HOUSING & SOCIAL CARE SCRUTINY PANEL

MINUTES OF THE MEETING of the Housing & Social Care Scrutiny Panel held on Thursday 13 December 2012 at 10am in the Civic Offices, Portsmouth.

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

Present

Councillors Sandra Stockdale (Chair)
Margaret Adair
Michael Andrewes
Mike Park

Councillor Steven Wylie as Cabinet Member for Housing (witness)
Councillor Peter Eddis, Chair of HOSP (observer)

Also Present

Nigel Baldwin, Housing Enabling Manager
Katie Cheeseman, Project Manager, Assistive Technology
Dr Julian Neal, GP & partner from the Portsdown Practice
Sarah Billington, Community Pharmacies (Hants & IoW Pharmaceutical Committee)

Maria Cole from the Residents' consortium observed the meeting.

47 Apologies for Absence (AI 1)

Councillors Smith & Windebank sent belated apologies for absence.

48 Declarations of Members' Interests (AI 2)

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

44 Minutes of Previous Meeting 22 November and Matters Arising (AI 3)

Councillor Park explained that he had been unable to attend earlier meetings due to his health but had read the previous minutes and had queries on the information regarding the Telecare service at Leonard Cheshire homes –
JW whether this was just for alarms or other equipment; further enquires would be made.

RESOLVED that the minutes of the previous meeting of the scrutiny panel held on 22 November 2012 be confirmed and signed by the chair as a correct record.

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

a) Dr Julian Neal spoke as a long standing partner and GP from the NHS Portsdown Practice (of over 30,000 patients) who also worked with private industry as a medical adviser to the second largest Telehealth provider. His involvement in Telehealth had been over 7 years and the Portsdown practice had won an SHA innovation funding grant to pilot Telehealth work with OBS Medical and he had worked with Telehealth Solutions Ltd since November 2011.

Dr Neal explained the biggest challenges to the Health Service being A&E hotspots and the "tidal wave" of chronic disease as people live longer. 15.4m people in England suffer from at least one long term condition eg. Asthma, heart disease, diabetes – and this was set to rise significantly over the next 25 years.

Dr Neal provided the following statistics on the nation's health:

- 72% of patient beds related to long term conditions
- 55% of GP appointments are for long term conditions
- 70% of health funding related to long term conditions

The three major conditions were chronic obstructive pulmonary disease (COPD) (which is often smoking related), heart disease and diabetes. COPD is affects 3 million people and is the 5th leading cause of death in the UK; costing £1 billion with heart failure having similar figures.

This is set against a climate of the NHS being challenged to make £20 Billion savings by 2015, leading to the QIP agenda (quality, innovation, productivity and intervention) asking the service to do more for less. Dr Neal state that the way to manage chronic conditions better is to use remote technology.

5 December 2011 the Department of Health published results of the whole systems demonstrator project in which patients had been given Telehealth equipment (phones/laptops etc) to enable them to measure pulse rates and other signs, for information to be relayed by blue tooth connections. The findings after 3 years included:

- mortality rates of those in the project had reduced by 45%
- 20% reduction in emergency admissions
- 15% reduction in A&E attendance
- 14 % reduction in bed stays

Conditions of the patients were monitored daily to see what variations there are and they were asked how they are feeling. Therefore trends could be detected and interventions made where there was cause for concern. This leads to both a reduction in admissions and those admitted could be discharged soon as there was equipment at home to help monitor them.

Dr Neal had worked with Telehealth Solutions for 2 years, developing algorithms on the data provided by the answers to questions by patients via

their kits. He assured the panel that the kit was simple to use with touch screen technology. Information is sent confidentially to the base company (in Watford) and levels of green, amber and red alert could be provided with the patients being contacted if an amber or green alert was triggered. There are specialist COPD and diabetic nurses to give advice.

At the **Portsdown Practice** since February 2012 100 COPD patients have signed up to Telehealth and there will be 100 with diabetes and others with heart disease.

Dr Neal believed that this gives an improved service which he would recommend to other GPs/CCG practice to analyse who would be in most benefit of the equipment if they are in danger of being admitted to hospital. Whist initially Telehealth had not been well implemented nationally he felt that this was because it only works effectively if the information is monitored centrally. One dedicated nurse can monitor up to 300 patients remotely. His own experience was that his patients bonded with the specialist nurse they dealt with at the time of recruitment.

The British Medical Journal had raised questions such as how this triage system could work at a busy urban practice. Dr Neal was undertaking studies with Imperial College London, observing patients over 2 years and comparing their results with the 2 years prior to uptake – looking at contact with out of hours service , home visits, hospital clinic attendance, visits to A&E etc. The results were due in January. He knew from results in USA and Germany that it works but wants to see exactly how well it works in the UK.

Analysing the costs with the CCG – 90% activity in primary care is for 10% of cost, and 50% in community care. So if reductions are made to hospital admissions and discharges are quicker this would save more money and provide better care. Patients felt more secure with the kit at home and they could take it with them elsewhere including on holiday.

Costs in Portsmouth 2010/11 – secondary care £218m, GP and primary care £52m.
Every admission to QA hospital costs approximately £2,200 to be admitted for a day. Dr Neal had graphs showing interventions which meant avoidance of admission, with associated savings.
In August 32 admissions were avoided so £64k was saved for one practice. The cost of the kit is approximately £1k – making a saving even when there is only one admission. These savings would be significant year on year.

Dr Neal wished to explain these benefits to other GPs and that this would also release time for GPs.

Questions were then asked by members and Dr Neal reported:

- Depression could be helped as patients are contacted regularly (with phone follow up consultations) and asked how they feel, and know that people care, and feel more in control of their condition.

- The workings of health budgets – the CCG had a responsive budget which pays for hospital admissions
- The Portsdown Practice are provided with the kit for free (due to Dr Neal's services to Telehealth Solutions) but commercially sourced kits would cost approx. £1,200.
- Telehealth was becoming important in developing countries where there were not sufficient nurses to deal with high levels of conditions such as diabetes (eg. India, Brazil, Mexico).
- Any drawbacks? – Dr Neal reported that these were few and far between and could be where a patient did not take to the installation engineer, or where they did not wish to have kit taken back when it is no longer needed. His own patients were enthusiastic about the service. There was the need to ensure the buy-in of GPs and nurses who should understand what it facilitated and what their role is and that it will ultimately make their job easier. He did not feel that there was social isolation of patients as there was regular contact.
- There are compliance and quality control measures to ensure the equipment is medically safe.
- NICE statistics were that 50% of all admissions for acute heart failure is due to the patient not taking their medication.
- There would be benefits for carers too and this could be considered for roll out to local authority homes and sheltered schemes.
- The innovative approach could also be expanded to the health centre at Somerstown Hub; it frees up space and GP time in practices with large building costs.
- It is not just suitable for the elderly but Dr Neal's younger diabetic patients like to use mobile phone technology rather than attend the surgery.
- Preventative work is also undertaken through Telehealth with health promotion and monitoring of lifestyles/diets.

Katie Cheeseman reported that she had discussed with Dr Neal regarding the expansion of Telehealth to another local practice to adopt a similar approach to Portsdown. He was happy to promote this at local meetings of GPs. There were also discussions taking place as to how this would be funded in the future, with the promotion of invest to save, and how this could become part of mainstream delivery.

b) Sarah Billington stated that community pharmacies endorsed Telehealth as a concept and the development of virtual wards, but stressed that it had to be the right adjustment for the individual patient. There was a choice of providers to consider.

She reiterated the concerns regarding the rise in patients with long term conditions taking medication and medicine not being taken as intended. Telehealth could help patients keep well and stay in their own homes, but there is a cost and all parts of the system need to be remunerated. For those

with dementia/memory loss the taking of medication is a particular issue.

Ms Billington responded to the previous discussion of the Pivotel automated tablet dispenser system this was one of such solutions and had practical problems. The pharmacies would see patients 6 times as often as the GPs giving support and reviewing medication. The range of aids included reminders, the use of trays and aids for getting tablets out of packages.

Katie Cheeseman reported that PCC Adult Social Care spend a lot on domicillary care visits and wished to encourage independence. The Pivotel medication trays had been trialled and were not suitable for all. She stressed the aim of working with the pharmacies to come up with solutions and to see if the service contracts with them needed to be revised. It was noted that the filling of the Pivotel trays was labour intensive and outside of the pharmacies' current contract. There are 40 pharmacies in Portsmouth and if this was added there would be implications (for the buying in of the service) and the need to ensure these devices worked effectively.

Ms Cheeseman reported that only 10 patients in Portsmouth currently use Pivotel but more requests are forthcoming.

Dr Neal commented that there is over-prescription of medication which is counter-productive. Ms Billington stated that adjustments should be made based on the needs of the individual (currently 5% of hospital admissions were due to the wrong medication).

c) Councillor Steve Wylie, Cabinet Member for Housing then spoke regarding the role of PCC's Housing Service. Housing had a role to play in securing better health and educational outcomes for residents. Telecare was part of the Housing Strategy and was used where appropriate in partnership with Adult Social Care.

The City Council's Telecare provision was not profit led and had to be affordable both to the resident and the Council. The service would be offered as appropriate to the individual's need.

In response to questions on the cost versus take up relationship Councillor Wylie stressed that PCC try to keep the cost down but that there was choice for individuals and their families when considering its suitability.

Councillor Sandra Stockdale thanked all the witnesses for their very interesting contributions.

46 Date of Next Meeting

This was agreed as Thursday 17 January 2013 at 10am subject to the availability of witnesses.

The meeting concluded at 11.45am.

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Councillor Sandra Stockdale
Chair