



North Staffordshire
Clinical Commissioning Group



Stoke-on-Trent
Clinical Commissioning Group

FINAL REPORT

GP to Care Homes Video-Consultation Connect Wave 2 Evaluation



**Redmoor
Health**

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EXECUTIVE SUMMARY

This report describes an independent process evaluation of the GP to Care Home Video-Consultation Connect Wave 2 programme. Between June 2018 and August 2019 NHS England invested £136,000 from the NHS England GP IT programme. A total of 16 GP practices and 31 care homes, across Stoke-on-Trent and Staffordshire, have taken part in the pilot at varying levels since its launch.

The evaluation explored issues such as: how the programme was implemented; reach of the programme; barriers and enablers to success; has the programme increased capacity in the GP practice by replacing face to face with video; and what could be changed to improve programme effectiveness. The evaluation was conducted through secondary analysis of programme data; surveys of stakeholders; and semi-structured interviews.

Findings

Video-consultation was used extensively within the programme to conduct a wide spectrum of patient care. The most extensive use of video-consultation was for GP-Patient consultations, whilst multi-disciplinary team meetings, medication reviews and minor acute illness assessments were also frequently used. Qualitative data gathered, suggests that as the programme became embedded within the pilot sites, GP practices and care homes are extending its use into new areas, highlighting the potential breadth of benefits from the use of digital technology.

Over the first 14 months, there have been over 4,000 care home patients engaged in the scheme. During this period, 1,941 GP to care home video-consultations were carried out, an average of 139 consultations per month. GPs report that this saved 1,566 face to face appointments. Following these consultations only 216 (13.7%) required a subsequent related face- face consultation. Data gathered suggests that the programme has positively impacted on: Staff travel time; patient consultation time; overall workload efficiencies; and patient consultation time. However, stakeholders acknowledge that there have been difficulties in quantifying these outcome measures.

No quantitative patient impact data was recorded. However, GP practices and care homes identified positive impacts on patient care in relation to: Overall quality; access to care services; timeliness of care; equity of care; patient safety; and patient centredness.

The evaluation found a number of barriers to use. The most significant being connectivity and coverage. To make this system workable for all requires more practices and care homes to engage, supported by significant investment in Wi-Fi and additional training in the set up and use of the equipment to enhance current operation. The requirement to collect output data relating to the impact of video-consultation was difficult. As such, the consistency and quality of data that has been returned has varied greatly and there is a need to develop systems and processes that mitigate this.

Conclusions

The use of video-consultation linking GP practices to care homes has led to range of positive impacts on patient care and service efficiencies. The settings involved have delivered the programmes as intended, forged closer working relationships and enhanced patient care, leading to reported efficiency savings across the system. The settings have embraced the use of new technologies and identified further potential for developing this work going forward. To maximise the potential of technology in the GP-care home interactions requires system-level change and investment. There is a need to bring stakeholders together to explore what could be possible to achieve to help break down these barriers.

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“Often people want a physical doing, you need to get the doctor out, the doctor needs to see them physically, but actually it’s about a mixture of things. Often decision making and coordination of care, doesn’t mean you necessarily need to be at a face-to-face level.”

(GP from the pilot programme)

1. CONTEXT

The use of ‘Technology Enable Care’ (TEC) is recognised by the UK government in policies which include the ‘NHS Five Year Forward View’, the creation of the ‘National Information Board’ and Technology Enabled Care Services and the Care Act 2014.

There is a growing body of research that highlights the potential for ‘Technology Enabled Care’ (TEC), to reduce healthcare costs, increase access to care and improve patient outcomes¹. The potential reach of digital technology can overcome geographic distance and shortages of Health Care Professionals (HCPs), while providing a more versatile and personalised approach to healthcare. In doing so it can provide cost-effective solutions at a time when the demands on health and social care services continue to increase.

Growth in the use of TEC has implications for health and social care providers. For example, there is increasing potential to support the shift of some physical assessments in care homes, or treatment in primary care and hospitals to home care via the use of digital communication such as e-visits and remote monitoring across many aspects of health care provision. One such use of TEC, that has the potential to transform care, is telemedicine and teleconsultation, including ‘the use of video conferencing facilities (or high-quality webcams) to enable remote consultations between patients and healthcare professionals, as well as peer to peer consultations between professionals².

One example of a system that offers considerable potential for alleviating pressures on stretched GP services, is video-consultation between GP practices and care home staff and residents. There are an estimated 5,153 nursing homes and 12,525 residential homes in the UK today³ providing accommodation to more than 426,000 people. Around 4% of people aged 65 or over, and more than 16% of people aged over 85 are resident in these homes⁴. Traditionally these residents generally receive their health care from visiting GPs and other primary and community-based professionals. The main features of this care are the assignment of a single GP practice to all residents (extended beyond normal GP hours), access to health care professionals with expertise in caring for older people with complex

1. Technology Enabled Care Services Resource for Commissioners, NHS Commissioning Assembly, January 2015 See also: http://www.commissioningassembly.nhs.uk/pg/cv_content/content/view/157329

2. Taylor K. Connected Health: how digital technology is transforming health and social care. London: Deloitte Centre for Health Solutions; 2015. Available at: www2.deloitte.com/content/dam/Deloitte/uk/Documents/life-sciences-health-care/deloitte-uk-connected-health-sm1.pdf

3. Later Life in the UK, Age UK, 2015

4. Care of Elderly People Market Survey 2013/14, Laing and Buisson, 2014

needs, care guidance to nursing home staff, improved medicines management, and approaches for managing people who are at the end of life. These services place a significant workload on primary care and increase costs for care homes.

There is growing body of evidence that indicates TEC have the potential to significantly improve efficiency and care in these settings. However, there is also evidence that health and care practitioners and care home owners and managers have not embraced and benefitted from TEC in the way that many other sectors have. It is reported that this is often due to perceived barriers to the deployment, with widespread concerns about issues such as quality, reliability, privacy and security and the cost of digital technology.

Across Stok-on-Trent and Staffordshire CCG's there is an underpinning strategic intent to deliver telehealth and technology enabled care to bring sustainable and up-to-date practice into health and at the same to realise the benefit from efficiencies, improvements and effective utilisation of technology in the NHS. Local pilot (proof of concept) initiatives have shown that innovative use of video-consultation type technology delivers significant and measurable improvements in the outcomes for nursing home patients including avoiding unnecessary emergency admissions.

To explore this further, Redmoor Health⁵ have been piloting a programme of video consultations between care homes and GP practices across Stoke-on-Trent and Staffordshire. This programme has been designed to understand whether the introduction of video-consultations can reduce costs in practices and achieve efficiency gains in utilisation of staff and productivity while improving health outcomes for patients and residents in homes by increasing speedy access to extended primary care.

1.1 BACKGROUND AND AIMS OF THE EVALUATION

The primary aim of the programme is to connect care home staff and residents with primary care clinicians utilising video-consultation. It is anticipated that this would improve the delivery of health care for residents in care homes and develop relationships and efficiencies between GP practices and care homes (see Logic Model, overleaf). The programme was funded by the NHS England GP IT programme with £136,000 being invested to cover the costs of training and ongoing support, the development and deployment of protocols, video-consultation equipment and an independent evaluation.

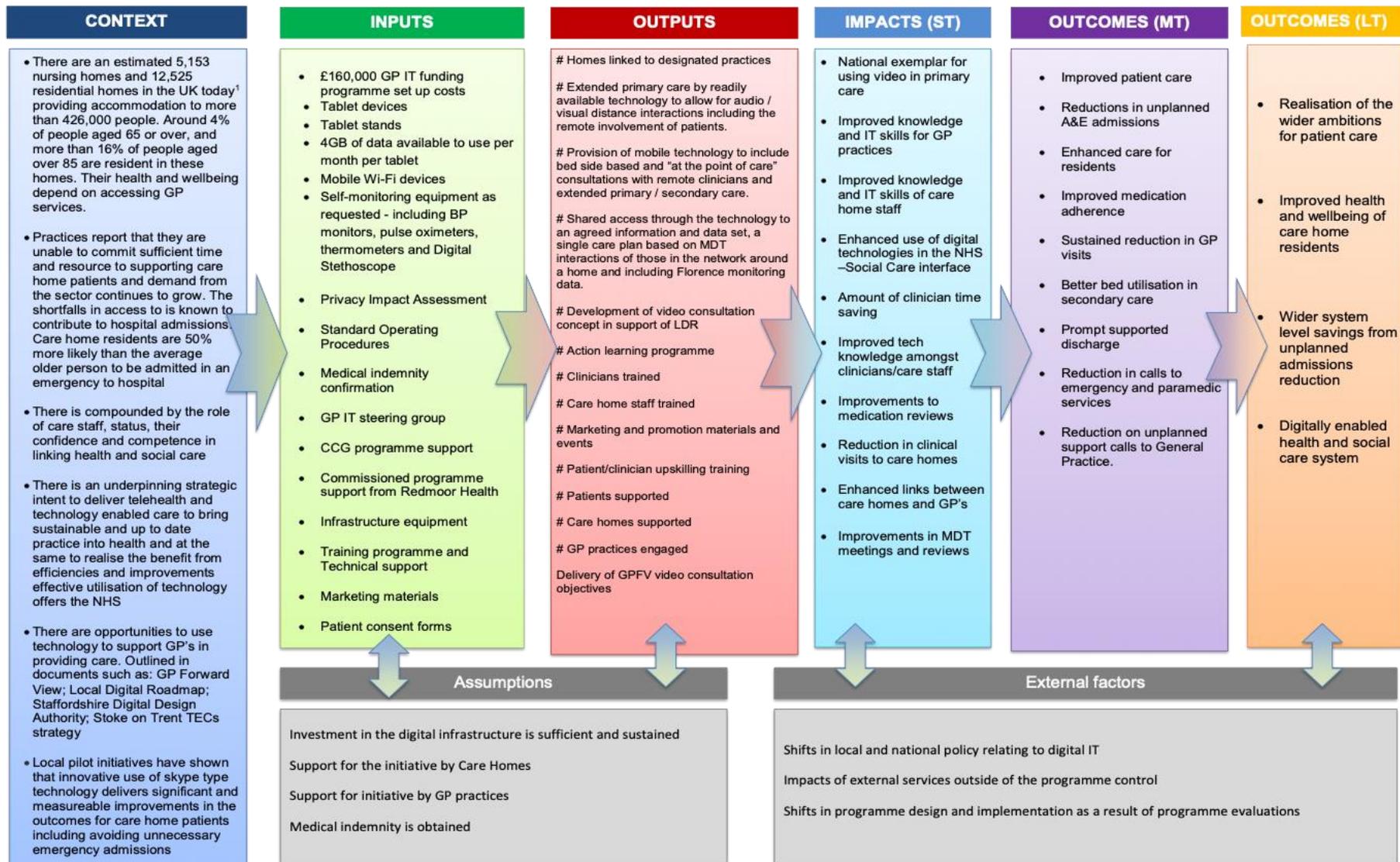
This report summarises the evaluation findings and attempts to highlight the contribution that the programme makes to improving efficiency, whilst maintaining high standards of patient care. In doing so it looks to explore the following research questions:

⁵ <https://redmoorhealth.co.uk>

- Has the programme increased capacity in the GP practice by replacing some face-to-face consultations with video-consultation? If so, what has been the result?
- What are the key barriers and enablers to the programme?
- What improvements could be implemented to develop the programme moving forwards?

1.2 GP VIDEO-CONSULTATION TO CARE HOME LOGIC MODEL

Figure 1: GP to Care Home Skype Connect Logic Model¹



¹ Model produced by Mike Parker. © 2019. mike.parker@progresshp.co.uk

2 EVALUATION METHODOLOGY

This section presents the methodology for the evaluation. It outlines the evidence upon which this evaluation is based and includes the methodology for each component. The process evaluation methodology makes use of both quantitative and qualitative data, adopting a mixed methods approach to data collection.

2.1 EVALUATION AIM

To undertake a process evaluation of the 'GP to Care Homes Video-Consultation Connect' pilot and explore the key learnings, successes and challenges, to inform future decisions.

2.2 EVALUATION OBJECTIVES

- To develop a detailed understanding of the project, through background desk research and discussions with Redmoor Health (Providers)
- To advise on the progress of the project through secondary analysis of pre-existing documentation and data
- To engage effectively with stakeholders involved in the project to gather new quantitative and qualitative data
- To analyse all available data and produce a report with clear recommendations based on objective findings of the independent research to inform future decision making.

The evaluation was conducted through a series of inter-linked work packages. It was agreed that no personal identifiable data would be reported in the evaluation.

Table 1: Methods used in the evaluation

Work Package	Evaluation Methods Used
Context Setting	<ul style="list-style-type: none">• Review of related policy and background documents• Meetings with the service provider
Secondary Data Analysis	<ul style="list-style-type: none">• Analysis of programme level data from the Care Homes and GP Practices• Analysis of external evaluation reports from the service provider
Stakeholder e-survey	<ul style="list-style-type: none">• Electronic survey (using Survey Monkey) distributed to key stakeholders. Questions explored included: Was the programme delivered in a manner as designed and intended; how was video-consultation utilised and was appropriate equipment provided; was the training provided adequate; how much time was spent using video-consultation and what were the barriers to use; what impact has the programme had on efficiencies and quality of care.
Stakeholder Insights	<ul style="list-style-type: none">• One to one interviews with identified key stakeholders from Primary Care and Care Homes, service providers and CCG leads• Interviews were digitally recorded and transcribed verbatim
Data analysis and reporting	<ul style="list-style-type: none">• All available data was analysed• Qualitative evidence was manually coded by the consultants against the question areas agreed with the commissioners. Data was then brought together and discussed by the evaluation team before being written-up into the report.

2.3 DATA COLLECTION METHODS

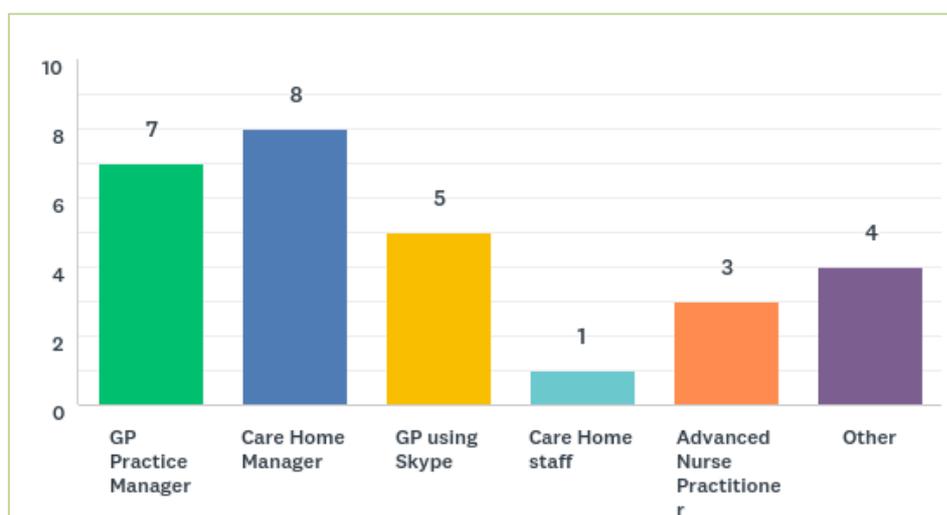
2.3.1 Data collection by service provider

Data was submitted by care homes and GP practices on a monthly basis for analysis by Redmoor Health. This data was predominantly output data, which was supplemented by qualitative data gathered by Redmoor during the programme.

2.3.2 E-survey data collection

A total of 26 surveys were returned, from a distribution list of 30. Of these 62% (n=15) were from GP practices and 38% (n=10) from care homes. Approximately two thirds of responses were provided by practice/care home managers and a third from HCP delivering the consultations.

Fig 2. Number of E-survey responses by role



(Source: e-survey. n=26 responders)

2.3.3 Stakeholder interviews

From a contact list of 14 stakeholders, a total of 9 individuals were consulted on the programme, ranging from CCG Digital Lead, Care Home Managers, GP's, Practice Managers, Nurse Practitioners and providers. This was achieved through a combination of 1:1 interviews with stakeholders and a small group discussion with the service provider. The interviews followed an agreed discussion guide that set out the key topics to be explored.

2.4 EVALUATION LIMITATIONS

- The evaluation was retrospective. The evaluators had access to previously collected and submitted programme data and this data varied in depth and breadth.
- Budget and time constraints limited the number of interviews. More interviews across a more diverse sample may have changed the findings.
- The issues relating to people in care, the ethics surrounding personal data gathering and budget constraints make it problematic to gather patient feedback on experiences of using video-consultation. Therefore, patient experience has not been explored within this evaluation.
- Primary data collection did not collect data relating to any untoward consequences (eg patient being inappropriately treated by video-consultation) or admission to hospital that could have been avoided.
- Stakeholders recognised that systems have not been put in place to assess any monetary values to changes in efficiency. The evaluation can therefore not report on cost savings for example.
- In any evaluation like this it is challenging to find and interview people who did not engage with or dropped out of the programme (as they then do not tend to want to engage in the evaluation). This might lead to a positive bias.

3 FINDINGS

This section presents the data gathered and analysed through this evaluation. It outlines data gathered by the service providers within the programme and new data gathered retrospectively by the evaluators through a provider e-survey and stakeholder interviews. The findings have extensively used direct quotes from stakeholders to emphasise the issues raised. These quotes are reflective of the combined view of stakeholders.

3.1 PROGRAMME RECRUITMENT

The pilot was launched in June 2018. In total, 16 GP practices and 31 care homes were recruited voluntarily onto the programme. At the time of this evaluation there were 12 GP practices and 16 care homes operational in the programme, alongside a team of mental health nurses. The programme is expanding into a further three GP practices and seven care homes in September 2019.

The participating organisations signed up to a Memorandum of Understanding (MOU) between Stoke-on-Trent and North Staffordshire CCGs and the care home / GP practice. Under the non-legally binding MOU the following commitments were signed up to.

Table 2: Commitments made within the MOU

GP Practice / Care Home Commitments	Redmoor Health (Provider) Commitments
Confirm it has read and understood the governance documents which will have been sent by the team at Redmoor Health and that they are adhered to	Provision of all training necessary to use video consultation
Commit to logging each video consultation and reporting this data to the CCG via Redmoor on a monthly basis via the reporting data sheet that has been provided	Onsite and telephone technical support
Ensure video consultation is not used for Discharge to Assess patients	Provision of equipment – Tablet device, tablet stand and mobile Wi-Fi device with pre-loaded Wi-Fi data
Understand that the practice is responsible for the safe keeping of the equipment that has been provided	Support with completing governance documents
Register any training needs with Redmoor which can be scheduled as part of the programme	Support with ensuring the care homes receive all the training, equipment and guidance on governance to enable them to use video-consultation safely
Liaise directly with Redmoor around any technical problems being experienced	Provide any necessary marketing materials to help support the programme
Ensure that any skills developed in the practice will be shared across the practice team	Ongoing training and support offered

There are clear protocols⁶ in place for GP practices and care homes on how video-consultation can be used safely, and these have been agreed by the CCG and the Staffordshire Digital Design Authority and received IG/sign off by Caldicott Guardian for SOP/PIA agreements. All protocols and project documentation have been adopted by the TEC steering group, for individual practices to adopt or adapt and take personal and professional responsibility for. These are available on the Staffordshire video-consultation pilot website⁷.

Stakeholder interviews identified that the key reason for signing up to the programme was a desire to test a new way of working with existing technology and innovation. They were keen to adopt the project innovation and deploy video-consultation to the benefit of patients and the potential beneficial outcomes in terms of efficiency savings.

“We wanted to explore a newer way of working and as part of that we wanted to adopt the digital workstream.” (GP)

“The GP suggested we use this video consultation via Skype, to see what advantages we could achieve from using this during our multidisciplinary meeting.” (Care Home Manager)

3.2 SET UP AND TRAINING

GP Practices and Care homes involved in the programme received the following equipment:

- Tablet devices
- Tablet protected cases
- Tablet stands
- 4GB of data available to use per month per tablet
- Mobile Wi-Fi devices
- Self-monitoring equipment as requested - including scales; BP monitors, pulse oximeters, thermometers and digital stethoscope and the training to support use
- Access to all protocols

The average equipment cost per GP practice was £1000 (tablet, case, stand, internet, special monitoring equipment). The average equipment cost per care home was £3000, since many care homes require multiple pieces of equipment to cover their site(s).

The majority of settings (81%) said the equipment met their needs. This was reflected in the stakeholder interviews, where generally interviewees were happy with the equipment supplied. Where interviewees and E-survey responders were not satisfied with the equipment, the reasons generally related to Wi-Fi connectivity, which negatively affected 53% of E-survey responders. Connection problems and technical issues were frustrating for stakeholders and

⁶ Protocols written by **Dr Ruth Chambers OBE**, Staffordshire STP's clinical lead for technology enabled care services programme, digital workstream & Honorary Professor Keele University, Visiting Professor Staffordshire University

⁷ <https://www.video-consultation.co.uk>

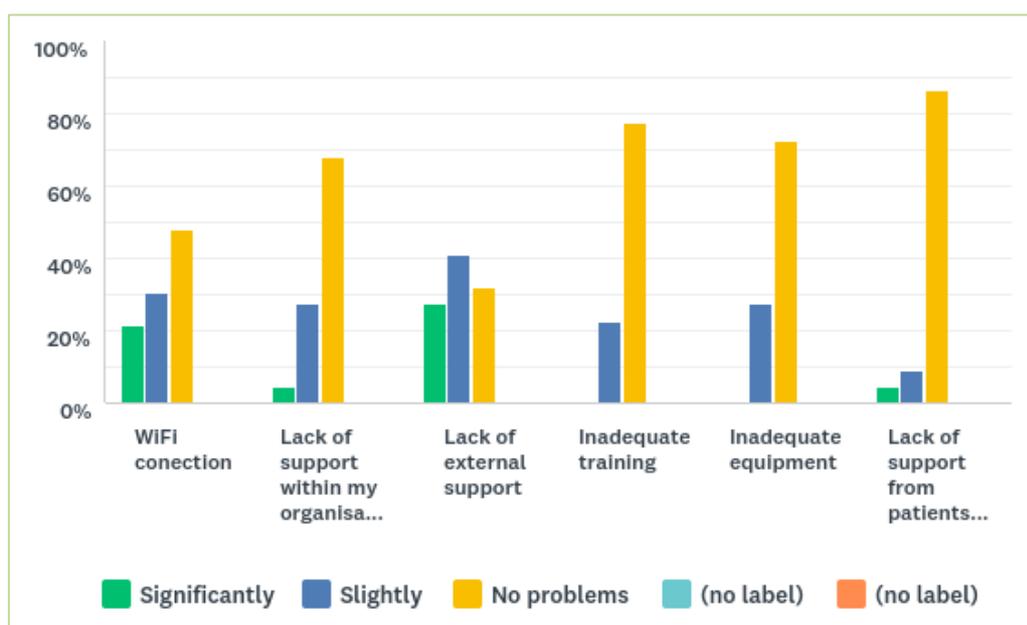
were mentioned by all interviewees. It was reported that the NHS Wi-Fi does not readily and easily support the use of video and some care homes have poor Wi-Fi or 4G signal as a result of poor infrastructure and old buildings. For some, this resulted in video-consultation sometimes not being the easy, efficient option to use.

“The NHS broadband speed is shocking, so we don’t piggyback on it. All our sites have got our own private internet access on top of that.” (GP)

“I have to log on and get a password to get an NHS connection, and sometimes it expires after so many times, so I have to get a new one and log in again to try and get a new one, but I find that the problem is the connection at the nursing home.”

(Nurse Practitioner)

Figure 3: Issues affecting programme deployment



(Source: e-survey. n=26 responders)

Other equipment issues identified included: The camera quality not being sufficient, leading to frustration from the GP attempting to liaise with the care home; and a desire to extend the range of equipment supplied. Some had addressed this by the purchase of a separate webcam.

“The resolution on the cameras is not good enough” (GP)

“We would like some advanced knowledge equipment, like for example the electronic stethoscope and a blood pressure monitor.” (Care Home Manager)

The training provided by Redmoor Health to all participating settings includes:

- Face-to-face discussion with managers and other key decision makers within each organisation. This provided an introduction to the pilot, and all the relevant information

such as governance documents and gathering patient consent is discussed.

- A follow up meeting with the other members of staff, such as nurses, care assistants, or GPs, to deliver the equipment that has been pre-set with various accounts to use video consultations easily. Training was often provided multiple times due to a high labour turnover within the care homes
- Supporting resources, such as video case studies
- Ongoing on-site and remote support.

The quality of the training provided was rated as *‘Excellent’* by 32% of E-survey responders and *‘Adequate’* by the remaining 68%. Interestingly when filtered to look just at care homes, those rating the training as excellent rose to 62% with 38% rating it as adequate. Stakeholder interviews reflected this, indicating that the training provided was *‘informative’*, *‘useful’* and *‘came with additional helpful support’*.

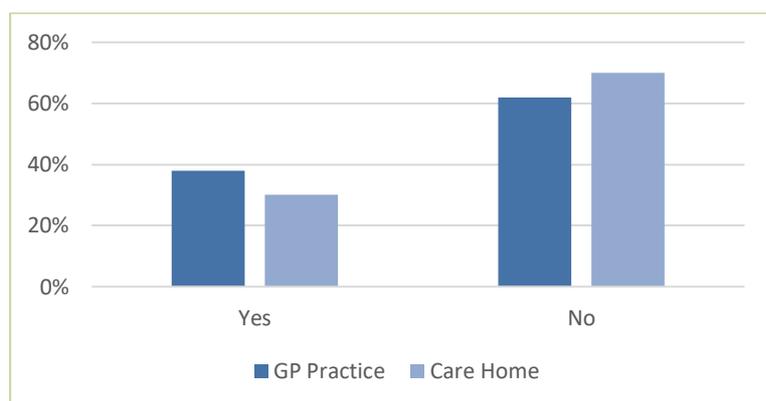
“Whatever questions we have, he [training provider] answered it in a way that we understand, and he gave us some hard copies on all the things we need to do as well. They are always available to speak to if I have questions.” (Care Home Manager)

Care homes and GP practices would welcome additional training, with 38% of GP practices and 30% of care homes stating that they would benefit from additional training (Figure 4 below). In particular there appears to be potential to not only train staff in use of the equipment supplied, but also to cascade the training to other staff and to provide additional training in its application to other areas of patient care.

“I feel I’ve probably not used it to its full potential. I tend to do it to the patient, to the nursing staff, I tend to do it to them rather than directly to the patients.” (Nurse Practitioner)

“Some staff have trouble with the equipment and would benefit from some extra training on the use of technology” (Care Home Manager)

Fig 4: The need for additional training



(Source: e-survey. n=26 responders)

3.3 THE USE OF VIDEO-CONSULTATION WITHIN THE PROGRAMME

Video-consultation was used extensively within the programme to conduct a wide spectrum of patient care. The consultations were generally delivered from within GP practices by GPs and Advanced Nurse Practitioners and in Care Homes by the ward staff and supported by the practice manager.

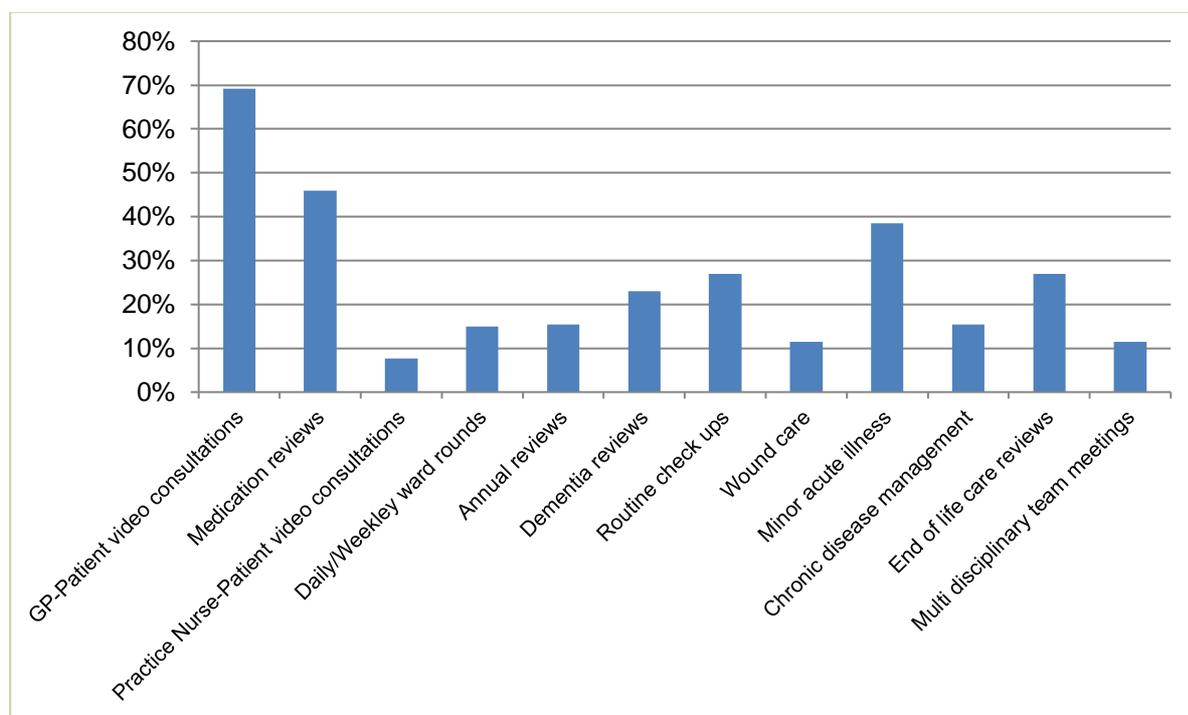
The E-survey highlights the breadth of these activities (Figure 5 below). The most extensive use of video-consultation was for GP-Patient interactions (69% of responders), whilst medication reviews (46%) and minor acute illness assessments were also frequently used (38%).

“We discuss all residents on Skype before the visit. Some then do not require to be seen in the home” (Care Home Manager)

“We are able to send bruises and rashes through email via the tablet.” (Care Home Manager)

“We have found that some of the prescriptions required are completed through a video-consultation, which is very effective and time saving.” (Care Home Manager)

Fig 5. Use of video-consultation within the programme



(Source: e-survey. n=26 responders)

The qualitative data gathered suggests that, as the programme has become embedded within the pilot sites, GP practices and care homes are now extending its use into new areas, highlighting the potential benefits from the use of technology. For example, one care home was initially only doing Multi-Disciplinary Team (MDT) meetings via video-consultation. However, once they had more experience using the equipment, they have started to do full GP video-consultations.

“We have discussed this, and we want to triage all visit requests they make to us through video-consultation. I am arranging a clinical demo of this. We are setting up a video surgery for palliative care reviews where we will discuss all the patients we have registered there. I went to our locality meeting recently and the coroner made it clear that he accepts video consultations for the purposes of a death certificate.” (GP Practice)

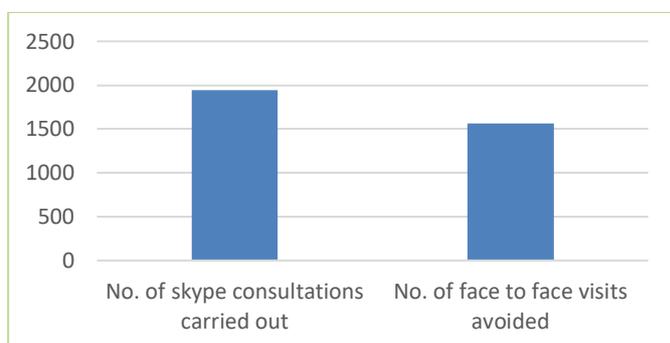
3.4 PROGRAMME REACH

The programme currently supports 16 care homes and 12 GP practices with the integration of video consultations into their delivery of care for residents. This support is furthered by other organisations, including North Staffordshire Combined Healthcare Trust (NSCHT) and the Care Home Coordination Centre (CHCC), being able to use this technology to provide support and advice to these homes.

To date there have been **4,072** care home patients engaged in the scheme. Over the first 14 months **1,941 GP to care home video-consultations** were carried out, an average of **139 consultations per month** (2.5 consultations per practice per week).

GPs report that this **saved 1,566 face to face appointments**. Following these consultations **only 216 (13.7%) required a subsequent related face- face consultation**. A further **836 Medication Usage Review (MUR)** were carried out using video-consultation.

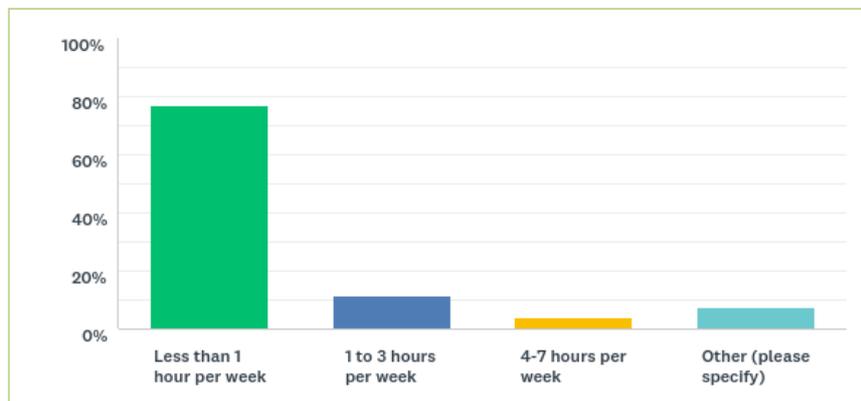
Fig 6: Video-consultation carried out by GP practices (June 2018-July 2019)



(Source: primary data submission)

Data gathered through the E-survey shows that 77% of responders spent less than 1 hour per week on video-consultations, 12% spent 1-3 hours per week and 4% spent 4-7 hours per week.

Fig 7: Time spent (per week) conducting video-consultations



(Source: e-survey. n=26 responders)

3.5 IMPACT OF THE PROGRAMME ON MEASURED OUTCOMES

“We’ve improved patient access through embracing new technologies and patient care has improved” (GP)

The evaluation looked to explore the impact of introducing video-consultations on the efficiencies within GP practices and care homes, alongside the impact of the programme on patient care.

3.5.1 Impact on GP practices

Data collection focused on efficiency savings relating to time spent consulting with patients; administration time; travel time; and overall workload efficiencies. Stakeholders acknowledge that there have been difficulties in quantifying these outcome measure. As a result, the consistency and quality of the data returned has varied greatly between GP practices and care homes.

GP practices report that using video for consultations had **saved 10,232 minutes (170 hours)** of GP travelling time, equating to **750.5 miles of mileage claims saved**. It is reported that this would most likely be a significant underestimation due to difficulties in practices quantifying the data.

“Some nursing homes are up to an hour drive from the practice. I can’t put figure on it [cost saving] though” (GP)

“Primarily saving [to me] is time but I can’t quantify this. It would be really in terms of the effectiveness of the consultations, so time is a marker” (GP)

Figure 8 lists the targeted outcomes that the GP practices reported within the E-survey. Out of the 15 GP practice responses, 86% reported that ‘staff travel time’ had been

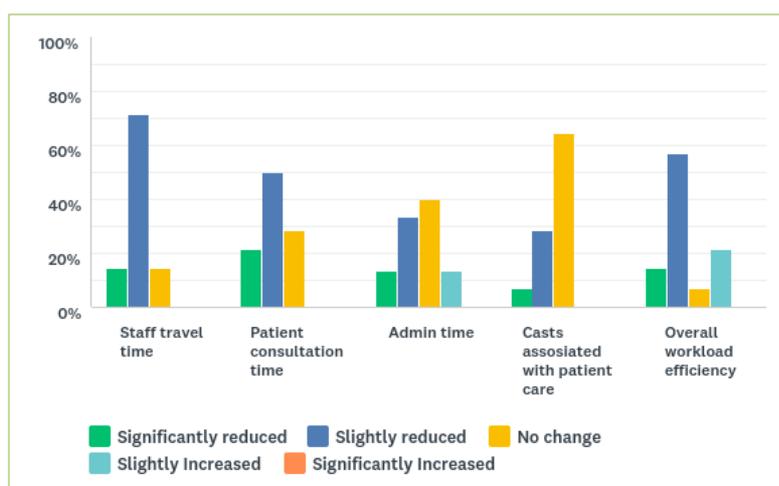
reduced; 71% reported that ‘*patient consultation time*’ had been reduced and 71% reported that ‘*overall workload efficiencies*’ had been improved.

“I can access the records and make changes without leaving the GP surgery.” (GP)

Just over a third (36%) reported that ‘*costs associated with patient care*’ had been reduced. Two GP practices reported that rather than reduce, administrative time had increased slightly. The reasons behind this increase related to the requirement for monthly monitoring data.

“Monthly monitoring reporting has been additional to my workload” (Practice Manager)

Fig 8: Impact of the programme on GP practices.



(Source: e-survey. n=15 responders)

3.5.2 Impact on care homes

Redmoor Health reported on the difficulties in accessing reliable data from care homes. Their systems are generally not aligned to the NHS systems and recording data was predominantly done on paper making accurate reporting difficult.

“I spoke with [Care Home Director], in detail about the position of care homes with regards to recording data. He detailed how care staff are more focused on carrying out the instructions of the GP rather than recording each individual patient who is discussed specifically through video. Further to this, care staff have different views about what counts as a video consultation.” (Service provider)

As we would anticipate efficiencies reported by care homes were less significant than those reported by GP practices.

“It doesn’t impact on our workloads at all, but reduces call outs for GPs” (Care Home Manager)

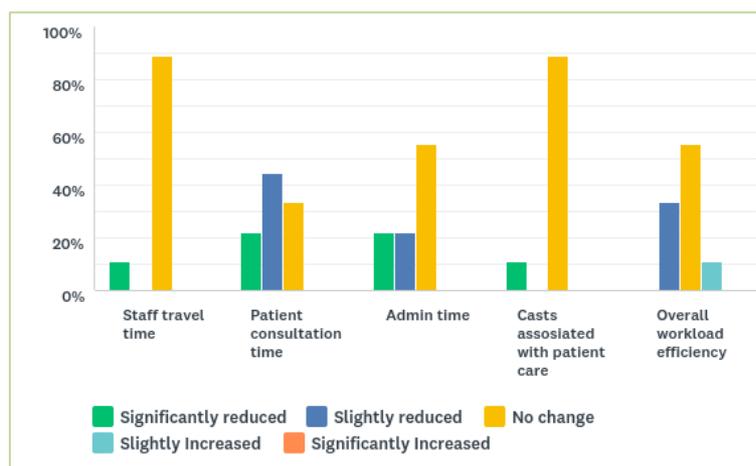
Encouragingly care homes did not report any negative effects on efficiencies with the exception of one care home that reported a slightly negative impact on overall efficiencies.

“There are definitely efficiency savings, but because we are always just staying here [in the care home], the GP, the CPN and the physiotherapists were the ones coming to the home for discussions, but with video consultations via Skype commands, it really saves time for them to travel.” (Care Home Manager)

Care homes did note a positive impact on ‘patient consultation time’ where 67% of the care home responders reported savings.

“We have found that some prescriptions required are completed when on Skype which is very effective and time saving, also that all residents on the list may not need to be seen on the visit which reduces time used for our nurse on the GP round” (Care Home Manager)

Fig 9: Impact of the programme on Care Homes.



(Source: e-survey. n=9 responders)

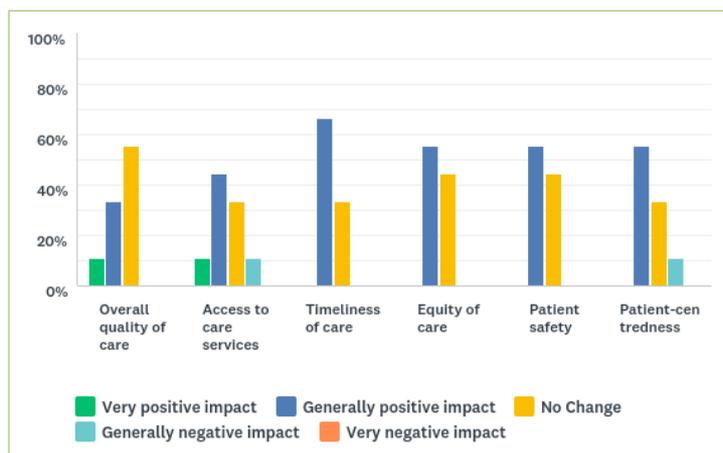
3.5.3 Impact on patient care

No quantitative patient impact data was recorded during the pilot. However, the E-Survey asked GP practices and care homes to identify any impact on patient care in relation to: overall quality of care; access to care services; timeliness of care; equity of care; patient safety; and patient centredness.

From a care home perspective (Figure 10) the responses to each of these was generally positive, in particular improvements in ‘timeliness of care’ (67%) and ‘access to services’ (55%). The only negative impact was reported by one care home on the patient centredness of care.

“Some families feel that this is not as comforting or accurate as face-face meetings” (Care Home Staff)

Fig 10: Impact of the programme on patient care (care home staff)



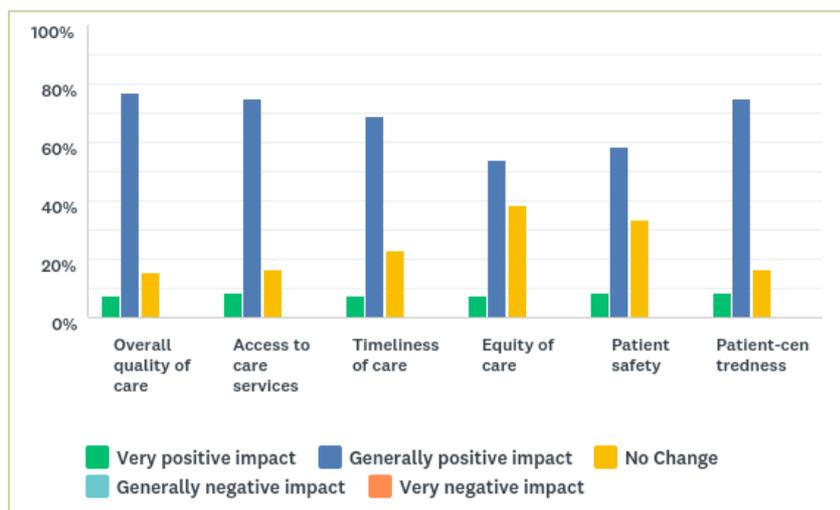
(Source: e-survey. n=9 responders)

GP practices also reported positively on the impact on patient care. 84% reported positive or very positive impact on ‘overall quality of care’, 83% on ‘access to care services’, 77% on ‘timeliness of care’ and 69% reported ‘improved patient safety’. (Figure 11)

“Where the care home has engaged, there has been a very positive impact on patient care” (GP)

“I can access the records and make changes without leaving the GP surgery.” (GP)

Fig 11: Impact of the programme on Patient Care (GP practice staff)



(Source: e-survey. n=15 responders)

One issue to consider in relation to patient care, when using video-consultations, was the complex needs of the patients in care homes.

“This is a pilot where you are actually seeing one of the most vulnerable groups of patients with more challenges, with higher morbidity, higher mortality, much more usage of non-elective activity, multiple medications, you have a patient group which is unique.” (GP)

“They are not patients that live in their own home, or ones that actually come to the practice. They are requiring 24-hour care. They have complex needs” (GP)

GPs were particularly positive regarding the ongoing continuity of care that the programme offered.

“So, to me, a real benefit we have seen, in terms of patients, one-to-one patients who have continuity of care were seeing the same clinician reemphasising the effectiveness of taking that medication or following that advice.” (GP)

“So, for example, med reviews. During those reviews not only are you actually doing the reviews, but you are actually seeing the patient as well” (GP)

An unintended outcome from using video-consultations was that it helped in communicating with relatives of patients and ensuring that they were involved and updated:

“We are keen to use video-consultations on the ward. It’s especially good at maintaining communication with relatives of patients. Some live long distance/overseas. (GP)

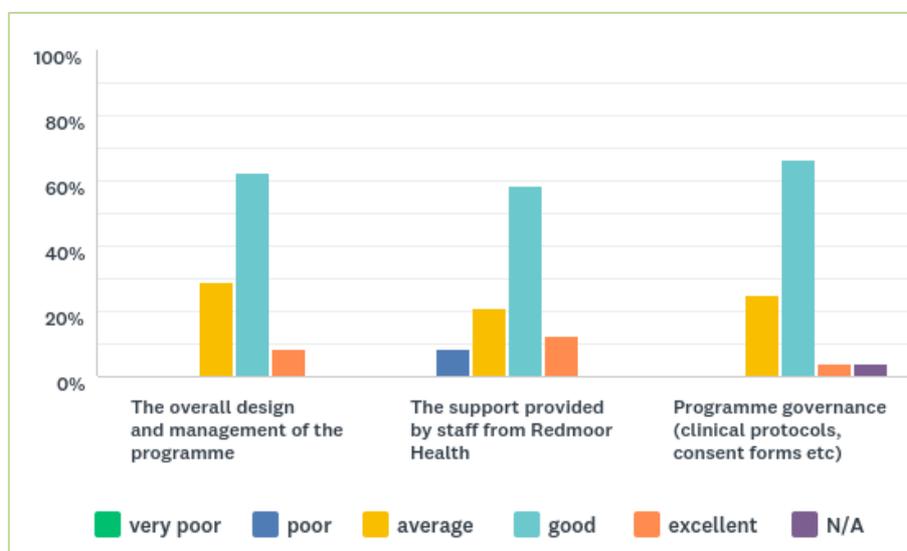
3.6 OVERALL VIEWS ON THE PROGRAMME

Reflecting on the programme as a whole the views of stakeholders was very positive. 71% rate the programme as ‘good’ or ‘excellent’ and 71% rate the ‘programme governance’ as good or excellent.

The main issues experienced was that overall communication between the service providers and the settings to assist in troubleshooting, (highlighted by 8% of E-survey responders) could be enhanced. Connectivity also needs to be improved. Both of these are discussed in more detail in the following section drawing on direct quotations from stakeholders.

“We could do with better access to somebody to troubleshoot when having problems. We need a dedicated response number that always staffed, within reason.” (Care Home)

Fig 12: How did you rate the programme overall?



(Source: e-survey. n=26 responders)

4 DISCUSSION

Within this discussion section we attempt to answer the questions set by commissioners and draw out the learning in relation to these key questions.

4.1 THE BENEFITS TO THE PRACTICE, CARE HOME AND PATIENT CARE

The evaluation has highlighted a number of benefits in using video-consultations. These benefits have been reported in:

- The primary data collection: where efficiencies were recorded in time and travel
- The E-survey of GP practices and care homes: where benefits were recorded in relation to administration time; consultation time; and overall workload efficiencies.
- The stakeholder interviews: regarding benefits in relation to the ongoing continuity of care that the programme offered; in facilitating a multi-disciplinary team approach to patient care; and efficiencies brought about through having access to patient notes whilst consulting with the patient or care home staff; and medicines management.

“It’s great because we have access to patient notes and can see the nursing home patients at the same time. It enhances a telephone consultation because [with video] you can actually see the patient, you can get their observation stats, so that’s really quick.” (GP)

“There are follow-up patients, where normally we would have to visit the home to make sure if they are okay. You can actually do that by video-consultation much more effectively as you’re actually not having to go [to the care home].” (GP)

However, it is clear that these efficiency savings are generally generated within the GP practice as opposed to the care home, since it is the GP practice that has to travel out to the care home, make hand written notes and transfer these onto the NHS IT systems.

“Video consultations done via Skype reduced the time significantly especially for outside health professionals to come in the Home for discussions” (Care Home Manager)

This is not to say that efficiencies have not been recorded by care homes. Most notably care home are benefiting from improved speedier access to health care professionals.

Providing real-time access to patient records and the ability to prepare in advance for any visit was also seen as very beneficial for both the GP practice and the care home. The new system allows GP practices to access and input data directly into the care records, avoiding the need for written notes.

“You’ve got the information on the computer, rather than controlling it through notes at the nursing home, or staff coming back and then looking through the notes ... I can print out prescriptions or whatever, I can do them in advance before I go out because it’s a bit more straightforward, or I can do blood forms and take them to the nursing home so that they’ve not to fill in a form, they’ve got correct details on there.” (Nurse Practitioner)

“This is being provided by their own GPs who actually are equipped in a sense where they have their full set of patient records, they can actually request a medication, request an investigation, see the hospital letter, with a touch of button, this is absolutely unique.” (GP)

Facilitating a multi-disciplinary team approach to patient care was also favourably supported by utilising a video-consultation.

“It is a very positive experience ... With regards to the video-consultation we were able to prepare everything that they [MDT] will need during the discussion, so a group chat video call really benefits for all of us in terms of efficiency” (Care Home Manager)

“Very, very positive, without the video-consultation, we have to leave the floor, and we have to wait for a certain room for all the health professionals to arrive, and sometimes we have to wait for at least an hour for this to be completed, before starting the discussions.”
(Care Home Manager)

“We see it as a real advantage, not just for care home staff, but also for the GP and the nurse practitioner and the physiotherapists involving under MDT meeting. It really saves their time to come here. It’s really time efficient for all of us, so that is one of the great advantages of this video-consultation.” (Care Home Manager)

The quality of the GP-patient relationship did not have to suffer if video-consultation was used effectively. The evaluation finds significant benefits relating to the patient and these

have been reported to include improvements in patient care, in patient access to services, timeliness and equity of care and patient safety. Where either care homes or GPs did not think that these had been positively affected, they showed no negative impacts.

“From a simple pure GP point of view, having seen that patient [via video] I am happy at the end of the consultation that I have actually done this work effectively, efficiently, to me that is a big tick.” (GP)

“This is not about saving time, saving money or people not going to hospital. This is to me, where I feel at the end of every consultation that actually, you know what, that made me feel good because I saw the patient, I had the information, and I effectively gave them the proper advice.” (GP)

“People shouldn’t look into the number of hours saved or time saved, it is a quality [of care] that is of utmost importance..... What I’m trying to say is that here [with video] you have the opportunity where a GP can actually provide continuity of care by using this.” (GP)

However, stakeholders from all sides recognise that the use of video-consultations is not right for everyone, it is not ‘one size fits all’ and it is just one tool in the box of multiple care systems. A consistent message emerging from the evaluation is that video-consultations are of benefit to particular patient groups with additional or complex needs – for example, those with mobility problems who are unable to access the practice or those with dementia who may find a visit to see a GP very distressing or for more routine appointments or medication reviews. Feedback from interviewees suggests that some believe that a face-to-face consultation is crucial for good-quality care. Therefore, being clear about its effective and relevant use and limitations was also important:

“There are certain things you can’t do, so going in and seeing someone [face-face] that’s, near death or speaking to relatives, there’s certain things I wouldn’t do [via video-consultation], even though I could do it I wouldn’t contemplate doing that at all.” (GP)

4.2 WHAT ARE THE KEY BARRIERS AND ENABLERS TO THE PROGRAMME?

“This is a worthy activity, but there are many individual and system barriers to making it a real success” (GP)

Both the E-survey responses and the stakeholder interviews identified particular barriers to using the IT systems effectively.

4.2.1 Coverage

GP practices report difficulties in situations where they have patients in multiple care homes, some of whom are not engaged in the programme. Conversely some care homes report frustrations where a GP practice they are linked to are not signed up to or have withdrawn from the service. To make this system work more effectively requires more care homes and GP practices to sign up to and to fully engage with the programme.

“We are looking after patients in three nursing homes and this project is deployed in only one of them. It would be more helpful if it could be deployed to the other two homes”

(Practice Manager)

“Unfortunately, we cannot use the equipment as the surgeries we worked with have pulled out of the consultation” (Care Home Manager)

4.2.2 Connectivity

The most significant barrier to utilising video-consultations is connectivity. Technical issues (most pertinently Wi-Fi connectivity and broadband speed) is the number one barrier. To make this system workable for all care homes and GP practices will require significant investment in Wi-Fi with the option to install additional, more reliable broadband.

Redmoor Health offer mobile 4G internet in the tablet devices and in external mobile Wi-Fi devices that can be used across the facilities. Although these have the clear benefit of providing remote internet to the tablets, they often aren't able to hold a strong signal throughout the practices and homes.

“The NHS broadband speed is shocking, so we don't piggyback on it. All our sites have got our own private internet access on top of that.” (GP)

“I cannot see any major disadvantage, or challenge in using the video-consultation, apart from when we are not able to connect this with our Wi-Fi connection” (Care Home Manager)

“If you were able to provide Wi-Fi good enough to run video all the issues that come up around training, learning, skills and processes are very easy to get over. The one problem you can't get over is connectivity” (Practice Manager)

A system integrated into main operating infrastructure would enable greater confidence and ease of use. It would help in recording of data and regular monitoring of usage. It would support video-consultations becoming normal practice and a viable option to support effective efficient patient care.

“As a stand-alone system it is not ideal being separate from main operating systems. The NHS Wi-Fi does not readily and easily support the use of video and some care homes have poor Wi-Fi as a result of poor infrastructure and old buildings. This leads to many of the issues faced and causes the most frustration and results in video-consultation not being the easy efficient option to use.”

4.2.3 Training

The majority of care home staff and GP practices feel that the current level of training provided is adequate and the training that was given as part of the programme was generally found to be informative, useful and they valued the additional support offered by Redmoor Health. However, the stakeholder interviews suggested that additional training would be welcomed and in particular highlighted that some staff need more training in the set up and use of the equipment to enhance current operation.

“Some staff have trouble with the equipment and would benefit from some extra training.”

(Care Home Manager)

By providing ‘specialised’ equipment, it made people think differently about using it for communicating with patients and care staff. Therefore, there is the potential to not only train in use of the equipment supplied but also in its application to other areas of patient care and for use in better communication between stakeholders.

“I feel that I’ve probably not used it to its full potential, and I tend to do it to the patient, to the nursing staff. I tend to do it to them rather than directly to the patients.” (Nurse Practitioner)

“The equipment has so much potential, not just in consulting with patients, but in communicating with wider staff involved in patient care, or even in simply enabling communication between the patient [resident] and their family” (GP)

We would welcome new tips and techniques about how to make more effective and efficient use of equipment.” (Care Home Manager)

Additionally, stakeholders raised problems caused by the levels of staff turnover, in particular within the care home settings. The training is often provided to staff who then leave the setting and take the knowledge with them. This raises challenges in relation to upskilling new staff and disseminating the training to a wider group of staff to avoid the knowledge being ‘lost’ to the setting.

4.2.4 Data Collection and reporting

The requirement to collect output and outcome data relating to the use of video-consultation was difficult. As such, the consistency and quality of data that has been returned has varied greatly.

Some organisations are able to collect and report data with few issues, and others find this problematic for various reasons and is often seen as an 'add on' and an 'additional workload.' There is a need to develop systems and processes that mitigate this.

“Monthly monitoring reporting has been an addition to my workload” (Practice Manager)

Of particular note is that care homes often report different quantitative data to that being reported by practices. It is suggested by stakeholders that GP practice data is more accurate than care home data since they use read codes and so are able to keep a digital record of any video consultations that have occurred in a given time frame. Most care homes only keep a paper record of this information.

Reflecting on the workloads of GP practices and care homes some stakeholders questioned what data was needed and what the data was to be used for. A number of interviewees indicated the need to only collect that is necessary and of use in understanding the impact of the system and the patient. Stakeholders are enthusiastic to improve the approach to data collection and reporting. They recognise that measuring outcomes is not straight forward and that the traditional data collection systems need enhancing to allow better collection of outcome measures. They recognise that to achieve this there is a need to upskill staff and to provide additional support. It would therefore be pragmatic and beneficial to agree a minimum core data set and set up electronic recording systems to make this task as simple as possible.

5 CONCLUSIONS

The use of video-consultation linking GP practices to care homes has clearly led to range of positive impacts on patient care and service efficiencies. Both care homes and GP practices have used the programme to deliver a wide range of imaginative and focused activities to test the usability of the system and have given extensively positive feedback on the programme.

Both care homes and GP practices appear to have delivered the programmes as intended, forged closer working relationships and enhanced patient care. This has resulted in efficiency savings across the system. From a GP practice perspective, the savings have related to reduced consultation time, reduced travel time and travel costs and reduced administration. From a care home perspective, the homes benefited from increased and

speedier access to primary care services.

The evaluation has identified the potential for addressing the barriers, raised by stakeholders, to allow the services to further refine their approach to delivery. Many of these barriers cannot be tackled in isolation. Indeed, the major barrier, that of Wi-Fi connectivity, will need system level support to enable the technology to be used to its utmost potential. Both GP practices and care homes have identified need for further training to enhance the skill set of staff in utilising the technology and a definite requirement for support in data collection. This provides a great opportunity for the delivery of further support and resources going forward.

Clearly investment helps incentivise change. Not simply in terms of finance or equipment but in terms of investment in time and culture. Overcoming many of the barriers to maximising the potential of technology in the GP-care home relationship requires system-level change and investment. There is a need to bring stakeholders together to explore what would be possible to achieve to help break down these barriers.

6 RECOMMENDATIONS

- **Commissioners, GP Practices and Care Homes** should consider continuing investment into this programme to support greater utilisation of TEC within patient care. This can be enhanced through inclusion of community pharmacists within the programme. This will support the need that by 2020 there will be a mandatory requirement for all the practices to provide some amount of consultations in the form of digital and will support the direction of travel towards a more digitally enabled health care system.
- **CCGs, Service Providers, GP Practices and Care Homes** should work together to address connectivity issues. In particular to explore potential for improving Wi-Fi Broad band connection within care homes and GP practices to improve reliability. This will support the use of video-consultations and address the major barrier to the programme.
- **The Service Provider (s) in partnership with commissioners** should continue to develop the monitoring and evaluation resources to further assess the impact of this type of intervention. These resources should focus primarily on simple, clear and consistent output and outcome measures agreed with settings. Additional monitoring and evaluation might be extended to include monitoring financial savings within the system, but this needs to be balanced against making the process too burdensome for practices and care homes.
- **The Service Provider and Commissioners** should consider developing guidance and training on monitoring and evaluation and produce a set of agreed data collection tools for care homes and GP practices to make the system as pragmatic as possible.
- **GP Practices and Care Homes** should continue to collect outcome data to assess the positive and negative impacts of the programme, in-line with the new tools suggested above.
- **The Service Provider** should develop a programme of further training and refresher workshops for **GP Practices, Care Homes and Community Pharmacy** staff, along with a system that ensures a timely and responsive technical support team. This is particularly important as frequent staff changes are an issue and a barrier to on-going development of the project and potential roll out. Identifying 'cluster' groups of staff to motivate and share learning or new ideas could be supported by an e-learning webinar on basic use of equipment.
- **All Stakeholders** should come together to discuss the findings of this evaluation through a facilitated workshop. This should be an open and honest discussion with clear action plans emerging from the event that all stakeholders commit to.