Telemedicine for care homes webinar question and answer summary July 2020

In collaboration with the Health Innovation Network, the Wessex AHSN Healthy Ageing team co-hosted a National Healthy Ageing Network webinar showcasing best practice telemedicine approaches #telemed4CareHomes. The event took place on 16th July 2020 and was chaired by Dr Emily Gibbs, Southwark CCG. Below summarises questions and answers posed to the presenters on the day and provides an additional useful resource to review when developing a telemedicine for care homes service.

Financial

	Bradford (Airedale)	**Croydon**	**Hampshire Hospitals NHS Foundation Trust**
How much money have you saved/Return on investment (ROI)?	It is difficult to measure what money is saved if the whole system does not transform as you will not be able to identify the full effect, e.g. if the homes that frequently call 999, continue to do so etc there will be no financial change. Initial findings are demonstrating a £4 ROI for every £1 spent on the service.	As per Bradford model.	The service is in its infancy, so it is too early to know return on investment. This is being captured as part of the evaluation that the Wessex AHSN Insight Team is undertaking for us. Happy to share when available.
Cost per call to the Service? Average length of each call?	Calls are expected to be 30 minutes in length. The cost per call is not contracted as costings are contracted per home.	As per Bradford model.	Calls on average to date are 50 minutes in length.
What sort (numbers) of resource is required in the hub?	24/7 clinical team, including Information Technology/Information Governance support	As per Bradford model.	The HIOW model at full effect will be: • 1* band 7 (clinical service lead) • 10* band 6 • 2.5 * band 4 admin The team are trained to offer technical support to care homes, as such, this is not paid for in addition.

Information Technology

	Bradford	Croydon	Hampshire
Does SystmOne integrate with all GP systems?	We are working on integration (as are the national digital teams)	We are working with the provider to allow shared views of SystmOne and Emis.	We are working on acquiring EMIS Web and GP Connect which will give us a view into patient records on SystmOne.
What is the existing hardware and software being used?	Provided for by our technology provider.	Provided for by our technology provider.	Microsoft Teams is used for video consultation, as such no cost to the acute or the care home. EMIS Web is used for prescribing, this is at an additional cost.
Who provided the hardware and software - funding?	The technical company we are working with which was funded by whoever commissions it (CCG and Local Authority)		The funding originally came from a Health System Led Investment (HSLI) Digital transformation bid that Hampshire Hospitals Foundation Trust (HHFT) were successfully awarded to roll the service out over Hampshire and Isle of Wight (HIOW), months before the onset of the pandemic. The care homes are expected to purchase and have their own hardware. The software (MS teams) was rolled out to all homes as part of Covid-19 response, as such the service did not fund this for the homes.

Information Governance

	Bradford	Croydon	Hampshire
Have all the care homes using the service achieved Standards Met in the Data Security and Protection Toolkit (DSPT)? If not, what mitigation have local teams put in place?	The care homes do not see the patient data, it is sent to the GP practice.	As per Bradford model.	Ahead of Covid-19 the Nurse Facilitators that work for the CCG was supporting all the homes to ensure that the standards were met, so they could get their generic NHS email account. With the onset of Covid-19, all homes were issued a generic email account by NHS England, as such we did not need to wait for the homes to get to standards met. After every consultation we send a record of the consultation to the Homes (to their nhs.net generic email account), then one to the GP surgery. The record is also automatically uploaded to the HIOW Care and Health Information Exchange (CHIE). Across HIOW the CHIE is being rolled out to each home. Each home will be able to view patient records via this method. For more information about CHIE visit here: https://careandhealthinformationexchange.org.uk/

Stakeholders

	Bradford	Croydon	Hampshire
How did manage to convince the CCGs and STP to grant service pilot?	Covid-19 monies were utilised to enable the work to progress.	This was one of our Quality, Innovation, Productivity and Prevention schemes	The funding originally came from a HSLI Digital transformation bid that HHFT were successfully awarded to roll the service out over HIOW, months before the onset of Covid-19. This funds a pilot then we can base the ROI on this, to develop the business case.
What challenges did you face with adoption and how were you able to get buy-in from the different stakeholders?	Main barriers have been that different GP PCNs wanting different approaches, for example some PCNs wanted us to provide a full service, other PCNS only required out of hours. To ensure we obtained buy in we held-3 times a week meeting of all stakeholders ensuring there was high level strategic buy in.		Collaborating with GPs early on will minimise they worry it will increase their workload, as such is v important that the service can prescribe independently. Some Integrated Care Partnerships (ICP) have existing services that work with care homes and those providers were not keen on the service moving into those areas. We utilised the local CCGs influence with those providers to enable better collaboration and integration.

Operational

	Bradford	Croydon	Hampshire
Did a GP from each PCN have to join the 'super rota'?	GP volunteers were requested with the skills we required.	As per Bradford model.	A super rota is being considered with neighbouring acute providers.
How do these models 'actually' link to GP Out of Hours (OOH)? For example, if a primary care home visit OOH is required, are they in the 'one team' and accept referrals? I am anxious homes will not have to 'start' again with GPOOH via 111?	These calls are directed to our out of hours provider.	As per Bradford model.	It would make sense for this function to be combined if you are developing a service from scratch. It would make sense to go via 111 and be patched through to the care home telemedicine service, we had planned to do this, but with the onset of COVID-19 , we had to go with the quickest route, we created an 0300 number.
How do you approve (quickly) a change in clinical care pathway (e.g. using a new remote technology that avoids the procedure in hospital)? Do you have any examples of this?	We held a joint planning group 3x a week with clinicians from each of the stakeholders. e.g. fracture neck of femur and head injury on anticoagulants	As per Bradford model.	We engaged with the clinical leads of each location that we are looking to roll out to. An initial set of pathways was established by the clinical lead of our Trust and this is the starting point for discussion and development.
Are the services open to domiciliary care providers or are there plans to extend to these?	The services are available via My Care 24 in Bradford	As per Bradford model.	Not yet, but this approach offers significant opportunity to support very high intensity users and individuals living with long term conditions.

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The care home staff are required to perform clinical assessments (e.g. blood pressure, temperature). Did you have to advise care homes to buy the equipment?	We bought it for them out of CCG funds	As per Bradford model.	When we rolled out, we asked all our care homes to tell us how much equipment they had. Where they had less than 1 piece of equipment per 20 residents, we bought them equipment from our HSLI Digital fund. This was not an optimal solution but obtaining observations is critical to ensuring the service is utilised appropriately.
Those that you discharge with no action do you audit further interventions regarding patients within a specific time frame - i.e. if repeat call within set day period?	We have done this when requested but not routinely. It is around 4%	As per Bradford model.	Presently no, but a good suggestion. Our service lead is looking to introduce review of onward referrals.
How is the surgery informed of the outcome of the call? e.g. starting a new medicine	As a system we are all on system one, so the outcome of the call is set up as a task for the GP with any changes to medication etc. needed	As per Bradford model.	All consultation summaries are sent to the GP practice
What rapid response services for care homes were already in place. Did you decommission any of this?	We worked closely with them at the start of the project, but as many staff are shielding or off sick etc or redeployed to support End of Life etc, weekend working was increased weekend working to support the system.	As per Bradford model.	N/A

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Are there any issues with cleaning the equipment (hardware) used in telemedicine calls with residents in between each call?			The training material that we developed (in collaboration with the Wessex AHSN) has material called the 'Care Home Telemedicine Booklet' on how to clean equipment here to mitigate any infection control risks: https://westhampshireccg.nhs.uk/telemedicine-for-care-homes/
Any thoughts on barriers to implementation by Care Homes?	As it is a new service, some care home staff and GPs may feel the service is an additional barrier between the home and doctors, so consideration on understanding how the service will benefit them is crucial.	It can take a long time to carry out the remote consultation Some staff fear new technology. Reluctant to lose good relationship with GP Deal with technical issues as they rise Review feedback from care homes as they arise and supplement with data.	Ensuring consistent and clear communication with Care Home and GPs will help engagement and uptake of the service. We described the benefits of the service to each stakeholder group.

Data

	Bradford	Croydon	Hampshire
What KPIs are used for teleedicine?	Call wait time, abandoned call rate, onward referral rate, technical help line wait	As per Bradford Model.	Impact metrics for the care home population have been developed with the assistance from the Wessex AHSN. We commissioned to evaluate the service • Reduced Ambulance conveyance • Reduced ED attendance • Reduced ED admissions • Reduced deaths in hospital (as they are supported to die at their home, where this is their choice) • Reduced DTOC • Reduced time in hospital • Reduced touchpoints and duplication in pathway • Increased no. of managed and treated in care home setting • Increased specialist palliative care activity • Observe impact on Community Nursing

			activity and Primary Care • Reduced care home reassessment (because they do not go to hospital reassessment should go down) • Improved patient experience and outcomes