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NHS@Home Hub: A Telehealth Service Evaluation 2024

Abbreviations

ACP	Advanced Clinical Practitioner
BNSSG	Bristol, North Somerset and South Gloucestershire
DILO	Day In the Life Of
GP	General Practitioner
HCP	Health Care Practitioner
ICB	Integrated care board
MDT	Multidisciplinary team
VC	Video Consultation
VW	Virtual Ward

Disclaimer & Reference of Source

This is an independent evaluation completed by Technology Enabled Care (TEC) Cymru. The TEC Cymru authors of this evaluation assume responsibility for the collection and interpretation of the findings, and therefore any dissemination of the evaluation and its findings would require reference to the original source.

Please reference the source as follows:

> *Cushing, A., Cox, J., Yeoman, E., Johns, G., Cook, M., Khalil, S., Bleasdale, RA., Ahuja, A. (2024) NHS@Home Hub: An Independent Telehealth Service Evaluation. Technology Enabled Care Cymru;* https://teccymru.wales/research

The Service Evaluation – Aims and Methodology

This report is an independent service evaluation of the NHS@Home Hub situated within Sirona care & health for Bristol, North Somerset and South Gloucestershire (BNSSG) ICB. This report, and the service evaluation by which it is based upon, were completed by Technology Enabled Care (TEC) Cymru.

The aim of the service evaluation is two-fold:

1) In 2023, TEC Cymru begun an all-Wales implementation of Telehealth. As part of their Phase Zero evaluation, TEC Cymru conducted a range of desktop and empirical studies to better understand the use of Telehealth in the UK and were keen to further explore the processes and roles existing within mature services, such as the NHS@Home Hub.
2) The NHS@Home Hub is an embedded Telehealth service in England and were keen to be part of an independent evaluation to further support their own evaluation and support TEC Cymru with their learning.

The methodological approach taken to gather data for this service evaluation was via participant observational approach. This included two full-time Researchers from TEC Cymru based on site for two-weeks (during February 2024), capturing and recording relevant information and processes of the service. This study was supported by several senior members of TEC Cymru, and the NHS@Home Hub.

A range of participant observations took place, including visits to the NHS@Home Hubs and the in-reach hospital teams. Data was gathered via a combination of

handwritten diaries, informal interviews and discussions and the completion of a 'Day in the Life of Series' with various staff members within the service.

Despite attempts to capture patient-level feedback (via surveys and telephone interviews), due to the acute nature of the NHS@Home patients, no patient or carer perceptions of the service were obtained.

The NHS@Home Hub – Overview of Findings

The NHS@Home Hub is a service situated within Sirona care & health for Bristol, North Somerset and South Gloucestershire (BNSSG) ICB, that provides a Telehealth service via a Virtual Ward (VW) to patients with acute conditions. The Telehealth monitoring equipment and dashboard used by NHS@Home is provided by Doccla. See the updated NHS@Home Infographic in Appendix 1.

NHS@Home distributes Telehealth equipment, and then remotely monitors patients who meet certain clinical criterion via a clinical dashboard, (see table 1).

This Telehealth approach allows the NHS@Home Hub team to remotely monitor patients, from within their own home. Once a patient (or carer) takes their required observations and responds to required questionnaires, the information is automatically uploaded to a clinical dashboard whereby NHS@Home staff can remotely monitor the measurements immediately. There is also a messaging service embedded within the clinical dashboard which allows clinicians to contact patients if there are missing observations or queries. The patients are also contacted via telephone call or in-person if necessary.

Patients can be onboarded to one of five clinical pathways/virtual wards; these include:

- Frailty,
- Respiratory,
- General medicine,
- Outpatient Parenteral Antimicrobial Therapy (OPAT) /IV antibiotics,
- Heart failure.

The total patient capacity of NHS@Home is split across the five available clinical pathways, of which, the service is not currently at full capacity. Patients are visited by clinical members of staff whilst enlisted onto the virtual ward. During these visits,

manual observations are obtained to ensure the accuracy of the digital equipment, as well as a consultation about how the patient is feeling, alongside an observation of the physical condition of a patient, e.g., skin sores, jaundice state, etc.

Some staff, depending on their qualification, can prescribe during their visit – which can be done electronically and is sent straight to the patients preferred pharmacy for collection, usually the same day.

The length of stay on the virtual ward varies depending on the pathway: The average length of stay on frailty and respiratory pathways is 10 days, whilst heart failure and general medicine are longer with 14 to 20-day stays, alongside OPAT patients who have an average length of stay, with the NHS@Home service, of 3 weeks, with some rare exceptions who may remain with the service for a number of months depending on their condition and needs.

The number of visits a patient receives is dependent on their pathway, severity and individual needs. For example: a low-risk respiratory patient will receive a visit on day 1, day 7 and day 10, or alternatively, an OPAT patient will receive at least 1 visit per day, for every day they are on the ward.

For the service, a day 1 visit to patients is essential to re-establish the patients' suitability for the service, whether they can manage with the telehealth kit, and if they require any additional social support, which can be provided by a social prescriber that is embedded into the NHS@Home service.

The NHS@Home team are split across several sites. Those that visit and manage the frailty pathway are situated at the John Milton Clinic, the respiratory pathway team are situated in New Friends Hall (sharing the space with the community respiratory team), whilst the OPAT/IV antimicrobials, heart failure pathways and in-reach teams are situated in either Southmead Hospital, Weston Hospital or Bristol Royal Infirmary.

Staff Capacity

Each virtual ward pathway workforce consists of a multidisciplinary team (MDT) which includes Consultants, Advanced Clinical Practitioners (ACP), Nurses, Occupational therapists, Physiotherapists, Paramedics, Health Care Assistants (HCA), administrative team members and a virtual clinician who may be employed by Sirona or Doccla.

Although each pathway works independently of each other, staff can be brought in from other pathways, if their demand allows, to help with capacity when required.

The NHS@Home service has capacity to employ 122 Full-Time Equivalent staff members with 20-30 members of staff working each day, which is a combination of working in-person within the hub and working from home. Some of the NHS@Home Virtual Clinician team are completely remote as they can monitor the patient dashboards from home.

NHS@Home has a central hub that contains medical staff, including ACP, conducting clinical assessments with patients virtually. The hub team also has a 'hub co-ordinator' who is responsible for processing referrals and escalations, there are usually two co-ordinators working Monday-Friday, and one at the weekend. Their responsibilities mainly include processing referrals into the NHS@Home service (for both step up and step down), managing escalations, and co-ordinating the out-reach staff calendars for their visiting schedules. The role of administrative support within the hub completes all administrative based tasks. The administrative team split is often two members situated in-person within the hub and an additional 1-2 members of staff who work from home. Approximately 20 hours per day of virtual staff time is dedicated to managing the clinical dashboard.

Case Studies of NHS@Home Staff

To understand the NHS@Home service and its processes further, an in-depth exploration of staff roles and responsibilities, via 'Day in the Life Of' (DILOS)' observations was conducted. In total, 9 DILOS were completed over the two-weeks and are attached as case studies in Appendix 2 of this report.

Systematic Procedures

There is a multitude of systematic procedures that are associated with the NHS@Home service. These include the following:

Referrals

Patients are referred to the NHS@Home service by a GP, paramedics or via in-reach teams. For the NHS@home team to onboard a patient, that patient needs to have been assessed by clinical staff and have a care plan already in place e.g., a course of antibiotics, oxygen weaning, rehabilitation etc. If there is a plan in place, the hub is

then able to allocate the patient to a virtual ward pathway. Referrals are the responsibility of the hub co-ordinator who is required to fill out a referral template for each patient who has been referred to the service.

The information contained within the referral template is highlighted below:

- Does the patient have capacity?
- Date of discharge
- Step up or step down
- Referrer
- Reason for referral
- General medical history
- NEWS2 score
- Sepsis history
- Pathway specific queries:
  - Respiratory: reason for referral, baseline, requirements, stability and RAG (what level of support do they need – red = clinical cause for concern)
  - Frailty: recent falls, competence, RAG
- Next of Kin details
- Are they housebound?
- How to gain access to property
- Safety concerns
- Information regarding the patient's care plan

Patient Eligibility

To be onboarded to the NHS@Home service, patients must be unwell enough to justify a physical hospital admission. The service is intended to be an alternative to inpatient hospital care, but also for those who do not require continuous medical intervention. However, the patient must also be able to manage their own health at home (or have a carer/support network available), including being able to monitor worsening symptoms and be able to call 999 if required.

Table 1: Inclusion and Exclusion Criteria

Inclusion Criterion	Exclusion Criterion
Presenting with an acute illness	Have major trauma
Do not require observations on the same day as referral or overnight	New-onset chest pain/ suspected stroke/ acute cardiac condition/breathless to the extent cannot complete full sentences
Baseline NEWS2 score <5	Complex symptomology
Pneumonia/Chest infections/COPD, asthma/low respiratory tract condition	Require multidisciplinary intervention through another service
Unable to wean off O2 in hospital, but stable enough to come home	Pregnant/6 weeks post-partum
Have been seen face-to-face by HCP	Not able to call for help if deteriorating
Able to monitor worsening symptoms and call 999 if necessary	Have asthma <50% or variability response greater than 25% pre and post nebuliser
	Presentation of acute mental health crisis with risk to self

Onboarding

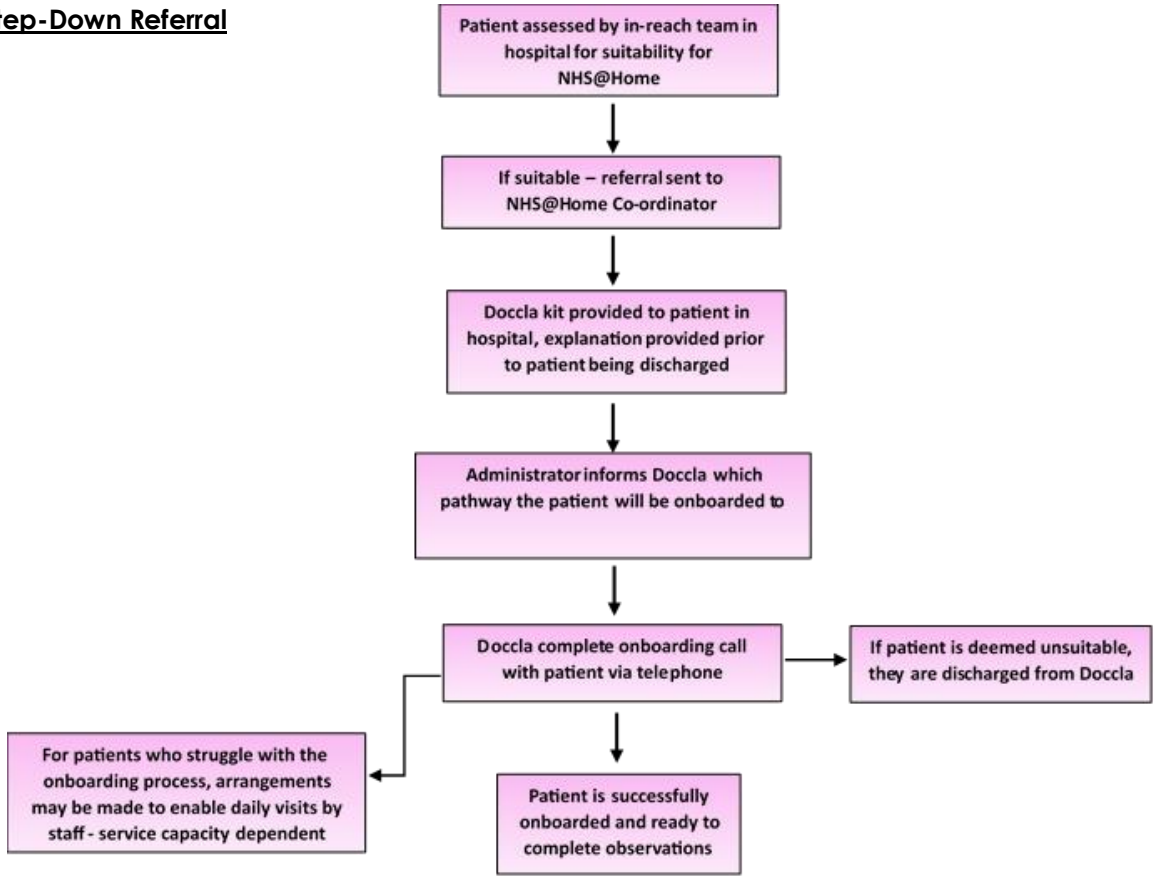
The onboarding of patients to the NHS@Home service is completed by teams at Doccla. When patients are onboarded onto the service, they are either stepped up from community only care or stepped down from in-hospital care. Approximately 85 per cent of patients are stepped down, with 15 per cent of patients being stepped up from community care.

The process of stepping down a patient from in-hospital care in most instances is linear for each patient. A nurse provides patients with a telehealth monitoring kit, explains how the technology operates and completes consent with patients after which the patient is discharged from hospital to their home. The NHS@Home Hub team informs the provider of which virtual ward the patient is being placed within and how often the patient's observations are required, and this information is then associated with the patient's telehealth kit. The provider then calls the patient to onboard them with the technology, this is usually done the day following hospital discharge. This process is reported to work well for many patients, but for those who it does not, the hub team will decide to explain the technology further, over the phone or visit in person if there are difficulties.

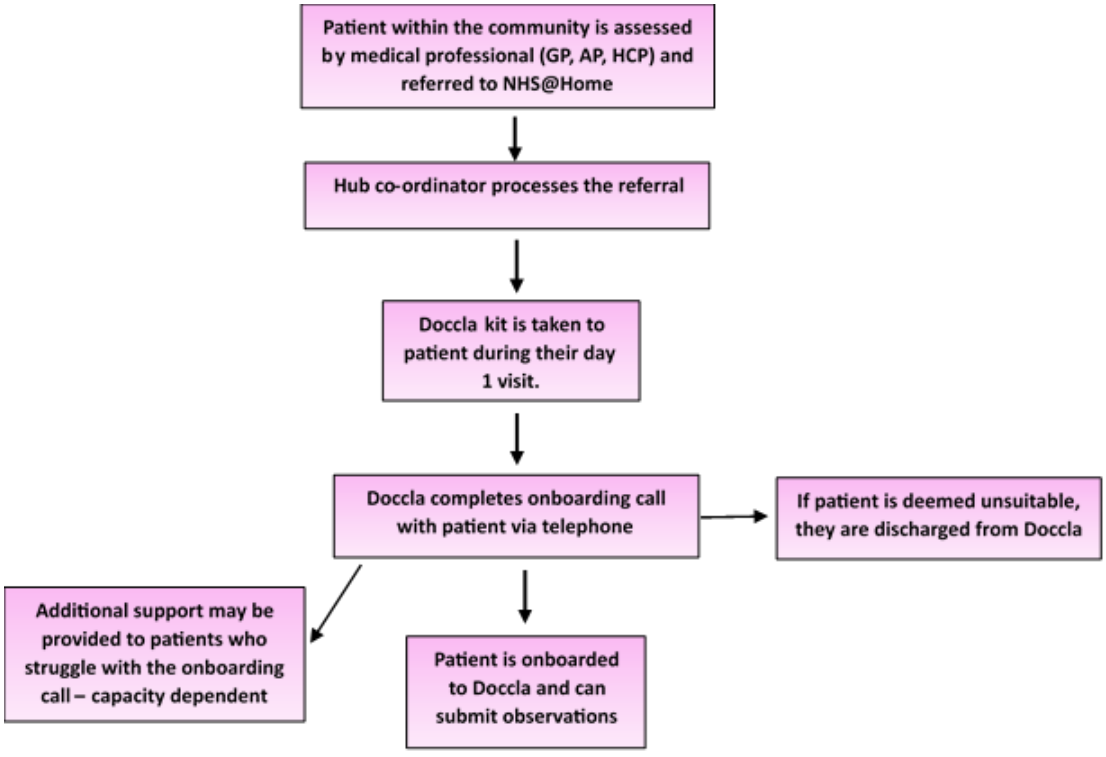
The step-up process mirrors the process incorporated during the step-down procedure. However, when the telehealth technology is delivered to patients, someone will carry out a safety/welfare check. Due to this, the process for patients being stepped up takes a little longer than for patients being stepped down.

Figure 1: Process Map: Onboarding (Step Down and Step Up)

Step-Down Referral



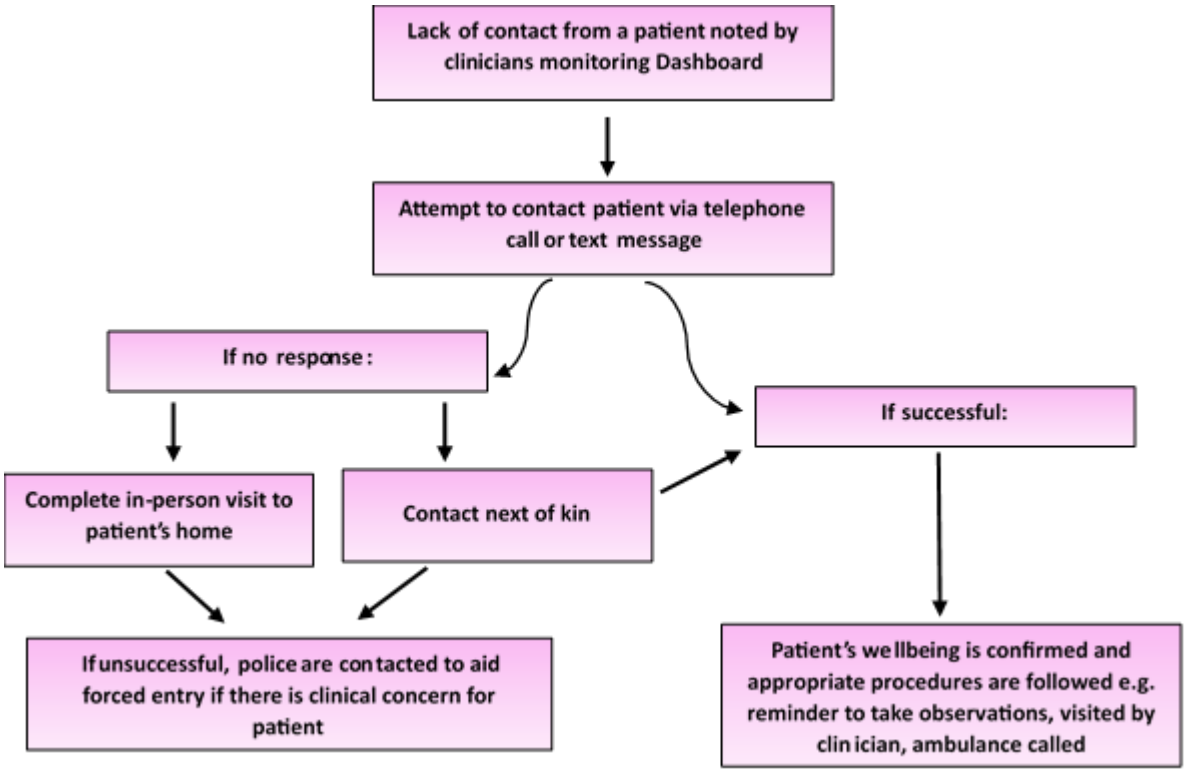
Step-Up Referral



Escalation Process

There are numerous escalation processes that are dependent on the needs of the patient. Any escalation procedure is discussed with senior hub members such as co-ordinators, managers and ACP's. Escalation can include a mix of telephone calls and/or SMS text messages, sending a postal letter and incorporating the police to conduct a welfare check. If there is clinical concern for the condition of a patient on the ward, the police can use force for entry. The utilisation of policing services and the use of force are only brought in for highly worrying instance.

Figure 2: Process Map: Escalation



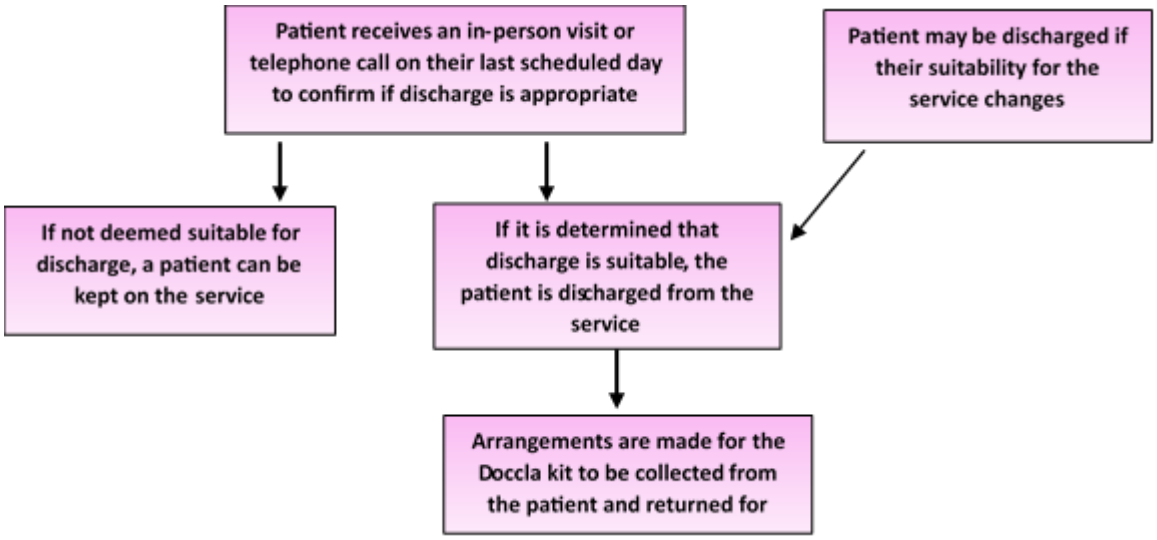
Discharge from the Service

Patient discharge from the NHS@Home service is triggered either by the completion of a pathway, which varies in length, or by the suitability of a patient to the service changes, such as if the patient fails to comply with treatment, or if they deteriorate and are admitted to hospital for longer than 48-hours. The discharge process for both possibilities is parallel and comprised of an in-person visit from a clinician, or an interview over the telephone to be assessed for discharge. Following a successful

discharge assessment, arrangements are made for the collection of the telehealth equipment.

If deemed not suitable for discharge, and if there is the capacity, the patient may be kept in the service for a little longer.

Figure 3: Process Map: Discharge



Patient Safeguarding

The remote nature of the NHS@Home virtual ward means that patient safeguarding requires a robust system to establish when complications may arise. The 'red alert' system embedded within the clinical dashboard draws attention to observation readings that may present as a clinical concern. All 'red alerts' are displayed at the top of the dashboard, to ensure that they are not overseen within the other incoming observation readings. The procedure for dealing with a red alert is to contact the patient within 30-minutes of the alert coming in, if the 30-minutes is lapsed, it is considered a breach. Although this system contributes to the awareness of red alerts, there are occasions where the volume of red alerts produces a negative effect as there is no order, chronological or otherwise, to the alerts within the dashboard. However, as more red alerts are inputted to the system, the dashboard can become complex and there is a high possibility of alerts becoming breached due to the lack of chronological order within the dashboard.

Further patient safeguarding is ensured via next of kin details being obtained during the onboarding process which can be utilised if communication with the patient is not

successful. Furthermore, there is a direct admissions connection to admit patients on a VW to hospital if their health deteriorates. This eliminates the pathway through A&E as the patient is admitted straight onto a physical ward. The hub team can pass this information onto the ambulance service, who are then aware of where to transport the patient within the hospital.

Service Benefits

The main benefit identified by staff was enabling patients to stay at home. Staff within the hub tend to be very patient-focused, which is reflected in their passion for enabling patients to stay at home whilst receiving medical care. This allows patients to take more ownership of their own health, whilst being in the comfort of their own home. It further enables quicker patient recovery, reducing the risk of hospital acquired infections, and generally provides a better level of care. All the staff members who took part in the 'Day in the Life Of' observations and additional interviews/discussions stated that this was one of the main benefits they associated with their role and of the service.

Some staff noted that working within an MDT is a large benefit to their role as utilising multiple roles within the NHS@Home Hub to provide care to patients provides multiple learning opportunities from other members of staff within the hub, both clinical and non-clinical. Furthermore, the interjection of an MDT allows for more efficient sharing of workload, especially with community teams who can support when the demand is too large for the hub.

Flexibility of the role, especially for those who are hired on a remote position was also expressed as a benefit by staff as the role has proven suitable for their lifestyles. There is also flexibility to work part-time and complete various hours throughout the week to further accommodate lifestyles. Staff associate working with the hub as having the ability to have a healthy work/life balance.

Service Challenges

Whilst there are many benefits associated with the NHS@Home service, some challenges were also unearthed as part of this service evaluation. Firstly, the use of different systems to access electronic patient records coupled with the requirement

to upload patient notes to two separate electronic systems was noted as a daily challenge as it provides a duplication of tasks. Signal and internet coverage can create extra and prolonged tasks during the uploading of patient notes, especially for visiting staff.

An additional challenge faced within the service is the lack of use of Video Consultation (VC) by the NHS@Home team with patients. Thus, the team are unable to obtain a physical assessment of patients during remote assessments. Physical symptoms such as blue lips or jaundice may be an early indicator of ill health whilst observations are presenting as normal. Although in-person visits do allow for a physical assessment, there may be an extended time between these visits where physical deterioration may occur, which VC could aid in the observation and recognition of.

Digital and dashboard infrastructure issues contribute to a disruption to the workflow for the service. The clinical dashboard categorisation does not currently present as an ideal system. The organisation of the 'red alerts' on the dashboard can present as a barrier to the workflow within the service, including increasing the associated occupational stress. Additionally reported observations are not always flagged within the clinical dashboard appropriately, there is the requirement for a higher level of medical qualification to monitor the dashboard to recognise these discrepancies. The training provided by the technology company, for patients regarding the use of the telehealth equipment has been seen on occasions to be insufficient. Patients are not fully aware of the correct procedures regarding the process of taking and recording their own health readings, which can have a negative effect on the clinical dashboard, which in turn, increases the workload for the NHS@Home team. Training by the provider is not completed by an HCP and the hub often find themselves contacting the outreach teams to conduct an in-person visit with patients consequently due to lack of education around the technology.

An additional challenge faced by the service is patient reluctance for the use of telehealth equipment which in turn produces a surge in inappropriate blue alerts (no data from a patient). This can cause additional tasks for clinicians who must establish the true blue/red alerts from those who are purposely not using the equipment. If a patient refuses to utilise telehealth equipment, they may remain within the service and daily observations are obtained manually by the visiting team, if capacity allows. Patient reluctance may not be the only factor for a low uptake by patients. Some

patients can face connectivity issues when using telehealth equipment within their own home, producing a delay in uploading health results to the dashboard. Connectivity and infrastructure barriers could contribute to a reduction in patient confidence and patient usage may be affected as a result.

Further challenges with the technology were associated with the accuracy of the equipment. Situations have arisen whereby inaccurate readings have incorrectly classified a patient as in a critical condition. These situations further increase the workload for staff as procedures, rightfully, call for patients presenting clinical concerns to be escalated and require in-person visits to ensure the health of the patient and the accuracy of equipment readings. Procedure states that all in-person visits by clinicians must consist of manual observation readings to ensure the provided telehealth equipment is accurate and that remote monitoring continues to be safe for the patient. The escalation process could benefit from being refined. At present, supplier clinicians will notify an ACP within the hub if an escalation is required, however they do not provide adequate information regarding the urgency of the escalation. Junior staff can also be seen to be reluctant to identify potential escalations, as they can be concerned that it will be an incorrect escalation. Further SBAR training may prove beneficial here, as recommended by a member of the NHS@Home respiratory team.

As is the nature with community work, there are many lone working risks that are associated with the service as staff are entering patients' homes independently. There are procedures in place to ensure staff safety, including the use of code words, which staff can use to signal for help from colleagues at the hub. One challenge that was noted by all staff who complete in-person work with patients was the extent of travel throughout BNSSG. The distance throughout the ICB can be extensive and travel can be extremely time consuming, and time could be allocated to the completion of other tasks including visiting other patients. Furthermore, although mileage is substituted for staff, it is calculated off the shortest distance between two points, however due to the infrastructure of the area, this may not always be the quickest route, so staff often find themselves without sufficient expenses reimbursed.

Finally, the requirement for information governance, whilst crucial, can contribute to an interrupted workflow as it provides a barrier to full collaboration between service

providers. This also includes access to different systems and entrance to physical locations.

Potential Changes to Workflow – Future Recommendations

Below are suggestions that have been unearthed because of this service evaluation. The researchers of this evaluation do not wish for these suggestions to come across as critical of the current proceedings but hope that they will provide some insight on how to improve the service for both the patients and the staff working within the NHS@Home Hub.

The increase of staff capacity may contribute to a better workflow. Many staff noted that a main challenge associated with their role was the requirement to travel throughout BNSSG which has contributed to a high staff turnover within the service. Employing more staff would allow for allocated travel zones, reducing the travel requirements for staff and ensure that patients were visited in a timely manner. Additionally, allocated zones could allow for lower lone working risks as other members of staff could be situated within the same area. If the employment of new staff is not currently feasible, the allocation of zones would still benefit the current staff. The utilisation of additional staff, contributing more to the use of MDT, could produce a better workforce. Collaborating with care agencies could utilise support work staff for patient safeguarding by preventing the interjection of social care services being implemented prematurely. This has been presented as desirable by staff. Similarly, the introduction of band 3 healthcare workers, who would be responsible for obtaining manual observations may aid with demand. In the instance of concern or confusion, these staff could contact more senior medical staff to address the concern or escalate the patient if necessary.

The service is not currently at full capacity; however, staff are currently expressing struggles with meeting demand. To allow more patients to be successfully embedded within the service, more staff may be required to meet the demand and ease the workload. The more patients that utilise a VW (when appropriate), the more hospital beds could be available for those patients who do not meet the criterion for a VW. Despite many staff expressing the desire for a larger workforce to support the current demand, there were many comments that contributed to the positive work-life balance that working within the NHS@Home hub produces.

Staff currently are required to upload patient information to two separate systems; EMIS and Careflow Connect. This duplicates the tasks associated with a single patient visit and when coupled with connectivity issues within the community, the uploading of patient notes can become tedious and time consuming. Utilising one system may reduce the workload on staff and the risk of missing information or transcription errors due to the duplication of tasks. Furthermore, this would reduce the time required for a single patient visit, which could allow for more patents to be seen or more observations to be obtained.

Better configuration of the red alert system within the clinical dashboard could improve workflow whilst increasing patient safety. As a result, this could produce a reduction in workplace stress for the clinicians responsible for the overseeing of the dashboard, especially junior staff. A chronological order of red alerts would ensure that alerts are resolved within a timely manner and reduce the number of alerts that are considered a breach. If the dashboard interface was altered correctly, the responsibility of monitoring the dashboard could be placed with less senior medical staff or potentially senior administrative staff, with the current proceedings, this would produce a safety risk for patients; consequently, the dashboard is currently strictly monitored by clinically trained members of staff only. This may elevate some of the workload for clinical staff who could place their time elsewhere. It is also important to consider addressing the potential insufficiency of training provided by the supplier to the patients, regarding the use of telehealth equipment and manual recording of observations. It is suggested that the responsibility of doing so should be led by an HCP to ensure the sufficient education and guidance is provided to each patient. The authors of this report understand that this responsibility does not lie with the NHS@Home Hub team, but rather with the technology provider.

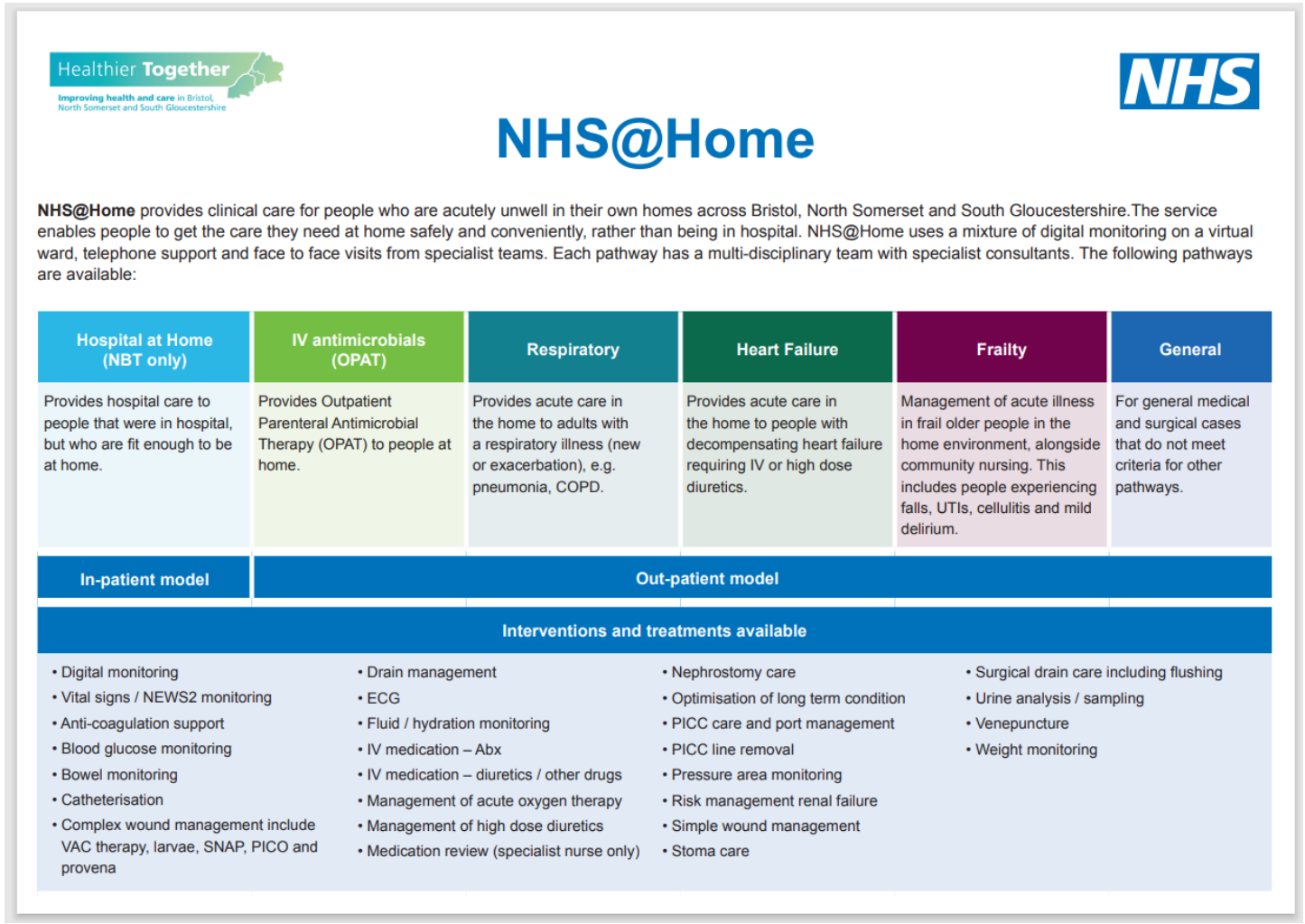
The utilisation of Video Consultation (VC) could be beneficial for the NHS@Home Hub services. VC could allow more in-depth patient assessments by clinicians who are situated within the hub or who work from home by providing access to assess the physical condition of the patient. This may increase the level of care provided for patients as symptomology may be noticed sooner. In the same breadth, VC could be utilised within the discharge process, producing a more in-depth assessment compared to a telephone appointment.

Finally, increasing patient usage of the telehealth equipment may help reduce the workload on staff by increasing the quantity of remote monitoring observation recordings, in turn reducing the requirement for travel throughout the ICB.

Conclusion

It is concluded that the service that the NHS@Home Hub and Sirona Care & Health provides is vital in aiding patient recovery, from the comfort of their own home. It enables patients to remain under medical attention, without the risk of hospital acquired infections and allows patients to take ownership of their own health. Whilst the service is crucial, there are some barriers that could be addressed to provide an improvement for the service, its staff and the patients it tends to. Finally, future integrations of virtual wards within other areas should note the importance of having a sufficient embedding in period, as is for most new technologies within healthcare. A willingness to adapt to new changes by staff is also crucial for the success of a service, however, change management procedures should be put in place to incorporate the challenges and benefits that staff experience daily.

Appendix 1: NHS@Home Infographic November 2023



Hospital at Home (NBT only)	IV antimicrobials (OPAT)	Respiratory	Heart Failure	Frailty	General
Step up / step down and who can refer					
Step down: NBT referrals only.	**Step down**: any hospital can refer. **Step up**: any healthcare professional can refer. Please ensure you have consulted with microbiology before making your referral.	**Step down**: any hospital can refer. **Step up**: any healthcare professional can refer.	**Step down**: any hospital can refer. **Step up**: referrals accepted from Community Heart Failure Team only.	**Step down**: any hospital can refer. **Step up**: any healthcare professional can refer.	**Step down**: any hospital can refer. **Step up**: any healthcare professional can refer.
How to refer					
Hospitals: please phone your NHS@Home team between 8am and 6pm and they will support you to refer: UHBW: **0117 3422327**. NBT: **0117 4140275**. **GPs / SWAST/ community nurses**: please use your usual routes e.g. week day professional line or SPA for Urgent Care response. If you are unsure or would like advice, please call the NHS@Home hub on **0300 125 5001** (7 days a week, 8am - 8pm). To discuss an individual with the Respiratory Clinical Advice and Guidance Team, please call **0333 230 1471** (between 8am - 6.30pm).					

Appendix 2: Day in the Life of Series

1) **A Day in the Life of an NHS@Home Social Prescriber – Direct Link**
2) **A Day in the Life of an NHS@Home Advanced Clinical Practitioner #1 – Direct Link**
3) **A Day in the Life of an NHS@Home Hub Clinician- Direct Link**
4) **A Day in the Life of an NHS@Home Community Clinical Nurse- Direct Link**
5) **A Day in the Life of an NHS@Home Advanced Clinical Practitioner #2 - Direct Link**
6) **A Day in the Life of an NHS@Home Community Physiotherapist #1 - Direct Link**
7) **A Day in the Life of an NHS@Home Community Physiotherapist #2 - Direct Link**
8) **A Day in the Life of an NHS@Home Registered Community Nurse - Direct Link**
9) **A Day in the Life of an NHS@Home Consultant - Direct Link**

A Day in the Life of an NHS@Home Social Prescriber

Name: NAH01
Job Title: NHS@Home Social Prescriber
Organisation: Sirona Health

Introduction
The role of an NHS@Home Social Prescriber (NAH01) was previously named a 'Clinical Navigator' until recently when the role transitioned. NAH01 felt that the previous role did not suit them or their working life, and after completing research and gaining a better understanding of what would benefit the service the role changed. The main responsibility of NAH10 is to help and support with care referrals and discuss pathways to prevent readmission, these are often holistic. The role of a Social Prescriber is adapting all the time; with many work from home opportunities, NAH01 will stay up to date with what support is available so that the rest of the team do not have to. This involves a lot of community research on council websites, social media and NHS futures. From this research, NAH01 will compile emails or letters of all the options available for a patient that they think may benefits from them e.g., groups to join or sessions to attend, including if they cost or are free. Most sessions can cost a small amount on a weekly basis, with more elaborate services e.g., cleaning services, being more expensive.

When working with the OPAT pathway, patient's will sometimes receive grants for refurbishments if their home is unsuitable for their health and care needs. NAH01 feels that this is a 'brilliant' benefit of the service. As well as this, the Social Prescriber role also involves spending time with the respiratory team at a pulmonary rehab group learning clinical skills from both clinicians' patients, where NAH01 has then in turn educated them on the Social Prescribing service available. Furthermore, on quiet days, NAH10 will provide support for the admin team.

Ultimately, the work NAH01 completes contributes both to those who require support but also aids those who cannot be supported by just regularly check-in. This person-centred way of working means all patients are grateful for the work NAH01 provides, where they are thankful and appreciative to have someone who listens. Through the hands-on approach of this role; of meeting with patients and attending groups to document how patients improve, NAH10 can further learn things from these patients about what help they may need going forward. NAH01 discussed how this is 'hugely helpful' as not all patients like the idea of having to exercise more and so it is important to find an alternative option that does not feel like exercise (art therapy instead of yoga, or gardening instead of a cross trainer at the gym). The role of being a Social Prescriber means 'thinking outside of the box', tailoring to individual needs and enabling these patients to take control of their recovery in a way that suits them. However, there are occasions when the role can be slow and not very engaging. It can become hard at times when patients do not want to accept help initially, especially when they are older.

Benefits of the role
It was noted that the benefits this role provides to patients are enormous. The service aids them in getting back on their feet mentally, making them feel a sense of community and most importantly reducing their overall chance of readmission. NAH10 expressed how they 'love' to see patients happy and developing new interest of hobbies that can have a positive impact on their recovery.

Challenges of the role
Despite NAH01 enjoying the role and seeing the benefits the service provides positively impacting patients, some challenges were also discussed. Firstly, some patients are often

difficult to get hold of and so therefore different ways to get a hold of them are tested, as well as getting them to trust in NAH10 and let them support. This can be those patients who are regarded as frail as they are often housebound and green social prescribing is not always suitable, and those who are found to be hoarding can be difficult to work with as the thought of decluttering is very overwhelming for them. As well as this, those patients who will not accept help have to be discharged and referred to the GP for another type of support, or to show that they have been prescribed to the service before and show details of why in case they are presented later with associated illness.

To overcome these challenges, NAH01 expressed that a Social Prescriber must understand and remember that the role requires being able to adapt easily and be resilient to any challenges that come their way. However, as it can sometimes get lonely, NAH10 will often go the Hub to see their colleagues.

What is needed to improve the service?

Furthermore, NAH10 discussed that to improve the service, there is a need for another member of staff to onboard with support with holidays and sickness. Currently, Band 3 are at the Hub helping with this recently. In the future, a bigger team who share a passion to help and are keen to message clinicians and patients about what help can be offered would also be helpful, to continue attending sessions to push the message across.

Conclusion

The role of an NHS@Home Social Prescriber is vital in ensuring that patients receive the best help and support that is suitable for them, as well as creating a better understanding for both clinicians and patients of the options that are available out there. Without this role, there would be a greater workload for other members of the Hub, as the research NAH01 provides helps support the care clinicians provide.

A Day in the Life of an Advanced Clinical Practitioner #1

Name: NAH02
Job title: Advanced Clinical Practitioner
Organisation: Sirona

Introduction
The role of an advanced clinical practitioner is a hybrid role, involving primarily office-based work, with occasional work from home opportunities. This is a full-time role for NAH02, with 30 hours based in the hub and 7.5 hours as MSc student work. NAH02 helps provide care to patients both in the community across Bristol, North Somerset and South Gloucestershire (including palliative care) and occasionally using a video consultation. They network with a wide variety of staff, including GP's, consultants and hospitals and will signpost patients to more appropriate services if they require healthcare that they cannot provide, primarily to either social services or social prescribing.

In a standard workday, NAH02 primarily sticks to caseload work and issues actions for each case, whilst attending meetings through the day such as board meetings and staff huddles. They very frequently prescribe and deprescribe medication for patients within each board round. If patients do not take medication and become unwell, they are admitted or re-admitted to NAH02's service. NAH02 has been in this role for 10 months, previously working for 10 years in community-based healthcare roles, after working in an acute trust and a hospice for 7 years, with future ambitions of remaining in community care and gaining their band 8a. NAH02 reports to the co-ordinator, with a team reporting to NAH02.

Technology, training and staff capacity
NAH02 uses a variety of telehealth technology as part of their role, namely Doccla, blood pressure monitors, pulse oximeters to monitor oxygen saturation, thermometers and digital scales. This technology is used for vital signs monitoring in patients that are frail. They also use video consultations to see patients but are only used if a clinician is physically present visiting a patient and is not used for general appointments. NAH02 feels that telehealth and video consultations should not be used as a substitute for face-to-face, but rather just to bolster the service provided to patients. NAH02 was unsure whether their role may affect DNA rates or not when compared to virtual. NAH02 also uses an iPad/iPhone, Microsoft teams and PC within their role. Three different systems are currently used for electronic patient records.

In regard to training and staff capacity, NAH02 notes that they have ongoing training from the university throughout their MSc, alongside support from their organisation for long-term developmental training. There are not enough staff members to cope with the demand on the service, with many staff members being employed through agency, with the demand on the service fluctuating day-to-day. It is felt that there are enough pathways, however, to support staff and citizen welfare and wellbeing. Finally, there is good communication within the role with ambulance services, however there can sometimes be a power battle.

Benefits of the role
There are numerous benefits identified by NAH02 linked to the role, the first being good social but professional relationships with colleagues, with them liking the teams that they work with. They also highlight good NHS benefits, including pension, sick pay, annual leave and work-life balance. The community work aspect is also highlighted as a benefit, with it being easier and providing a different manner of working. NAH02 also believes that there is less stress in this role than in others and when compared to agency work.

NAH02 feels that there are various social benefits to the role, highlighting that it provides pride to them from their family and gives them gratitude when they are able to make a

difference to patients, specifically stating that there are little things that they do in the role that can help them go above and beyond for patients, and helps them carry out their job to the highest level. Whilst NAH02 states a general love of nursing and providing care to patients, they also specifically focus in on palliative care being an aspect of the job that they particularly like, as it can leave a positive lasting impression with the family and that it is a privilege to do this work.

Challenges of the role

Regarding telehealth technology, often friends and family may agree to telehealth care, however when the patient returns home, this is often then seen differently and patients are unable to use tech, creating a potential barrier to care for patients of difficulties using the technology, especially within the older generation. Telehealth is also commonly affected by connection issues. NAH02 also feels that they are not 'tech savvy', which can make the role more difficult to undertake. Whilst telehealth has allowed a potential increase of workload, if all patients become ill at the same time it can cause a surge in capacity which then makes it difficult to manage.

One of the main challenges identified of the role is the commuting. NAH02 highlights the difficulties of driving to different areas within Bristol, North Somerset and North Gloucester, which can sometimes take very long. A further challenge of the role is the three different systems used for electronic patient records, which can provide issues.

It is felt that the role is too clerical and operational, with NAH02 believing that they would enjoy more face-to-face care with patients. It is also felt that there are currently not enough staff to deal with capacity demand and specifically that there are not enough band 5 and clinical band 6 staff members. This is due to a lack of funding and opportunity meaning that there are currently less band 5's coming out of university.

Finally, there are various risks involved with the role. These include concerns about personal safety, mental health risks linked to the isolation of working from home and high clinical risks with substantial amounts of responsibility held.

What is needed to improve the service?

There is a need for more staff to deal with the capacity demand and for more staff to be trained in the future, specifically more band 5 staff members and clinical band 6 staff members to then develop into band 7. They are unsure what telehealth they would like to see more of in the role.

Conclusion

In conclusion, this role appears to be wide-ranging with a hybrid working scenario, including both admin and clerical tasks alongside providing virtual and community care (palliative care being the most liked aspect of this). NAH02 feels that they really enjoy their job and the ability to leave a positive lasting impression on patients and their families and friends. There are various social and personal benefits identified, allowing a good work-life balance and professional relationships with colleagues. However, there are various challenges, including difficulties with telehealth such as difficulties using it, connection issues and various patient electronic record systems being used. Commuting is seen as a big challenge with a large geographical area to cover. Pressures to meet capacity demand are often created by a lack of staff numbers and/or skill level, especially when demand increases during fluctuations, with agency staff covering creating additional pressure. Finally, there are various personal risks associated with the role. Efforts to increase staffing numbers and funding to produce more highly skilled staff is needed to improve the service.

A Day in the Life of an NHS@Home Hub Clinician

Name: NAH03
Job Title: NHS@Home Clinician
Organisation: Sirona Health
Health Board: Bristol, Somerset and South Gloucestershire ICB

Introduction
The role of an NHS@Home Hub Clinician (NAH03) is a fully remote position that is incorporated onto a virtual ward at Sirona Health, based within Bristol, North Somerset and South Gloucestershire (BNSSG). The main responsibility of NAH03 is to monitor the patients all virtual ward and their observation data on the Doccla clinical dashboard. NAH03 has been situated within this role for 3 years, with previous work experience on a covid virtual ward and prior to this working as a theatre recovery nurse and a pain specialist. NAH03 completes 17 hours a week over two days, with a working pattern split of 09:30-14:00 and 16:00-21:00 on both days.

Priority is first given to 'red alerts', which are readings that may cause clinical concern. Following this, priority moves onto 'blue alerts', which come about when a patient has not submitted their readings. There are many tasks that are associated with the acknowledgment of red and blue alerts, including checking patient observation results, calling patients who present concerns, speaking with outreach team, and co-ordinating care accordingly. Ultimately, the work NAH03 completes contributes to patients not having to be admitted to hospital, which in turn reduces the risk of hospital acquired infections, or 'pyjama induced paralysis' whilst still receiving a high level of care. If there is an occasion where a situation cannot be solved via a telephone call, NAH03 can request a visit from the outreach team to take physical observations, stool samples etc.

Patients situated within the virtual ward are provided with a Doccla kit box, including a blood pressure monitor, pulse oximeter, thermometer and a tablet/smartphone. Additional technology is provided for patients on specific pathways which can include; glucometer, ECG device and weighing scales.

Technology, Training and Staff Capacity
The technology used daily within the role of an NHS@Home Hub Clinician includes a laptop, headset and any other equipment that would help the clinician to access the Doccla dashboard, where they are able to observe patient data. The role does require a digitally literate individual. The role of telehealth is essential for NAH03 role and without it, the position would not be available.

NAH03 noted that there is generally enough staff to meet the demand of the service, although at times they may experience a shortage of staff due to multiple annual leave occasions occurring simultaneously, however the workload is still achievable. Communication with the wider team is frequent, which helps to manage the clinical dashboard effectively and collaboratively and although the position is remote, NAH03 does not feel like she is part of a team less because of this. First hand communication with outreach care teams, advanced clinical practitioners and occupational therapists is also essential via teams chats and calls. Additionally, NAH03 feels very supported within their role, stating there are plenty of pathways that support staff wellbeing and welfare.

Benefits of the role
There are many benefits that are associated with the role of NHS@Home Hub Clinician, including the flexibility and convivence that comes with a remote position, especially for those with school aged children. NAH03 describes her role as enjoyable and fulfilling and

feels grateful that they can empower patients to take more responsibility for their care whilst enabling them to stay at home.

Challenges of the role

Although NAH03 finds her role enjoyable, there were some challenges noted. Firstly, the lack of video consultation was noted as a challenge as it does not allow for physical checks of determination in patients e.g., blue lips or clammy face. As well as this, the remote aspect of the role means that family dynamics cannot be a factor in assessments, however if there are concerns for a patient, making an appointment with the outreach team is an easy process, which allows for reassurance within the role.

Occasionally, there can be technical problems with the clinical dashboard which can present as a problem if not corrected in an appropriate time frame. Furthermore, there are occasions where patients are reluctant to use technologies, this produces more "blue alerts". There are no risks that are associated with the role.

What is needed to improve the service?

NAH03 noted that to improve the service they provide there are a few minor discrepancies with the Doccla dashboard that, if corrected, would enable for a more efficient service to be provided to patients. Although this was noted as nothing extensive.

Additionally, the utilisation of video consulting platforms may further improve the service that Hub Clinicians provide by producing a more holistic and full rounded assessment of a patient's well-being.

Conclusion

The role of an NHS@Home Hub Clinician is vital in ensuring that patients receive a high level of care whilst at home. They can observe and monitor a patient's health via a clinical dashboard and using telehealth equipment, without which, NAH03 role would cease to exist.

A Day in the Life of a Community Clinical Nurse

Name: NAH04
Job Title: Community Clinician Nurse

Introduction
The role of an NHS@Home Hub Community Clinician Nurse (NAH04) is split between working at the John Milton Clinic in Bristol, North Somerset and South Gloucestershire (BNSSG) and going out into the community for visits with patients. The main responsibility of NAH04 is to attend community visits specifically for frailty and respiratory patients, measuring their test results to report back to the Hub. 3-4 visits per day are usually completed as a baseline amount, and between 5-6 on a busier day working from 8am-8pm.

Prior to completing community visits, NAH04 will typically begin the day by completing admin tasks and delegating caseloads throughout the team. Patient's notes are then read, and equipment checks are processed, to ensure that all is in working order. Routes are then planned, and patients are contacted via telephone to inform of NAH04's rough arrival time. Visits between patients often take a varied amount of time between each as each patient is different and requires different needs. Once NAH04 has completed their community visits, they then return to the office to complete a write-up of patient notes to then upload. Any circumstances that have escalated for certain patients where information needs actioning is discussed with NAH04's supervisor. In some cases, NAH04 can often be called out to other visits between returning to the office, where they offer additional support to the respiratory department whose service closes at 6pm.

Since NAH04 must complete in-person community visits, remote working is not an option. Due to this, video consulting is not used to contact patients either and Telehealth interventions are not implemented due to the face-to-face nature of the role. The contribution of the role means that NAH04 visits multiple patients to help and support them, while making a difference in a role they have always wanted to do.

Technology, Training and Staff Capacity
The technology used daily within the role of a Community Clinician Nurse includes a blood pressure monitor, pulse and oxygen SAT monitor, thermometer and weighing scales, all used to help measure and observe patients. The role requires individuals who are confident in using this type of technology, to record measurements accurately. The influence of Telehealth has massively affected the role and workload with them now being a Telehealth Hub, however NAH04 has communicated that they prefer the use of manual readings when using the technology listed above, due to the ability in obtaining accuracy of results.

It was however noted that the service relies heavily on agency staff with only three permanent band 5 and two agency staff currently working at present. NAH04 specifically reports to their team co-ordinator as well as ACP and ACL. In terms of training and development, this is received at the start of the role by shadowing another member of staff, but there is however no ongoing training throughout the role. Regarding medication management and adherence knowledge, this is not specifically important in the role of a Community Clinician Nurse, but it is however important that patients receive the correct medication in which NAH04 is able to recognise.

For those citizens who require additional help and support, they are signposted to their GP by NAH04, or this can be discussed between NAH04 and their co-ordinator or ACP/ALP, where they will then phone and discuss the available support. Additionally, while working in this role, there is little interaction with the ambulance service, however, there have been experiences when if a patient has required one, family members will wait with them, or

Community Clinician Nurses will arrange for someone to look for the ambulance while they sit with the patient.

Benefits of the role

There are benefits associated with the role of an NHS@Home Hub Community Clinician Nurse. Specifically, for NAH04 as they work on a part-time contract through an agency this allows flexibility within the role so that they can take the time to still enjoy hobbies. Furthermore, they are able to help and support patients in a role that they love to do where they feel that they can make a positive difference.

Challenges of the role

Despite feeling fulfilled by the role, NAH04 has explained some challenges and difficulties that they have faced. Firstly, the constant travelling between destinations to reach patients is often a struggle encountered, as BNSSG is a large area meaning travel time is often long between destinations. It was also noted that there is sometimes risk when dropping samples at surgeries for analysis, as these may sometimes not get collected. Therefore, NAH04 described that although time consuming, they will personally deliver these to pathology at the local hospital to ensure they are tested.

Additionally, further risks associated with the role were communicated, including the dangers of lone working where it is important to read the patients notes and acknowledge any problems the patient may have, so that NAH04 can 'pair-up' with another member of the team if feeling unsafe. To improve the service, and potentially this risk, NAH04 suggested the employment of more staff and to also have the opportunity to attend patient visits with ACL/ACP to learn more about their role and how they assess patients.

There is also concern from NAH04 about using Telehealth to collect patient results, as although the technology provides instant readings, they are fearful about the accuracy of these, as they are not 100% confident the kit provides correct readings. Therefore, NAH04 does prefer to take manual readings to avoid any inaccuracies.

Conclusion

The role of an NHS@Home Hub Community Clinical Nurse is important as they ensure frailty and respiratory patients are visited regularly for all health screening to take place, where appropriate measurements are taken and reported to the Hub. While Telehealth is used among this service, concerns for its accuracy were noted as well as a preference for manual readings to avoid any discrepancies in the readings. It is important to know that there is limited knowledge of other Telehealth innovations that could be implemented into this service, and so further awareness of this is vital to ensure best care is provided.

An average DILO of a Hub Clinician

	Time stamp	Main Responsibilities
Visit 1	09:50-10:45	In patients own home. Frailty patient who needs full observations completed. Care explanation provided to patient's partner regarding discharge.
Visit 2	11:00-11:45	In care home. Weight and BP required. Bedbound patient so proved difficult but patient willing to help.
Visit 3	12:35-13:30	In patients own home. Patient recently received radiotherapy – BP, Temp, O2, pulse, breathing and bloods required.
Pathology	13:55-14:10	Dropped off bloods obtained from visit 3 to pathology
Notes	14:30-20:00	Re-visit daily caseload, write up all patient notes. Locate and escalate any patient concerns noted during visits.

A Day in the Life of an Advanced Clinical Practitioner #2

Name: NAH05
Job Title: Advanced Clinical Practitioner
Organisation: Sirona
Health Board: BNSSG ICB

Introduction
The role of Advanced Clinical Practitioner (ACP) provides in-person support to patients who are onboarded onto a respiratory virtual ward. NAH05 is a prescriber and other responsibilities whilst on in-person visits include conversing with patients regarding outcomes of patient health questionnaires, obtaining blood samples, completing in-person observations. All of this information is recorded via EMIS and Careflow Connect.

It is important that for their care that patients adhere to medication management, if patients do not take prescribed oral medications, they are deemed not acutely unwell and will be discharged to a GP. The Sirona Respiratory Service Mission Statement is "Providing individualised quality care to empower people with respiratory conditions to live a healthier life" and as a result the service NAH05 provides contributes to patients being able to be discharged from hospital. If patients are required to be signposted for additional support, the team interact with the Welsh Ambulance Service Trust (WAST).

Technology, Training and Staff Capacity
On an average day the technologies that NAH05 interacts with include a telephone, computer and health monitoring equipment with the service offering telehealth equipment to its service users. The use of telehealth equipment by patients allows staff within the NHS@Home Hub to have a virtual touchpoint with as many patients as possible. The role of ACP requires a digitally literate individual to balance the technical systems involved with the role., NAH05 is a digitally literature person. NAH05 noted that there are occasions where the IT systems within the hub are slow or may fail respond. Furthermore, connectivity issues arise when visiting patients within their own homes which has an ongoing influence on the ability to complete the required tasks associated with visiting patients i.e., uploading notes to patients file on EMIS.

At present, there are enough staff to meet the demand of the service, with the ability to utilise staff from the community respiratory team if extra support is required. Despite this, it can occasionally be difficult to meet the demand for prescribing as not many members of the team are qualified to complete prescribing, however, the electronic nature of this does aid with completion. Interactions with the wider team are positive as an ACP, with collaborations possible to aid with workload, responsibilities and capacity.

Benefits of the role
The ability to help patients who would otherwise require hospital care was noted as a large benefit to the role of ACP by providing a service to poorly people at home. Additionally, working within a multi-disciplinary team provides great knowledge and learning opportunities for all staff.

Challenges of the role
Although the role of ACP provides a positive societal influence for patients, there are some challenges that NAH05 associates with the role. Firstly, the volume of travel that is required to complete the daily tasks for the role of ACP within the respiratory VW pathway. As the trust covers a large area, travel to a single patient can take a significant amount of time and although milage is substituted, it is calculated via the shortage journey via milage. Due to city traffic, this often is not the most time effective route and as a result, the milage reimbursement for staff can be insufficient for the travel completed.

An additional challenge that NAH05 must overcome is the restrictions of the telephone template that is used when communicating with patients. There is a lack of free text boxes to elaborate on responses from patients, which would provide a more rounded understanding of the patient's health. Furthermore, certain scoring systems e.g., BORG scale are difficult to describe over telephone but are still required when speaking to a patient.
There are also lone working risks that are associated with the role of ACP due to community work and entering patient's homes. There are however policies in place to ensure staff safety, including the use of code words for staff to use that would signal to the hub that support is required.

What is needed to improve the service?
Although NAH05 noted that there were enough staff to meet the demands of the service, it may be beneficial for both staff capabilities and the direct influence on patients to increase staff capacity to delegate staff to specific clusters or areas throughout BNSSG. This would reduce the travel time for staff and in turn would allow for more patients to be visited within a time frame, a factor that would prove beneficial if the demand on the service increased. Additionally, a reduction in the level of documentation, including the duplication of online systems would be beneficial in reducing the time and individual tasks associated with a single patient visit.

A Day in the Life of a Community Physiotherapist #1

Name: NAH06
Job title: Band 5 Community Physiotherapist
Organisation: Sirona

Introduction
The role of a community physiotherapist is a hybrid role within the respiratory team of Sirona, with most of the work done out in the community, however the days can begin either working remotely from home or in the office. The start of the day entails preparation for community visits later in the day and includes organising and assessing caseload, reading notes, checking emails, planning routes and ensuring all equipment is prepared and fully-functioning. Days then either entail community visits or holding educational and rehab classes in public areas, including gyms, for patients with respiratory conditions. The community visits are conducted 1 day a week and encompass visits to up to 5 patients' dependant on current caseload, with visit nature varying dependant on patient needs. Following community visits, NAH06 will then return either to the office to attend MDT's if scheduled, or either the office or home to type up patient notes, make any required patient calls and other admin tasks. This role also entails showing patients how to set up and use the telehealth kits, as well as checking if patients are using it correctly and ensuring there are no issues.

This is a full-time role, with work hours being 9am-5pm Monday to Friday. All work is done for patients in the Bristol, North Somerset and South Gloucestershire area (BNSSG). If a patient requires care that NAH06 cannot provide, they can contact an external individual or organisation to contact the patient or pass on the individuals/organisation's details to the patient. They can also refer to their seniors in ACL or ACP to get advice on the situation. NAH06 can also provide education or advice on certain medications for a patient.

NAH06 has been in this role for 18 months with previous experience as a junior physio. They report to ACL, ACP or management with nobody reporting to them.

Technology, training and staff capacity
This role does not involve any video consultations with patients, with all appointments taking place face-to-face. To conduct physical observations, they use a Doccla kit including blood pressure monitors, pulse oximeters and technology to measure pulse and heart rate but do mention that this is not always entirely accurate. They also use a laptop and a mobile phone as part of their role, with communication within the respiratory team frequently taking place on teams or phone call (in addition to face-to-face). NAH06 mentioned that they feel confident in using the digital technology. NAH06 does also mention that they are not entirely sure what telehealth equipment is available. NAH06 is also unsure whether DNA rates are affected or not by not being virtual within their role. Patient notes are typed up onto EMis and Careflow Connect.

Regarding training, NAH06 is currently undertaking this role as part of a 3-year BSc in Physiotherapy, with the role providing ongoing training towards this. The role also involves shadowing for a week or fortnight (unclear what decides which of these), with CPD opportunities frequently. NAH06 stated that they are unsure whether there are currently enough pathways in place to support staff.

Regarding staff capacity, NAH06 feels that there are currently enough staff members to cope with the demand of the role, however this may not remain the case if workload and demand increased.

Benefits of the role
NAH06 highlights various benefits of the role. The role of a band 5 community physiotherapist is a flexible one and suits their lifestyle, with them stating that they enjoy the job as they enjoy helping and supporting people. They mention that being able to get out into the community is a benefit, as well as the wide-ranging diversity of tasks within the role and each day being different. The role is seen as a highly rewarding one by NAH06. A further benefit is the relationships within the respiratory team, with the team being seen as a close-knit group.

Challenges of the role
There were also various challenges presented to NAH06 within this role. When referring to the telehealth equipment used, NAH06 highlights that accuracy can often be off, as a result often deciding to take manual observations instead. However, NAH06 does also say that the accuracy has improved recently. There are also further technological issues with WiFi regularly dropping, which occasionally force NAH06 to work from home to avoid potential internet issues.

Travel is another challenge presented within this role, with the BNSSG area being a large one, the role sometimes requiring travel of over an hour to see a single patient. Another challenge within the role is the service very regularly changing its policies and procedures, with NAH06 believing that it can be difficult to stay on top of. There is also a lot of responsibility within the role to ensure effective communication and to get things right, with patient visits holding the most responsibility (over educational/rehab sessions).

Finally, NAH06 highlights the risk of lone working within this role. Occasionally, they may feel unsafe within this role, but that there are safety procedures that can be implemented such as delaying a visit, calling into the office or on teams or pairing up with others.

What is needed to improve the service?
Blood glucose monitors would be very useful as a lot of patients have diabetes. Whilst it was not stated by NAH06, a more stable internet connection would help improve the service, allowing individuals in this role to work from the office if they desire to. It was also repeatedly highlighted that telehealth technology is not as accurate as NAH06 would expect, but it is unknown the reason for this.

Conclusion
In conclusion, this full-time role is a highly flexible one, with a hybrid working system, in which NAH06 assists patients through either the running of educational and rehab classes or with community visits to them. This is alongside admin-focused tasks carried out either at home or in the office. Whilst telehealth technology in the form of Doccla kits is available, there are issues regarding its accuracy and can lead to manual measurements being taken instead. Training is of a sufficient level in the job and demands are currently being met by staff capacity. The role is seen as a highly enjoyable one by NAH06, albeit often holding heavy responsibility, with the diversity of tasks appreciated. However, there are various technological issues that can impact the work in this role, as well as difficulties commuting, uncertainty about safety on some community visits and too-often policies and procedure changes. Blood glucose technology is encouraged to improve the service, alongside more consistent Wi-Fi and higher accuracy of telehealth technology.

A Day in the Life of a Community Physiotherapist #2

Name: NAH07
Job title: Band 5 Community Physiotherapist
Organisation: Sirona

Introduction
The role of an NHS@Home Hub Physiotherapist (Band 5) working at the Sirona organisation, in Bristol, North Somerset and South Gloucestershire (BNSSG) experiences a different working day each day. For a Community Physiotherapist working here, their typical day will begin by looking at caseloads and attending meetings regarding the caseload and capacity, before then travelling to visits. Patients are not contacted via Video Consultation and instead will be called via telephone to inform of arrival, with on average, 3-4 visits being completed each day. For this individual (NAH07), this is part-time Monday-Wednesday, 8am-8pm. Following the completion of visits, patient notes will be completed back at the office prior to making any further calls to them, as well as attending any MDT that might be needed regarding the patients. NAH07 will report back to ACP if needed, while they are relied upon as a line manager for a navigator.

Opportunities to work from home in this role are very rare. However, approval to start from home when reviewing caseloads and to finish note writing at the end of the day is becoming more common but is often dependent on the location of the first and last visit and how close this is to the office and home. The contribution of this role means that NAH07 can help and support the public in a role that they love and value, due to the everchanging aspects involved daily. Where they also feel at home in the job they complete with a helpful team by their side.

Technology, Training and Staff Capacity
Technologies used within this role include ECG machines, blood-glucose and bladder scanners, nebulisers and the Doccla Kit (including blood pressure, thermometer, oxygen probe and respiratory rate). However, it is policy that while out on visits Community Physiotherapists use their own equipment for manual readings, as this will inform of any problems with the Doccla Kit, or technology equipment being used. Often, poor signal and internet connection is experienced while out on visits, making it impossible to upload notes onto a computer. Therefore, paper notes are taken first to avoid any disruption. Telehealth used has come a long way since Covid, with the technology being very fast paced and constantly changing, here, problems can be reported quickly and easily, with them being changed or fixed in a short period of time.

The consensus was noted that there needs to be higher recruitment levels as NAHO7 disclosed that there is not enough staff to cope with the demand of the service, as locum/agency staff are heavily relied upon. The introduction of Band 3 Healthcare workers was a solution suggested by NAH07, so basic checks and visits could be completed. To be able to progress into Band 6 roles, it was also suggested that the virtual staff can apply for these as they have all the knowledge and experience of this, but no opportunity.

Regarding training, there are lots of courses available (blood, safeguarding, link practitioners, shadowing of various team members, and a prescribing course in the future), all which Sirona pay for. It is felt that there are enough pathways to support staff and citizen welfare and wellbeing, where NAH07 also had a lot of interaction with wider teams on other pathways, particularly those of the Respiratory pathways.

Although not confident, and is potentially an area for further training, medication management and adherence are important in the context of the role. NAH07 is however able to recognise and follow notes/prescriptions. A full assessment is also fully understood

when citizens may require additional help and support. NAH07 will find out what help is needed and then discuss with ACP/ALP to provide this support. Furthermore, involvement with the ambulance service is infrequent as they have little contact with them, however one incident did see them being dealt with four times in one day.

Benefits of the role

The flexibility of the role is perceived as beneficial as all 32 hours can be completed easily across the week, with the opportunity to work overtime if needed. With a case load that is not regarded as 'heavy work', work life can be left at the door enabling a healthy balance between work and personal life.

Telehealth plays a beneficial role as it allows NAH07 and team members to not only monitor the patient remotely and every few days, but also allows them to remain home where most comfortable and be visited as and when needed.

Challenges of the role

NAH07 discussed challenges that are experienced in the role, this included risks of lone working. There are however procedures in place for this. A Teams channel is monitored by a member of staff who will check in at every point, as well as this there are emergency codes (Purple Folder) used when ringing the office if a staff member on a visit feels uncomfortable. Staff members can also pair up prior to a visit or contact ACP/ALP and possibly leave the visit for someone else.

Additionally, challenges with the escalation procedure have been experienced previously. When a patient started to deteriorate while on a visit, both the office and ACP/ALC were too busy to answer with the escalation procedure not working at this time in the situation. This created a challenging infield complex situation, which has since been learnt from with the instalment of an escalation phone which changes hands multiple times a day.

As mentioned previously, a major problem is often the lack of signal and internet coverage, which often creates extra work when having to make paper notes first before transferring onto a computer. Finally, challenges with the equipment itself were discussed. If the equipment is cold, or the patients house is cold then the equipment will not work properly to record measurements. NAHO7 also disclosed that they do not deem themselves as digitally literate and lack confidence in using the technology.

Conclusion

The role of an NHS@Home Hub Physiotherapist is a flexible one with lots of changes occurring in the role daily. This is a hybrid role where the staff work both from the office for the collation and write-up of notes, while also going out into the community to work with patients. Doccla Kits and a variety of other technologies are encouraged for use in this role, which is perceived positively by NAH07, as it means patients can remain home for remote monitoring to be visited as and when needed. However, various challenges were noted regarding both the technology used and from experiences in the role, including issues of lone work where a higher demand for improved staff capacity is concerned, and patient deterioration risks. When considering the challenges faced when using Telehealth, confidence to use the equipment and issues with the equipment itself not working properly were frequently noted within this role. A greater awareness of further Telehealth services that could be employed that are available for the role needs advancing, so that knowledge of technologies to provide best care can be improved.

A Day in the Life of a Registered Community Nurse

Name: NAH08
Job title: Registered Community Nurse
Organisation: NHS@Home Team - Southmead

Introduction
The role of a registered community nurse is primarily involving care for patients out in the community, as the name suggests. There is a slight hybrid nature to the role, with NAH08 able to start their workdays at home, but involves primarily fieldwork. A typical workday involves meetings, visits and admin duties. Medication management and adherence is considered a very important part of this role. NAH08 mentioned that the role does not involve a lot of contact with ambulance services or any wider teams. This role involves a balance between care and clinical work. Shifts typically run from either 07:00-19:30 or 09:30-21:30, however bank shifts are also available which run from 07:00-14:00. NAH08 works in this role part time, with 2 x 12.5 hour shifts a week plus their bank work. NAH08 has been in this role for 4 years, but working slightly longer than this when you include bank shifts.

They report to their co-ordinator and do not have anyone reporting to them; however, they may have new starters shadow them. All work is done for patients in the Bristol, North Somerset and South Gloucestershire area (BNSSG). If a patient requires care that NAH08 cannot provide them, they will speak to their coordinator for more advice and information.

Technology, training and staff capacity
This role does not involve any video consultation appointments with patients, with all care being provided face-to-face. As part of their role, NAH08 use Doccla kits for physical observations, a PC, a laptop and a printer. As a service, they offer Doccla, IV drivers and Doccla scales. NAH08 did mention that they do not feel digitally literate, with them feeling anxious about any sort of digital change. They also said that they were unsure of whether their role would change DNA rates if it was done virtually or not. No specific infrastructure issues were named regarding accessing telehealth services for staff. NAH08 stated that telehealth allows them to gather more information and know more about a patient, and that it is good for both patients and staff, being a huge cultural change.

Regarding training, this role does not receive Doccla training, but does receive general clinical training. This includes training for venepuncture, cannulation, catheterisation, central lines, bowl management, NG tubes, IV therapy and antibiotics. NAH08 felt that there are enough pathways in place to support staff and citizen well-being, mentioning that there is the generic pathway that takes care of most patients.

Regarding staff capacity, NAH08 feels that there currently are not enough staff members to meet workload demands, as several members of staff left last summer (at the time of writing this report) and are only just being replaced over the next few weeks (also at the time of writing this report).

Benefits of the role
NAH08 noted many benefits of the role, the first benefit being that they feel there is a very nice balance between clinical and care work in the role. They also state that they like the team they work with, and they enjoy the flexibility of the job that comes with the bank work. Overall, NAH08 states that they love their job and that it has its place in healthcare.

Challenges of the role
Whilst NAH08 stated that they did not have anything that they really disliked about the role, because of each day being different but still having a routine each day. However, they did go on to a few challenges and risks within the job, the first being the quality of referrals. Its

mentioned how often referrals can be quite 'clunky', effectively not correctly filling out the referral forms correctly and streamlining the process. NAH08 states that they have tried to overcome this challenge by explaining how to efficiently and correctly fill out the referral form to consultants and staff who have filled out a referral form. Another challenge relates to the telehealth technology, with connection sometimes being poor which causes issues for the technology as well as NAH08 feeling that they did not receive sufficient training for using the Doccla kit.

There is a risk within this role of lone working when visiting patients in the community. This is helped by an app called 'People Safe' that individuals within this role will download. This app has an in-built alarm, that when triggered will send an alert to the hub, which will then allow them to listen in on the individuals phone to see what is happening. Another way the risk of lone working is limited is by 'buddying up' on visits in which they feel they may be at risk attending alone.

What is needed to improve the service?

To improve the service, firstly more staff need to be hired to help capacity meet the demands of the workload. A more streamlined referral process would also be a useful change to occur in the future to make the service more efficient. Finally, Doccla training for staff in this role would appear to be a welcome change to aid in improving care.

Conclusion

In conclusion, this is a role primarily working out in the community to visit patients and provide care, but with a small working-from-home element. NAH08 works in this role part-time, but full-time shifts and bank shifts are available. All appointments are carried out face-to-face, using mainly Doccla amongst other technology. Currently, there is not enough staff to meet demands, but this should be changing soon. NAH08 enjoys this job, citing flexibility, balanced work and social benefits. However, challenges include poor efficiency of referrals, connection issues, lack of Doccla training and the risk of lone working.

A Day in the Life of an NHS@Home Consultant

Name: NAH09
Job title: Consultant

Introduction
The role of an NHS@Home Hub Consultant working in the Acute Frailty Service involves working both hands-on with patients while also remaining at the Hub. A typical working day for NAH09 will firstly begin with patient discussions with an ACL at 9:00AM Monday and Wednesday, with any significantly ill patients who need to be checked in on first highlighted. Patient history checks are completed via computer as well as reasoning for why they are on NHS@Home. Daily actions are identified, and visits are scheduled. ACL will hold the escalation phone for the day in case of patients calling through for advice. Between 14:00-15:00 Monday and Wednesday those working on virtual wards will discuss patients with the ACP and make management plans for discharge. As NAH09 works part time, Monday – Wednesday 9:00-17:00, on Tuesday they are based at Western General Hospital (WGH) working in the emergency department for frail patients, identifying any patients that could be discharged early and put onto the NHS@Home Hub.

One day a month, NAH09 will conduct education sessions with ACP, UCR and NHS@Home staff to provide teaching and bring the teams together for topics such as: end of life conversations, how UCR can feed patients into NHS@Home and how the teams can support patients receiving care from home. Working from home has not been an option for NAH09, since starting this post 1st April 2023; before previously working in emergency medicine, it is vital that they are always on-site due to the nature of the role. No staff members report to NAH09 as all ACP's will go to their own line manager, however as this role is set for two years its continuation is currently uncertain.

NAH09 is attracted to this role as they enjoy the fast-paced environment and feel a sense of reward in giving older patients their independence and quality of life back. With the biggest impact of the role on society being to support wider hospitals and care homes, by reducing numbers of admitted patients and reducing potential workload and burnout for social care teams, through keeping patients healthy. However, time pressures in emergency departments were discussed as difficult to meet with frail patients, as NAH09 disclosed that care for them is more time consuming.

Technology, Training and Staff Capacity
Technologies used in this service include the Doccla Kit. However, this was not viewed by NAH09 as 'useful' or massively 'helpful' and causes confusion as these older patients do not fit into the 'normal boxes' for certain measurements, such as blood pressure measurements. Staff in this service were also provided with both a work mobile and laptop. Video consultations are not used with these patients, and they are instead contacted via telephone, with NAH09 not considering themselves as digitally literate.

As patients are visited in their homes, DNA rates are not impacted using Telehealth. However, it has been mentioned that patients often feel overwhelmed with the number of calls received in a day (on our way calls and checking in calls), as there is a lot of miscommunications across the teams regarding patient observations and who has been called. All teams at Sirona need to be more 'joined up' so that they feel as one. However, remote monitoring does play a 'helpful' role for NAH09 as vitals can be checked to address if a patient is within normal range remotely, when they phone in reporting feeling unwell. This aids in checking if they are well or not at a quicker pace than having to attend in-person and knowing if you need to respond. Despite this, telehealth use has not impacted NAH09's role as they perceive no difference between nurse visits VS Doccla. They did however

mention that workloads can increase when Doccla will escalate patients who do not need require this (due to inaccurate readings), which can be a hinderance on workload.

NAH09 feels that there are not enough staff members in the team and to increase this would mean the ability to successfully see more patients throughout the day. Despite the stretch in staff, there are daily interactions across the wider team at the Hub, where discussions will be had if anyone has questions or needs supporting with a patient. Training is not provided in this role, but staff in this service can apply for conferences. When discussing additional help and support for citizens, NAH09 concluded that the Social Prescriber of the team is knowledgeable on what support is available across the whole region to supply this, as well as when discussing caseloads with the MDT team they will note how this support can be provided.

The task of medication management and adherence is a big part in this role, as NAH09 will often have to prescribe and check-in on the suitability of medications with the patient's condition. Additionally, working with the ambulance service is also a major role for NAH09. When working at WGH, patients are taken directly from the ambulance staff. Meanwhile, through the NHS@Home Hub service 'FACE' (used with GPs) if paramedics have a 75+ patient with frailty that they perceive should be admitted to hospital, a GP will answer their requests through FACE and provide alternatives to this. The consultant working that day will also interject and provide alternatives, often placing them on the NHS@Home service where UCR staff will then go and visit the patient or provide them with a 'same day' emergency care appointment. Ambulance staff will almost always ask for advice from NHS@Home for frail patients.

Benefits of the role

Many benefits were noted by NAH09, including the improvement of skills especially when working in the community where NAH09 was not sure of this before being in the role, as well as the ability to have face-to-face discussions as live escalations occur. Furthermore, by having the new 'doctor role' in the hub, this has been beneficial as the team are now more confident in taking risks as the Doctor can see a 'wider picture'. Allowing the team to take on more patients and allow more time spent with those who are even more poorly. Lower banded team members (who complete a lot of visits) on return to the Hub will provide live updates of how the patient is feeling, as it has been recognised that Doccla records do not always match with how the patient feels. These live in-person updates are beneficial to the wider team. Additionally, NAH09 expressed that the team they work with is 'fantastic' at supporting patients with difficult conversations and providing moral support to ACPs. Finally, telehealth services have brought benefits to the role as it helps to confirm if patients are unwell/well, and how to respond and escalate if needed.

Challenges of the role

NAH09 also discussed challenges that are faced in this role, firstly, regarding the Hub facility. With this being an open plan office, it can sometimes be too noisy with multiple meetings and calls happening throughout the day and therefore distracting. It was suggested that smaller rooms would be ideal for days like this. NAH09 also disclosed how the change from being hands-on with all patients in emergency departments compared to only visiting some out in the community has been a challenge to adapt to, where they must now rely on notes from other staff and Doccla readings. Furthermore, associated with this, there are perceived risks when relying on notes from initial referrals when not having seen the patient. NAH09 expressed that there needs to be observations on the patient during on-boarding as opposed to just GP and Paramedic telephones. As well as this, there are concerns for what would happen with patient visits if the there was a majority team sickness, and doubts for patients living alone with no one to always be on standby to escalate them. There has been additional work to overcome these challenges with NAH09 now feeling they can be reliant and trust the team more since spending more time with them. Finally, telehealth specific challenges concerned the Doccla kit and a lack of accurate readings when recording

measurements for patients with conditions such as, Atrial Fibrillation, as the kit cannot detect the different volumes in blood pressure. In turn increasing extra hours in the working day to rectify this.

What is needed to improve the service?

NAH09 suggested more integration with UCR and Social Care teams so that 'health' and 'care' are combined to be more successful if together. The inclusion with Social Care teams will mean they can ensure patients are 'safe at home.' Suggestions of a bigger team were also a need as it is often difficult completing home visits, especially as BSSNG is a large area to cover and is not always the best use of staff time when completing one-hour drives between patients. Additionally, NAH09 also informed that they would like to see Doccla boxes and fall sensors for when patients are alone in the home, as well as the opportunity to explore interventions for those patients with delirium. Finally, NAH09 also suggested that they would require better access to a variety of interventions (e.g., IV fluids) if they are to replicate hospital care exactly from the home, to ensure the same quality service is available.

Conclusion

The role of an NHS@Home Consultant working in the Acute Frailty Service is a hybrid role in the sense they are found working hands-on with patients while also sometimes remaining at the Hub office. Unfortunately, the perception of the Doccla kits used in this role is that this telehealth can sometimes be unhelpful due to the nature of the patient's conditions, where the technology cannot always produce accurate readings. Despite this, NAH09 pointed out how beneficial live updates from the team on visits are, as well as how the new advanced 'Doctor role' helps the team to see a wider picture. A greater integration across teams, regarding GEM service, Care Home Hub, UCR and Social Care was described as a desirable move, that must be implemented to ensure patient safety, improved inclusion of services and the enhancements of better-quality care.