HOUSING & SOCIAL CARE SCRUTINY PANEL

MINUTES OF THE MEETING of the Housing & Social Care Scrutiny Panel held on Thursday 18 October 2012 at 10.00 am 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
Phil Smith (Vice-Chair)

Also Present

Nigel Baldwin, Housing Enabling Manager
Katie Cheeseman, Project Manager, Assistive Technology
Flor Deasy, Telecare Technician
Joanne Wildsmith, Democratic Services

Members of Nigel Baldwin's Telecare team (Hayley, Opal & Joyce) were also present to observe at the meeting and answer questions if needed, plus Maria Cole representing the Residents' Consortium.

38 Apologies for Absence (AI 1)

These had been received from Councillors April Windebank and Mike Park.

39 Declarations of Members' Interests (AI 2)

There were no declarations of members' interests at this meeting.

40 Minutes of Previous Meeting – 18 September 2012 (AI 3)

RESOLVED that the minutes of the previous meeting of the scrutiny panel held on 18 September 2012 be confirmed and signed by the chair as a correct record.

There were no matters arising.

41 Advancing the Use of Technology in Adult Social Care (Telecare and Telehealth (AI 4)

Portsmouth City Council Witnesses

a) The panel first heard from Nigel Baldwin, the Housing Enabling Manager responsible for Telecare, who explained the development of Portsmouth City Council's Telecare service. This had grown out of the local authority housing stock where the sheltered housing developments had incorporated elements of Telecare since the 1960s although there had been recent accelerated upgrades in technology in schemes.

PCC's Telecare service is now administered by Community Housing and the service provides approximately **3,000 connections** – of which:

2,000 to PCC local authority sheltered housing
1,000 to Portsmouth residents in their own homes who need the service.

Since the 1990s this had been marketed to all Portsmouth residents.

Accessing the service and cost - The non-sheltered PCC referrals often come from individuals, their families and friends or professionals in the social care and health field such as occupational therapists. The team is based in Community Housing private sector housing team and install a variety of equipment which was shown at the meeting. They have strong links to the local authority housing's sheltered housing schemes.

The equipment can be installed within a matter of days and PCC takes pride in undertaking this swiftly compared to other providers and in offering to demonstrate the equipment in people's homes. The equipment is rented at a cost of £5.40 per week. Officers assess what is the most appropriate equipment for the person's needs. The £5.40 is a flat rate and replacement equipment is provided when it is needed and maintenance undertaken.

The rate of £5.40 had been set from April 2012 plus there is an extra charge for a night responder service, so where this is incorporated the rate would be £7.50 per week.

It was noted that the old batteries go back to the provider Chubb and the pendant unit can be exchanged and the information programmed in. Equipment would only not work where the client switches it off and it is rare for there to be a need to repair, other than when the batteries go or when there are accidents with them. The technicians recommend that people test the equipment once a month and there is a record of this testing and this information is given in an advisory pack.

It was reported that the call centre is under contract with Southampton City Council and this provides a link to a suitable response.

As people's circumstances change replacement or different equipment can be fitted for free (within the set charge).

How Telecare works - the equipment installed provides a trigger via a telephone line to a **monitoring centre** which is staffed on a 24 hour basis, all year round, giving a continuous service to ensure cover. Non-PCC tenants are required to have two unofficial carers who can be family, neighbours etc (or they can nominate paid cover or pay for an Adult Social Care scheme or private scheme) to visit the caller to deal with the problem. The monitoring centre staff have the skills to talk to the caller and decide if emergency services need to be called. Should there be no response from the nominated people PCC would use staff to go and check on them. It was noted that the night service is funded by Adult Social Care and that Housing staff (estate officers) could respond where needed.

Discussion took place regarding the calling of an **ambulance** as whilst it was noted that there is the aim to reduce the number of expensive ambulance callouts by giving a professional response members questioned whether in some instances this could delay receiving medical attention. It was noted that sometimes the staff would be able to help with placing someone back in bed if they had fallen out and did not need to go to hospital as the night time service has two officers attending together. The Telecare service takes into account the medical background of the clients and the monitoring centre seeks to ensure an appropriate response.

Range of Equipment

b) Flor Deasy, Telecare technician was present to show the equipment used through this service and talked members through the implementation of each piece of equipment which included:

- The **home hub** is fitted into the mains and phone (usually activated by a pendant press button) which has a pre-programmed telephone number so the monitoring centre would also know who was calling, where they are, their medical condition, their two named carers and could have a conversation with them to ascertain the situation.

- A **key safe** - This has up to four digits for a personal number so that entry could be gained in an emergency and this is also part of the night time service.

- **Smoke and gas detectors**

- **Chair and bed exit sensors** these can both be used where, for example, there are mental health or debilitating problems.

- **Door exit sensor** which could set off an alarm which could be helpful for Alzheimer patients as could the movement sensors – these can be fitted with a pre-recorded familiar voice (usually of a family member) which is set off by the sensors to give advice to the client.

- The **pull cords** similar to those used in sheltered housing schemes.

- An **epilepsy sensor** which would alert family members if there was a seizure at night.

- **Bed wetting sensors** – to call a carer.

- **Flood detector** – if the bath overflows this could call the carer.

- **Alarms** that could be put by peepholes in case there was fear of an intruder.

- **Extreme heat sensors** linked to the thermostat and this calls the call centre – the gas detectors were fitted above the cookers which is helpful for patients with dementia.

It was explained that the call centres would know when the batteries were going flat. One client who has a high number of these aids will participate in making a **DVD** to explain the work of the service as he was saved, from serious injury or worse, by a sensor when his bed was on fire. It was noted that there was no age restriction for this equipment.

Monitoring
The panel questioned whether there was a review of the frequency of callouts. It was noted that the trends were monitored with Adult Social Care and those living independently could now have more complex needs as this equipment was part of a range of interventions. Members felt there should be a recommendation that Adult Social Care are aware of and keep note of the Telecare facilities take-up to use as a monitoring tool. It was reported that there was an increased trend of referrals from health and social care professionals which now amounted to about 20% of referrals.

It was noted that not everyone has landline telephone lines and so there was a conversion kit used with SIM card technology for mobile phones which was often used in **domestic violence** cases. This would ensure that silent calls could be used to alert the police and recording could take place for evidence purposes. Members asked if the impact of false alarms being raised from cords and pendants but it was noted that the call centre would talk to the person to ascertain if it was a false alarm.

Equipment was also installed for those financially supported by Adult Social Care and in residential care homes and respite centres used by Adult Social Care with staff using pagers to be alerted of calls.

The main **advantages** were seen as:

- The products help promote independence in the home

- Reducing the need for nursing care

The marketplace is broadening with other technologies being available to ensure that it is not just about the home environment but the whole lifestyle e.g. a GPS system could be used to track movement outside the home with set parameters before an alarm went off.

PCC are not the only providers and so there is choice of other services but they are not all based locally. PCC offer swift responses to referrals to install and show how equipment works but there are other third sector and private providers.

c) Katie Cheeseman, the Project Manager for Assistive Technology in the Integrated Commissioning Unit gave a presentation on advancing the use of technology in Social Care with particular emphasis in Telehealth. Copies of her presentation were circulated at the meeting.

She explained that the national agenda was looking at merging social care with health care and locally in Portsmouth the reablement and rehabilitation teams were going out to contract with Solent NHS Trust. The aim of this was for integration and promoting efficiency in services. There are 1.7 million users of Telecare nationally; predominantly these are the community alarms service users. Katie was in the process of developing a **Telecare and Telehealth strategy**. In future plans would be formed in response to the trends seen. She was liaising with the Clinical Commissioning Group (**CCG**) which was a group of GPs who decide upon the funding of medical services and working with Southampton City Council too, to bring initiatives together.

Katie explained that whilst Telecare and Telehealth are both types of assistive technology that enable health and social care services to be provided remotely to people in their own home, they are quite distinct in their **definitions** and uses:

- **Telecare** is characterised by continuous, automatic and remote monitoring to manage the risks associated with independent living. Examples include sensors that can detect movement, falls, and bed occupancy. It is not intended to replace human contact it is designed to support the safety, independence and well-being of individuals, and to support carers.

- **Telehealth** is the remote exchange of data between an individual and a health care professional, and aims to assist in the diagnosis and management of health care conditions.

Examples of telehealth include monitoring blood pressure and blood glucose levels for clinical review by a health professional using phone lines or wireless technology. This would enable a nurse to access information at a GP surgery and to consider appropriate responses and Telecoaching could take place with the advising by professionals over the phone and setting goals for people with regard to their healthcare. This type of remote diagnosis could also be used by consultants being contacted at their homes by use of a laptop to help make a diagnosis via Skype or other systems. There were also online self-management tools available such as ‘Know your own health’, ‘Beating the blues’ etc. With the advance of technology smart phones were able to have applications added with health benefits.

Katie then referred to the **key strategic drivers:**

White Paper – 'our health, our care our say'

Transforming Social Care (LAC (2008)1) – contains several references to Telecare.

Whole Systems Demonstrator Pilot

3million lives (2012) - The Department of Health (DH) believe that implemented effectively as part of a whole system redesign of care, telecare and telehealth could benefit at least three million people with long term conditions and/or social care needs. Lessening the burden on long term NHS costs and improving people's quality of life through better self-care in the home setting.

The **economic and demographic imperatives** meant that more older people needed to be supported and locally the reductions in the grant to the city council's budget there would have implications. This would mean that there was a need to change the management of long term conditions.

Future Trends for the management of long term conditions:

- a shift from a reactive to a more proactive, organised, preventative and multidisciplinary model of care (e.g. Virtual Ward).
- increased partnership working between the patient and the health and social care professional
- A more structured and systematic approach to hospital admissions
- Promotion of self-management and self-care though education and training, peer support, tools and devices (such as telehealth), information and healthy living
- An improved design and targeting of clinical interventions
- Redesign of incentives schemes e.g. Year of Care

Key local strategic drivers:

- Portsmouth Health & Well Being Strategy
- Portsmouth Carers Strategy
- Portsmouth CCG 5 year business plan
  - Reduction in non-elective admissions
  - Reduction in re-admissions
  - Reduction in outpatient and follow- up appointments at hospital
  - Reduction in occupied inpatient bed days for those with dementia

Growing Evidence Base
Katie then referred to studies from elsewhere:

(i) Aberdeenshire Council Telecare Project Final Evaluation Report (2008) had calculated that the cost of savings achieved as a result of installing telecare and other associated technology into the homes of 31 individuals demonstrated financial savings in three main areas:

- Hospital days saved - £23,190
- Reduction in care home days -£301,600
- Reduction in sleepover nights - £4,260
- Representing an overall financial saving of £329,050

(ii) North Yorkshire Council have invested resources in putting telecare into older people's homes. A financial analysis of people using telecare showed:

- a 38% reduction in costs against traditional models of care, either delaying or not requiring residential care or reducing the level of domiciliary care required, saving over £1m.

- Savings are expected to increase as the demand for telecare increases.

- About 75% of telecare users are older people, about 20% are people with learning disabilities and the remaining 5% fall into multiple categories.

(iii) Research undertaken by **FACE** 'Investing to Save: Assessing the Cost-effectiveness of Telecare' which found that:

- that a widespread, targeted use of telecare could create potential savings of between £3m - £7.8m for a typical council, equating to 7.4% - 19.4% of the total older peoples' social care budget for an average council.

- the average weekly cost of telecare provision to meet each service user's needs where recommended was £6.25, in comparison to an average weekly pre-telecare package cost of £167.

(iv) The experience of **NHS North Yorkshire and York** was that the PCT had prioritised the development of care pathways for long term conditions and integrated telehealth provision into this. A summary of achievements from the first phase trial in 2010 showed that there was a reduction in acute based activity for patients using telehealth for longer than 6 months, with a 40% reduction in non-elective hospital admissions and a further drop of 28% in A & E attendances.

(v) The **Kent TeleHealth Development Pilot** looked at the management of people with long term conditions and the pilot of a telehealth programme which was rolled out through a GP practice based model and a community matron model. This focused on three conditions: chronic obstructive pulmonary disease, chronic heart disease and diabetes. The results of the pilot described that:

- if used in a targeted way it was more cost effective than traditional methods of service delivery
- resulted in fewer hospital admissions (A & E admissions and bed days of care) while also indicating a range of positive outcomes for patients and their carers including increased general physical health.

Katie then outlined the **benefits/'improving outcomes':**

- Empowering people to manage their own health conditions – and being better informed
- Enabling individuals to be independent for longer
- Improving physical and emotional well-being
- Better quality of life
- Enabling positive risk-taking (personalisation)
- Lessening the likelihood of hospital admission
- Improved outcomes for carers using telecare e.g. less stress, peace of mind, able to retain employment, break from caring etc.

Development plans by PCC

Portsmouth City Council, through Katie, is developing a telecare and telehealth **strategy** for a shared vision for integrated services. Glenis Jones is the champion for this at the city council and reports are being prepared for the CCG to ensure involvement of the GPs in the process. The strategy would be informed by

- A population needs assessment
- Review of current provision available in the city
- Stakeholder consultation – hearing from the users of the equipment
- Local projects – '*testing the water' e.g. dementia challenge*
- Learning from best practice elsewhere– talking to other local authorities regarding their experiences
- Future needs - responding and monitoring provision
- Understanding the infrastructure required to support the new technology
- Soft market testing – inviting in the providers of equipment

Other steps being taken are:

- Recruitment of a Telecare Advisor
- Establishment of Tele-advisory Group (TAG) – integrated 'operational' buy in – housing, social care & health
- The city council's governance arrangements include the establishment of a Health & Well-being Board.

During members' questions the following issues were raised:

- **Publicity** of telecare – Nigel Baldwin further reported on his work with Adult Social Care colleagues regarding producing a DVD which would also be made available through the PCC website and could be used for training of new staff in Housing and Social Care.

- With regard to **other local authorities' pricing** - Katie reported that some were making the service free (Hampshire County Counci is currently going through a tendering process) where there is fair access to care eligibility as they were convinced that this would lead to savings in the future. Surrey and other local authorities were also exploring this route.

- It was questioned whether the **price** would put off some people for taking up services that would benefit them? It was reported that telecare is assessed as disability care and the council were working to provide equipment at a minimal cost which can be balanced by a reduced residential care cost but it was noted that telehealth provision has to be free under as it is linked to the NHS.

- The **security of data** storage and the implications of this was raised, with the use of the internet for transfer of information and this was balanced with the usefulness of monitoring people's health. It was noted that **Solent NHS Trust** are already using equipment to do this and they would be delivering an evaluation report in January 2013.

- **Suitability** of equipment – it was realised that not all people were suitable for technical support but thorough assessments are undertaken to see what would be of use to them. Telecare has a wide range of equipment and this is advancing swiftly.

- **Spend to save bid**? – it was noted that the Transformation work at PCC involves the Rob Watt, the Head of Adult Social Care, who would be looking at the potential investment in equipment and the capital costs versus the long term savings that were anticipated to be generated by the reduction of residential care costs.

Councillor Stockdale as chair thanked all three officers for their very informative and interesting presentations.

Date of Next Meeting

This was agreed as Thursday 22 November 2012 at 2.00 pm.

The meeting concluded at 11.50 am.

JW/DMF
19 October 2012
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