Get with the programme? A look at health and wellbeing boards through the lens of telehealth and telecare.

This Viewpoint provides an opinion on the progress of health and wellbeing boards in making headway with the adoption of telecare and telehealth. It also lays out opportunities that telecare and telehealth represent to local boards as they develop their role as strategic enablers and system leaders across health, care and wellbeing. It is part of a series of reports and commentary commissioned by the Housing Learning and Improvement Network on telecare and telehealth to act as a catalyst for system change and improve capacity in the sector to support people to live well at home.

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Introduction

With mass structural changes in the NHS underway and the social care system facing considerable challenge, the Government, NHS Commissioning Board and local leaders will need clearer narrative on sustainable, future models of care if we are to address the stark pressures facing the system - such as the rising numbers of people with long term conditions in England, who already account for 70% of the NHS budget.[1]

Localism in its new form is a major opportunity to face up to the tough questions that politicians and policy makers at the national level have often shied away from: rationing, decommissioning and system overhaul. In this context, embracing the potential of telecare and telehealth at the level of health and wellbeing boards would seem to be an obvious contribution to the overarching goal of reducing unplanned and institutionalised care, and moving care from acute to community setting. Minister for Care Services, Norman Lamb MP, has recently called for innovation within the NHS, stating that *'telecare and telehealth can be transformational in terms of enabling independent living.'*

About telehealth and telecare

Telecare is defined by the Department of Health as *'helping people, especially older and more vulnerable individuals, to live independently and safely in their own home. It includes services that incorporate personal and environmental sensors in the home, and remotely, that enable people to remain safe and independent in their own home for longer.'* [2] Mike Clark, a recognised authority on telecare and telehealth, points out that *'telecare is already reasonably well established at scale, although there is potential for many more people to benefit through improved products and services, and opportunities presented by increased uptake of personal budgets.'*

Telehealth is defined as *'monitoring equipment to record and measure patient's physiological status and health conditions. In tandem with individually created chronic disease management regimes, it can significantly enhance an individual's quality of life. Electronic sensors or equipment monitor vital health signs remotely from home or while on the move.'* Nick Goodwin of the Kings Fund adds *'Telehealth is often more complex than telecare, with a higher regulation threshold'.*

At a national level, the Department of Health has made clear its commitment to the *'enormous potential'* of both telehealth and telecare by launching 3 Million Lives in December 2011 – an initiative that aims to work with industry to improve the lives of three million people over the next five years, by increasing access to telehealth and telecare technologies as an integral part of health and care services.[3]

At a local level, there is an enormous opportunity for leaders to make best use of health and wellbeing boards to create an environment that harnesses the potential benefits of telehealth and telecare to transform local service delivery. *'Interoperability will be important'* believes Mike Clark, *'boards have a crucial role in asking how services and systems will be integrated across health, housing, social care and a range of commissioners and providers.'*

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[1] - *Long Term Conditions Compendium of Information*, Department of Health. See:
www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_134486.pdf

[2] - *Social Care Bulletin*, May 2012, Department of Health. See:
http://socialcarebulletin.dh.gov.uk/2012/07/13/prevention-and-early-intervention-the-technology-of-independence

[3] - See: www.3millionlives.co.uk

This is food for thought given that boards are now charged with acting as 'system leaders', and can act to reshape the local health and care system by tackling funding silos and focusing on wellbeing and communities. Admittedly, few may be holding their breath for a brave new era of partnerships given the underwhelming record of NHS and local authority collaboration in England over the last 30 years. However, breaking down organisation silos and engineering the 'real change' towards genuine collaboration demanded by Norman Lamb MP is exactly the task set to local boards[4] - and economic pressures, changing need and rising demand create stronger imperatives for this than ever before. A classic example of this is the London Borough of Barnet's well reported 'graph of doom' which shows spending on residential and nursing home care will consume the totality of the local authority's budget by 2032. Although unashamedly designed to shock rather than inform, it can be credited with a seed of brutal if inconvenient truth. In facing up to meltdown scenarios such these, leaders have a stark choice between service rationing or new care models that meet needs more effectively and efficiently.

The evidence base in support of telehealth and telecare is not rehearsed here as it is discussed at length elsewhere, and will grow substantially in the next 6 months with the conclusions of the Whole System Demonstrator programme, the largest randomised controlled trial of telehealth and telecare in the world. However, *'it is reasonable to say that local authority commissioners and providers are generally convinced from their own programmes and other UK findings of the value of telecare as part of housing and social care services'* offers Mike Clark. Telehealth is a slightly more complex picture. Nick Goodwin clarifies: *'Despite some controversy around the cost-effectiveness of the Whole System Demonstrator programme, the evidence from the trial did show significantly reduced mortality in those patients receiving telehealth and fewer hospital admissions compared to the control group.'*

Regardless of the future evidence from the programme, evidence of effectiveness will represent only one aspect of a wider, pressing case for board engagement on the issue. Telehealth and telecare are natural considerations for boards charged with promoting integration. Boards are ideally placed in this regard as change agents, bringing leaders from across the health and care spectrum together. Neither telecare nor telehealth sits comfortably in a single commissioning stream or area of clinical expertise and both require a single, agreed definition and shared leadership if they are to realise their full potential, especially if the board is pursuing outcomes based commissioning approaches that blur traditional funding silos and services.

In the future self-funding can only become more of an issue in telecare and telehealth, as highlighted recently by London think tank The Strategic Society.[5] *'Low cost consumer products and services could well gain ground and public sector providers will need to offer more flexible options'* warns Mike Clark, *'and in telehealth an increasing number of people are likely to request their health records and outcomes from self-monitoring - with the risk of overwhelming clinicians if they do not take earlier action.'* Nick Goodwin at the Kings Fund adds; *'the capabilities of new technologies – especially smart phones, tablet computers and the internet – will provide entirely new, accessible and more consumer friendly systems than those deployed in the whole system demonstrators'.*

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[4] - Department of Health Press Release, 11 September 2012. See:
http://mediacentre.dh.gov.uk/2012/09/11/11-september-2012-norman-lamb-kings-fund-integration

[5] - *Who uses telecare?* The Strategic Society, 2012. See:
http://haec-clients-public.s3.amazonaws.com/ssc/pdf/2012/09/06/Who_Uses_Telecare_1.pdf

Plans for a national roll out of personal health budgets by 2014 for all those eligible for NHS Continuing Healthcare beg the question as to how greater individual-level commissioning may impact on telecare and telehealth, given the likely appeal of such services for anyone concerned with maintaining independence and staying in their own home.

Next steps – as boards find their feet

The low profile of telecare and telehealth in the output of health and wellbeing boards so far can be explained by boards working to establish themselves before moving onto specific, priority issues of service design. However, commissioning cycles in the NHS and social care continue regardless and communities will increasingly expect boards to find their voice on specific, 'hot topic' local issues. When this happens, telehealth and telecare may prove attractive to boards looking around for Cost-effective and evidence-based alternatives in lieu of outgoing service models. Board members will need to have confidence in a rounded, corporate understanding of the topic, and a shared view of its relevance to the local context.

In anticipation of progress, boards would do well not to wait for permission from the centre before taking action. *'At present there is no clear mandate for telecare or telehealth cascading from the DH to the NHS Commissioning Board, and so on to Clinical Commissioning Groups'* argues Mike Clark. He adds *'similarly there is little clarity as to how all domains of the Quality Outcomes Framework might impact. There is also relatively low coverage of telehealth and telecare in NICE care pathways and quality standards for the major long term conditions.'* In other words, leadership will need to be local, as will the details on investments, shared rewards and new working arrangements.

Boards can also start by tackling common misunderstandings around telehealth and telecare. Research by the Good Governance Institute found that there is a mixed understanding as to what telecare actually is between local authority commissioners, let alone across health and social care.[6] There is also a limited understanding of telehealth and the potential benefits from the technology amongst all health and care professionals. In order to demonstrate seamless leadership, boards will have to articulate the case for change, based on a shared view of evidence for effectiveness. Local case studies for telecare can be encouraging – such as the experiences of Wakefield and Oxfordshire, where annual savings of approximately £1m were reported in adult social care. However, this success must be weighed against programmes which have been less positive in outcome. Mike Clark notes that the problem is also perhaps not so much lack of evidence as different professional attitudes and expectations: *'the threshold for evidence of effectiveness is higher for say GPs than their social care colleagues, meaning some GPs will struggle where evidence is not to clinical standards. By and large, social care commissioners have been less risk adverse, and are prepared to try things where it has made practical sense and people have clearly benefitted'.* Regardless of what evidence is available, all boards will have to assess evidence against the context of local proposals, including the informed risks they might be prepared to take.

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[6] - *Care and support at home: an audit of telecare services in England*. Good Governance Institute, Sept 2012. See:
http://www.good-governance.org.uk/archive/care-and-support-at-home-an-audit-of-telecare-services-in-england

A chance to build board leadership – and to test it

Any discussion around the further adoption of telecare and telehealth will be an interesting litmus test of health and wellbeing boards' leadership skills. After all, it is possible that discussions will run over into the bigger elephants in the room, such as efficiencies and changing need. Innovative and forward-looking boards will seize this challenge, casting themselves as change agents by an understanding of priority issues and translating them into solutions that impact on service provision and spend.

Many boards also need to test the models through which their strategic leadership interfaces with real, service-level and system transformation, for example by combining big picture analysis with complex, 'deep dive' investigations in specific areas of care where local priorities warrant it. This bi-focal view will be crucial if they are to join the dots between commissioning streams, spot synergies and grasp 'best bet' investment and disinvestment opportunities. Certainly, the future-proofing and multi-agency leadership necessary for effective mainstream telehealth and telecare planning implementation are exactly the kind of functions that effective health and wellbeing boards are well placed to bring together. Running a focused workstream on a such a detailed topic will be an interesting test of a board's ability to round up expertise, delegate responsibility, quickly digest key perspectives and reach executive conclusions within manageable time frames.

These discussions will test the new culture and governance models of the board. Despite warm words about localism, system leadership, 'place' approaches and outcomes-based commissioning, effective change will be impossible if individual members revert to protectionism when 'their' budgets, services and workforce are under the spotlight. Reversion to tribalism will quickly relegate boards to the lower tier of decision making, and therefore irrelevance. If early talks run into trouble, this may be a sign that the basic foundations of the board, such as governance, working processes and shared values, are on shaky grounds.

Many of the delivery models for telecare and telehealth also represent a challenge to professional skills and learning. As Nick Goodwin highlights, *'90% of the challenge is about building relationships, skill and local commitment. Boards will need to consider the implications for the workforce – both in terms of capacity and capability – to ensure professionals are able to roll-out these systems at scale. The potential challenge from professional and organisational bodies should not be underestimated'.* The most difficult issue may therefore be winning hearts and minds, encouraging professional leaders to become advocates for change and not barriers to it. *'Skills are very important but professional values and ethics also need to be addressed'* says Mike Clark. *'Clinicians need to be convinced that telehealth will not harm their patients and that a significant number will benefit'*.

The new statutory duty to lead integrated working presents the board with an opportunity. It can use telecare and telehealth to flush out views about the inability of previous local partnerships to drive improved outcomes and efficiencies through cost sharing or new investments, understand the barriers to change, and learn lessons about what will need to be different this time. *'There is no significant evidence yet of fully integrated telecare and telehealth services at a local frontline level'* says Mike Clark *'although rather more scope and examples for backend integration'*.

Boards can also use telecare and telehealth as a springboard for developing more personalised services, and boost patient and service user engagement at the same time. Jeremy Porteus at the Telecare Learning and Improvement Network, the sister network to the Housing LIN,

highlights recent research on governance which shows that older people and those with a long term condition still do not have an effective voice. He states, *'people are all too often either locked into services that create further dependency or locked out from co-creating solutions that can enable their self-care or provide interdependence. Boards need to realise the flexibility of telecare and telehealth systems make them an ideal platform for service providers to personalise care and engage patients in a debate about quality of life.'*

The Joint Strategic Needs Assessment (JSNA) and joint health and wellbeing strategy (JHWS) are also excellent opportunites to lay bare the extent of the challenges facing the health and care system and highlight the benefits and contributions of both telecare and telehealth as part of the solution. A key part of the JSNA is to consider future needs and aspirations, and to consider how best to respond as a community. NHS and local government are obliged to 'have regard' to the JSNA and JHWS when developing commissioning plans. As the ultimate leaders of the JSNA, boards have the power to demand data and information from all organisations represented on the board, a powerful opportunity when building the case for change.

The intelligence generated by the JSNA and the priorities set out in the JHWS are perhaps the board's strongest mandate to address local gaps and drive whole system approaches. Whether part of the process or provided elsewhere, boards may also need to combine JSNA and JHWS with strong local business cases in support of telehealth and telecare. This will be crucial if they are to secure commitment for resource alignment or formal budget pooling from CCGs, who will ultimately be beholden to the NHS Mandate, the national NHS Commissioning Board, regional oversight, and a pervasive and enduring focus on efficiencies, such as the QIPP programme.[7]

However, many JSNAs have very poor coverage of telecare and telehealth either as a strategic priority or commissioning recommendation. *'There is some work on risk-stratification and predictive modeling for telehealth and long term conditions which could be better incorporated into JSNA, but we need to be much clearer about who benefits'* believes Mike Clark. *'Overall however, telecare and telehealth are still marginalised in whole system mapping.'* This underlines the steep learning curve many JSNA processes will face if they are to support the role of the health and wellbeing board as strategic market enablers. Kevin Alderson from Tunstall believes however this is key to success: *'boards that think big, truly look at the whole system impact of telehealth and telecare services, and make sure that they understand the size of the potential financial return, will be able to lead strongly and confidently. They will also be able to hold their local service delivery system to account much more effectively. This could release millions of pounds worth of resources into the system'.*

Where to start?

Local health and wellbeing boards can start by looking at the assets and expertise around the table. *'Health often has the cash, but social care the experience'*, says Kevin Alderson, *'it will be important to trust each other and marry the two. Directors of Adult Social Services might well be natural leaders for telecare and telehealth, finding themselves in a good place between housing, care, financial pressures, and more established relationship with elected members.'* But GPs can also take the lead and demand better service planning and provision for a sizeable number of their most frequent attendees both in terms of time and ultimate cost.

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[7] - See Department of Health website: www.dh.gov.uk/health/category/policy-areas/nhs/quality/qipp/

In the longer term, boards will need to think more strategically about the potential role, demand for and benefits of telehealth and telecare. Nick Goodwin comments that *'many older patients with the most complex needs have been uncomfortable with telehealth – you can't expect people to embrace it overnight. Commissioners should also seek to target patients with less complex needs than they do at present since the evidence suggests that the most vulnerable are far less comfortable or able to use new technology effectively'.* By focusing on supporting those with low level health and care risks at an earlier stage of the chronic disease pathway, commissioners will begin to see a shift in mindset and attitudes that will ultimately lead to a normalisation of new information and communication technologies.

Final outlook

The biggest risk to effective board leadership is the temptation to allow long lead in times for working arrangements to bed in before looking at complex local issues. Whilst core governance models and working cultures do need to be clearly laid out from the start, they will also need testing with real, local discussions about services and money. Boards may also pick up the brief in future only to find the rest of the health and care economy has forged ahead without them. *'There is a real risk that few health and wellbeing boards will spend much time on specific service approaches within the first 2-3 years'* cautions Mike Clark. *'In the meanwhile, natural alliances and shared investments for telecare and telehealth will likely develop in social enterprises and progressive hospital foundation trusts looking to secure income from commissioners as they develop community services and hospital inpatient activity reduces.'*

Health and wellbeing boards should consider which they would prefer – leading a single local vision for the future of telecare and telehealth or playing catch up further down the line in a consumer-driven market devoid of local strategic oversight. *'Whatever the baseline set by past investment and current practice, it is essential that health and wellbeing boards show leadership so that local health, housing and social care economies can start to develop programmes for joint improvement from a coherent, integrated local plan'* argues Jeremy Porteus.

Ultimately, telecare and telehealth present an enormous opportunity for health and wellbeing boards to move into the next phase of leadership, if they want it. In the words of Norman Lamb MP *'a lot of ways of working will have to change. People will have to move out of their comfort zones and look at what is better for local people, not what is better for their own organisations'.* No one said it was going to be easy, but strategic discussions around telecare and telehealth could pave the way towards building skills, confidence and ways of working for a new generation of health and wellbeing boards, undaunted by their role in leading change.

Note

The views expressed in this paper are those of the authors, and not necessarily those of the Housing Learning and Improvement Network. Our thanks and acknowledgement to Mike Clark, Nick Goodwin, Kevin Alderson, and Jeremy Porteus for their contribution to this viewpoint.

Further reading

- Board Assurance Prompt - specialised housing for older people. Housing LIN, GGI and Contact Consulting, 2012
  www.housinglin.org.uk/Topics/browse/HousingOlderPeople/
  OlderPeopleHousingProvision/Telecare/?parent=987&child=8545

- Board Assurance Prompt – older people living in general needs housing. Housing LIN, GGI and Contact Consulting, 2012
  www.housinglin.org.uk/pageFinder.cfm?cid=8614

About the Housing LIN

Previously responsible for managing the Department of Health's Extra Care Housing Fund, the Housing LIN is the leading 'learning lab' for a growing network of housing, health and social care professionals in England involved in planning, commissioning, designing, funding, building and managing housing, care and support services for older people and vulnerable adults with long term conditions.

For further information about the Housing LIN's comprehensive list of online resources and shared learning and service improvement opportunities, including site visits and network meetings in your region, visit www.housinglin.org.uk

The Housing LIN welcomes contributions on a range of issues pertinent to housing with care for older and vulnerable adults. If there is a subject that you feel should be addressed, please contact us.

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