PE1566/Y

Dr David Patterson Letter of 27 November 2015

Dear Sigrid Robinson

I am writing to support the petition relating to patient self-monitoring in Scotland.

I have been running an anticoagulant and stroke prevention service in NC London for several decades. We are in the process of developing a service which will enable a large proportion of our patients to self-test and self-manage their oral anticoagulants. We already have this service running having piloted it s few years ago. Not only will they self monitor their anticoagulation, they will monitor their own Blood Pressure and their activity level which are the other major risk factors for stroke. We are now have in place an eLearning package for patients (and developed with their help) and strong Clinical Governance as well to ensure that the services are safe. Thus we are calling this service a Stoke prevention service including anticoagulation.

Suitable patients with adequate support actually control their own risk factors including the control of their INR, much better than the health care professional can. This has been demonstrated in the UK and in Europe. I am sure this relatively new role for our patients which enables them, with adequate support, to become more confident and competent, to play a major role in looking after their own health. This will have many positive effects on their health.

I am enclosing a brief document on the evolution of our services in NC London which is now spreading across the UK. I hope it will serve to show that patient self-monitoring is a very important service to develop for anticoagulation, stroke prevention and other services

Yours sincerely

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Patient Self-Monitoring and Community based Anticoagulant and Stroke Prevention Services with Hospital supported Cardiovascular Services

WHO IS INVOLVED?

Our service have evolved from 2 hospital out-patient departments, 30 General Practices, three community pharmacists, one polyclinic and one community hospital. There is now a growing cohort and a rapidly growing interest of patients who are self-testing or self-managing their anticoagulation or who want to start doing so. **This cohort of patients undertaking self-testing or self-management obtain better results than those obtained by the Health Care Professional.** This translates into a lower incidence of strokes. They will be supported by the hospital anticoagulant and stroke prevention services, a birth to grave web-based Electronic Health Record (EHR) with incorporated advisory systems, clinician and patient education and clinical governance with outcome measures.

BACKGROUND

North Central London has evolved a shared care and patient centric approach to community delivered anticoagulant and stroke prevention services. The service has been progressively developed in iterative steps, piloting and learning from each new model of care delivery and now embracing an increased number of patients who self-monitor. It is also embarking on heart failure, frail elderly, and services for other long term condition.

THE MODEL OF CARE

Electronic Health Record (EHR)

The software was developed by CHIME at UCL over 2 decades of research. It is a web based EHR and standards based (ISO/EN 13606 OpenEHR compatible). This defines the standards of data quality, confidentiality, access control and interoperability. The clinical governance and clinical outcome measures are supported by the software which is interoperable with a wide range of hospital and GP systems and tools (www.heliconhealth.co.uk).

True web based functionality enables a single clinical record to be accessed by any accredited clinician from wherever they are situated geographically. The information they add into the structured record can then be seen by any other accredited user. They also have access to the rich clinical advisory components of the EHR. This sharing of information has numerous advantages and circumvents all the problems associated with the many “silos” of clinical knowledge.

Clinician and Patient eLearning

The accredited blended learning, a combination of both distance (eLearning) and face-to-face learning, has been developed both for the patient as well as the healthcare professional (HCP). It is designed at CPD (continuing Professional Development) level for the HCP. It is now available as an App for any smart phone.

For the patient the intent is to help develop their ability to self-monitor. It enhances their confidence and improves their competence. This will facilitate shared decision making with clinicians and better enable them to understand the diagnosis and the treatment. The patient learning also acts as a subject matter for the HCP who is expected to learn more about the patient learning requirements and will apply this knowledge in their future clinical practice.

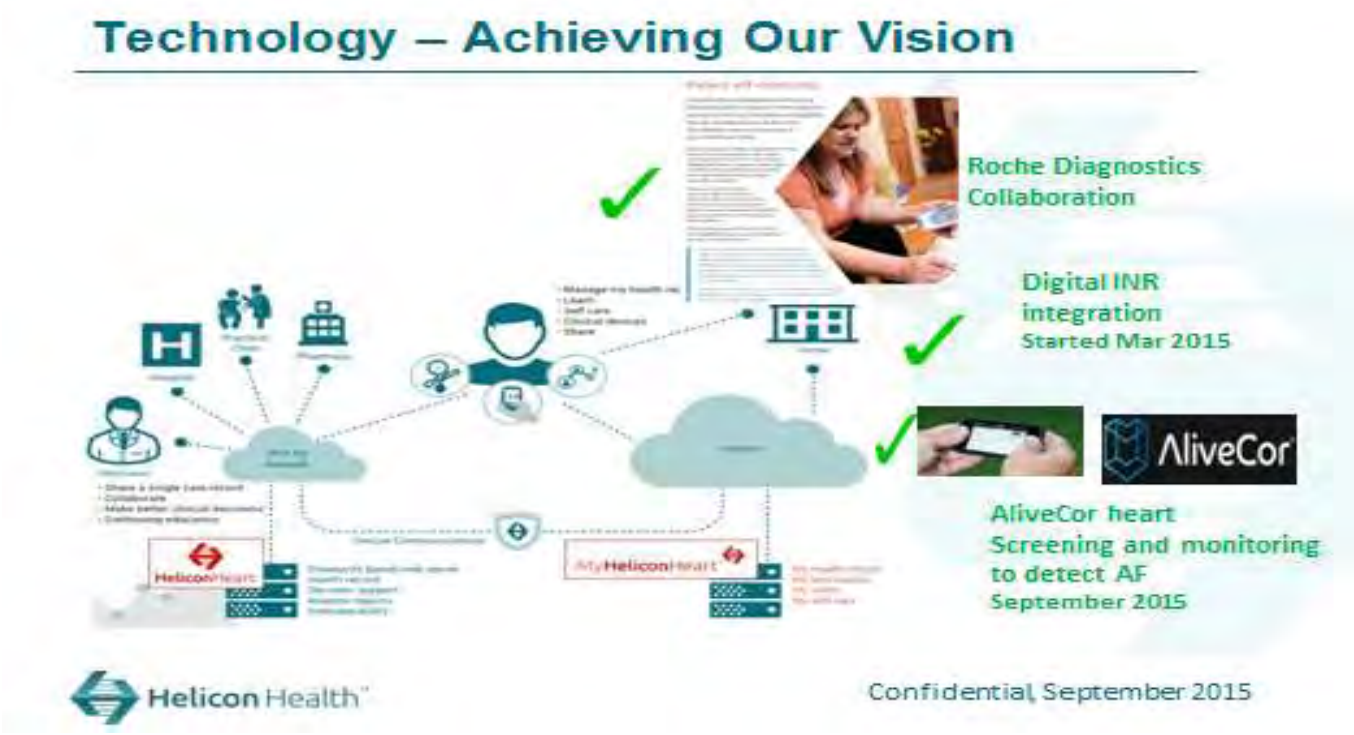
This educational eLearning for the patient will enable us to determine which patients are suitable for self-management, as well as defining those that should continue with self-testing.

Clinical Governance

The Clinical Governance Board includes patients, hospital consultants (haematology and cardiovascular), anticoagulant practitioners (GPs, Nurses, Pharmacists), commissioners and clinical GP leads, as well as an academic social scientist, a statistician, a computer scientist, an academic legal advisor and an IT representative from Whittington Hospital. The Governance embraces both site visits as well as the performance of "real-time" audit for each site or across all the sites.

We now collate a wide range of data, from blood test results to the QA of the instruments and devices used on each of the delivery sites. This enables us to monitor and measure the quality of all aspects of the anticoagulant and stroke prevention services, including patient self-monitoring. It stretches from education to patient outcomes and the safety of the clinical environment.

THE INVOLVEMENT OF THE PATIENT AND CARER



Near patient testing devices enables the service to become more distributed, with delivery closer to the home of the patient and in the patients home. We have developed and piloted a self-monitoring programme for patients and developed the clinical governance to support it. We are now developing a "suite" of functions (MyHeliconHeart above). These will range from a Patient Health Record, the development of linked applications for smart phones or tablets as well as means to enhance the social and family networks of the patient.

HELICON HEALTH

Helicon Health is a UCL spin out company which partners the Whittington. This partnership serves to combine the wealth of knowledge within UCL and the Whittington, with Helicon's innovative, integrated approach, which offers a package of support

comprising information and management systems with additional clinical advisory systems, as well as education of clinicians and patients and the strong clinical governance. This coherent and integrated package together with the associated Standard Operating Procedures (SOPs) enables the very different models of care delivery to all operate to a demonstrable high standard of quality.

The current cost of stroke is a huge health and economic burden. Stroke costs £2.8billion every year; the AF related stroke costs over £2billion with £485m being spent on acute care for AF-related stroke. The costs can be reduced by 20% with better management of their AF.

We work with public health which enables us to define the local prevalence of disease. We are also working both with the CCGs and with **NICE where our "distributed" model of service for anticoagulation and stroke prevention is shown as a "learning example".** The shared planning of the service help to determine the means of delivering a high quality and cost-effective service that meets the needs of the local population.

FUTURE PLANS OVER NEXT MONTHS

The recent establishment of acute stroke units in the UK has improved the outcome of patient sustaining strokes. There is now a rich source of data available about the co-morbidities of patients who are admitted with a stroke (The Sentinel Stroke National Audit Programme). Thus at a CCG level we can access anonymised timely data about the number of strokes occurring to patients in that CCG in the past months and the presence and or treatment of their co-morbidities such as heart failure, cholesterol levels and hypertension.

We will progressively increase the numbers of patients undertaking self-testing or self-management in the knowledge that their results are better than those obtained by the Health Care Professional. We can plan to increase the breadth of their own testing of measures such as blood pressure and exercise/activities as well as monitoring their own heart rate with an application (AliveCor). This enhances the confidence and the competence of the patient. It also makes the business case for establishing these self-monitoring patients very persuasive indeed. The Clinical Governance approach will be developed to encompass this broader approach to the management of their long term conditions.

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