Appendix 1

Key Points Raised at the Series of Preliminary Design Seminars held between 31 March – 3 April 2008

The following principles were derived from initial consultation/Design Seminars and will form the basis for establishing an integrated consultation and implementation process for the introduction of large scale Telehealth Remote Monitoring in Northern Ireland:

Principles

- Improving patient care is the priority
- Comprehensive engagement at a local and regional level is necessary
- An effective partnership for design and implementation including Commissioners, GPs and Trusts is essential
- An evidence base needs to be consolidated and shared widely
- An evaluation framework should be established as soon as possible.

Points and questions raised during the Design Seminars

Patient Focus

1. How do we overcome the lack of human contact if we remove/reduce nurse visits, primary and secondary care contact?
2. What % of your patients on Remote Monitoring would have a daily phone call? (ANSWER: 20-30% of patients "alarm" and get a call every day. If green, no phone call)
3. Is the contact one way? Can the patient call up the Telemonitoring Nurse? (ANSWER: Yes, contact is two way).

Secondary Care

1. The US system is set up with Secondary Care Consultants only. GPs/MDs don't seem to have been involved? How do Cardiologists and the GPs interact?
2. Severe COPD end stage core, how have you dealt with that? (Individual assessment?)
3. Will hospitalization rates be a key factor?
4. A randomised group e.g.: Renal patients may be a good foundation for remote monitoring
5. We need to ensure that Telehealth/Remote Monitoring is part of the bigger picture and not seen as replacing Cardiologist, Physicians, etc.

Nursing

1. What % of the “alarms” is dealt with by the Nurse?
2. When an alarm goes and the triage nurse makes a call, does that end their responsibility? (ANSWER: No, protocols are in place)
3. Is it a Specialist Nurse who does the triage or a Generalist Nurse? (ANSWER: Tends to be latter with access to specialist support as needed)
4. Is this system being introduced because of the possible shortfall in skilled Nurses, etc. - would money not be better spent in training and enticement of more Nurses and Doctors, or will we end up with no Nurses even for Monitoring?

Primary Care

1. Can ECCH reduce Primary Care workload?
2. Is it Primary Care Physicians who respond to the “alarm”? (ANSWER: No, Nurse usually, only when outside competencies of the Nurse do the Doctors need to get involved)
3. Is it important that when we are building protocols, we include additional aspects and questions?
4. Do patients go back into the programme if needed?
5. Why stop Remote Monitoring if this is working well?
6. Issue of patients using or misusing monitoring equipment
7. A safety analysis should be completed
8. How quickly can we set a patient up with Remote Monitoring?
9. Vast quantities of data will be available. How can we ensure that we maintain the projected benefit of this? e.g.: pharmacy/medicine use
10. GPs should be key partners in the design and implementation and continuing development of Remote Monitoring in NI. Dual ownership and responsibility will need to be put in place between Trusts and Primary Care.

General

1. What difficulties have you encountered in terms of patient compliance and how did you overcome these?
2. Average stay on Partners Telemonitoring is 76 days. Why so short? (ANSWER: This is due to medical insurance system in the US, but 76 days can be extended through review)
3. Who does the report go to? Concern might be inundated with information
4. Is this all about physiological data or do you do any video monitoring? (ANSWER: Found it not to be effective – a Nurse visit is still required)
5. Are you aware of anyone who has been able to bring together Health & Social Care data?
6. Can we have some quick wins with this?

7. How will this be commissioned? (ANSWER: Resources available for Telemonitoring, also additional resources for case management)
8. What capacity will there be for building more Remote Monitoring? E.g.: regular contact with patients
9. How should the ECCH engage with the service in the future?
10. Is this cost effective compared to current systems?
11. Will an outside provider be commissioned to offer this service?

Information Technology

1. From an IT perspective, will systems be developed to allow interoperability and systems knowledge?

Three Question Areas

1. Do you agree that Remote Monitoring is a good idea?
    - The response from all seminars/meetings was a universal ‘yes’
    - Specific response: This has very good potential to assist a wide range of patients and families to build confidence post-discharge and develop skills of self management, which in turn can prevent readmissions
    - Yes, in principal, but would like to know how this compares with current practice, Nurses contacts/monitoring, expert patient initiatives and control group with no intervention
    - Yes, it will be useful to see the evolution of the phased approach.
2. What are the critical factors, which must be addressed to ensure success? Communication between patients, Nurses, GPs, hospitals, education and training.
    - Very positive development; two concerns:
        i. Can experience of a different healthcare system be directly transferred to a NI context where the incentives, behaviours and drivers are different?
        ii. What will the impact on the ‘whole system be’ and how will this be monitored? We need an agreed integrated care pathway, which is constantly refined and resourced. Who will do this?
3. How should the ECCH engage with the service in the future?
    - Make sure Clinicians and Practitioners are actively engaged through workshops
    - Engagement at a local level is essential.