SIAN JONES: AN EXPLORATION OF THE LARGE SCALE IMPLEMENTATION OF TELEHEALTH MONITORING IN BRISTOL

This tale starts in 2010 when Bristol PCT, Primary Care Trust, as the commissioning organisation, was at the time were thinking about how to set out some firm foundations for the future in response to significant challenges. And these challenges included the increasing older population with a greater number of comorbidities. We were keen not to be tweaking around at the outside of this but we had to really take everything in our hands and go forward with a high degree of ambition and, at the time, also we were starting to think about technology and innovation and how we could do things differently, but up against that were also challenges and thoughts around the cost. How much is it going to cost us to introduce technology to support patients and health care and what would the return on investment be and what are the outcomes and the benefits that we might see from this? Would it be something that we really wanted to do?

It was difficult because the evidence base was so inconclusive but anyway, despite that, we managed to put together a very successful business case which was based on the evidence that was made available to us and also talking to people around the country and finding out what they were doing and we went through a lengthy procurer process and awarded the three year contract to Safe Patient Systems. We chose COPD and heart failure because at the time that’s where the greatest evidence base was.

Our aim was to implement or deploy 600 units across Bristol within a very tight timeframe with an expectation that we’d start to see outcomes and improvements within that same year and that included significant savings. We had decided that our approach should be to provide Telehealth to our community nursing teams, it would be a tool for them to manage patients in the community, these patients that are case managed so more complex, at greater risk of admission and they would use Telehealth as a tool so when they had referrals made to them Telehealth would be one of the interventions they would consider in their management.

We expected to see a reduction in unplanned admissions and also in contact with primary care and we were also very keen to see how this might affect the way that community staff worked as well and we were keen to see an increase in their productivity.

The ride became slightly bumpy and the challenges started to emerge. We wanted to be sure that the solution, technology was out there embedded into the community, being used with patients as soon as possible because we wanted to see benefits come through as quickly as possible. So our approach was very much around that term deployment and about pushing out the kit and Safe Patient Systems worked with us to set out a rigorous project structure to support this, but when we pull in the community services to work with us, the third leg of our stool, that’s when things started to get a little bit rockier because of course a rigorous project structure doesn’t really fit very well with the less predictable clinical side.

The other issue that we were facing was that our community services were actually going through an organisational restructuring. So in some ways you could think of that as being a positive because we could start to weave in Telehealth in to the new structure but because commissioners hadn’t actually set up a very effective engagement and communication plan in the run up to this initiative the community services were just heads down focusing on their organisational restructuring. It was also starting to get all of us to think about the way the nurses were working and how technology
might change that way they might work and we had recognised that there was quite a paternalistic approach to the care where nurses...well both patients and nurses...had an almost mutual dependence on each other and there was this checking just in case type of behaviour going on where the nurses would be contacting and popping in to see how the patient was doing and clearly technology, this telehealth was going to come in between that because we wanted to reduce the amount of contacts and use remote monitoring as a replacement there.

There were the three different cultures and because this had been a very rushed initiative there was very little time to sit back and reflect on those cultures and how we should work together, recognise the differences and work together more effectively.

The pressure was huge to deliver, to deploy all these 600 units in a very tight timeframe to get the benefits that we anticipated and the nurses resisted again because of the fear of increasing workload and we hadn’t engaged with primary care so the recruitment was very much down to community nurses and there was more that we could have done to engage with primary care who weren’t really involved and as we were pushing patients on and getting them set up on telehealth we hadn’t really thought beyond that in terms of ‘well, what’s our process for monitoring them to be sure that they’re getting on with it once they’re on there and then what’s the process for discharging them?’

So we knew then that after several months, we thought we’ve just got to do something about this. The tension between three parties was getting quite intense. So what we did initially was to start to review this idea of deployment and pushing for getting patients established on telehealth and we started to settle it down a bit, make it more open and engaging with the clinicians around selection and looking to see how telehealth can support care, but early on we recognised that there were some staff who were very much engaged and they were very useful in supporting their peers to get involved, sharing their experiences and learning and trying to engage with these other staff, but this was taking quite a bit of time out of their clinical role. So it was actually Bristol Community Health who had the idea to invest a bit of additional resource to back Phil, a community matron, who then became the champion community matron for telehealth and spent her time then doing much more proactive engagement and running workshops and identifying links in the three localities across Bristol.

Around about probably about twelve months actually after we started this the telehealth support team was established and they are there to support patients in getting used to the equipment and to troubleshoot and to resolve any technical issues and to be a liaison between the clinical staff and also with Safe Patient Systems as well.

It took about 18 months to turn a corner from the beginning of going down this route until we actually started to feel that Telehealth was becoming embedded and we just felt like everything was starting to settle down and it was at that point where we started to look to see what was actually going on. So we did an early evaluation during 2014 and we’ve just...sorry, 2013, and we’ve just built on that now.

So all along the patients have been overwhelmingly positive about telehealth and they’ve used words like reassuring and how it’s provided peace of mind to them.

We’re seeing this as a tool to support self-management and we’re measuring empowerment using the LT6 survey and we’ve seen some increase in that since using telehealth.
Considering the nurses were a very mixed bag in terms of engagement and support of this it’s really satisfying to see now such positive feedback coming from them and positive experience and we recognise, as I mentioned earlier, this paternalistic and mutual dependency between the nurses and the patients and actually the contacts have reduced yet despite that the nurses and patients are both expressing positive experiences of Telehealth. We’re interested to see that GP practice contacts have reduced and the longer the patient is on Telehealth the fewer contacts that they make with their practice.

The people involved in setting up this Telehealth initiative are people with long experience working in the NHS, understand about change, have worked in change, have had service improvement roles, yet it suddenly went all out of our heads this idea of what change management is all about. We didn’t assess the readiness for change, we didn’t actually take forward any of the knowledge that we had we just went bombarding straight into this idea that we must deploy these units and we must get them out into the clinical setting and there was just this desperation that we had to start to see outcomes as soon as possible and the focus was very much on this deployment. So our learning from that is very much around thinking about incremental implementation and assessing the readiness for change. All of this is common sense but I’m highlighting it because even though we have this experience we still fell flat on our face.

I can’t say that the tale has ended with us all being happy ever after but we’re looking forward to the outcome of the next twelve months and then that will enable us to see where this journey will take us next. So thanks for listening and I’ll take any questions later, thank you.

Great, thank you very much.