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Sustaining innovation in telehealth and telecare

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What we will cover

• Overview of WSDAN sites (England)
• Overview of our methodology
• What we discovered
  – Themes
  – Patterns
• Lessons in terms of sustainability
WSD and WSDAN Sites

Cornwall, Kent, Newham

Croydon
Birmingham
Barnsley
Southampton
Nottingham
Leicester
Leeds
East Riding
Norfolk
Lincolnshire
Lancashire
Hull
Methodology

• Collected notes over past 2/3 years from WSDAN meetings and visits
• Additional recent interviews with staff at six WSDAN sites
• SWOT analysis completed by WSDAN participants
Themes from interviews

• Major themes
  – Data management
  – Leadership styles
  – Workforce practices

• Other themes
  – Patient empowerment
  – Personalisation
  – Trust
  – Evidence (Data- and evidence-based decision making)
Data management

• Data integration
  – Record systems do not communicate with each other
  – Outsourced services will keep minimal demographic and/or contact information
  – No health or medical information
  – Patient consent/confidentiality appears to be an issue
Data management

• Data integrity

  – How can you be sure source of data comes from the client or patient?
  – How can you now when there has been a keystroke, input error?
  – What standard protocols are there to assure that accurate migration of data from home devices to nurse to GP?
Leadership styles

• Well-developed skills of persuasion
  – Ability to understand what is important to different audiences

• Willingness to take risks
  – Spin out as social enterprises
  – Proactively seek funding/opportunities

• Ability to establish external links
  – Vendors
  – Universities
  – Aware of what is happening in other sites

• Continuity and commitment
  – The most successful sites enjoyed a continuity of leadership
Workforce practices & development

• Difficulty in changing mindset of what it means to provide care
• Staff development seen as an issue
  – How to manage increased caseloads
    • Professional development to help staff adhere to clinical processes and protocols
    • Professional development to enable staff to adhere to business processes
  – Need for some basic training
    • Understanding how to manage data
    • Data manipulation and analysis techniques
  – Need to come to scale
    • Veterans Administration
      – Three VA telehealth training centers enabled over 6,000 staff to be trained and have helped sustain a rapid pace of telehealth expansion
SWOT analysis / Strengths

- **Health Care respondents**
  - Leadership and local champions
  - Stakeholder involvement
  - Body of local knowledge of what works
  - Focus on self-care and long-term conditions
  - Strategies for prevention and/or personalisation
  - Innovative ways of working
  - Vision from the top of the organisation
  - Consent, confidentiality and privacy issues
  - Entrepreneurial thinking

- **Social Care respondents**
  - Leadership and local champions
  - Availability of local and robust evidence base
  - Focus on self care and long-term conditions
  - Innovative ways of working
  - Data management
  - Stakeholder involvement
  - Results of outcomes and evaluations
  - Consent, confidentiality and privacy issues
  - Building a business case
  - Integrated working
SWOT analysis / Weaknesses

• Health Care respondents
  – Workforce skills
  – Data management
  – Working without additional funding
  – Effects on carbon footprint
  – Resistance to change and innovation
  – Integrated partnerships and pooled funds
  – Decommissioning extant services

• Social Care respondents
  – Ability of commissioners and providers to innovate
  – Data management
  – Results of outcomes and evaluations
  – Staff acceptance of change and innovation
  – Rate of technology adoption
  – Availability of broadband
  – Workforce skills
  – Fair access to care services criteria
SWOT analysis / Opportunities

- **Health Care respondents**
  - Consumer market for products and services
  - Personalised services with budget options, choice and control
  - Building a business case
  - Digital inclusion
  - Integrated partnerships with pooled funds
  - Results of outcomes and evaluations
  - Identifying clients who would most benefit
  - Mainstreaming pilots and projects

- **Social Care respondents**
  - Integrated partnerships with pooled funds
  - Support for the wider population
  - Changes in caseload management
  - Link with QIPP
  - Technology standards for equipment
  - Managing service integration
  - Body of local knowledge of what works
  - Digital inclusion
  - Predictive modeling and risk stratification
  - Consumer market for products and services
  - Challenges to existing models of care
SWOT analysis / Threats

• **Health Care respondents**
  – Challenges to traditional models of care
  – Staff acceptance of change and innovation
  – Rate of technology adoption
  – Resistance to change and innovation
  – Consent, confidentiality and privacy concerns

• **Social Care respondents**
  – Resistance to change and innovation
  – Challenges to traditional models of care
  – Personalized services with budget options, choice and control
  – Fair access to care services and criteria
  – Innovation during financial constraints
  – Working without additional funding
  – Costing of services for personal budgets
  – Consent, confidentiality and privacy concerns
Health and Social Care System in England from 2013
(Mike Clark/15 February 2011)
Health and Social Care System in England from 2013
(Mike Clark/15 February 2011)

- Funding
- Accountability

Funding from Government grants, local income etc

- Parliament
- Department of Health
- 10 SHAs
- 151 PCTs
- 152 social care authorities
- 8000 GP Practices
- 50m Patients, users, public

Joint Strategic needs Assessment
QIPP Performance Mgmt
Health and Social Care System in England from 2013
(Mike Clark/15 February 2011)

- Funding
- Accountability

1. Parliament
2. Department of Health
3. NHS Commissioning Board
4. GP Consortia
5. Patients, users, public
6. 151 PCTs
7. 10 SHAs
8. Joint Strategic needs Assessment
9. QIPP Performance Mgmt
10. Funding from Government grants, local income etc

152 social care authorities
Health and Social Care System in England from 2013
(Mike Clark/15 February 2011)

Funding

Accountability

Funding from Government grants, local income etc

152 social care authorities

Shared services across authorities

Independent/Commercial
Districts
Voluntary Social Charities enterprises
Trading arms

Providers

10 SHAs

QIPP Performance Mgmt

Joint Strategic needs Assessment

New Partnerships

151 PCTs

GP Consortiums

Patients, users, public

Any Willing Providers

Acute Hospitals
Mental Health Trusts
Community Health Trusts
Care Trusts
Social enterprises
Consultancies
Voluntary
Independent/Commercial
GP Provider Services

Acute Hospitals
Mental Health Trusts
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Care Trusts
Social enterprises
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Independent/Commercial
GP Provider Services
Health and Social Care System in England from 2013 (Mike Clark/15 February 2011)

- Parliament
- Department of Health
- NHS Commissioning Board
- Monitor (economic regulator)
- Care Quality Commission

- Funding
- Accountability

- Funding from Government grants, local income etc
- SHAs cease in April 2012
- QIPP Performance Mgmt
- PCT clusters by June 2011, cease – April 2013
- Joint Strategic needs Assessment
- New Partnerships

- 152 social care authorities
- 10 SHAs
- 151 PCTs
- GP Consortiums
- Patients, users, public

- 151 PCT clusters by June 2011, cease – April 2013

- Any Willing Providers
- Acute Hospitals
- Mental Health Trusts
- Community Health Trusts
- Care Trusts
- Social enterprises
- Charities
- Consultancies
- Voluntary
- Independent/Commercial
- GP Provider Services

- Shared services across authorities

- Independent/Commercial Districts SW
Team
Voluntary Social Charities enterprises Trading arms

Providers
Health and Social Care System in England from 2013 (Mike Clark/15 February 2011)

152 social care authorities

Health and Wellbeing Boards

Joint Strategic needs Assessment

151 PCTs

GP Consortiums

Patients, users, public

New Partnerships

Community Teams exit PCTs by April 2011

Shared services across authorities

10 SHAs

Public Health role moves - 2013

Public Health England

Funding from Government grants, local income etc

Public Health

Department of Health

NHS Commissioning Board

Monitor (economic regulator)

Care Quality Commission

Funding

Accountability

Any Willing Providers

Acute Hospitals

Mental Health Trusts

Community Health Trusts

Care Trusts

Social enterprises

Consultancies

Voluntary

Charities

Independent/Commercial Districts

SW Teams

Voluntary Social Charities enterprises

Trading arms

Independent/Commercial Providers
**Health and Social Care System in England from 2013**

(Mike Clark/15 February 2011)

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**GP Consortia**

**Challenges:** GPs cannot commission services from themselves. GPs may not be convinced of the value of telecare and telehealth. It is unlikely that GP Consortia will buy telecare/telehealth devices and maintain inventory.

**Opportunities:** GPs will need to urgently look at referral management, urgent care and the high overall costs of managing people with long term conditions. Managed services based on outcomes for population groups which use technology solutions could become more popular. There is likely to be more risk stratification and predictive modelling to ensure that patients are on the most effective care pathway. GP Consortia may work more closely with social care authorities on integrated responses. QoF and other incentives and reimbursements may be relevant.

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**Local authorities**

**Challenges:** Major service cuts in backoffice and some frontline services (including contracted services). SP and prevention funding significantly affected. FACS criteria becoming restricted to ‘Critical’ and some ‘Substantial’. Higher charges. Move towards 100% personal budgets remain challenging. Some services outsourced or re-tendered. Some contracts re-negotiated at lower prices. Possible payment by results for social care in the future.

**Opportunities:** Improved pathways for re-ablement, post discharge and embedding of technology support into programmes. Support for carers. Integration into personal budget arrangements. Future health and well-being activities/JSNA.
Provider landscape – potential changes:
• Increased numbers of personal budgets in social care (currently pilots in health) - micro service providers
• Focus on outcomes and risk sharing
• Vertical and horizontal integration
• End to end solutions for population groups
• Price competition
• Legal challenges where no level playing field
• Hospitals make wards, operating theatres and other facilities available to other providers as well as earn more income from self-funders. Acute hospitals responsible for 30 days post discharge on electives from April 2011
• Consolidation – from hospital services to telecare control centres
• Some community GP provider units emerge – minor surgery, diagnostics, ultrasound, chemotherapy
• Extended role of pharmacists
• Changing role of NHS Direct, commencement of 111 services
• Consultancies providing commissioning and transaction support, referral management, risk management and predictive modelling, care pathway improvements, AWP procurement
• Trading arms, social enterprise spin-offs and possible outsourcing with funding for social work practices (DH pilots)
Providers

**Challenges:** – see AWP panel (opposite)
Downward pressure on service providers because of local authority cuts may see business failures. Some consolidation of the provider market for telecare may be disruptive. Response support for telecare could prove too costly for many organisations. Social Work Practices with delegated funding not yet established. Personal budgets including telecare not yet established. Services not currently based on outcomes. High FACS criteria users may not be the greatest beneficiaries from telecare.

**Opportunities:** – see AWP panel (opposite). Potential for innovation with trading arms, spun out social enterprises working with suppliers etc.

AWPs

**Challenges:** Telecare and telehealth providers not yet geared to becoming potential AWPs on their own or in partnership – predominately equipment vendors on the current Buying Solutions Framework for telecare/telehealth. It will take time for community healthcare teams to become fully established in their new environments. Many organisations are not used to EU tendering and price competition. There are business risks associated with reducing contract costs and tariff income. Potential for fragmentation of services amongst different providers. Possible higher costs to providers of more individual transaction handling. Some services may not meet foundation trust requirements. Hospitals not ready for ‘30 day post discharge’.

**Opportunities:** Potential for integrated activities (eg post discharge telecare and telehealth support) that are outcome-based. Consolidation (eg control centres) with scope for improving effectiveness and efficiency. Potential for innovation – simpler solutions, more consumer-focused offerings, risk sharing across organisations. Health and social care integration and joint working across providers. Support for personal health budgets. GP providers/pharmacists and other organisations supporting patients/users with long term conditions using technology support. QIPP activities and alignment.

Health and Social Care System in England from 2013

(Mike Clark/15 February 2011)
**Patients, service users, carers**

**Challenges:** Few telecare services are provided through personal budget arrangements. Supporting People funding is affected by local cuts. Telecare and telehealth are currently not consumer products for self-purchase. Charges are increasing. Telehealth pilots are limiting availability of technology to a wider population. Possible provider consolidation is disruptive.

**Opportunities:** Telecare/telehealth embedded in re-ablement and post-discharge pathways as well as prevention programmes. Openings for consumer products, simple telehealth solutions using mobile phones/TV/Smart metering etc.
Summary

• Telecare adoption (1.6-1.7m installs) is steadily increasing and there are examples of scaling whilst telehealth home remote monitoring remains at an early adoption stage (6000 installs)
• The pressure of finding significant cash releasing efficiencies as well as establishing a robust evidence base for telehealth and telecare is leading to further challenges for commissioners and providers – more evidence is being expected for technology-supported services than most other health and social care activities
• There are tensions between opportunities for integration and the possibility of fragmentation (organisational and processes) during a period of rapid change eg ‘care homes and hospitals’ versus ‘care in the home’
• Planned NHS modernisation will not happen overnight – it could take at least two and possibly five years to start to embed home health based remote monitoring in care pathways with integrated data management even with a strong push, incentives and provider innovation
• Technology innovation is running several years ahead of service innovation and transformation
• Providers are likely to be more innovative than commissioners but may not have the money to invest
• Integrated, end to end solutions using technology as appropriate to deliver outcomes for population groups are more likely to gain traction then building local inventory that is not fully deployed
• Simpler, more flexible solutions are needed to build and engage a consumer market
Thank You

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