

## Telecare, hospital discharge and reablement

The current overview of resources is a follow-up of **ripfa's** *Telecare: a review of the evidence*<sup>1</sup> written for Cumbria County Council and submitted on 26 March 2010. The current follow-up concentrates on the evidence of using telecare in reablement. Since all online searches defined by 'telecare'/assistive technologies' AND 'reablement'/re-ablement' returned no results, the search and subsequently the content of the current review was expanded to incorporate also 'hospital discharge' and 'intermediate care' in relation to telecare.

There is a vast amount of literature/research evaluating telecare programmes in general; what follows is an overview of identified excerpts from these texts that focus specifically on **reablement/hospital discharge**. No research texts focusing exclusively on telecare and reablement were identified yet.

**Note:** The current overview constitutes an addition to **ripfa's** evidence review quoted above.

### 1. West Lothian is given as a model example for proven impact on hospital discharge

*'Telecare.. helped West Lothian **achieve the lowest proportion of delayed hospital discharges of older people** in Scotland and **reduced the average stay in private care homes from 36 to 18 months**'*

Yeandle S (2009) *Telecare: a crucial opportunity to help save our health and social care system*, The Bow Group <http://www.bowgroup.org/files/bowgroup/TelecarePaper%20-%20Healthcare.pdf> (**A detailed overview of the West Lothian case is on p46**)

*Building an evidence base for successful telecare implementation* – updated report of the Evidence Working Group of the Telecare Policy Collaborative chaired by James Barlow [http://www.ssiacymru.org.uk/media/pdf/f/4/APPENDIX\\_B\\_CSIP\\_Telecare.pdf](http://www.ssiacymru.org.uk/media/pdf/f/4/APPENDIX_B_CSIP_Telecare.pdf)

### 2. The Bow Group report—quoted above—provides evidence for the following **benefits** of telecare

- 'Reduced use of high cost care or hospitalisation'
- 'Improved quality of life'
- 'Greater patient security and self management and reduced mortality'
- 'Mild to moderate' measurable clinical outcomes, especially re mental health and (to a lesser extent) heart disease
- 'Savings were made in acute bed days and professional time' in telemonitoring of people with 'acute unstable conditions'

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<sup>1</sup> [http://www.ripfa.org.uk/onetoone/projectoutputs/doc\\_download/312-telecare-a-review-of-the-evidence](http://www.ripfa.org.uk/onetoone/projectoutputs/doc_download/312-telecare-a-review-of-the-evidence)

- 'The number of home visits to COPD patients using telemonitoring devices 'dropped by around 80%', with a separate study<sup>80</sup> showing 'savings in acute bed days' (Yeandle 2009).

**3.** The Bow Group report lists also plenty of **examples** of cost-savings in general and how those have been achieved: Northamptonshire, North Yorkshire, West Lothian, Swindon, Essex, Croydon (Yeandle 2009, **pages 45-48**).

**4.** Increase of **speed of hospital discharge** has been demonstrated by Partnerships in Scotland

- By the end of 2007/08, 20 Partnerships reported having reduced the number of delayed discharges (used as a proxy for increasing the speed of discharge), with these savings being made across 21 projects.
- During this period it is estimated that the number of discharges facilitated by TDP funds was 517, with an accompanying saving of 5,668 bed days.
- The number of bed days saved for each facilitated discharge appears generally to be between 7 and 15 days.
- The main beneficiaries were older people.

Beale S, Sanderson D & Kruger J (2009) Evaluation of the Telecare Development Programme: Final report, the Scottish Government  
<http://www.jitscotland.org.uk/downloads/1235404195-B59058%20Final%20Report%20low%20res.pdf>

Reading this report in full is highly recommended. Here is some further numerical breakdown from the report

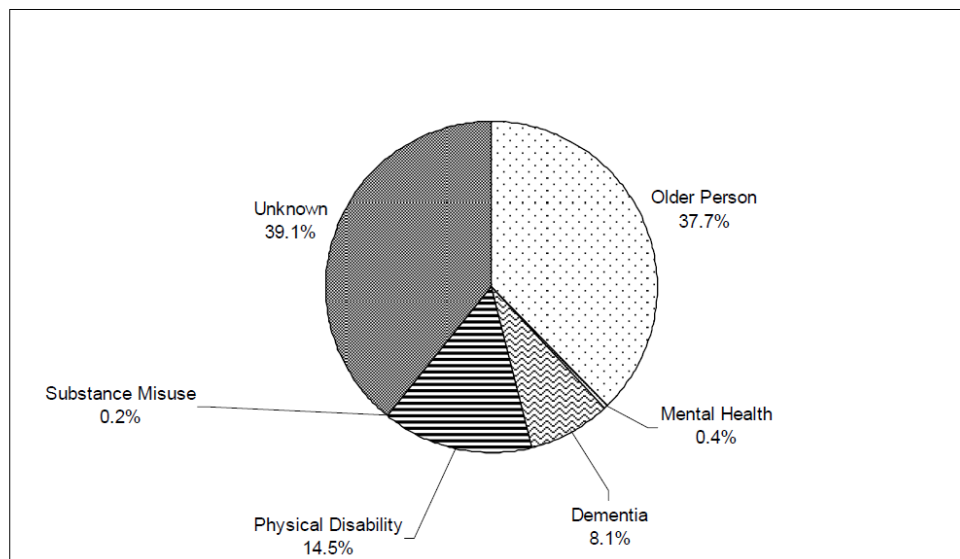
**Table 10 Scottish Telecare Development Programme: savings achieved**

Outcome	Actual Savings Achieved April 2007 – March 2008		
	Saving	Estimated monetary value	
Hospital bed days saved by facilitating speedier hospital discharge	5,668 days 517 discharges	£1.7m	15.5%
Reduced unplanned hospital admissions – bed days saved	13,870 days 1,220 admissions	£3.34m	30.0%
Care home bed days saved by delaying entry to care homes	62,993 days 518 admissions	£3.42m	30.7%
Nights of sleepover care saved	Info. n/a	£0.55m	5.0%
Home check visits saved	Info. n/a	£1.79 m	16.1%
Locally identified savings, e.g. reduced waking nights	Info. n/a	£0.30m	2.7%
No. of TDP funded telecare users	7,902 users		
<b>Estimated verifiable savings as a result of Scottish TDP</b>		<b>£11.15m</b>	<b>100%</b>

Source: Beale et al (2009), *op. cit.*

The breakdown by client groups is also worth noting; as stated above, **the main beneficiaries from speedier hospital discharge were older people:**

**Figure 5.1: Distribution of categories of clients for whom discharge from hospital was facilitated by TDP funds\***



\* When compared with Figure 5.3, it appears that a disproportionate number of bed days were saved for clients in the older people category, compared with number of discharges facilitated in this client group. This is because some Partnerships reported the client group for bed days saved but not for facilitated discharges.

**However**, another report (also Scotland) claims demonstrated a potential **discrepancy between expectations and realities** when hospital discharge / bed-savings are concerned.

**Table 4: TDP Generated Efficiencies 2008/9**

	Partnership Expectations		Partnership Achievements	
	2006-8	2008/9 <sup>a</sup>	2006-8	2008/9
Number of hospital bed days saved due to reduction in number of delayed discharges	24,793	9,637	5,668	3,679
Number of hospital bed days saved due to reduction in number of unplanned hospital admissions.	14,880 <sup>b</sup>	9,528	13,870	11,416
Reduction in number of care home bed days purchased	76,535	68,251	61,993	78,991
Number of nights sleepover care saved	12,798 <sup>c</sup>	25,727	11,707	10,868
Number of home check visits saved	261,506	267,699	314,463	45,750

Monitoring Telecare Progress (2009) Newhaven Research  
[http://www.jitscotland.org.uk/downloads/1242917400-Telecare%20Development%20Programme%20\(2008-2010\)%20Evaluation%20-%20Monitoring%20Progress%20Final%20Report%202008\\_9%20-%20May%202009.pdf](http://www.jitscotland.org.uk/downloads/1242917400-Telecare%20Development%20Programme%20(2008-2010)%20Evaluation%20-%20Monitoring%20Progress%20Final%20Report%202008_9%20-%20May%202009.pdf)

The above demonstrates—as pointed out by the authors—more **planned** than achieved efficiency in terms of hospital bed days saved; the demonstrated efficiency regarding care home beds was higher.

## 5. Telecare and reablement

An interesting observation made by the Telecare Think Tank (Wales):

An identified failing in current provision for reablement is that the teams generally work office hours or, at best, a 12 hour day shift from 8am to 8pm. Although there are no set hours for the Conwy team, it is clear that the issue of **weekend working and of night shifts hasn't yet been addressed**. Similarly, the role of telecare in reablement will need to be considered alongside the form of most appropriate response to identified emergencies. Wrexham does not currently offer a reablement service.

Telecare Think Tank (2007) North Wales Regional Collaborative Approach to Telecare: Feasibility Study <http://www.ssiacymru.org.uk/index.cfm?articleid=2911>

In addition to Andrew Lansley's words of governmental commitment regarding reablement<sup>2</sup> the Welsh Health Minister Edwina Hart said back in spring 2010:

Our aim is to deliver safe services as locally as possible to people's homes. People understand that for access to highly specialised services, they may have to travel, but for more routine services, they should be able to go to their local hospital or GPs surgery. The plan recognises that through additional training for staff or by using telecare, patients can get more services locally, including pre and post-operative care. It could be, for example, that a patient would go to the local hospital for tests and scans but have an appointment with a consultant at another hospital by using telecare, reducing the need to travel.

What's on the political agenda for telecare and telehealth? *The link: the quarterly magazine of the Telecare Services Association*, Spring 2010  
<http://www.telecare.org.uk/files/48444/FileName/SpringLink2010.pdf>

## 6. Telecare, reablement and hospital discharge: **advantages and concerns**

These were outlined by CSIP in 2005; what follows on next page is an excerpt from the original table.

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<sup>2</sup> *Hospitals are responsible for patients for 30 days after discharge – integrating the care that is provided in hospitals and in the community, giving the hospital a stake in the quality of reablement support for people as they return home.*

[http://www.dh.gov.uk/en/MediaCentre/Speeches/DH\\_117331?utm\\_source=twitterfeed&utm\\_medium=twitter](http://www.dh.gov.uk/en/MediaCentre/Speeches/DH_117331?utm_source=twitterfeed&utm_medium=twitter)

Area	Advantages	Barriers and concerns	Comment
Discharge planners	<ul style="list-style-type: none"> <li>Prompt discharge from hospital.</li> <li>Early discharge planning needed. Pre-admission information from district nurses (DNs) and GPs and better links with Occupational Therapists (OTs)/Allied Health Professionals and Home Improvement Agencies</li> </ul>	<ul style="list-style-type: none"> <li>Inappropriate identification of patients who could benefit from telecare</li> <li>Telecare could lead to lack of confidence in equipment</li> </ul>	<ul style="list-style-type: none"> <li>Control centres could provide a "care coordination and reference role" as well as the monitoring service provision itself</li> <li>Utilise the work of Home Improvement Agencies (HIAs) to tackle disrepair, property health &amp; safety checks and provide aids and adaptations</li> </ul>
Intermediate care, Step-up, Step-down	<ul style="list-style-type: none"> <li>Support intermediate care programmes and rehabilitation</li> <li>In- patient units can give time to test equipment and gain user and carer confidence</li> </ul>	<ul style="list-style-type: none"> <li>Lack of telecare awareness of Primary Health Care Team particularly GPs and district nurses may lead to uncertainty of benefits</li> </ul>	<ul style="list-style-type: none"> <li>Follow up after discharge vital to sustain clients rehabilitation and confidence in telecare</li> <li>Assess 'move-on' housing with care options such as extra care</li> </ul>

CSIP (2005) *Telecare Implementation Guide*, Department of Health  
[http://www.dhcarenetworks.org.uk/library/Resources/Telecare/Telecare\\_advice/Telecare-Implementation-Guide-19-July-2005.doc](http://www.dhcarenetworks.org.uk/library/Resources/Telecare/Telecare_advice/Telecare-Implementation-Guide-19-July-2005.doc)

## 7. Telecare and hospital discharge: **ethical issues**

...There may be situations such as **hospital discharges** where there is insufficient time for personalised information, repeated visits, home trials or presence of independent advocates, although liaising with carers is imperative. Sometimes the pace of installations planned by commissioners, associated with pressure to achieve performance targets, will also militate against the thorough approach to gaining consent advocated here. An ethical approach to telecare provision must balance the potential beneficent outcomes gained by rapid roll-out against the disadvantage of introducing telecare before it is fully understood and accepted by the individual.

Perry J, Beyer S, Francis J & Holmes P (2010) Ethical issues in the use of telecare, Social Care Institute for Excellence <http://www.scie.org.uk/publications/reports/report30.pdf>

## 8. Reablement **case studies**

**8.1** Mrs B has a history of falling. Following discharge from hospital she was provided with a basic telecare package that included a bed pressure sensor that could detect when she left the bed during the night and turned on the lighting to her bathroom. It would then trigger an alarm if she did not return to bed within an agreed time.

The package was programmed to record how many times Mrs B left her bed during the night. A few weeks after it was installed it was noticed at the control centre that

Mrs B's nocturnal visits to the bathroom had increased significantly over a three day period. They alerted a care professional and Mrs B was diagnosed with a urinary tract infection which was then quickly treated enabling a full and quick recovery.

Department of Health (2005) Building Telecare in England, Department of Health  
<http://www.independentliving.co.uk/building-telecare.pdf>

**8.2** Mr C, a man diagnosed with autism was transferred to hospital following the breakdown of his placement due to challenging behaviour and a number of serious violent incidents. He was identified as needing a specialist highly staffed service outside of the county due to his health needs and his behaviour.

His care manager was concerned that he did not want to live outside the local area and felt that the same serious issues might arise in a highly staffed environment as his behavioural issues seemed to increase with more intensive staffing.

He moved out of hospital twelve months ago and is currently living in his own house back in his local area with low key, arms-length support from the same provider. He has an epilepsy sensor and a bed sensor to manage the risks of nocturnal seizures and he wears a fall detector during the day. He is happy with the support he receives and how it links in with the technology as he understands it means that he gets to live where and how he wants to.

### **Benefits**

- The cheapest quote for an Out of County placement for Mr C was over £2,500 per week – his support package locally is £400; equating to a notional £109,500 p.a.

CSED (2010) *Efficiencies in Telecare: Cheshire East Council*<sup>3</sup>  
[http://www.csed.dh.gov.uk/library/Resources/CSED/CSEDProduct/CSED\\_Cheshire\\_East\\_LD\\_case\\_study\\_web\\_version\\_14Feb.pdf](http://www.csed.dh.gov.uk/library/Resources/CSED/CSEDProduct/CSED_Cheshire_East_LD_case_study_web_version_14Feb.pdf)

## **9. Evidence emerging from local telecare programmes**

Here is some local evidence from service evaluation; we did not come across anything detailed about quality of life outcomes.

**9.1 Carlisle Housing Association Careline Service** worked with Carlisle and District Primary Care Trust to develop a plan of care supporting early discharge. A designated COPD team and a team from Careline were jointly trained on the use of Telemedicine Units. Clinical parameters were set by clinicians for each individual patient and if the reading from the Telemedicine units deviated from set levels an alert would be forwarded to Carlisle Housing Association Careline Services. They would inform the COPD

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<sup>3</sup> All SCED case studies available at <http://www.csed.dh.gov.uk/AT/caseStudies/> A brief summary of many of many local studies is available in [Harris \(2007\)](#)

team and any required intervention would take place. This system provided 24 hour medical care and response.

*Outcomes:*

- Prior to development of the service, the **average length of hospitalisation** was 10 days. From 2004 onwards this reduced to five and a half days. Based on a clearly significant 50% reduction the trial was extended and then mainstreamed and budgeted for each financial year.
- A qualitative questionnaire showed that patients and carers (once familiar with the technology) **felt less anxious and more in control** of their condition and they complied with prescribed therapies. Their self-esteem increased and this led to better self-management.
- Reduced hospital stays lessened the risk of hospital acquired infections. For health professionals – monitoring at home prevents longer hospital stays, prevents traditional bed blocking, and provides cost savings for the Trust.

Curry R & Lethbridge S (2009) An International Centre of Excellence in Telecare: Background and Development, SEHTA <http://www.sehta.co.uk/files/ReportICE-T.pdf>

**9.2 The Northern Ireland Project** In Northern Ireland Fold Housing Association worked with 14 Northern Neighbourhoods Health Action Zones to develop and implement Telecare. Fold Telecare is the largest social alarm monitoring and response service in Northern Ireland and supports 20,000 customer connections. The aim of the project was to utilise innovations in technology to develop a Telecare service which enabled and supported older people to feel safe in their homes.

Telecare systems were installed in 153 units over 15 months. Houghton, Fisk and Fisk (2005) undertook an evaluation including interviews with users, carers and key agency stakeholders. Results indicated that installation of the Telecare packages with related 24-hour support services had a positive impact on the lives of the older people. Both users and carers reported that users' confidence had increased, as did their independence and feelings of security and safety. The service seemed to have been a factor in enabling some people to remain living in their own homes, as 26 per cent of users reported that they had been thinking of moving before they were offered Telecare support.

In interviews with service stakeholders, Telecare was perceived as having had a preventative and responsive role, facilitating independence and providing reassurance and peace of mind for users. **Despite the project being linked to hospital discharge, stakeholders were divided over whether or not Telecare could facilitate discharge or reduce admissions to care by itself.** Telecare was successful mostly as part of a package of care which responded to individual needs, and which included community and family support (Houghton, Fisk and Fisk, 2005).

Alaszewski A & Cappello R (2006) *Piloting Telecare in Kent County Council: The Key Lessons*, Centre for Health Services Studies, University of Kent [http://kar.kent.ac.uk/3580/1/Alaszewski\\_PilotingTelecare\\_Dec\\_2006.pdf](http://kar.kent.ac.uk/3580/1/Alaszewski_PilotingTelecare_Dec_2006.pdf)

## 10. User views

In spite of the fact that these are general and not necessarily related to reablement, we include them here due to their importance.

### 10.1 *What deters end users and carers from using telehealth and Telecare services?*

- **The potential for loss of privacy and Confidentiality**
- **Loss of social interaction** - There are concerns about the potential for such technologies to lead to less social interaction. Social interaction is very important to most older people, and in some cases interaction with formal carers is a main source, whether face-to-face or over the telephone. In some instances older people fear that telecare technologies will be used to replace traditional 'human effort' and that staff will inevitably be withdrawn as a consequence of the introduction of telecare services. There is also some evidence that replacing some face-to-face contact with telephone contact would not necessarily be perceived negatively by end users – as long as the quality of the interaction is satisfactory.
- **Trust** - Lack of trust in the institutions delivering ALTs was also in evidence. In one study older people were sceptical that there would be sufficient clinical resources to respond to alarms and crises.
- **Stigma** - Some older people expressed concerns about the stigmatisation they perceived to be associated with ALTs. The intrusive or stigmatising impact of ALTs was attributed to the unsightly 'medical' appearance of much of the current telecare equipment.

Damodaran L & Olphert W (2010) User Responses to Assisted Living Technologies (ALTs) – A Review of the Literature, *Journal of Integrated Care*, 18(2), 25-32

**10.2** This study interviewed patients and professionals about their experiences of home telemonitoring during the first six months following hospital discharge. The telemonitoring was used daily by patients in their home to monitor signs and symptoms of heart failure and the information was read by a heart failure nurse in secondary care. Overall the study demonstrated how telemonitoring is more than a technology platform. It relies upon patients' and professionals' knowledge and skills and has the potential to enhance patient care. Patients found the equipment easy to use and adopted it into their everyday routines. However it integrated less easily into traditional healthcare practices and highlighted **where care was not seamless between primary and secondary care**. The research findings therefore indicate that telemonitoring cannot be placed into existing services without some discussion between the key players in the different healthcare sectors.

Department of Health (2009) Research and development work relating to assistive technology 2008-09, Department of Health  
[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_102240.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_102240.pdf)

## 11. Research and evaluation methods

The majority of local research and evaluation has been in the area of cost-efficiency. The studies related to service user views / satisfaction have utilised the traditional (phenomenological) qualitative methods. We suggest that if the quality of life / quality of care outcomes are at the centre of attention, the general personal outcomes measures available for adult social care are used<sup>4</sup>.

### 11.1 Here is an example of a cost-efficiency measure.

Financial analysis of care service provision is challenging, not least because the nature of services required is unique to each individual needing care... To make the task tractable, two case study areas were chosen for investigation. These were the Falkirk and Forth Valley, and the West Dunbartonshire local care partnerships. In each area, a local group of health and care service and finance managers was established.

It was agreed with both groups that attention would centre on calculating the financial costs of care packages being provided to meet the needs of a small number of telecare service users that could be considered as 'typical' within each area. No preset number of typical service users was specified, but in the end both areas settled on providing profiles for six typical service users.

The groups were asked to identify the major components of the overall care packages being received by each of their typical service users, as well as to establish what would be considered acceptable locally as a realistic alternative package of care. The alternative package had to exclude telecare.

Discussions were then held with the two groups to determine suitable unit cost data for each component of each typical/alternative care package.

The partnership groups were encouraged to generate financial information internally wherever possible, but both were also provided with a copy of the most recent data on unit costs of health and social care published by the Personal Social Services Research Unit (PSSRU) at the University of Kent (Curtis, 2008), either to use for cross checking purposes, or to draw upon as an alternative data source if it was felt to be suitable and necessary.

Using the information provided by the partnerships, a spreadsheet model was built for each that calculates an annual cost for the care packages for each typical service user. The model also records whether the cost of providing component elements of each package falls to a social or a health care provider.

These calculations were discussed with the case study area groups and subsequently amended on the basis of feedback received.

*Exploring the Cost Implications of Telecare Service Provision* (2010) Newhaven Research  
<http://www.jitscotland.org.uk/downloads/1267434067-Care%20Package%20Cost%20Modelling%20February%202010.doc>

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<sup>4</sup> *Measuring Personal Outcomes in Adult Social Care: A Review*  
[http://www.ripfa.org.uk/onetoone/projectoutputs/doc\\_download/468-measuring-personal-outcomes-in-adult-social-care-a-review](http://www.ripfa.org.uk/onetoone/projectoutputs/doc_download/468-measuring-personal-outcomes-in-adult-social-care-a-review)

**11.2** It is recognised that RCTs may not be feasible in the context within which most types of telecare arising from the Preventative Technologies Grant are being deployed. Moreover, local care services are unlikely to have the expertise, time or resources to conduct an RCT.

**Nevertheless, as a minimum, care and support services introducing telecare should collect data on the changing care outcomes, delivery processes (e.g. impact on jobs and work practices) and costs and savings as the scheme is being deployed and mainstreamed. This should be made publicly available for other researchers to carry out detailed evaluation.**

*Building an evidence base for successful telecare implementation* – updated report of the Evidence Working Group of the Telecare Policy Collaborative chaired by James Barlow  
[http://www.ssiacymru.org.uk/media/pdf/f/4/APPENDIX\\_B\\_CSIP\\_Telecare.pdf](http://www.ssiacymru.org.uk/media/pdf/f/4/APPENDIX_B_CSIP_Telecare.pdf)

## 12. Conclusion

While telecare and particularly its impact on cost-efficiency and prevention has been extensively researched, it is still early for any specific research findings regarding telecare in reablement. This reflects an earlier point about the lack of research on the broader context in which telecare is applied.

The limited trials of telecare services have generally been evaluated with a view to exploring their individual clinical outcomes, rather than systemic impacts. The work reported here suggests that an increased emphasis should be put on understanding the *systemic impacts* of the implementation of service innovations *over time*. While clearly more research and better data are needed, this paper has given some indications that overly optimistic assessments of the systemic effects of telecare in the short to medium term should be avoided – *in the short-term focusing on medium frailty clients and lower cost solutions might be more viable from a policy and clinical effectiveness perspective*. The importance of the time dimension of implementation is so strong in the case of telecare for two reasons. First, as we argued earlier, the particular characteristics of this type of care service and its users prevent rapid change.

Bayer S, Barlow J & Curry R (2005) Assessing the impact of care innovation: Telecare, Tanaka Business School, Imperial College  
<http://www3.imperial.ac.uk/pls/portallive/docs/1/43011.PDF>

**Note:** One relevant article was identified that we have got no direct access to electronically. Here is the abstract

Champion J (2010) Telecare to support reablement in delaying a need for long-term home care, *Journal of Assistive Technologies*, 4(3), 60-63

It is now accepted that a course of personalised, well-planned support services for up to six weeks can prevent or delay the need for an older person to receive long-term home care and other labour-intensive community services. Telecare can play an important role in managing the risks, both during the reablement period, and in

the months following service delivery, irrespective of whether the individual needs long-term homecare. This paper describes an innovative approach to provision that has been adopted in the Vale of Glamorgan, in which the service has been designed and is delivered by the Reablement Team. It is planned to expand the number of people being offered the service in the future by stratifying them using a new algorithm, and then support them subsequently with a pro-active telephone calling service called CATRIN.

If there is an interest in this article, we will try to locate the full text.

## References

Yeandle S (2009) *Telecare: a crucial opportunity to help save our health and social care system*, The Bow Group <http://www.bowgroup.org/files/bowgroup/TelecarePaper%20-%20Healthcare.pdf>

Jarrold K & Yeandle S (2009) *A weight off my mind: exploring the impact and potential benefits of Telecare for unpaid carers in Scotland*, University of Leeds and Carers Scotland <http://www.sociology.leeds.ac.uk/assets/files/research/circle/carers-scotland-report-dec-2009-web.pdf>

Bayer S, Barlow J & Curry R (2005) *Assessing the impact of care innovation: Telecare*, Tanaka Business School, Imperial College <http://www3.imperial.ac.uk/pls/portallive/docs/1/43011.PDF>

Beale S, Sanderson D & Kruger J (2009) *Evaluation of the Telecare Development Programme: Final report*, the Scottish Government, <http://www.jitscotland.org.uk/downloads/1235404195-B59058%20Final%20Report%20low%20res.pdf>

Department of Health (2005) *Building Telecare in England*, Department of Health <http://www.independentliving.co.uk/building-telecare.pdf>

Harris A (2007) *Summary of the evidence for the effectiveness of Telecare*, Dorset County Council <http://www.dorsetforyou.com/media.jsp?mediaid=129785&filetype=pdf>

Damodaran L & Olphert W (2010) *User Responses to Assisted Living Technologies (ALTs) – A Review of the Literature*, *Journal of Integrated Care*, 18(2), 25-32

Department of Health (2009) *Research and development work relating to assistive technology 2008-09*, Department of Health [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_102240.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_102240.pdf)

Telecare Think Tank (2007) *North Wales Regional Collaborative Approach to Telecare: Feasibility Study* <http://www.ssiacymru.org.uk/index.cfm?articleid=2911>

\* Work Package 2: Baseline Research

\* Work Package 3: Investigation of the potential for the joint procurement of telecare equipment and maintenance

\* Work Package 4: Investigation into the potential of developing collective policies, service standards, processes and training

\* Work Package 5: Investigation into the potential for expansion and integration of telecare services

\* Work Package 6: The Impact of IP-Based Communications on Telecare Service Users and Providers

\* Work Package 7: Final Report & Recommendations

Perry J, Beyer S, Francis J & Holmes P (2010) *Ethical issues in the use of telecare*, Social Care Institute for Excellence <http://www.scie.org.uk/publications/reports/report30.pdf>

Curry R & Lethbridge S (2009) *An International Centre of Excellence in Telecare: Background and Development*, SEHTA <http://www.sehta.co.uk/files/ReportICE-T.pdf>

What's on the political agenda for telecare and telehealth? *The link: the quarterly magazine of the Telecare Services Association*, Spring 2010 <http://www.telecare.org.uk/files/48444/FileName/SpringLink2010.pdf>

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[http://kar.kent.ac.uk/3580/1/Alaszewski\\_PilotingTelecare\\_Dec\\_2006.pdf](http://kar.kent.ac.uk/3580/1/Alaszewski_PilotingTelecare_Dec_2006.pdf)

CSIP (2005) *Telecare Implementation Guide*, Department of Health  
[http://www.dhcarenetworks.org.uk/library/Resources/Telecare/Telecare\\_advice/Telecare-Implementation-Guide-19-July-2005.doc](http://www.dhcarenetworks.org.uk/library/Resources/Telecare/Telecare_advice/Telecare-Implementation-Guide-19-July-2005.doc)

*Exploring the Cost Implications of Telecare Service Provision* (2010) Newhaven Research  
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*Monitoring Telecare Progress* (2009) Newhaven Research  
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*Building an evidence base for successful telecare implementation* – updated report of the Evidence Working Group of the Telecare Policy Collaborative chaired by James Barlow  
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