



PWYLLGOR CYLLID FINANCE COMMITTEE

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| DYDDIAD Y CYFARFOD: DATE OF MEETING: | 25 February 2021 |
| TEITL YR ADRODDIAD: TITLE OF REPORT: | Technology Enabled Health and Care Business Case |
| CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR: | Huw Thomas, Director of Finance |
| SWYDDOG ADRODD: REPORTING OFFICER: | Rhian Dawson, Integrated System Director Carmarthenshire |

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA

SBAR REPORT

Sefyllfa / Situation

The pace and scale of the Health Board's (HB) digital response, coupled with the emergence of Technology Enabled Care (TEC) nationally and internationally has realised a number of opportunities that can be taken forward.

Growing sources of evidence show that investment in TEC, and its adoption within core elements of care pathways, can realise significant benefits that support the HB's design assumptions and strategic aspirations.

The business case which this SBAR introduces, and which is attached at Appendix 1, aims to support these assertions further, with a detailed appraisal of costs, benefits, deliverables and further opportunities.

The Committee is asked to endorse the investment in TEC, subject to Executive Team approval on 24th February 2021, which will initiate a transformative programme of work (to be fully evaluated), which will, in turn, support progress towards the future blueprint for digital transformation.

Cefndir / Background

The HB has recently produced a 'Digital Response' to support its strategic vision of working together to drive excellence in care for patients and communities. The Response signals a commitment to the development of the organisation's digital capabilities to transform the performance of roles and delivery of care to the HB's population.

The emergence and subsequent value of TEC is recognised internationally as integral to improving the wellbeing and independence of individuals in the community who have care and support needs. The value of TEC is also well documented in relation to prevention and proactive management of individuals who do not have care and support needs eg. those at risk of, or who are, living with chronic conditions. It therefore presents significant opportunities to fulfil the aspirations articulated in the HB's strategy '*A Healthier Mid*

and West Wales’ to transform pathways across the whole healthcare system, from prevention to the provision of specialist care.

‘Telehealth’ systems can support patients in self-managing their conditions and remaining more independent, and can enable earlier hospital discharge, reduce patient dependency on Primary Care services, and support rehabilitation services.

These systems can include various types of TEC equipment which will take and store patients’ readings, and enable monitoring, either centrally, or remotely by an individual. They may also be much less intrusive, for example, monitoring via regular phone calls, checking on the patient’s wellbeing or asking specific questions regarding patients’ health or recovery.

‘Telecare’ systems are used widely in social care, but tend to be reactive in nature, triggering alerts to call centres and monitoring functions to initiate an appropriate response. The Regional Transformation Programme (Welsh Government Transformation Fund) has, however, initiated the implementation of care pathways that support vulnerable individuals on a more proactive basis.

The investment referred to in the business case continues this theme of proactive care, and also supports the wider spectrum of care and support. The business case will demonstrate the impact of the planned deliverables from the initial investment.

Asesiad / Assessment

The HB finds itself in a unique position, given the array of opportunities that influence the business case, including:

- The drive of the Digital Response which will underpin the transformation programme and significant change activities through the duration of the strategy;
- The presence and successes of Delta Wellbeing as a key partner organisation which can facilitate the core health monitoring function and also provide a holistic assessment of health and care needs, realising the aims of an integrated approach to TEC;
- Visionaries within the HB both at a strategic and operational level who are able to lead the changes that TEC will bring;
- Linked initiatives such as the Value Based Healthcare Programme and the pathway re-design priorities which will influence the implementation plan;
- Project management resource from the Transformation Programme Office to support the rollout and continued development of the project

The business case brings together these opportunities and explores further the proposed acquisition of devices for home monitoring, access to a robust monitoring platform, the integration with the Delta operating mode and finally the growth of current successful usage of TEC within the *Florence Simple Telehealth* text messaging system.

The risk in terms of a ‘do nothing’ approach to Telehealth and wider developments of TEC within Health and Social Care is that pressure will continue upon the capacity of the HB and social care workforce to support patients in the community, and opportunities to be more proactive in monitoring cohorts of patients will be missed, which can create significant demand both in Primary Care and Community services, and also upon the HB’s acute system.

Argymhelliad / Recommendation

It is recommended that, following Executive Team approval on 24th February 2021 to proceed with the investment in TEC:

- Finance Committee takes assurance that this opportunity has significant importance strategically as a key component of the HB's change programmes;
- Finance Committee fully considers the impact of not investing in TEC upon the HB's Unscheduled Care system.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

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| Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor: | 4.3 Conduct detailed scrutiny of all aspects of financial performance, the financial implications of major business cases, projects, and proposed investment decisions on behalf of the Board. 5.5.6 Reviewing financial proposals for major business cases (and investment decisions) and their respective funding sources. |
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score: | Not applicable |
| Safon(au) Gofal ac Iechyd: Health and Care Standard(s): | All Health & Care Standards Apply |
| Amcanion Strategol y BIP: UHB Strategic Objectives: | 3. Growing older well. 4. Improve the productivity and quality of our services using the principles of prudent health care and the opportunities to innovate and work with partners. |
| Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2018-2019 | 4. Improve Population Health through prevention and early intervention, supporting people to live happy and healthy lives 7. Plan and deliver services to enable people to participate in social and green solutions for health 8. Transform our communities through collaboration with people, communities and partners 2. Develop a skilled and flexible workforce to meet the changing needs of the modern NHS |

Gwybodaeth Ychwanegol:

Further Information:

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| Ar sail tystiolaeth: Evidence Base: | Links to attributable evidence are included within the business case |
| Rhestr Termau: | Explanation of terms is included within the report |

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| Glossary of Terms: | |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y pwyllgor cyllid: Parties / Committees consulted prior to Finance Committee: | Transformation Programme Office |

| Effaith: (rhaid cwblhau) Impact: (must be completed) | |
|---|---|
| Ariannol / Gwerth am Arian: Financial / Service: | Details of equipment purchase costs are included in the Business Case |
| Ansawdd / Gofal Claf: Quality / Patient Care: | The Business Case identifies benefits in terms of care quality, enabling patients to take greater ownership of their health through monitoring by accessing their health information via their mobile device. |
| Gweithlu: Workforce: | A Digitally Enabled Workforce will enhance the delivery of care to patients. |
| Risg: Risk: | Risks and mitigations are included in the Business Case |
| Cyfreithiol: Legal: | Not applicable |
| Enw Da: Reputational: | Benefits of Technology Enabled Health and Care Provision |
| Gyfrinachedd: Privacy: | Not applicable |
| Cydraddoldeb: Equality: | An EQIA screening will be performed on initiation of the programme |



Technology Enabled Health and Care Provision

Business Case

V1.0 Finance Committee 25th Feb 2021

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BACKGROUND

The Health Board has recently outlined a “**digital response**” to support the strategic vision of working together to drive excellence in care for our patients and communities. It signals a commitment about how we develop our digital capabilities to transform how we perform our roles and deliver care to our population.

The emergence and subsequent value of Technology Enabled Care (referred to as TEC) is recognised internationally as integral to improving the wellbeing and independence of individuals in the community who have care and support needs.

The value of TEC is also well documented in relation to **prevention and pro-active** management of individuals who do not have care and support needs e.g those at risk of, or are, living with chronic conditions.

It therefore poses significant opportunities to enable the aspirations in our strategy “A Healthier Mid and West Wales” to transform pathways across our whole system, from prevention to specialist care.

At the heart of this business case is an example of the digital vision to collaborate with local partners. It will see the role of Delta Wellbeing being an integral part of a holistic approach to TEC. Supporting our patients and clinicians with access to a monitoring platform, integration with the Delta Connect programme, as well as developing the appropriate response where an unscheduled need arises. This adds significant value to the project. The benefits to be realized will aim to show the added value of Delta integration as oppose to the option of access to a basic triage monitoring platform directly.

This business case will aim to justify the investment in TEC to realise significant benefits as well as support the transition towards achieving our strategic aspirations.

AIMS & OBJECTIVES

The progression of TEC projects will enable significant transformation of our pathways. Acquisition of such devices & systems will aim to:

- Support pro-active care through home monitoring, highlighting risks before they occur i.e fall or acute episode
- Support the independence and wellbeing of our population, by offering help to help themselves in monitoring their health
- Provide an outlet for a greater holistic approach to health and care needs, linking monitoring platforms to the Delta Connect programme

- Support our design assumptions for the delivery of our strategy, by reducing the need for follow up outpatient appointments, and supporting early discharge
- Transform the ways of working for our clinicians, by having a seamless monitoring platform, resulting in greater patient experience and impact on capacity.
- Use a Value Based Healthcare approach to inform the requirements of the solution, in parallel with the need for robust measurement of outcome measures & benefits monitoring

The project will effectively be a key component for the wider transformation and re-design of our key pathways, dovetailing with the rollout of the Value Based Healthcare programme. Timelines for the transitions of these projects to implementation will also consider the above.

Vision

***“Technology will no longer be an enabler for care & support.
It will be accepted as a new normal across all tiers of provision, from
prevention to specialist care”***

The aims of this project supports the vision for the digital response in that this project will achieve:

Digitally Connected Patients – the ability for patients to take greater ownership of their health through monitoring and able to access this information via their mobile device (TBC based on requirement)

Digitally Enabled Workforce – enhancing the way health professionals monitor their patients, through an active monitoring platform that links seamlessly with existing technologies such as video conferencing software, patient records. Able to be accessed on any device from anywhere at any time.

Business Intelligence and Analytics – Improved use of data to promote pro-active care through active monitoring i.e software that detects the likelihood of a fall. As well as supporting the longer term aspirations of the use of data in line with our digital aspirations

Digital Infrastructure – Solutions are able to provide secure access and ensure interoperability between multiple clinical platforms. The aim is to enhance ways of working, not duplicate effort.

PROJECT OUTPUTS / DELIVERABLES

The project has established firm foundations developing a baseline of the current usage of TEC within our services. This has allowed the project team through its work and that of a scoping workshop held on 17th December 2020 to develop the desired outputs for the project.

These desired outputs have taken a “requirements gathering” approach, working closely with key stakeholders to inform the specification and business case

Continued engagement with these stakeholders is another deliverable within the project.

Phased approach

As outlined in the vision statement, the presence of Technology Enabled Care across our whole system of care and support will become a new normal, and a flagship of the “digital response” to the Health and Care strategy.

However, the level of change and positive impact is significant, and as such is reflected in a proposed phased adoption of TEC products. It takes a sensible approach balancing the level of initial investment, risk, and the ability of change management over a sustained period.

The specific outputs to support rollout are expanded on in the project plan within **Appendix A**

The project plan will continually develop the roadmap for implementation of these technologies. Careful patient cohort selection is needed in order to maximize the benefits of TEC. The project group will continually monitor patient selection and incremental progress of the deployment so remain on track with this important aspect of the project.

Consideration of the wider benefits will also drive this, such as the benefits in the community to GP’s, primary care and the community teams supporting patient care. The clusters will be a key group that can promote these new ways of working and benefits.

Links will be sought with the Lightfoot programme, as a source of intelligence that can be used to target cohorts at a cluster level. Tactically this will be important as managing a range of smaller deployments at a cluster level can provide a richer source of lessons learnt and promote local ownership and empowerment of the project.

Chronic disease management

The first cohorts proposed for this project will benefit from what is often referred to as “remote patient monitoring” – electronic sensors that remotely monitor vital signs, linked to a comprehensive monitoring and response pathway.

Initially the deliverables will focus on the management of complex patients with chronic disease prevalence to realise benefits in productivity, self management, and reduction in likely visits to primary care, or more acute unscheduled episodes in A&E attendances and admissions. (See benefits map page 6 for further information)

Heart failure will be the first chronic disease area chosen, given the complexity in managing their conditions once diagnosed. 190 patients have initially been identified health board wide by the specialist teams that can benefit from these technologies.

COPD will also be targeted at a cluster level, in high areas of prevalence, proposed at this stage as Amman Gwendraeth cluster. Interest has been high from local GP’s as well as the presence of a specialist nurse in this cluster for respiratory. It is hoped that a tangible difference will be seen on the impact of exacerbations and admissions at PPH. This initial rollout will also support the wider aims of local targeted rollout as eluded to in the phased approach above.

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| <p>1A. Acquisition of a range of peripheral sensors</p> | <p>These peripherals monitor vital signs for patients, including blood pressure, oxygen saturation, blood glucose and temperature. The requirements gathered will mean that the solutions will have automated readings sent to a monitoring platform via Bluetooth.</p> <p>Through market research and support from Delta Wellbeing, these peripherals will be bought in bulk, to realise economies of scale from market pricing.</p> |
| <p>1B. Comprehensive triage monitoring platform</p> | <p>Clinicians will be able to monitor patients via a remote monitoring platform. It will have an array of functionality that will transform ways of working for our clinicians.</p> <p>Patients will be set up on the platform with clinicians able to access care records, details of treatment teams, as well as new and pending enrolments.</p> <p>Importantly, from a monitoring perspective, the platform will allow clinicians to set parameters for vital readings, ensuring that any abnormal results result in the most appropriate intervention.</p> |
| <p>1C. Delta Wellbeing integration</p> | <p>The triage monitoring platform will be fully integrated with the Delta Wellbeing operating model. On assessment, a range of monitoring and support options will be available to support the holistic needs of individuals. This can include:</p> |

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| | <ul style="list-style-type: none"> • Monitoring of alerts triggered from readings outside the parameters set, with the appropriate intervention agreed by the clinician. • Prompts / calls initiated when appropriate such as reminders to take readings. • Integration with the Delta Connect programme – providing a full wellbeing assessment, pro-active wellbeing calls, digital support, engagement with community assets and a 24/7 response service <p>Delta will also provide the installation and support the assessment process of individuals who will benefit from the peripherals.</p> |
| 1D. Florence text messaging | <p>Expansion of the existing Florence text messaging service which sends patients reminders and health tips tailored to their individual needs. It works on a decision tree / algorithm basis.</p> <p>Clinicians can adjust the settings on Flo for each patient, defining when messages should be sent, what information they are asking for and how the system should respond. Flo then sends regular text messages to patients helping them to monitor their health, sharing any information sent back by the patient with the person managing their care.</p> |
| 1E. ARMED falls prevention technology | <p>The emerging range of AI and technology enabled care solutions includes wearables, sensors, remote monitoring devices, portals and apps, allowing risks to be managed and issues to be identified before problems occur.</p> |

Evidence from national and international case studies has shown that when TEC is combined with a robust health education and chronic disease management programme, it can significantly improve an individuals health and quality of life.

Each of the deliverables has outlined benefits maps to begin the strong theme of benefits realisation and evaluation within this project.

BENEFITS MAPPING

A number of strategic goals are clearly demonstrable from this project. For expansion in terms of benefits mapping, these goals have been sourced from our strategy “A Healthier Mid and West Wales: Future Generations Living Well” as well as the Digital Response as a key enabler for our overall strategy.

| Deliverables / Outputs | Short term benefits (from new “state”) | Longer term benefits (outcomes) | Corporate objectives / strategic goals |
|--|---|---|--|
| <p>A. Acquisition of a range of peripheral sensors</p> <p>Blood pressure monitors Weighing scales Pulse oximeter Glucometers Thermometers</p> | <p>Reduce number of home visits Improve self-management by patient Reduction in number of visits to GPs and primary care Reduction in number of specialist nurse home visits Reduction in number of clinic visits, virtual or F2F to secondary care Reduced mortality rate at 12 months Duration of the use of the telemedicine device Reduction in number of "any admissions" during 12 months</p> | <p>Reduction of the number of virtual/face-to-face contacts with GP, consultant and /or Specialist Nurse.</p> <p>Improvement in self management by person living with Type 2 Diabetes</p> <p>Improved quality of life with relevant medication adjustments</p> <p>Trend data assessment to maintain optimum identified oxygen saturations as deemed by clinician</p> <p>Improved access to clinicians</p> <p>Decreased travel times / costs, improved quality of care</p> | <p>Admission avoidance</p> <p>Reduction in outpatient appointments</p> <p>Reduction in length of stay due to speedier discharge</p> <p>Empowering citizens</p> |



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board



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| | | Treat larger numbers of patients with fewer or more limited resources | |
| B. Comprehensive triage monitoring platform | <p>“Live” data to closely monitor patient vital health signs</p> <p>Greater usage of data from integration with other devices such as Fitbits</p> <p>Automation of alerts that can be set for readings received out of range</p> <p>Multiple teams to access information to support digital culture change</p> | <p>Provision of an Urgent Emergency Care Hub</p> <p>Greater productivity for supporting teams, using the monitoring platform</p> <p>Collaborative approach to looking at all patients needs i.e emotional and practical support. Able to be all seen through an integrated monitoring approach</p> <p>Support risk stratification techniques</p> | <p>Digitise patient interactions</p> <p>App integration with systems</p> <p>Friction free information exchange</p> <p>Accessible records across Hywel Dda</p> <p>Championing connected care</p> |
| C. Delta Wellbeing integration | <p>Basic level monitoring of data generated through use of peripheral devices</p> <p>Delta staff able to perform basic monitoring and manage alert within appropriate parameters</p> | <p>Integration of wellbeing support to look at more holistic approach to care and support</p> <p>Citizens supported across all tiers of prevention, from help to help themselves, through to help in hospital</p> | <p>Increase accessibility, flexibility and efficiency of services so that people can gain the right support at the right time</p> |

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| | <p>Pro-active calls to provide prompts to patient where additional support is needed to maintain use of peripherals</p> <p>Provide safe, effective and more personalised innovative model of quality care and support</p> | <p>Greater management of chronic conditions by focusing on aspects of wellbeing that can maintain a healthy lifestyle</p> <p>Help generate efficiencies and add value through more flexible and appropriate use of workforce capacity and skill mix.</p> | <p>Full integration of the platform into service re-design and delivery</p> |
| D. Florence text messaging | <p>More detailed regular monitoring of chronic conditions</p> <p>Regular output of information for clinician to access via simple interface</p> <p>Prompts follow ups such as need to make an appointment or speak over the phone</p> | <p>Encourages patients to stick to their treatment plans</p> <p>Supports human aspects of regular contact, reducing loneliness and isolation</p> <p>Develops a knowledge base for how Flo can be used more widely</p> | <p>Digitise patient interactions</p> <p>“Faster” interaction with patients, streamlining work for clinicians</p> <p>Enhancing patient experience</p> |
| E. ARMED falls prevention technology | <p>Immediate data gathering – machine learning & algorithms to identify anomalies</p> <p>Warning flags raised on patient record</p> | <p>Supports pro-active monitoring and risk stratification</p> <p>Empowerment of self-management and independence</p> | <p>Reduction in unscheduled admissions</p> <p>Business Intelligence and Analytics –</p> |

| | | | |
|--|--|---|--|
| | <p>Immediate risk profile being developed – “predictive modelling”</p> | <p>Integration with PowerBI</p> <p>Ability to see gradual deterioration</p> | <p>Improved use of data to promote pro-active care</p> |
|--|--|---|--|

An important next step of the project will be to agree with key stakeholders the requirements for progress monitoring, including baselining, identifying KPI’s and other measures, as well as key roles and responsibilities in this regard. This will be expanded further within the project plan.

Dis-benefits

One of the “should haves” within the requirements gathering exercise has seen the integration of back end systems in terms of interoperability and data sharing with the triage monitoring platform.

This will not form part of the initial rollout, but will be developed in due course. Therefore in the interim, a slight dis-benefit will arise from clinicians having to access multiple platforms to support their processes.

Evaluation framework/benefits realization

The benefits map above outlines the high-level correlation between the project outputs through to our strategic aspirations. This will be expanded on as a key part of the project plan to ensure a robust monitoring and evaluation framework is put in place.

The supplier engagement via Delta Wellbeing has committed to supporting Hywel Dda with development of a robust evaluation framework and the need to continually review and monitor proficiency of these new technologies. The process will entail at the outset:

- Scrutiny of the benefits map & identified measures
- Assessment of feasibility to measure/ capture
- Baselining and comparison to ensure that we able to contrast
- Roles and responsibilities involved in this aspect of the project
- Evaluation support from a commissioned partner

The provider has also committed to the funding of an evaluation partner, such is their desire to show proof of concept of their own product development.

QUANTIFICATION OF BENEFITS

The benefits map included in this business case aims to convey the link between some of our strategic goals and the short & longer term benefits realized from this project.

Many of these benefits can be attributed to quantifiable measures and are based on evaluations and case studies of similar initiatives. It must be said, that a level of pragmatism should be taken when assessing the value of these benefits, as case studies have shown us that there are a number of variables that impact the level of confidence in benefits realized. These include:

- Scale and speed of implementation
- Level of dis-benefits arising from the project
- Level of usage of the devices by patients
- Extent of workforce transformation in adopting TEC within pathways of care
- Extent of motivation & self-management ability of patients to help themselves monitor and manage their health & wellbeing

With this in mind, the following benefits are quantifiable:

| Benefits | Unit cost (£) * | Pre TEC** | Post TEC*** | Saving per patient | Yr 1 (£) (500) | Yr 2 (£) (750) | Yr 3 (£) (1000) |
|------------------------------|--------------------|-----------|-------------|--------------------|-------------------|-------------------|--------------------|
| Reduction in bed days | 561.34 | 12 | 10.32 | £943.05 | 471,526 | 943,051 | 1,414,577 |
| Reduction in GP appts | 30 | 24 | 12 | £360.00 | 180,000 | 360,000 | 540,000 |
| Reduction in A&E attendances | 419.00 | 6 | 5.1 | £377 | 188,550 | 377,100 | 565,650 |
| TOTALS | | | | | 840,076 | 1,680,151 | 2,520,227 |
| CUMULATIVE BENEFIT | | | | | 840,076 | 2,520,227 | 5,040,454 |

It is important to note that these benefits are all classed as financial, but not cash-releasing.

* The unit cost of the benefits noted above, are outlined by NICE

** Pre TEC instances are based on expected attendances per patient, per annum

*** Post TEC instances are based on metrics from the Whole System Demonstrator Report which include:

- 15% reduction in A&E visits
- 20% reduction in emergency admissions
- 14% reduction in elective admissions
- 14% reduction in bed days
- 45% in mortality rates

Benefits realization

For the purposes of a Value for Money assessment, the quantification of benefits should be considered against the timelines associated with rollout of the project to the initial cohort identified. As well as the level of confidence in achieving the level of benefit as described above.

The implementation plan refers to the incremental rollout by chronic disease area. It is therefore advised that any notional payback of these benefits will not be immediate.

Other benefits

Whilst the benefits above cover many of the headlines, there are further benefits which broadly speaking should be recognized also:

Increased productivity – Improvements to the efficiency of processes in managing patients remotely will free up capacity for clinicians to focus on other demands.

Savings to Social Care – Whilst this is difficult to quantify, evidence points towards savings to social care, given the premise of TEC is to support happy, healthier living at home, providing greater independence and longevity in growing older well.

Economic impact – Reduction in GP visits and attending repeat appointments will result in less days taken off work, less travel time. Hypertensive patients can also be off work for several months awaiting results etc. Frequent monitoring will alleviate those issues to some extent.

Benefits mapping will be focused on as a specific area within the workplan. The presence of an evaluation partner will significantly help in this regard (see further information describing the benefits map and evaluation framework)

HIGH-LEVEL TIMELINES

- Nov – Dec 20 – Requirements gathering & baselining
- Dec 20 – Stakeholder workshop
- Jan 20 – Appraisal of requirements gathered and business case development
- Jan/Feb 21 – Commissioning options / process
- Feb 21 – Alignment with VBHC programme to support Heart Failure as initial focus area
- Apr 21 – Prepare first areas for rollout to embed the changes
- May 21 – Realise first new capabilities from implementation and consolidate
- Jun 21 – Begin second cohort (COPD) preparedness to transition to new model
- Oct 21 – All initial patients identified will have the opportunity for remote monitoring in place
- Jan 22 – Initial evaluation report of early findings. Indication of whether to proceed to Y2 & Y3

Longer term milestones will be developed as part of project planning and the role of the strategic oversight group.

RISKS

| Risk identified | Mitigation |
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| Lack of patient engagement: <ul style="list-style-type: none"> ○ Perception that the equipment will restrict their activity and routines | Listed as a key output within the project plan to focus on the patient engagement methods. Build on existing relationships |

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| <ul style="list-style-type: none"> ○ Fear of isolation; perception of loss of relationship with nurse/doctor ○ Misunderstanding of the potential benefits | between patients and those supporting their health and care needs. |
| Care pathways not integrated; poor service planning and resource allocation | The project plan proposes a project board type function will provide the necessary input into the future development of the project |
| Duplicated review by clinicians | Clear roles and responsibilities will be made known for the patient reviews and other key tasks. To be developed with the chronic disease supporting teams |
| Telehealth is too labour intensive | Initial installation, setup, onboarding and patient / staff engagement is a significant undertaking, however the project plan will take an organized structured approach to rollout. |
| Lack of planning for sustainability and up-scaling of the service | Project planning & governance is proposed to reflect the upscaling and future opportunities associated with this work. |
| Equipment is not matched to patient needs | Patients will undergo a thorough assessment of their holistic needs as part of re-designed pathways |
| Ineffective service evaluation; lack of insight into what works and what does not; no local ownership of patient data | Robust benefits monitoring & the use of an evaluation framework will underpin the rollout of the project. An evaluation partner will also be commissioned to support the work |
| Lack of interoperability between primary care systems and secondary and with telehealth monitoring systems | Deemed within the requirements and part of the digital competencies – will be assessed as a project risk as implementation matures |
| Benefits not realized as planned | Exit strategies in contracting and return of peripherals as necessary |

BUSINESS CASE EVOLUTION AND PROJECT PLANNING / IMPLEMENTATION

The deliverables in this business case will provide a firm foundation on which to begin our journey towards the future vision that technology is no longer seen as an enabler. It becomes an aspect of care and support that is considered “normal” as per the project vision

The business case will evolve naturally along with the project plan focusing on opportunities such as:

- Growing the prevalence of TEC in our pathways, supporting early discharge and rehabilitation, as well as targeting falls and frailty pathways and linked initiatives
- Developments in Unscheduled Care pathways
- Partnership approaches to look at assistive technology and telehealth within an integrated approach
- Targeted approach at a cluster level to promote local ownership and empowerment in the project