Response to NHS Chief Executive’s Open Call for Evidence and Ideas

Respondent ID: 291

Organisation name: Docobo Ltd

Type of response: Online
Respondent ID:

291

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Please choose the description below that best fits your organisation’s main role:

Private sector (med tech)

What can the NHS and NHS Commissioning Board learn from national and international best practice to accelerate the pace and scale of adoption of innovations throughout the NHS?

UK Successes in Telehealth:

In our work with the NHS, Docobo meet with many excellent people, providing excellent services with innovative technology. Innovation can only be successful when the role of the individual is mixed with technology. Docobo can cite numerous cases in the UK where significant success has been achieved with doc@HOME telehealth. Much of this is due to commitment of individuals who embrace the technology and adapt their roles; and where management approach is supportive and enabling.

Case Study: NHS South East Essex NHS Direct/Docobo Ltd

65 patients were monitored over 7 months commencing April 2009. 11.8% reduction in the length of Community Matron face to face visits; 75% reduction in A&E visits; 83% reduction in hospital admissions; 72% reduction in 999 calls; 56% reduction in GP visits. Furthermore, 80% of patients and carers who responded believe it has helped them to better understand their condition and to care for themselves.

Case Study: NHS Solent Healthcare promotes self management in patients with COPD

Using doc@HOME telehealth, patients with COPD were trained to recognise their symptoms and self manage acute exacerbations. Telehealth monitoring enabled earlier detection intervention exacerbations. The technology allowed the staff to provide and enhanced service without adding to the team. In December 2009 - December 2010 192 admissions.

Importance of Management Support for Mainstreaming Success

In the UK there are numerous successful telehealth pilots, many supported by government
funding, that have failed to mainstream. Where management are not supportive, even the most successful pilot will not develop to a mainstream service.

Case Study: University Hospitals Leicester, Glenfield Hospital
A successful pilot, funded by £80,000 government preventative technology grant through Leicester City Council, and lead by senior clinicians realised net savings of £270,000 inappropriate admissions in 12 months in 40 patients. Furthermore, patients reported improved quality of life and ability to self manage. In the absence of management support, and further commissioning of the service by either the hospital and the PCT the pilot ceased to continue when funding ended and failed to mainstream. The service was abruptly withdrawn and patients who had been previously supported again began to re-admit.

Importance of Collaboration across Primary and Secondary Care

There is little incentive for acute hospitals to keep patients out of hospital if, for them this mean a loss of income to the acute. There are however examples (such as Kettering General Hospital and Queen Elizabeth Hospital, Birmingham) where the PCT funds the acute to provide a service to support patients on discharge and keep them from re-admitting. This provides for better patient care in the right place.

Importance of Collaboration across Health and Social Care

Technology that supports a patient at home typically has benefits for both health and social care. Therefore, savings in each cannot be viewed in isolation. In areas where Health and Social care are integrated then much larger savings can be realised, and services jointly commissioned to the benefit of both.

Case Study: Inverclyde Community Health and Care Partnership, 2009-10

NHS Greater Glasgow and Clyde in partnership with Inverclyde Council piloted a new model of care for long term conditions to match level of care to need. Fundamental to improving care delivery was the facilitation of multidisciplinary collaboration and effective information sharing across organisations. In 2009-10 a reduction in 26 admissions was observed in 10 COPD patients. A new role was created for a respiratory Specialist Nurse who managed monitoring of the patients. All patients reported that they saw their GP less as a result of this. The study concluded that telehealth can be effective in shifting the balance of care from an acute to primary care setting. This pilot has achieved acclaim as finalist of the 2011 E-Health Insider awards.

Case Study: Managing heart failure patients in Knowsley

A 12 month doc@HOME telehealth pilot in 8 patients with complex heart failure patients was undertaken by partnership between the Metropolitan Borough of Knowsley and Knowsley NHS. Between March 2009 March 2010 the pilot showed savings of £5600 per patient, with an overall cost saving for the project of Â£185,000. The service now continues to be developed.

Personalisation

Use of telehealth in the UK is typically limited to management of a small number of LTCs such as COPD and CHF. The potential is far wider, and a greater understanding is required in the NHS of the capabilities of remote telehealth monitoring technologies and how these can be bespoked to meet the needs of each individual. Telehealth enables professional staff to develop innovative
ways of managing complex patients. For example, the doc@HOME devices can be tuned to each individual, allowing personalised care.

Case Study: Management of an Elderly Lady with Downs Syndrome

Health and Social care staff at Knowsley utilised doc@HOME telehealth to manage an elderly lady with Downs and respiratory problems, enabling her to stay in her own home and environment, and preventing her from being placed into a Nursing Home. Not only was she able to continue to live the last days of her life, happy and content in her own home and environment, the team also managed to wean her off oxygen. By not admitting into a nursing home, savings to the social care budget alone were in excess of £35,000.

Furthermore, a range of systems and capabilities are now becoming available to meet different levels of clinical need at optimum cost-benefit, and also solutions across care pathways and reaching into also social care issue.

Examples of these are:
- Telehealth monitoring with vital signs monitoring for complex conditions.
- Availability on either dedicated devices or on tablet based Apps for the more technologically able.
- New devices such as the 'CarePortal', (an outcome of UK investment and collaboration through an Technology Strategy Board ALIP project) that meet both health and social needs of the individuals, allowing connectivity for social networking of isolated individuals, access to local community services.
- Lower down the triangle of need, are email and SMS based technologies are being developed, to support patients to self manage.

Export of UK SME Innovation

UK Innovation has great UK export potential. Docobo's products are already in use in Australia and New Zealand.

Case Study: Remote Monitoring of COPD in Australia

A randomised controlled trial was used to compare the outcomes for clients receiving the telehealth monitoring (intervention group) with the outcomes for clients receiving usual care (control group) for a period of six months, with 40 patients receiving telehealth monitoring (intervention group) and 40 patients using usual care. The annual cost savings, when health system usage costs were accounted for was $105,528 for this group over a full year or $2,931 annually per person.

What can be learnt from International Organisations

Case Study: Australian Innovation brought to the UK

In September 2010, Docobo became the UK as sole distributor for Silverchain, Australia of ComCare. Comcare is a mobile community staff management tool that has grown from the ground up over 17 years of use by a community healthcare organisation. It is highly relevant to todays UK NHS - it enables the right complete care to be delivered in the right place - â€˜making every intervention count at the lowest possible cost. It has delivered produce huge benefits to Silver Chain in terms of efficiency and cost savings: a days activity of a nursing team 62 hours of travel reduced to 27 hours; 3708 km reduced to 1620km. Community clinical IT systems available in the UK have limited logistical functionality, whereas, efficient management of a mobile
workforce, which requires delivery of specialist care over widespread rural and urban geographies, is a logistics operation. ComCare provides both clinical and logistical functionality, managing staff rosters, travel time, lone worker protection and also access to patient data at the point of care. Massive savings have been estimated by UK NHS organisations by one trust from a £500k/year investment.

In summary, in many areas of the UK and internationally, successful telehealth programme are in place. Patients are benefiting and health and care organisations are experiencing significant savings. The NHS need to find ways of replicating these successes nationally.

**What specific actions do you think national NHS bodies, such as the NHS National Commissioning Board, need to take to encourage and stimulate the successful and rapid adoption and spread of innovations throughout the NHS?**

Reticence and risk aversion at a local NHS level prevents adoption and wide-scale diffusion. Individual commissioners are not prepared to take the risk that they may not replicate the successes. We still hear about more pilots commencing, lack of evidence, and the need for proof that the innovation ‘that it will work in my patch’, rather than than the embracing the existing evidence both in the UK and internationally.

In the case of telehealth the DH Whole System Demonstrator was intended to provide such evidence, however the delay in reporting of the results is currently hindering adoption.

The UK NHS needs to be prepared to accept evidence from elsewhere in the UK and overseas as viable and representative of what can be achieved locally.

There is too much time and expense wasted by 're-inventing the wheel' in each locality. Evidence for commissioning of technology needs to be collated nationally and provided for support to local commissioners - i.e. a template for a business case for telehealth.

More incentives for innovation, such as the CQUIN payments, may also encourage innovation.

Technology crosses the boundaries of Health and Social care and we need to overcome the problem that 'spendings by one organisation realises savings in another'.

Collaboration between Health and Social care is essential for savings to be realised to the benefit of the local health economy and for patients to benefit.

**Do you have any further comments about accelerating the adoption and spread of innovation in healthcare?**

Thank you for the opportunity to provide this evidence and comment.

We would like to be able to follow up interesting comments and case studies. Can we contact you for this purpose?

Yes

Do you want to be kept in touch with the next steps in this process?
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<th>Do you want to be included in a wider community of interest?</th>
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<td>Yes</td>
<td>What specific actions do you think local NHS bodies, such as providers and Clinical Commissioning Groups, need to take to encourage and stimulate the successful and rapid adoption and spread of innovations throughout the NHS?</td>
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<td>Clinicians have to be prepared to change the way they work, and must be trained, supported, encouraged, and if necessary compelled to do so by their managers. NHS Management need to be engaged, supportive and able to evaluate the benefits and to commission development of the service. If innovation is to happen the division between primary and secondary care, due in the main part to financial contracts, needs to be addressed. This is actively prohibiting innovation adoption of technology that will benefit the local health economy as a whole. Acute Hospitals need to be rewarded for reducing these admissions and for supporting patients on discharge. PCT commissioners need to engage with the acute hospitals locally to develop these contracts</td>
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