



**Views on day-to-day service issues
and the role of telehealthcare:**
a report from the Model for Optimising
Sustainable Telehealthcare programme

June 2014



most





Views on day-to-day service issues and the role of telehealthcare:
a report from the Model for Optimising
Sustainable Telehealthcare programme
Good Governance Institute

Authors:

Christopher Smith, Researcher, Good Governance Institute
Andrew Corbett-Nolan, Chief Executive, Good Governance Institute

Reviewed by:

Thomas Mytton, Researcher, Good Governance Institute
Donal Sutton, Researcher, Good Governance Institute

This report is part of a growing series of reports developed by the Good Governance Institute (GGI) that consider issues contributing to the better governance of healthcare organisations. GGI is an independent organisation working to improve governance through both direct work with individual boards and governing bodies, and by promoting better practice through broader, national programmes and studies. We run board development programmes, undertake governance reviews and support organisations develop towards authorisations.

Other recent GGI reports and board development tools have considered board assurance, patient safety, clinical audit, quality and safety of telehealth services, services for people with long-term conditions, diabetes services, better practice in treatment decision-making, productive diversity, the board assurance framework, integrated governance, governance between organisations and of course good governance.

GGI is committed to develop and promote the Good Governance Body of Knowledge

© 2014 GGI Limited ISBN 978-1-907610-27-1

GGI Limited, Old Horsmans, Sedlescombe, near Battle, East Sussex TN33 0RL is the trading entity of the Good Governance Institute

info@good-governance.org.uk

www.good-governance.org.uk



Executive summary

The MOST project, is a collaboration between Tunstall Healthcare (the world's leading telehealthcare provider), NHS North Yorkshire, Ernst and Young, and the Nuffield Trust, as part of the Technology Strategy Board's Assisted Living: Economic and Business Models and Social & Behavioural Studies competition. It has the dual goals of developing a toolkit and demonstrating the deployment of new product solutions that would enable the upscaling of telehealth services.

The MOST Toolkit, produced as a result of this collaboration, is a guidance document designed to explain the processes of developing and implementing a large-scale telehealth project from the viewpoint of both the commissioner and the service provider.

This report analyses the impact of changes in the health landscape since the inception of the MOST project and also summarises the findings of a series of interviews and focus groups held with commissioning managers and GPs in early 2014, the results of which make the case for the greater implementation of telehealthcare.

Contents

1. Introduction	1
2. Changes in the health landscape since the inception of MOST	2
3. What do GPs need as a priority to support older patients better?	3
4. What do commissioning managers need as a priority to support older patients better?	5
5. Suggested telehealthcare solutions	6
6. Key points from the toolkit that are of most help providers	8
7. Conclusions	9

1. Introduction

The Model for Optimising Scalable Telehealthcare (MOST) research project

Earlier this year, the Good Governance Institute (GGI) alongside Tunstall Healthcare (UK) Limited undertook a piece of research linking contemporary telehealthcare implementation issues to the MOST (Model for Optimising Scalable Telehealthcare) Toolkit. The culmination of this project has provided us with an opportunity to reflect on our findings and situate them in the context of wider changes in both the NHS and the health and social care landscape.

Telehealthcare is an umbrella term used to capture two main strands of technology enabled care services: telehealth and telecare. Telehealth is the use of equipment to monitor people's health in their own home, while telecare is a combination of alarms, sensors and other equipment that helps enable people to live independently.

The MOST project was initially a collaboration between Tunstall Healthcare (the world's leading telehealthcare provider), NHS North Yorkshire, Ernst and Young, and the Nuffield Trust, with the dual goals of developing a toolkit and demonstrating the deployment of new product solutions that would enable the up scaling of telehealth services. In particular, the Toolkit was designed to explain the processes of developing and implementing a large-scale telehealth project from the viewpoint of both the Commissioner and Service Provider.

However, since publication, the whole healthcare commissioning system has experienced the largest ever reorganisation in the NHS. Indeed, Simon Stevens, current Chief Executive of NHS England has expressed how he intends to "back CCGs and give them every chance to succeed" as the magnitude of changes occurring to the commissioning landscape will require "CCGs to prove themselves".¹ The changes, shifting commissioning responsibility away from the Department of Health to NHS England, and the new Clinical Commissioning Groups (CCGs), and placing emphasis on the need for joined up care have impacted on the way telehealthcare is commissioned and delivered, and have effectively out-dated the toolkit.

Furthermore, whilst these changes have been underway, mixed messages have been drip-fed back from the Whole Systems Demonstrator (WSD) trial polarising opinion around telehealthcare.

By carrying out a range of interviews and focus groups, GGI was able to garner the opinions of GPs and commissioning managers around the implementation of telehealthcare, and also understand the key service issues they face in relation to treating their 'increasing older populations. It is the findings of this work which fed into the review of the MOST Toolkit and which this paper will summarise.

¹ Policy Update, Macmillan Cancer Support, 2014

2. Changes in the health landscape since the inception of MOST

The reforms to health and social care that were implemented in 2013 have had a significant impact on the way health is commissioned and also on the ability of the MOST Toolkit to maximise its full potential.

In 2013 the Health and Social Care Act came into being. With this came substantial reforms to the structure of the NHS, including the programme for developing NHS trusts to foundations trusts, shifting commissioning responsibility away from the Department of Health to become NHS England, and the creation of CCGs. The Act also gave a duty to NHS England, CCGs, Monitor, and Health and Wellbeing Boards (HWBs) to encourage joined-up services between health and social care, with the Better Care Fund set up to help facilitate this. The results of these changes have caused a shift away from process driven targets to those which concentrate on outcomes for the individual, altering the commissioning and service design landscape. A focus on integrated care, and in turn more alignment between sectors and service providers, should contribute to the positive uptake of telehealthcare.

Particularly important in this are CCGs. Although CCGs have existed in shadow form to Primary Care Trusts (PCTs) since January 2011, the 2013 Act formally brought them into existence. All GP practices are required to become members of a CCG, and they have now taken over the commissioning of the majority of local services. CCGs differ from PCTs in that they are smaller and more numerous; covering smaller areas but with reduced resources, their capacity for commissioning and implementing telehealthcare is likely to be diminished. The shift also means that GPs are now at the heart of deciding which needs and services are of most importance and relevance in local communities.

Another important element of the newly incorporated Health and Social Care Act is the acceleration of the 'personalisation agenda' whereby patients have a personal health budget and are able, effectively, to self-commission their pathway of care. Customers will be able to choose different providers in different sectors, encouraging the formation of a diverse range of services, including telehealthcare. It is important that awareness around telehealth is increased for this to have a significant impact.

In a period of austerity and shifting population demographics these changes will have a big impact on the way telehealthcare is provided and commissioned. For instance, it has been reported that the transfer of some community health services to NHS Foundation Trusts may result in the de-prioritisation of community care, and telehealthcare, as Trusts receive more funding for delivering acute services. Reductions in local authority budgets and capping of NHS budgets also coincide with increasing demands for services.² The need for technological solutions, such as telehealthcare, is increasing but with resources stretched thin the appetite for commissioning may be significantly reduced.

This study, by incorporating the views of GPs and commissioning managers on the key service issues they face, and on a range of telehealthcare solutions, will argue that telehealthcare if accepted and utilised properly would work well in a revised NHS.

² Lysa Morrison and Steve Sadler, Validation of the MOST Toolkit within the context of integrated care and against service standards and guidelines, 2014

3. What do GPs need as a priority to support older patients better?

Between January and March 2014, GGI ran a series of interviews and focus groups with GPs and commissioning managers seeking to determine some of the key service issues that they face, and whether they thought the implementation of certain telehealthcare options at scale could provide a solution to these service issues. This section will outline the results of the first sessions, and in particular will look at three key themes that emerged: isolation in the senior/society as a whole; patients struggling to maintain their independence as a result of a lack of services or awareness and understanding of their condition; and the escalating demands that GPs are now put under.

Isolation of older people

One of the most regularly flagged issues by GPs around their older population was isolation and loneliness. It was suggested that this was frequently the result of a recent bereavement, the movement of children and close family, and also, increasingly, as a consequence of changing British lifestyles, in particular the decline of community and neighbourhood ties.

Recent bereavement was singled out as a risk factor that had the capacity to destabilise a patient physically as well as psychologically. One GP was particularly struck by the extent and speed of the decline in patients following bereavement, noting that:

“When I’ve seen people in their seventies and eighties, even the ones who were in quite good health, quite mobile and quite independent, it’s a huge impact upon them even when you see them two or three years later”.

It was highlighted that those who were recently bereaved were liable to wane because they had often lost their purpose, their carer, and their sole regular contact, and as such underlying symptoms which had been suppressed were likely to flare up.

Another GP suggested that what they were now facing was an “*epidemic of loneliness*” where once the patient is “*stuck behind four walls, that’s all they see, four walls*”. Whilst expressing concern for this population, the GPs we spoke to also highlighted how loneliness and isolation, heavily linked to heightened anxiety and depression, regularly led to repeat and unnecessary appointments which were taking up valuable time. This was seen as significant with one GP describing how they saw the same patient at least once every two or three weeks. Others flagged how for some of their patients, talking to or seeing their GP was among the only social contact they had and as such was important to maintain, so as not to risk destabilising the patient.

This tallies with the findings of Age UK who, in May 2014, reported that more than 1 million people aged 65 and over feel lonely always or often, with recent studies demonstrating that extreme loneliness can double the impact of obesity and increase the likelihood of premature death by 14%.³

As will be highlighted in subsequent sections of this report, GPs are under increasing pressure from government targets and growing and unrealistic patient expectation, which they are struggling to fulfil and to which patient isolation and loneliness are adding.

Patient inability to maintain their independence

Another issue emanating from the GP interviews, centred on how patients were struggling to maintain their independence, often as a result of a lack of services or not understanding their condition properly. It was suggested that many patients were of the mindset that if they had a health problem it was the responsibility of the ‘system’ to make it go away. It was recognised that this was, in part, the fault of GPs and other services that, historically, have not excelled at creating or encouraging shared pathways of care. Indeed, one GP lamented her training, which had meant that she was “*not that great at taking the time to get that feedback and creating something shared,*” but recognised that in a modern NHS, patient ownership of care pathways was important, and that she would have to modify her behaviours to achieve this.

³ Age UK, Over 1 million older people in the UK feel lonely, 2014

Others highlighted how often a ten minute consultation simply was not enough time for their patients to become sufficiently informed, and that those patients who were proactive, attended external sessions, and took the time to understand their condition were “less frustrating”. In part, it is about education, in part it is about changing behaviours. In the future, as a result of shifting population demographics, GPs will have less and less time or inclination to see the so-called ‘worried well’, and accordingly there will need to be a transfer to a more engaged and educated patient. The potential of personal health budgets to incentivise this shift was highlighted, with the hope being that these would assist patients in taking ownership of, and playing an active role in, their pathway of care while also realigning their expectations.

Similarly, when pressed it was suggested that, though GPs often rely on charities to provide support for an older patient especially if the family is unable to, “the person has to fall into a certain illness group or has to be over a certain age to qualify,” and that caring for and accommodating this population was a “constant challenge”. It was argued that “we [in the UK] don’t have a sufficiently robust community service to support them [the patient] when they could be maintained independently.” In particular, the shortage of appropriate staff was highlighted: “someone to go in on a regular basis to make sure they’re [the patient] okay”. This lack of service capacity is juxtaposed with increasing and unrealistic expectations of close friends and family members, in turn creating greater GP workload.

The GPs we spoke to also pointed out that there was a flipside to this: stoic older patients, those who preferred to keep their independence and autonomy and were extremely unlikely to present to a GP. For these people, still likely to contract a long-term condition, the best level of care was deemed “whatever feels less intrusive, so it doesn’t feel like something is being done to them.”

Escalating GP workloads and the future of care

The most prevalent issue raised by the GPs we spoke to was the increasing workload and the pressure this brought to their practice. It was suggested that a large gap existed in making sure routine assessments were not always doctor or practice-based. There was a recognition that “as the older population increases in numbers and as our population mix changes, [GPs] will have to do more of the chronic monitoring,” and that “the chronic monitoring will have to be done in a systematic way that allows [GPs] to get the relevant data without actually physically having to see everyone, so that we don’t see older people well”.

Patient led remote monitoring has the potential to provide GPs with up to date, effective readings and was something that was deemed extremely useful. Those we spoke to did, however, warn against an information overload. Data, collected by their patients and available at the click of the button, would be appreciated but it would need to be filtered, perhaps formatted into an easy to read and use dashboard, and not force fed to GPs.

As before, it was mentioned that this was about having the right people in the right roles, so that the correct cases get escalated to the GP. It was argued that capacity is currently at breaking point, and there is a need to look at different ways of doing things so that GP appointments can be released to deal with the more complex and urgent cases. If this could be achieved, then GPs felt that “having these measures, having some information would be exceptionally useful in getting a fuller picture.” One GP went as far as to state “I think the whole concept is very much the way of the future,” having a high degree of patient ownership in order to keep them at home rather than institutionalised.

Joined up data was also seen as extremely desirable but currently a long way from realisation. The point was raised by a number of GPs that they often see patients who have, unbeknownst to them, been directed their way for a diagnosis or medication change. As summed up by one participant, “we need to be able to know what there is to know and currently, we can’t, because there are all these different IT systems, [that] they have failed to bring...together”. Particular solutions that were highlighted as useful include a virtual warden who could monitor care homes etc. remotely, and an integrated virtual patient record. Ultimately, it was agreed that “we can’t send carers in to the aging population. In the future, we’re going to have to find other ways”. Integrated virtual monitoring is one such way.

4. What do commissioning managers need as a priority to support older patients better?

In contrast to the GPs we spoke to, the commissioning managers, from CCGs and Commissioning Support Units (CSUs), tended to look at the bigger picture, highlighting integration and delivering patient care in the right place, by the right people and at the right time as the fundamental areas for improvement.

Integrated care

The need for integration and more joined-up services was something that was highlighted at some point by all of the commissioning managers we spoke to. The lack of integration between health and social care was seen as a key service failing, with several commissioning managers arguing that *“at the moment older people living with frailty tend to be the only ones who know exactly who is caring for them”*. Single care records for patients were therefore seen as potentially a hugely valuable tool. Individually, organisations might be well run and productive but it is the *“in-between”* that is causing problems. Capacity is incredibly tight and better communication and working between services could help to reduce the number of avoidable admissions, maximise resources, and contribute to higher standards of patient care.

Some progress has been made: Health and Wellbeing Boards and the creation of the Better Care Fund were cited as positive steps towards more joined up services. However, in general the view put across of the NHS was one of an organisation that is out of step with technological developments in other fields, and in need of modernisation. When technology has been utilised effectively between services it has yielded extremely promising results.

Right care in the right place and at the right time

Another key issue raised by commissioning managers centred around the need for patients to be seen in the right place, at the right time, and by the right people. Improving patient care, it was suggested, should be a major priority, more important than individual disease prevention and financial security. Linked to the lack of joined up services and also to waste in the system, patients are often not being seen for adequate periods of time nor by the right healthcare professionals. Indeed, one commissioner warned of an NHS where uniform ‘factory care’ became the norm, and challenged his colleagues to do more to champion personalised care over homogenous service.

Ever present in this debate is the tension between finding the best course of treatment for the patient, and the need to save money. Given the demands for austerity in the NHS over the coming years, this is a tension that is likely to increase, further polarising opinions around telehealth. While the use of technology in the treatment of older people with frailty, including remote care and access to information online, could improve efficiencies in a number of areas, it also runs the risk of increasing cases of isolation and thus placing more pressure on social and psychosocial care.

In light of this, special thought needs to be given to how telehealthcare can best be matched to the needs of an aging and increasingly isolated population. The commissioning managers we spoke to argued that today’s older people with frailty are not viewed as sufficiently different from the rest of the population, in the way that children or cancer patients are, and therefore are not seen to warrant separate and specialised care. Indeed, since 2010 older people are having to wait on average a whole day longer in hospital before they are able to be relocated to a residential care home, amounting to almost 2 million bed days over the last four years. Furthermore, Age UK reports that:

“Many older people who struggle with everyday tasks such as getting out of bed and dressing, bathing, preparing meals or doing the shopping are assessed as only having ‘low’ or ‘moderate’ needs and so do not qualify for any help at all”.

The consequence of this is that, although the population of over 65s in the UK grew by more than a million people between 2005/6 and 2012/13, the number of those receiving assistance from social care services fell by 27.2%.⁴ One respondent lambasted a system that he argued saw *“older people...[as] just slightly older middle aged people”* as *“patently nonsense”*, suggesting that this mentality was at the heart of the *“poor quality of care that we see.”* Older people need to be treated with understanding and compassion, and telehealthcare needs to find its role within this.

⁴ Age UK, Massive fall in care spend for older people since 2010, 2014

5. Suggested telehealthcare solutions

Incorporating this feedback, Tunstall Healthcare designed a series of telehealthcare solutions to address the problems highlighted. These are detailed in a number of case studies below and clearly demonstrate how technology can be mapped to meet the various needs of the NHS.

Four 'solutions' were produced to address the issues of social isolation, frailty, living with a long-term condition and improving integrated care.

Isolation

Using the case study of 'Carmen', a 66 year old widow, Tunstall were able to demonstrate how telehealthcare can relieve feelings of Isolation in older people:

- *"Carmen is 66 and emigrated to the UK in the late 1990s. Her immediate family now live in a number of locations around the UK and also in her country of origin".*
- *"Since her husband died in 2009 Carmen has been feeling increasingly isolated. She lives in a one bedroom flat in a sheltered housing scheme. Despite this, she doesn't feel part of the community, rarely interacts with other residents or neighbours and is anxious about her general health as she feels there is no immediate circle to provide adequate care for her".*
- *"Carmen visits her GP practice regularly, often because she experiences feelings of loneliness. In most cases, she is advised to continue with her present medication and diet."*

How could technology help Carmen?

Carmen's life can be drastically improved simply through the provision of a tablet computer pre-loaded with customised software containing a range of simple, easy to navigate tools. In 2012, a National Office of Statistics study reported that only four in every ten people aged over 75 in the UK have ever accessed the internet, something which was seen as socially inhibiting.⁵ This tool would provide easy access to the internet and the outside world, allowing the user to better manage their medicine intake, keep in contact with family and friends and importantly their GP, and maintain a more active social life in general.

Frailty

- *"Doreen is 91. She is forgetful, lonely, and isolated. She has regular contact with the GP practice via community nursing teams and regularly telephones the surgery.*
- *"Unfortunately, because of her condition Doreen struggles to get out to visit the practice. Although she has a care package that includes supervision with medications, she is still uncertain about whether she takes them as recommended".*
- *"Doreen is unsteady on her feet and has a walking aide at home that she doesn't always remember to use. She falls frequently which results in hospital admissions. Discharge can often be delayed by days due to her complex care issues".*

How could technology help Doreen?

Telecare could help Doreen better manage her frailty. By installing a series of sensors in her home, Doreen could be prompted to put on her falls detector in the morning, to eat and drink at the correct times, and could also receive medication reminders from her telecare unit. Sensors also mean that the right people are made aware if Doreen hasn't accessed her medicine dispenser or if she has fallen. Doreen's relatives, carers and clinicians all have access to her activity records via an online portal, relieving the stress attached to having a frail and isolated relative, reducing the health impact of a fall and improving the accuracy and level of care Doreen can receive.

Long-term conditions

- *“Jim is 72, has COPD, is a smoker, and lives with his wife in their own home. As a result of his condition he suffers from shortness of breath, chest pains, and excessive sputum. This reduces mobility and has resulted in unplanned admissions to hospital”.*
- *“Jim has been advised to stop smoking and has also been advised to join an exercise group, but he hasn’t attended the classes to date. So far his adherence to these recommendations has been patchy”.*
- *“Jim’s wife Maureen is worried about his health, but feels as though she is just repeating what the clinicians have told him and that because she lacks any kind of specialist knowledge she cannot do anything else other than ‘nag’ him”.*

How could technology help Jim?

Jim uses telehealth to improve his quality of life. By using a telehealth monitoring device Jim is able to record his vital signs information which, if needs be, can be escalated as an alert to a responding clinician. If Jim flags up a problem, such as experiencing acute shortness of breath, a member of the community team will get in contact to see how he is feeling. His GP also has access to his records and are able to carry out consultations remotely through the device. By monitoring his own vital signs and symptoms in his own home, Jim is able to reduce his number of hospital and GP visits, take ownership of his condition and offer reassurance to his wife and family.

Integrated care

- *“Edith is 80 and lives alone; she suffers from rheumatoid arthritis and a history of heart failure. She is increasingly susceptible to falls due to her worsening condition”.*
- *“Via adult social care services, her housing provider funds a telecare package that is designed to reduce the impact of falls and includes medication prompts”.*
- *“Edith is also having her vital signs monitored by a telehealth hub installed in her home so clinicians can monitor and track her vital signs”.*

How could technology help Edith?

An online health portal, designed for use by formal and informal carers, health professionals, along with relatives and friend circles, could help improve Edith’s quality of life. The health portal would securely record and store information around many aspects of Edith’s wellbeing and would be accessible online only via a secure login with restricted information limited to appropriate ‘Views’. The portal would gather data on Edith’s daily activities, which could be used as input to making a condition diagnosis.

Edith would be able to interact with the portal via direct messaging, or by carers and clinicians changing aspects of her care plan online. Ultimately, the online portal could offer reassurance to Edith and her family allowing her to take ownership of her condition, could reduce hospital admissions and GP visits and provide more accurate and up to date data on all aspects of Edith’s care to clinicians.

6. Key points from the toolkit that are of most help to providers

Alongside these solutions, the MOST toolkit has been developed from the experience gained through previous large-scale telehealth programmes. The purpose of the document is to explain the processes involved in the development and implementation of a large-scale telehealth projects from the perspective of the Commissioner and Service Provider. The key points for Commissioner and Service Providers from the Toolkit are summarised below.

Designing a telehealth programme

The MOST Toolkit set out the following key questions to consider when designing a telehealth programme:

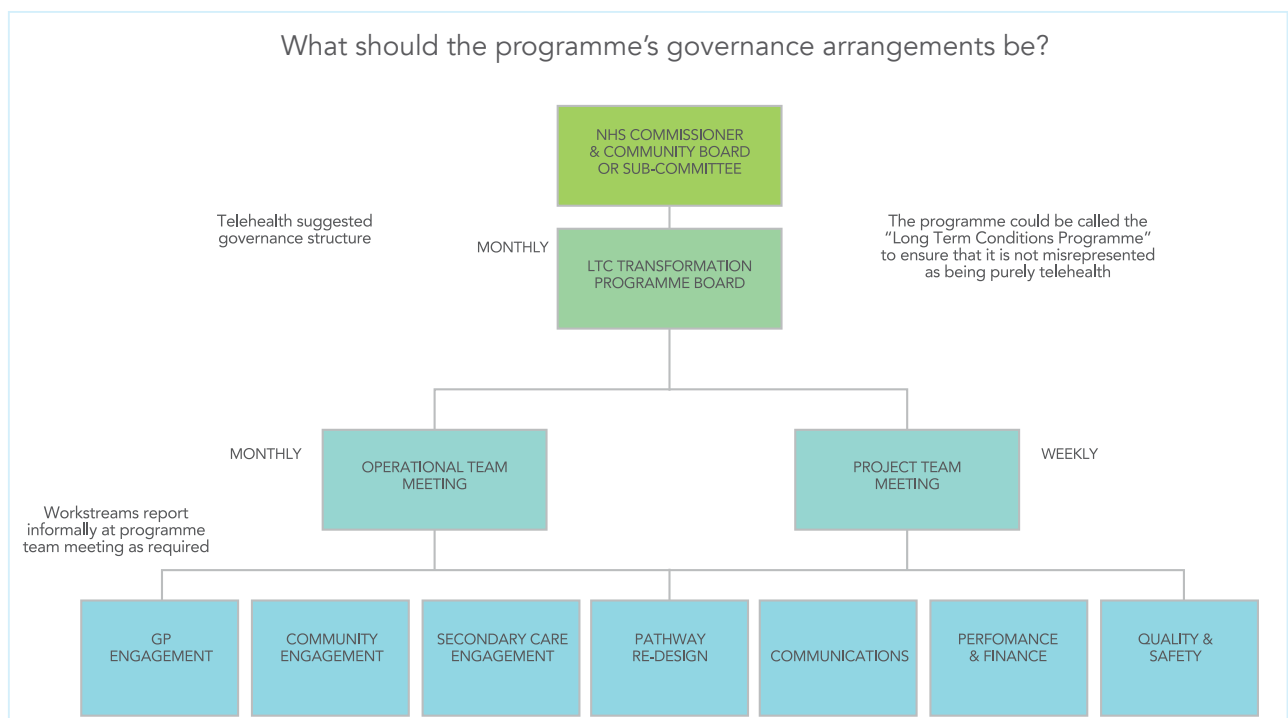
1. What are the programme objectives?
2. What are the benefits that can be realised?
3. How will the service be delivered in the future?
4. How will the previous services have to change in order to deliver the objectives and benefits?
5. What are the estimated costs, efforts and timescales associated with the project?
6. What are the risks associated with the programme?
7. How should a telehealth system be installed?
8. What staff and patient training is necessary?
9. How best can the data be monitored?
10. How best can trend-data be interpreted?

The Toolkit also defined the following key elements of telehealth service design:

The implementation process:

A telehealth service should be implemented across four stages:

- i) Phase 0, the set up phase, whereby the business case and contracts are signed off on, key stakeholders are identified and engaged and core team members are confirmed.
- ii) Phase 1, initial engagement, whereby the overall programme design and governance and engagement strategy are defined and agreed, primary/community care and acute trust engagement takes place, a potential long list for patients is drawn up and there is understanding and agreement on clinical pathways and service delivery.
- iii) Phase 2, implementation and deployment, whereby the scope of service redesign is established, clinical training takes place and criteria for patient selection are defined.
- iv) Phase 3 sees the full deployment of units.



How should patients be selected?

The responsibility for selecting patients is with the NHS Commissioner, Community Service and clinicians. At the commencement of the programme it is advisable to pinpoint at a high level those patient groups that will most benefit from telehealth. This will be important when prioritising locality rollout, and also as a valuable tool with which to begin discussions with primary/community care and other clinicians.

Which of the identified patients are actually suitable for telehealth?

Patients who fit the criteria outlined by the clinicians in the care pathways, or who have been identified through the generation of a long list, will not always be suitable for telehealth. This is often a result of physical barriers to using the equipment. It is necessary to understand that selection criteria for the use of telehealth is not binding, and that there will always be patients whom the primary clinician deems will not be suitable to use the equipment.

How to design and commission the new care pathways?

The new care pathways will not become operational until the NHS Commissioner and community service has specified them in its contracts for the following financial year. This will require:

- A careful consideration of the key changes to the pathways.
- Where applicable, a cost benefit analysis of those key changes likely to impact on NHS Commissioner & Community Service resources.
- Service specifications to be produced for primary, community, and secondary care.
- A key decision will be whether to produce one service specification for "specialist" services, including community specialist nurse practitioners and consultant led teams at the acute trust.
- Separate service specifications should be produced for non-specialist community services where there is a significant impact from the new care pathways. It is unlikely that these pathways will affect the role of case managers and community matrons significantly, however this decision should be made jointly with the NHS Commissioner & Community Service.
- Information to be produced for the contracting team to evidence the fall in levels of non-elective care that will be achieved through the deployment of telehealth and the new care pathways.
- Pathway design workshops could include expert speakers/discussion panels, group exercises to critique the current pathways, identify challenges and implementation, and agreement of patient selection criteria.

7. Conclusions

This report has tried to demonstrate how technology and in particular telehealthcare can be an important part of a revamped NHS. From talking to a range of GPs and commissioning managers we were able to isolate a variety of key service issues that affected their ability to deliver the best level of care for their patients. These were:

- Isolation issues in older people.
- Escalating GP workloads.
- Maintaining independence in older people living with frailty.
- The need for integration.
- Right care, in the right place and at the right time.

Of particular importance was the recognition by both GPs and commissioning managers that a lack of capacity coupled with the need for better-integrated services is inhibiting the ability of clinicians to provide the best level of patient care.

More general conclusions from each of the organisations involved in the MOST project are included below:

The Good Governance Institute

Our learning from this body of work has underlined our need to:

- a) Continue to promote debate on telehealthcare in board rooms.
- b) Consider extending research amongst providers.
- c) Create a single language for telehealthcare by promoting the quality standard.
- d) Support and better understand quality and patient safety issues for telehealthcare through our up-and-coming patient safety in telehealthcare report.
- e) Promote the role of telehealthcare within the integration agenda.

Tunstall learning

The project reinforced that there is an overwhelming need for alternative and more affordable models of care delivery in managing long-term conditions. It is understood that care can often be provided more effectively closer to a patient's normal environment. It is also recognised that technology is a necessary enabler for change, particularly where: new models include care at a distance; where sustainable delivery needs the repeatability and auditability characteristic of good technology implementations; and where technology can encourage people to take responsibility for managing their own health, and these have been reflected in a set of guidance materials that assist in the construction of services at scale. A first version of a 'toolkit' was created that summarised the learnings of the project.

The project has already had a significant impact, for example in shifting partner emphasis towards the delivery of managed services, to enable easier access to technology-enabled services.

A significant number of manual processes were identified for removal through the adoption of scaleable and technology-enabled solutions, ranging from referral management to automated electronic health record (EHR) interfaces.

Tunstall will use the project outcomes to inform the optimisation of services and products for large scale telehealthcare programmes.

Ernst and Young learning

E&Y will take their project learnings into ongoing work with NHS England and other healthcare organisations.

The MOST project has enabled E&Y to remain in a position to support and advise the technology and health industries on the adoption of technology across healthcare.

E&Y had a minor role in the project with the production of a telehealth toolkit which is going to hopefully be used to guide and support national policy. This helps raise the awareness of the brand and promotes E&Y as the trusted advisor on this subject.

The Nuffield Trust learning

The Nuffield Trust was pleased to be involved in the MOST project as it enables our organisations to:

1. Further refine our evaluative methodology.
2. Help to clarify the debate on the effectiveness of telehealth in a scalable context.

The programme was beneficial in expanding our evaluative methods and working with a diverse group of partners. For prospective participants we would suggest:

1. Having strong project management in place to oversee the administrative requirements of the programme.
2. Have strong relationship building skills to obtain the most benefit from working in multi-disciplinary projects.



www.good-governance.org.uk

Chris Smith - **Researcher**
chris.smith@good-governance.org.uk

Andrew Corbett-Nolan - **Chief Executive**
andrew.corbett-nolan@good-governance.org.uk