

TELECARE DEVELOPMENT PROGRAMME

Review of Telehealthcare Learning Forums August 2009 – March 2010

From August 2009 to March 2010, three Learning Forums were held in Rothesay, East Kilbride, and Livingston. These workshops were convened so that participants could share experiences, enable greater peer support, and facilitate effective implementation of technologically-supported home health monitoring projects. All three NHS boards represented at the forums exhibited steady progress in the implementation of their telehealthcare schemes.

Progress on NHS Argyll & Bute Telehomemonitoring Project

The aims of the project are as follows:

- Engage patients and their carers in the monitoring of their condition
- Raise awareness of symptoms and possible deterioration before it reaches a critical point
- Monitor a patient to see trends in their condition and offer appropriate care at the right time
- Results viewed remotely so consultants can track the progress of a patient's condition
- Prevent crisis admission to hospital and possible onward moves to out-of-area sites
- Empower patients to be part of disease management and become 'experts' in their own condition
- Increase local nurse knowledge of long term conditions with remote support provided by specialist nurses
- Become part of the anticipatory care plans for patients with long term conditions

There are currently four telehealth pilot areas in Argyll and Bute which have been funded as part of the national Telecare Development Programme. These four areas are:

1. Bute

Fifteen patients with Chronic Obstructive Pulmonary Disease (COPD) have received remote monitors and support to monitor their conditions. Support comes from the local district nurses who monitor the results daily and respond appropriately (phone, visit, retake). They are supported by specialist nurses across the CHP. The aim is to increase local nurse knowledge of long term conditions. There is also a surgery POD based in the health centre. This will capture a range of readings from patients who use the health centre ie- blood pressure,

new patient checks and weight. These readings can lead to QOF points collection and health education programmes. Currently the patient receives a paper slip of their readings and hands it in to reception where the data is inserted manually into GPAS.

2. Oban

A POD has been installed within this sheltered housing complex, and 30 individual swipe cards have been supplied to help support residents with long term conditions. Local district nurses will check these readings daily, with suitable residents chosen by the GP and local nurses. There will also be a POD in Lorn Medical Centre in Oban. This will capture a wider range of readings than Bute, due to the nature of the practice activity - they also do medicals for off-shore oil workers. The view is that the system can monitor anything they have developed medical protocols for. Argyll & Bute also aim to target flu clinics to raise awareness of the POD amongst patients and staff and encourage greater usage.

3. Isle of Luing

This approach involves the community and first responders who are located on the island. Luing has a population of around 200 people, and, although not hugely distant from Oban, they are considered remote. The ferries stop at 10pm and there is no medical staff on the island and no helipad. There is one shop and two village halls. A POD is being installed in one of the village halls, with individual swipe cards allocated to people with a range of long-term conditions. Patients will be selected in conjunction with the surgery on the mainland. The service will link to first responders who are located on the island, and also aim to link to the Out of Hours Hub which is currently being further developed by NHS Highland. In addition an individual home POD has been installed in the home of one man with wireless broadband. Payment for broadband is recognised as an issue which will require to be resolved. Currently there are different payment mechanisms in place to get the projects up and running.

4. Greater Glasgow and Clyde collaboration

20 POD units have been purchased to assist in the support to heart failure patients. Ten units are being employed in GG&C area, five units in Helensburgh, remaining five for the rest of A&B. Another learning point noted was that the units all had to be individually PAT tested. Links have been made with the specialist heart failure nurse, district nurses and cardiac specialist nurse. There has also been an extension of part-time heart failure nurse service (using several of the heart failure nurses to review the information).

A study conducted by the UHI Millennium Institute and the University of Aberdeen has shown that initial early indications of the programme are positive, with high levels of satisfaction recorded among patients and carers. The project also was the winner of a 2009 Scottish Health Award: Improvement and Innovation category.

For the future, Argyll and Bute is looking to accomplish the following objectives:

- Mainstreaming the use of telehealth.
- Considering technological supports within discharge planning.
- Undertaking further evaluation and extension of the use of surgery pods.
- Planning a roll-out of COPD home pods.
- Working towards agreement with the project manager to extend project time in order to better embed telehealth within community teams.

Progress on NHS Lanarkshire Telehealthcare Project

The aim of Lanarkshire's telehealth project is to treat individuals with long-term conditions more proactively, nearer to their home, and earlier in the course of their disease. They have developed four objectives to achieve this end:

1. Develop an electronic COPD patient record to track and record information across an integrated pathway
2. Use an Interactive Voice Response (IVR) system to provide an early indication of health changes
3. Develop the role of care managers to provide early intervention
4. Empower patients to manage their own condition

Lanarkshire has deliberately taken a minimalist technology approach by opting to employ a simple push-button telephone for use by patients with COPD to transfer readings once a week to the health service. Patients call a freephone number which accesses the IVR system. The four GP practices that are involved in the project can then access the results.

The project is progressing well against its objectives. Though the patient database suffers from time-consuming double-entry of data due to a lack of IT integration, the IVR system has generally worked well; care managers have found that they are developing increased confidence, knowledge, and better local disease management skills through training; and initiatives supporting self-care have led to reductions in hospital admissions.

One clear challenge has been in finding patients for inclusion in the project. There are currently only 38 patients across the four participating GP practices, and the project manager and GPs are attempting various methods to increase participation. These include having local practice managers mail an initial letter to prospective patients and then chasing-up those patients who fail to respond; reviewing SPARRA data to identify patients; and identifying suitable referrals from the Respiratory Home Support Service.

All told, however, Lanarkshire is steadily achieving its project objectives.

Progress in NHS Lothian

This is a series of projects which seeks to explore the role of telemetry in the management of long-term conditions. Through the development of a suite of reporting mechanisms and the active recruitment of patients in the areas of COPD, heart failure, childhood obesity, hypertension and diabetes, the programme has collected a large amount of qualitative and quantitative data which has provided new insights into the interaction between patients and carers.

Initially, there was a feeling on the part of patients that the technology was too impersonal, they weren't familiar with the metric measurements that were required by the technology at that time, that they didn't entirely understand what their respective scores meant, and some confusion over the wording of the automated e-mails. For carers, the impersonal nature of the equipment was another chief concern, as was delineating roles between patient and carer, and issues surrounding the transmission of information. COPD patient recruitment has also proved problematic and incentives are now used to boost numbers along with staffing, standardising protocols, monitoring, and costs.

However these concerns have in the main been addressed and the project has shown to improve patient well-being and has made nursing better targeted and more efficient. The system is working to reassure patients and carers, reduce anxiety, ensure faster access to a GP, and has prompting patients to take a more proactive role in maintaining their health. While logistical issues continue in the development phase, positive perceptions on the part of patient and carer have been consistently evident throughout the life of the project.

Overall, the general impression of the pilot project has been positive, and the team is making good progress in achieving its objectives.

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