

Care Navigation/Telehealth Care Services: South West Yorkshire Partnership NHS Foundation Trust

Telehealth monitoring in patients' homes in Barnsley helps reduce hospital readmissions and length of stay by enabling patients to better understand their illness and take more responsibility for managing their long-term conditions at home. Important features include remote data-monitoring and close partnership working with the local authority.

South West Yorkshire Partnership NHS Foundation Trust provides community, mental health and learning disability services across Barnsley, Calderdale, Kirklees and Wakefield. It also provides some medium secure (forensic) services to the whole of Yorkshire and the Humber. Over 98% of services are currently delivered in the community.

Aims

Care Navigation/Telehealth Care Services support people in Barnsley to be active participants in their care and maximise their potential for independent living. Telehealth is intended mainly for people with one or more long-term conditions, and aims to monitor patients' vital signs/symptoms from their home on a daily basis. The service also educates patients to understand and manage their conditions.

Structure

A telehealth unit is installed **in the patient's home** and they are trained to upload daily data on their vital sign readings, including blood pressure, concentration of oxygen in the blood and weight.

An office-based multidisciplinary team of staff nurses, all band 5 NHS-trained community nurses, monitors the data. The service is located at Mount Vernon Hospital.

Characteristics

- around 235 people in Barnsley have access to a telehealth unit in their home
- operates Monday to Friday 9am to 5pm, Saturday and Sunday 8:30am to 4:30pm
- a person's condition is monitored and observed from their home
- integrated with the community matron service, the heart failure specialist nursing service and the community chronic obstructive pulmonary disease (COPD) specialist nursing service
- patients who use this service require monitoring, ie vital signs, assistance with medication titration, symptom management

The service operates **seven days a week** from 9am to 5pm Monday to Friday, and from 8:30am to 4:30pm on Saturday and Sunday.

Telehealth is publicised as a **non-emergency service**. Patients are advised to ring their GP or dial 999 in an emergency.

How patients benefit

Risk stratification Patients are selected using a risk stratification tool, or following referral from their GP or specialist nursing service.

Remote data monitoring The patient-reported data and records of physical symptoms, health knowledge and health behaviours are transmitted daily to the Telehealth Care Service, where care navigators review them to identify clinical trends. Patients are categorised on a daily basis as green, amber or red, indicating their risk status.

Patients have a named staff nurse who monitors their data and provides 'telephonic care'. Staff nurses build up an understanding of the patient's 'norms' and are able to spot signs of deterioration. They direct the patient to other health, social care and third sector services, such as stop smoking services. Diabetes and heart failure referrals are made electronically through SystemOne, helping patients navigate the most appropriate care. Patients or their carers can contact care navigators on a freephone number.

A patient's care can be escalated for a short-term intervention. If a patient is in danger of deteriorating, staff nurses pass their data to community matrons or a relevant specialist nurse, who would schedule a visit.

This is a 'step-down' service, and how long patients use it depends on the individual. Usually patients spend about six months with the service, although this can be extended if staff nurses and the patient deem it appropriate. The community matron or specialist nurse decides when to remove the home-monitoring kit and discharge the patient.

Joint working Telehealth monitoring is part of an integrated range of services provided by the trust. Patients can access one or more of these depending on their needs. They include:

- care navigation – patients receive advice, information and support to stay well; care navigators direct them to the most appropriate services to help them manage their long-term condition

Enabler: partnership working

Telehealth is integrated with the local authority's Independent Living at Home service and aims to provide seamless social care as well as healthcare. For example, staff nurses can liaise with the Independent Living at Home service to arrange grab rails or other home equipment to be fitted.

- health coaching – using motivational interviewing, staff nurses teach behaviour change techniques to patients to help improve their care and self-manage their condition
- post-crisis support – staff nurses contact the patient on discharge from secondary care to discuss the reason for admission and offer telephone support to reduce the chance of the patient being readmitted.

Patients over 18 years old and with at least one long-term condition can access any combination of these services. The referral criteria for telehealth monitoring are based on the patient being known to a community matron/specialist nursing service for the management of their long-term condition.

Impact

The service is measured against key performance indicators, including reductions in:

- hospital admissions
- GP appointments
- visits from community nursing services.

The service may support patients to effectively self-manage their conditions by giving them the right equipment and helping them to understand their conditions. The trust reports that the service reduces anxiety among patients with long-term conditions, and anecdotal evidence from staff suggests it improves self-management. Around 45% of patients using the service said they were visiting their GP less.

Trust service data, based on provision to 235 patients, indicate that the Care Navigation/Telehealth Service has decreased users' demand for services such as accident and emergency and community nursing:

- fewer hospital admissions since installation of the Telehealth equipment
- improved patient outcomes from preventing more intrusive and expensive services further along the care pathway
- about 45% fewer GP attendances among those accessing care navigation, health coaching interventions
- about 20% fewer GP attendances among those accessing telehealth technologies.

The trust reports the service has enhanced its other community-based care schemes – for example, by creating capacity among other community teams. The Care Navigation/Telehealth Service benefits community matrons and specialist nursing services by providing daily advice and support. This enables teams to 'step down'

patients from their caseload and concentrate on the more severely ill. Patients are supported in a less resource-intensive way, enabling community matrons and specialist nurses to manage larger caseloads and visit patients needing face-to-face intervention.

More information

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This is one of a suite of case studies designed to increase awareness of the impact of moving healthcare out of hospital. For more materials see [Moving healthcare closer to home](#)