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Which three million lives?

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Foreword from Carl Atkey, Head, Appello

2012 is proving to be *the* year for telehealth. After a decade of trials and pilot projects, the Coalition Government and Department of Health have put their weight behind telehealth as a means of improving health outcomes for three million of the 15 million people in England with long term conditions, as well as delivering efficiency savings for the NHS. Telehealth has been placed firmly as an innovation in the QIPP agenda and as an opportunity for investment in the UK life sciences industry.

The Department of Health envisages taking a strategic and leadership role; it will be up to local players and industry to create the market that makes the change happen. However, there is a clear and explicit expectation from the centre that PCT clusters and emerging clinical commissioning groups (CCGs) will deploy telehealth more widely than the current estimated 6,000 users. Financial penalties may be imposed on those that do not.

Yet it appears there is still a gap between the policy statements and the reality on the ground. At a round table organised by Appello, GPs and clinical commissioning group leaders supported telehealth in principle. However, they expressed doubt about the breadth of the evidence base and in particular whether it gave them enough information on which to select patients who might benefit most from telehealth. In other words, they said “yes” to three million lives but asked: “which three million?”

This was not their only concern. Participants had doubts about the strength of the business case, including whether the funding mechanisms exist to allow any cash savings to accrue to them rather than other parts of the health service. Commissioners do not yet know what a “good service” looks like and how they might best commission one.

This paper explores the challenges identified by this expert round table and examines what needs to happen next to close the gap between policy and practice.

We are trying to help find answers and have established the Telehealth Forum, bringing together organisations including the NHS Alliance, the National Association of Patient Participation, the British Lung Foundation, members of the Royal College of GPs and Royal College of Nursing, and Appello. Its purpose is to develop information and educational materials that are shaped from the bottom up by patients and their carers, in collaboration with the doctors and nurses responsible for their overall care and, in due course, for commissioning services for people living with long term conditions.



Carl Atkey
Head of Appello



¹ See appendix 1: Setting the National Direction

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Foreword from Dame Helena Shovelton, Chief Executive, British Lung Foundation

The British Lung Foundation supports people affected by lung disease through the individual challenges they will face and helps them to understand their condition by providing them with clear and comprehensive information. We believe that telehealth could provide many healthcare professionals with a tool to do something very similar for their patients. Any tool which helps patients to retain control and better self-manage their condition has to be broadly welcomed.

From a patient's perspective telehealth can provide a number of clear advantages. In keeping patients informed, it provides clear, up-to-the-minute, understandable information for the patient about their own condition. It also provides comfort, added security and reassurance for many very vulnerable patients who are otherwise feeling isolated and alone. In terms of logistics it can also substantially reduce the amount of time patients spend travelling to and from healthcare providers. During cold winters this is a distinct positive for the patient particularly in avoiding infections in waiting rooms. Not all these advantages would necessarily be viewed as clinical benefits by commissioners but for patients they are very real.

Telehealth can clearly complement but is not a replacement for face-to-face healthcare services. It can assist the health professional and the patient to develop a trusting, caring and effective relationship but it cannot do this on its own. It is another tool in the professional's bag to be used where and when appropriate for both parties. When to use telehealth has to remain a clinical judgement not one dictated by cost.

The challenge for emerging clinical commissioning groups will be to judge the value of this new tool and to invest resources accordingly. In terms of telehealth we would encourage commissioners to listen to their patients, to ensure that the patient experience of telehealth is effectively fed into the commissioning process. Their thoughts and experiences should play a vitally important part in any cost/benefit commissioning exercise.

We look forward to participating in the newly established Telehealth Forum and contributing to the development of telehealth in meeting the needs of patients with long term conditions.



Dame Helena Shovelton

Chief Executive
British Lung Foundation



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Foreword from Stephanie Varah, Chief Executive, National Association for Patient Participation

Established in 1978, The National Association for Patient Participation (NAPP) is uniquely placed as the only UK wide umbrella organisation for patient-led groups within general practice. NAPP provides essential support to patients, GPs and practice teams through a comprehensive range of evidence-based high quality resources. NAPP has over 30 years' experience and expertise in promoting, supporting and developing patient participation groups (PPGs).

NAPP fully supports the use of telehealth and recognises the great potential that it has to empower patients giving them more ability to better understand and manage their own care. Telehealth can help general practice to strike a new relationship with patients in which they become active participants in the care and services they receive. Effectively engaging with patients is fundamental to quality improvement and the provision of responsive services – these principles lie at the heart of NAPP's work.

We believe that the PPG movement has the potential as a mechanism to make patients more aware of the benefits of telehealth, and, importantly, to influence the design and development of telehealth into becoming a highly patient-focused service.

However, reliable, understandable and practical information for patients and commissioners will be essential in order to facilitate this - few people really understand what the terms 'telehealth' and 'telecare' mean. NAPP is therefore committed to supporting and working with the Telehealth Forum to ensure the development of telehealth services and information is patient-led.



Stephanie Varah

Chief Executive
National Association for Patient Participation



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Executive summary

This White Paper, published jointly by telehealth service provider Appello, NAPP and the British Lung Foundation argues that the Government's Whole System Demonstrator (WSD) headline results and 3millionlives campaign have yet to provide patients, health professionals and commissioners with clear, practical information to support the commissioning of telehealth.

In the context of the publication of the initial findings of the WSD headline results and in the run up to the full report, this White Paper examines several questions essential to the effective commissioning of telehealth and achieving the best outcomes for patients, namely:

- **If telehealth can benefit three million of the 15 million people in the UK living with a long term condition, which three million lives should we be focusing on?**
- **How many of the three million lives will be new users? And how many will be supported by telehealth as opposed to telecare?**
- **Do clinical commissioning groups have the tools to identify how savings would accrue to them?**
- **How will clinical commissioners know what a “good” telehealth service looks like?**

The WSD headline results show a striking reduction in mortality, as well as encouraging data around reducing use of secondary care services. Other sources have shown that telehealth has a high degree of patient satisfaction, especially where there is a large, highly skilled clinical support element to the service. However, where is the practical information and guidance for commissioners on which patients would benefit most?

This White Paper argues that there is a requirement to develop clear, understandable, practical and localised information for commissioners, health professionals and patients to enable telehealth to be used effectively. Especially important will be engaging with patient support groups both to develop patient education around telehealth and to raise awareness of the possibilities that the service can offer.

This White Paper has been produced following an expert telehealth round table attended by health professionals, commissioners, academics, patients, and representatives from the pharmacy and charity sectors.

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Round table attendees

Participants to the Round Table event included:

- Dr Michael Dixon (Chair), Chairman, NHS Alliance
- Carl Atkey, Head of Appello
- David Barrett, Nurse Lecturer in Telehealth, University of Hull
- Andy Davey, Managing Director, Appello
- Deborah Evans, Director of Pharmacy National Pharmacy Association
- Mike McKeivitt, National Services and Development Manager, British Lung Foundation
- Carol McPaul, Practice Manager, Surrey Docks Health Centre
- Dr Ishani Patel, an RCGP E-Learning Fellow and part of the North West London Cancer Network
- Dr Ashwin Shah, GP Lead Newham Health Partnership, one of the WSD pilots
- Mark Stevens, Sales Vice-President, CentriHealth
- Sue Summers, Assistant Director of Quality and Self-Care NHS North West
- Jonathan Thorpe, Project Manager, Centre for Telehealth, University of Hull
- Patricia Wilkie, President National Association for Patient Participation
- Lynn Young, Primary Care Adviser Royal College of Nursing

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The policy practice gap

To mark the first release of the WSD headline results in December 2011, Appello and Salix Consulting convened a round table debate at the King's Fund in London to explore this changing context and what it means for clinical commissioning groups. It was chaired by Dr Michael Dixon, OBE, a practising GP and chairman of the NHS Alliance.

Participants agreed that the evidence base was strong enough to show that telehealth works and it is something they should be doing. As one participant said:



From a patient perspective it makes perfect sense as there are very real benefits to people with long term conditions.



The WSD headline results show a striking reduction in mortality, as well as encouraging data around reducing use of secondary care services. Other sources have shown that telehealth has a high degree of patient satisfaction, especially where there is a large, highly skilled clinical support element to the service.

However, participants questioned whether the clinical evidence base for telehealth is detailed enough to support decision making by clinical commissioning groups.

Participants were not clear from the evidence they had seen what exactly about telehealth produces these results. Is it the daily monitoring? Is it the input from clinicians? Does it promote better self-care? There is also a lack of evidence to support commissioners in deciding exactly what to do and for which groups of patients. How should patients be selected? What should be done for them? Which of the 15 million patients with long term conditions might benefit most?

It was agreed that GPs and clinical commissioning group leads need more information.

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“ **The evidence base is strong enough for us to be doing something. Then there is the question of exactly what we should be doing.** ”

“ **We need to understand what the breadth of telehealth means.** ”

“ **How clear is it what the patient criteria should be? We need data to be able to work out the specifications of the service we are going to commission.** ”

There was a call from GPs at the meeting for narrative case studies to support the clinical trials data. They were keen to understand the impact telehealth has on patients and their informal carers by promoting self-care and independent living. Participants were also keen to learn from the experience of those that had used telehealth in practice including patient selection criteria, changing use of primary and community resources over time and how to make access to telehealth equitable, for example by those who do not speak English.

“ **Commissioners will also require evidence that is applied, peer led and practical.** ”

Participants from Appello, the British Lung Foundation, Royal College of Nursing and NAPP agreed that this requirement for information must be met and as a result the Telehealth Forum has been established to put together information for commissioners, health professionals and patients.

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From policy to patient

It is crucial that telehealth is not presented to the public as a cost saving measure, participants agreed. This would lead to patients feeling abandoned and make them unwilling to take part. There was a clear need to engage with patient support groups both to develop patient education around telehealth and to raise awareness of the possibilities that the service can offer.

“ I looked at the web sites and journals of ten patient organisations in the last ten days and not one of them mentioned telehealth. We need to make the public aware.”

“ If telehealth is presented as a cost cutting measure the public, it will not work. They will feel abandoned.”

“ Never underestimate the patient voice. Patients want to self manage and they want telehealth. I believe we're pushing against an open door.”

Telehealth services need to put the patient and family at the centre and link into secondary, primary and community care. Services need to include patient education around self-care as well as access to support from healthcare professionals when it is needed. Secondary care must be involved in patient selection criteria alongside primary care and have an interest in viewing patient data.

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From policy to purse

Do clinical commissioning groups have the tools to identify how savings would accrue to them?

The results from the WSD show reductions in secondary care use and a small reduction in the tariff. While this was encouraging in that it demonstrated reduced inappropriate use of NHS resources, it was not cash releasing nor did it impact on primary care financing. Participants also felt that the business case was also extremely narrow. It did not seem to take account of potential costs in primary and community care, for example in changing use of community nursing resources or changes in GP attendances. Is telehealth an add-on or an instead-of service for community and primary care? The business case also did not offer enough information about the difference in benefit to rural and urban areas or the social benefit, such as return to work.

“ **Most of the cost analysis is based on secondary care costs but it is more complex than that. It may be that the community matrons involved in a telehealth project spend the first hour of their day looking at patient data. That also has a cost.** ”

“ **It is also about the district nurses' time and the GPs' time. How many appointments are we saving or using and are we using appointments for something more efficient and effective.** ”

“ **The messages are very mixed. My gut feeling is that it would be right thing [to commission telehealth services] for a whole range of issues. However we also go back to the evidence: is it going to save money and is it good value for money? I don't think it is a quick win and you would need to go to scale before you started to see the cash benefits.** ”

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How will clinical commissioners know what a “good” telehealth service looks like?

With many players now in the marketplace, making it possible for people to buy services independently, and with personal health budgets on the horizon, participants were clear about the need for accreditation of telehealth providers and a better understanding by commissioners of what a high quality service looks like.

At a basic level, they were not entirely clear about how telehealth works and what elements make up a service. There was a general concern about gaps in governance structures that would allow clinical commissioning groups and individuals to assess the quality of telehealth services. It was unclear to participants, for example, whether telehealth providers required registration with the Care Quality Commission (CQC). They were also unclear about what service level agreements they might reach, what key performance indicators might look like and whether they would expect to pay the capital costs or pay a fee-for-service.

“

I do not want my mum to be buying something from a rascal organisation.”

“

It does come down to service. If you are monitoring somebody everyday but doing it wrong, it will not work.”

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Conclusion and next steps

The national direction has been set; the debate at the round table demonstrated that while clinical commissioning group leads see value in telehealth, there are gaps in both the evidence base and their knowledge.

If “local players” are to develop their local marketplaces, they will need:

- better understanding of how telehealth works and what it can deliver and for whom
- a guide to help them identify those that would benefit from the service most: the ‘three million’ lives
- access to evidence-based high quality patient education materials
- more qualitative and quantitative evidence about the clinical benefits of telehealth
- a more robust business case that takes into account the community and primary setting as well as the acute setting
- better understanding of the emerging mechanisms for funding telehealth
- more clarity around governance of telehealth providers
- clear commissioning guidance.

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What is telehealth?

The terms telecare, telehealth and telemedicine are often used interchangeably when in fact they have distinct meanings.

Telecare:

using sensors around the home linked to a home unit and monitored 24 hours a day, 365 days a year by a monitoring centre, allowing swift action to be taken should an incident occur.

Telehealth:

using remote monitoring devices in people's homes to measure biometric signs such as blood pressure, pulse, temperature or blood oxygen levels. Patients send their measurements electronically to a monitoring service. This triggers reactions at given levels, for example a telephone call or home visit from a nurse.

Telemedicine:

delivering medical services using remote technology, for example video conferencing healthcare professionals or professionals with patients or remote viewing of images such as x-rays by clinicians.

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Appendix 1: Setting the national direction

December 2011 saw a series of announcements to set the NHS on the road to deploying telehealth much more widely. These were:

- Release of the first results from the WSD projects
- 3millionlives campaign
- The NHS Operating Framework for 2011/12
- The NHS Review of Innovation, Health and Wealth

The Whole System Demonstrators and the 3millionlives campaign

The WSD study was a randomised control trial set up in 2008 to test telehealth against conventional care in three locations: Kent, Newham and Cornwall. In the trial, 3,030 people with diabetes, heart failure or chronic obstructive pulmonary disease were given access to telehealth.

In December 2011, the Department of Health published the first findings, which showed that “if used correctly” telehealth delivers:

- 45% reduction in mortality rates
- 15% reduction in A&E visits
- 20% reduction in emergency admissions
- 14% reduction in elective admissions
- 14% reduction in bed days
- 8% reduction in tariff costs

It said that “at least three million people with long term conditions and/or social care needs could benefit from using telehealth and telecare.”

The Department of Health launched the 3millionlives campaign in partnership with industry, the NHS, social care and professional organisations to achieve this.

The Department of Health’s role will be to provide more detailed results from the WSD trial as well as national leadership and strategic direction. It will be up to local organisations and industry to create the market and deliver the change.

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The NHS Operating Framework

This sets out for managers what their priorities should be over the next 12 months.

The Operating Framework for 2011/12 sets telehealth firmly in the QIPP (quality, innovation and productivity) agenda:



The role of innovation, too often the forgotten element of QIPP, will be critical. Rapidly spreading changes that improve quality and productivity to all parts of the NHS will be crucial: a clear example is the use of telehealth to improve services for patients with long-term conditions.



PCT clusters and clinical commissioning groups are expected to take it up more widely:



Telehealth and telecare offer opportunities for delivering care differently but also more efficiently. Use of both of these technologies in a transformed service can lead to significant reductions in hospital admissions and lead to better outcomes for patients. Using the emerging evidence base from the Whole System Demonstrator programme, PCT clusters working with local authorities and the emerging CCGs should spread the benefits of innovations such as telehealth and telecare as part of their ongoing transformation of NHS services. They should also take full consideration of the use of telehealth and telecare as part of any local reconfiguration plans.



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The Innovation, Health and Wealth Report

In 2011, NHS chief executive David Nicholson appealed to the NHS to come up with innovative ideas for transforming healthcare. The subsequent report, published in December 2011, identifies telehealth as one of six high impact innovations that it expects PCT clusters and clinical commissioning groups to consider. It sets out two important financial issues:

- CQUIN (commissioning for quality and innovation) payments, that currently make up 2.5% of trusts' £60bn income, will be linked to these high impact actions. In other words, those that fail to commission new telehealth services will be penalised financially. Telehealth may also form part of the proposed "innovation score card" for commissioners, again linking financial reward to innovation.
- The Department of Health intends to develop a "tariff for assistive technologies" that would provide incentives to innovate. It will also work with industry to find ways to fund telehealth through revenue costs rather than capital.

Summary

- The Coalition Government and Department of Health want to see telehealth provided more widely and set the strategic direction, including new funding mechanisms, and provide leadership.
- Local PCT clusters, clinical commissioning groups and industry are expected to work together to develop the local market.

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Appendix 2: Glossary of terms

Clinical commissioning groups (CCGs)

These are the entities which will take on responsibility for commissioning many NHS funded services under the reforms. CCG is the new terminology which replaces “GP consortia”, to reflect the wider involvement of other clinicians. The term “GP commissioning” is also no longer in use, for the same reason. CCGs will have statutory responsibility from April 2013. Budgets are already being handed down from primary care trusts (PCTs).

Department of Health (DH)

The Department of Health provides strategic leadership for public health, the NHS and social care in England. The Department of Health’s purpose is to improve England’s health and well-being and in doing so achieve better health, better care, and better value for all.

Patient participation groups (PPGs)

Patient participation groups (PPGs) operate within GP surgeries and health centres. Their priorities are developed and agreed locally in order to meet local needs and to reflect the interests and energies of the participants.

Primary care trust (PCT)

A statutory, locally managed, free-standing NHS organisation, responsible for improving health, commissioning and delivering health care for local residents. These are being gradually replaced by CCGs and will have disappeared completely by April 2013.

PCT clusters

PCT clusters have been created to consolidate management capacity, with single executive teams each managing a cluster of PCTs. These new clusters are not statutory bodies, nor are they permanent features of the landscape, but they are necessary to sustain PCT capability and support CCG development.

Quality, innovation, productivity and prevention (QIPP)

QIPP is a large scale transformational programme for the NHS, involving all NHS staff, clinicians, patients and the voluntary sector and will improve the quality of care the NHS delivers whilst making up to £20billion of efficiency savings by 2014 -15, which will be reinvested in frontline care.



Disclaimer

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