

case study



Sector: Health

Client: NHS Doncaster and Doncaster MBC

Application: Mainstreaming
Telehealth

the challenge

Long-term conditions like COPD, heart failure and diabetes account for most of the emergency hospital admissions in Doncaster. Improving the management of these illnesses in the community will help reduce the number of unplanned admissions and improve the prioritisation of health resources.

Condition	Number of people in Doncaster
Diabetes and Mellitus	14,989
COPD	7,637
Heart Failure	3,139

Source: QOF 2008/09

Life expectancy is set to increase in Doncaster over the next 10 years and we expect to see the number of people aged 65 and over increasing from nearly 50,000 to around 62,000. A corresponding increase in the number of people with long-term conditions is expected, as the prevalence increases with age.

How did NHS Doncaster determine their strategy for managing the above and how is telehealth keeping people healthy and providing support to those who need it?



“Our aim is that people should be ‘living with’ rather than ‘suffering from’ their condition or conditions. New telehealth technology will help our frontline staff to care for patients better, but of equal importance is that it will improve the quality of life of patients and help them become more independent.”

Dr Kevin Lee GP and clinical lead for long-term conditions from NHS Doncaster



"A key factor is that the equipment is helping us to keep a watchful eye over everyone but freeing up more time to concentrate on those patients who need extra help. It doesn't take away the personal contact but means we can target our resources when and where they are most needed." Mags Dowie, Community Matron

telehealth in Doncaster

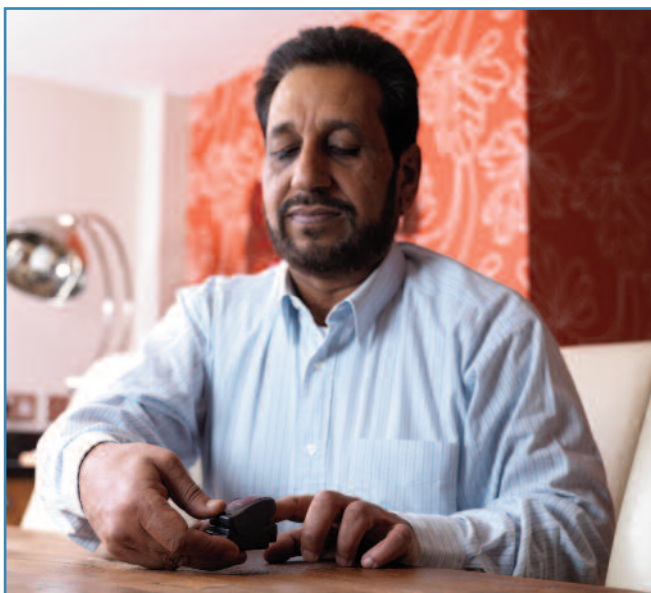
NHS Doncaster has invested in 180 telehealth systems which are being installed between March 2010 and March 2012.

Through the introduction of telehealth in the community, the aims are to:

- Reduce the number of **unplanned admissions** for patients with long-term conditions
- Improve patients' **quality of life** and the lives of their carers
- Ensure support can be provided at an **early stage** when needed
- Enable clinicians to **prioritise visits** and manage case loads more effectively

The service will operate under existing community nursing cluster teams in Doncaster as part of the Integrated Community Care Pathway (ICCP).

For COPD (chronic obstructive pulmonary disease), telehealth will be used by community matrons to assist with the long term case management of COPD patients and for CHF (chronic heart failure), telehealth will be used by Heart Failure Specialist Nurses to observe patients with the condition following hospital discharge to prevent readmission to hospital.



key objectives

for NHS Staff

- Improved prioritisation of community nursing visits
- Prioritisation of clinical case loads based on clinical need
- Increased support for patients who are at risk of hospital admission
- A reduction in unplanned hospital admissions and A&E attendances
- Reduced number of community nursing visits for patients using telehealth machines
- Reduced length of stay through facilitation of early hospital discharge
- Reduction in hospital readmission rates

for patients

- Improved self management
- Increase in confidence in managing their condition
- Reduced condition related anxiety and depression
- Reduction in unplanned hospital admissions
- Improve patient's quality of life





Vera is one of the first to benefit from telehealth in Doncaster

The challenge

Vera has serious chest problems and needs a round-the-clock supply of oxygen supplied from an oxygen concentrator. She is constantly anxious about her condition.

Solution

Vera was provided with a telehealth system which enables her to monitor her vital signs at home rather than having to go to her doctors or needing a nurse to visit. Telehealth enables her to keep contact with local nursing staff and helps her stay out of hospital.

How does it work?

Every weekday, at a pre-set time, the **my**medic unit alerts Vera that it is time to conduct her health interview. The **my**medic health interview guides Vera using its clear text display and pre-recorded voice announcements, through a series of self checks of her blood pressure, temperature and oxygen saturation levels. The results are then automatically sent to Vera's community nursing team for assessment via the telephone line.

Outcomes

Vera says *"It's so easy and a man with a lovely sounding voice talks me through the whole process and tells me exactly what to do. He asks me questions like 'Is my breathing any worse today than normal?' and I then press the yes or no button depending on my answer. It's reassuring to know that the NHS is keeping an eye on me to prevent anything going wrong."*

The daily 'MOTs' of Vera and patients with a variety of incurable conditions are then checked by health workers like community matron Mags Dowie, using a



secure web link and password. The system provides an early warning of potential changes in a patient's condition so action can be taken to avoid an emergency hospital admission.

"The self-checks are quick and simple to do and help patients to take greater control over managing their own health. Working with Tunstall, we have been able to tailor the units to suit patients with different conditions."

Telehealth is enabling us to see from a distance when health problems are starting to escalate so we can help patients like Vera manage how to deal with it. This includes, for example, advising her when to take antibiotics. We also liaise with the patient's family doctor when we need additional advice."

A key factor is that the equipment is helping us to key a watchful eye over everyone but freeing up more time to concentrate on those patients who need extra help. It doesn't take away the personal contact but means we can target our resources when and where they are most needed."

Mags Dowie, Community Matron

For further information
please call 01977 660206



next steps

Telehealth will be evaluated every six months to determine the impact that the service is having on people with long-term conditions.

NHS Doncaster are working closely with Doncaster Metropolitan Borough Council to make the **links between telehealth and telecare** and ensure that alongside telehealth, telecare can also be used to improve patient experience and offer carers peace of mind.

The heart failure specialist nurses are planning to use telehealth as part of a project to help patients manage their heart failure as soon as they come out of hospital.

The model that the team currently use has been shown to reduce readmission to hospital and improve quality of life. Using telehealth alongside this usual service will help to monitor their patients more closely and they are hoping to extend its use to more people over the coming months.

Feedback so far has been very positive with patients reporting that they feel more in control of their condition and have increased confidence knowing that a nurse is keeping an eye on their condition more regularly.

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Tunstall Healthcare (UK) Ltd, Whitley Lodge, Whitley Bridge, Yorkshire DN14 0HR
Tel: 01977 661234 Fax: 01977 662450 Email: enquiries@tunstall.co.uk

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