

“By deploying the telehealth system for community-based care we are empowering patients, reducing anxiety, promoting independence and so improving overall quality of life. Telehealth also educates patients to be aware of their symptoms, to manage them, reducing part of the burden on healthcare providers.”

Mike Ore, Head of Service Delivery, Community Health Services

## What community matrons had to say

Community Matrons reported that as a result of the telehealth project:

- Home visits were reduced
- They were better able to prioritise their workloads
- The service prevented exacerbation of their patients' conditions
- Interaction with Sefton Careline enabled a more preventative approach
- An improved quality of service was offered to patients
- Patients benefited from reduction in anxiety, better medication compliance, increased knowledge and self management
- Integrated working between health and social care was greatly improved.

## Next steps

Future objectives for the telehealth service include:

- Expanding the patient groups and settings telehealth is offered to, including a myclinic multi user telehealth solution's residential care schemes
- Embedding telehealth into reablement programmes
- Engaging further with the acute sector and GP practices.

## Joe's story

“Joe” is 59 years old and has been managed by the Community Stroke Service for over two years. In addition to having suffered a stroke, he also has secondary factors including hypertension, type 2 diabetes, morbid obesity and shortness of breath. His activities of daily living were severely curtailed and quality of life reduced. Joe was keen to be part of the telehealth project and measured his blood pressure, oxygen saturations, pulse, temperature and glucose levels at least daily. As a result he:

- Gained a good understanding of his condition and consequently takes more responsibility for his wellbeing
- Stopped smoking, has become more physically active and has lost 3 stones in weight
- Reduced his blood pressure considerably
- Reduced blood sugars, therefore reducing the amount of Insulin he required dramatically
- Is less short of breath, and feels better in general
- Has not needed as many visits from his Community Stroke Nurse
- Has required fewer visits to the GP practice
- Has had no A&E or hospitalisation since the introduction of telehealth.

“Telehealth has given me and my family the greatest sense of security ever. I now feel like I'm in control of managing my own health.”

Joe, 59, Halton

Further details about 3millionlives can be found at:

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# Managing long-term conditions using telehealth in Halton and St Helens

## The challenge

Approximately 15 million people in the UK have a long-term condition and their management is one of the greatest challenges facing the NHS today. Halton & St Helens Primary Care Trust in Widnes conducted a 12-month pilot to evaluate the benefits of embedding telehealth within its care pathways for people with long-term conditions.

The PCT hoped that telehealth would work in conjunction with existing services to achieve better outcomes for patients, improve their experience of care, and achieve greater operational efficiencies thereby increasing its capacity to provide high quality care and support for the growing number of people in the region with long term conditions.

*“Telehealth has been a great benefit to me. It helps me manage my condition on a daily basis whereas before if I became unwell I would wait another day to see if my condition improved. Sadly it never did, and I would end up in hospital for long periods of time. I now know when I’m becoming unwell and it’s acted on immediately.”*

Participant in the NHS Halton & St Helen’s Telehealth Pilot

## What we did

A total of 60 telehealth packages were commissioned from Tunstall Healthcare and offered to patients from three chronic disease areas – heart failure, COPD (chronic obstructive pulmonary disease) and stroke.

Telehealth systems are set up in the individual’s home, and patients are given training on how to use the mymedic unit and associated peripherals to monitor their vital signs and symptoms.

Each day, patients take their own blood pressure, oxygen levels, weight and temperature, and answer a series of health-related questions. This information is automatically transmitted in real time down the phone line, via the mymedic unit, to Sefton Careline’s monitoring centre.

Here, operators use a triage software platform to view and manage the data received. Clinicians work with staff at Sefton Careline to set up a record for each patient which includes contact details and information on their medical condition, and contains parameters for each patient’s readings.

If these parameters are exceeded, operators will receive an alert, and can contact the patient to request that they retake their readings. If the readings exceed the pre-set parameters for a second time, the patient’s community matron or GP can be contacted.

