new post is created which acts as a specialist practitioner for Telecare across all of Warrington, reporting to the Steering Board the post holder should be responsible for delivering the changes recommended in this Telecare strategy. The current AT officer based in Carecall shodul report to this post.

- This post could be a ‘short term’ change agent to ensure Telecare is fully embedded.

- Regular Telecare multi-stakeholder events such as the summer 2010 AT/ Telecare Strategy day should be held to continue raising the profile of AT in Warrington.

The Telecare Association ‘R to R’© model

The TSA ‘R to R’© model is a visual pathway of the full Telecare cycle from Referral to Response, Telecare and At is much more than just equipment but a dynamic process of identifying need and using a wide range of technology to reduce and minimise risk and need.

CI has used each of these components to map against the current service.

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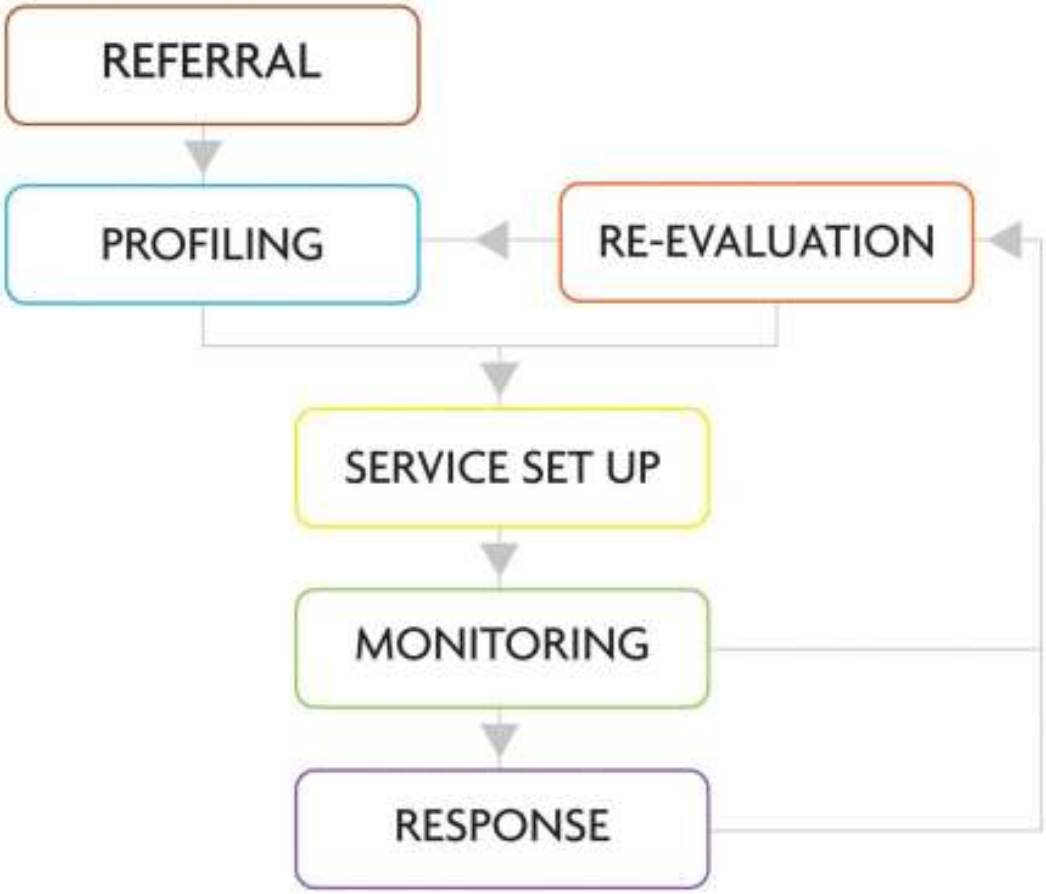
Referral to Response Model



21. Referral

Currently, there are a number of routes by which people receive a 'Community Alarm' or 'AT' equipment.

For a Community Alarm they can come to the initial contact service for social care, directly to CareCall or be referred through either route by a professional or other third party. However, in order to receive AT they have to have taken part in an assessment of their needs and a referral is then made to CareCall. CareCall scrutinise the recommendations made by the practitioner and if in agreement with it they will install or arrange the installation of the equipment. If on reviewing the recommendations they feel that further work is required they will work with the referrer and individual to agree a suitable package of equipment.

Referral at present is a confused process and requires standardisation.

There needs to be a clearly understood access point and streamlined pathway into AT either as a stand alone pathway or integrated to into other pathways such as falls etc.

The pathway must be open access to health, care or self funding.

Consideration will need to be given with regard to the AT pathway to to expedite the provision of AT in emergency situations and particularly to support hospital discharge and admission avoidance.

22. Assessment

Quality assessment is key to people engaging with services that meet their needs and associated risks.

AT can be used to support the assessment process by providing daily activity and lifestyle monitoring of an individual within their home setting. This can even

change the type of care package that would otherwise have been offered and ensures care / support has an evidences base.

Equipment of this type allows professionals and individuals, carers and nominated others to view via the internet, what the individual's behaviour has been over a given period of time. This quickly helps to identify normal routines and any exceptions to this which may indicate the need for further investigation or action. This technique can support the assessment process across all client groups and services, ensuring the best course of action for the individual is identified. This assessment approach can also help to inform carers, family and friends.

Currently a small numbers of the lifestyle monitoring telecare equipment 'Just checking' tool has been used by the Carecall staff.

It is recommended that lifestyle monitoring is used for a much wider range of clients than currently as a tool for assessment.

It is recommended that a range of health and social care staff identify the potential for AT through the assessment process with the individual.

This would include Social Workers, Occupational Therapists, Community Nurses, Specialist Nurses including Community Matrons, Intermediate Care team members and GP's.

Contact Warrington staff, which provide the 'front door' to other social care functions, could with the support of a clear simple assessment with appropriate triggers be able to identify the need for and prescribe simple pieces of equipment or to assist self-funders. It was however felt that in order for them to do this they would require someone with AT knowledge to be based within the team, such as an AT Champion. This would ensure correct assessment and

prescription by introducing a layer of scrutiny. This approach of identifying need would support the preventative agenda.

The Single Assessment Process has not been implemented within Warrington so the sharing of information is limited, duplication of assessment is common and full identification of an individual's health and social care needs is incomplete.

At the present time, it is primarily social care staff that identify AT as a potential support tool. It is recommended that a 'Trusted Assessor' protocol is established between the key partners to ensure that whenever needs are identified, AT is considered at the earliest opportunity. To achieve this, a clear, comprehensive AT pathway must be developed and implemented across Warrington.

It may be necessary to develop mechanisms for support planning where health or other partners have identified the potential for AT and where the person is not working currently with social care and where the individual falls into the 'preventative' category of need. This would avoid all AT assessment coming through social care. It would also prevent duplication of assessment as identified in the Single Assessment Process guidance (DH, 2001) and it will speed up the process for the individual.

Joint budget considerations may need to be considered to achieve this. If health staff continue to be unable to prescribe AT following assessment it is recommended that a minimum dataset of information should be shared with social care from the health needs assessment.

Appropriate and pertinent triggers must be included within all assessment documentation including any self-assessment completed by individuals under.

It is recommended that AT is indentified as part of mainstream assessments and that is it not viewed as a separate function.

23. Prescription / support planning

Support planning is the critical point at which AT should be considered following the assessment and identification of needs and risks. AT should always be the 'opt out' position which practitioners should consider. This is the case within adult social care but not within other partner organisations. However, AT currently does not meet complex needs and is not used routinely as a tool in the support planning 'tool kit' despite being the default position.

AT should always be prescribed within a person-centred framework and be bespoke to individual need. AT is not suitable for all.

AT packages will require expert scrutiny when developed to ensure that the prescription is correct. In the longer term, the level of scrutiny required should decrease as individual broker's expertise with regards to AT increases.

Self-funders present an additional challenge as practitioners express concern relating to knowing they are safe and that the equipment they purchase is suitable and of a good quality.

It is perceived by practitioners and managers that a risk averse approach to support planning is practiced by many at the moment and that this may represent a barrier to the mainstreaming and wider use of AT within Warrington.

It is recommended that through training and awareness raising and with particular reference to assessment risk management and support planning, a culture change can be achieved.

It is recommended that information be provided to self-funders to sign-post them to reputable suppliers. Further discussion will need to take place to agree where this information held and who will keep it up to date.

24. Equipment

In relation to AT, Warrington is innovative and creative in its future vision for AT. For most people this vision is still very much at the 'blue sky' stage and has not been translated into implementation for individuals. Often people are still unaware of the types of equipment available and how they may be suitable.

At present there is a limited choice of AT equipment as Carecall contract with only one main equipment supplier.

It is recommended that Warrington Council uses the Buying Solution framework to maximum effect in order to significantly increase the range of AT equipment to the users, carers and patients.

It is also recommended that web-sites such as the Telehealth commissioning tool [3] and the t-cubed web site for stand alone AT are used to keep Warrington informed and up to date with the technology available.[4]

Often small pieces of AT equipment such as a memo minder for dementia sufferers to remind them not go out in the dark recorded by a family member can stop non-purposeful night wandering and reduces delays the need to move an older person out of their home. Significantly reducing cost and supporting the individual to remain independent for longer.

Further development is required with regards to the use of equipment to support these key priority areas, as identified in the attached equipment summary of this strategy:

- Acquired brain injury
- Assessment

3

- wm nhs telehealthcare commissioning toolkit.pdf
- toolkit prototype for review v1.1 sept 10.ppsm

4 www.t-cubed.co.uk

- Carers
- Dementia
- Detecting changes in conditions
- Environmental support
- Independent travel
- Confidence building and familiarity for later fuller usage of AT (e.g. transition, prevention)
- Intermediate Care
- Falls
- Medicine management
- Mental health
- Long-term conditions management
- Supporting day services in a range of settings
- Working i.e. being supported in the workplace and getting to work

A detailed AT breakdown against risk is being developed and will be attached.

Considerations have also been given to the changes which are occurring in the way that services/functions will be provided.

One example of this is the move within mental health from people accessing traditional day services to a greater usage of leisure services. With this move comes greater independence and the need for different types of support for the individual especially as many of these services require more independent activity with less formal support provided. Other more traditional types of equipment, not within the AT realm, including hoists and ramps will also be required to support this change of focus.

Equipment provided by CareCall is currently available for people to view at Warrington Disability Partnership (WDP).

The range held by them should be extended to include a broader range of AT and stand alone equipment. A wide range of venues for demonstrating equipment should be made available to ensure equipment is as widely publicised as possible...

See the 'Neigbourhoods' section of this report. The Carers Centre could also hold a range of equipment for demonstration as could The Gateway. Following refurbishment at CIL, the Council's Carecall service will be arranging the installation of a telephone line and a range of equipment to enable a wide range of Telecare equipment to be demonstrated 'live'. People also need to know about AT early in their pathway journey.

The promotion and use of AT by the Intermediate Care service is not a high as it could be and it is recommended that greater use is made within this service.

This will then support people receiving an IC service, promote AT and increase familiarity with the equipment in preparation for continued or future use.

25. Telehealth

The use of Telehealth equipment has been considered in the past but has not moved to the implementation stage. It is implicit in some of the Warrington strategies and is a way of supporting expert patients' development; it empowers patients and their carers.

The Community Matrons in Warrington are keen to use Telehealth to support their patients with a range of LTC's including COPD and therefore it is suggested that a phased approach to the development of a Telehealth service is undertake.

It is essential that engagement takes place by a credible champion with GP's GP commissioners as well as the Secondary Care COPD Teams. Areas of

good practice locally such as Leeds and Hull are areas where links could be developed to learn from their experience using Telehealth.

As the PCT finances are under extreme pressure at present a return on investment plan should be developed for Telehealth.

It is viewed that it can support a number of pathways including COPD. GP's and other health professionals will be required to engage further to enable the spread of usage. By tying the use into the pathways that health staff already work within, engenders greater use.

COPD and other respiratory conditions are identified flashpoints for Warrington and it is recommended that Telehealth services are implemented to address associated needs.

Whilst it is encouraging that there exists the desire to be innovative with regards to AT in Warrington a phased approach to implementation is advised to ensure that the basics/ building blocks are embedded before attempting to provide more complex support. This will result in a quality basis on which to further develop the provision.

26. Installation

Installation is a key aspect of the R to R© model. If installation is not undertaken quickly post assessment, to a high standard and is able to cover a wide range of equipment then Warrington's ability to use Telecare and AT to support individuals risk will be significantly reduced.

27. Review

Very little review of a person's needs in relation to AT provision is being carried out.

It is recommended that a review is carried out two weeks after installation to ensure that the equipment if working as it should and that the person is comfortable with how to use it. AT should also be considered when scheduled reviews are then subsequently carried out to ensure that the equipment still supports the persons identified needs and risks.

Further consideration must be given to reviewing AT which is supporting someone as a preventative measure, where they are not eligible under FACS and where they will not routinely be receiving a review of their needs.

28. Response

It is felt, by the majority of partners that the current lack of a formal response service for recipients of AT may in 'put people off' taking up the service.

It is recommended that a formal response service be established through the reconfiguration of existing resources as a matter of urgency.

It should be noted that the WBC Out of Hours (OOH) service does currently provide response in a limited number of instances following a request from CareCall to act.

The Out of Hours team consists of Social Workers, AMHP's and Support Workers who are home based and called upon when required. 70% of the issues raised with them can be dealt with on the phone. Referrals made from CareCall to this team tend to be in response to people wandering. It is also often the same people wandering and patterns of need are established. There is in place and agreement with the Police to assist when the need is identified after 12pm. Before this time a Support Worker would attend.

CareCall pass the issue to the OOH team within approximately 5 minutes. It is presumed that this is to ensure a quick response and as they have no ability to respond.

However, the speed of this passing of responsibility can cause some problems if the activation is by accident, the person is at home and CareCall have not initially been able to raise them. In some instances the OOH team has been able to contact them very quickly following the referral. It should be noted that this type of referral is only received approximately twice a week. The Police do not feedback regarding any action taken.

A range of possible options exist for the provision of a formal response. However, further work will need to be carried out to determine the viability and suitability of each option. The possible options are listed below. However, it is recognised that additional resources would be required to fully support this development with any option chosen.

- Contracting with a Domiciliary care agency
- Neighbourhood wardens
- Neigbourhood volunteers
- Out of hours team
- 24 Hour Extra Care Team
- Reablement Team
- Learning disability providers (share response)[5]

Consideration should also be given to the impact that the lack of a formal response service has on partners. i.e Whilst the Ambulance Service does not currently report problems with responding to alarms triggered and monitored by CareCall, if demand were to increase, that position is likely to change.

As described below the Ambulance Service responded to 580 calls from CareCall per annum. (June 2007/08).

[5] ***note that these suggestions are not listed in any preferential order and the list is not in any way exhaustive.***

Many of these calls are to lift people following a fall. It is recommended that the any future formal response service should incorporate this function into its service specification. If the response service was part of the Intermediate care or re-enablement service could be assumed that many of the ensuing hospital attendances or admissions could be avoided.

SUMMARY OF 999 CALLS MADE TO AMBULANCE SERVICE

During the year June 2007 to May 2008, staff at Carecall manually carried out a review of calls made to the ambulance service. As this was a manual exercise there may be the odd call which was not recorded.

580 calls made to 999, of which 68% were as a result of a service user having fallen, and almost 16% due to breathing difficulties or chest pains, and understandably the majority of these were in the winter months.

Unfortunately the outcome of the ambulance calls was not known in 42% of the calls, this was due to it not being clear at the time of the call whether the user was going to hospital or not and the operator was unable to find out the outcome.

However it is noticeable that the whilst the ambulance was called fairly evenly though out the 24 hour period, there were potentially fewer admittances during the period 23.00 to 7.00 am.

The peak month for calling an ambulance was January

Escalation protocols and specified pathways are required for all parties to follow in response to activation.

Informal responders should also be asked for their consent to take on this role and this should be documented within a written consent form. In addition, it is felt that carers are less likely to advocate using AT if no response it available due to the impact this will have upon their own lives. Often AT is viewed as means to cut services and contact time with workers.

It should be recognised that different response models will be required to meet the range of needs of individuals and their carers.

A detailed specification should be drawn up for a response service and commissioned accordingly.

29. Care Call

Carecall in Warrington has 3773 connections and handles handle over 200,000 calls per year, on average it deals with 550 per 24 hours.

The current numbers Telecare are:

Installations 2008/9	133
– Over 65	126
– Under 65	7
Installations since 2004	406
Current Users	286
Sensors etc in use	386
Sensors etc since 2004	633

As well as the community Alarm and Telecare service it offers:

- Out of Hours call handling:
    - Social Services
    - Homeless
    - Gritting
    - Highways
    - Environmental
- Carers Card
- Lone Worker
- Domestic Violence/witness protection

The Telecare Services Association has estimated that centres with less than 10,000 connections can at best break even, but are more likely to be run at an annual loss requiring subsidies from other sources (e.g. housing revenue account, general rate fund) in order to survive.

In 'The future direction of Telecare Call Handling Services in Scotland' in September 2008(6). It concluded that the small local monitoring centres will come under increasing financial pressure because they will be unable to afford the capital and staff investments needed to expand service provision.

Regional centres may become the preferred model of provision, offering sufficient connections to achieve economies of scale whilst extending partnership working across local authority boundaries. Larger centres will have the capacity to provide not only remote telemonitoring services for vital signs but also health coaching services involving the employment of nurses and other healthcare delivery staff within the alarm handling centre to support chronic disease management.

CareCall provides the monitoring for both the community alarms and AT. In addition they provide a range of other monitoring services to WBC. CareCall are reported to be providing a quality monitoring service. However there is no formal way at present that the quality of their service can be demonstrated.

A quality mark accreditation should be gained such as the TSA Telecare Code of Practice for the relevant services that they deliver.

In order that Carecall continues to be viable it is recommended that once accreditation is achieved that they offer their services to other local authorities in areas such as mental health etc. Carecall could also offer non-clinical triage

[6] http://www.ssiacymru.org.uk/media/pdf/e/e/T-Cubed_JIT_Scotland_Future_Call_Handling_Report_(Version_2.1).pdf

and monitoring to patients on Telehealth and other services such as message taking for Community Nursing teams.

Carecall state that they have the capacity to grow as demand increases however as recommend above a clear access pathway needs to developed in order to ramp up the numbers of service users receiving Telecare and AT.

An area highlighted as good practice is that Carecall have access to and annotate on Care First. This means that care managers can see when a service user has had AT equipment installed and what the package consist of.

It is recommended that Care Managers not only use this information as part of their case reviews but request individualised Carecall reports as part of their review on any relevant calls outs to inform their review of the service user's risks.

The KPI framework is recommended as a way of managing Carecalls performance and providing a top level view of areas that the Steering Board and relevant care teams wish to integrate further.

30. Monitoring centre software

Carecall currently use the market leader's software, however:

- it is outdated
- not interoperable with other types of Telecare other that its own equipment/protocols,
- has limited reporting functionality
- is unable to support choice in equipment or
    - support provide large scale automated pro-active prompting
    - a wide range of telehealth, mobile technologies, SMS texting etc.

Carecall is currently reviewing the options for changing the software and the cost of changing.

It is recommended that the software is changed to one which give Carecall a wider, flexible software platform which supports Warrington's AT vision.

In addition to the traditional monitoring services provided there are other functions that monitoring services should be commissioned to undertake and new software will support this provison.

For example, proactive calling is recommended as an approach for adoption in Warrington. This involves the identification of individuals who would benefit from a short-term series of calls from the monitoring centre. These calls may support people in the following situations:

- Individual of concern following hospital discharge
- Individual of concern and who is working with services resulting in admission avoidance
- Medicines management / compliance

These recommendations are in line with the recent Government announcement. [7] on re-ablement, of which AT should be an integral part.

7

Re-ablement

The government is providing a £70 million cash boost to fund re-ablement packages for elderly people discharged from hospital.

Re-ablement packages give people who are leaving hospital after illness or injury help and support for six weeks. The packages help them settle back into their homes by providing services at home to provide initial practical support or possibly changing their home environment so they can get around better.

The extra £70 million will be allocated to primary care trusts to be spent this financial year across the health and social care system and PCTs will be expected to work closely with hospitals and local authorities.

Health Secretary Andrew Lansley said: “Too many patients don’t get the seamless effective service they should when they leave hospital. They leave an environment in which they have been cared for around the clock to go home, sometimes alone, with no help. Too often they end up back in hospital because they haven’t had help readjusting to life at home.

From next April, the NHS will have new responsibilities for people’s care needs for 30 days after they leave hospital, and hospitals will not be paid for services provided to readmissions within that time. In the last ten years there has been a 50 per cent increase in the number of emergency readmissions and it is hoped that the extra funding will help reverse that trend. It is expected to benefit around 35,000 people.

Please note that this is not an exhaustive list and requires further consideration. Well developed bespoke escalation protocols are required for each AT client to support proactive calling. The time-limited nature of provision ensures that the service does not become perceived as a ‘befriending service’ and so is able to offer services to more people as the client group changes frequently.

31. Maintenance / re-use of equipment

As the use of increases across Warrington the need to put in place a robust contract in place for Telecare/ AT maintenance, care and repair, battery replacement, asset management, refurbishment and de-contamination will increase.

It is recommended that a specification is developed in lien with the TSA standards is developed and commissioned.

32. Mainstreaming

AT has not historically been viewed by the majority of managers or practitioners as a core function within social care or health. Whilst there is now amongst managers a view that AT is an 'opt out' rather than 'opt in' service this does not translate into the numbers of people being offered AT to support their needs and to reduce riskCulture change is required to ensure the successful implementation of AT. This change management should be planned, joint and comprehensive. Robust project management is required to steer this. AT as the default position will assist this.

It is recommended that an AT 'expert' continues to work with practitioners to enhance learning and development. It is recommended that this post is based in the Council and that the current Carecall Telecare officer whilst based in Carecall should report into this post.

33. Building provision / re-provision

Increasingly residential settings commissioned by Warrington are using AT more. Any new properties should have AT overlay built into them to allow for the future use of Assistive Technology by any resident.

Any new builds or building currently under construction such as the Cantilever House building programme, which is focusing on the provision of one bedroom flats and two person bungalows for use by people with learning disabilities should be informed by the AT Strategy.

Some examples of current and potential usage of AT within residential settings are detailed below.

Within the learning disability services (LD) the 17 group homes are all hardwired however it was reported that very little AT is used within people's own homes. It is also unclear whether there is any AT overlay.

It was reported that the LD short break unit which can accommodate up to 52 people, could make more use of sensors and pagers to assist staff working in this large building to support residents.

Within James Phoenix House (9 bedded respite unit) there is no AT overlay and there still exists a waking night service supported by the use of baby monitors. It was reported that carers probably view respite as still only providing traditional type services.

The Family Placement service provides essential placements of people with an identified learning disability within a family setting either for a fixed period for respite (sleepovers, day, night) or permanently. There are in excess of 40 homes used for this purpose. Little or no use of AT is made within these private dwellings. The Speak Up Group reported that equipment in these settings would help them to feel confident and secure, to help the family feel confident to leave them alone and enable greater independence. A range of AT equipment could also be deployed to support the individual's needs. Issues may arise where placements would be for limited periods of time as each individual's needs would be different. However, the individual may already be used to using equipment within their regular home setting and so would benefit from continuing to use it.

It is also particularly important that carers and children coming through transition and where their need for AT is likely to be longer term, become familiar and use the equipment as early as is appropriate.

The newly commissioned Continuing Care Dementia Hospital which will provide 20 beds for Warrington people and should be AT enabled.

Comprehensive budget management is required of prescribed equipment would be required. Monitoring of the finances will need to be carried out from within the commissioning team.

34. Neigbourhoods

Neigbourhoods are an integral way of working to support local communities within Warrington by identifying what is needed in each local area and identifying solutions. Adult social care services are moving towards aligning themselves with a neighbourhood focus. One example of neighbourhood working was the Connected Care pilot which focused on what carers wanted to improve the quality of their lives. The approach is now being rolled out to other neighbourhoods. Increased access to AT was identified as a positive approach to supporting carers. Volunteers are also working within neighbourhoods as wardens.

The focus of a neighbourhood approach is very much on the further development of local support networks including the current development of community hubs. Neighbourhood wardens, of which there are 10 across Warrington, support the work locally and committees identify the needs of local people and steer developments accordingly. Four are based in the Central neighbourhood and two each in East, South and West. Central has more wardens as this has the highest population concentration. The service runs during the week only between 8am and 9pm. There are not any plans to provide a 24 hour service. It should be noted that wardens do not provide emergency response. Wardens are however, very well placed to identify potential need.

Wardens provide reassurance to local residents. They build relationships and are able to identify who is vulnerable or who may require support in the future. The ‘Safe and Secure’ scheme is where wardens visit identified vulnerable people in sheltered housing schemes. Within this scheme door chains and personal alarms are being installed. The wardens also work with the Fire

Service to install smoke detectors. The wardens refer into the social care teams if any other equipment is needed. However, as their knowledge of AT is minimal they are not aware of the full potential and ofhow AT can support individuals to life independently with confidence within their own home. Opportunities are therefore not being optimised at the present time.

Neighbourhoods are a way of raising awareness at the community level or identifying need and ensuring people are supported.

35. Awareness and communication

Communication between the statutory groups, individuals and carers has not been as robust as it could have been, however, it is accepted that everyone is still learning about AT included statutory services. Whilst the 'CareCall' brand is very well established and understood very little is known about AT. It is recommended that a joint communication and marketing strategy is agreed and developed by the AT partners and that an AT Steering Group is responsible for ensuring that it is acted upon and refreshed at regular intervals depending on the current requirements of the service. This should then be implemented across Warrington.

Forums and groups which represent the users of services and their carers are integral to the spread of understanding and knowledge about AT. They are also key to the success of AT going forward. They have been invaluable to the development of this strategy and should be encouraged to continue to be invovled to ensure that AT continues to be a dynamic, flexible service.

It is critical that the real motivations for using AT are understood and that the benefits to individuals and their carer's are reiterated as there exist some misconceptions that AT is about cost cutting and reducing services.

Promotion in public places such at supermarkets and shopping centres were seen by individuals and carers as good venues at which to raise awareness.

Existing events and awareness raising days should be incorporated into the strategy. For example, Warrington's Disability Awareness Day, an annual event which is widely attended, could promote AT as well as at the annual Carers Day.

36. Skills and knowledge

There exists a relatively low level of knowledge within social care front line teams about the range of Assistive Technologies available and the impact and support that these can provide to individuals and their carers. At present there is very little knowledge of AT within health and hence a very low level use of equipment.

A knowledge gap currently exists amongst potential users of AT equipment and their carers. Support needs to be given to increase knowledge and mainstream AT.

Also, there exists a predominantly traditional view of how AT can meet needs, this has not developed to include the use of AT and other stand alone equipment.

It is essential that home-care staff and other visiting professionals are also aware of the AT equipment, how it works and how to interact with it. For example, home-care workers should be aware that they need to switch the door alarms on and off on arrival and when leaving the property.

Some practitioners have been identified as 'AT Champions' and have undertaken a higher level of training.

The AT Champions initiative should be reviewed to identify all teams across Warrington Council and its partners to each have an identified AT Champion.

The existing AT Champions need to be developed further to have a higher profile within each of the teams in order to support colleagues with AT and help them in turn to increase their own knowledge and skills.

Regular support and AT Champions awareness meetings should be arranged by the new post holder, who should be responsible for keeping the AT Champions up to date. To engage wider audience regular market places by AT providers should be held with all key stakeholders invited to attend.

It is recommended the 'Champions' programme is further developed and expanded.

37. Learning and development

There is very little information available to practitioners, individuals and carers in relation to the equipment, how it works and what they need to do in relation to it. It is recommended that Warrington develops a range of support materials for use across all partners. An example of a page from a CI AT resource folder for another area is attached.

A comprehensive training programme is required for implementation across all partner organisations, teams and services for those that will be working directly and indirectly with AT.

It is recommended that a competency framework is developed and that people are trained to the competency level relevant to their role. A full learning needs gap analysis should be carried out prior to the delivery and design of the training programme.

Where possible practitioners should be trained in multi-disciplinary groups to facilitate joint learning and sharing of expertise across specialist. An approach of this type will also facilitate relationship building. Joint training will ensure resource efficiencies can also be made.

It is recommended that training sessions use real case studies as integral to any course content.

38. Carers

Carers in Warrington have not to date been supported by AT. It is the intention of the partners that in future AT will be used to support carers to continue in their caring role but with a better quality of life. For example, the use of bed and enuresis sensors can eliminate the need for a carer to sleep in the cared for persons room at night as they will be alerted should the person get up or wet the bed.

In supporting carers with AT, Warrington is further strengthening its commitment to assist them in continuing to work and to pursue learning opportunities. By having a hub and sensors the carer is in many cases able to leave the person within the home for longer.

However, unless a formal response service is available the impact that AT has may be minimal as the carer is unable to go any distance or be away from the cared for person for any length of time in case they need to respond to an alarm activation.

Carers also have a fundamental role in promoting the use of AT and the new post holder should ensure carers groups are engaged in regular awareness session so that they become familiar as the what AT is and it benefits.

39. Funding and charging

AT is currently funded via a specific grant given to CareCall by WBC. In 20010/11 this was £80,000. Whilst to date the funding of the service has not

been a problem if demand were to increase for equipment this would cause ongoing funding issues. With the desire for AT to be a mainstream function and for the Community Alarm and AT services to become one cohesive service the future service funding requires consideration.

It is recommended that the funding for those people who are eligible to receive services under Fair Access to Care Services (FACS) and for whom AT is suitable then the funding will be integral to the person's personalised budget. Where a person is not eligible for services when checked against FACS then the service, which is likely to be a basic one consisting of the hub and pendant, is paid from a grant given by WBC. This will support those people who require services as a preventative measure.

Standard packages of AT equipment can be costed and published to assist people with developing their own support package. A tariff of approximate costs should be developed to assist individuals and brokers with this task. The challenge with this is keeping it current and correct.

It is recommended that a central repository of information for AT prices be held centrally on the internet. It is to be established who will maintain the content. Each provider could be ask to maintain their own information but this would require them having access to the web administration rights which may not be possible.

Where the AT package desired by the individual is greater than their personalised budget or threshold set for health they will be able to self-fund the element of the equipment package not covered by their budget. Protocols will need to be established to support this.

Within the Learning Disabilities service efficiencies can be achieved by the reduction in the waking and sleeping night services though the use of AT. This

reduction has already started and efficiencies are already being realised. More importantly, AT is less intrusive, less restrictive and allows the individual to get a better night's sleep but with the confidence that should help be required it can be summoned. Carers are also supported by the approach. £82,000 pounds have already been saved using this approach.

Each care package which is recommended for Telecare should be required to show the return on investment and financial benefits.

Initial work has been undertaken on this but is being built on by CSED using the ROI tools.

It is recommended that AT and Telecare care can be commissioned out of existing budget holders budget so that there is a clear link made between AT enabled care packages & expenditure.

Further consideration should be given as to whether AT and the Community Equipment service should be integrated in future. Some areas have taken this approach however many others consider that he synergy between the two is not strong enough.

With regards to the funding of the service further discussion needs to take place between the partners to identify the financial model to be used. An options paper is being develop with regard to this.

Consideration should be given to the redirection of funds from the acute setting to the community This would broaden the support the ethos of people receiving support closer to home. An Invest to Save business case would support this approach.

AT certainly lends itself to opportunities for joint commissioning and shared resources being deployed.

It is recommended that the funding of Telehealth equipment is from a separate funding source identified by NHS Warrington.

40. Performance framework

To date, very little performance data has been collected in relation to CareCall services for use by WBC and other key partners. CareCall does collect and analyse standard data but the Council collects, analyses and reports on very little AT related information.

Also, currently it is very difficult to report on outcomes achieved as no base line is collected initially. It is recommended that a robust performance framework is implemented which collects relevant data at all stages of the R to R model.

An example KPI framework is attached in Appendix 3.

Goal setting and outcome identification should also be established at the support planning stage with the individual and/or carer in order that this information can be measured and reported on. This will in turn help to inform future business planning.

41. Contractual arrangements

It is recommended that AT specifications are developed and incorporated into all contracts / SLA's where AT related services are being commissioned. Commissioning should be joint across social care and health.

The elements of commissioning for AT which must be considered are as follows:

- Community Brokerage (for personalisation)
- Equipment

- Maintenance
- Installation
- Refurbishment
- Disposal
- Monitoring
- Response

The use of AT is not currently built into any contracts or SLA's with residential care providers.

42. Information technology / Information sharing

Social care and health services use different IT systems for recording client and patient information. The information from these systems is not routinely shared and is used by the host organisation only. There are plans for Carefirst to be available for use by health staff within health sites.

It is recommended that a joint protocol is established to ensure that information relating to AT can be shared between organisations.

This will also facilitate the feedback of information from the monitoring centre to the assessing organisation and to the key worker, if one has been identified. It is essential that key triggers are identified which would indicate the need for escalation to another party. Individuals would be required to give their consent to the sharing of information between partners. Clear explanation regarding the need for information sharing should be explained fully to the individual.

The WBC web-portal which individuals will be able to access should contain information about AT. It will provide access to an on-line self-assessment. It must be ensured that this self-assessment contains the right triggers to indicate the potential for AT. It is planned that the web-portal will go-live in early 2011.

43. Mental Capacity

The Mental Capacity Act (2007) must be considered at all stages of the AT pathway. A person's capacity should initially be considered at the Assessment stage to determine whether they have the capacity to make a particular decision. In this case, it would be, where appropriate, the decision to have AT. If a person is assessed and it is found that they do not have the capacity to make this decision then a best interest decision should be made on their behalf. The best interest decision maker must be the most appropriate person to make this decision using the best interest decision checklist to assist them in this determination. The best interest decision maker may be the same person as the initial assessor of another, more appropriate person.

Capacity issues must also be considered when looking with the person at what equipment is most suitable. All AT packages are bespoke to individually assessed need. In essence, some equipment will suit some people and not others. Cognitive impairment may render the use some equipment less suitable. For example, for some people with later stage dementia, equipment with which they have to interact may not be suitable. Others may find a voice coming from the hub disturbing. However, all cases involving issues of capacity should be considered individually.

44. Partnership working and pathways

Warrington Borough Council and NHS Warrington and Community Services have demonstrated their commitment to a joint working approach with regards to AT. The key to the successful implementation of AT is the standardisation of the approach to be adopted with a joint pathway, protocols and procedures being developed and implemented. The service will operate within a person-centred framework and ensure that it delivers a high quality, cost effective and efficient service.

The Third and Private sectors are also key partners and work with the emergency services is essential to ensure a joined up approach to support vulnerable individuals.

Engagement with GP's needs to be further strengthened to ensure that there is true joined up working with a neighbourhood focus as GP's are seen as critical to this local focus.

Very little joined up working in relation to AT and identified pathways and frameworks happens. For example, the newly re-established Community Falls Service makes very little use of community alarms or AT and do not prescribe equipment or consider more than the basic community alarm to meet need. Even when alarm type services are needed they refer onto another party to take this forward. They state that as they often do not carry out a home visits identification of potential AT support would be difficult. No use is made of information from CareCall regarding fallers. CareCall do not have the mechanisms in place to refer people into the falls service / pathway. However, the team does have a target to reduce Accident and Emergency visits by fallers by 5% over the next two years. AT would help them to achieve this.

It is recommended that work is undertaken to ensure that AT dovetails with all existing pathways within health and social care, across Warrington. Mechanisms for the monitoring centre to refer into the Falls Service should be established and monitored within the performance framework. IT should support recording of this data which can be shared, with permission.

45. Monitoring arrangements for the strategy

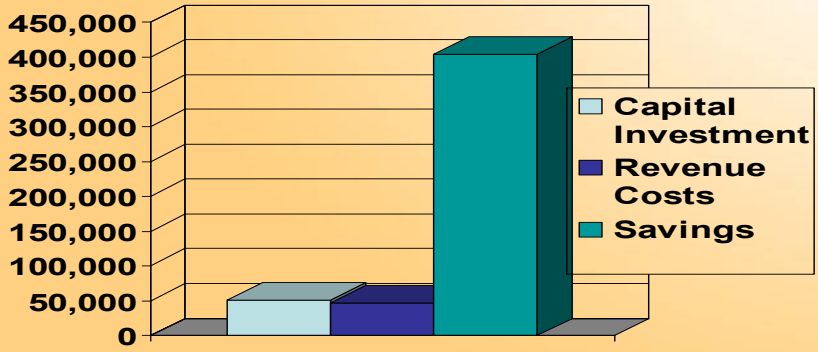
The implementation and monitoring of the strategy will be overseen by the AT Project Steering Board which already exists but should be widened out to include other groups such as users and carers.

A detailed three year implementation plan with associated targets for the implementation of a mainstreamed AT service will be developed in partnership with Warrington Borough Council, NHS Warrington and Community Services.

The plan and targets will be agreed by the Project Steering Board who will monitor implementation to ensure that the strategy is shaping services in the way intended. A lead commissioner from NHS Warrington and the Warrington Borough Council will be identified and they will be tasked with delivering the implementation and reporting progress and issues to the Project Steering Board.

Appendix 1

Financial Impact for former Cheshire County Council 2008/09



The figures are given in pounds.

The savings figure consists of £212,000 of cashable savings and £192,000 of notional savings. Some of these figures relate to savings initiated in previous financial years through the use of technology as part of a support package.

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Appendix 2 * CSED Information Outcome	Minimum target for 2007-2010	Actual achieved Apr 07-Sep 07	Actual savings achieved Apr 07-Mar 08 Est monetary saving	
Hospital bed days saved by facilitating speedier hospital discharge	46,500	1,800	5,668 days 517 discharges	£1.7m 15.5%
Reduced unplanned hospital admissions - bed days saved	Info not avail	Info not avail	13,870 days 1220 admis	£3.34m 30%
Care home bed days saved by delaying people to enter care homes	225,000	6,900	61,993 days 518 admis	£3.42m 30.7%
Nights of sleepover care saved	46,000	1,250	Info not avail	£0.55m 5%
Home check visits saved	905,000	107,000	Info not avail	£1.79m 16.1%
Locally identified savings eg reduced waking nights	Info not avail	Info not avail		£0.30m 2.7%
No. of TDP funded telecare users	13,505	6,005	7,902	
Estimated verifiable savings as a result of Scotland Telecare Dev Prog	£43m	£2.9m	£11.15m	

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Appendix 3
– CARELINE key performance Indicators

Code	Careline reporting - Monitoring	Reporting type and schedule
1	Number of calls received (in bound)	Numbers monthly/accumulated total per annum % of those calls leading to direct call out of emergency service by Careline % of calls triggered by service user % of calls triggered by falls alarm % of calls triggered by bed occupancy monitor % of calls triggered by smoke/ gas detector % of calls triggered by intruder alarm % of calls triggered by other. % false alarms (note: this needs defining)
2	'Lost' service users	Numbers monthly / accumulated total per annum
3	Total number of active service users	Numbers monthly / accumulated total per annum
4	Frequent 'callers'	As above / accumulated total per annum
4	Time taken to answer the call (TSA standard)	%
6	Line Utilisation (TSA standard)	%
7	Service users who have not called in the last six months (tested units)	Numbers monthly / accumulated total per annum
8	Service users who Careline have made contact of the number above	Number from above and % per month / accumulated total per annum
9	Total number of outbound pro-active calls	Monthly / accumulated total per annum

Code	Careline reporting- Response	Reporting type and schedule
1	Keys held	Number / Accumulated annual total
2	Keys returned	Monthly/Accumulated annual total
3	Number of calls outs per hr across 7 day week	% of those call outs responded to with 30 minutes % of those call outs responded to with 1 hour % of those call outs requiring a forced entry % of those call outs requiring an emergency service (fire, police ambulance) to attend called by the Careline.
4	Post Call action	Number of SU referred to TBC Adult Social Care services for care/ support review - per month number / Accumulated annual total Number of SU's referred to Falls Service. Number of SU's referred – other services (list) Number of clients referred back to TBC for re-assessment of needs.
	Careline reporting- Service user feedback	**Reporting type and schedule**
1	Customer feedback of those who have had a responder	Service user's surveys undertaken for all who had used the service in the past 12 months; (Reporting twice yearly - September and February).
2	Customer feedback – of those who have monitoring	Service user's surveys – this will be 10% of the current total Careline users. Six monthly surveys.

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STAKEHOLDERS CONSULTED

INTERVIEWS (telephone or face to face)				
	Surname	**Forename**	**Organisation**	**Job Title**
1	Armstrong	Nick	NHS Warrington	Clinical Commissioning Support Team Lead
20	Horton	Jane	Warrington Disability Partnership	Chief Officer
21	Kitchloft	Geraldine	Warrington Housing Association	Manager, Older Persons Agency
22	Lawton	Alison	PCT	Community Respiratory Team
23	Leigh	Sandra	PCT	Community Matron, Community Falls Service
4	Blott	Joe	WBC	Director of Community & Neighbourhood Services
24	Mawer	Brian	WBC	Manager for Access for social care & OP/CMHT
5	Bottomley	Helen	WBC	OOPs service
26	Bradburn	Hilary	NHS Warrington	Acting Head of Service - MH & LD
6	Baker	Jo	NHS Warrington	Head of Mental Health Care Service
27	Osborne	Dave	WBC	Service Manager
8	Carmichael	Cate	NHS Warrington	Deputy Director of Public Health
28	Pacey	Frank	WBC - Supporting People	Commissioning & Contract Manager
9	Charnock	Terry	WBC	Principal Officer – complaints, direct payments
29	Peers	Anne	5BP	Lead Occupational Therapist
30	Ravenscroft	Bill	Chair of LD Partnership Board	Chair of LD Partnership Board
10	Chesterton	Henry	WBC - ILM	Team Leader - PD team
31	Reid	Trish	CSU	Performance and Contracts Manager
11	Collins	Chris	WBC - Community Services	Principal Officer – OP and ILT
32	Richardson	Beccy	5BP	Operational Manager
12	Coleman	Roz	Carers Centre	Operations Manager
33	Robertson	Rita	NHS Warrington	Director of Health Improvement
13	Cooper	Diane	WBC - Independent Living Services	Service Manager OP & PD
34	Shaw	Mike	WBC	Policy & performance
14	Cowley	Dave	WBC	Head of Housing Services
35	Shepherd	Beryl	CSU	Head of Intermediate Care Service
15	Critchley	Jane	WBC	Neighbourhood Manager
36	Smith	Roy	WBC	Elected Member - Housing and Homelessness
16	Dawson	Teresa	WBC	Principle Officer
17	Dixon	Dawn	WBC - Care Call	Carecall Officer
18	Hart	Wendy	WBC - Care Call	Carecall Manager
19	Higgins	Val	Changing Together	Consultant
3	Barron	Peter	WBC & NHS Warrington	Assistant Director for Integrated Care
25	Mercer	Mary	WBC	Director of Mental Health Commissioning

	Surname	Forename	Organisation	Job Title
37	Smith	Julie	WBC - Community Services	Principal Officer - OP & PD
38	Sweeney	Jackie	WBC - Community Services	Self Directed Support Officer
39	Taviner	Mandy	Changing Together	Consultant
40	Toolan	Alison	WBC	Interim Team Manager
41	Tudor	Jackie	NHS Warrington	Acting Community Services Manager - Adult Nursing
42	Walker	Shelley	Warrington Hospitals	Head of Therapies
43	Wallace	Tommy	WBC	Head of Customer Services & Business Change
44	Wood	Gideon	WBC	Social Worker, OPCMHT
45	Wycherley	Janice	WBC	Commissioner, Joint Commissioning

FOCUS GROUPS / GROUP MEETINGS	
1	TASC Users & Carers Group
2	SpeakUp group
	Warrington Disability Partnership

Background

Warrington Borough Council Community Services and NHS Warrington commission and directly provide a comprehensive range of Social Care, Housing Related Support, Health and Personal Care services across all adult service user groups within the Borough.

As part of the transformation of health and social care services, both NHS Warrington and Warrington Borough Council are committed to provide increased choice, control and independence for Warrington residents and to deliver services that secure operational and service efficiencies.

The Transforming Adult Social Care (TASC) Project board in response to the Putting People First agenda have identified the requirement to develop and deliver a range of Projects to further develop Social Care and Low Level Support services across the Borough. The project areas are:

- Safeguarding
- Assistive Technologies
- Communication and consultation
- Leadership and Strategy
- Commissioning
- Support Processes
- Workforce
- 3rd Sector and Community
- Health Partnerships
- Self-Directed Support
- Financial

This is complemented by a range of research based work streams delivered by NHS Warrington to identify opportunities to develop and implement Telehealth and Telecare across services provided or commissioned by the Trust.

In partnership with a number of existing external provider organisations who deliver Supported Accommodation for Adults with a Learning Disability a range of opportunities have been identified to develop independence for service users and deliver service efficiencies through the use of Assistive Technology.

The Commissioning Directorate at NHS Warrington has undertaken some initial research around the potential delivery of Telehealth within the unscheduled care agenda. It is believed that a joined up approach to Assistive Technology may identify further opportunities to contribute to the health improvement agenda.

Therefore, it was on the basis that NHS Warrington and Warrington Borough Council tendered for the development of a strategy which will provide the overarching framework and strategic direction in relation to promoting independence, modernising service delivery and securing efficiencies.

At this same time, there was also a tender for a Learning Disability Implementation Pilot. This Pilot was seen as an opportunity to demonstrate both the utilisation and impact of using Assistive Technology solutions to increase independence, well being and secure service efficiencies across a cross section of people with a Learning Disability receiving Adult Social Care services in Warrington. It aimed to include working alongside a number of Social Workers from the WBC Community Learning Disability Team to review, evaluate and recommend the application of AT solutions to further develop service provision across a number of existing Learning Disability services.

Background to telecare in the UK

The term 'assistive technology' refers to 'any device or system that allows an individual to perform a task that they would otherwise be unable to do, or

increases the ease and safety with which the task can be performed' (Royal Commission on Long Term Care 1999).

Assistive technology ranges from very simple tools, such as calendar clocks and touch lamps, to high-tech solutions such as satellite navigation systems to help find someone who has got lost.

Telecare is care provided at a distance using information and communication technology. It is the continuous and automatic or remote monitoring of individuals by means of sensors to enable them to continue living in their own home, while minimising risks such as a fall, gas & flood detection, and other real time emergencies and life style changes over time.

Telecare can be remotely delivered and is location independent. It is flexible and expandable to meet changing individual needs. It fits into a care package derived from an individual assessment of need which can include domiciliary care, assistive technology and home nursing care.

The origins of telecare in the UK are a development of the community alarm services. The provision of personal alarms in a sheltered housing complex connecting to a control centre has developed as more sophisticated sensors have been introduced for monitoring and reducing risks to the individual in their own home. In addition, telecare has expanded from community alarms into dispersed alarm units in individual homes. Over 1.6 million service users are receiving telecare in the UK.

It can be stand alone equipment or attached via a phone line to a monitoring centre or carers alarm.

Building Telecare in England

The Department of Health published its ‘Building Telecare in England’ report in 2005. It stated that telecare offers choice and flexibility of service provision, from familiar community alarm services that provide an emergency response

and sensors that monitor and support daily living, through to more sophisticated solutions capable of monitoring vital signs and enabling individuals with long-term health conditions to remain at home.

It added that:

- people are living longer but less likely to have family support
- over next fifty years, over 65s will rise from 9.3 million to 16.8 million
- 1 million people are carers
- the number of people requiring community based health and social care support is expected to increase considerably over next decade
- people will have higher expectations, will want greater control and be able to manage their own risks
- people want independence and dignity

Telecare offers choice and flexibility of service provision, from familiar community alarm services that provide an emergency response and sensors that monitor and support daily living, through to more sophisticated solutions capable of monitoring vital signs and enabling individuals with long-term health conditions to remain at home. It also

- Promotes independence and enables choice
- Helps manage demand
- Alongside other interventions can bring real efficiency

The types of Telecare and Assistive Technology

- Basic Community Alarm Services (Introductory Telecare), dispersed and non- dispersed (or hard wired)

- Extended Alarm-Based Telecare with a range of sensors to support independent living
- Lifestyle Monitoring
- Telehealth
- Monitoring centre Proactive Calling
- Standalone AT

Telecare:

- Increases Quality of Life for the person receiving Telecare and their carers
- Releasing staff time and other resources that can be redirected to support other activities or people
- Achieves financial savings to ensure efficiency and best value[8]

Cost Efficiencies

A number of studies have already been undertaken to determine the cost efficiencies that telecare can bring. A review of the Scottish Telecare Development Programme identified that for 7,900 telecare users the estimated savings were £11.15 million in 2007-08. A review of two small telecare pilots showed savings of between £3,600 and £4,300 per person over the traditional package of care, with users being diverted from or delaying entry to residential care. [9]

10. Telehealth

Telehealth is the remote exchange of data between a patient at home and clinicians to assist in diagnosis and monitoring, typically used to support

[8] TATE project report, Welsh Centre for Learning \Disabilities

[9] See Appendixes 1 and 2 from CSED.

patients with Long Tem Conditions. Among other things it comprises home units to measure and monitor temperature, blood pressure and other vital signs parameters (and the answering of targeted questions) for clinical review at a remote location.

11. The Evidence base

The Kings Fund have commented that 'there is a growing body of evidence and experience suggesting that health care systems that combine multidisciplinary teams, self-management support and clinical information systems can lead to better management of patients with chronic illness.' Telehealth systems could clearly assist in the delivery of such an approach while also providing data for long term analysis or timely preventative interventions. (10)

The Veterans Health Administration (VHA) has evaluated, piloted, re-evaluated, and deployed Telehealth technologies in a continuing process of learning and improvement over the last 7 years that stands in vivid contrast to patterns of adoption in the US private healthcare sector.

In 2002 the VHA produced a detailed technology assessment of Telehealth in the management of CHF. Rita Kobb and colleagues had demonstrated a 60 percent decrease in hospital admissions, 81 percent decrease in nursing home admissions, and 66 percent decrease in ED visits among 281 RPM-monitored veterans with CHF, in comparison to 1,120 veterans who did not use the technology.(11)

Other VHA studies reported similar conclusions, for other diseases and conditions. The technology assessment recommended continuing trials to learn more about optimal target populations and clinical and financial impact.

10 CSIP Briefing 2008

11 R. Kobb et al., "Enhancing Elder Chronic Care through Technology and Care Coordination: Report from a Pilot," Telemedicine Journal and e-Health 9, no. 2 (2003): 189–195.

However Telehealth is a disruptive technology; its relies upon a reorganisation of care processes that include physiologic monitoring, protocol driven decision support, newly defined roles for clinical and nonclinical providers, and telecommunications that place patients at a distance in space, and frequently time, from the providers of their care. It also relies on a disruption of the usual business model for care of chronic disease, shifting some responsibilities to the patient and nonclinical providers; reducing use of and revenues for emergency departments.(12)

Telehealth, where proven, can offer the type of radical change in healthcare provision required to deliver the outcomes envisaged in 'Our Health, Our Care, Our Say' and support Lord Darzi's drive towards the development of personalised care plans.

In terms of conditions appropriate for telehealth, COPD and heart failure are the two that have been most extensively monitored through telehealth systems to date and the potential savings are considerable.

Hospital inpatient care is the biggest single health care cost, accounting for approximately 60% of the total cost of heart failure in the UK (£375m, 2000) and the cost of COPD exacerbations to the NHS is £550m PA (2004) resulting in 1.2m bed days (1999).

Diabetes is another condition appropriate for telehealth and Diabetes UK estimate that it costs the NHS £1m per hour (10% of the NHS annual budget).

Almost all studies of telehealth show a positive impact on people's health and general sense of well-being and some reduction in healthcare system usage. For example, the Carlisle Housing Association trial showed almost a 50% reduction in average length of stay. However evidence like this from the UK is

[12] Remote PatientManagement: Technology-Enabled Innovation And Evolving Business Models For Chronic Disease Care Remote patient management technologies are attracting new interest from organizations at risk for the consequences of poorly managed chronic disease care. by Molly Joel Coye, Ateret Haselkorn, and Steven DeMello. CDC Jan 2009

sketchy and most programmes, have been simply too small to have produced statistically valid results. However the following provide some additional evidence to the success of such services:

Newham

- reduction in hospital use
- modified patient disease management behaviour
- improved interaction with health and social care providers
- improved medication and treatment compliance
- enabled early intervention in and prevention of acute exacerbation of chronic disease.

Currently all large-scale evidence comes from North America, but the evidence is compelling. One study of 62,000 patients with diabetes, COPD, heart failure and coronary artery disease reduced hospital admissions and A&E attendances by almost 50%, and re- admissions for COPD reduced by 50.6% and A&E visits by 65.5%.

The DH's WSD Programme is driven by the need to understand the true benefit of integrated health and social care supported by advanced assistive technology (telehealth and telecare). The key to proving the business case is a robust evaluation. The DH has put together a consortia of UK universities to deliver the evaluation which will be extremely robust and has been designed as a randomised control trial, focusing on individuals with chronic obstructive pulmonary disease (COPD), heart failure and diabetes, and adults with social care or health and social care needs at risk of hospital admission.

The evaluation will look at the extent to which these assistive technologies

- promote individual's long term well-being and independence
- improve individual's and their carer's quality of life
- improve the working lives of staff
- are cost effective

- are clinically effective

The evaluation will be complemented by structured lessons learnt to help inform future mainstreaming of this activity.

The three sites are Kent, Cornwell, Newham. Thousands of service users will benefit from the programme, making it the largest trial of telecare and telehealth in the UK to date. Each site will recruit up to 1,000 patients/users for telehealth and up to 1,000 patients/users for telecare it will report its findings early 2011.

13. National Picture relating to Assistive Technology – Dementia strategy

The Department of Health's published its first ever National Dementia Strategy in February 2009. This is recognised as a landmark document that will transform the quality of dementia care. It sets out initiatives designed to make the lives of people with dementia, their carers and families better and more fulfilled. The challenge of dementia is that:

- It presents a huge challenge to society, now and in the future
- currently 700,000 people in the UK with dementia
- Approximately 570,000 live in England
- costs the UK economy £17 billion a year
- in the next 30 years, number of people will double to 1.4 million, with costs trebling to over £50 billion a year

The aim of the strategy is to ensure that significant improvements are made to dementia services in:

- Improved awareness

- Earlier diagnosis and intervention
- A higher quality of care

The Strategy is to be a catalyst for a change in the way that people with dementia are viewed and cared for in England. It has 17 objectives; number 10 is relevant to Telecare:

'Consider the potential for housing support, housing-related services and telecare to support people with dementia and their carers. The needs of people with dementia and their carers should be included in the development of housing options, assistive technology and telecare. As evidence emerges, commissioners should consider the provision of options to prolong independent living and delay reliance on more intensive services.'

The new Collation Government supports the increased use of Telecare and technology to support it's health and care agenda. Whilst in opposition the, current Health Secretary stated.

'Innovative new care interventions are being developed for example Telecare, but we need to be able to resource it'.

'We propose a separate ring fenced Public Health budget that is a real opportunity to have a specific resource to support Telecare.'

Further the White Paper – Liberating the NHS states:
The Government will seek to break down barriers between health and social care funding to encourage preventative action (Telecare). Later this year (2010) the Government will set out its vision for adult social care, to enable people to have greater control over their care and support so they can enjoy maximum independence and responsibility for their own lives.

It states that the Government wishes to '*increase self-care and the use of new technologies for people with long-term conditions'.*

14. Local Strategies relating to Telecare

There are a broad range of strategies which have been developed across a broad range of topics in Warrington. Some of these are joint and others organisation specific. Assistive Technology is contained within many of these strategies but not in any great depth.

The Warrington AT Strategy aims to flesh the detail out.

Below are summaries of a range of the most pertinent strategies and the relevance of AT to their aims.
The JSNA shows that high blood pressure, diabetes, circulatory diseases, emergency and mental health admissions linked to deprivation. JSNA shows that those living in the poorer areas of Warrington have higher levels of ill health and a poorer quality of life.

Demographic information & context within strategies

Health & Social care strategic plan for Warrington 2008-2011

The key themes of the Health & Social care strategic plan for Warrington 2008-2011 relevant to Telecare are:

- Financial & personal costs will escalate if co-ordinated steps are not taken to minimise prevalence & to raise personal awareness & responsibility within LTC prevention & management

- The aim is to address the spectrum of needs of people with LTCs from self-management through to EOLC services

- The pathway of many LTCs indicates that effective care cannot be delivered without an encompassing health & social care approach & commitment

- The population of >85 year old will double by 2026.

- Older people have a higher prevalence of chronic diseases & need for both health & social care services. Typically 20% of the >85 population will present with dementia, which is significant due to the requirement for integrated service provision.

- As part of TASC, development & co-ordination of preventative services is high on the agenda.

- There is a growing evidence based to support the theory that both clinical outcomes & mental health well-being are improved when the person feels in control of their care

- Use of new and innovative technology as one of the 'principles' in their approach to change

- Evidence that electronic monitoring & telemonitoring is effective in the management of LTC

Joint Commissioning Strategy for Physically and Sensory Disabled Adults in Warrington 2009-2012 [13]**.** This a three year plan for meeting the needs of physically and sensory disabled people in Warrington.

Two of the key commissioning priorities are to:

[13] NHS Warrington, Warrington Borough Council

- ‘Establish a programme of work to identify and overcome barriers to independence in Warrington, to lead to the development of a long-term plan to achieve the objectives of the Independent Living Plan.’

- ‘Further develop support services for carers of physically and sensory disabled people through joint work with Warrington Carers Strategy thematic groups’.

AT fits in with both of these although it is not explicitly mentioned.

The strategy explicitly states that ***‘Telecare should be integral not marginal’***

Under a section headed ‘Housing and Adaptations’ it is stated that there is insufficient specialist and adapted housing for people with acquire brain injury. ***AT could be part of the solution.***

Strategy for an ageing population Phase 1: Addressing the needs of older People 2009-2015 (Warrington Partnership’ By 2026 43% of the population in the Borough will be over 50 and there will be fewer younger people.

The vision talks about a number of areas for action. One of these if ‘Safe and Stronger’ where people within active communities feel safer. Another is ‘Healthy and Active’ where people can enjoy good health and wellbeing.

AT supports both of these and if it is set up on a neighbourhood basis this adds strength. It does make mention of adaptations to support people to stay at home safely.It also makes mention of working with partners to promote the use of holistic home assessments that at the wider needs of older people.

Warrington Strategy 2010-2013 for Mental Health and Wellbeing[14] This strategy emphasises that: 'Public engagement is the key to successful implementation of any strategy'.

It states that: 'In Warrington, as elsewhere, the prevalence of dementia is increasing, with the number of people who suffer with dementia, set to double over the next 20 years'

This strategy seems to have superseded the following strategy

Warrington Mental Health Strategy for Older People April 2007 – March 2010[15]

There are six priorities within which there are a number of actions. The most relevant actions are listed below:

- To further develop intermediate care for older people and mental health including crisis response to prevent admission.

- Extend the use of Telecare and evaluate its achievement to date.

Self Care Strategy Plan 2010 /11

Emphasis in this plan on supporting people with LTC to optimally self-care. Putting the person and/or carers 'in charge' .

The benefits are identified as being:

- Benefits to patient:
- Improved quality of life
- Better symptom management
- Improved feeling of wellbeing

[14] *NHS Warrington, WBC*
[15] *WBC, NHS Warrington and 5 Boroughs Partnership*

- Increased life expectancy
- Benefits to primary care:
- Reduction in inappropriate consultations
- Possible reduction in visits by frequent attenders
- Fewer visits to GP's for minor ailments
- Better use of medicines
- Allows GP's to focus on the most challenging cases
- Benefits to PCT and wider health community:
- Potential reduction in number of hospitalisations
- Reduction in visits to GP's
- Medicines intake regulated better or reduced

Many of the outcomes identified above can all be delivered by the use of Telehealth.

The locally developed self-care model includes equipment (broadly not AT specific).The Action Plan states: 'Link into integrated Health and Social Care AT Strategy.'

15. Developing a comprehensive community learning disability services infrastructure

The objective is to transform the quality of care, service model & configuration of services with people with LD across the 4 boroughs. This is to be achieved through the development of a more effective range of community support services to enable people to remain at home & avoid hospital admissions

The service will be committed to achieving the outcomes of 'rights, inclusion, independence & choice' and to ensuring it 'sticks with' individuals in spite of the difficulties experienced in meeting their needs.

Integrated Community LD teams will lead to a greater level of admission avoidance & accelerated discharge from inpatient services. Funding will be based on the principles of supporting individuals to live independent fulfilling lives, resources currently committed to inpatient services should migrate to community services as activity migrates.

Key elements of the model of care proposed

16. Warrington Carers Strategy 2007-2010

976 Warrington residents identified themselves as unpaid carers at the 2001 Census. This represents over 10% of the population. Of these, 4110 people stated that they provided 50 or more hours of care per week

A report by Carers UK estimates that numbers of informal carers in the UK could increase from 5.7 million in 2001 to 9.1million in 2037

Eight key priorities for carers in Warrington – of these most important to AT can be seen to be Priority 2: Identification & assessment of carers & their needs.

17. Strategic Commissioning Plan 2009/10 – 2013/14 (2010/2011 Refresh)

Biggest causes of ill health and premature mortality in Warrington are alcohol, CVD & COPD.

Approach is about building services around patients, bringing care closer to home, via the development of integrated pathways of care, focusing in particular on the major causes of ill health in Warrington: CVD, COPD, alcohol & mental health.

Strategic goals: improve healthy life expectancy for all & reduce inequalities, prioritise earlier interventions in care pathways, improve the quality, safety, patient experience & cost-effectiveness of commissioned services, optimise health outcomes whilst achieving sustained financial balance.

NHS Warrington is taking forward its 'Care Closer to Home Strategy'. This strategy will describe a vision for the provision of services in the community for the next 5-10 years. A range of clinical pathways will be reviewed to identify opportunities for improvement in quality, defined as: safety, clinical effectiveness, efficiency, cost-effectiveness and patient experience.

An estimated 10, 000 people in the Warrington population provide care for a relative with a mental health condition

Issues with accessing GP & OOHs in situations where acute symptoms cause the cared for to refuse to seek help or access help

NHSW has 'disappointing performance' on their VSA05 target for Unscheduled admissions

NHSW historically funded 1.4% below target - £4m under allocation

AT hits Goal 2 of NHSW's Strategic Goals: ***all evidence suggests that earlier intervention improves health & decreases morbidity***

Over the course of 2010/11, our objective & goals for improving patient safety include: to reduce unintended deaths & accidents through: a reduction in the number of falls sustained by older people.

Key initiatives impacting on prevention are: falls programme: this initiative involves systematic implementation of NICE falls prevention guidance, with implementation co-ordinated between health & social care

In the 'delivery' section of the strategy plan: research into the feasibility of Telemedicine & Telecare, which supports our Care Closer to Home Strategy

18. Warrington Joint Strategic Needs Assessment March 2008

Warrington's population currently stands at 194, 000 (mid 2006 ONS estimate). Warrington has a slightly younger population than the national and regional averages. However, over the last 10 years the percentage of people aged over 65 has increased from 13.9% to 15.1%. This ageing population is set to continue, with projections suggesting that the population of the borough will continue to age as a faster rate than the national average.

The population over 85 is expected to double from 3, 300 in 2006 to 6, 600 in 2026.

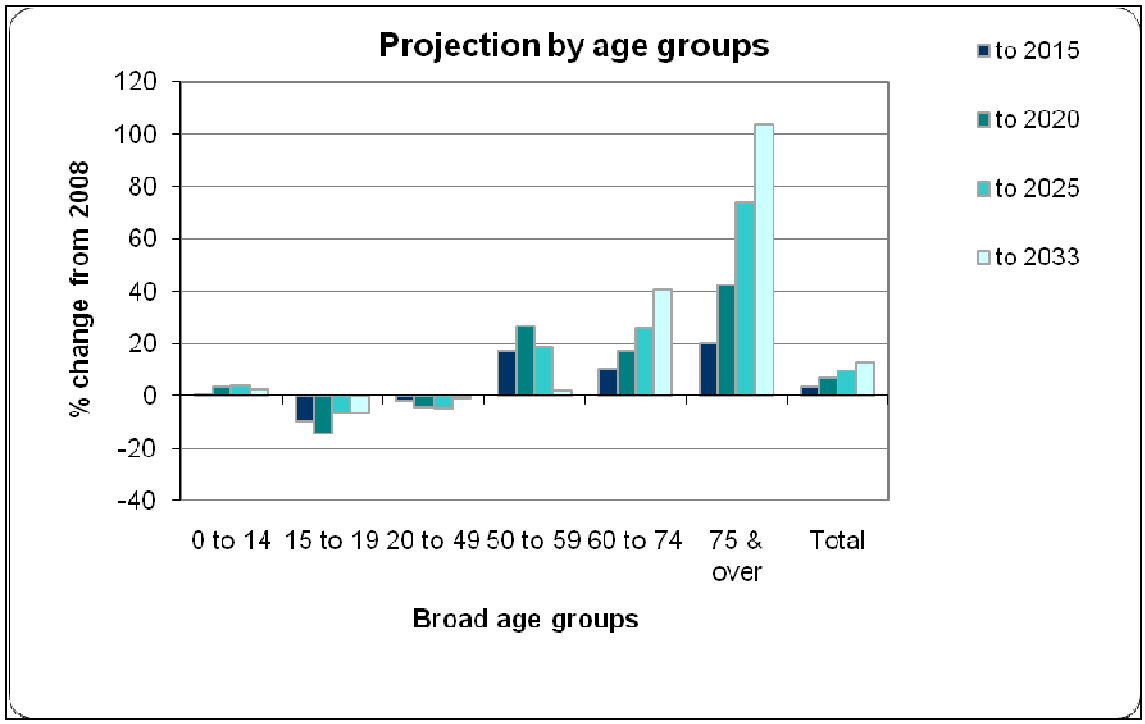
Warrington has a relatively small black & minority ethnic population, with 97.8% stating their ethnic group as white

Health status, as measured by life expectancy & mortality rates, is worse than the average for England. The major contributors to life expectancy in Warrington are circulatory, respiratory & digestive diseases

The rate of hospital admissions in Warrington is significantly higher than the England average. There is a significant correlation between deprivation & emergency admissions at ward level.

Two different projection models have estimated that the number of people with dementia will increase from under 1000 diagnosed in 2006 to 3300 in 2021

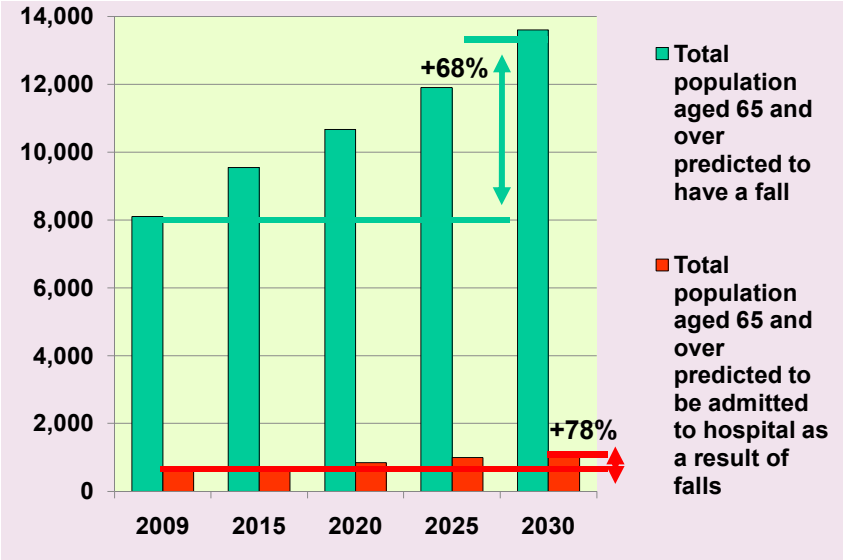
In 2006/07, 1400 patients were diagnosed with severe mental illness; the prevalence of severe mental illness is strongly correlated with deprivation



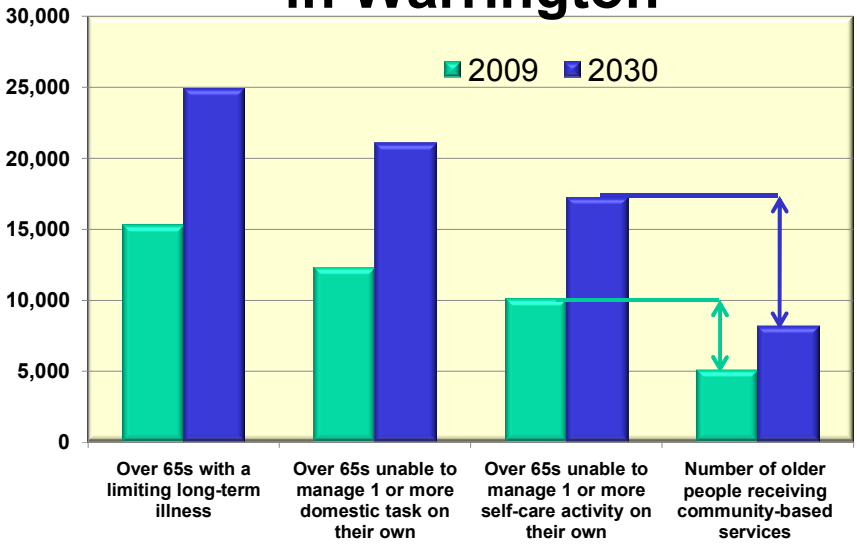
The following graphs identify the areas that AT should be targeted and the growth in demand.

choose independence

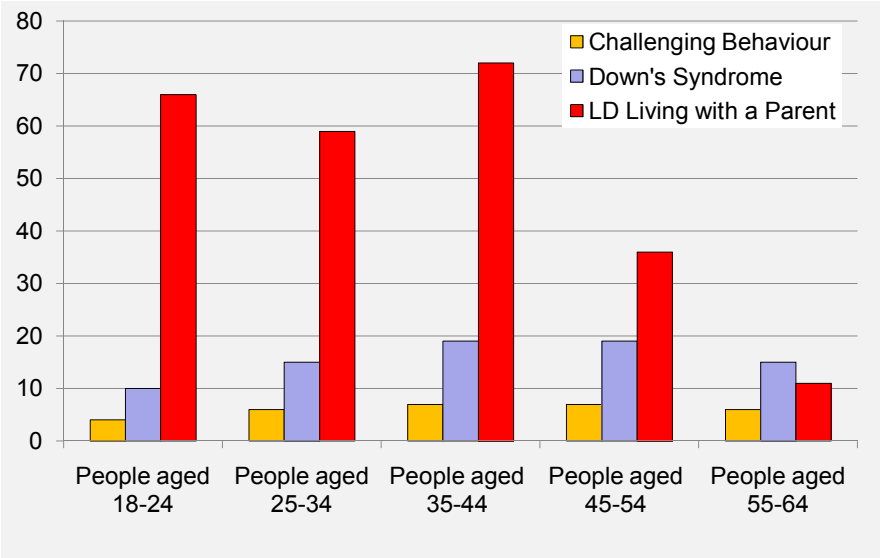
Warrington Falls Predictions



Demand for Support Services in Warrington



Learning Disabilities in Warrington



Older Carers