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Portsmouth CITY COUNCIL

NOTICE OF MEETING

HOUSING & SOCIAL CARE SCRUTINY PANEL

THURSDAY, 12 SEPTEMBER 2013 AT 2.00 PM

EXECUTIVE MEETING ROOM GUILDHALL

Telephone enquiries to Joanne Wildsmith CCDS Tel: 9283 4057
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Membership

Councillor Sandra Stockdale (Chair)
Councillor Steven Wylie (Vice-Chair)
Councillor Margaret Adair
Councillor Michael Andrewes
Councillor Lee Mason
Councillor Mike Park

Standing Deputies

Councillor Caroline Scott
Councillor April Windebank
Councillor Steve Wemyss

(NB This Agenda should be retained for future reference with the minutes of this meeting.)

Please note that the agenda, minutes and non-exempt reports are available to view online on the Portsmouth City Council website: www.portsmouth.gov.uk

A G E N D A

1 Apologies for absence

2 Declaration of Members' Interests

3 Minutes of Previous meeting - 24 June 2013

Minutes attached.

RECOMMENDED that the minutes of the previous meeting of 24 June

2013 be confirmed and signed by the Chair as a correct record.

4 Advancing the use of technology in Adult Social Care (Telecare & Telehealth) (Pages 1 - 62)

The panel's final report will follow to be available for sign-off at this meeting.

RECOMMENDED that the panel officially sign off this report that is due to be submitted to Cabinet on 7 October 2013.

5 New Topic for review - Hospital Discharge Arrangements in Portsmouth (Pages 63 - 64)

The draft scoping document is attached and is subject to amendment during the review.

RECOMMENDED that the scoping document for this review be approved.

6 Dates for future meetings

The panel members will discuss dates/timings for future meetings to receive evidence on their new review.

Please note that agenda, reports and minutes are available to view on line on the Portsmouth City Council website: www.portsmouth.gov.uk

Full Council and Cabinet meetings are digitally recorded, audio only.

4 September 2013

Portsmouth CITY COUNCIL

Housing & Social Care Scrutiny Panel

REVIEW TO CONSIDER ADVANCING THE USE OF TECHNOLOGY IN ADULT SOCIAL CARE (TELECARE & TELEHEALTH)

Date published: 12 September 2013

Under the terms of the Council's Constitution, reports prepared by a Scrutiny Panel should be considered formally by the Cabinet or the relevant Cabinet Member within a period of eight weeks, as required by Rule 11(a) of the Scrutiny Procedure Rules.

Preface

This review into advancing the use of technology in Adult Social Care by the Housing & Social Care Panel has looked at the City Council's own well established provision of Telecare in the city and the more recent and evolving area of Telehealth which is provided through the health services.

The purpose of this review is to raise awareness of the assistive technology provided in the city, by the Council and other providers, to some of the most vulnerable residents. This is available not only to older persons but to disabled people and medical patients who have long term conditions. The emphasis is on promotion of independence and on giving targeted support. This is at a time of financial constraints and a focus on preventative measures which will lead to savings, not only to the Council but to our health partners. Telecare and Telehealth have monitoring procedures in place to encourage confidence and safety of clients and which also give reassurance to their families and carers.

We heard how residents already benefit from these expanding services and how other local authorities have quantified the savings that can be made in terms of reductions in residential care and hospital admissions. We also looked at areas where partnership working will be advantageous.

I would like to take this opportunity to thank all those who contributed to the review in attending meetings and providing valuable information and to my fellow panel members whose enthusiasm and knowledge for this topic aided this process.

I am grateful to Nigel Baldwin, Katie Cheeseman and Joanne Wildsmith for their support throughout the review and to all of the witnesses: Melissa Daniells, Alison Croucher, Angela Dryer, Caroline Elder, Flor Deasy, Jason Hope, Dominic Dew and Councillor Steve Wylie (all from PCC), Lesley Hammer (Leonard Cheshire Disability), Dr Julian Neal (Portsdown Practice), Sarah Billington (Hants & IoW Pharmaceutical Committee), Katherine Barbour (Wessex Health Innovation & Education Cluster), Graham Pink (Housing 21), Darren O'Higgins (Tunstall), Debbie Clarke (Solent NHS Trust), Gail Glew (Southern NHS Trust), Jo Gooch and Dr Kevin Vernon (CCG), Dianne Sherlock (Age UK Portsmouth) and also to Maria Cole of the Residents' Consortium for her attendance and input.

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Councillor Sandra Stockdale
Chair of the Housing & Social Care Panel
Date 12th September 2013

CONTENTS

Review to consider advancing the use of technology in Adult Social Care (Telecare & Telehealth)

1. PURPOSE & OBJECTIVES

1.1 The purpose of this report is to present the Cabinet with the recommendations of the Housing & Social Care Scrutiny Panel following its review to consider "*advancing the use of technology in Adult Social Care (telecare and telehealth)".*

Scope of the review

1.2 At a meeting on 18 September 2012 the Housing & Social Care Scrutiny Panel agreed the following scoping objectives for the review:

- To gather evidence on the current provision of technological solutions (e.g. telecare and telehealth) to adult social care clients by the City Council and other organisations
- To raise awareness of the telecare services currently available to promote and assist independent living
- To understand recent research on the benefits of advancing telecare and telehealth provision in the city
- To investigate how advances in technological solutions will benefit Portsmouth residents, the local authority and partner organisations
- To influence the developing Telecare and Telehealth commissioning strategy

During the review the panel further looked at the experience of other local authorities:

- To consider the approach of other local authorities to see if the council could adopt measures which work elsewhere or learn lessons from their experience

Composition of the Panel

1.3 The review was allocated by the Scrutiny Management Panel to the Housing & Social Care Scrutiny Panel which comprised Councillors Sandra Stockdale (Chair), Phil Smith (Vice-Chair), Margaret Adair, Michael Andrewes, Mike Park and April Windebank. From May 2013 the panel changed to add new members Councillors Lee Mason (for April Windebank) and Steve Wylie (for Phil Smith).

(The designated Standing Deputies for 2012/13 were Councillors Steve Wemyss, Carole Scott, Lee Mason & Lynne Stagg.)

1.4 The Panel met formally to take evidence on 9 occasions

1.5 A list of meetings held by the Panel and details of the written evidence received are attached as Appendix 1. The minutes of the Panel's meetings are published on the Council's website and copies of all the documentation reviewed by the

Panel is available from the Customer, Community & Democratic Service upon request.

2. EXECUTIVE SUMMARY

2.1 **Objective 1** - **To gather evidence on current provision of technological solutions (Telecare and Telehealth) to adult social care clients by the City Council and other organisations**

The panel first looked at the current in-house provision of Telecare by PCC's Community Housing and heard of its importance from the Cabinet Member for Housing as being an affordable and reliable option for residents (providing a service to 3000 people). This is mainly the pendant alarm with a hub unit (community alarm) operated via a monitoring service (currently delivered by Southampton CC) to call out help, with an extra option (with additional charge) for a night service delivered by PCC's Adult Social Care. An appropriate response can help to reduce the number of costly ambulance callouts. The panel members viewed the extensive range of equipment available including smoke and gas detectors, chair/bed/door/exit/flood/ heat and epilepsy sensors. These were suitable for clients with a range of needs and conditions and promoted independence in the home and reduced the need for residential/nursing care.

PCC is the largest provider of sheltered housing in the city (with 1500 properties) and the panel heard from the Sheltered Housing Manager about the Housing Service's provision of housing-related support to enable PCC tenants who are over 55 (or with support needs) to live as independently as possible at home. The graduated range of support was explained for Category 1, 2 and 2.5 blocks.

The panel considered the referral routes based on the experience of an occupational therapist, including reablement hospital placements, for which Telecare equipment being in place allowed earlier discharge home. The pendant alarm system would also prevent escalations of incidents such as long lies on the floor (with associated medical risks) following a fall, and help avoid hospital admissions. The possible barriers to take up of Telecare included cost and the need for two named responders.

Leonard Cheshire Disability is an alternative provider of extra care sheltered housing in the city and their Service Manager outlined the support to two major facilities developed in partnership with Housing 21 at Brunel Court and Milton Village, where staff provide 24 hour support. The Housing 21 Manager of Brunel Court also met the panel to explain the Telecare Lifeline service which is charged as part of the rent, and gave safety and reassurance to residents and staff. The Tunstall equipment allows monitoring of the number and type of call outs and the response given but was not currently used in conjunction with Telehealth and compatibility of systems could be further explored. Large settings such as these meant that there should not be social isolation through the use of technology in the home unit as there were also communal areas and contact with scheme staff.

Age UK Portsmouth use Tynetec equipment for personal alarm systems installed by their own engineers, with over 50 peripherals that can be added. Their referrals are from their own visiting staff, self-referrals, family members and from GPs (who they would welcome more involvement from). The Bradbury Centre has equipment on display to encourage take-up.

The less well established, but expanding, provision of Telehealth is covered later within Objective 4. Equipment allows medical professionals to access patient information remotely to consider appropriate responses and interventions.

2.2 **Objective 2** - **To raise awareness of the Telecare and Telehealth services currently available to promote and assist independent living**

PCC have produced a promotional DVD to publicise Community Housing's Telecare service which features clips of residents who have been helped by the community alarm service stating the value of this for reassurance to them and their relatives.

Witnesses felt that there would be advantages from joint marketing campaigns and partnership work on this is encouraged to benefit all involved and so that residents have wider choice. PCC's Project Manager for Assistive Technology estimates that 12-14,000 Portsmouth residents would benefit from Telecare and Telehealth provision. PCC held an event for the public at the Oasis Centre in March 2013 which panel members visited informally, and it was useful to get the feedback from stakeholders attending but more was needed to be done to engage with the public at other PCC events. Some local authority websites include virtual tours of 'smarthomes' to illustrate the range and use of equipment available. Marketing should tackle the misconceptions that the equipment is cumbersome and that it is only for alarm systems for older people.

DVDs are also produced for staff training purposes and the panel viewed one used by Solent NHS Trust and the Wessex HIEC on Telehealth which is used to familiarise staff with the systems' capabilities and benefits which include assistance in prioritising visits.

2.3 **Objective 3** - **To understand recent research on the benefits of advancing Telecare and Telehealth provision in the city**

The government's 3Million Lives initiative seeks to promote assistive equipment to lessen the burden on health care costs and to promote greater self-management. The Department of Health's 2011 findings from the Whole Systems Demonstrator project found that the provision of Telehealth equipment to enable patients to monitor and relay their pulse rates and other signs had led to significant decreases in mortality rates, emergency admissions, A&E attendance and bed stays in hospital.

Locally there is a need to respond to reductions in council and health budgets through a preventative agenda and encouragement of self-management and self-care. Professionals working locally flagged up issues at the March 2013 Telecare Drop in Day such as the lack of awareness of services available in the city and that they are seen as solutions for older persons, whereas equipment is available to assist other care groups including those with learning disability and with secondary mental health needs.

Further public consultation is planned by PCC through a telephone survey of Telecare customers and by visits to carers support groups. This will help inform the Telecare business case by the Project Officer for Assistive Technology.

2.4 **Objective 4** - **To investigate how advances in technological solutions will benefit Portsmouth residents, the local authority and partner organisations**

Dr Neal of the Portsdown Group Practice in Portsmouth is a local and national pioneer for Telehealth, promoting its benefits to other GPs, as the way to tackle the growing rise in long term medical conditions associated with an increasing ageing population. The three main conditions that could be tackled through assistive technology are COPD, heart disease and diabetes. He reported that 72% of hospital bed occupancy, 55% of GP appointments and 70% of health funding relate to long term conditions. The use of the Telehealth Solutions system allows one dedicated nurse to monitor up to 300 patients remotely. Reductions to hospital admissions and swifter discharges would make significant savings; admission to hospital itself costs over £2,000, so for the Portsdown Practice in 2012 it was estimated that 32 hospital admissions were avoided so potentially £64,000 was saved (elsewhere the price of the kit would need to be factored in). Patients have equipment at home to help monitor their progress, giving them a feeling of security and as this is portable it is not restricting for them. The GPs can also benefit by the release of their time, travel and ultimately space in their surgeries.

Automated medication dispensers can be provided as a Telehealth tool to help prompt the taking of regular medication. This is useful in encouraging compliance and can be used in sheltered housing but is dependent upon the cooperation of community pharmacies in filling them, which is a contractual issue. There is currently low usage in Portsmouth. The Community Pharmacies' representative stressed that the right adjustment has to be made for the individual patient and even with these devices the correct taking of medicines cannot be guaranteed.

The Wessex HIEC is keen to promote Telehealth and Telecare to help prevent hospital admissions and result in earlier discharges with support being put into the home environment. This also assists those with long term health conditions to manage their own health needs and to stay in their own homes for longer. A barrier to the expansion of Telehealth could be the reluctance by some GPs who question the evidence that this is the more effective way to care for patients. (Referrals are more often made by occupational therapists than GPs for Telecare support.)

Solent NHS Trust are working in the Portsmouth and Southampton area to develop the use of Telehealth for patients with COPD, and the Wessex HIEC estimates the optimum size for benefit would be twice that of these two councils. Some council models have involved developing the use of the monitoring centre by incorporating CCTV services, others work in close partnership with private companies who provide Telecare services on behalf of the Local Authority and many are offering a free introductory period for Telecare to encourage take-up. The government is keen for local CCGs to encourage take-up of Telehealth as part of their service delivery. In 2006 the Preventative Technology Grant funded a Telecare officer post in Adult Social Care as well as Telecare equipment to help develop local initiatives.

Solent NHS Trust is using Telehealth to provide health care at home by monitoring the vital signs of people with specific long term conditions and the

targeting of community matrons visits. The monitoring equipment is suitable for use by older and younger age groups and developments are being made to make it smaller, and mobile phone functionality is currently being used in Southampton and this should extend to Portsmouth soon.

The panel also heard from Southern NHS Trust which is working with equipment providers Tunstall on a one year pilot study on the use of their Telehealth home monitoring systems; these transfer health readings within set parameters which, when breached, trigger alerts to clinicians for interventions to be made. Telehealth can also prompt the use of "rescue medication" at home to ensure that patients do not run out of prescribed supplies and there is not delay by needing to visit health centres. It is believed that this could also help prevent hospital admission. Southern NHS Trust has 300 machines and 80 patients currently using the systems. The community nurses refer many housebound patients to the scheme with their central monitoring team analysing the collected patient data. Once the evaluation trial results are available consideration will be given to extending the use to other conditions such as diabetes.

The last health authority evidence was heard from Portsmouth's Clinical Commissioning Group (CCG). The CCG's IT strategy and commissioning plan would only have small references to Telehealth as they did not wish to invest heavily in unproven technology in the hope of making savings, but their providers could chose to buy Telehealth kit and there was most interest in the Florence pilot which uses mobile phone technology to assist remote care, and the GPs are able to sign up to this.

2.5 **Objective 5** - **To influence the developing Telecare and Telehealth commissioning strategy**

The City Council has appointed an Assistive Technology Project Manager to develop a Telecare and Telehealth business case at a time of merging social care and health care responsibilities nationally. She is working closely with the local health bodies (such as on reablement contracts), the CCG on the funding of medical services (such as pharmacy contracts) and Southampton City Council on joint initiatives. This work will be reflected in the PCC's development plans for integrated services.

The panel looked at the personalisation agenda operated through Adult Social Care (ASC) for clients to have say in the allocation of their personal budgets, subject to the necessary financial assessments.

Approximately half of ASC clients have a community alarm (with the income generated by charging people for the service going to Community Housing) with an expectation that individuals use their attendance and disability allowances to help fund this. ASC does provide a night response service with qualified responders from the reablement team trained to provide personal care on site, thereby helping to reduce ambulance call-outs and the level of hospital admissions. It was noted that day time responders nominated by individuals can be members of the public (relatives, neighbours or friends) who do not usually have any formal training to fulfil this role and the possibility of offering basic training to improve safety could be explored. The equipment plus this back up

response can in some instances prevent more costly escalations involving emergency services. More work to identify the benefits of Telecare provision is being undertaken as well as work to improve performance monitoring.

Telecare is considered when discharging patients from hospital. The discharge panel forms will ensure that Telecare is given consideration to meet the client's needs. The Telecare Advisory Group is reviewing the learning and development needs of local staff to ensure Telecare is seen as a real choice in the provision of care.

The business case is being prepared to mainstream the use of assistive technology to provide a cost effective service tailored to the needs of vulnerable clients. It will also investigate the first six weeks of Telecare to be provided free of charge for those accessing the reablement pathway. The provision of equipment to prevent accidents and keep people safe also means that reassurance is given to carers. It is important that a performance monitoring framework and a service evaluation model are in place to prove savings are being made by keeping people safe in their own homes, which not only reduce the need for more traditional methods of care delivery, unscheduled hospital admissions and lengths of stay in hospital but also have health benefits and improve outcomes for the clients who wish to remain as independent as possible for as long as possible. Marketing of Telecare services will also be developed to target wider groups, not just those already in need of assistance, but to include the "worried well" and those people preparing for their older age which will help to prolong people's independence and may help prevent or delay those coming into the system.

2.6 **Objective 6** - **To consider the approach of other local authorities to see if the council could adopt measures which work elsewhere or learn lessons from their experience**

The panel heard of the potential savings from partnership working; this could lead to economies of scale with the purchase of equipment. Participation in joint Telecare marketing campaigns had been successful for London boroughs. Initial discussions have already taken place with Southampton CC to expand the use of technology with the learning disability service and to promote mobile technology for secondary mental health patients.

A representative from Tunstall, who are major providers of Telehealthcare equipment to councils nationally, gave examples of their work with the public sector.

- Hillingdon unitary authority launched a new model care initiative in 2011 which was free to the over 85s for six weeks as part of their reablement package. There had been a corresponding reduction in residential placements from 8.08 to 3.57 per week and a 10% reduction in home care hours purchased.

- Blackburn with Darwen Council use joint infrastructure that will allow elements of both Telecare and Telehealth with the aim of reducing residential placements and increasing uptake - 1000 users had been

attracted in 18 months and there had been an 18% reduction in residential care admissions.

- Birmingham City Council has entered into a £14m contract with Tunstall where the LifeCare model allows a variety of contract combinations between private and local authority providers.

- At Essex County Council a change of approach has meant that Telecare packages are considered at the start of assessments, involving families and requiring an 'opt-out'.

- Bristol City Council has combined Telecare and CCTV services and doubled its income to £1.2m from this.

- Milton Keynes Council has combined Telecare and Telehealth services where it is predicted that up to £340k each year may be saved in terms of GPs attending patients in their homes.

- Surrey CC provides free Telecare for six weeks on discharge from hospital.

Findings from research at other councils and partnership work with health bodies include:

- Aberdeenshire Council - their 2008 evaluation report of 31 individuals with Telecare equipment estimated savings of £329,000 in terms of hospital days, care home days and sleepover nights saved.

- North Yorkshire CC had found a 38% reduction in costs against traditional models of care (residential placements or reducing domiciliary care at home) where telecare had been installed in older persons' homes, saving over £1m.

- A study by FACE 'Investing to Save: Assessing the cost-effectiveness of Telecare' compared an average Telecare weekly cost of £6.25 to an average weekly pre-telecare package cost to a council of £167.

- In York a trial study with the PCT in 2010 on Telehealth provision had shown a 40% reduction in non-elective hospital admissions and a 28% reduction in A&E attendances.

These results suggest that assistive technology not only increases independence and self-awareness of health conditions, but also lessens the likelihood of hospital admission and gives reassurance to clients and their carers (and allows breaks from caring duties).

3. CONCLUSIONS

1. Barriers to take-up include cost which may put off some Adult Social Care (ASC) clients from accessing services that would benefit them. PCC is working to provide Telecare equipment at a minimal cost which can be balanced by a reduced residential care cost. (See paras 6.10.1, 8.2.7)

2. Some local authorities and providers are making the service free or with a free introductory period as they are convinced that this would lead to savings in the future. (See paras 7.3.6, 11.10, 11.11)

3. Whilst not all ASC clients may be receptive to technical support thorough assessments are undertaken to see what would be of use to them. Telecare and Telehealth offer a wide range of equipment and this is advancing swiftly and can reach a wider client group. (See paras 6.7.1, 6.13.7, 7.2.7 and Section 9)

4. As part of responding to budget reductions at PCC 'Transformation' work by the Head of Adult Social Care would investigate 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. (See Section 10)

5. The Business Case for PCC's Telecare is being prepared to investigate integrated services and reports are being prepared for the CCG to ensure involvement of the GPs in the process.

6. The panel was pleased to hear that Portsmouth GP, Dr Neal, is willing to be involved in the promotion of the expansion of Telehealth to another local practice to adopt a similar approach to the Portsdown Group. He will explain the benefits of Telehealth to other local GPs in the CCG as their main interest in Telehealth is via the Florence text messaging project. (See 9.2, 9.8)

7. Take-up and referral levels are linked to the awareness of staff; it is dependent on the frontline social workers, OTs and reablement staff being kept abreast of developments especially where staff change. (See paras 6.14.6, 7.3, 9.5.8)

8. Another barrier to take-up of Telecare services can be the lack of suitable persons to nominate as responders in cases where there are no family members. (See paras 10.16)

9. In sheltered housing settings assistive technology aids are invaluable as long as these are monitored to high standards. (Sections 6.8, 6.12, 6.13)

10. When Telehealth elements need to be added to a Telecare package there is not an increased cost as the NHS body would usually pay for the Telehealth element. (See paras 6.13.8)

11. Reliance on technology may lead to social isolation but this wider issue is being addressed by PCC to assess and direct residents to other community assets and activities where appropriate. (See paras 6.13.9)

12. The Telecare pendant alarm can dramatically reduce the risk of a long lie on the floor (and associated medical risks). (See paras 6.19, 6.14)

13. The Panel heard that advantages could be achieved through partnership working - agencies could work together to make economies of scale to reduce the prices of purchasing equipment and on joint marketing. (See paras 7.2.1, 11.1)

14. The Wessex HIEC estimates that the ideal population size for optimum benefit for assistive technology would be double the size of the two local authorities (Portsmouth & Southampton). (See paras 9.5.3)

15. The feedback from the stakeholders attending the Telecare drop in day indicated that the public have a lack of awareness of systems available. (See paras 7.1, 7.2, 8.2)

16. Telehealth equipment gives increased independence to patients who feel more secure with the kit at home (generally and at time of discharge) and they could take it with them elsewhere, including on holiday. (See para 9.2.9)

17. Security of data storage needs to be considered, with the use of the internet for transfer of patient information, to be balanced with the usefulness of monitoring people's health. (See paras 9.6, 9.8)

18. PCC's Health Overview Scrutiny Panel (HOSP) liaises with the Care Quality Commission (CQC) regarding their remit to inspect GPs, to encourage more uniform provision of services between surgeries. PCC's Health & WellBeing Board has also now been established. Both bodies will be able to take forward Telecare and Telehealth as part of the public health agenda. (See paras 9.2.16, 10.4)

19. The automatic pill dispensers have the potential to positively impact upon medication compliance and safety for patients, leading to increased safety, reduced hospital admissions and improving quality of life. (See para 9.3)

20. Assistive technology is an alternative option for staff/individuals/carers to traditional care e.g. a medication prompt via a kit rather than a carer or health visitor always having to visit. (See paras 9.6, 9.7)

21. Local authorities are saving money on behalf of the NHS and are taking on the public health role. The preventative agenda (such as the prevention of falls) benefits both the NHS and the local authority in reducing social care admissions. The night service sends out qualified responders who provide personal care on site and this has significantly reduced costly ambulance call outs and hospital admissions and the provision of Telecare fire detectors can prevent call outs by the fire service. (See para 9.2, Sections 10 and 11)

22. There are separate 'silos' of funding as provision is currently covered by different departments internally and with alternative providers externally. (See para 10.19)

4. RECOMMENDATIONS

REC 1: The Head of Adult Social Care and the Head of Community Housing should ensure that Telecare and Telehealth can become part of mainstream delivery and reach a wider client group and not just be seen as tools for older persons, but for use for younger patients (such as mental health and epilepsy) and in cases of domestic violence. (conclusions 1-3)

REC 2: A Spend to Save bid should be made, backed by the business case on Telecare, for the expansion of services to the most vulnerable clients who would benefit from this service but who may not be taking it up on cost grounds, and that assessment of care packages include Telecare at the start of the process. (conclusion 4)

REC 3: That PCC work closely with Dr Neal in the promotion of the expansion of Telehealth based on the positive results from the Portsdown Practice and that encouragement be given to the inclusion of Telehealth at PCC's Somerstown Hub health centre. (conclusions 5 & 6)

REC 4: PCC to ensure that the relevant staff (in Adult Social Care in particular) are kept aware of Telecare availability and the expansion of Telehealth through training. (conclusion 7)

REC 5: The Head of Adult Social Care and the Head of Community Housing to develop a plan to encourage suitable Telecare responders and monitor the use of responders and their level of training (and consider training of members of the public) to ensure safety, give confidence and to avoid more costly escalations. (conclusion 8)

REC 6: At Milton Village sheltered housing development the pull cord response times need to be improved (in line with Brunel Court) to give a more uniform service. (conclusion 9)

REC 7: Officers to continue to investigate how different systems work and consider their compatibility for future integration of equipment from different providers. (conclusion 10)

REC 8: Portsmouth CC to look at pursuing further partnership work with Southampton CC, other local authorities and other providers. A joint marketing approach should include good news stories on positive outcomes in the local outlets such as The News and on websites and the local PCC publication Flagship. (conclusions 12 & 13)

REC 9: In further exploring combined work between Portsmouth and Southampton on Telecare processes should be in place for the monitoring of take-up. (conclusion 14)

REC 10: Marketing should include an up to date leaflet and website information available regarding all options not just PCC's telecare. The PCC website could have links to other useful sites and ask others (such as Portsmouth Pensioners' Association) to include information on their own website regarding the availability of different systems. PCC's website should include a virtual tour to show a

'smarthome' indicating how monitors and sensors could be positioned in each room. (conclusion 15)

REC 11: Venues for promotional events should be expanded to go out into the community, such as attendance at PCC festivals and at local churches, lunch clubs and the Frank Sorrell Centre. (conclusion 15)

REC 12: PCC to keep informed of the findings of Solent NHS Trust's evaluation of data security in Telehealth and the success experienced by local GPs involved in the 'Florence' project via the CCG. (conclusion 17)

REC 13: HOSP and the Health & WellBeing Board be requested to ask that there be inclusion of questions raised with the CQC on Telecare and Telehealth provision in Portsmouth. (conclusion 18)

REC 14: PCC to continue to liaise closely with the community pharmacists regarding their key role in the provision of the automatic pill dispenser service. (conclusion 19)

REC 15 The PCC's business case for Telecare be followed up by the Telecare Advisory Group (TAG) with further work with health colleagues and partner agencies to gain citywide ownership of Telecare and the expansion of Telehealth. (conclusion 20)

REC 16: That the savings be quantified and promoted which are being made by the provision of Telecare (being subsidised by Adult Social Care for the night time service and being provided by Community Housing) not only to other departments at PCC but to the wider health and emergency services, and efforts be made to recover savings (conclusions 21 & 22)

REC 17: Due to the existing silos of funding by different departments for Telecare, SDB look at ways that this can be addressed within the organization. (conclusion 22)

(N.B. the allocation of actions and the anticipated resource implications of these recommendations are set out in Appendix 2)

5. ADVANCING THE USE OF TECHNOLOGY IN ADULT SOCIAL CARE (TELECARE AND TELEHEALTH)

Introduction

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, with their own distinct 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

- **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.

Neither of these is intended to replace human contact but are designed to support the safety, independence and well-being of individuals, and to support and reassure both users and carers.

Objectives of the Inquiry

6. **OBJECTIVE 1:** To gather evidence on the current provision of technological solutions (Telecare and Telehealth) to adult social care clients by the City Council and other organisations

Portsmouth City Council (PCC) Provision of Telecare
In gathering evidence on the current provision of technological solutions the panel heard firstly about Portsmouth City Council (PCC)'s in-house provision of Telecare.

6.1 Councillor Steve Wylie, Cabinet Member for Housing PCC stressed that the City Council has a role to play in securing better health and educational outcomes for residents. Telecare is part of the Housing Strategy and is used where appropriate in partnership with Adult Social Care. The City Council's Telecare provision is not profit led and has to be affordable both to the resident and the Council. The service would be offered as appropriate to the individual's need. PCC try to keep the cost down to remain competitive as there is a choice for individuals and their families when considering its suitability and choice of provider.

6.2 Nigel Baldwin, PCC's Housing Enabling Manager explained to the panel 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 technological advancement. Since the 1990s this had been marketed to all Portsmouth residents.

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

2,000 are to PCC local authority sheltered housing residents

1,000 are to Portsmouth residents in their own homes requiring the service

6.3 **Accessing the PCC service**

The referrals (which are not part of the sheltered housing schemes) often come from individuals, their families and friends or professionals in the social care and health field such as occupational therapists. There are increasingly more referrals from health and social care professionals. The team is based in the Community Housing Private Sector Housing team and install a variety of equipment which the panel members had the opportunity to view. The team also has 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.

6.4 **Cost**

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 (and remained at this for the 2013/14 financial year) plus there is an extra charge for a night responder service, so where this is incorporated the rate would be £7.50 per week (rising to £7.59 for 2013/14).

6.5 **Reliability of equipment**

The equipment is reliable and recyclable with the pendant units going back to the provider Chubb. Here the pendant unit with their batteries can be renewed. The call centre know when the batteries are going flat and an alert is sent so that they can be changed. Equipment would only not work where the client switches it off. It is rare for there to be a need to repair, other than when the batteries go or when there is accidental damage. 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. As people's circumstances change replacement or different equipment can be fitted for free (within the set charge).

6.6 **Range of Equipment**

Flor Deasy, an experienced PCC Telecare technician showed the panel the equipment which included:

- The **home hub -** This 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.

- **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 -** The gas detectors are often fitted above the cookers which is helpful for patients with dementia

- **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 a message of advice/reassurance to the client

- **Pull cords** similar to those used in sheltered housing schemes

- **Epilepsy sensor** which would alert family members if there was a seizure at night

- **Bed wetting sensors** – to alert a carer

- **Flood detector** – if the bath overflows this would call the carer (to minimise flood damage)

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

- **Extreme heat sensors** these are linked to the thermostat and which alert the call centre

6.7 **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[1]. Non-PCC tenants are required to have two unofficial carers to act as responders 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 estate staff to go and check on them. It was noted that the additional night service is funded by Adult Social Care.

6.7.1 Whilst the aim is to reduce the number (and expense) of ambulance callouts by giving a professional response members questioned whether in some instances this could delay receiving medical attention. In some instances 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.

6.7.2 One client who has a high number of these aids had participated in making the service's promotional 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 and those living independently could now have more complex needs; this equipment was part of a range of interventions.

[1] The call centre is under contract with Southampton City Council

6.7.3 As not everyone has landline telephone lines there is 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.

6.7.4 The marketplace is broadening with other technologies being available so 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.

6.7.5 PCC Telecare equipment is 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:

- Promoting independence in the home
- Reducing the need for nursing care

6.8 **PCC Sheltered Housing**

6.8.1 Alison Croucher, PCC's Sheltered Housing Manager provided the panel with information on the use of Telecare and Telehealth in sheltered housing in Portsmouth. PCC's sheltered housing service provides housing-related support to enable residents to live as independently as possible in their own home. The service does not provide personal care, medical care or first aid. However staff will work with or seek advice from other agencies as necessary to support residents to meet these needs if required.

6.8.2 To receive the Sheltered Housing Service the applicant must be over 55 (but those under 55 with support needs may be considered), have a defined housing need and a defined support need. Eligibility is usually decided via an assessment and there may be some waiting time until a suitable property becomes available.

6.8.3 There are approximately 1500 sheltered accommodation properties in the city that have been designed or adapted to meet the support needs of elderly or vulnerable people. There are several different property types, mainly one bedroom flats and bed-sits although there are some two bedroom flats and a few bungalows. The common factor to is that they are linked to a 24-hour alarm system. Zoned care agencies provide Night Support for residents and this arrangement works well. Generally it is the Scheme manager or social worker who makes referrals for Telecare.

6.8.4 Category 1 blocks (24 blocks, mainly within the Portsmouth area)[2]

- Accommodation with a mix of general needs and residents with support needs.
- There are 827 category 1 residents in Portsmouth.

[2] There are 24 Category 1 blocks, 6 Category 2 blocks and 7 Category 2.5 blocks. Category 1 blocks range from 2 to 25 floors, they are mainly within the Portsmouth City area. Most are close to facilities such as shops, bus routes, post offices and health centres but a few are more remote.

- A pull cord alarm call system is in place in most blocks but in some circumstances a 'stand alone' system that requires a BT landline is necessary.
- Since 2010 49 stand alone units have been installed in Category 1 blocks. The expectation is that numbers of units will increase.
- Key safes have been very useful in Category 1 accommodation as they allow swift access in an emergency and access to carers on a daily basis.
- Door exit monitors have been fitted in 2 cases of early dementia
- Fall trigger kits have been used in 2 cases when patients have regularly failed to wear pendants
- Bed exit sensors have been installed in 2 cases where service users have been found out of bed and very cold
- Onsite support is available Monday to Friday (9- 5pm). Generally this is one Scheme Manager per block. They will arrange regular contact and support with the resident to meet individual need; to enable them to live independently in their home, if on duty they will also respond to alarm calls.
- When staff are not on duty, alarm calls are taken by the call centre in Southampton who arrange for an appropriate response, usually a representative from the Out of Hours Response Team to be sent.
- Staff can provide a range of support tasks including liaison with social workers, emergency shopping and collecting prescriptions. Other support can be arranged as required depending on the individual need and personal circumstances of the resident.

6.8.5 Category 2 blocks (6 blocks just outside the city boundary)[3]
Same as for the Category 1 properties, with the following additions:

- Specific accommodation for older people with support needs, there are no mixed blocks.
- Onsite support is available Monday to Friday (9- 5pm). Generally this is a scheme manager and one or more support assistants.
- A pull cord alarm call system is in place in all blocks although generally there is minimal need for additional Telecare products (2 cases over 2 years)

6.8.6 Category 2.5 blocks (7 blocks, 5 are within the city)[4]
Same as Category 1/ and 2 properties, with the following additions:

- Specific accommodation for older, frail people with higher support needs, there are no mixed blocks. There are 359 residents in Category 2.5 blocks in Portsmouth.
- Dedicated on-site support is available 24 hours a day 7 days a week. Generally this is a Scheme Manager and Support Assistants.
- Support staff can prepare and provide a heated meal if requested (there is a separate charge for this), domestic support such as cleaning can be arranged.
- In addition to pull cord alarms, the following telecare products are used:
    - Door exit sensors x 6 cases of dementia
    - Automated medication dispensing hubs x 5 cases.

[3] Category 2 blocks are all situated in the Crookhorn, Leigh Park and Wecock Farm areas

[4] There are 5 Category 2.5 blocks within the city, 1 at Cosham and 1 at Paulsgrove, most of these are 2 to 3 floors high and contain in the region of 40 to 50 properties each.

6.8.7 The Telehealth tablet dispensers have not worked as well as hoped in these settings, mainly due to the issue of getting the hubs installed (it took 6 months in one case) and to be refilled by community pharmacists (as there was some reluctance experienced).

Whilst Telecare products are very useful in helping people stay in their own homes for longer, the counter argument by some Scheme Managers is that some residents delay the move into residential care for too long because of this equipment.

6.9 **Referrals for Telecare Services**

The panel heard the experience of Melissa Daniells a former occupational therapist who is seconded to the PCC Telecare Project, who had previously worked 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 Queen Alexandra (QA) Hospital she was aware of instances 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. Time lying on the floor is associated with increased mortality: a study had found that up to half of the elderly participants will die within 6 months after a lie on the floor of an hour or more[5]. The telecare pendant alarm can dramatically reduce the risk of a long lie on the floor.

Anonymised examples were given 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.

[5] Wild D, Nayak US, Isaacs B. How dangerous are falls in old people at home. British Medical Journal (Clinical Research) 1981; 282:266-8

- 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 and 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 Carbon Monoxide) 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.

6.10 **Barriers**

6.10.1 The panel heard that possible barriers to the installation of telecare could include:

- Cost - not everyone who wanted or needed this could afford the c.£7 per week. There had previously been some Supporting People financial assistance but this had been cut and now funding was on an ad hoc basis and there had been general savings made to both council and health budgets.

- Need for Two responders - PCC telecare declines referrals 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.

- Whist carrying out a valuable service for the most vulnerable PCC does not provide a Telecare service 24 hours, with an additional charge for the night response service.

6.10.2 **Client Group** – when considering the breakdown of resident type was i.e. care and nursing homes versus individuals in their own homes it was reported by the Wessex HIEC that there are 1.7m users of Telecare in England and in Portsmouth the ratio was thought to be 4:1 with the majority accessing services in local authority housing and extra care facilities rather than private home owners. This majority was using the community alarm devices with a large potential market for peripheral devices to be developed. This was dependent upon the staff and the clients having confidence in the equipment.

6.11 **Provision by other organisations**
The panel also received evidence of external organisations providing Telecare equipment, sometimes in a partnership arrangement with PCC.

6.12 **Leonard Cheshire Disability** (LCD)

6.12.1 The panel considered Leonard Cheshire Disability as an example of an external extra care sheltered housing provider using telecare facilities. Lesley Hammer, The Service Manager for LCD explained the support the organisation provides at extra care developments (Brunel Court and Milton Village) and to 299 service users in the community (Zone PO3) under a contract awarded by Portsmouth City Council (PCC). LCD provides support to all members of the community, not just ex-service personnel.

6.12.2 LCD provides extra care support to residents at two facilities in the city: Brunel Court and Milton Village. Both centres were developed and are owned by Housing 21 in partnership with Portsmouth City Council. Each room in both facilities has a pull cord alarm which was procured by Housing 21 from Tunstall Healthcare (a provider of telehealthcare products) and which is paid for as part of the service charge. In addition, a number of residents also have other telecare equipment such as door exit sensors. LCD does not offer private care to residents at Brunel Court or Milton Village.[6]

- **Brunel Court** has 55 flats to rent and part share-own, some wheel chair access, assisted bathrooms, care on site 24 hours a day and a day centre on site. The response time at Brunel Court is very fast as carers receive the alarm call direct, are on site and can contact service users over the phone to discuss their needs or take other action (such as calling an ambulance) as needed.

- **Milton Village** has 65 one or two bedroom extra care flats on three sites, which are designed for those who need some personal care and support with their daily living. There is also an on-site care team who provide 24-hour care and support to meet individual needs. The three sites are Osprey Court (16 rented flats), Crane Court (12 rented flats) and Brent Court (12 rented flats and 25 shared-ownership flats).

6.12.3 The level of care provided by the staff is 24 hours a day, 7 days a week, which when combined with the use of telecare means that people can stay in their homes for much longer than would otherwise be the case.

> EXAMPLE from LDC: In one case where a service user was suffering from dementia, a door exit sensor was fitted with a tape of her son's voice asking her to go back in and wait for someone to come. In this case the service user was reassured and calmed by the tape.

6.12.4 LCD would only ask to have people moved out of extra care if they became a danger to themselves or others. The Service Manager was only aware of two cases over a 20 year period where LCD had not been able to care for people. It

[6] Housing 21 developed the land for Brunel Court and Milton Village under procurement from PCC and that it procures the services of LCD. To become a resident at Brunel Court or Milton Village service users need to be a resident in Portsmouth, be living in housing no longer suitable for their needs, have had an assessment of their needs, need help with personal care of at least four hours per week and be aged 55 or over.

was usually the family who made the decision to move an individual into residential care.

6.12.5 The response time at Milton Village to the pull cord alarms is slower than at Brunel Court, as the flats are spread out across the three sites and the underground wiring for the system was not installed when the sites were developed three years ago. A system has however been put in place where alarm calls go to the call centre in Southampton before the information is relayed to carers by mobile phone. This slows down the response rate and additional delays can be caused if the mobile phone is in use. However, the calls are prioritised at the call centre in the same way that the carer on site would respond ie. if an ambulance is required the call centre staff make the call. PCC's Assistant Head of Adult Social Care is aware of the situation and is looking at ways of improving it further.

6.12.6 For information gathering, monitoring and the management of the centres, collating information about the number and nature of alarm calls is important. At present carers at Brunel Court can obtain a printout of information relating to alarm calls. The equipment providers Tunstall are developing a system whereby information will be sent through to a computer with information about the number of calls, type/ reason of calls and response rates. This would allow managers to see patterns which would be a significant step forward and a very useful tool.

6.12.7 Of the 299 service users in the community (Zone PO3 in Portsmouth) supported by LCD, 45 use telecare services[7]. Telecare products in the community are procured from a number of different providers. Often social workers identify the need for telecare products for service users in their own homes. The cost of telecare and access to suitable phones are reasons why more people do not chose to use it. LCD does not charge PCC to have carers on standby to respond to pull cord alarm calls but does make a charge if care has to be provided and a carer visits the service user.

6.13 **Housing 21**

6.13.1 Graham Pink the Brunel Court Manager explained that Housing 21 are also providers of extra care housing as a major national housing association for older people. Brunel Court in Portsmouth consists of 55 flats with the Royal Albert Day Centre on site (run by PCC) for dementia sufferers. The care provider for Brunel Court is Leonard Cheshire Disability with Housing 21 being the housing provider. Their residents have a range of disabilities and current ages range from 51 to 99. Their care packages include at least 4.5 hours a week (including leaseholders).

6.13.2 The 'Communicall Vision' alarm system in place is the Tunstall model for grouped housing; an electric system with power backup, using a dedicated telephone line. This promoted independence through the use of pendants/bracelets and providing emergency red cords in each flat. Each resident has an identification number (usually their flat number) and the on-site carer carries a handset around with them to receive calls and make calls out to emergency services. This handset can also be used to broadcast announcements to residents (e.g. testing of fire alarms). If 2 or more calls are received at once to the handset a waiting system is used- it will be dialled 4 more times before being routed to the

[7] In the community responses are made via the call centre which makes contact with next of kin or designated person, whereas in Brunel Court and Milton Village the support workers respond.

monitoring centre within a few minutes. The handset also receives information about fire sensors (and all the flats have heat and smoke detectors).

6.13.3 Speech boxes are located in the doorways and can be used to answer the main door of Brunel Court. Residents' TV screens (or separate monitors) can show a picture of who is at the front door so they can assess if they should give access to the caller. Other equipment provided there included door and bed monitors (which were useful for residents with dementia), floor monitors (for those prone to falling) and intruder sensors for vulnerable clients.

6.13.4 The **cost** of their telecare Lifeline service is £3.46 per week (as at 2012). This used to be paid for by housing benefit but is now built into their rent as a support charge (there is not an opt-out as it is sheltered accommodation). The equipment is replaced free of charge (unless there is persistent loss as units cost £40 each). Additional equipment would be added on without extra charge through Housing 21's adaptions budget.

6.13.5 The benefits of the communications system were the safety given to residents and staff, with visitors also being able to use it to call for assistance, and for reporting of lift breakdowns. The system could be subject to overuse by some residents to the detriment of other more needy callers and the door system link up could clash with an emergency call. Therefore they were asking Tunstall to provide a separate system for the front door. The carers' handsets were bulky but replacement ones were likely to be lighter in the future. Brunel Court thereby gave a sense of security whilst still promoting independent living. Some of their residents were used to residential care and they have to understand the level of service, ie. what is included.

6.13.6 There is a need at PCC for extra care places with a new scheme due to open in Queen Street, for which Housing 21 is the developing housing association partner with the City Council. [8]

6.13.7 **Integration of systems**
Brunel Court did not have Telehealth users in 2012 but with the use of Tunstall telecare equipment there was the potential for this to be expanded. Tunstall provided a fast response in resolving equipment problems, recognising the vulnerability of these residents.

6.13.8 Elsewhere the Docobo Telehealth equipment was provided through Solent NHS and there is the need for more to be provided to homes via community nurses. When telehealth elements needed to be added to a telecare package there should not be an increased cost as usually the NHS body would pay for the telehealth element.
Further work is needed on how these systems work together and if there is compatibility.

6.13.9 **Social Isolation** - The panel members queried whether the systems exacerbated depression, with less human contact. It was felt that social isolation is a wider issue than the replacement of brief medical visits for which the quality of contact

[8] As part of the '4 Sites' extra care scheme, this is a block of 43 extra care flats being built in King William Street, off Queen Street, which will open in October/November 2013.

could be negligible. There is the need for PCC to look at this issue and assess and direct residents to other community assets and activities. At the sheltered housing schemes residents like to see a manager and the carers at Brunel House are available 24 hours a day and there is the use of a shared dining room and social events in the communal area.

6.14 **Age UK Portsmouth**

6.14.1 The Panel heard from Age UK Portsmouth, a voluntary sector provider of telecare. Dianne Sherlock, Age UK Portsmouth's (Age UKP) Chief Executive Officer believes that there should be a presumption of independence. Age UK Portsmouth aims to encourage an acceptance that wearing the pendant for the alarm system is not a sign of age, but of altering health with maturity. They also wish to encourage the use of devices earlier, which would in turn reduce falls. Once a fall has occurred to someone in their eighties another is likely within six months and this was not just due to health factors but also to the environment of the home. Greater awareness of community alarms would encourage earlier participation.

6.14.2 Age UK Portsmouth worked with Tynetec (equipment provider) for the installation of the personal alarm system and there were over 50 peripherals that could be added such as bed exit alarms. Age UK Portsmouth have 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 by the user.

6.14.3 Age UK Portsmouth is working closely with:

- Age UK nationally to provide equipment to allow people to stay on in their own homes for longer
- Local representatives involved in developing the dementia strategy in the city
- The University of Portsmouth regarding innovations in flooring
- Solent and Southern NHS Trusts on health initiatives
- The Red Cross who give support to their home service on reablement work

6.14.4 **How their alarm system works**

This automatically dials a national call centre in Devon which had 24 hour cover and they speak to a human operative 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.

6.14.5 **Referrals to Age UKP**

These came from a variety of sources; from the Age UK home assistants and information officers going out to the community as well as self-referrals and from families and from GPs. It is important that people were aware of all the devices available not just from Age UK but also from the city council and others and Age UKP 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.

6.14.6 Age UKP would welcome GPs becoming more involved. They found the same doctors making the referrals and Age UKP's Chief Officer did attend their committee meetings to encourage participation and be aware of the range of equipment for referral purposes.

6.14.7 **Telehealth Provision**

The provision of Telehealth by health authorities is examined in greater detail within Objective 4 (regarding advances in technological solutions). 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 advice given 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 are able to add applications which are designed to have health benefits.

7. OBJECTIVE 2: To receive evidence on what is currently being done to raise awareness of the telecare services currently available to promote and assist independent living

7.1 **PCC's Telecare DVD**

7.1.1 The panel members viewed the third cut of the DVD/website film produced to publicise the Telecare work at the city council which would also be made available through the PCC website and could be used for training new staff in Housing and Social Care. PCC's Community Housing Service were producing two films: the first one was a promotional one for prospective customers and carers and the second was for professionals (which was still in production) for trainers in social care to use.

7.1.2 This promotional film showed customers feeling safe and secure in their homes and giving their experience of the pendant system and how it was easy to have installed. It also showed that this was appropriate for a range of ages not just the older clients but younger ones with learning disabilities who benefit from this independence.

7.1.3 Caroline Elder, Business Improvement Officer at PCC, reported that the film would be available on the PCC website and there would be some DVD copies available. There would also be a version made with subtitles.

7.1.4 Quotes from the DVD illustrating the reassurance given by telecare:

"Before I had the pendant I had a terrible accident in the garden. I thought I was alright but I couldn't get up. I cried out for help, I had nobody here. Luckily I crawled to the door where I had two hand rails and I got myself on my knees indoors and had to sit all night in pain, I couldn't move. I just wish I'd had that pendant round my neck but now I've got it I feel safe and secure and know that I've got help any day." Pauline

"Before we had the monitor if Laura had a bad day of seizures then I would have to sleep downstairs with her so obviously it's made things a lot better." Laura's Mum/Carer

"My father's very keen to continue to live in his own home and to be as independent as he can be. He has carers visiting during the day, but if there was a problem at another time we know that because he will always be wearing his neck pendant he could press that alarm". Ann

7.2 **Marketing of equipment**

7.2.1 PCC is one of a range of Telecare providers available in the community with Age UK being the fourth biggest provider (in the city PCC is the largest provider). The higher the take-up there was of telecare the cheaper it could become to provide if economies of scale were realised and partnership working took place such as on joint marketing strategies.

7.2.2 Age UK Portsmouth has equipment set up at its Bradbury Centre so people could see this before signing up. The aim was to make presentation of the equipment there a fun experience. Age UKP also aim to make the wearing of the pendants less stigmatised and encourage the cords to be decorated (as long as they had safety release mechanisms).

7.2.3 Telecare needs to 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.

7.2.4 There was information on the national Age UK website which is kept up to date and used plain English and their Hampshire site linked to many other useful sites.

7.2.5 Telehealth expansion is also being encouraged; there was soon to be a second surgery in Portsmouth following Dr Neal's lead at the Portsdown Surgery (outlined in Objective 4). The Project Manager was meeting further with the community pharmacists regarding the issue of refilling the automated pill

dispensers. A current review of 16 individuals using the automated dispensers would be used to persuade the CCG of the usefulness of this Telehealth tool.

7.2.6 PCC's Project Manager for Assistive Technology estimated that 12-14,000 people in Portsmouth would benefit from telecare and telehealth provision

7.2.7 70% of these residents were in their own homes so there was a huge market not yet tapped into including those with learning disabilities. Some people could pay for the provision which would also need to be explored further.

7.2.8 As well as providing information on Telecare products and services for service users being available in leaflets (from libraries, GP surgeries, PCC and other organisations); Flagship magazine, PCC website etc. There were promotional events taking place such as the stakeholders event on 15 March 2013 at the Oasis Centre (outlined within para 8.2) to illustrate the range of products available. Some local authority websites such as Medway Council had virtual tours on their websites which showed a 'smarthome' with monitors and sensors positioned in each room.

7.3 **Telehealth Training DVD**

7.3.1 The panel members also viewed a DVD produced by Solent NHS and the HIEC which would be used for staff training on telehealth to address the worries of staff regarding issues such as:

- monitoring
- the urgency of response
- the compatibility of computer systems etc.

7.3.2 The DVD showed how the Solent NHS wished to provide reassurance to staff that they would be able to deal with more patients in a shorter time and patients would take on some responsibility in monitoring their own health whilst being confident that someone was on the end of the phone and a visit could be arranged where necessary. The community nurses could then spend more time dealing with patients who needed their input.

7.3.3 The panel was advised that promotion should reach those who were in need of the services and those who should be aware such as those with aging parents. Alternative venues could be considered for promotional events such as at the festivals held in Portsmouth (such as the Rural and Seaside Festival at Castle Field on 4 to 6 May 2013), the city council's over 60s festival and at local churches. Other suitable venues to reach target groups could include the Bradbury Centre where they held lunch clubs via Age UK Portsmouth and the Frank Sorrell Centre in Southsea (where the Portsmouth Disability Forum is based).

7.3.4 Evidence was received to demonstrate that there is a need to tackle preconceptions regarding telecare costs and equipment; marketing should be put into context with the use of suitable terminology and stories of positive outcomes. With regard to 'cumbersome' or intrusive equipment it was noted that the Telecare base units were being upgraded and there are clip-on and wrist versions available as an alternative to the pendant alarms.

7.3.5 It was noted that there had previously been a useful equipment demonstration centre at the Vanguard Centre however this had been closed down and new opportunities should be taken to promote the equipment so that people were aware of what is available. PCC were going to tender regarding a joint equipment store which may provide an opportunity to link telecare equipment in to demonstration sites developed by the new provider. Hampshire County Council had a mobile sensory van that could visit community centres.

7.3.6 PCC's Project Manager for Assistive Technology was looking at comparator councils to see what they provided online and some did have links to providers that were not just internally their own and she would be visiting Dudley and Solihull, West Sussex, the Isle of Wight and Poole to meet with commissioners and providers. Uptake was encouraged by Richmond Council with the provision of telecare being provided free for the first six months.

8. OBJECTIVE 3: To understand recent research on the benefits of advancing telecare and telehealth provision in the city

8.1 Two of the key strategic drivers at a national level are:

3million lives (2012) [9]

Whole Systems Demonstrator Pilot

8.1.1 **3million lives** is a concordat between industry and the Department of Health promoted to lessen the burden on long term NHS costs and improving people's quality of life through better self-care in the home setting. The Secretary for State for Health Jeremy Hunt is promoting this relationship. There is a newsletter to subscribe to for updates and details of campaigns on their website[10].

8.1.2 **Whole Systems Demonstrator Pilot -** 11 areas have been identified where both telehealth and telecare will be implemented at significantly higher levels to show how savings can be generated and evaluate the improved quality of life. PCC has expressed its interest in involvement in future such initiatives.

8.1.3 Dr Neal reported that on 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.

8.1.4

The findings for the Whole Systems Demonstrator after 3 years included:

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

[9] The Department of Health 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

[10] www.3millionlives.co.uk

8.1.5 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 sooner as there was equipment at home to help monitor them.

8.1.6 Economic and demographic indications are that more older people needed to be supported when locally there are reductions to the city council's budget. This would mean that there was a need to change the management of long term conditions through both telecare and in particular telehealth initiatives. The future trends for the management of long term conditions will include :

- 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

8.2 **Feedback from Telecare Drop in Day**

8.2.1 The aim of the stakeholder event held on 15 March at the Oasis Centre was two-fold, firstly to provide members of the public, service users and carers, health and social care professionals with an opportunity to view a range of telecare products and services on offer to raise awareness of the potential for this type of technology. Secondly, to seek views about current telecare services in the city and to gather their feedback about the future shape of telecare provision. This had generated 35 completed surveys with a mix of returns from the professionals attending, members of the voluntary sector and staff but there had only been five from members of the public.

8.2.2 Fourteen telecare equipment suppliers and service providers exhibited on the day: Supra, Tyntec, Bosch, Chubb, Portsmouth City (PCC) Council Telecare Team, Buddi, Health Innovation & Education Cluster, Just Checking, Smart Living, Tunstall, PivoTelll, Aster Living, Guiness Care and PCC's night responder service.

8.2.3 Whilst the event was seen as a successful networking event, six key themes emerged from the completed feedback forms:

- General concern that the cost of telecare services to individual users is prohibitive.
- General lack of awareness about telecare services available in the city.

- Concern that there is a lack of familiarity among the general public and others about the availability of technology and its potential to support people to live independently.

- Concern that many potential telecare users are not accessing telecare as they do not have 2 local family members, neighbours or friends to act as responders in the event of an alarm being triggered.

- Telecare equipment should be prescribed on the basis of assessed needs and the ability of the equipment to meet these needs rather than simply selecting from a limited range of equipment.

- Worry among professionals that telecare is only seen as a solution for older people to the detriment of other care groups including learning disability and those with secondary mental health needs.

8.2.4 Members of the panel had attended the drop-in day and had found it useful to speak to the providers. These had included the 'Just Checking' service which provided good profile monitoring of the habits of clients and which was used by Hampshire County Council and Dorset County Council as a subscription service.

8.2.5 To address the lack of public attendance at this event further public feedback would be sought by PCC by:

- Undertaking a telephone survey with a random selection of of customers who use the current PCC telecare service.

- The Project Manager for Assistive Technology would embark on visits to some of the carers' support groups in the city to collate further feedback about telecare provision.

8.2.6 These steps would help gain a more comprehensive view of current provision and what future provision should look like and the feedback from this work along with the responses from the stakeholder event will be used to inform the telecare business case.

8.2.7 Ten customers completed the following telephone interview (eight were direct service users and two were carers). All were happy with the service and would recommend it to others. The main reason given for needing Telecare was in case they had a fall. In general they reported that Telecare provided peace of mind, security and independence. Three out of the ten were not happy with the current cost of Telecare and two said that decreasing the cost would help. Three people reported that they had problems with false alarms including grandchildren pressing the button accidentally. Whilst this is only a small survey it provide anecdotal evidence of how Telecare has helped prevent carer stress, long lays on the floor and improved people's quality of life and independence in Portsmouth.

9. OBJECTIVE 4
To investigate how advances in technological solutions will benefit Portsmouth residents, the local authority and partner organisations

9.1 The panel sought evidence from local health representatives to gain an understanding of the advances in technological solutions, centred on the more recent developments in Telehealth.

9.2 **General Practitioners (GPs), Telehealth and Dr Neal's Research**

9.2.1 As part of the investigation of advances in Telehealth being promoted in the city the panel heard from Dr Julian Neal, a long standing partner and GP from the NHS Portsdown Group Practice (of over 30,000 patients), who also worked with private industry as a medical adviser to the second largest Telehealth provider (Telehealth Solutions Ltd). The Portsdown practice had won a Strategic Health Authority (SHA) innovation funding grant to pilot Telehealth work with OBS Medical.

9.2.2 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. He provided the following statistics on the nation's health:

9.2.3

- 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

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

9.2.5 This is at a time when the NHS is 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. A way to manage chronic conditions better is to use remote technology.

9.2.6 Dr Neal had worked with Telehealth Solutions[11] for 2 years, developing algorithms[12] based on the data provided by the answers to questions by patients via their kits which were 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 red alert was triggered. There are specialist COPD and diabetic nurses to give advice. At the Portsdown Practice in 2012, 100 COPD patients signed up to Telehealth (and there will be 100 patients with diabetes and others with heart disease).

9.2.7 Dr Neal believed that Telehealth gives an improved service which he would recommend to other GPs/CCG practices to analyse who would be in most benefit of the equipment if they are in danger of being admitted to hospital. Whilst initially

[11] Since becoming Medvivo
[12] Processes for calculations and procedures

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. At Portsdown Practice the patients bonded with the specialist nurse they dealt with at the time of recruitment to Telehealth. There are compliance and quality control measures to ensure the equipment is medically safe.

9.2.8 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 of research in USA and Germany had been positive and the results in the UK were due in January 2013 that would indicate how it works here. [13]

9.2.9 He reported that 90% activity in primary care[14] is for 10% of cost. 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.

9.2.10 Costs in Portsmouth 2010/11 – secondary care15 £218m, GP and primary care £52m.
To be admitted to Queen Alexandra (QA) hospital costs approximately £2,200.

9.2.11 In August 2012 32 hospital admissions were avoided so £64k was potentially saved for the Portsdown practice.

9.2.12 The cost of the kit is approximately £1k 16– making a saving even when there is only one admission. These savings would be significant year on year.

9.2.13 **Benefits** include:

- Releasing time for GPs - it frees up space and GP time in practices with large building costs.
- Reducing depression as patients are contacted regularly (with phone follow up consultations) and asked how they feel. They know that people care and feel they have more control of their condition. (The Portsdown patients were enthusiastic about the service.)
- Versatility - it is not just suitable for the elderly - younger diabetic patients like to use mobile phone technology rather than attend the surgery.
- Preventative work can be undertaken through Telehealth with health promotion and monitoring of lifestyles/diets.

[13] The British Journal of Healthcare Management 2013 Vo l 19 No 4 reported on Dr Neal's results 'Telehealth: a case study in a large GP practice'
[14] Primary Care - is healthcare provided in the local community (such as by GPs and pharmacists) rather than in a hospital setting
[15] Secondary Care - is healthcare provided by a specialist, who does not have the first contact with patients, often at a hospital setting
[16] The Portsdown Practice is provided with the kit for free (due to Dr Neal's services to Telehealth Solutions) but commercially sourced kits would cost approx. £1,200.

9.2.14 **Drawbacks**, whilst few, could include:

- 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.
- Lack of 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.

9.2.15 PCC's Integrated Commissioning Unit's officers later reported on the project's findings in which 71 COPD patients participated.

The headline findings are that Telehealth at the Portsdown practice has resulted in:

- 67% reduction in GP face to face consultation
- 85% reduction in GP home visits

Dr Neal's study, based on this group, had also indicated significant (over 50%) reductions in both A&E attendance and unplanned admissions to hospital. Whilst these figures are open to scrutiny by the hospital authorities they do show the importance of identifying trends of medical conditions through Telehealth to enable appropriate interventions to be made before hospitalisation is required.

9.2.16 PCC's Health Overview Scrutiny Panel was tackling the Care Quality Commission regarding their remit to inspect GPs and asking for services to be more uniform between surgeries so there would be the opportunity for the inclusion of questions on telecare and telehealth.

9.3 **Automated medication dispensers**

9.3.1 As part of Telehealth provision members heard that these dispensers (also referred to as pill hubs) can be used for regular medication. A short term need for pain killers or antibiotic medication cannot be accommodated. The device has a number of sockets which pop open at the appropriate time. Usually these dispensers are ‘stand alone’ but they can be linked to a call centre. Moreover, the potential for prompt calls to be made to service users to help remind them to take the medication was being considered as patients still need monitoring to ensure that they actually take their medication on time.

9.3.2 The automatic pill dispensers can have a very dramatic impact upon medication compliance and safety for frail older people in particular. These were a useful tool in delivering care in sheltered housing settings. The hubs were tamper proof and with cuts to social care services these devices could help service users and their carers enormously.

9.3.3 The automatic pill hubs are not currently being used by PCC as community pharmacies are not willing to fill them. The community pharmacies wanted to assess all service users wishing to use the system and that this had caused the

programme to break down. Research from NHS Midlands & East showed that pill hubs did help service users comply with medication needs.[17]

9.4 The role of Community pharmacies in Telehealth

9.4.1 Sarah Billington, Chief Officer, Hampshire & Isle of Wight Pharmaceutical Committee 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.

9.4.2 The community pharmacists acknowledged the rise in patients with long term conditions taking medication and had concerns that medicine is not being taken as intended.[18] Dr Neal confirmed that that there is over-prescription of medication which is counter-productive. For those with dementia/memory loss the taking of medication is a particular issue. The community pharmacists' representative stressed that adjustments should be made based on the needs of the individual (stating that currently 5% of hospital admissions were due to the wrong medication being taken). The pharmacies would see patients 6 times as often as the GPs giving support and reviewing medication.

9.4.3 The PivoTell[19] automated tablet dispenser system is one of such solutions but has some practical problems. The PivoTell medication trays had been trialled and were not suitable for all. The range of aids included reminders, the use of trays and aids for getting tablets out of packages. In 2012 Adult Social Care were only aware of 10 patients in Portsmouth currently use PivoTell but more requests are being received.

9.4.4 PCC Adult Social Care wish to encourage independence and reduce spending on domicillary care visits. PCC's Project Manager for Assistive Technology is working with the pharmacies to come up with solutions and examine whether the service contracts with them need to be revised as the filling of the PivoTell 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.

9.5 Role of the Wessex HIEC in Telehealth

9.5.1 The panel heard from Katherine Barbour, the HIEC's[20] Telehealth/care work stream programme manager. The HIEC brings health and social care together with academia and industry. Their aim was to prevent admissions and make stays in hospital shorter and put support in place to help earlier discharge. Their mission was to increase use of Telecare and Telehealth to support those with long term health conditions to live in their own homes where possible.

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[17] The Automated Pill Dispenser Project by NHS Midlands and East - 'the right pills at the right time delivering the right outcomes'

[18] NICE statistics were that 50% of all admissions for acute heart failure is due to the patient not taking their medication

[19] PivoTell Ltd are manufacturers of reminders and pill dispensers

[20] HIEC = Health Innovation & Education Cluster, Department of Health funded initiative

9.5.2 Solent NHS' work also covered the Portsmouth and Southampton area for community services and they were using Telehealth for patients with chronic obstructive pulmonary disease (COPD). The HIEC has gathered case study examples showing savings through the use of Telehealth for patients with physical disabilities, dementia and severe epilepsy.

9.5.3 For Telecare there was combined work between Portsmouth and Southampton although the HIEC estimated that the ideal size for optimum benefit would be double the size of the two local authorities. There is potential to use the model of other authorities to combine with other services such as CCTV - as evidenced at Bristol City Council (see para 11.9)

9.5.4 **Costs, Income & Savings**
Income could come from a range of sources including from private companies buying into a service such as use of monitoring centres. Savings could be made residential care homes which previously had night time carers and the use of epilepsy monitors could mean that a carer was not needed on site.

9.5.5 **Work with Solent NHS**
Funding had been given by the Technology Strategy Board to develop the use of Telehealth with patients. They were working on how to add functionality to monitors to give extra benefits such as internet access to communicate with family and order in medication. So there was movement away from single function equipment. This work was with the equipment provider Docobo and there was further work with Age UK evaluating the project.

9.5.6 **Work with CCG**
The HIEC linked with Solent NHS Trust for the CQUIN[21] project, an ongoing contract to provide Telehealth equipment in Portsmouth. Whilst the Portsdown Practice embraced Telehealth many GPs were sceptical (wanting to see evidence and wanting to ensure that the equipment can deliver). GPs can make savings by renting the equipment and companies are keen to showcase their products. The government announcement on 'Directed Enhanced Services'[22] encourages GPs to have Telehealth as part of their service delivery. The Portsmouth CCG will be rolling out a new project for stroke sufferers using a text messaging service (see later reference to the 'Florence' project by the CCG in para 9.8.2). This would be a 12 month pilot study, funded by NHS Stoke with no cost to the service users. This preventative/early intervention project would rely on self-management by the patients.

9.5.7 **Department of Health funding** - this had first been provided in 2006 as a preventative grant to fund posts at the City Council as well as equipment, thereby developing the infrastructure to develop Telehealth initiatives.

9.5.8 **Social Worker referral** - Whilst the awareness of social workers had been higher than for GPs it was reported that their induction programmes did not always include Telecare/Telehealth at this time.

[21] CQUIN= Commissioning for Quality & Innovation, a health service payment framework
[22] National Health Service - The Primary Medical Services (Directed Enhanced Services) Directions 2013 makes reference to remote care monitoring plans for long term conditions

9.6 **Solent NHS**

9.6.1 Debbie Clarke Associate Director, Solent NHS explained their work in Portsmouth and Southampton in bringing together the agenda of telehealth and telecare and investigating the NHS having a central monitoring function. Solent's aim was to give good NHS care within people's own homes and avoid hospital admissions where possible. This work was part of the role of the community matrons and allowing people greater choice and the nurses were available to visit to monitor conditions.

9.6.2 Solent had attracted national and international funding to become one of the whole systems demonstrators sites[23] and they were trying to embed telehealth in health care and to adjust the expectation that nurses always see people in person.

9.6.3 The nurses are qualified to interpret the information provided through the telehealth systems and can visit patients where they need to talk to them regarding the information received and contact can be made with the GP where appropriate.

9.6.4 There are 9000 service users of Telecare in Portsmouth and Southampton.

9.6.5 In respect of Telehealth Portsmouth patients were using the Docobo system where people can answer simple questions on their health for longer term conditions and the patient would know if their own statistics were within a normal range. If it is not within this range a central team will pick up this information and know when to intervene.

9.6.6 This approach was not just suitable for older patients but for the younger age group and they were looking at innovative kit to make systems smaller and more portable. This 'safe patient system' using mobile phone functionality was currently being used in Southampton and they hoped to bring this to Portsmouth soon.

9.6.7 Solent NHS worked with commissioners to secure additional funding to buy in systems for Portsmouth. The overall aim to support Telehealth is for the Single Point of Access/monitoring centre to be extended from daytime only to a 24 hour service.

9.6.8 Telehealth was already being used to monitor how wounds were progressing. It also reduced travel time for professionals and they were able to speak to more patients. The community matrons have mobile phones and laptops and there was a whole strategy around the new technology; the patient's safety was most important to the staff and staff need to attend the training on the use of the telehealth equipment.

[23] The whole system demonstrators programme is a Department of Health research project to find out how technology can help people manage their own health while maintaining their independence.

9.7 **Southern NHS Trust**

9.7.1 Gail Glew Lead Clinician for Productive Community and Telehealth Co-ordinator, explained her role and 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 (see paragraph 8.1.1).

9.7.2 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 (but is not an emergency service).

9.7.3 The panel members viewed examples of the equipment used such as the arm cuff which could be used for blood pressure, as well as 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-invasive 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. This is can also be used for the management of long term conditions such as COPD and heart failure.

9.7.4 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. Patient data is assessed by the clinicians and this is colour-coded so it would flag up where breaches of parameters occurred.

9.7.5 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.

9.7.6 **Findings and benefits so far**
Southern NHS Trust had received 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. Readings could prompt the use of rescue medication[24] at home (where there were frequent occurrences) so patients could use prescribed 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. Visits were still

[24] This is medication prescribed by doctors for patients medical conditions to be used if their condition worsens e.g. antibiotics and steroids for patients with COPD

undertaken by nurses, when needed, who undertake appropriate and timely visits with back-up telephone support. This allowed clinicians to prioritise patient visits.

9.7.7 Southern NHS Trust's 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 the service in other community teams in the future).

9.7.8 **Future possibilities** 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

9.7.9 **Equipment**
Whilst Southern's equipment 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.

9.7.10 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.

9.7.11 The referrals 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.

9.7.12 Southern Health clinicians are responsible for the monitoring and whilst the healthcare support workers undertake monitoring they do not make the final decisions on health matters. The base unit can be set to take readings and prompt people at certain times. It will show 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.

9.7.13 **Level of prevention**
Southern's 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 appears to have been a reduction in secondary care once people were able to come off telehealth and this was being investigated further. It was noted that the evaluation of the trial would be published in April and it was hoped 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.

9.8 The Clinical Commissioning Group (CCG)'s perspective and 'Florence' pilot

9.8.1 The Panel heard from Jo Gooch, the Chief Finance Officer of Portsmouth CCG and Dr Kevin Vernon, CCG Clinical lead who explained the history of the CCG which had been fully operational from 1 April and which is developing a strategy for information technology not just for Portsmouth but for the Fareham and Gosport and South Eastern Hampshire area. This would be taken to the CCG board for approval in July. Their IT strategy would have reference to Telehealth but it was not a significant part of the strategy. The CCG would not commission this as a service in itself but the CCG wished community care to be provided for patients so that if they decide that this should be part of a package the CCG would be supportive of that to provide the best care for patients.

9.8.2 The CCG is not responsible for primary care provision but has an interest in the overall services that are run. The CCG have an overview of what is being spent on community services and the providers can choose to buy kit; as a matter of accountability they did not wish to heavily invest in unproven technology in the hope of delivering savings. However one area being looked at is enhanced service use of Telehealth to see how this can be used in the GP practices with involvement in the "Florence" pilot. This project is financed by NHS Stoke as a pilot for one year and uses mobile phone technology to help with remote care. This uses a text messaging service based on specific clinical protocols including hypertension, diabetes, smoking cessation and kidney failure. The service can send messages but can also request specific information back from the patient such as vital signs, medication compliance or health behaviour information, which is available for the GP to manage their patients, however there is no 24 hour monitoring service.

9.8.3 It is up to the GPs if they wish to take part in this[25] and it is separate to Dr Neal's wider Telehealth provision at the Portsdown Practice. After a year the data from the pilot will be analysed. The CCG's view is that evidence for Telehealth can be seen as contradictory although the CCG would like to be supportive of innovations where there are proven results. The Florence model was regarded as a well-validated, simple and affordable solution.

9.8.4 Dr Kevin Vernon, a GP based at the Lake Road Practice, stated that he personally is yet to be convinced on the results of Telehealth, and enjoyed the social interaction with his patients. The term Telehealth is used for a huge area of remote monitoring which could vary from the small applications for mobiles for diabetes results to the large piece of kit installed in homes by Tunstall. His perspective is that it was not yet known how effective it is or how much it would save on hospital admissions. However local GPs were engaging in the Florence programme; the text messaging service would be used to monitor raised blood pressure with the information being sent to GPs via mobile phone technology. This was simple and easy to use and was also helpful for those who disliked having blood pressure readings taken at a health centre. For many local GPs the

[25] In Portsmouth 20 of the 27 GP practices attended an AIM (advice and interactive messages) workshop and as at 24 June 2013 seven had signed up to participate with the deadline being the end of June.

Florence experience was an exploratory step into the area of Telehealth. There were ten types of text messaging services through Florence, some being reminders regarding taking medication however there are over 200 pathways available. The CCG wished to see how easy it is to use and if it makes a difference before further expanding its use locally. It was also noted that Telehealth lends itself to involvement by younger patients who embrace technology, with conditions such as asthma or diabetes, as this could enhance compliance if used properly.

9.8.5 The CCG's commissioning plan would only have a small reference to Teleheath, and the plan was reported to PCC's Health & Overview Scrutiny Panel on 13 June 2013. The panel heard that Dr Neal's findings would be presented at a GP information sharing session where good practice is discussed.

10. OBJECTIVE 5: To influence the developing Telecare and Telehealth commissioning strategy

10.1 Katie Cheeseman, PCC's Project Manager for Assistive Technology, explained her role in the Integrated Commissioning Unit and purpose of her appointment to develop a **Telecare and Telehealth strategy.** The national agenda is 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. In future plans would be formed in response to the trends seen. PCC is 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 to work jointly on initiatives.

10.2 **Key local strategic drivers included**:

- The Portsmouth Health & Well Being Strategy[26]
- Portsmouth Carers Strategy[27]
- Portsmouth CCG 5 year business plan[28] which aimed for
  - 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

[26] This can be viewed at: http://www.portsmouth.gov.uk/media/JHWellbeingStrategy201213and201314.pdf

[27] The PCC Carers Strategy can be found on the PCC Website at http://www.portsmouth.gov.uk/yourcouncil/17300.html

[28] The Portsmouth CCG Commissioning Plan/Operating Plan Final Draft March 2012 can be seen at: http://www.portsmouthccg.nhs.uk/Downloads/Portsmouth%20CCG/120412%20PCCGCommissioningPlan.pdf

10.3 **PCC's Social Care Development plans**

The Project Manager for Assistive Care hoped to develop a telecare and telehealth strategy for a shared vision for integrated services. Glenys Jones in Adult Social Care 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. This work 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

10.4 It was noted that there was a merging of health responsibilities for local authorities (with responsibility for public health budgets) and provision of safety was incorporated within this. The preventative agenda (such as the prevention of falls) would benefit both the NHS and the local authority in reducing social care admissions.

10.5 The draft business case for Telecare was continuing to be developed by PCC's Integrated Commissioning Unit and there would be further detailed discussions with internal departments, other partners and service providers under the direction of the Telecare Advisory Group. This draft business case will include information needed to support the development of a spend to save bid.

10.6 **Individual Budgets**

Angela Dryer, Assistant Head of Social Care (Assessment, Care Management & Social Work) explained the personalisation agenda. This is the aim of Adult Social Care (ASC) to give people choice and control over how the services they receive are delivered. These Adult Social Care (ASC) clients should now have an individual budget, and a support plan. The support plan will indicate what their needs are and how they will be assisted in meeting their needs. People still need to be eligible for ASC services following that assessment. This will include a financial assessment to determine whether or not any financial contribution is required for the individual.

10.7 The target was for those receiving ASC services to have their personal budget in place by March 2013. This target had been reduced to 70% and the achievement rates were 78% for older persons, and approximately 65% for those with physical disability, thereby giving an overall achievement rate of 70.4%. Final figures were still awaited regarding the take up for those with learning disabilities. There were also some self-funders for whom Adult Social Care agree to help identify the appropriate support. Direct payments is a form of individual budget. Whilst exact figures are not available this is a small percentage of the 400 ASC clients as most used these budgets for their personal care needs. Adult Social Care covers only 3% of the Portsmouth population but this is a vulnerable client group.

10.8 **Use of Technology in ASC**
This is wider than use of just the community alarm and was about making social workers, occupational therapists and all referrers aware of the availability of telecare services for when they carry out their assessments. It is estimated that between 50- 60% of ASC users have a community alarm (for which they need to have responders available). Individuals are charged for the service and income received goes back to Community Housing. As a rule ASC will not cover the weekly cost as it was expected that the individuals will use their attendance allowance/disability allowance, but in exceptional circumstances ASC have and would fund this as part of a package of care.

10.9 ASC does provide a night response service (available between 9.00 pm and 6.00 am) which responds to calls via the community alarm system. This service has led to savings to health partners in both admission avoidance and reduction in calls to the ambulance service. The night service is part of the reablement team so they are qualified responders who provide personal care on site and this has significantly reduced hospital admissions (which can cost £250 for transfer by ambulance plus hospital admittance cost).

10.10 As well as the community alarms there were other pieces of equipment that could be used in the assessment criteria such as bed exit monitors, gas protectors, flood alerts, door exit monitors which are currently provided free of charge to individuals who are ASC clients. Telecare provision is considered in all discharges from hospital and is prioritised in order not to delay the discharge. The hospital discharge panel forms completed by staff organising a package of care includes telecare as a consideration and ASC wish to make this system more robust to ensure staff do consider why telecare is not a suitable option and the wording would be changed on the form to encourage its use. All staff have received telecare awareness training and are aware of how to refer into the service.

10.11 The **Telecare Advisory Group** (TAG) chaired by a senior manager from ASC (Glenys Jones) is reviewing provision, what is needed and how telecare can be established as a real choice in the provision of care.

10.12 Following on from the Telecare stakeholder event in March 2013 a number of concerns had been raised (not specific to ASC) with the ensuing action plan to address these issues:

Issue	Action	When
Lack of awareness about telecare services and how this helps to meet the personalisation agenda	• Revisit available training and update in line with changes to telecare service • As part of planned support planning training for ASC staff include telecare as option within this.	end June 2013 May

Issue	Action	When
Concern that cost of telecare/health will have significant impact on budget	Work with ASC staff via training to ensure they 'think telecare' as a real option and utilise, not just console but other individual items.	Ongoing
Staff not fully aware of benefits to all client groups.	Cover within training.	May 2013
Panel forms only ask if telecare has been considered.	Review and update form to ask if telecare is not suitable and why not?	May 2013

10.13 The **business case** is being compiled with the fundamental aim of a future service to mainstream the use of Telecare and associated assistive technology in order to, where appropriate, provide more person-centred cost-effective care provision to vulnerable people who meet fair access to care criteria. The business case will be discussed at a TAG meeting on 8 April and the Adult Social Care management team in May 2013. There would then be further work with health colleagues and partner agencies to gain citywide ownership of Telecare.

10.14 **Revised Contracts**
The Project Manager for Assistive Technology informed the panel of her work with the CCG regarding the revision of their contracts such as with the community pharmacists.

10.15 **Costs and Savings**
The business case would look at the need to investigate the first six weeks of intervention where telecare solutions would help prevent people moving straight into care. A small outlay in telecare equipment costs etc. such as a gas detector (which could cost approximately £750 could be countered by the potential saving in the cost of an accident which was equivalent to eight weeks of domiciliary care for a person. Some providers (Aster Living) gave free trials of their equipment as they were confident that the reassurance given by the equipment would encourage people to continue with the contract. This extra value was hard to quantify but was similarly seen for carers where their anxiety is lessened where bed monitors are used for dementia patients so that they could be alerted where necessary rather than have to stay with the patient during the night.

10.16 **Responders**
The panel heard that ASC night service members of staff are trained in personal care and this too saved on ambulance call outs although it is hard to quantify. Where the responders are members of the public they were not trained but offering training could be considered through the Learning & Development Department. There was also the need to monitor the use of responders and their level of training to ensure safety and to avoid a more costly escalation.

10.17 Where there are repetitive call outs of a less urgent nature this is managed on an individual basis to determine if changes are required to care packages etc. in order to lessen call outs etc. ASC has returned to a system of named social workers or occupational therapists which was helpful in this communication so that there is a regular point of contact with clients.

10.18 **Budgets**
The panel noted that Adult Social Care fund the provision of the night responder service but Community Housing were charging residents for the service and the income generated went back in to the Community Housing budget. The savings generated by ASC were also benefiting the local health economy. It needs to be demonstrated to the CCG that provision of a robust telecare service including a 24/7 responder service could generate savings being made through the preventative steps - there could be savings of approximately £2.5k for hospital admissions per patient. Therefore the business case would include the cost benefit analysis. The monitoring tools needed to be in place to ensure there was a robust performance model to prove savings being made by keeping people safe in their own homes to reduce unscheduled admissions to hospital and the gain in health regarding long term prognosis.

10.19 The panel also noted that there could be potential savings to the ambulance service (as well as to the health budgets) for which they were not directly contributing. It is important to have the evidence to show the impact made by the technology such as the fall monitors and look at statistics of fire deaths in Portsmouth that could be prevented by the smoke and gas detection units. Collaborative work, such as joint marketing strategies, would mean a move away from separate 'silos' of funding.

10.20 **Reaching wider client groups**
The Project Manager for Assistive Technology reported that ASC is also working to encourage a development of the market of the "worried well" to signpost people who were not yet ASC clients to encourage primary prevention and thereby delay them coming into the system.

11. OBJECTIVE 6 - To consider the approach of other local authorities to see if the council could adopt measures which work elsewhere or learn lessons from their experience

11.1 **Partnership Working**
In consideration of partnership working and in gathering evidence on the other objectives of this review the panel heard of the experiences and research from other local authorities. The panel heard 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.

11.2 **Southampton City Council**
A joint event is being discussed with Southampton CC regarding the learning disability service exploring technology and also looking at the inclusion of children. There would also be a secondary mental health event regarding the use of mobile technology. Southampton unitary authority is using the equipment provider Tynetec for a package for eight individual units for patients with dementia.

11.3 **Tunstall's Partnership work with Councils**
Tunstall are major providers of Telehealthcare equipment to local authorities nationally and Darren O'Higgins outlined Tunstall Healthcare Group's work with other councils. They are a large group established for over 50 years who are

specialists in the provision of support equipment on a global scale although they were based in the UK. They specialise in solutions to aid people in their independent living (and supplier for 75% of telecare users in the UK). They were a founder member of Continua[29] and a partner in the 3 Million Lives government initiative (see para 8.1.1).

Examples are given below of Tunstall working in partnership with other councils:

11.4 **Hillingdon unitary authority** - a new model care initiative had been launched in 2011 which took an innovative approach to be offered free for the over 85s and for six weeks as part of their reablement package and was predominantly used by those in their own homes. In the marketing of this they wished to get round the unfamiliar label of "telecare" and therefore had promoted it as a "home safety package" which came with a pendant, smoke detector and bogus caller button and other sensors dependent upon need.

At Hillingdon 1212 new installations had taken place in a year, 565 of which had been self-referrals. There had been a corresponding reduction in residential placements from 8.08 to 3.57 per week, and a 10% reduction in home care hours purchased.

In parallel a telecare service delivery plan had been developed incorporating a business plan, leadership plan, staff engagement plan and local service provision plan. The two supporting elements were the involvement of partners in the voluntary sector and the development regarding self-funding where there was ability to pay.

11.5 **Blackburn with Darwen Council** - elements of both systems of telecare and telehealth could be installed in people's homes through joint infrastructure with the aim of reducing residential care and increasing the number of users (from 60 to 1800). The initiative to encourage this had been a "hearts and minds" approach to ensure that all referrers understand the process. This had been successful in attracting 1000 users in 18 months and the residential care admissions had been reduced by 18%. They had worked with the PCT on telehealth with the council funding the telecare equipment, the NHS funding the telehealth equipment and they had jointly funded the service provision. Blackburn had some telehealth non-clinical monitoring and there was a process to get information obtained referred to the clinicians.

11.6 **Birmingham Council** has entered into a £14m contract with Tunstall and uses the LifeCare model which allows a variety of contract combinations between private and local authority providers. A single lead supplier is contracted to manage the whole service. Uptake was dependent on the frontline social workers OTs and reablement staff being kept abreast of developments via training especially where staff change. In Birmingham there were telecare assessors that go to visit and can install equipment there and then.

[29] The Continua Health Alliance is comprised of technology, medical device and health care industry leaders in the field of personal telehealth.

11.7 **Nottinghamshire County Council** had used the same model but a different approach by selecting a combination of private and local authority provision. Monitoring was won by a district provider monitoring centre. Equipment supply and installation was undertaken by Tunstall.

11.8 **Essex County Council** has implemented a change in approach so that telecare packages should be considered at the start of assessments with an opt-out approach and relatives are very much part of this process. This emphasis here is on prevention.

11.9 Examples of combined Telecare and CCTV services can be seen at **Bristol City Council** which had doubled its income to £1.2m from combining services there. **Milton Keynes Council** has combined their Telecare and Telehealth services, and had found that this had made responses faster and more appropriate. They had also predicted savings of up to £340k per annum in preventing GPs attending and so there would be additional benefits for GPs requiring less travel.

11.10 **Surrey County Council's** Telecare service for patients on discharge from hospital was free for six weeks but it was found here that a lot of residents did not wish to continue with the service after the free period.

11.11 **West Sussex County Council**
Officers from the Integrated Commissioning unit visited West Sussex in May 2013 to look at their model of Telecare. A detailed outline of the offer to people across West Sussex was obtained, both those eligible for care package and for self-funders. It was noted that Telecare is provided free of charge (to the service user) for 13 weeks and after this period 70% have gone on to pay for Telecare privately.

11.12 **Growing Evidence Base**
Katie Cheeseman, PCC's Project Manager for Assistive Technology referred to studies from elsewhere:

(i) **Aberdeenshire** Council Telecare Project Final Evaluation Report (2008)[30] 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 = £329,050

(ii) **North Yorkshire** Council has invested resources in putting telecare into older people's homes.[31] A financial analysis of people using telecare showed:

[30] The Aberdeenshire CC final evaluation report can be accessed at http://www.aberdeenshire.gov.uk/about/departments/AberdeenshireTelecareProjectEvaluationReport.pdf

[31] The North Yorkshire report can be accessed at http://www.northyorks.gov.uk/CHttpHandler.ashx?id=3453&p=0

- 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 (the remaining 5% fall into multiple categories).

(iii) Research undertaken by **FACE**[32] 'Investing to Save: Assessing the Cost-effectiveness of Telecare' which found 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**[33] 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** [34]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:

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[32] FACE (Functional Analysis of Care Environments) - FACE Recording & Measurement Systems Ltd report can be accessed at http://www.face.eu.com/general-announcements/face-report-highlights-how-widespread-targeted-deployment-of-telecare-could-save-councils-up-to-7-8m/

[33]The NHS North Yorkshire & York findings can be found here: http://www.yorksandhumber.nhs.uk/document.php?o=7523

[34] The Kent evaluation report "Promoting and Sustaining Independence in a Community Setting" can be found at: https://shareweb.kent.gov.uk/Documents/adult-Social-Services/professionals-and-projects/WSD/Telehealth%20Full%20Report%20FINAL_Layout%201.pdf

- if used in a targeted way it was more cost effective than traditional methods of service delivery
- It 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.

11.13 **Benefits**

These studies show "improving outcomes" which include:

- 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.

12. **EIA** - a preliminary Equalities Impact Assessment (EIA) has been carried out; if the recommendations are supported by Cabinet further EIAs may be appropriate.

13. **Legal Comments**

There are no specific legal comments relevant to this report save that should matters progress then any implementation of the recommendations should be conducted in a way to ensure that regard is paid to the relevant elements of the Equality Act 2010. In addition if it is proposed that there are co-working arrangement with other Authorities or organisations/undertakings then it would be appropriate to involve Legal Services with regard to detailed comments with respect to risk, contractual obligation and employment aspects related to policy delivery.

14. **Finance Comments**

14.1 This report raises a number of proposals that aim to maintain and improve telecare/teleheath services to Portsmouth Residents at a reduced cost, and this is welcomed in the current challenging financial climate.

14.2 It is important to ensure that Financial Services staff are involved at an early stage in the production of any proposed spend to save bid. This will ensure that accurate Financial Appraisals for each of the schemes/options can be produced, in order to identify the option that delivers best value for money to the Council and quality of service for the residents.

14.3 It is important that the Business Case should not include any bias relating to the sources of funding of each option, and any S.151 Officer financial recommendations will reflect only statutory funding issues such as the ring fencing of the Housing Revenue Account. If required, the Financial Appraisal(s) will also identify any necessary adjustments to Cash Limits that might be required between services for each option being considered.

APPENDIX 1

Meetings held by the Panel

DATE	WITNESSES	DOCUMENTS RECEIVED
18 September 2012		Agreed Scoping Document
18 October 2012	i) Nigel Baldwin, PCC Telecare Manager ii) Flor Deasy, PCC Telecare Technician iii) Katie Cheeseman, PCC Project Manager for Assistive Technology	
22 November 2012	i) Lesley Hammer, Service Manager, Leonard Cheshire Disability ii) Alison Croucher, PCC Sheltered Housing Manager	The Automated Pill Dispenser Project - West Midlands Improvement & Efficiency & Midland and East NHS joint project
13 December 2012	i) Dr Julian Neal, GP from the Portsdown Practice ii) Sarah Billington of the Hants & Isle of Wight Pharmaceutical Committee iii) Councillor Steve Wylie, PCC Cabinet Member for Housing	
17 January 2013	i) Katherine Barbour of the Wessex Health Innovation and Education Cluster ii) Graham Pink from Housing 21	3 Million Lives - press release of 19 January 2012

DATE	WITNESSES	DOCUMENTS RECEIVED
14 February 2013	i) Darren O'Higgins, Tunstall ii) Debbie Clarke, Associate Director Solent NHS Trust iii) Caroline Elder, PCC Community Housing	Solent NHS Trust staff training DVD viewed Viewed early version of PCC's publicity DVD on telecare services
7 March 2013	i) Gail Glew, Telehealth Implementation Co-ordinator, Southern NHS Trust ii) Dianne Sherlock, Chief Executive Officer Age UK Portsmouth iii) Melissa Daniells occupational therapist/telecare service PCC	
4 April 2013	i) Angela Dryer Assistant Head of Adult Social Care - on personalisation budgets ii) Katie Cheeseman PCC Project Manager - telecare stakeholders event feedback	Articles circulated: The Commonwealth Fund (USA) - case studies in telehealth adoption January 20123 - scaling telehealth programs: lessons from early adopters Housing Learning and Improvement Network - A look at health and wellbeing boards through the lens of telehealth and telecare - September 2012 BBC Online - Health page 4 April 2013 'NHS remote monitoring "costs more" '
12 June 2013	Jo Gooch & Dr Kevin Vernon, Portsmouth Clinical Commissioning Group - the CCG's perspective of Telehealth	

DATE	WITNESSES	DOCUMENTS RECEIVED
24 June 2013	Jason Hope & Dominic Dew, PCC, Integrated Commissioning Unit	Update paper on Telecare & Telehealth

APPENDIX 2

Budget and Policy Implications of the Recommendations

12.	RECOMMENDATIONS	Action By	Deadline	Resource Implications
1	The Head of Adult Social Care and the Head of Community Housing should ensure that Telecare and Telehealth can become part of mainstream delivery and reach a wider client group and not just be seen as tools for older persons, but for use for younger patients (such as mental health and epilepsy) and in cases of domestic violence.	Rob Watt, Susannah Rosenberg & Alan Cufley	November 2013 - for the business case which is being developed. A telehealthcare strategy will follow which will address expansion and utilisation of the private market.	Future implications are unknown at present but work being undertaken by existing staff.
2	A Spend to Save bid should be made, backed by the business case on Telecare, for the expansion of services to the most vulnerable clients who would benefit from this service but who may not be taking it up on cost grounds, and that assessment of care packages include Telecare at the start of the process.	Rob Watt/ Susannah Rosenberg	As per recommendation 1 above.	Future implications are unknown at present but work is being undertaken by existing staff. A financial assessment will be part of the business case.

12.	RECOMMENDATIONS	Action By	Deadline	Resource Implications
3	That PCC work closely with Dr Neal in the promotion of the expansion of Telehealth based on the positive results from the Portsdown Practice and that encouragement be given to the inclusion of Telehealth at PCC's Somerstown Hub health centre.	Susannah Rosenberg	Ongoing - PCC's role in Telehealth is limited to influencing only via the Integrated Commissioning Unit. It is too late to hardwire the Somerstown Hub but stand-alone equipment can be considered.	On-going work by current staff; future implications unknown.
4	PCC to ensure that the relevant staff (in Adult Social Care in particular) are kept aware of Telecare availability and the expansion of Telehealth through training.	Rob Watt Alan Cufley And the Telecare Advisory Group (TAG)	Ongoing	Within current resources; key staff (project manager and a secondment post) are working on this with the TAG.
5	The Head of Adult Social Care and the Head of Corporate Assets, Business & Standards develop a plan to encourage suitable informal Telecare responders and monitor the use of responders and their level of training (and consider training of members of the public) to ensure safety, give confidence and to avoid more costly escalations.	Rob Watt & Alan Cufley	April 2014	Dependent upon the outcome of the Responder Review due to start in late 2013. The TAG is considering linking with the Voluntary & Community Sector (VCS) to support this and will include in the Telecare Strategy.

12.	RECOMMENDATIONS	Action By	Deadline	Resource Implications
6	At Milton Village sheltered housing development the pull cord response times need to be improved (in line with Brunel Court) to give a more uniform service.	Justin Wallace-Cook	October 2013 - the new provider Servacare is reviewing and deploying staff differently.	Within existing resources.
7	Officers investigate how different systems for Telecare and Telehealth work and consider compatibility of equipment from different providers.	Susannah Rosenberg & Alan Cufley	In progress	Future implications are unknown at present but work is being undertaken by existing staff; this will be considered within the business case.
8	Portsmouth CC to look at pursuing further partnership work with Southampton CC, other local authorities and other providers. A joint marketing approach should include good news stories on positive outcomes in the local outlets such as The News and on websites and the local PCC publication Flagship.	Rob Watt Susannah Rosenberg & Alan Cufley	In progress - periodically as appropriate	Within existing resources - the TAG is investigating a joint approach with the Southampton CC equivalent TAG.
9	In further exploring combined work between Portsmouth and Southampton on Telecare, processes should be in place for the monitoring of take-up.	Rob Watt Susannah Rosenberg & Alan Cufley	In progress; the take up in the LA and NHS is known but it is unknown for the private market. This work will be part of the strategy development.	Will be accommodated within new monitoring contract and strategy development. The TAG will liaise with Southampton CC as above.

12.	RECOMMENDATIONS	Action By	Deadline	Resource Implications
10	Marketing should include an up to date leaflet and website information available regarding all options not just PCC's Telecare. The PCC website could have links to other useful sites and ask others (such as Portsmouth Pensioners' Association) to include information on their own website regarding the availability of different systems. PCC's website should include a virtual tour to show a 'smarthome' indicating how monitors and sensors could be positioned in each room.	Alan Cufley	December 2013	Website being reviewed as part of PCC's overall project. Marketing material is under review within existing resources.
11	Venues for promotional events should be expanded to go out into the community, such as attendance at PCC festivals and at local churches, lunch clubs and the Frank Sorrell Centre.	Alan Cufley	Ongoing	Within existing resources. The TAG is also sourcing data to inform promotion from the Joint Strategic Needs Assessment and gathering feedback from professionals
12	PCC to keep informed of the findings of Solent NHS Trust's evaluation of data security in Telehealth and the level of success experienced by local GPs involved in the 'Florence' project via the CCG.	Susannah Rosenberg	Report back in 1 year	Within existing resources
13	HOSP and the Health & WellBeing Board be requested to ask that there be inclusion of questions raised with the CQC on Telecare and Telehealth provision in Portsmouth.	HOSP & Health & WellBeing members		None

12.	RECOMMENDATIONS	Action By	Deadline	Resource Implications
14	PCC to continue to liaise closely with the community pharmacists regarding their key role in the provision of the automatic pill dispenser service	Susannah Rosenberg & Integrated Commissioning Unit	Ongoing work with pharmacies	Currently £1800 per person per year but there are cheaper, locally developed options emerging. Costs fall to the NHS.
15	The PCC's business case to be followed up by the Telecare Advisory Group (TAG) with further work with health colleagues and partner agencies to gain citywide ownership of Telecare and the expansion of Telehealth.	Susannah Rosenberg & TAG	Ongoing	Future implications are unknown at present but work is being undertaken by existing staff and this forms part of the TAG's remit.
16	That the savings be quantified and promoted which are being made by the provision of Telecare (being subsidised by Adult Social Care for the night time service and being provided by Community Housing) not only to other departments at PCC but to the wider health and emergency services, and efforts be made to recover savings.	TAG	This forms part of the Business case - November 2013	A financial appraisal will be shared with interested departments.
17	Due to the existing silos of funding by different departments for Telecare, SDB look at ways that this can be addressed within the organization.	SDB - (via Angela Dryer and Alan Cufley)	As above.	The financial appraisal will include the required information for Head of Service to work collaboratively.

APPENDIX 3

Glossary

A&E	Accident & Emergency hospital department
Age UKP	Age UK Portsmouth
ASC	Adult Social Care
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
COPD	Chronic Obstructive Pulmonary Disease
GP	General Practitioner/Doctor
HIEC	Health Innovation & Education Cluster
HOSP	Health Overview & Scrutiny Panel - at Portsmouth City Council
LCD	Leonard Cheshire Disability
NHS	National Health Service
OT	Occupational Therapist
PCC	Portsmouth City Council
RSL	Registered Social Landlord (housing association)
SDB	Strategic Directors Board - at Portsmouth City Council
TAG	Telecare Advisory Group - at Portsmouth City Council

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Housing & Social Care Scrutiny Panel

DRAFT - Scoping Document

Review Title: Hospital Discharge Arrangements in Portsmouth

Background

This topic was agreed by the Scrutiny Management Panel on 5 July 2013 and forms part of the Housing & Scrutiny Panel Scrutiny Panel's 2013/14 work programme.

Objectives of the Inquiry

- To gather evidence on the current processes for discharge care arrangements for **adults** leaving hospital
- To consider what leads to delays in transfers of care and the implications of this
- To investigate what arrangements are put in place for patients' return to home or suitable accommodation to ensure continuation of appropriate care
- To identify ways of developing improved, well co-ordinated and timely discharge arrangements between agencies.

Possible Witnesses

Representatives from:

Portsmouth City Council (PCC) departments - Housing Management (including Sheltered Housing staff) and Housing Options (Elaine Bastable), Community Housing (Bruce Lomax re adaptations to properties in the private sector), Adult Social Care (social work assessments), OTs and Public Health and PCC's Chair of HOSP.

Health Professionals in the Health Service - Portsmouth Hospitals Trust (PHT) and the Clinical Commissioning Group (CCG)/GPs

Patients - through bodies such as Healthwatch, PCC's Residents Consortium Link Group, Age UK Portsmouth

Personal care provider agencies.

Work Plan and proposed dates of future meetings

Monthly meetings to be arranged.

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