Digital North West London
Transforming Care through Digital Solutions

Market research into demand, behaviours and motivations for digitally enabled care

NHS
North West London Collaboration of Clinical Commissioning Groups

1. Brief

1.1 Context

North West London (NWL) Collaboration of Clinical Commission Groups (CCGs) and the Healthy London Partnership are jointly seeking a supplier to inform an evidence base that will support delivery and uptake of existing and new digital services. This is to understand citizen's needs, motivations and behaviours with regards to digital tools and services.

To support delivery of a number of digital strategies we require new evidence on:

- the factors that drive and sustain digital utilisation for targeted populations;
- the features that enable people to become and stay connected with the NHS and their benefits;
- understand key diversity needs specific to London to deliver digital inclusion agenda (e.g. those with visibility and hearing difficulties);
- how to improve citizen experience and outcomes, and efficiencies for the NHS.

The Personalisation and Self-care Programme is part of the Healthy London Partnership (HLP) which is a collaborative of the 32 CCGs in London and NHS England (London region). HLP has 13 programmes of work which collectively contribute to delivery of the *Five Year Forward View* articulated within the new models of care that emerge from the five Sustainability and Transformation Plans (STPs) and the seven Local Digital Roadmaps across London.

NWL CCGs STP sets out a vision to improve self-management and enhance personalised and integrated care with citizens taking a more active role through the use of digital services and apps. The STP is committed to supporting the market to develop health apps that enable self-care for targeted populations in a way that enables connection into the mainstream workflows of health and care.

Availability of online services in the NHS is patchy and in some areas uptake is slow or people register but never actually go back to use the services (i.e. booking appointments). Digital apps and wearables are generally disconnected from the NHS workflows (i.e. a nurse has to transcribe the data from apps into the care plan). This is because in order for people to connect into NHS systems and move data into their record, they would need to go through certain levels of security such as identity verification and authorisation processes.

NHS England has a work programme underway to enable this level of connectivity through some form of online account or NHS passport (Personalised Health and Care 2020, p 24). This will enable people to register for online services in a way that recognises who they are (i.e. to authenticate their identity); enables them to register their preferences and access a range of online transactions and services.

The hypothesis is that connected online services will have greater utility to different user groups for example:

i. Frequent users of health and care services (i.e. those with long term conditions) who want to take a more direct and active role in managing their health and well-being
ii. Carers who want to have permission and convenience to access data and services on behalf of ('by proxy') those they are caring for.
iii. The digitally literate, highly mobile and time poor, who want the convenience of conducting transactions in real time (i.e. booking appointments, ordering repeat prescriptions, e–consultations and web chats with a clinician, tracking test results and receiving alerts).
iv. Clinicians who want their patients to be more engaged and for this to be connected into the health and care workflow.
v. People, who want to ensure their preferences and emergency contacts can be registered, stored and accessed by NHS agencies (such as NHS 111) at a time of crisis, for example people with End of Life, Continuing Care or mental health crisis care plans.

1.2 The ask

The supplier will properly test:

The functions – what online services and transactions that people most value, for example this might include:

- Accessing your medical record (held by your GP)
- Accessing your care plan
- Conducting transactions such as booking appointments, ordering repeat prescriptions
- Receiving alerts and notifications – (i.e. test results)
- Contributing to care plans – (i.e. uploading own measurements from apps and wearables)
- Managing a personal health budget
- Having a telephone, e-consultation (skype) or webchat instead of going to a GP surgery or an Outpatient appointment
- Accessing self-help service (i.e. symptom checkers) and peer support (i.e. online forums)

The features - how do people want to be able to do this? Areas to explore might include:

- In registering for online services, what levels of security, identity verification process would people expect to undertake in order to get access to online services?
- How do people want to log into online services - through an official NHS website or through other routes?
- What features will increase digital inclusion for people with disabilities and those for whom English is not a first language?
- Features that would support people who are not digitally literate?

Using a segmented population approach, as highlighted in appendix B, to produce a clear understanding of:

i. **How to get citizens digitally connected and activated**

- What do people see as the main advantages/benefits of transactions (e.g. convenience) and what types of transactions would they value most?

- When are people more likely to be engaged in online services?
- What particular functions or features would make different population groups more likely to access digital tools and services (i.e. webchat) and what would be deemed appropriate for specific formats?
- What would engender trust in the process of accessing digital tools?
- What would make people not use digital services – (i.e. complicated process, poor navigation, lack of trust in the process, fear of data security breaches, having multiple log-ins and having to remember multiple passwords)
- The impact of service availability on people's motivations and behaviours (i.e. limited service availability when booking appointment slots)
- An understanding of what factors result in digital solutions NOT being accepted
- What are people's tolerance thresholds (e.g. what levels of security are the prepared to go through before they get bored/frustrated and don't bother to complete the process?)

ii. **How to drive digital inclusion**

- What functionality and features would enable socially excluded groups to become more digitally enabled (e.g. learning disabilities, sensory disabilities, people for whom English is not a first language, people who are not digitally literate). There is a requirement to work with lay partners to look at groups with low levels of digital literacy.

We are therefore seeking a supplier that can build on existing research (compendium of evidence can be supplied by the project team); learn from what has worked and what has not worked and what we can learn from other service industries that may translate to the NHS.

2. Statement of work

What we call our requirements	**Market research into target population demand, behaviours and motivations from digital enabled self-service and self-care**
Where we want the supplier to work	Supplier is to work from their home base and report to the client on a regular basis.
Organisation the work is for	This work is a collaborative project between North West London Collaboration of CCGs (NWL CCGs) and the Personalisation and Self-care Programme. The Personalisation and Self-care Programme is part of the Healthy London Partnership (HLP) which is a collaborative of the 32 Clinical Commissioning Groups in London and NHS England (London region).
Why the work is being done	Personalised Health and Care 2020: sets out the role of digital technology in transforming outcomes for citizens and communities. London's health and care organisations share an emerging vision (Appendix A) through HLP to enable digital empowerment for its citizens, harnessing the power of technology to empower and support people to maintain independence and lead full and active lives in their homes and communities, keeping them well for longer. HLP and NWL CCGs have agreed to work together to develop with people and communities a strategy for 'digital empowerment' that nurtures local innovation and supports the development, delivery and uptake of existing and new digital services that could be made

	available through a citizen account.
Problem to be solved	NWL CCGs and the Personalisation and Self-care programme want to understand public demand, motivations and expectations (population segmentation in Appendix B) in using online services in their interaction with the NHS. To understand better the online services people value most, what would motivate them to use them/not use them and what tools and services are most beneficial to which population groups: • what populations want from connected digital services (demand) • how different populations would like to interact with digital services (behaviour) • and how best we can create and sustain demand through understanding the behaviour of different populations (motivations and experience)
Who the users are and what they need to do	General population as segmented in appendix B.
Any work that's already been done	Review of the literature is included in the compendium of evidence. This includes Conjoint Research commissioned by NHS England (2015). DigitalHealth.London is supporting 40+ suppliers through their Accelerator Programme to bring personalised digital tools and services to the market. We would expect suppliers to utilise published information on features that help specific user/disability groups in accessing online services.
Existing team	The supplier will be expected to work closely with the existing teams at NWL CCGs and the Personalisation and Self-Care Programme.
Working arrangements	The supplier is required to set a manageable and clear plan identifying when outputs, outcomes and benefits will be realised. Expenses are to be absorbed by the supplier in their day rate. Access to patient groups for interviews need to be arranged by the supplier – ideally through existing relationships the supplier has. The project team can assist the supplier with introductions to specific community groups if required.
Security clearance	Members of the team in direct individual contact with patients will need to have DBS clearance.
Latest start date	23 February 2017
Expected contract length	Until 31 March 2017
Additional terms and conditions	Standard contract will be used.
Budget	£25,000 - £30,000 excluding VAT
Summary of the work	NWL CCGs and the Personalisation and Self-care Programme are looking for a supplier to inform a new evidence base, adopting a population segmentation approach, detailing the demand, behaviour, motivations and experience of people with regard to digital tools and services. Ensuring that the supplier leaves a legacy by equipping the project team with the skills, knowledge and the capability to carry out its own market research activities Project Requirements: • Identification of digital behaviour across NWL to validate and further scope out opportunities to enhance local digital services.

	• Expand and build on local engagement with NWL groups across the spectrum of the population. • Use a blended approach for gathering information to maximise participation and richness of information (e.g., crowdsourcing, online forums, focus groups, existing community groups, face to face surveys for members of the public). • Proactively seek out views from a wide range of people, especially those that are hard to reach. • Maintain an inclusive approach and provide opportunities to hear views from wide range of stakeholders (e.g., local Healthwatch, health and social care service users, carers, family members, frontline staff). Methodology: • Engagement plan produced against each of the specified population segments (Appendix B). • Individuals and groups identified to engage and methodology developed for inviting them to participate. • Facilitation of a public campaign which optimises crowdsourcing and other approaches providing opportunities for people to feed in their views in a number of ways (e.g., digital platforms, focus groups and individual interviews). Key Deliverables: • Online platform created for capturing the views of the public and accessible by the project team for up to a 3-month period beyond 31 March 2017 (period can be negotiated). This is so the project team have the option to collect, extract and analysis additional data. • Quantitative and qualitative data captured evidencing demand, behaviour and motivations by different populations. • Framework developed on how digital care plans, self-care apps and other connected digital services can support agreed target populations, the benefits they can realise and the role professionals have in encouraging uptake defined. • A repository containing the raw data collected, which is extractable in a reusable format. • Final report produced summarising the core themes from the above data analysis and setting out how to drive improved digital engagement and take up of digital services, this report will be completed by no later than 30 April 2017 and will include: ➢ Identification of key success factors required by connected digital solutions to be adopted by the population. ➢ Identification of modes of failure causing digital solutions not be accepted by the target population. Key deliverables timeline: • 24 February – Project Commences • 24 February – 17 March - create engagement plan, identify target groups and begin public campaign. This will include two progress reports to the project team on the following dates: o Progress Report 1 – 03 March 2017 o Progress Report 2 – 09 March 2017

	• 17 March – 31 March – Raw data collected from the public campaign and shared with the project team alongside an interim summary of the key findings. This will take the form of: o Progress Report 3 (raw data plus analysis) – 24 March o Progress Report 4 (raw data plus analysis) – 31 March 29 – 31 March – Handover/training on online platform from the provider to the project team. 31 March – 30 April – Creation of Final Report, this will include two draft report submissions and reviews from the project team on the following dates: o Draft Report 1 submission – 12 April 2017 o Draft Report 2 submission – 21 April 2017 o Final report submission – 30 April 2017 3 April up to 30 June – Project team's access to online platform expires. This period is negotiable.

3. Response to our Requirements

Proposals should be submitted in writing to Charlotte Owen, HLP's Personalisation & Self-Care Project Officer by emailing charlotte.owen6@nhs.net by 12noon on **Wednesday 22 February**.

Interested suppliers have the opportunity to book a 30min telecon with the project team on 17, 20 and 21 February. Please contact Charlotte to book your appointment.

i. Format of Responses

- Proposals should be no longer than 8 pages of A4 in length.
- Responses should be constructed in the context of the ask (section 2) and address all the requirements and key deliverables in the Statement of Work.
- Credentials from existing clients should be attached along with the submission, where similar forms of service and projects have been undertaken.
- Include the names, job-titles and CVs for the team who would be delivering the work
- Include 3 referees from previous purchasers of similar services within last 3 years

ii. Response timeline

Activity	Time/Date
Statement of Works issued	Wednesday 15 February
Submission of responses	12noon on Wednesday 22 February
Presentations	Thursday 23 February
Proposed date for supplier to commence to work	Friday 24 February

Shaun Crowe
Personalisation & Self-Care Programme Lead
Healthy London Partnership
6 February 2017

Appendix A: (Draft) Vision: Success in 2020

Londoners are more proactive in their care and report improved outcomes due to their enhanced role in shared decision-making. Supported by a vibrant and diverse supply market and new digitally-enabled processes, self-care becomes the norm. New Care Models empower Londoners to take control of their health and wellbeing drawing upon a wider network of support made available by family, friends, voluntary and community groups, as well as heath and care services when needed.

This results in:

a) **Care decisions are shared, helping to reduce unwarranted variation and supporting patients to make informed choices.** Patients are routinely and systematically involved as active partners with clinicians in clarifying acceptable care, treatment or support options and choosing a preferred course of action. Decision aids to help people think are widely utilised to help patients and clinicians think through the pros and cons of different care, treatment or support options.

b) **Care planning and self-management is hardwired into how care is delivered.** Meaningful care planning takes place for people with long-term conditions or ongoing care needs which guides the choices and actions of the patient and their professional team. This care plan is digital and can be shared between care settings and is owned by, and useful for, patients, their families or carers. People living with long-term health conditions or care needs are offered support to improve their confidence and their capacity to manage their own health and wellbeing. This is achieved through greater take-up of evidence based approaches such as self- management education, peer support, health coaching and group based activities

c) **Personal Health Budgets and integrated personal budgets, including NHS and social care funding, are available to everyone who could benefit (in line with Mandate requirements).** In each CCG area at least 1-2 people per 1,000 of the population has a PHB or integrated personal budget incorporating NHS funding. PHBs should be in place for NHS Continuing Healthcare and Continuing Care, people with high cost packages of support (e.g. people with a learning disability); and in specific areas where the model will deliver a positive impact (e.g. end of life care, mental health).

d) **Social action beyond the NHS helps people improve their health and manage their wellbeing.** CCG and local authority commissioners support the local population in building community capacity and resilience. Social prescribing schemes and other community-based support are widely available to the public through primary care. Strong partnerships between the NHS, statutory partners and voluntary groups deliver health prevention and support for patients, carers and their families. Shared leadership promotes community- based activities aiming to strengthen local skills, knowledge and resilience to improve health and wellbeing.

Appendix B: Population Segmentation

The market research and crowdsourcing exercise will be applied to some or all the following population groups. These are aligned to local Sustainability & Transformation Plan modelling Groups.

Description of the groups

	Description of group
1 Mostly healthy adults <75	▪ People aged between 16-75 who are mostly healthy and do not have LTCs, cancer, serious and enduring mental illness, physical or learning disabilities and advanced organic brain disorders ▪ Includes those who have a defined episode of care, e.g., acute illness with full recovery, maternity
2 Mostly healthy elderly (>75) people	▪ Same as group 1 but for those who are above the age of 75
3 Adults (<75) with one or more LTCs	▪ People aged between 16-75 who have one or more long-term conditions, e.g., HIV, COPD, diabetes, heart disease ▪ Includes common mental illnesses, e.g., depression, anxiety
4 Elderly (>75) people with one or more LTCs	▪ Same as group 3 but for those who are above the age of 75
5 Adults and elderly people with cancer	▪ People aged above 16 who have any form and stage of cancer
6 Adults and elderly people with SEMI[1]	▪ People aged above 16 who have a mental-health problem (typically people with schizophrenia or severe affective disorder) who experience a substantial disability as a result of their mental-health problems, such as an inability to care for themselves independently, sustain relationships or work
7 Adults and elderly with advanced organic brain disorders	▪ People aged above 16 who have a decreased mental function resulting from a medical disease rather than a psychiatric illness; includes dementia as well as other conditions such as Huntington's and Parkinson's disease
8 Adults and elderly people with learning disabilities	▪ People aged above 16 who have a difficulty learning in a typical manner that affects academic, language and speech skills ▪ Excludes mild conditions that does not have an impact on social relationships or work
9 Adults and elderly people with severe and enduring mental illness	▪ People aged above 16 who have a FACS eligible physical disability ▪ Excludes physical disabilities, including sensory disabilities, that are not FACS eligible ▪ FACS eligibility includes an inability to perform 3 or more household tasks
10 Adults and elderly people who are socially excluded[2]	▪ People aged above 16 who have chaotic lifestyles who often have limited access to care ▪ Includes the homeless, alcohol and drug dependency

1 Severe and enduring mental illness
2 For example, the homeless, people with alcohol and drug dependencies
Source: Whole Systems Integrated Care module working group