HOUSING & SOCIAL CARE SCRUTINY PANEL

MINUTES OF THE MEETING of the Housing & Social Care Scrutiny Panel held on Thursday 7 March 2013 at 2.00 pm in the Civic Offices, Portsmouth.

(NB These minutes should be read in conjunction with the agenda for the meeting.)

Present

Councillor Sandra Stockdale (Chair)
Councillors Margaret Adair
Michael Andrewes (from 2.15)
Mike Park
Phil Smith (Vice-Chair) (from 2.10)

Also Present

Nigel Baldwin, PCC Community Housing Enabling Manager
Maria Cole, Residents' Consortium (Observer)

11 Apologies for Absence (AI 1)

There were no apologies for absence.

12 Declarations of Members' Interests (AI 2)

There were no declarations of members' interests.

13 Minutes of Previous Meetings – 14 February 2013 (AI 3)

RESOLVED that the minutes of the previous meeting held on 14 February 2013 be confirmed and signed by the Chair as a correct record.

14 Advancing the use of technology in Adult Social Care (Telecare & Telehealth) (AI 4)

The following evidence was received.

(i) Gail Glew, Lead Clinician for Productive Community and Telehealth Co-ordinator, Southern NHS Trust

Gail Glew presented to the committee and explained her background as a community nurse. Southern Health NHS Trust were interested in the government statistics regarding the geographical and demographic challenges for the health service and believed that telehealth was a tool in managing long term conditions. The priority was to help people in their own homes to promote self-care and independence and this linked in with the government initiative 3 Million Lives.

Southern Health were working closely with Tunstall for a **one year pilot study** which would end in April when there would be an evaluation report. Whilst telemedicine used video conferencing facilities the locally used Telehealth was a home monitoring system set in the patient's home in which the readings could be set on a daily or weekly basis. Clinicians can then undertake early intervention work as it enables them to pick up on when patients were becoming unwell. She stressed that this is not an emergency service.

Gail had brought with her examples of the **equipment** used such as the arm cuff which could be used for blood pressure, other pieces of equipment regarding oxygen levels, pulse rates, taking temperature, scales and a range of periphery devices such as those used for monitoring diabetes (it was noted that the technology was not yet there to make this non-evasive in the case of diabetes monitoring). The monitoring unit had a short lead and plug for the telephone line but the rest of the periphery equipment used Bluetooth technology to send information via the telephone line to the computer software at the team base. These could be used for the management of long term conditions such as COPD and heart failure.

The clinicians can set pre-determined questions, on a triage system, to assess the patient's health such as asking if they were experiencing difficulty in breathing. Alerts are then triggered when the patient goes out of the set parameters. This data is transferred using a Freephone number so there is no charge for this and the equipment has a low energy cost. Slide 9 showed example of data (not showing actual patient data) that would be assessed by the clinicians and this is colour-coded so it would flag up where breaches of parameters occurred.

Meetings are held with the doctors to identify the patients who are at risk of going into hospital as the software captures these trends. An example of intervention could be giving a patient oxygen needed for the night.

Findings and benefits so far

Gail reported that the heart failure team at Waterlooville had six patients, five with heart failure, one with hypertension, five patients seen at Queen Alexandra Hospital with COPD and there were six community teams being established (currently with only three patients but expecting more COPD patients to use this).

Gail gave examples of **feedback** from patients on the difference that telehealth was making to their lives to allow not only independence but involvement by partners who could be supportive in using the equipment. There was also the use of **rescue medication** at home (where there were frequent occurrences) to ensure that patients do not run out of vital antibiotics, steroids or similar medication and are not delayed by needing to present to their health centre which in turn could help prevent hospital admission. She stressed that this is not taking away nurses' tools but giving them another tool. Visits were still undertaken but nurses could undertake appropriate and timely visits

with back-up telephone support. This allowed clinicians to prioritise patient visits.

Future possibilities

These were identified as

- Use in residential and nursing homes
- Multi-use Telehealth clinic kit pilot
- Managed telehealth system
- Use of other peripheries - ECG monitor, blood coagulation testing, Glucose Meter and Peak Flow monitor

Questions

The following information was in response to questions from panel members:

Use of telephone installation - It was noted that whilst this was only available through the telephone line for the standard monitoring there was an alternative available from Tunstall but it is more expensive. It was also recommended to keep the equipment within the same room (if it is broadband there is a special ADSL adaptor) to ensure that the signal is well received. The nurses were good at undertaking the initial home assessments and there is technical back-up from Tunstall engineers to assess the homes.

Suitability of equipment - The suitability of equipment would also need to take into account the dexterity and cognitive ability of the patient and sometimes the help of the carer was needed. It is not suitable for all patients, as for some it could make them anxious.

Referrals - These are mainly from the community nurses who are seeing housebound people rather than those going into surgeries being referred by the doctors. They had 300 machines and 80 patients.

Monitoring - Southern Health clinicians are responsible for the monitoring and whilst the healthcare support workers undertake monitoring it is not them making the final decisions on health matters. The base unit can be set to take readings and prompt people at certain times and it will tell the person the reading and store it then automatically download it. It was noted that for the health authorities the cost per unit was £1,500.

Level of prevention - Gail reported that the information team was collecting the data to look into the level of prevention although this was hard to determine. There were slight increases initially in clinicians' visits then this tapers off and telephone consultations would increase which would lead to some reduction in hospital admissions. It was however noted that there had been reduction in secondary care once people were able to come off of the telehealth and this was being investigated further. It was noted that the evaluation of the trial would

be published in April and she was hopeful that there would be funding based on this evidence to plough back into the project. This could then be extended to other areas such as diabetes to send information to the GPs.

(ii) Dianne Sherlock Chief Executive Officer, Age UK Portsmouth

Dianne Sherlock spoke to the panel about her passion for the city and citing that there should be a presumption of independence. She wanted Age UK Portsmouth to encourage an acceptance that wearing the pendant for the alarm system is not a sign of age but of altering health with maturity, to encourage the use of devices earlier, which would in turn reduce falls. She referred to information from a Surrey physiotherapist that once a fall had occurred to someone in their eighties another was likely within six months and this was not just due to health factors but also to the environment of the home. Her goal was to get more people involved in community alarms and encourage participation earlier. Age UK Portsmouth is working in partnership with the University of Portsmouth regarding flooring.

Age UK Portsmouth worked with Tynetec for the installation of the personal alarm system and there were over 50 peripherals that could be added such as bed exit alarms. They were working closely with Age UK nationally to provide equipment to allow people to stay on in their own homes for longer. Dianne personally was involved in the dementia strategy in the city.

Age UK Portsmouth had their own engineers for installation and repairs and the units were replaced every five years as it was important (especially if there was dementia) that the batteries were always working as these may not be checked regularly.

Referrals could come from the Age UK home assistants and information officers going out to the community as well as self-referrals and from families as well as from GPs. She felt it was important that people were aware of all the devices available not just from Age UK but also from the city council and others and she stressed that Age UK would like to work in **partnership** with the city council. They were already working with peer organisations across the county with close links to Southampton and the Isle of Wight. Their area of particular interest was the PO1-PO7 but they extended to Petersfield and Fareham.

Age UK Portsmouth had equipment set up at the Bradbury Centre so people could see this before signing up. They tried to make presentation of the equipment a fun experience and she offered the panel members viewing of this. This work married in with health initiatives and they were working with Solent and Southern NHS Trusts and they also working on **reablement** work with the Red Cross who gave support to their home service. They also aim to make the wearing of the pendants less stigmatised and encourage the cords to be decorated (as long as they had release mechanisms).

Questions

In response to members' questions the following information was provided:

Marketing: How could this be marketed as being more than just a pendant? Information is presented to clients on the range of equipment available and there was work with partners to agree a strategy on the peripherals. Age UK Portsmouth hopes to reach their customers early and that people would be open to talking about their health conditions and needs including falling. She agreed that marketing could include good news stories on positive outcomes in the local outlets such as The News and on websites and the local PCC publication Flagship. There was information on the website of their national organisation which is kept up to date and used plain English and their Hampshire site linked to many other useful sites. It was suggested that the pensioners' association could include information on their own website regarding the availability of different systems.

Role of the GPs - Dianne would like to see them get more involved. They were the same doctors making the referrals and she did attend their committee meetings to encourage participation. Most of the referrals were from the individuals or their family who saw the benefit of the equipment when viewed at the Bradbury Centre where they could see it in action.

How the alarm system worked - This dialled a national call centre in Devon which had 24 hour cover and they speak to a human so there was a personal triage system and the call centre staff would have details of the next of kin to contact the person on the list of responders.

(iii) Melissa Daniells, PCC (former Occupational Therapist seconded to Telecare Project)

Melissa outlined her previous history of working at the Victory Unit **rehabilitation** unit (for social services) where she was involved in helping arrange for telecare to be installed for patients before they returned home and she could give reassurance to their carers that they were not needed 24 hours a day. She had also worked with the Portsmouth Rehabilitation and Re enablement Team (formerly The Independent Living Service) so knew of the confidence given to patients by having telecare installed and when she had worked at QA Hospital she had heard stories of people being left on the floor at home for several hours before being found as they did not have the telecare alarm system. These were the sort of situations that the telecare providers were trying to avoid. Their aim was for people to accept help to avoid crises happening. Melissa advised that time lying on the floor is associated with increased mortality. One study found up to half of people will die within 6 months after a lie on the floor of an hour or more. Wild D, Nayak US, Isaacs B. How dangerous are falls in old people at home. British Medical Journal (Clinical Research) 1981; 282:266-8. The telecare pendant alarm can reduce the risk of a long lie on the floor dramatically.

Melissa then gave anonymised accounts of where telecare had assisted people:

* A husband had been his wife's carer for many years as she had dementia. He had a heart attack and was taken to hospital. When he came home he was less mobile but still wished to be her carer. When Telecare was installed, he was able to use his pendant to get her help. Unfortunately there were some problems with the phone provider. When there was a fault with the phone line - they could not prioritise the repair despite the phone line being needed for telecare. During the 72 hours it took for the phone line to be repaired the couple were at increased risk and their family had to visit frequently.

* An elderly man with no family had not been to his local church café for 2 days. They checked on him at home and found that he had been on the floor for three days. Telecare gave him the confidence to come home after a long hospitalisation. He found the Telecare particular valuable at night time. The PCC night responder service came out to help him several times when he had problems with his catheter or when he had a fall out of bed. He admitted that he would have sold his home to move into residential care if it was not for Telecare and the night responder service.

* A lady had fallen and broken her wrist but declined telecare as she didn't think she would get on with the technology. Relationships with her family became strained as she was frequently calling them for reassurance. She unfortunately fell and broke her arm a year later. She then accepted Telecare. After telecare was installed her relationship with her family improved as she admitted that she wished that it had been installed earlier.

* A lady with moderate dementia had been admitted to a nursing home for emergency respite .She did not settle in the nursing home and her family wanted to trial her being at home again. Telecare sensors were set up around her home as she was not able to remember to use her pendant. Environmental detectors (heat, gas and CO) were set up so that she could continue to have access to the kitchen. A bed exit sensor was put on her bed so that her family would get a call if she did not return to bed after an hour. Also a door exit monitor was put on her front door as she had a habit of opening it overnight. It was set on a timer so that the family would get a call if she opened the door in the middle of the night. Her return home was successful and her dementia symptoms (disorientation, restlessness) improved substantially.

Melissa then outlined possible **problems** or barriers to installation of telecare

- Cost - not everyone who wanted or needed this could afford the £7 per week
- Need for Two responders - PCC telecare declines referral unless the client has two people who are able to check on them. Many people do not have any family and other people only have family outside of Portsmouth. People have the option of paying a care agency to be the responder but this can be prohibitively expensive.
- PCC has a night response service but does not provide a service 24 hours and they carry out a valuable service for the most vulnerable.

Questions were then asked by the panel with the following responses:

- Melissa confirmed that she would be prepared to share stories to publicise the importance and benefits of telecare.

- Help with costs - The panel asked if there was any money to help with independent living - Nigel Baldwin responded that there had previously been some Supporting People help but this had been cut and now funding was on an ad hoc basis and there had been general savings made to health budgets. Melissa confirmed that she would advocate telecare being part of a care package as it would help people afford it. It was reported that telecare was not means tested.

- Partnerships - It was pointed out by Dianne Sherlock that agencies could work together to make economies of scale to reduce the prices of purchasing equipment. It was also noted that in London boroughs there was joint marketing of telecare. Portsmouth could look at pursuing this with Southampton council.

- Increasing the number of responders - It was asked if there could be some encouragement of neighbours to act in a voluntary capacity though it was noted that there may be training and vetting issues here if it was done formally. Melissa advised that many people have neighbours as responders.

- It was noted that the main Health Overview Scrutiny Panel who was tackling the **Care Quality Commission** regarding their remit to inspect GPs and asking for services to be more uniform between surgeries and the panel members suggested that there could be inclusion of questions on telecare and telehealth.

Councillor Stockdale, as chair, was very grateful to all three speakers for their enlightening presentations and thanked Joanne for organising this.

15 Date of Next Meeting (AI 5)

It was agreed that the next meeting should take place on Thursday 4 April at 2.00 pm.

Members were also reminded that there was a drop-in day at the Oasis Centre on 15 March regarding telecare products.

For the next formal meeting on 4 April it was asked that the personalisation budget issues could be explored further and an invitation extended to the Cabinet Member for Health & Social Care as well as representatives from Adult Social Care. There was also a request for the meeting with users of the services to be facilitated and Dianne Sherlock offered support for this to be hosted at the Age UK Portsmouth HQ at the Bradbury Centre.

The meeting concluded at 3.50 pm.

JW/DMF
11 March 2013
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