

REVOLUTIONISING HEALTHCARE: Expanding Remote Health Monitoring across BLMK

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In a stride towards enhancing healthcare accessibility, a successful Remote Health Monitoring (RHM) pilot initiated by Cambridgeshire Community Services NHS Trust (CCS) in early 2021 set out to transform healthcare services across Bedfordshire, Luton, and Milton Keynes (BLMK). The ambitious project, boasting partnerships with Central and Northwest London NHS Trust (CNWL) and East London Foundation Trust (ELFT), aimed to revolutionise patient care. By harnessing user-friendly RHM technology, provided by tech innovators Doccla, patients can now receive personalised care within the familiar confines of their homes.

UNDERSTANDING THE PROBLEM TO DEFINE THE GOAL AND IMPLEMENT CHANGE

This initiative came in response to a pressing challenge. The healthcare system is under strain due to a burgeoning population, leading to a scarcity of clinical time for patients in critical need. Community staff are spending valuable clinical time travelling between patients' homes to complete general health observations or deliver equipment. At CCS we recognised the need to bridge the gap, ensuring timely and efficient healthcare interventions.

OUR THINK QI APPROACH

DEEP DIVE:

Shared learning from pilot... we were able to share outcomes, lessons learnt and pathway insights that were developed in the CCS pilot which helped other providers understand where they could make improvements by implementing RHM pathways.

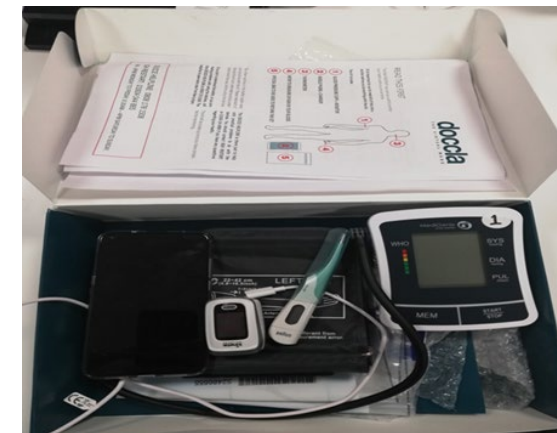
Engagement and system working... a stakeholder group was formed where we could agree milestones, make decisions collectively and break down any barriers.

Co-production... We encouraged clinical teams to learn from each other and share what was working well as well as providing shadowing opportunities. In addition, we met with patients throughout the project to collect feedback and identify further areas for improvement.

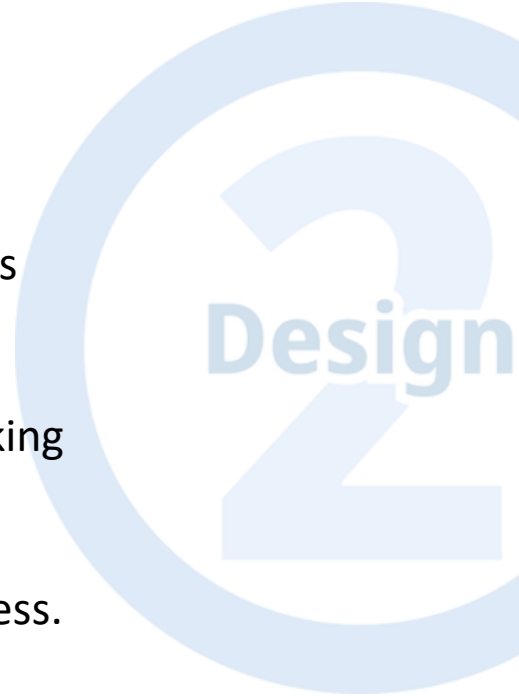
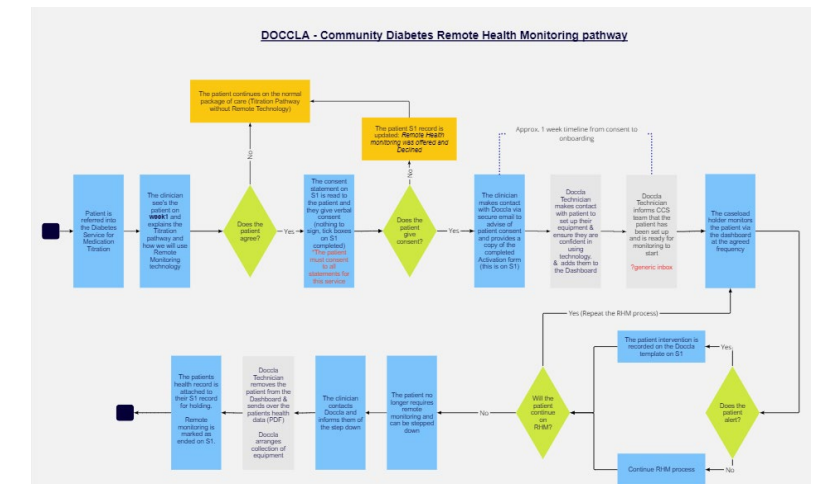
DESIGN:

We wanted to ensure that the RHM pathways were being implemented to enhance current ways of working. All clinical teams had a say in how pathways would be delivered in their service area and so each pathway was co-designed with them, and they were reviewed at regular points to ensure they were working for them.

Doccla adapted well to changes and often produced new solutions if we are unsure of how best to progress. To encourage use of the pathways we implemented named champions within clinical teams that were able to drive the RHM work.



- RHM Kit:**
- Smartphone
 - BP Machine
 - Pulse Oximeter
 - Scales
 - Thermometer
 - Instruction Manual



DELIVER:

The work to expand RHM Pathways across BLMK started in October 2021 and ran for 18 months. We aimed to have a minimum of 350 patients on a RHM pathway with a potential of up to 950 patients at any one time. Through this time, we built strong stakeholder relationships with ELFT & CNWL, we conducted multiple focus groups with our patients and the relationship with our tech provider became invaluable.

- **Roles & Responsibilities:** We agreed key roles across BLMK to ensure we were well joined up. This involved Doccla recruiting a Project Manager that would play a pivotal role in bringing all three Trusts together to share learning and agree outcomes.
- **Innovative Care and Support:** Multiple new RHM pathways were implemented across BLMK, including Heart Failure, Respiratory, Hypertension and Diet Screening to name a few.
- **Addressing language barriers:** With over 150 languages spoken in Luton, we worked with Doccla to translate literature in the top 5 spoken languages as a starting point.
- **Patient engagement:** We regularly sought feedback from our patients by way of quarterly and post discharge surveys. In addition, we held multiple focus groups both in person and virtually that were led by our co-production team to capture lived experiences and to help breakdown any unknown challenges.
- **Comprehensive resources:** We developed a robust Standard Operating Procedure (SOP), templates and literature to support teams and our patients.
- **Branching out:** We were able to start working with our primary care networks to implement GP led RHM pathways.

OUTCOMES:

441

PATIENTS WERE equipped with RHM equipment

220

LESS DAYS IN HOSPITAL

16.5%

REDUCTION IN HOSPITAL ADMISSIONS

BENEFITS/SUCCESSSES:

- Patients are equipped with remote health monitoring technology: **441**
- Patients are self-managing and take ownership of health condition: **95%**
- Improved patient convenience and peace of mind: **75%**
- Reduction in Hospital admissions: **16.5%**
- Reduction in A&E attendances: **16.2%**
- Reduced length of stay in acute setting: **220 Days**

System costs:

A typical A&E attendance costs approx. £200 per patient.

A typical Hospital admission costs approx. £400 per patient.

The total saving to the system (based only on the CCS data as reported): **£175,520.**

The savings to the system made by CNWL and ELFT have not yet been reported, so we are unable to show the full project activity.

LESSONS LEARNT:

- **Data Collection:** The data collection across all three providers has been hard to obtain. There have been many benefits such as time saving that cannot be quantified in real time or as a cost saving. We believe earlier work with the analytic teams across all partners along with system1 experts could have helped this.
- **Resource Investment:** We underestimated the amount of clinical resource we would need to build pathways. This caused some delays and pressure on the clinical teams who were facing winter pressures and other system demands.
- **Small Pilot:** It worked well starting off with a small pilot (100 units), we were able to identify outcomes with a small cohort to then expand on these and rollout across the ICS.
- **Hands-on approach:** The project team were very involved with the clinical teams. This helped to strengthen relationships even further, make changes swiftly and hear real-time feedback and suggestions.

EVOLVE:

Further development of pathways will be led and rolled out by our Senior Clinical Lead for Frailty with work well underway to implement a High Intensity User pathway that will work as a central monitoring hub for this caseload.

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