Seminar notes: Telehealth, telecare and new technologies in UK healthcare

Feb 24 2010

These unofficial notes come with a 'health warning'. Our reporter said "Trying to listen, understand, type and read what was on the screen was not easy!" Comments have been posted on the original item.

Introduction

1) Peter Fouquet – President - Bosch
   Defining Telehealth and Telecare
   Delivery of telehealth services without the use of travel
   15.5 million people with LTC and 8.5 high users of telecare

2) Murray Bywater – manager Silicon Bridge
   Going through various definitions
   Telecare, Telemedicine, Telehealth, eHealth, Healthcare IT, Electronic Patient Record
   Electronic health record
   eHealth requires the infrastructure to grow. This has been the hold up.
   50 billion Euros
   15-20 billion Euros potential
   EHR are a waste of money
   EPR we can deliver today.
   Integration of medical and diagnostic devices
   Standards are helping set the tone of the market – interoperability
   GE is setting up global eHealth unit

3) Johan Maghiros head of EU commission
   Personal assistance – socio-economic impacts
   1000 billion Euros is the EU expenditure on health eHealth market is 14.2 million Euros. (5-10 years)
   Telemedicine and telecare 0.9% of the overall eHealth expenditure.
   0.4% is remote monitoring.
   Personal health systems – multi parametric sensors, lab on chip tests and diagnosis, interactions and interfaces and intelligent diagnosis and treatment.
   Still not there yet.
   Largest pilot is the WSD in UK. Will provide data on benefits of this technology
   Reduce visits to GP 40%
   Admission reduced 50%
   50% less days off work
   No clear policy push
   "Change focus from disease management to human management"

   Note: If you store all people's data from birth then you end up with a lot of data that no one is going to use.
   Need to focus down to more key environment and produce common understanding of information.
   Health records are key.
   Certainly not national.

Life portal approach is the answer to storing information centrally.
Away from state taking full responsibility on to individuals taking control of their own health. Proxy people in the middle e.g. GPs etc. 25 years to bottom this.

Telehealth and Telecare cost benefits and commercial benefits

4) Ilena Welte – Bosch
   a. Evidence that the system can collect data
   b. UK most ready market for Telecare and Telehealth
   c. Support management and self directed care
   d. Two way feedback GP central to management of information
5) Terry Young Brunel
   a. Key communities – NHS Social services and companies – patient, carer and relatives
   b. What is the total package
   c. What is the business model of these partners?
   d. Profitability?
   e. Will it save hospital resources
   f. Effectiveness and efficiency for social services??
   g. The people who pay – who is paying for what? How do they know they are getting a good deal for their money?
   h. How do private payers know they are getting value for money?
   i. Delivery: Prescription? Menu? The market? Routes not interoperable.
   j. Can you mix and match services
6) Ali Rogan – Tunstall
   a. WSD Cornwall 1600 people
   b. Significant quality of care – improved motivation
   c. George controls his own health through telehealth
   d. NHS Leeds – increase nursing capacity by 50%

Relationships with service users

7) Alex Fox Princess Royal Trust for Carers – TYZE.org
   a. Secure caring network
   b. Shared calendar
   c. Technology for ongoing support etc
   d. Carers can coordinate a rota for assistance
   e. Web can support caring networks
8) Sally Anne Pygall – Telephone Consultation Services
   a. Telephoning people to give advice
   b. Achievable cost savings (£30,000 per 1,000 people) *[See additional notes at end. Ed.]*
   c. Telephone triage
   d. GPs do not receive any telephone training
9) David Sinclair - National Longevity Centre
   a. 10 big challenges and opportunities
   b. Older person as consumer not designed for older people

c. 7 out of 10 older people have never used the internet
d. Data sharing
e. New providers: Tesco

10) Jan Trethway
    a. Swindon
    b. "Swindon use AT in its entirety"
    ????? Do they understand what AT is?

Post-break

11) Colin Callow
    a. Technology Adoption Programme
    b. Perceived thin evidence base
    c. Cardiac remote monitoring and follow up
    d. Managers must seek out evidence for the use of new technologies
    e. Gathering the right evidence for decision makers
    f. Supporting increased adoption of systematic corporate management processes
    g. Identifying new technologies that are candidates for new resources
    h. Identifying which can receive less resources
    i. Decommissioning of outdated practices and processes and commissioning new technologies
    j. Map adoption process from start to finish
    k. Disseminate best practice across NHS
    Queens University doctor asked: are we decommissioning or the decommissioned?
    l. What funding to the technology adoption centre?

12) Dr Nick Robinson AD LTC and Telecare NHS direct
    a. Digital platforms
    b. Moved from fixed point contact to remote contact
    c. 24 hours a day access
    d. 3 million patients have used the system checkers
    e. 50 % will be advised to treat themselves at home. 11% to A&E
    f. 51.7 million people accessed the service on the WEB
    g. 120,000 referrals to GP
    h. The figures of people with conditions are getting bigger
    i. The pyramid is getting bigger
    j. Carers are getting smaller in number
    k. Number of NHS staff is getting smaller
    l. Need to use all forms of technology to get the information across

13) Dave Munday – Unite Union
    a. Make it happen survey
    b. Accessing computers can take time

14) Simon Brownsell
    a. How to spread innovation in the NHS
    b. Risk – barrier to evidence
    c. No problem in doing major initiatives but NHS says we need perfect evidence before we do something
    d. Who benefits and who pays
    e. Failure to introduce things
    f. No problem with pilot as long as it feeds decision
    g. Tension between innovation and controlled risk
    h. Investing in telehealth means disinvesting in something else.
    i. WHO comparison of eHealth and telehealth will be out in next few months
    j. Timing is right to do things.
    k. Pilots were set up to fail

15) Ram Dhillon - surgeon
    a. Why telehealth projects have failed
    b. Disease management and self care
    c. Bigger fish to fry for cost benefit is the lower tier Kaiser pyramids
    d. Less likely to get people into the pyramid
    e. Acute sector look after these lower pyramids
    f. To get innovation at this level is very hard
    g. Clinicians need to be got on board early on
    h. Expediting adoption, eg Statins took ten years to get adopted after the evidence was in
    i. Where do you get funds from?
    j. Ring-fenced money works
    k. Best practice is a stumbling block as it is personality centred
    l. No one interested in pilots
    m. Serious money required

    Q is the way forward proactive or reactive?
    RD - Ethical society needs to fund top end of pyramid but if it is change and we tackle the big group in the middle. Diabetics are not unwell until the trend hits
    We need devices that pick up trends
    NR – need to work with young kids... are we preventing them from smoking and taking exercise? This is down to Govt policy
    DM – walking up stream we pull people out but never find who pushed them in. The reduction of staff these families are not able to identify safeguarding issues.
    SB – Prevention harder to do as identification. Market easier as people can go out and get the equipment. People with telehealth might get better services and a tow tiered system.
    RD – how much Govt spends on H-Promotion vs organisations send on burgers and alcohol?

Cost Benefits of Improved Triage Skills (Out of Hours)
Additional notes supplied by Sally-Anne Pygall

If we assume an average reimbursement of £60.00 per hour for each doctor, we can calculate the approximate cost of each call, each PCC visit and each home visit.

The average triage time of 7.1 minutes (Unit Costs of Health and Social Care 2008 for 'in hours' GP telephone triage call length) would mean that in a 6 hour shift, a doctor could triage 8 calls an hour.

However, given breaks between calls, call volumes and tri role duties, it would be fair to assume no more than 45 calls would be triaged in a 6 hour period. This would equate to a cost of £8.00 per call if the outcomes was advice (TADV) only. From my experience, however, most clinicians do not triage more than 6 calls an hour on average during a 6 hour shift, which would make the cost of each call £10.00.

If patients require a face to face consultation following telephone triage, the average clinic appointment time is 10 minutes. The cost of a clinic appointment will be £20.00 per patient (triage plus clinic time) whilst the average home visit of 20 minutes would equate to a cost of £30.00 (triage plus visit time).

Diverting 1000 inappropriate home visits (i.e. where the patient did not clinically need a home visit) to advice only or a clinic, would save approx £20,000 - £30,000.

As I said, the costings are based on figures from the Unit Costs of Health and Social Care 2008. This is information commissioned by the DH.