case study

Sector: Health	**Application:** Telehealth - Managing Long Term Conditions
Client: Leeds Primary Care Trust	

the challenge

Leeds Primary Care Trust (PCT) was created on 1 October 2006, following the merger of Leeds North West, Leeds West, Leeds North East, East Leeds and South Leeds PCTs.

The PCT is responsible for ensuring that the people of Leeds have access to the health services they need, along with directly providing a wide range of community-based services across the city.

Like many other areas in England, people in Leeds are facing ever increasing health problems which can put a strain on local resources in terms of both time and associated costs.

Key statistics for Leeds:

- The average length of stay in hospital for a Chronic Obstructive Pulmonary Disease (COPD) patient is 8 days
- The estimated cost of an acute episode (exacerbation) for a person with severe COPD ranges from £1,400 to £1,600
- COPD counts for 1 in 8 medical admissions
- National, chronic illnesses cost accounts for approximately 65% of all healthcare annual expenditure

Focussing on COPD patients, Leeds PCT is utilising Tunstall's latest telehealth technology to monitor patient health and help the individual and their carers to develop the knowledge, skills and confidence to care for themselves and manage their condition effectively.

All the reassurance you need

Tunstall

Over the six month period the Nursing Team saved approximately 55 nursing visits

the project

Aims

The telehealth pilot began in October 2006 with the following aims and objectives:

- To improve the quality of life of patients with long term conditions in Leeds
    - Reduction in anxiety levels by promoting independence and increasing patient knowledge of their own condition
- To reduce unplanned emergency hospital admissions for COPD patients
- To reduce the length of stay in hospital for COPD patients, whilst increasing capacity
- To assist in case management, whilst reducing workload burden and allowing effective case management of large patient case loads
- To achieve budgetary savings
- To encourage partnership working

Background

The Respiratory Team at Leeds Primary Care Trust provide their service to adults who are diagnosed with COPD. The team is multi disciplinary and areas of service delivery include: hospital environments, community settings including the patient's home, community centres and GP surgeries.

The project supports the Government's policy and strategic objectives in Health and Social Care, by assisting with reduction of the length of time people with COPD need to stay in hospital, keeping people independent in the home and making improvements in long term conditions disease management.

Project Design

This telehealth project used Honeywell HomMed Genesis monitors to remotely measure patients' vital signs. The monitors were installed by the Specialist COPD Nursing Team in patient's homes. The team were also responsible for technological support and the removal of the telehealth equipment.

Referral Process

A specialist COPD Nursing Team was responsible for receiving referrals to the service and for the initial assessment of the patient. Referrals to the service are taken from a wide range of health professionals, e.g. GP's, including those which result from patients presenting to A&E, through the Early Discharge Scheme and supported discharge.

"The team were great, informative, brilliant and first class."

"It reassured me knowing the Respiratory Team was there for me."

"A good idea and it should expand to other patients."

Monitoring and Response

The patient's condition is monitored daily at a time convenient to them. The COPD Nursing Team knows when to expect the observations and check to see if they fall within per-determined parameters, via a 'traffic light' system. If the vital sign readings give rise for concern, the COPD Nursing Team will telephone the patient to make sure they are alright and either ask them to take their readings again or arrange for an appropriate response (GP or ambulance for example). The COPD Nursing Team will fax reports through to the Consultant or GP (e.g. in the event of the patient's hospitalisation).

Any cause for concern is followed up by the COPD Nursing Team, who may bring forward any scheduled visit as necessary. Other responses may include one or more of the following: advice over the telephone, advising the patient to rest or take some other restorative action and repeat the observations after an agreed period of time (usually 20 minutes); a home visit by the COPD Nursing Team or the patient's GP. They are able to refer patients for additional support services where appropriate to do so.

It was important that the patients did not become reliant on the 'full-time' use of the home monitoring technology. Once a patient had stabilised their chronic condition and become better educated on the importance of medication regimens, exercise, diet etc., the equipment was moved to another high-risk patient. This was normally after 2 months. This was made clear to the patient when joining the project and the patient signed a consent form to say they agreed to this.

Once discharged from the project, patients were asked to complete a feedback form to allow the team to gain valuable insight into the patient's experiences of the telehealth monitors.

conclusions and next steps

The initial 6 month project which began in October 2006 has received considerable praise from patients who felt reassured knowing that if they felt unwell, help was close at hand.

Vicky Walker, Clinical Lead for Respiratory Services said:

"I have to say the patients think it is fantastic - they have amazed me with how much they appreciate the equipment. They even dust it."

Patients involved in the pilot said:

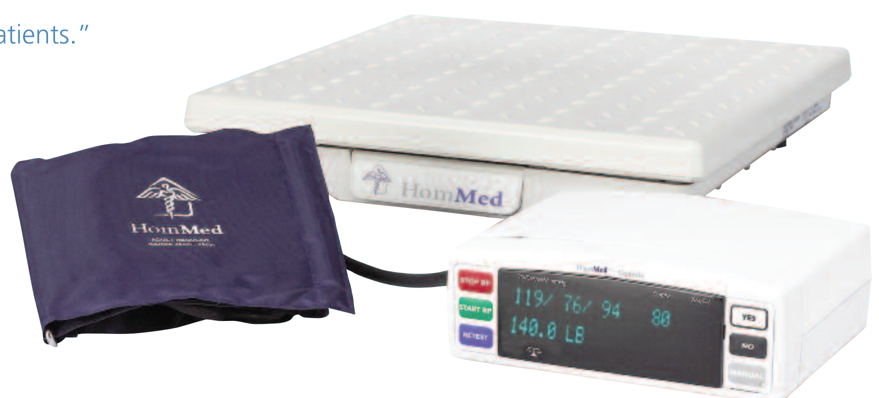
"The team were great, informative, brilliant and first class."

"It reassured me knowing the Respiratory Team was there for me."

"A good idea and it should expand to other patients."

Over the six month period the Nursing Team saved approximately 55 nursing visits.

Leeds PCT is thrilled with the results of the project and is hoping to roll out another pilot for heart failure patients and patients under the care of the Community Matrons.



For further information please contact marketing on 01977 660206

complete confidence - total reassurance

Tunstall is the world's leading provider of telecare and telehealth solutions, supporting older people and those with long-term needs to live independently, by effectively managing their health and well-being.

Established in 1957 and based in Yorkshire, Tunstall provides a complete end to end solution, from installation through to service and maintenance.

- We lead the market in the quality and reliability of our hardware, software and systems integration
- We work in partnership with a wide range of organisations to provide essential telecare and telehealth services
- We are committed to providing excellent customer service and support
- We can provide bespoke solutions that draw on our expertise and resources
- We are constantly innovating, developing and delivering new solutions to meet the changing needs of a changing population

Tunstall

www.tunstallgroup.com

Tunstall is a founder member of the Continua Health Alliance

Our policy of continual development means that product specification and appearance may change without notice. Tunstall does not accept responsibility for any errors and omissions contained within this document.

© 2008 Tunstall Group Ltd. ® TUNSTALL, LIFELINE and AMIE are registered trademarks.

A member of the Tunstall Healthcare Group

Tunstall Group Limited, Whitley Lodge, Whitley Bridge, Yorkshire DN14 0HR
Tel: 01977 661234 Fax: 01977 662450 Email: enquiries@tunstall.co.uk

150/6/07