Telemedicine for care homes: a strategic implementation guide

August 2020 Version 1
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Introduction to the care home telemedicine project

In April 2020, a new telemedicine service which provides instant advice for care home residents (with and without nursing care) was launched by Hampshire Hospitals NHS Foundation Trust (HHFT), North and West Hampshire CCGs and other local organisations, including Wessex Academic Health Science Network (AHSN).

Initially accessible between 8am and 8pm every day, the service provides faster access to care and advice in care homes, to avoid unnecessary ambulance call outs, attendance to the Emergency Department (ED) and admissions. It is important to note, the telemedicine service provides urgent advice for care homes and does not replace routine GP face-to-face or virtual consultations or emergency care.

In the UK, 405,000 older people (aged 65+) currently live in care homes. This represents 16% of older people over the age of 85 (British Geriatrics Society 2020). Within Wessex, there are around 23,500 care home beds. Within Hampshire there are approximately 13,900 beds across 354 care homes (Care Quality Commission 2020 and health data library) ➤https://bit.ly/3fy32Gx.

The telemedicine project, due to launch later in 2020, was accelerated to help provide care for some of the most vulnerable people in the community during the Covid-19 pandemic. A phased, but rapidly increasing approach, has seen the service initially launch in 104 care homes in Hampshire. As the service grows, it will be accessible to care homes all day, every day, across all of Hampshire and the Isle of Wight (HIOW) - approximately 650 care homes.

The service means care homes can virtually talk to a specialist clinical team, in the event of sudden and unexpected deterioration or health event. This includes falls, trauma, new confusion, pain management, breathlessness and suspected infections (not exhaustive).

Clinicians working on the telemedicine service can also prescribe medication and send prescriptions electronically to a chosen pharmacy, meaning there is no need to visit a hospital or wait for an out-of-hours GP to visit. This makes treatment or symptom control much faster. Mutually-agreed care plans are also securely emailed to the care home at the end of the call, and automatically uploaded to the Care and Information Exchange (CHIE), meaning GPs and community teams will be able to view what the outcome of the consultation was online.

The North and Mid Integrated Care Partnership (N&M ICP) agreed seven key change programmes for joint delivery across the system to attain financial and operational sustainability. The funding for this business case has been awarded by the HIOW Sustainability and Transformation Partnership (STP) - Health System Led Investment Fund. HHFT will allocate this resource over a three-year period. Robust data analysis and evaluation methodology has been set-up to inform the long-term funding required for the service.

To date (July 2020), the service has:

- Avoided ambulance conveyances per week: 8
- Preventions of admissions to ED per week: 6
- Preventions of admissions to hospital per week: 4
- Calls into the service per week: 15

wessexahsn.org.uk
Once scoping is completed, the model agreed and detailed, the implementation phase will start.

This guide will take you through the implementation process of launching a care home telemedicine service. The guide has been designed as a system-wide strategic resource for Sustainability Transformation Partnerships (STP), Integrated Care Systems (ICS), Clinical Commissioning Group (CCG) and acute NHS trusts to use when planning and implementing telemedicine services for care homes (with or without nursing). If you like, a blueprint for service launch, to show how this works in practice.

It contains:

- Guidance for implementation
- Links to a range of resources to support and inform thinking
- Case studies from Hampshire Hospitals NHS Foundation Trust (HHFT) and West Hampshire CCG to provide real world validation

A health warning

Thinking needs to be system wide within an STP/ICS footprint, including local authorities, and multiple health organisations in order to ensure intra-operability and maximise benefit, sustainability and affordability. Setting-up localised services to care homes on an ICP (Integrated Care Partnership) or Primary Care Network (PCN) footprint runs the risk of the homes being overwhelmed by different operating systems, stakeholders and worsening communication. It will also be more costly overall and harder to sustain.

This guide is aimed at a strategic level, to help develop and implement telemedicine services by collating in one place all the resources and lessons learned from service development in the Hampshire and the Isle of Wight STP.

This is a working document, developed in collaboration with HHFT and West Hampshire CCG.

This guide has been developed alongside a staged implementation of a Telemedicine Service Hub in the Hampshire and Isle of Wight STP footprint, which was fast tracked as a result of Covid-19.

This guide should be read in conjunction with the telemedicine for care homes: a strategic scoping guide ▶️ https://bit.ly/31qJyQJ.

“I am really proud of how our system spanning health and social care has come together to support the most vulnerable people in our society and those that care for them.”

Dr Lara Alloway
Chief Medical Officer, Hampshire Hospitals Foundation Trust
Please note, this is an operational guide and can be used in tandem with the Evaluating Nonadoption, Abandonment, and Challenges to the Scale-Up, Spread, and Sustainability (NASSS) framework ( ►https://bit.ly/2BnwW2e). The framework will illuminate general areas of focus within the NASSS domains.

During the scoping stage you will have set-up sub groups for each section of your project with a lead who will report to the overarching steering group.

During the implementation phase leadership will be key to success.

‘Extreme Teaming’ is one such approach and advocates multiple leaders from different system partners at all levels who will engage, commit and flex across the system sharing and pooling experience, knowledge and skills as required to deliver an innovative end product. Learn to love ‘extreme teaming’ as you implement the service.

Development of an implementation tree will enable you to depict the hierarchy of tasks and subtasks that need to be completed ►https://bit.ly/32ZeEzK.


We hope you find the guide useful. If you have any feedback or suggestions for future updates, please get in touch with us at healthyageing@wessexahsn.net.

“"It is an innovative approach, we are taking our clinicians and healthcare virtually into care homes and in doing so making our services more accessible, timely and patient friendly.”

Naomi Ratcliffe
Project Director, Hampshire Hospitals Foundation Trust
Having scoped finance and activity to determine the service model you want to implement, you now need to set some measures for monitoring progress against your aims and objectives.

• What financial metrics need to be monitored?
• Where can this information be obtained from?
• Are there organisational templates that can be used?
• How regularly will this information be updated and provided to the key stakeholders within the steering group?
• What does success look like financially and from an activity perspective?
• How will you manage the expectations of system partners? Financial realisation will take up to 24-months from full rollout of the service at the earliest, but are there other indications of success that can be used?
• Who within the project group has the appropriate skill set and experience to do this and help monitor these metrics?
• What are the quality benefits you want to measure alongside the financial aspects? A telemedicine service will offer significant quality benefits, including enabling people to die in their place of choice, reduce delirium, reduce falls and hospital acquired infections and improve care home confidence and resilience.
• It is important to capture resident and staff case studies to highlight qualitative benefits alongside the financial impact to demonstrate quality-led commissioning.

“As the service touches multiple parts of the health and social care sector, the financial impact will be felt across the whole system. We must therefore work together to understand the full implications.”

Finance Lead
Once scoping is complete, implementation in respect of workforce will focus on the practicalities of recruiting to the telemedicine service and training staff.

**Recruiting to the telemedicine service**

- What HR/recruitment support do you need? You may be recruiting to a whole new service and need job descriptions developed and banded.

- Where will the service be located? What other resources do the staff need to undertake the role required? Can staff work remotely, and if so, how? How will their security and safety needs be met? How will they be supported and supervised?

Consider how staff knowledge and experience can be maximised and spread throughout the telemedicine team.

**Training considerations for the telemedicine service:**

During the implementation stage, recruitment for the team can start in earnest when you have confirmed a go-live date. At this stage, it is important not to forget how you’ll provide training and ongoing refresher training within the following areas:

- Familiarisation with the new service and clinical pathways. Do they need frailty awareness training?

- Remote consultation and assessment skills.

- Enhanced communication skills. Do you need your staff to be able to hold difficult conversations with care home managers and residents?

If you are using any new systems do they know how to access and use them? What are the administrative processes for the service in regards to admissions, documentation and templates, etc?

Clinical pathways for the service, handover process (SBAR), RESTORE2™/NEWS2, community referrals, Anticipatory Care Plans, End of Life Care conversations (advanced communication), and an understanding of the service’s patient group.

Process in and out of hours. Remember telemedicine service staff may need support from a senior team (e.g. consultants, GPs).
Training considerations for GP practice/primary care

The approach is unlikely to require new staff. However, planning needs to be made in terms of who will take part in the telemedicine service, any additional training within the GP and primary care setting they will need, and how they will be supported and supervised.

“It has been important for our local workforce, coming together from different professional backgrounds and places of work to share their experience for the benefit of patient care and for their own learning. These clinicians are also reciprocally taking their experience of the telemedicine service and understanding of care homes back into their host organisation.”

Project Director
Digital

Digital requirements will have already been scoped, so the implementation phase will see the realisation of rolling out hardware, software and development of processes.

During the scoping stage, you should have completed a digital impact assessment and developed standard operating procedures for all parts of the service accessing systems.

At this stage, you should also consider access to shared records such as Summary Care Record [https://bit.ly/3jTUnll, https://bit.ly/3cV4W2w] to enable trusts, care homes and GPs to access their patients’ records.

Some digital components are recommended to be completed in all settings:

- Completion of Digital Impact Assessments, development of Standard Operating Procedures, training, communications following consultation; how will GP/Primary Care/care homes see the results of the consultations? How will these form part of the resident’s health and social care record?
- What guidance/training needs to be provided about secure transfer of identifiable information, and do staff understand the importance of using a generic NHS.net account to transfer information?
- Who is responsible for the download and installation of software, and troubleshooting IT problems?

What do care homes need?

Hardware:

- Consider the purchase of tablets/laptops to enable consultation wherever the resident is located in the home.
- Consider screen size if the device is being used directly with a resident.
- Check the home’s WiFi signal – boosters may be required.

Software:

- Who can facilitate setting-up a generic NHS.net email address? Further information can be found here [https://bit.ly/2AWXhna].
- Consider software and assessment equipment to be used when accessing the service, e.g. remote monitoring software.
- Consider who will install software and train on use of software.
- For video conferencing: what training is needed on the chosen system?
  - HHFT use Microsoft Teams as their video conferencing tool, but other video conferencing tools are available. Be aware that not everyone will have the same version of the chosen system. Further information on implementing, accessing and using Teams guidance can be found here: [https://bit.ly/2XSeJSV] and here [https://bit.ly/2AjJ4kq].
- If other systems are planned to be used, guidance on setting-up your video conferencing solution may be needed.
- For further resources on video conferencing in care homes please visit [https://bit.ly/2AjJ4kq].
What does the telemedicine service/GP practice need?

Hardware
- Once you have scoped and decided what’s needed, source and purchase the appropriate hardware. Consider ongoing maintenance and how you will troubleshoot any issues.

Software
- Select software, portal and develop training package to support. Consider use of programmes such as eConsult [https://bit.ly/30x36Cx] and Attend Anywhere [https://bit.ly/30uowAh]. Other platforms are available.
- Select software, portal and develop training package.
- Consider interoperability, Information Governance (ensuring transfer of information using NHS.net email account).
- Accessibility – What version of Windows does everyone have?
- HHFT use Microsoft Teams as their video conferencing tool, but other video conferencing tools are available. Be aware that not everyone will have the same version of the chosen system. Further information on implementing, accessing and using Teams guidance can be found here: [https://bit.ly/2XSeJSV] and here [https://bit.ly/2AjJ4kq].
- Guidance on setting-up and using video conferencing software, e.g. Microsoft Teams may be needed. Link to Teams training here [https://bit.ly/2Uzhh6l].

“While the role of champion is a key function, it is important that it becomes part of everyday business. It should not be seen as one person’s responsibility.”

Project Manager
Telemedicine champions

A key success measure, identified from sites who have implemented telemedicine, is that each care home and each GP practice should nominate a telemedicine champion(s).

This is a member of staff who can promote the use of telemedicine internally, aid liaison within their care home/practice/hub colleagues, and gather knowledge and skills to support colleagues and troubleshoot problems.

Suggested activities to be undertaken by the telemedicine champion are as follows:

Care home telemedicine champion
- Act as the care home point of contact for telemedicine roll out, training and day to day issues
- Support training of staff to effectively use telemedicine for the care of their residents
- Update colleagues on changes or additions to the telemedicine service
- Highlight areas where telemedicine could be better used
- Promote to primary care and social care staff as appropriate
- Monitor the use of telemedicine locally and keep a log of any issues
- Act as a point of contact for colleagues and patients who have queries about the system
- Promote telemedicine with residents and their family
- Liaise with GP practice and telemedicine service colleagues as required

General practice telemedicine champion
- Act as the care home point of contact for any issues with the telemedicine service
- Highlighting benefits of the service to promote use
- Highlight areas where telemedicine could be used more effectively
- Monitor the use of telemedicine locally and keep a log of any issues
- Act as a point of contact for colleagues and patients who have queries about telemedicine
- Provide training to other colleagues/care home staff as needed

Telemedicine service provider champion
- Act as the point of contact for operational queries from care homes
- Support the roll out and training of care home champions
To make full use of a telemedicine service it is important that care home staff are aware of their residents’ wishes and relevant legal documentation completed with the resident or their family.

Embedding best practice approaches as you implement the services is a key ingredient for success.

To use a telemedicine service to its full potential, some preparatory activities need to be undertaken at the care home. Ensuring that each resident’s care wishes are discussed (with the resident and their family) and recorded, will ensure that these wishes are taken into consideration in the decision marking process during the consultation. These discussions should involve a member of the care team and a clinician as well as the resident and their family, so does need careful planning. Covid-19 highlighted that these discussions and records are not always carried out, making the delivery of appropriate care more difficult.

We have developed a care home readiness checker that you can use with care homes to get you ready for implementation and can be found on page 15.

From a system-wide and strategic perspective you will have considered what care home training may be needed, particularly in areas such as having difficult conversations for all who may be involved.

This process will not be unusual for care home staff but it may not always be done.

Compliance with the Mental Capacity Act ▶️https://bit.ly/30ziA9d will underpin discussions. Assessment of Mental Capacity with reference to The Deprivation of Liberty Safeguards (DOLS) is also required as part of preparedness. It would also be helpful if there was system-wide agreement on a form of Advanced Care Plan and documentation such as ReSPECT ▶️https://bit.ly/2MRYLSk to aid consistency of approach and sharing of decisions and changes.

A comprehensive list of key documents and care home resources can be found on page 13 and at ▶️https://bit.ly/2NO8p8V
## Useful resource links

<table>
<thead>
<tr>
<th>Key component parts</th>
<th>Abbreviation</th>
<th>Links</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment Escalation Plans</td>
<td>TEP Tools</td>
<td><a href="http://torbayandsouthdevon.nhs.uk">torbayandsouthdevon.nhs.uk</a> <a href="http://northdevonhealth.nhs.uk">northdevonhealth.nhs.uk</a></td>
</tr>
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</table>

**Having difficult conversations**

<table>
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<tr>
<th>Links</th>
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</table>
Assessment of residents’ health status

In the implementation phase, care home staff may need to be upskilled in assessing their residents and being able to communicate their concerns to the call handler at the telemedicine service.

Accurate assessment of residents, including the ability to quantify when ‘they are just not right’ is key in getting the most from a telemedicine service and helps reduce care home staff anxiety.

The RESTORE2™ tool has been developed specifically for this purpose and has been recommended by the British Geriatric Society (2020) and is free to use.

You will need to consider:

• Who needs to be trained in assessment and communication?
• Who will undertake the training?
• What training should consist of? Is training on clinical equipment required?
• How will competency be assessed and who will undertake this? How will competency be maintained?
• How will the CCG and local authority support or lead this training?

RESTORE2™ resources can be found on page 24 and additional materials are available from:

• West Hampshire CCG – workbook, training pack, competency documents and online videos [https://bit.ly/2Aup3Yb].
• Health Education England – 14 short (2-3 mins each) videos, to help you improve the skills you need to use RESTORE2™ [https://bit.ly/3cUFURa].
Driver diagram: care home telemedicine readiness checklist

This care home telemedicine readiness checker aims to help you and care homes to achieve readiness for the implementation of a telemedicine service.

**Aim measure:**
Telemedicine service implemented and used effectively

**Primary driver – Outcome measure(s)**
Elements required to use Telemedicine service effectively are in place

**Secondary drivers – process measure(s)**
Training completed and assessed. Staff familiar with all components

**Primary drivers:**
Care home staff are trained in RESTORE™ and component parts:
- RESTORE2™ and RESTORE2™ mini, SBAR
- Documents are available to record NEWS and SBAR
- Hard copy RESTORE2™, NEWS, SBARD available
- Prompt sheets, SBAR, Flowcharts (telemedicine pathway)
- Telemedicine/ RESTORE2™ Champion in each home

**Secondary drivers:**
- Equipment is procured or available to enable vital signs monitoring. Thermometer, sphygmomanometer (blood pressure cuff machine measurement) pulse oximeter (oxygen % measurement).
- Training on equipment use and care (including infection control)
- Training on normal parameters for vital signs
- Training on RESTORE2™ and documentation

**Measures:**

**Aim measure:**
Telemedicine service implemented and used effectively

**Primary driver – Outcome measure(s)**
Elements required to use Telemedicine service effectively are in place

**Secondary drivers – process measure(s)**
Training completed and assessed. Staff familiar with all components

- Residents have Advanced Care Plans (ACP) in place detailing their wishes e.g. ReSPECT
- Review whether Treatment Escalation Plans (TEPs) are in place/required. Implement if required

- IT capability is in place: WiFi, tablets, portable phone (ability to call from resident’s location). Moveable station for GP rounds
- Connectivity: NHS.net email address, Microsoft Teams (or other video conferencing service)
- Information Governance (IG) has been considered and addressed: consent, access to case records, e.g. ACP, TEP, ReSPECT, PoA
- Service is defined and agreements in place

- Training on ACP: clinicians, home staff. Involve relatives as required/appropriate
- Process in each home for developing ACPs with residents and their relatives as appropriate
- Develop individual ACPs as appropriate

- Assess WiFi capability, and address if inadequate/absent
- Licences, generic NHS.net email – consider who has NHS email address – (all staff or shift leaders)
- Training in use of NHS.net email, video conferencing service (e.g. Microsoft Teams) with resources to support troubleshooting
- IG: Review consent and document access (ACP/TEP/ReSPECT/POA)
- Service parameters agreed – SOP, Social Contract

- Plan for evaluation of the service is in place. e.g. admission and conveyance avoidance, EOL in place of choice. GP consultations, care home staff satisfaction, resident satisfaction

- Evaluation parameters determined and data collection set-up.
Once your service model is agreed and you have scoped the components required to set-up the service, you will have a clearer picture of your service pathway, and what clinical and other service pathways will be required to make it work as intended.

As part of the scoping exercise, a lead clinician will have been identified to support the project.

At the implementation stage, the clinician will be needed to set-up clinical pathways to support staff managing calls.

- How will these pathways work across organisational boundaries?
- Consider how to escalate for specialist advice and support
- What onward referral pathways are needed, and who will engage with the key leads across the system?
- Develop a decision tree connecting the call co-ordinator to all options available for right care, right place, right clinical advisor or need for additional services.

What do I need to consider to support the implementation of the service and clinical pathways?

- As well as secure email to and from the care home using a generic NHS.net email account, recording the consultation on a shared care record is essential in ensuring seamless care for the resident and improved communication across the system. If this is not possible, you may need to consider interim solutions.

- In Hampshire, we use CHIE (Care and Health information Exchange), a secure system which shares health and social care information from GP surgeries, hospitals, community and mental health, social services and others. CHIE helps professionals across Hampshire and the Isle of Wight and surrounding areas to provide safer and faster treatment by:
  - Making sure the doctors, nurses and others involved in care are able to access a resident’s medical history.
  - Enabling the review of the medication residents are currently taking.
  - Viewing information about their allergies, test results and other important medical and care information.
When implementing the new service, ensure that all your clinical pathways are updated, co-produced where possible, and communicated with all relevant stakeholders.

Pathways to consider include:

- Acute medical team links
- Community referral – including GPs, community nurses and matrons
- Specialist nurses, mental health
- Community district nursing teams
- Rapid response teams to access support from Allied Health Professionals (e.g. physiotherapists, occupational therapists, dietitians), specialist wheelchair needs, social services support as needed.
- Palliative care team support

Other considerations:

- How will safeguarding concerns be raised, communicated and monitored?
- How will the quality of the service pathway be reviewed?
- Will there be Clinical Pharmacist support for prescribing, medicines optimisation advice, or specialist areas, e.g. palliative care, antibiotics, etc?
- Prescriptions: what are the practicalities of acute trust prescribing for community setting (which may be very complex)? How will controlled drugs be prescribed and dispensed? If there are no nurses in the care home, what is needed in terms of administration and record keeping? (e.g. Medical Administration Records in care homes chart and who will support or provide these?)
- Direct hospital admission: What parameters are there for this? Does this differ depending on which hospital the care home is aligned to? Have you engaged with your local ambulance service and will they be able to convey?
Quality improvement

Setting-up robust measures and regularly measuring progress against your success criteria is vital, not only in showing achievement, but also to identify any patterns developing that might need closer inspection as to what is happening.

“Be prepared to flex, adapt and improve on your approach. Use data to tell a story and embed quality improvement in your service development. Plan, do, study, act cycles and run charts are your friends!”

Project Director

To help identify whether the new telemedicine for care homes service is having the intended impact on your key metrics, we recommend using a Statistical Process Control (SPC) chart to present your data.

The example below is a SPC chart showing performance against a telemedicine target. In this chart, a dip in the percentage of residents remaining in their own homes after telemedicine input in August was inspected and identified to be due to operational issues. In October, the service model was refined leading to further improvement in performance.

Measuring and reviewing regularly (monthly, weekly or even daily depending on your project) rather than reflecting back after a longer defined period allows rapid action to be taken, looking at why there has been an adverse or positive change. It can also provide a corporate history of the changes you have made to the service and the impact they have had.

A selection of proven tools to support quality, improvement and redesign are available from NHS Improvement and Making Data Count ➤https://bit.ly/3dRWXDU
Evaluation

Ideally, the evaluation planning and process will have been designed during the scoping phase.

This means the main activities during the implementation phase is **data collection** and evaluating the **data collected**.

Setting-up new data collection processes can be difficult, especially if there is a manual element involved. It’s a good idea to review the data collected as early as possible to identify and address any issues. Data collection templates can be set-up in Microsoft Excel for manual data collection.

These templates can utilise the data validation functions to restrict and validate data entered, resulting in better quality data and making analysis easier. For example, drop down boxes can display a list of options rather than allowing free text.

An example template can be found at [https://bit.ly/3g5UwQ4](https://bit.ly/3g5UwQ4)

“A phased approach will enable scheduled interim analysis, thereby enabling opportunities to evaluate and adapt the programme of work against outcomes.”

**Project Director**
Communication and engagement

In the implementation phase, communication and engagement focus will change from engaging people to design and scope the service, to communicating what the service is and how it can be used.

- Engage with your organisational communications team at the earliest opportunity to provide support.
- The framework on page 23, suggests stakeholders and how you might communicate with them.
- Continue to review your communication approach and adapt as required. Some parts of the system may need more focused communications and some less.
- You will also need to consider the best approach to regularly update stakeholders on service progress and changes.
- Consider highlight reports to send to system forums; the report will proactively provide an update to help support the implementation and embedding of approach.
- Identify key system meetings where primary messages can be promoted.
- Be creative in your communication, providing case studies and opportunities for learning, where a resident’s journey has gone well, evidence best practice and provide opportunities for improvement.

Remember that you will have internal and external stakeholders. It is important to consider the content and the format of communication to ensure all stakeholders are communicated with simultaneously.

The following table provides a framework of communication approaches you can use with your stakeholders.
<table>
<thead>
<tr>
<th>Who</th>
<th>Suggested information and format</th>
<th>Aspects to consider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telemedicine Lead Organisation Internal staff</td>
<td>Webpages and staff intranet, launch event flyers, webinar, service leaflet, staff e-newsletters, social media, videos</td>
<td>Decide who needs what. Colleagues directly affected need more than others, e.g. ED needs more detailed explanation than maternity</td>
</tr>
<tr>
<td>Care homes: Management, Staff, Residents, Family</td>
<td>Flyers, leaflets, training, care home Q&amp;A sessions, Care Association groups, care home WhatsApp groups, webinars, shared recordings of online events/presentations, e-newsletters, videos</td>
<td>What information will be needed for care homes to understand what the service provides e.g. service pathway, hours of opening</td>
</tr>
<tr>
<td>Community Partners: Primary care, Allied Health Professionals, other roles, e.g. pharmacists, social prescribers</td>
<td>Flyers, posters, formal communications, TARGET events, organisational websites, social media, e-newsletters</td>
<td>How will the service impact on them? What do they need to know about the service in order to support it?</td>
</tr>
<tr>
<td>GPs Local Medical Committee</td>
<td>GP forums, TARGET events, online portals, CCG quality newsletters, e-newsletters, social media</td>
<td>Ensure communications are directed to the assigned GP for the care home. How will the service link in with local GP provision into care homes?</td>
</tr>
<tr>
<td>Local Pharmaceutical Committee (LPC)</td>
<td>LPC Committee, information on the LPC website and in newsletters</td>
<td>What will the impact of the service on Community pharmacies be, both in and out of hours? What do they need to know about the service in order to support it?</td>
</tr>
<tr>
<td>Ambulance Provider 111 Provider</td>
<td>Flyers, leaflets, updated pathway algorithm, website, videos</td>
<td>What guidance do local ambulance providers and 111 call handlers need to know?</td>
</tr>
<tr>
<td>Local Authority Safeguarding teams Care Agencies</td>
<td>Flyers, leaflets, updated pathway algorithm, website, social media</td>
<td>What do they need to know about the service in order to support it?</td>
</tr>
<tr>
<td>Other acute trusts and CCGs</td>
<td>Internal newsletter, addition to directory of service, e-newsletter, website</td>
<td>Is it clear which care homes are using the telemedicine service? How will it affect them?</td>
</tr>
<tr>
<td>Voluntary and Interest Groups e.g. Age UK local groups, Carers UK, Alzheimer’s Society</td>
<td>E-newsletter, information on host website</td>
<td>How does the service impact on them? What do they need to know to support/promote the service?</td>
</tr>
<tr>
<td>System Forums e.g. New Models Of Care</td>
<td>Formal publication, webinars, social media, discussion forums</td>
<td>What the service is and aims to achieve, launch dates, etc?</td>
</tr>
<tr>
<td>NHS England Regional Team</td>
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</tbody>
</table>

Examples of Hampshire Hospitals NHS Foundation Trust and West Hampshire CCG best practice approach in communicating a new service in system, posters, flyers are available at ➤ https://bit.ly/2XUBPs5

“We adopted an array of communication methodologies to involve service users in the design and implementation process. We achieved this through information gathering workshops, checkpoint meetings, action and progress groups and testing via concept scenarios.”

Senior Commissioning Manager
Resources section

There are a wide range of resources, implementation guidance and training packages already in existence to help the set-up and delivery of telemedicine services.

Here are a few useful websites:

### Telemedicine for care homes models
- **Airedale NHS FT**
- **Hampshire**
  - [https://bit.ly/2UEsFOh](https://bit.ly/2UEsFOh)

### Digital links
- **NHS Digital**

### Shared Care Records (CHIE)

### Assessment of residents health
- **Distribution of the National Early Warning Score (NEWS) in care home residents paper**
- **RESTORE2™**

### Anticipatory care planning
- **ReSPECT**
- **ACP for Residents with dementia**
- **Gold Standards framework**
- **A framework for planning difficult conversations**
- **Training staff in how to have difficult conversations**

### Mental Capacity Act
- [https://bit.ly/3cQF1sU](https://bit.ly/3cQF1sU)
Example of a stakeholder mapping process

The three Is
Identify who the key stakeholders are for your chosen population:
1. Who is influential?
2. Who will be impacted by the work?
3. Who is/will be involved in the work?

Stakeholder grid
Plot your stakeholders on a graph. This tool will help you identify the suitable approach.

Stakeholder involvement plan
The table below is an example of how you can log who your stakeholders are, their level of involvement and how you plan to communicate with them.

The tool will help you review your stakeholders and identify those who may not be involved but are highly influential.

Empathy map
Brainstorm the perspectives of your stakeholders and what could be affecting their thoughts. Map each stakeholder individually.


<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Type</th>
<th>Level of impact</th>
<th>Level of Influence</th>
<th>Current commitment</th>
<th>Engagement plan</th>
<th>Communication plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>Influenced</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>e.g. Invite to next project team meeting or invite to next project board</td>
<td>e.g. Include in group mailing list to ensure they are always informed</td>
</tr>
<tr>
<td></td>
<td>Impacted</td>
<td>Medium low</td>
<td>Medium low</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Involved</td>
<td>Low</td>
<td>Low</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Resident assessment using RESTORE2™ and RESTORE2™ mini

Health Education England and other NHS collaborators have developed 14 short (2 – 3 minutes each) videos, to support care staff to improve the skills needed to use RESTORE2™. These can be found here ➤ https://bit.ly/3e7UDcY the videos look like this:

**Health Education England videos:**
1. Introduction to sepsis and serious illness
2. Preventing the spread of infection
3. Soft signs of deterioration
4. NEWS What is it
5. Measuring the respiratory rate
6. Measuring oxygen saturation
7. Measuring blood pressure
8. Measuring the heart rate
9. Measuring the level of alertness
10. How to measure ear temperature (ear)
11. Calculating and recording a NEWS score
12. Structured communication and escalation
13. Treatment escalation and resuscitation
14. Recognising deterioration in people with learning disabilities

More information about RESTORE2™ can be found here ➤ https://bit.ly/2Y1jXLY on the West Hampshire CCG Website.

**What if my team is not trained to complete clinical observations?**

- You can use RESTORE2™ mini which uses Soft Signs and SBARD to help identify and communicate concerns about residents’ health and wellbeing
- It does not include NEWS2™ (which is the part involving clinical observations)
- RESTORE2™ mini can be found here ➤ https://bit.ly/3hmL6ke (scroll halfway down and select the RESTORE2™ mini tab).
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