Telemedicines
Information sharing event
Housekeeping

• Keep your mic on mute / camera off
• Use speaker view not gallery
• Use the Chat function to ask questions and comment
  – Put a ‘Q’ at start if it’s question, rather than a comment
  – Add your organization and role to any question
• Meeting is being recorded and will be made available
• All slides and recording will be shared on NHS Futures Platform
• Use #Telemed4CareHomes on Twitter
Welcome and Introduction – Dr Emily Gibbs

Approximately 400,000 older people in the UK live in care homes – three times the bed base of acute sector in England (BGS 2020)

Care home residents particularly vulnerable to COVID19 – 19,000 Covid deaths between March and June 2020 (29% of all care home deaths) (ONS 2020)

Local systems require early response and multi-disciplinary input when residents become unwell - challenges in delivering under traditional model and under Covid
Welcome and Introduction – Dr Emily Gibbs

Telemedicine support has been opportunity to provide a ‘hub’ of remote support with MDT and out of hours access

Aim to hear from three areas – Bradford, Croydon, West Hampshire – how their Telemedicine service has supported local care homes and what are the lessons in implementation and delivery

Promotion of Wessex AHSN Telemedicine Scoping and Implementation Guides – chance to build a network to continue sharing learning
Telemedicines
Information sharing event
Care@Home
Supporting patients with telemedicine during Covid-19 – the Bradford Approach

Dr Sara Humphrey & Nurse Consultant Rachel Binks
Right place - replicable model

- 39 Prisons
- >800 Nursing/Residential Care Homes
- Supporting > 20,000 residents
- 14 CCG contracts
- >35,000 clinical video consultations each year
Right care today

Teleconsultation
- Prison health care
- Care at home
- Nursing & residential care
- Supporting end of life patients

Electronic Patient Record
Registered Practitioners
Video Assessment

24/7 clinical hub
- improving patient experience
- changing patient flow
- reducing costs

Airedale Digital Care Hub
NHS Foundation Trust
Right time – care anywhere
Telemedicine Virtual Support

Referral Required

Goldline 24/7 Patient Care

END OF LIFE

No referral required

Airedale Digital Care Hub

COPD

MyCare 24

My Home
Wall Boards

Band 6 Queues

Band 6 Waiting Calls

<table>
<thead>
<tr>
<th>Queue Name</th>
<th>In Queue</th>
<th>LWC</th>
</tr>
</thead>
<tbody>
<tr>
<td>FollowUp_Appointment</td>
<td>0</td>
<td>00:00</td>
</tr>
<tr>
<td>Multiple_Patient_Queue</td>
<td>0</td>
<td>00:00</td>
</tr>
<tr>
<td>Single_Patient_Queue</td>
<td>0</td>
<td>00:00</td>
</tr>
</tbody>
</table>

Agent Stats 1/1

<table>
<thead>
<tr>
<th>Agent</th>
<th>Handled</th>
<th>Talk Time</th>
<th>Ready Time</th>
<th>NotReady Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agent 16</td>
<td>3</td>
<td>00:20:48</td>
<td>00:04:17</td>
<td>00:00:00</td>
</tr>
<tr>
<td>Agent 6</td>
<td>3</td>
<td>00:19:18</td>
<td>00:00:32</td>
<td>00:00:00</td>
</tr>
<tr>
<td>Agent 17</td>
<td>3</td>
<td>00:16:53</td>
<td>00:17:15</td>
<td>00:00:00</td>
</tr>
<tr>
<td>Agent 5</td>
<td>3</td>
<td>00:16:38</td>
<td>00:22:13</td>
<td>00:00:00</td>
</tr>
<tr>
<td>Agent 7</td>
<td>2</td>
<td>00:22:04</td>
<td>00:00:00</td>
<td>00:03:52</td>
</tr>
<tr>
<td>Agent 3</td>
<td>1</td>
<td>00:19:50</td>
<td>00:14:59</td>
<td>00:00:00</td>
</tr>
<tr>
<td>Agent 1</td>
<td>1</td>
<td>00:01:01</td>
<td>00:23:18</td>
<td>00:00:00</td>
</tr>
</tbody>
</table>

Calls In Queue: 0
Longest Wait Now: 00:00
Calls Abandoned: 0
Abandon Rate: 0.0%
Calls Handled: 30
Calls Offered: 30
Agents Logged In: 7
Agents Ready: 6
Agents Not Ready: 1
Agents Talking: 0
Ave. Time to Answer: 00:41
Longest Wait Today: 05:18
Remaining in their place of residence

[Line graph showing percentage remaining in place of residence from Apr-17 to Oct-18, with percentages ranging from 80% to 100% and slight variations throughout the months.]
Onward referrals (Apr-17 to Nov-19)

- 60% No onward referrals;
- 25% Referral to GP;
- 10% Referral to general practitioner out of hours service;
- Referral to district nurse;
- Referral to community matron;
- Referral to collaborative nursing care team;
- Referral to Social Services;
- Referral to community rapid response team;
- Referral to palliative care service;
- Referral to mental health crisis team;
Falls-related consultations

- Percentage of consultations that result in an ambulance request

Legend:
- Did not request an ambulance
- Did request an ambulance
- Percentage of consultations that result in an ambulance request
Supporting patients with frailty during Covid-19 – the Bradford Approach

• Using the existing assets of the Airedale Digital Care Hub
Supporting patients with frailty during Covid-19 – the Bradford Approach

• A system wide Care@Home developed an enhanced offer of care with Airedale Digital Care Hub

  LA, Acute Trusts, Care Trust, Primary Care, PCN, GP, community Matrons, Care Homes, Voluntary sector, CCG
Frail Patient with Escalating Needs

Telemedicine Virtual Support

Mental Health Advice 8-8pm

Referral Required

Super-Rota Virtual Support

Palliative Care Advice 24/7

No referral required

Referral Required

Goldline 24/7 Patient Care


MyCare 24/7

My Home
Supporting patients with frailty during Covid-19 – the Bradford Approach

• Develop a ‘Super Rota’ of expert clinicians from across the system to support personalised decision making in a patient's own home/care home moving expertise where it is needed
Support into the Digital Care Hub

- Remote or From Digital Care Hub
- 8am-Midnight
- 1:1 Difficult conversations with patients, families and care home staff
- Personalised decision making
- Expertise from Care of the Elderly, Rehabilitation consultants, A&E, GPwSI, GPs with an interest in Palliative Care, Care homes, Older People, Urgent Care

**Daily 1 hour ‘Huddle’ for Support**

**DISCHARGE TO ACCESS**
- Open to all Super Rota staff & Local Clinicians
- With access to pharmacy support, Palliative care consultants, Care of Expert Pharmacy Support 2/7 a week

Super-Rota Virtual Support

- Mental Health Advice 8-8pm-8pm
- Liaison Nurses
- Rapid Consultant Palliative Care Advice 24/7
- Consultant Advice
- Pharmacy Support 2/7 a week

Bradford District and Craven Clinical Commissioning Group
Personalised considered decision making supported using the ‘Three wise men approach’

3.0 Clinical Decision Making

3.1 Tiered Approach – Levels of Decision Making if you are uncertain whether a patient should be admitted or remain at home

- **Level 1**: GP/ANP Assessing Patient
- **Level 2**: Bronze – Super Rota who will talk to...
- **Level 3**: Silver – A&E & COE from Acute Trusts
- **Level 4**: Gold – ‘Gold’ Ethics Team (BRI or AGH)

**SILVER SUPPORT**
- < 75 years to contact A&E consultant
- > 75 years to contact Care of the Elderly Consultant (if in a care home > 65 years)

Bradford A&E until midnight 01274 382119 or unavailable through Switchboard 01274 542200
AGH A&E Consultant 01535 293866
ED registrar (most senior from midnight to 0800) 01535 294479 Care of the Elderly consultants on call via switchboard 01274 542200 (BRI) or 01535 652511 (AGH)

Include YAS if and where appropriate
24/7 SUPPORT from Palliative Care via Hospice Marie Curie 01274 337000 or Manorlands 01535 642308

**GOLD SUPPORT**
- For difficult decisions that Level cannot be resolved at 3
- In these circumstances the patient should probably be admitted & decisions made in hospital
Supporting patients with frailty during Covid-19 – the Bradford Approach

• Using GP ASSIST on System One to enable Primary Care to access services and understand pathways
FRAIL PATIENT with escalating needs

- Are they in a Care Home?
  - Yes
    - Patient identified as End Of Life
      > put on GSF > DNAR if possible
      > Refer to Gold Line
      Tel: 01535 292768
      EPACCS IDCR
    - They will already be registered with "ImmediCare"
      home should escalate with them
      > All nursing/medical/prescribing / social care needs
      > All pets think GSF & DNAR
      > No Referral required
  - No
    - Assess for frailty score CFS
    - Rockwood Frailty Scale

- If entering from COVID triage Moderate branch

- CFS > 5?
  - Yes
    - Practice Triage Assess patient for this problem and manage as non-fail
  - No
    - COVID-19 Suspected
      - C19 Triage Tool

- Manage as per triage pathway OP to perform home visit if required as per RED guidance

- Known to Community Matron
  - Manage & Visit if appropriate
  - Put a plan in place
    - All Pts think GSF / DNAR
      If Advice needed from SuperRota
      Consultant support
      Contact via my Care 24

- NOT Known to Community Matron
  - Primary Care Assessment

- Refer in to My Care 24 with plan
  - Click here for My Care 24 Pathway

- CRISIS SUPPORT
  - ACCT / WYDN / CM / Social Care

- Virtual Super Rota (GPWSH(consultants))
  - Gold Line 01535 292768
  - ImmediCare 01535 292768
  - My Care 24 01535 292768

Bradford District and Craven
Clinical Commissioning Group
Supporting patients with frailty during Covid-19 – the Bradford Approach

• Develop Pathways of care to maximise resources and reduce unnecessary transitions of care
Supporting patients with frailty during Covid-19 – the Bradford Approach

Specific frailty pathways

1. COV-19 RB & Triage
2. Frail patient and COVID-19 ICDR Pathway (leading on to the Care Home Pathway)
3. Pneumonia and complicated COVID-19
4. Delirium resource/pathway
5. Managing frail patients [includes sick day rules]
6. Hip fracture/NOF
7. Falls pathway /head injury in care homes
8. End of life pathways
9. Medical certification of cause of death
10. Cardiac Arrest in a Care Home
11. Verification of Death with Care Home staff

These pathways will be accessible to all system partners either via the ASSIST tool on SystemOne, or via the shared OneTeam folder.
Supporting patients with frailty during Covid-19 – the Bradford Approach

• Ensuring external partners Supporting new pathways of care
Working with YAS

- Available: 24/7, 365 days a year
- 01535 292764 (MyCare24 and Immedicare - telemedicine) and 01535 292768 (Goldline)
- Bradford, Airedale, Wharfedale and Craven areas
- Manned by health and care professionals with GP/Consultant cover (08:00-00:00)
- Function and purpose:
  - To support shared decision making for frail patients (especially with regards to Covid-19)
  - Clinician to clinician dialogue
  - Ability to visualise patient via telemedicine
  - Avoid hospital attendance wherever possible
  - Ability to request prescriptions and access appropriate community resources
- Team has access to relevant systems to allow review of patient records in order to support discussion and decision making (including advanced care plans and DNACPR records)

- Patients who are not frail (CFS of <5)
- Patients triggering acute pathways (PPCI, Stroke, #NOF etc.) unless diagnosis is unclear or clinician feels conveyance is not in patients best interests (refer to inclusion criteria for details)

- Possible outcomes:
  - Home management/end of life meds/DN referral
  - Provision of antibiotics
  - Palliation via GP
  - Home visit
- Contact the Digital Care Hub for a clinician to clinician discussion if uncertain on correct pathway or treatment plan

- Contact the Digital Care Hub for all patients in a care/nursing home setting, prior to conveyance
- Where hospital attendance is not deemed to be in the best interest of the patient (including stroke and #NOF patients or if diagnosis is unclear)
- Also for patients in their own home with a Clinical Frailty Score of ≥5 (see next page)
- If advance care planning needed/already in place
- For falls with head injury (anticoagulants included)
- Parkinson’s (Airedale/Craven) and COPD patients (Bradford, Airedale and Craven)

- Provide SBAR handover and the following information:
  - Name, DOB and NHS number (if known)
  - Past medical history/comorbidities
  - Clinical Frailty Score and CRB65 score (see next page)
  - Any known advance care plan or DNACPR
- Contact NOK wherever possible, with patient consent if they have capacity
- If referral accepted the HCP at the Digital Care Hub will take clinical responsibility for the follow up of patient care – if not accepted then this responsibility remains with the YAS clinician and an alternate care plan must be devised
Supporting patients with frailty during Covid-19 – the Bradford Approach

- Developing a robust clinical decision making tool to ensure all decisions are considered, personalised, documented and supported

Developed from tools supplied with thanks from Nottingham Dr. Julie Barker – End of Life Lead, Nottingham & Nottinghamshire CCG

Dr. Thilan Bartholomeuz – Clinical Lead – Mid Nottinghamshire ICP

Dr. Hilary Lovelock – Governing Body GP – Nottingham & Nottinghamshire CCG
Considered Personalised Decision Making

**ASSESSMENT OF THE DETERIORATING PATIENT IN THE COMMUNITY DURING THE COVID-19 OUTBREAK**

For use of the SUPER ROTA V3

Ensure basic care, privacy and dignity is maintained and that reversible factors are considered and acted upon. If in doubt ask for support (details at end of form) or call 999 for immediate emergency response.

This form can be used prior to and at the time of deterioration in combination with existing Advance Care Plans

- **Name:** M/F
- **DOB:** Age:
- **NHS No.:** Last seen date:
- **Location:** Date: Time: Patient reviewed: Face to face: Via video link: Via telephone: Notes only reviewed:

Background – relevant issues (significant diagnoses, recent events / procedures / admissions / patient views)

**Summary of current events and existing treatment (refer to Advance Care Plan / recent discussions if available). Consider LPA**

<table>
<thead>
<tr>
<th>Current Observations</th>
<th>NEWS Score</th>
<th>Temp</th>
<th>SpO2</th>
<th>RR</th>
<th>Pulse</th>
<th>BP</th>
</tr>
</thead>
</table>

- **Distress:** Yes No
- **Delirium (see flowchart):** Yes No
- **Is the patient:** Alert Responding to voice Responding to pain Unconscious

Have any critical drugs been missed (steroids, diabetic medications, Parkinson’s medications)? Any new drugs (e.g. opiates) which may have caused a change?

- **COVID-19 status:** Unlikely Possible Probable Likely

- **Functional status 2 weeks prior to current acute illness**
  - Circle frailty status (CF5) on diagram
  - Use Top Tips CF5 to help decision making
  - If ≤5 or any one with stable long-term disabilities e.g. cerebral palsy, learning difficulties, autism do an individualised assessment of frailty. Do not use CF5. If in doubt seek specialist advice
  - Can they walk 500m or climb stairs? Yes No
  - SOB at rest or on minimal exertion? Yes No
  - Knowledge of Goldline or on GSP? Yes No
  - Evidence of physical or cognitive decline in the last 2 months? Yes No

**Are there any current Escalation or Emergency Care Plans in place?**

<table>
<thead>
<tr>
<th>Resuscitation status</th>
<th>For CPR</th>
<th>DNACPR</th>
</tr>
</thead>
</table>

- **Patient’s priorities, statements or decisions known?** & have these been discussed specifically in the context of the COVID-19 outbreak?

- **Patient next of kin / friend / advocate / power of attorney / other (circle):**
  - **Name:** Contact details:

**Consider patient capacity: Best interest Decision needed?**

- **Yes**
- **No**
- **Discussed with:**

For patients not already identified as End of Life

Information recorded on this form will strongly influence survival from any acute event, whether with or without COVID-19. Hospital resources to treat non-COVID-19 related illness may be limited & the risk of developing COVID-19 through hospital admission is significant. This should be taken into consideration & discussed with patients or their representatives.

**Overall poor prognostic features that may be present individually or in combination:**

- Clinical Frailty Score of 5 or higher prior to current events.
- Pre-existing severe or end stage disease (heart failure, COPD, dementia).
- New or worsening respiratory failure (SATS <92% on air or <88% if chronic hypoxia).
- Signs of circulatory failure (systolic BP <90, pulse >110).
- Deteriorating conscious level, unable to eat or drink, requiring high levels of care.

Please note any COVID-specific pathways which have been used (e.g. Stroke / Falls / Fracture NOF):

- **Considering escalation of care & treatment in hospital call A&E ≤ 75 or COE > 75 (+65 from Care Home BFD 01274 382119 /01274 542200 AGH A&E 01535 293865 / 01535 652511 24 hr Consultant Palliative Care support via Marie Curie 01274 337000 Dr Manorlands 01535 642308 If decision cannot be made at this level admit the patient**

- **Manage with MyCare24 support in community and consider hospital admission if required**

- **Manage supportive with MyCare24 support in community – but no escalation to hospital**

**Clinician(s) name(s):**

<table>
<thead>
<tr>
<th>Sign</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**Discussed in 'super-rotta' MDT or with second line A&E/COE**

- Where delirium is suspected please see delirium pathway.
- For support in recognising patients approaching end of life, see End of Life and Palliative Care in Covid-19 documents.
- Ensure anti-emetics (including antiemetics) are prescribed for individual patients where appropriate.
- Avoid use of oxygen for the dying. Use antiemetics drugs.
- Seek advice / support from specialist teams where needed.
- Don’t miss RED flag problems that may need emergency assessment – see separate Care Home guidance for falls (with or without suspected head injury) and suspected hip fracture.
- Inform, involve, support and communicate with patients. Advise how to call for help, and the time and purpose of the next planned visit.

**Emergency Contact Numbers:**
CLINICAL CONSOLE FOR THE ASSESSMENT OF THE DETERIORATING PATIENT IN THE COMMUNITY DURING THE COVID-19 OUTBREAK

Please ensure basic care, privacy & dignity is maintained & that reversible factors are considered & acted upon. If in doubt ask for support or call 999 for immediate emergency response.

Click the 'Start Consultation' button. Once completed & saved, a view of your consultation will appear below. Any tools you may require can be found in the menu on the right of the console.

Click the 'Remotely access video consultation' button for instructions about how to access the patient's hub nurse in the video consultation room.

---

**Latest Consultation using COVID-19 Clinical Consultation**

**COVID-19 Clinician Consultation: 16 Apr 2020 11:21 by SB**

- **Consultation Record**
  - Summary of current events & wellbeing
  - Current medication
  - Patient's EPR
  - Any critical drugs been missed (steroids, diabetic medications, Parkinson's medications). Any new drugs (e.g. opiates) which may have caused a change?
  - Contact Method

- **Last NEWS2 Score (last 24hrs)**
  - The 0.02 NEWS2 ICRI template has no information to show. Double click here to record values.

- **Last CRB65 Score (last 24hrs)**
  - The 0.03 CRB65 Score ICRI_crh template has no information to show. Double click here to record values.

- **Last recording of CFS via Rockwood scoring tool**
  - The Rockwood Frailty Scale template has no information to show. Double click here to record values.
Are there any current recommendations for emergency care and treatment?

Patient’s priorities, statements or decisions known and have these been discussed specifically in the context of the COVID-19 outbreak?

Consider patient capacity: Best interest decision needed?

Best interest decision made on behalf of patient (MCA 2005)

Clinical decision options (click tick to record decision in the notes):

- Considering escalation of care & treatment in hospital call A&E < 75 or COE > 75 (> 55 from Care Home). If decision cannot be made at this level Admit the patient BFD 01274 362119 switcheboard 542200 AGH 01535 293666 switcheboard 652311
- Manage with MyCare24 support in community and consider hospital admission if required
- For palliative treatment in community with GoldLine support (End of Life Care)

Palliative Care Consultants are available 24/7 via the switchboards

For patients not already identified as End of Life

Information recorded on this form will strongly influence survival from any acute event whether with, or without Covid-19. Hospital resources to treat non-Covid-19 related illnesses can be limited & the risk of developing Covid-19 through hospital admittance is significant. This should be taken into consideration & discussed with patients or their representatives.

Overall poor prognostic features that may be present individually or in combination:

- Clinical Frailty Score of 5 or higher prior to current events
- Pre-existing severe or end stage disease (heart failure, COPD, dementia)
- New or worsening respiratory failure (sats < 92% on air or <88% if chronic hypoxia)
- Signs of circulatory failure (systolic BP<90, pulse >110)
- Deteriorating conscious level, unable to eat or drink, requiring high levels of care

Considerations & Tips

Where delirium is suspected please see delirium pathway

For support in recognising patients approaching end of life, see End of Life and Palliative care in Covid-19 documents

Ensure anticipatory medicines (including antipsychotics) are prescribed for individual patients where appropriate

Avoid use of oxygen for the dying. Use anticipatory drugs

Seek advice / support from specialist teams where needed

Don’t miss RED FLAG problems that may need emergency assessment – see separate Care Home guidance for falls (with or without suspected head injury) and suspected hip fracture.

Inform, involve, support and communicate with patients. Advise how to call for help, and the time and purpose of the next planned visit

Click ‘OK’ to save
Supporting patients with frailty during Covid-19 – the Bradford Approach

• Outcome data
(7a) Number of Confirmed Cases in Bradford Care Homes

- Current Cases
- Total To Date

(7b) Number of Confirmed/Suspected Deaths in Bradford Care Homes

- Total
- Number in Care Homes
- Number in Hospital

NB: Please note that care home data is only representative of those care homes who are reporting outbreaks/data to the Local Authority.

(4a) Number of Registered Deaths (ONS) - Bradford & Craven

- Registered Deaths - All Causes
- Registered Deaths - COVID19

(4b) % of COVID-19 Registered Deaths by Place of Death - Bradford & Craven

- Other Communal Establishment
- Hospital
- Hospice
- Home
- Elsewhere
- Care Home

Dates: 27th March to 1st June.
GP feedback

"Of all the changes in the 15 years I have been working this is the greatest change which has reduced workload I can remember. I don't mind the extra "late" duty doc visit as this is more than made up in the drop in other visits. A big thank you to all involved”

Care Home Manager

“Telemedicine is brilliant, the staff are always using it, I hardly get any phone calls during the night, as she used to, staff would be lost without it”,

“you know you are passing the responsibility onto Telemedicine”.
Supporting patients with frailty during Covid-19 – the Bradford Approach

• Successes, challenges, learning and outcomes
## Outcomes and learning

<table>
<thead>
<tr>
<th>Successes</th>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Building on existing relationships</td>
<td>Cross organisational I.T. – hardware and software</td>
</tr>
<tr>
<td>Revised clinical pathways on GP ASSIST</td>
<td>Governance of cross boundary clinical pathways</td>
</tr>
<tr>
<td>Remote service offer expanded</td>
<td>The ‘one size fits all’ for primary care</td>
</tr>
<tr>
<td>Evidence that care if happening closer to home</td>
<td>National press – negative messages</td>
</tr>
</tbody>
</table>

### Outcomes and Impact

| People receive clinical care in the safest setting for them               | Action learning greatly accelerates progress – PDSA approach               |
| Secondary care resources are protected from inappropriate demand         | Virtual meetings have aided, not hindered                                  |
| Strengthened community response to managing complex cases                | Balancing pace of change – clinical, evidence-base and governance          |
| Reduced pharmaceutical waste and work load                               | Include primary and community care staff in all development and decision making |

<table>
<thead>
<tr>
<th>Learning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action learning greatly accelerates progress – PDSA approach</td>
</tr>
<tr>
<td>Virtual meetings have aided, not hindered</td>
</tr>
<tr>
<td>Balancing pace of change – clinical, evidence-base and governance</td>
</tr>
<tr>
<td>Include primary and community care staff in all development and decision making</td>
</tr>
</tbody>
</table>
Supporting patients with frailty during Covid-19 – the Bradford Approach

• Next Steps
### Enhanced Health in Care Homes (EHCH) Framework (10 year Plan)

<table>
<thead>
<tr>
<th>Care element</th>
<th>Sub-element</th>
</tr>
</thead>
</table>
| 1. Enhanced primary care support for care home residents | Access to consistent, named GP & wider primary care services  
Medicines reviews  
Hydration and nutrition support  
Access to out of hours/urgent care when needed |
| 2. MDT in-reach support | Expert advice and care for those with the most complex needs  
Helping professionals, carers and individuals with needs navigate the health and care system |
| 3. Re-ablement and rehabilitation to promote independence | Rehabilitation and reablement services  
Developing community assets to support resilience and independence |
| 4. High quality end of life care and dementia care | End of life care  
Dementia care |
| 5. Joined up commissioning between health and social care | Co-production with providers and networked care homes  
Shared contractual mechanisms to promote integration (including CHC)  
Access to appropriate housing options |
| 6. Workforce | Training and development for social care provider staff  
Co-ordinated workforce planning across all sectors |
| 7. Data, IT and technology | Linked health & social care data  
Access to care record and secure email  
Better use of technology in care homes |
Further potential for co-ordinating care

- **Primary Care enhancement** – GP Triage/DN and Community Team support
- **MDT conferencing** with Community Nurses, GPs, Digital Hub, Care Homes and staff working in Offender Health
- **Virtual Training /Supervision to Care Home Staff/Offender health Staff**
- **Virtual/Remote Discharge** – from hospital back to the care home/Prison
- **Provision in patient’s own home**
- **Diversion from NHS 111 and 999**
  - Non emergency calls are intercepted and passed to the Digital Hub for assessment and management
Innovation potential

“The innovation that telemedicine promises is not just doing the same thing remotely that used to be done face to face, but awakening us to the many things that we thought required face to face contact, but actually do not.”

David D Asch MD, MBA,
Perelman School of Medicine, University of Pennsylvania
Dr Sara Humphrey, Associate Clinical Director Frailty & Dementia Bradford District &Craven CCG
GP Advisor, Yorkshire & Humber Dementia and OPMH Clinical Network
E: sara.Humphrey@bradford.nhs.uk

Rachel Binks, Nurse Consultant Digital and Acute Care, Airedale NHSFT
E: rachel.binks@nhs.net
Telemedicines
Information sharing event
Implementation of Telemedicine in Croydon Care Homes

Daniele Serdoz
One Croydon Programme Manager
What is the Immedicare Telemedicine Service

- Secure video link between nursing and residential homes and the Airedale Digital Care Hub.
- 24/7 access, 365 days
- HD videophone to a team of specialist nursing and consultant support undertaking a clinical consultation, whenever a concern arise about a resident
Implementation approach - Ingredients for success

- Early buy in from all system partners
- Dedicated team to lead implementation and change management
- Build relationship with homes
- Consider other opportunities for technology utilisation
- Strong engaged manager and assertive GP are crucial
- Deal with issues to avoid losing confident in the service
- Telemedicine champion in care homes
- Establish clear pathways and target operating model
- Data to support change management
- Dedicated team to lead implementation and change management
Change Processes – GPs

1. Engagement Letter
   1.1 Engagement Letter emailed to GP relative to Care Home.

2. Follow-Up Call
   2.1 During Follow-Up Call
      2.1.1 Confirm receipt of letter
      2.1.2 Confirm Care Home(s) covered
      2.1.3 Confirm Practice primary contact

3. Practice Visit
   3.1 Before Initial Visit
      3.1.1 Supply all relative documentation
   3.2 During Initial Visit
      3.2.1 Share information leaflets
      3.2.2 Summarise our approach and next steps
      3.2.3 Confirm new pathway and practice responses to Telederm and Care Homes.
      3.2.4 Suggest Consents & Engagement plan for practice.
      3.2.5 Suggest Care Home Telederm champion.
      3.2.6 Suggest Practice Telederm champion.
      3.2.7 Provide all commms for feedback.
   3.3 After Initial Visit
      3.3.1 Collate initial visit change readiness actions

4. Info Pack
   4.2 Included
      4.2.1 Teledermic commms
      4.2.2 Frequently asked questions
      4.2.3 Complete Vodafone 4G survey
      4.2.4 GP Log Book
      4.2.5 Posters/ stickers for practice

Gate Checkpoint

5. Care Home Go-Live
   5.2 During Go Live
      5.2.1 Notify Practice of Care Home going live
      5.2.2 Confirm new BAU
   5.3 After Go Live
      5.3.1 Confirm follow up visit at least two months post Practice going live with Telederm

6. Follow Up Visit
   2.1 During Follow-Up Visit
      2.1.1 Hold feedback workshop
      2.1.2 Take all questions/ comments back to Doc Croydon/ Telederm
      2.1.3 Engage with relative services to improve if required.
Change Processes – Care Homes

1. Care Home Go-Live
   - After 1 week

2. Follow-Up Call
   - 2.1 During Follow-Up Call
     - 2.1.1 Confirm Go-Live date
     - 2.1.2 Check if home used the service
     - 2.1.3 Confirm name of telemedicine champion
     - 2.1.4 Describe information pack and next steps
     - 2.1.5 Organise follow-up visit
   - After 1 week

3. Care Home Visit
   - 3.1 During Care Home Visit
     - 3.1.1 Discuss usage of service by home
     - 3.1.2 Identify any perceived barriers or gaps
     - 3.1.3 Discuss champion roles and responsibilities
     - 3.1.4 Posters display locations
     - 3.1.5 Laptop management process
     - 3.1.6 Reinforce key messaging
   - After 2 weeks

4. Monitoring
   - 4.1 Weekly monitoring of usage
     - 4.1.1 Report from imedcare on usage
     - 4.1.2 Data from GPs on calls and usage
     - 4.1.3 Care home dashboard design
     - 4.1.4 Share data with LA contracts team

5. Follow-Up Call
   - 5.1 During Follow-Up Call
     - 5.1.1 Review usage report for home
     - 5.1.2 Identify any additional support needed
     - 5.1.3 Set up follow-up meeting to review progress

6. Care Home Visit
   - 6.1 During Care Home Visit
     - 6.1.1 Review care home dashboard
     - 6.1.2 Plan for ongoing support to fill any gaps
     - 6.1.3 GP feedback

Gate Checkpoint

Care Attendees
- Project lead
- Care Home Manager
- Telemedicine champion
- Optional Attendees:
  - Inmedicare team

Control & Monitor
Croydon Telemedicine Pathways

Telemedicine Service: First Port of Call for Unscheduled needs

No onward referral required. Nurse in hub
- Consults
- Assesses
- Advises
- Monitors if necessary

Non-urgent medical attention needed. Referral made:
- GP (in-hour)
- District nurse
- Palliative care team (if end of life)
- Other service via DoS

Urgent medical attention needed. Referral made:
- GP (out of hour)
- GP (in hour)
- LIFE Rapid Response
- Palliative care team (if end of life)
- Other service via DoS

Immediate medical attention required, life threatening.
- Call 999
- Provide advice while paramedics arrive

Any concerns about a resident or resident becomes unwell

In an emergency always call 999 first then the Hub for support until the paramedics arrive

Pathway 1
- No onward referral required. Nurse in hub
  - Consults
  - Assesses
  - Advises
  - Monitors if necessary

Pathway 2
- Non-urgent medical attention needed. Referral made:
  - GP (in-hour)
  - District nurse
  - Palliative care team (if end of life)
  - Other service via DoS

Pathway 3
- Urgent medical attention needed. Referral made:
  - GP (out of hour)
  - GP (in hour)
  - LIFE Rapid Response
  - Palliative care team (if end of life)
  - Other service via DoS

Pathway 4
- Immediate medical attention required, life threatening.
  - Call 999
  - Provide advice while paramedics arrive

In an emergency always call 999 first then the Hub for support until the paramedics arrive

Any concerns about a resident or resident becomes unwell

Telemedicine Service: First Port of Call for Unscheduled needs

In an emergency always call 999 first then the Hub for support until the paramedics arrive

Any concerns about a resident or resident becomes unwell

In an emergency always call 999 first then the Hub for support until the paramedics arrive
Targeted engagement with care homes to increase utilisation

- The number of weekly calls to the service has been steadily increasing since targeted engagement with the care homes commenced in July 2019.
- Average number of calls shifted from 38 calls a week to 75 (excl. Covid peak).
Overall Utilisation by month since April 2019

Number of Telemedicine consultations vs number of Care Homes using the service

- Homes not using it
- Homes using it
- Activity

Data for each month from April 2019 to May 2020.
Telemedicine Key Outcomes for May 2020

- The average response time was 2 min 03 seconds
- 88% of consultations resulted in the residents remaining in their place of residence
- 9% of consultations resulted in an ambulance called to assess
- 67% of consultations resulted in no onward referrals being made to other services
- Where the care home stated they would have called a GP, in 62% of cases the telemedicine service did not refer to a GP
Challenges in implementation

- Variation in utilisation by care homes
- Care home staff turnover
- Local pathways and services may not always be clear
- Variation in care home staff confidence with using it
- Wifi and connectivity issues take time to resolve
- Change management time consuming – plan ahead
Number of calls adjusted by Care Home Size
Barriers to utilisation (as described by the care homes)

• It can take a long time to do the consultation
• Registration process takes too long
• Some of the staff fear new Technology
• Old habits die hard
• Reluctant to lose good relationship with GP
• Home doesn't believe that Telemedicine benefits them as the Nurses already know what they are doing
• Would recommend to Residential homes, not necessarily Nursing homes
• Have had some negative feedback from other homes
• Have experienced a few Tech issues

Use data is to show this is not the case

Strong Manager and Assertive GP

Utilisation data suggests otherwise

Deal with issues straight away
What GPs have told us... (based on feedback from our Practice visits)

"I have noticed a very positive difference from our Care Home. Clearly, this is working very well and I am looking forward to what other technological solutions may be suggested" - GP

"Requests to visit our Care Home have dropped enormously. This is because Telemedicine has been advising the home internally and dealing with any issues that we otherwise would have had to come and visit" - GP

"Telemedicine has made a huge, huge impact on our workload already. We are able to focus on our patients in practice and organise our working day's more effectively" - GP

GP Practices

• Reports can, at times, be rather long and repetitive. A highlighted box on the form signifying next steps for GP, if required, would be helpful.

• Access to EMIS for everyone would be ideal.

• Ask GPs about patient history before requesting a visit. GP may have visited patient the day before for example.

• Can Telemedicine link to a chemist which is open over the weekend?

• Despite GPs constantly pushing back, there are still some nursing homes calling the practice and requesting a visit."
What are we trying to address?

Delays in discharging patients from hospital while waiting for care homes assessment as to whether a patient is appropriate for that particular home and that they could meet client needs.

What are the reasons for these delays?

• Lack of staff availability to undertake the assessments is often cited as a key reason for delays.
• Time of day and day of week they are asked to attend; Availability of a suitable person to attend (usually the head nurse or registered manager)
Remote assessments via telemedicine laptops support a timely, safe transfer of care for people in hospital into the care home setting and minimise unnecessary travel and time for care home staff travelling to the hospital site to perform face to face assessments.

**Key Principles**

- Designated Hospital Staff facilitates and coordinates remote assessments.
- Utilisation of remote assessments should be considered first – within 6 hours of contacting the home

**PLEASE NOTE: THESE ARE NOT TRUSTED ASSESSMENTS** – Care homes are still carrying out the assessments themselves
Opportunities – Remote assessments

What outcomes have been achieved from remote assessments?

1. Reduction in the average number of days waiting for assessments - from 4.4 days to 0.8 days
2. Shorter assessments times - 43 minutes on average
3. Decision by the home made and communicated to staff and ward on the same day in 82% of cases
4. Improvement in the number of days from Assessment to Discharge - from 7.2 to 5.7
5. Improved relationships between care homes and Croydon University Hospital.
Feedback received from Care Homes following a remote assessment.

<table>
<thead>
<tr>
<th>Feedback received from Care Homes following a remote assessment.</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I think the remote assessment process is brilliant for both the patient and us [...]. I could see myself using this medium more in the future. Croydon is embracing technology which is amazing. So well done” – Amberley Lodge Manager.</td>
</tr>
<tr>
<td>“Just to inform you that JG is settling nicely at our Nursing Home. The remote assessment was very successful and convenient. It saved me a lot of time from travelling to CUH. I always take a cab to all my assessments and the remote assessment is not only convenient but saves money. I am looking forward to more of remote assessments!” – Albany Lodge Deputy Manager.</td>
</tr>
<tr>
<td>“The Care Home Liaison and Coordinator was very professional and very helpful. She actually invited a nurse that was looking after the gentleman I was assessing that morning to take part in the assessment and that gave me a clear view of the clients’ condition” – Mary’s Home Manager.</td>
</tr>
<tr>
<td>“The Remote Assessment went very well and I was really impressed with it. It also made a big difference having the Care Home Liaison and Coordinator to gather and send all the necessary information as this would usually take a long time on the ward as the nurses are all so busy” – Addington Heights Manager.</td>
</tr>
</tbody>
</table>
What would you do differently

- **DO NOT UNDERESTIMATE THE TIME IT TAKES!**
- **MORE WORK WITH GPs**
- **MORE FOCUS ON COMMS AND ACHIEVEMENTS**
- **BRING IN THE LOCAL AUTHORITY TEAMS EARLY ON**
- **DO NOT ASSUME EVERYONE KNOWS HOW TO SWITCH A LAPTOP ON**
Telemedicines
Information sharing event
HIOW Care Home Telemedicine Service

Naomi Ratcliffe – Project Director HHFT
Rebecca Wheeler – Senior Commissioning Manager WHCCG

https://westhampshireccg.nhs.uk/telemedicine-for-care-homes/
Background

• HHFT and WH CCG joint project to support acute and unexpected deterioration need within care homes
• Based on the success of the Airedale Model in North Yorkshire that was funded by Vanguard money in 2014
  – lower demand for GP services 40%
  – reduction in ED attendances 33%
  – reduction in ED admissions 25%
• The development of a specialised/centralised Telemedicine service for Homes across HIOW.
• Aims to reduce demand on UEC:
  – Ageing increasingly complex and comorbid population
  – NHS is experiencing a worsening position in regards to attracting and retaining an appropriately trained workforce, esp. for UEC. A consolidated approach offers enhanced ICS resilience.
Timeline

- **Pre-COVID-19** to commence late summer 2020 and rolled out over the HIOW geography over 2.5 yrs
- **COVID-19** - rapid rollout
  - **April 2020** - North and Mid ICP and Romsey & North Baddesley PCN ~ 85 CHs and the Step Down Holiday Inn Facility
  - **May 2020** - Eastleigh Health, Chandlers Ford and Eastleigh Southern Parishes PCN ~ 107 CHs
  - **July 2020** – remaining South West ~ 180 CHs
  - Portsmouth and Southampton city fast followers
Approach

- Strength based
- Collaboration and co-production
- Governance – project board and workstreams
- Innovation
- QI
- Data
Care Home requirements to participate

- ReSPECT
- NHS.net (generic)
- RESTORE2

Andover War Memorial Hospital
Basingstoke and North Hampshire Hospital
Royal Hampshire County Hospital
Benefits

Residents

- Stay at home, less likely to become agitated, disoriented, delirious
- Reduced rates of hospital acquired infections, falls, deconditioning.
- Enable people to die in their place of choice
- Improved experience and enhanced quality of life

Care Home

- Expedient access to secondary care professionals with +++ experience in assessing and managing acute exacerbations in elderly and frail
- Enabling a two way discussion in real time about deteriorating residents
- Development of an agreed risk sharing plan about how to manage residents
- Increased staff confidence and competence

NHS Services

- Reduced and appropriate utilisation of a under-resourced and overstretched workforce/resource
- Improved bed flow, decreased DTOC and LOS = Improved system resilience
- Decreased demand on OHH services
- ? Reduced demand on in hours primary care services
How Care Homes can access the service


• **Use** the service for unexpected and sudden change

• **Don’t use** the service for routine and predictable care
The Telemedicine Service Pathway

Concerned About Resident?

Before you call, if possible:
Assess using RESTORE/mini
Check the Advance Care Plan
Complete SBARD Tool

Call 0300 772 7765

Telemedicine consultation with clinician:
Outline concerns using SBARD and the resident’s wishes (as per ACP)

Agree actions, implement and review

Electronic Prescription

Discharge

Referral to community services, e.g. GP/other

CHIE: A record of all consultations and agreed actions will be recorded on CHIE, along with any new or updated ReSPECT forms. If your care home does not have access to CHIE (yet) the service can email a record of the consultation and ReSPECT form to the care home’s NHS.net

Escalate to a more senior clinician, e.g. doctor
<table>
<thead>
<tr>
<th>S</th>
<th>Describe Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Who holds POA and their contact details...NOK contact details...</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B</th>
<th>Provide Background</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The client has lived with us since (date of admission)</td>
</tr>
<tr>
<td></td>
<td>They have been admitted to hospital **times in the last 6 months</td>
</tr>
<tr>
<td></td>
<td>In the last month the client has been admitted to hospital with**** /seen by the GP with****</td>
</tr>
<tr>
<td></td>
<td>They are also known to suffer from (outline all known medical problems in clients records with particular note of underlying heart problem, diabetes, respiratory problems, renal problems, dementia)</td>
</tr>
<tr>
<td></td>
<td>The clients’ medication list includes.......</td>
</tr>
<tr>
<td></td>
<td>In cases where the client does have a DNACPR/ACP/Respect please outline what this plan states</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A</th>
<th>Provide client assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Summarize the facts and give your best assessment on what is happening:-</td>
</tr>
<tr>
<td></td>
<td>I think the current problem is *** OR I don’t know what the problem is but the client is deteriorating</td>
</tr>
<tr>
<td></td>
<td>The normal NEWS score when the client’s well is *** the current NEWS score is ***</td>
</tr>
<tr>
<td></td>
<td>The most recent weight is ***kg (weight on admission ***kg)</td>
</tr>
<tr>
<td></td>
<td>The client is currently able/not able to eat &amp; drink</td>
</tr>
<tr>
<td></td>
<td>The client is currently able/not able to walk and the normal mobility is.......</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>R</th>
<th>Make Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>What actions are you asking for? (What do you want to happen next )</td>
</tr>
<tr>
<td></td>
<td>2 recommended outcomes are possible:</td>
</tr>
<tr>
<td></td>
<td>Convey the person to hospital for further assessment. This decision will be based upon the premorbid functional/cognitive status, the co-morbidities and the likelihood that hospital care will improve outcome (client will be a candidate for treatment which can’t be delivered in the care home e.g. oxygen/intravenous treatment).</td>
</tr>
<tr>
<td></td>
<td>Stabilise the person in the care home either with an agreed action plan and clear criteria indicating when a further referral is needed OR Palliate the person in the care home which may require an updated RESPECT form to be sent, End of Life medications prescribed (available locally) and a drug administration form sent to allow the community team to deliver medication.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D</th>
<th>Make decision</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>What have has been agreed?</td>
</tr>
<tr>
<td></td>
<td>Clearly document the agreed plan in the patients records</td>
</tr>
</tbody>
</table>
**Situation**

- Date & Time of call
- Name of caller
- Source (GP / SCA / Care Home / Other – please specify)
- Care Home name and location (Postcode)
- GP Surgery
- Does the care home have trained nurses (Yes / No)
- Has the resident been in contact with a health commissioner (Yes / No)
- Current situation / reason for call
- Name of Practitioner

**Background**

- How long has the patient been at the care home?
- Number of admissions to hospital (in past 12 months)
- Reason for admission(s) (including date)

**Details of any recent GP visits / calls**

- Respiratory problems – Yes / No
- Please specify
- Heart problems – Yes / No
- Please specify
- Diabetes – Diabetes type II
- Please specify
- Renal problems – Yes / No
- Please specify
- Dementia:
- Any other, please specify

**Co-morbidities**

**Current medication**

**Any allergies**

- Do they have a medication compliance aid (Y / N) and details if available
- Do they have a DOAC/DOXIP?
- Do they have a transition care plan (e.g. TewSPECT)?
  - If yes, is it specific to an existing condition?
  - Is this condition the reason for this call?

**What does the plan state?**

**Assessment**

- Action taken already at the care home
  - NEWS / RESUS2 score
  - Weight
  - Any swallowing problems (eating and drinking)
  - Mobility and transfers (walking aids, distance, wheelchair, assistance required)

- Responder:
- Current:
- Co-admission to care home:
- Current:
The Telemedicine Service Pathway

Concerned About Resident?

Before you call, if possible:
- Assess using RESTORE2 mini
- Check the Advance Care Plan
- Complete SBARD Tool

Call 0300 772 7765

Telemedicine consultation with clinician:
- Outline concerns using SBARD and the resident's wishes (as per ACP)

Agree actions, implement and review

- Discharge

- Referral to community services, e.g. GP/other
- Electronic Prescription

Escalate to a more senior clinician, e.g. doctor

CHIE: A record of all consultations and agreed actions will be recorded on CHIE, along with any new or updated ReSPECT forms. If your care home does not have access to CHIE (yet) the service can email a record of the consultation and ReSPECT form to the care home's NHS.net.
Care Home COVID 19 Deterioration Prevention Pathway

Resident condition deteriorating – (Soft signs of deterioration)

Assessment

Take observations and consider soft signs, News2/RESTORE, with knowledge of Treatment Escalation Plan (RESPECT/ACP) if available

**MILD**

- **O₂ Sats 95%* or higher**
- Or any of Resp Rate ≤ 20, Pulse ≤ 90 = NEWS2 0-2
  
  *≥86% if baseline sats of 88%

- Check RESPECT/ACP

**MODERATE**

- **O₂ Sats 93-94%**
- Or any of Resp Rate 21-24, Pulse 91-130 = NEWS2 3-4

- *84-86% if baseline sats of 88%

- Check RESPECT/ACP

**SEVERE**

- **O₂ Sats 92%* or lower**
- Or any of Resp Rate ≥ 25, Pulse ≥ 131, new confusion

- ≈ NEWS2 ≥ 5

- *<84% if baseline sats of 88%

- Check RESPECT/ACP

---

**COVID Symptoms ranked by severity**

- **BREATHLESSNESS**
  - Myalgia
  - Chill
  - Severe Fatigue

- Sputum
- Dizziness
- Cough
- Nausea/vomiting
- Diarrhoea
- Headache
- Sore throat
- Nasal Congestion
- Loss of taste/smell

---

**Key decisions**

- Key information
- Escalation
- Communication
- Re-escalation

---

Contact Telemedicine/GP* if concerned or require support

**UTI**
- Chest pain
- Trauma ?fracture
- Trauma Neck
- Trauma head
- Stroke
- Decreased oral intake
- Breathlessness
- Sepsis
- Delirium
- EoL
- Skin
- Falls

---

**UTI**
- Chest pain
- Trauma ?fracture
- Trauma Neck
- Trauma head
- Stroke
- Decreased oral intake
- Breathlessness
- Sepsis
- Delirium
- EoL
- Skin
- Falls

---

**COVID Symptoms ranked by severity**

- **BREATHLESSNESS**
  - Myalgia
  - Chill
  - Severe Fatigue

- Sputum
- Dizziness
- Cough
- Nausea/vomiting
- Diarrhoea
- Headache
- Sore throat
- Nasal Congestion
- Loss of taste/smell

---

**Key decisions**

- Key information
- Escalation
- Communication
- Re-escalation

---

Contact Telemedicine/GP* if concerned or require support

**UTI**
- Chest pain
- Trauma ?fracture
- Trauma Neck
- Trauma head
- Stroke
- Decreased oral intake
- Breathlessness
- Sepsis
- Delirium
- EoL
- Skin
- Falls
Telemedicine Service for Care Homes

What is the Service?
Telemedicine is a service allowing assessment and clinical support of residents using teleconferencing, when the clinician and resident are not physically in the same place.

Information for care home staff
The Telemedicine Service Pat

Concerned About Resident?

Before
Answers
Check if

Call

West Hampshire
Clinical Commissioning Group

Care Home Telemedicine Service: Frequently Asked Questions
This is a live document and will be updated on a regular basis with frequently asked questions about the Hampshire Hospitals Foundation Trust Telemedicine Service.

TELEMEDICINE

1. What are the benefits to the system in using a telemedicine service?
QI Approach

deterioration on pathway -

Plan

Act

Do

Study

Clinical observations

Equipment

Prescribing

Workforce

Lifelight

Andover War Memorial Hospital
Basingstoke and North Hampshire Hospital
Royal Hampshire County Hospital
Logic Model: Care Home Telemedicine Support Service in Hampshire & Isle Of Wight

In this CONTEXT

With increasing pressure on secondary care, a new tele-conferencing service is planned between care homes and acute hospitals, to facilitate the assessment and treatment of deteriorating patients in their care home whenever possible, or return patients requiring hospital services to their care home as soon as possible.

<table>
<thead>
<tr>
<th>INPUTS</th>
<th>ACTIVITIES</th>
<th>OUTPUTS</th>
<th>OUTCOMES</th>
<th>IMPACTS</th>
</tr>
</thead>
</table>
| • Funding from Hampshire & IOW STP  
• Video conferencing facilities at all sites  
• Training  
• 24/7 technical support  
• Adequate internet connectivity in care homes  
• Staff to host including Band 4 to triage  
• Care homes to attain ‘Entry level’ as a minimum on the DSP Toolkit  
• Prescribing rights for hospitals  
• Use of RESTORE2 and ReSPECT in all care homes  
• Alignment with existing services | • Video conference calls between care homes and acute hospitals as an alternative to GP, Out Of Hours (OOH), 111 or 999  
• Acute hospitals remote prescribing medications using nearest open pharmacy  
• Creation and improvement of ReSPECT forms  
• Creation of treatment plans  
• Facilitation of onward referrals to other services | By care home;  
• Number of video conference calls  
• Number of video conference calls where RESTORE2 wasn’t used  
• Number of medications prescribed by the acute hospital  
As a result of video conference calls;  
• Number of ReSPECT forms created and amended  
• Number of treatment plans created  
• Number of onward referrals facilitated  
• Number of ambulance conveyances  
• Number of unnecessary ambulance conveyances avoided | • Improved communications between care homes and acute hospitals  
• Upskilling of staff in care homes and improved staff satisfaction and confidence  
• Improvement in ReSPECT forms (completeness)  
• Reduced Out Of Hours (OOH) calls and visits  
• Reduced 111 and 999 calls  
• Reduced number of unplanned GP call outs to care homes  
• Reduced ambulance attendances  
• Reduced ambulance conveyances  
• Reduced ED attendances  
• Reduced emergency admissions  
• Reduced deaths in hospital  
• Reduced Delayed Transfers Of Care (DTOC)  
• Reduced time in hospital (ED & in-patient)  
• Reduced touchpoints and duplication in end to end pathway  
• Increased number of patients managed and treated in care home setting  
• Increased specialist palliative care activity  
• Possible impact on community nursing activity  
• Reduced care home re-assessments  
• Improved patient experience and outcomes | • Reduced ambulance conveyances  
• Reduced ED attendances  
• Reduced emergency admissions  
• Reduced deaths in hospital  
• Reduced Delayed Transfers Of Care (DTOC)  
• Reduced time in hospital (ED & in-patient)  
• Reduced touchpoints and duplication in end to end pathway  
• Increased number of patients managed and treated in care home setting  
• Increased specialist palliative care activity  
• Possible impact on community nursing activity  
• Reduced care home re-assessments  
• Improved patient experience and outcomes |
Care Home Engagement and ED attendance/hospital admission

184 calls to date

CH's Target (107) vs CH's Achieved (44)

Did the call prevent an unnecessary hospital admission?
38 calls *did* prevent
(average of 3 preventions a week)

Did the call prevent an unnecessary ED attendance?
71 calls *did* prevent
(average of 6 avoidances a week)
Call Coding

- UTI (suspected)
- Skin complaints
- General deterioration
- Falls
- Chest infection (suspected)
Outcome of call

- OTM01: Admission (12%)
- OTM03: Discharge (23%)
- OTM04: Community Nurse referral (4%)  
- OTM05: Follow up call by Telematics (10%)
- OTM06: GP follow up routine (3%)
- OTM08: Medication Prescribed (7%)
- OTM11: Palliative care/EOL (5%)
- OTM12: SCAS Practitioner (1%)
- OTM13: Other (4%)
- OTM07: Other (1%)

Andover War Memorial Hospital
Basingstoke and North Hampshire Hospital
Royal Hampshire County Hospital
Require a prescription?

- Yes: 34%
- No: 66%

Did the call prevent a SCAS or GP contact?

- No: 61%
- Yes: 39%
Care Home Telemedicine Support Service in Hampshire and Isle of Wight

In the first three months:

- 184 cases
- 71 prevented department attendances
- 38 prevented hospital admissions
- 21 patient has been transferred into an acute setting, everyone else received support with their clinical condition or advice about medication.

Quality Improvements:

- Improved communications between care homes and acute hospitals.
- Upskilling of staff in care homes and improved staff satisfaction and confidence.
- Improvement in RMoSECT forms (completeness).
- Reduced Delayed Transfers Of Care (DTOC).

Outcomes:

- Prevented admissions to and deaths in hospitals.
- Prevented ED attendances and emergency admissions.
- Prevented number of unplanned GP call outs to care homes.
- Avoided ambulance attendances.

- Reduced 111, 999 and Out Of Hours calls and visits.
- Increased care given in the patient's care setting.
- Reduced pathway touchpoints and duplication.
- Improved patient experience and outcomes.
Challenges

• Workforce
  – Long term workforce solutions once shielding workforce are no longer available
  – How to recruit to the team without destabilising other ICP based Urgent and Emergency Care services

• Existing acute prescribing process, not fit for purpose

• Communication and Engagement hindered by large geography, multiple organisational partner landscape

• Variable Care Home Utilisation

• Ability of Care Homes to take Clinical Observations

• Benefits realisation and understanding of system savings
Next Steps and Future plans

• Proactive support to Care Homes via Primary Care Network based Care Home MDTs
• Develop a Hampshire and Isle of Wight system approach
• Opportunities in relation to Teletriage and Rehabilitation of residents in their home environment
• Focus on preventative and proactive care esp. if coupled health monitoring apps and Care Home MDTs
• Learning and training platform
• Utilising a strength based approach to problem solving
  – we became more agile and co-produced solutions to enable fast paced transformation for local problems
  – working this way developed strong multi-partner relations that will act as a spring board for phase two transformation
Thank you for your time
Healthy Ageing Programme
Telemedicine for Care Homes – Strategic scoping and implementation guides
Cheryl Davies Programme Manager
16 July 2020
What has changed?

- Roles
- Working relationships
- Use of technology
- Working patterns
- Working location
- Behaviours

What is the innovation?

- Live operational ‘how to’ guide
- Built on real life experiences in a live setting, identifying best practice approaches in the form of case studies
- 2 easy to access guides developed in collaboration with West Hampshire CCG and Hampshire Hospitals NHS Foundation Trust
- System wide scoping and implementation framework for STPs, CCGs, ICS’ to consider when developing a telemedicine service for care homes – a blueprint for service development
- Bite size sections for your steering group to action
- Links to a range of resources to help you build an exemplar service
- Can be used with other implementation frameworks
Why did we develop the guide and why is it different to other strategic documents?

- Lots of different telemedicine approaches across the UK emerging but no standardised approach in developing the supporting infrastructure across systems
- Wanted to create a go to guide to maximise impact on the care home system
  - What do care homes need to do?
  - How do you know if they are digitally ready?
  - What training and support do they need?
  - How will you measure the impact on the system?
- As a network, working with system leaders we wanted to capture a best practice for scoping and implementing telemedicine for care homes as there are different aspects to consider before go live
- This approach has enabled learning and experiences to be shared and showcased via real life case studies so colleagues recognise and relate it to their practice
What do the guides include?

- Digestible chapters to match your workstreams
- Visual prompts to help you track your journey
- Hints, tips, best practice approaches and frameworks
- Real world validation case studies
- Linked resources

Contents

1. Introduction
2. Case study: Benefits
3. Service and activity
4. Evaluation
5. Communication and engagement
6. What next
7. Contributions

Digital

"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

Resources to support development and delivery of telemedicine services

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 as a signpost to useful websites:

Telemedicine for care homes models

- Airedale NHS FT
- Hampshire
  - https://bit.ly/2UEsFOh

Anticipatory care planning

- ReSPECT
- ACP for residents with dementia
- Gold standards framework
### Best Practice Resource pack

Downloadable tools including digital scoping template, Care Home readiness checker and example evaluation questions.

**Telemedicine Resources**

<table>
<thead>
<tr>
<th>Name of resource</th>
<th>Type of resource</th>
<th>Brief summary of resource</th>
<th>Developed by</th>
<th>Online link</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training Information for Care Homes</td>
<td>Downloadable poster</td>
<td>A group of care home researchers from two National Institute of Health Research Applied Research Collaborations (NIHR ARC) responded to a request for support from Care Home Managers for information about eight topics relevant to care home staff during the pandemic.</td>
<td>National Institute of Health Research</td>
<td>[<a href="https://arc-go.nihr.ac.uk/covid-19-projects-announcements">https://arc-go.nihr.ac.uk/covid-19-projects-announcements</a> and information/covid-19-resources-training-information](<a href="https://arc-go.nihr.ac.uk/covid-19-projects-announcements">https://arc-go.nihr.ac.uk/covid-19-projects-announcements</a> and information/covid-19-resources-training-information)</td>
</tr>
<tr>
<td>Restore2™</td>
<td>Web page with downloadable resources</td>
<td>Comprehensive set of resources developed by Wessex AHSN Patient Safety Collaborative and West Hampshire CCGs, including downloadable information, videos and guidance.</td>
<td>Wessex AHSN – Patient Safety Collaborative</td>
<td><a href="https://wessexahsn.org.uk/projects/329/restore2">https://wessexahsn.org.uk/projects/329/restore2</a></td>
</tr>
<tr>
<td>Telemedicine for Care Homes</td>
<td>Webpage</td>
<td>Summary of Hampshire Hospitals Foundation Trust and West Hampshire CCGs Telemedicine Service</td>
<td>Wessex AHSN</td>
<td><a href="https://westhampshireccg.nhs.uk/telemedicine-for-care-homes/">https://westhampshireccg.nhs.uk/telemedicine-for-care-homes/</a></td>
</tr>
</tbody>
</table>

**Frequently Asked Questions**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Telemedicine for Care Homes: A Strategic</td>
<td>Downloadable resource</td>
<td>A resource for Sustainability Transformation Partnership (STPs), Integrated Care Systems (ICS) and Clinical Commissioning Groups (CCGs)</td>
<td>Wessex AHSN</td>
<td>In development – launching late July 2020</td>
</tr>
</tbody>
</table>

Includes a frequently asked question guide.

Dynamic links to exemplar information.

Variety of resources to help you scope and implement approach.
Feedback

As an operational manager, I would have been delighted to be given a guide like this! It tells me everything I need to consider when setting up a telemedicine service.

Really easy to use and follow – the visuals and case studies really bring the guides alive.

I think it is very comprehensive and if people follow those steps, they won’t go far wrong!

Healthyageing@wessexahsn.net
What has changed?

- Roles
- Working relationships
- Use of technology
- Working patterns
- Working location
- Behaviours
- Decision making

Where can I find out more?

- Guide launched by end of July 2020 – final touches and updating with emerging new resources
- We will send you a personal copy
- Once live, tweet and share widely and share your experiences!

@wessexageing

#Telemed4CareHomes
Panel Discussion
Next steps and Close

• Recording will be available as a downloadable resource
• Presentations will be available
• Review of questions not answered today and responses compiled as part of event summary feedback
• Please do contact presenters for further information and details
• Development of online NHS Future Platforms forum to share best practice
Telemedicines
Information sharing event