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Our roundtable panel

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Editor of Pulse – Chair

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IMAGES: PHIL WEEDON

The future of telehealth

Pulse editor **Steve Nowottny** joined a panel of leading GPs and experts last week to discuss the future of telehealth and hear their views on the evidence, the impact on patients and the practicalities of rolling it out among GPs. Here are the highlights from the debate

SN Telehealth is a crucial area for the NHS. What is it and how can it be deployed in general practice?

PH A simple definition is that it's an aspect of the treatment process that can be done at a distance from the clinician, and from a patient's perspective that usually means in their home. We should think of it as a tool to aid clinical patient management, not an end point in its own right.

WH With telehealth we can understand for a given patient how variables like blood pressure and heart rate vary over time in a way we've never seen before. You can screen your patients, know where the most poorly ones are and then home in on them, which you couldn't do for everyone in one go.

CN This isn't some new big idea, but it's being promoted as one. When I became a GP it was normal to look at peak flow diaries and phone patients up to see whether they were getting better or worse. GPs would appreciate telehealth more if it was allowed to develop in a meaningful way, rather than being seen as something imposed through a central imperative.

StN The terminology can be confusing. You can talk about telehealth in terms of a device that exchanges information between a patient and a healthcare professional and back to the patient. The danger is people asking: does telehealth work? Well, that's quite naive because telehealth is a device embedded in a service, and the question is: does the service using the technology work?

AK-B One of the important discriminators is the speed of response. So one aspect is getting an instantaneous response, and then there's looking at the data trend. How you deploy telehealth affects surgeries and how it feels to run it for both professionals and patients.

MM My issue with telehealth is that it's been vastly over-hyped. There are huge problems in the way the Government publicised the findings of the Whole Systems Demonstrator trial before it was published. That's one of the reasons why many GPs are concerned, particularly when we have evidence from the US that telehealth can come with unexpected harms and increased mortality rates. So many interventions in the trial came under the umbrella of telehealth – how do we know what was actually being tested?

Coming soon

The full video of the telehealth roundtable debate will be out in the New Year at pulsetoday.co.uk/videos

SN Paul Hitchcock, do you want to respond to the point about it being over-hyped by the Department of Health?

PH Whether it was done in the right or wrong way, it has certainly kickstarted the agenda and the fact that we are having discussions like this [one today] is very positive [for taking telehealth forward].

StN Margaret suggested there's lots of evidence about harm, and I would question that. Separating out the political element from the evidence is crucial, otherwise we confound the evidence with the policy decision.

CN What we're seeing is an agenda driven by statistics, arbitrary figures and an ideology in its own right, which diminishes the ability to look at the concept of telehealth. So when you say 'telehealth' is good for patients, you're referring to a multitude of different interventions, some of which are normal practice for GPs.

SN Let's look at the evidence, which is the key question facing GPs. Professor Newman, you led what is the world's largest randomised controlled trial of telehealth in practice – the Whole Systems Demonstrator study. Could you summarise your findings?

StN We ran the study in three centres and followed up the 3,000 patients for 12 months. The findings indicated a significant reduction in mortality and some reduction in hospital admissions, particularly in emergency care. One concern about telehealth is that people will become lonely and isolated and their quality of life will deteriorate. That certainly is not what our evidence showed – the WSD study found no difference between telehealth and controls on quality of life and psychological wellbeing. In terms of cost-effectiveness, it didn't reach the NICE criteria for quality of life change – it was about £80,000 per QALY, with the [cost-effectiveness] threshold being £30,000. However, patient cost and convenience aren't included in that. The issue is to design a service that will bring economies of scale.

AK-B I was clinical director for the cohort in Newham. The groundswell of opinion was that patients wanted to keep the equipment. And while there's apprehension about implementing any sort of remote technology, by the time practices have got comfortable with it, they want to continue using it because it's improving the way they can deliver health. This is my anecdotal observation.

CN My first concern is what will be the impact on workload, interactions and activity in GP surgeries? Second, has there been a diverting of staffing and effort placed on patients receiving telehealth at the expense of other patients? Third, £80,000 per QALY for an intervention in telehealth is a huge sum of money, and we know the NHS is not choosing to pay for other interventions.

Also, the study wasn't designed to look at health inequalities but many of us have an intuitive feeling that this initiative isn't going to be applicable to all categories of the public. I don't think you can base a political policy on this with so many unanswered questions.

StN We did measure GP workload and we found no change, although the findings haven't currently been published. Whether there's an increase in GP workload depends on how you organise the service. If you embrace the whole element of care at the GP surgery or if you have a front-line call centre or a nurse looking at the figures as well as a threshold for each patient on your computer, depending on the design you may reduce the number of patients who present in the GP's surgery.

PH The point about health inequalities is important. If you're looking at patients with more complex needs or who struggle to engage with the system, how do you give them more time? You need to say, OK, I would like to use other methods for some of my patients to free up time.

SN Will Haynes, you've championed telehealth in Gloucestershire. What do GPs need to consider before adopting a telehealth solution?

WH All practices are different and you need to decide how the equipment can fit in with how you are managing conditions. You may want to learn from other practices' system changes, and you need to work out who are going to be the lead clinicians. How are on-call doctors going to respond to the demands that come from telehealth? There is a certain degree of background 'noise' as a result of having tens or hundreds of patients on this form of monitoring. Some of that could be filtered out effectively by call centres, just to reduce false alerts.

Then you have nurses or doctors who need to respond to genuine concerns that something has changed for a patient. You can then monitor how the patient is responding to a treatment, and you can do that from your consulting room rather than having to visit the patient every time. You still want to go back to good clinical practice; it still comes down to the patient and modifying your systems to that individual patient. I think that's fundamental. Yes, there is an impact on GP workload initially, but in the longer term it's beneficial for both the nurses and the GPs.

CN We have to be careful not to extrapolate the experience of pilots to the entire GP profession. If you're involved in a pilot, you have volunteered because you feel you're able to and are motivated to participate.

WH In our patient survey, 89% were very keen to continue with telehealth, rating it as very good or excellent. There is a degree of anxiety that goes along with these long-term conditions; if you can allay some of that by reassuring, where appropriate, that their condition is behaving in a healthier way, it helps patients get on with their lives.

SN We've mentioned workload, but what other issues are putting GPs off embracing telehealth?

WH We need to target groups of patients where it is beneficial and avoid patients where it's not – in terms of patient experience, clinician experience and longer-term health benefits.

PH The organic process of doing it where it works is what we're talking about. When I first got involved with 3millionlives I thought, actually that's a very soft policy. Thirteen million people have long-term conditions and we're talking about improving only three million of them over five years. Seeing it driven by clinicians who are saying 'yes, this bit is useful for me, this bit isn't', in exactly the way you're describing, is pretty close to the official policy.

CN Why come up with figures? Why not say, we want to improve the management of patients who have heart failure or COPD and the interventions that are available include telehealth, but they also include employing a cardiac nurse in the community? I've not seen any studies comparing choices head-to-head. These are real trade-offs.

MM We've had lots of randomised controlled trials, but they don't seem terribly useful. But we do know that pulmonary rehabilitation, heart failure nurses or specialist pharmacists who help people with heart failure are incredibly useful. My concern is that we're going to see funding being moved from what we know works in the community to what we suspect might work.

WH In terms of the telehealth equipment, initially it is costly when you're dealing with small numbers, but as numbers increase I suspect the production costs go down dramatically.

StN The big cost drivers in healthcare are based around patients' perception of their health. They are the ones who take themselves to emergency care or make appointments in general practice. So taking their views seriously is absolutely critical.

SN What has been the impact on patients?

AK-B When I first became involved, I assumed patients would miss the face-to-face contact and that telehealth would work best for patients who already had a therapeutic relationship with the person delivering it. But the anecdotal feedback was that face-to-face contact wasn't missed. There's also research from elsewhere. Evidence from the Veterans Association was really important in changing my opinion. They provided telephone support to patients with post-traumatic stress disorder by carers who the patient had never met. It was very successful; in some ways it was more acceptable to patients.

There's also the reassurance it gives to next of kin, and we saw this in Newham, whether they live with the patient or further away.

StN The role of care givers is interesting. Evidence from the US shows that telehealth and telecare are often introduced and paid for by the children of elderly parents for their own reassurance. That's really important. The model of telehealth that's gaining favour is that you establish the relationship first, then discuss the possibility of using a device as part of care. You can then choose not to assign it to individuals who aren't comfortable with it.

MM I've no doubt that a lot of what we do in general practice can be done without face-to-face contact. There's no question that if it's more convenient or easier for patients to leave me a message or speak to me on the phone then that's fine. The important thing is it's part of a contextual relationship, not a substitute.

Rather than looking at lots of results for people who are feeling quite well, I'd target my resources to the person who's really not feeling well and is concerned about their health.

Professor Stanton Newman

Our findings indicated a reduction in mortality

SN We're going to wrap up by considering what can be done to ensure a wider roll-out of telehealth, if appropriate. Where do you think GPs are at and what needs to be done next?

CN We need to get rid of the hype and the idea that this is a panacea. We should allow commissioners and practices to improve services using technology where it's appropriate. The workload issues concern me greatly. Diverting workload away from our immediate priorities is worrying, and there are already huge pressures on GPs.

PH GPs are going to be delivering primary care to their own patients, but also commissioning secondary care. The role of the 3millionlives team is about facilitating and supporting how you do these things, because I don't think we're a million miles apart. This is a way of saying what's best for your given population, your given area. It's not a panacea, it's going to be used where appropriate. From my perspective at the Department of Health, our immediate next step is much closer engagement with the GP community than we've achieved to date.

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