SCHEDULE 2 – THE SERVICES

Service Specification

Service Specification No.	Integrated Diabetes Care
Service	Eastern Cheshire Clinical Commissioning Group Integrated Diabetes Care including European Union project Sustainable Technologies for Older People – Get Organised (STOPandGO)
Commissioner Lead	Eastern Cheshire Clinical Commissioning Group
Provider Lead	TBC through outcome of tender
Period	Commencing in July 2016
Date of Review	TBC as part of contract negotiation

Contents

1 Introduction to Integrated Diabetes Care in Eastern Cheshire - including Sustainable Technologies for Older People Get Organised

1.1 Eastern Cheshire Clinical Commissioning Group

Eastern Cheshire Clinical Commissioning Group (Eastern Cheshire CCG) is made up of 23 Eastern Cheshire based GP practices and is one of 211 CCGs in England. The main purpose is to ensure high quality healthcare, through commissioning appropriate healthcare services for the 204,444[1] residents of Eastern Cheshire. Eastern Cheshire CCG GP practices are organised into five neighbourhood teams which include:

1. Macclesfield
2. Congleton and Holmes Chapel
3. Bollington, Disley and Poynton
4. Knutsford
5. Chelford, Alderley Edge and Wilmslow

There are 38 Pharmacies, 42 dentists and 48 opticians. There is one District Hospital in Macclesfield and 2 Community Hospitals.

1.2 Caring Together

Eastern Cheshire CCG is partnered with the following organisations through its local Transformation Programme, known as Caring Together; East Cheshire NHS Trust, Cheshire and Wirral Partnership NHS Foundation Trust, Vernova Community Interest Company Ltd and Cheshire East Council. All services procured by each of these partners should adhere to the principles, ambitions and standards as laid out in the Caring Together strategy. See Appendix 1 (www.caringtogether.info)

1.3 Cheshire Pioneer – Connecting Care

Eastern Cheshire, West Cheshire, South and Vale Royal CCG's are part of the Cheshire Pioneer Programme called Connecting Care across Cheshire, one of 14 sites to be chosen to be part of a 3 year programme, for integrating care. The objective is to improve the health and wellbeing of residents in Cheshire by focusing on implementation of ground-breaking models of care and support based on integrated communities, integrated case management, integrated commissioning and integrated enablers. (cheshirepioneer.co.uk).

1.4 European Sustainable Technology for Older People – Get Organised Project

Eastern Cheshire CCG is a core partner in the European Sustainable Technology for Older People – Get Organised (STOPandGO) Project 2(see appendix 6). STOPandGO is a three year project, which has been established to support the European priority of supporting innovative solutions and purchasing health care, to ensure cost effective care and enhanced wellbeing for the aging population. Eastern Cheshire CCG is one of 7 procurers of 4 Member States (Italy, Spain, United Kingdom and Netherlands) involved in the project across Europe and the UK representative. Eastern Cheshire CCG is committed to innovatively procuring sustainable technology at scale in order to help meet the objectives laid out by the EU.

[1] www.easterncheshireccg.nhs.uk
[2] https://www.easterncheshireccg.nhs.uk/About-Us/stopandgo.htm and www.stopandgoproject.eu

Project STOPandGO has as its primary objective to use the tool of the Contract of Public Innovation (PPI) to coordinate and harmonize the public sector demand on services for elderly people enhanced by digital technologies. More specifically STOPandGO aims:

- To develop the European Specification Template, i.e. European guidelines to define and manage public tenders for the procurement of health and social services enhanced by digital technologies that will enable the implementation of innovative care models for elderly people
- To ensure that commissioned services are innovative, or based on existing technologies that are to be utilised in a new and innovative way
- To test and evaluate the procurement process through a number of co-funded tendering activities performed by the 7 EU Procurers.
- To produce a consolidated release of the European Specification Template (EST), suitable for use in all the European Regions to support EU strategies depicted in the "Strategic Implementation Plan" (SIP) of "European Innovation Partnership on Active and Healthy Ageing" (EIP on AHA)

The STOPandGO approach to innovating models of care focuses on three key factors:

- Support **collaboration** among care professionals involved in service delivery
- Support empowerment of people with long term conditions and their carer/families through **activation**
- Support integrated **governance**

Eastern Cheshire CCG has designed Integrated Diabetes Care with technology and education as key enablers. This innovative procurement moves away from technology being procured as stand-alone solutions used in isolation as is often the case to; enabling integrated working across multidisciplinary teams, supporting clinical expertise in sharing information and supporting people to be empowered to self-manage their health and wellbeing.

There are four UK based partners involved in the European STOPandGO Project: The UK partners are working together with all European partners to support sharing best practice in procurement of technology enabled care. The UK based partners are;

- Eastern Cheshire CCG
- North West Coast Academic Health Science Network
- Telecare Services Association
- Knowledge Transfer Network

This specification and Intention To Tender documentation has been defined in coordination with the other procurers involved in the STOPandGO project and was based on the common specifications defined in the EST - European Specification Template. These specifications are intended to promote the activation of innovative services enhanced by digital technologies to promote the introduction of models of Integrated Care primarily oriented to the elderly people.

Eastern Cheshire CCG's primary role is overseeing the procurement exercise of this project and to ensure that provider organisations which are successful in securing a contract deliver on the outcomes outlined for the target population.

Collectively the four partners will work together to ensure that through the Technology Enabled Care Services procured, the project delivers on all the targets and outcomes set through evidence which is based on quantitative and qualitative data.

Further information can be found at:
https://www.easterncheshireccg.nhs.uk/About-Us/stopandgo.htm

1.5 National / Local Context and Evidence Base

Diabetes is one of the biggest health challenges facing the NHS today and as such, has been highlighted as being both a priority at national and local level, to improve health outcomes for people with Diabetes, whilst at the same time controlling healthcare spend.

At a national level the areas highlighted are as follows:

- Lack of access and uptake of structured education
- High level of variability of care in both primary and secondary care
- Feedback from people with Diabetes that the care they receive appears fragmented
- Too many people who have Type 1 or Type 2 Diabetes have poor glycaemic control
- Achievement of all '9 Care Processes'[3] is low, which increases the likelihood of future complications that can be avoided with good diabetes care

Overwhelming clinical evidence suggests that good glycaemic control through day to day monitoring of blood glucose, optimisation of blood pressure and Haemoglobin A1c (HbA1c) checks make a significant difference to outcomes for people with Diabetes. Diabetes however, continues to remain one of the commonest causes of end stage renal failure, blindness in people of working age and avoidable amputations. Diabetes is one of the most common of all long term medical conditions. In addition a significant number of people with Diabetes, will also have coronary heart disease, hypertension, stroke and mental health problems (notably 1 in 5 people with Diabetes also have clinical depression[4] and for those with anxiety and/or depression health care costs increase by about 50%).[5]

In 2010/11 it was estimated that the Diabetes direct cost to the UK was £9.8 billion which equates to 10% of the total health resource expenditure. Furthermore it is estimated that 80% of these costs are incurred in treating potentially avoidable complications[6]. It is recognised that there remains gaps in service provision and challenges in the care provision for people with diabetes.

1.6 Local Context and Case for Change in Eastern Cheshire

Eastern Cheshire population data estimates that approximately 22,000 people are at high risk of developing Diabetes within Eastern Cheshire[7]. There are currently 1,985 people in

[3] http://www.nice.org.uk/guidance/index.jsp?action=byID&o=12165
http://www.hscic.gov.uk/catalogue/PUB12421/nati-diab-audi-11-12-care-proc-rep.pdf

[4] The prevalence of co-morbid depression in adults with Type 2 diabetes a systematic review and meta-analysis. Diabetes. Med 23(11) (2006) 1185-1173 ALI and Stone et al.
[5] Chronic conditions and comorbid psychological disorders Seattle Millman (2008) Melek Norris et al.
[6] Estimating the current and future costs of Type 1 and Type 2 Diabetes in the UK – Diabetes Medicine July 2012
[7] Cheshire East Public Health Data 2014/15

Eastern Cheshire who have been identified through the National Health Checks[8,] as registered with Pre-Diabetes. There is a risk that unless Eastern Cheshire CCG addresses the situation through prevention of Diabetes, empowering people to take responsibility for their own health and wellbeing, the number of people who develop Type 2 Diabetes will reach epidemic proportions.

A greater understanding and knowledge of the complexities of Diabetes has led to increasing difficulty in accurately diagnosing or classifying the type of Diabetes. In March 2011, a report by the Royal College of General Practitioners (RCGP) and NHS Diabetes was published which examined the issue of coding, classification and diagnosis of diabetes in Primary Care in England. The summary findings of the report included an algorithm to provide guidance to healthcare professionals on making a new diagnosis of Diabetes. There are currently 9,524 people who are registered in Eastern Cheshire as having Diabetes with approximately 952 people having Type 1 Diabetes and 8,572 people having Type 2 Diabetes.

There is commitment from commissioners and providers across the Caring Together transformation programme, for the need to radically reshape the delivery of care for the population. Although there have been some successes in changing the way services are delivered, more needs to be done to ensure services closely and consistently meet the needs of the local people and are affordable. For some people services are fragmented, reactive and difficult to access. Feedback from staff is that it is sometimes difficult to respond to the needs of the people they support in a way they would like.

The outcomes for people with Diabetes in Eastern Cheshire are currently above the national average and spending on prescribed diabetes medication is below national average[9]. As a result, Eastern Cheshire CCG is delivering good outcomes and value for money (see Appendix 3).

1.7 Technology

The use of technology enabled care such as telehealth and telecare in Eastern Cheshire has to date been through standalone solutions and has not been maximised to its full potential. There is an opportunity to empower people with Diabetes and the care professional's co-ordinating their care, through the application of technology into the day to day management of diabetes, this could include:

- Remote monitoring to provide early identification of deterioration of glycaemic control
- Better communication between the person and integrated team
- Provision of education
- Access to coaching to support empowerment through self-management
- Remote monitoring to support early discharge

1.8 Integrated Diabetes Care Enablers

Eastern Cheshire CCG is in the process of commissioning a range of technologies, which will enable the delivery of Integrated Diabetes Care including;

[8] Eastern Cheshire CCG Contracts Data 2015
[9] Yhpho.org.uk Diabetes outcomes versus expenditure (DOVE) tool

- As partner organisation in the Cheshire Pioneer Integrated Digital Care Record - Cheshire Care Record
- Procuring a Risk Stratification Tool, that includes a wider range of health and social data. (see Appendix 4)
- As a partner contributing to the definition and development of innovative services, enabled by technology in the context of a European project called STOPandGO (European Sustainable Technology for Older People – Get Organised. See Appendix 4)

1.9 Education for people who have Diabetes

Diabetes education for people who have diabetes and their family or carers across Eastern Cheshire has been opportunistic, as part of consultations and annual reviews by GPs, Practice Nurses and Specialists. An education programme has been commissioned in 2015/16 for newly diagnosed people with Type 2 Diabetes; however there is no formalised education for people with Type1 Diabetes or people who have existing diagnosis of Type 2. Therefore there is a requirement to expand the current service provision relating to education.

1.10 Eastern Cheshire Integrated Care Model

Integrated care is a fundamental principle of the Caring Together Transformation Programme and informs our approach to Diabetes care in Eastern Cheshire.

Empowerment of people sits at the centre of our integrated care model, so that people are empowered to take responsibility for their own health and wellbeing (see Appendix 2).

Community Based Co-ordinated Care (CBCC)[10] is the first model to be commissioned under the Caring Together Transformation Programme and includes the development of two integrated teams:

1. The Integrated Community Teams (ICTs) that comprise multidisciplinary professionals from health and social care. These teams will provide proactive care co-ordination to people who are at high risk of unplanned hospital admission

2. Short Term Assessment Integrated Response and Recovery (STAIRRS) will provide assessment and response within 2 hours of a crisis

The Integrated Diabetes Specialist Team will provide specialist support to CBCC (STAIRRS and ICTs), Primary Care and Hospital Acute Care as outlined in Figure 2 Eastern Cheshire CCG Integrated Care System, showing the working together to achieve the system-wide cost savings and outcomes. The Integrated Community Team Model of Care is illustrated in Appendix 7 and how the Diabetes Specialist Team integrates in planned and urgent care is illustrated in Appendix 8.

2 Population Needs in Eastern Cheshire

The population of Eastern Cheshire in 2015 is 204,444 people and can be summarised as a growing and aging population. The following data is extracted from the Office of National Statistics for Eastern Cheshire:

[10] Community Based Co-ordinated Care (CBCC) Specification 2015

- The population is forecast to increase moderately by 4,100 (2%) to 208,100 by 2020 and by 28,000 (14%) by 2035
- The age structure of the population is forecast to change significantly, with a 42% increase in people over 65 years of age and a 92% increase in those aged over 85 years by 2035
- 59,500 or 20% of population is over 65 compared to national average of 16% (2011 Census)
- Eastern Cheshire has the fastest growing over 65 and over 85 years populations in the North West[11], with more than 1 in 5 people being over 65. This ratio is higher than the national average of 16%, and will become nearer to 1 in 4 people by 2021[12]

2.1 Growing Burden of Disease - Prevention

- In the UK 7 million people are estimated to have Pre-Diabetes and thus have a high risk of developing Type 2 Diabetes. If this is equally distributed across the country Eastern Cheshire would expect approximately 22,000 people to have Pre-Diabetes[13]
- The prevalence of Diabetes in Eastern Cheshire is 5.7% compared to 6.% in similar CCGs [14]
- Deprivation levels in Eastern Cheshire are lower than the national average at 4.5% (9,180) of local people living in an area that is in the 20% most deprived in England [15]
- Practices within the Eastern Cheshire CCG have a Pre-Diabetes Register and through The National Health Check Programme and opportunistic screening, there are 1,950 people currently registered as pre diabetes[16]
- 7.3% of the population of Eastern Cheshire is classified as obese. There are 3 GP practices in Congleton and Macclesfield, being above the national average. The areas in each of the towns where the GP Practices are located also correspond to the areas of greatest deprivation within Eastern Cheshire[17]

2.2 People who have Type 1 and Type 2 Diabetes

- Eastern Cheshire CCG had a lower than average spend and significantly higher than average outcomes for 2012/13 (See Appendix 2 Diabetes Community Health Profile for Diabetes, Eastern Cheshire CCG. 2012/13)
- There are 9,524 people who are registered in Eastern Cheshire as having Diabetes with approximately 952 people having Type 1 Diabetes and 8,572 people having Type 2 Diabetes
- Completion of the 9 Care Processes [18]recommended by NICE is 68% (2012)
- The number of people with Diabetes meeting treatment targets (glucose, BP and cholesterol) was 33.8% (2013)

2.3 Complex Diabetes Care

- Increasing numbers of people with Diabetes also have co-morbidities, especially

[11] Cheshire East Joint Strategic Needs Assessment 2012, population projections 2010
[12] Office for National Statistics 2010
[13] National Diabetes Information Service – Eastern Cheshire Diabetes Prevalence Model for England
[14] www.healthierlives.phe.org.uk – Eastern Cheshire CCG
[15] Office for National Statistics 2010
[16] CCG Contract Monitoring
[17] Eastern Cheshire Risk Stratification Tool April 2015
[18] National Institute for Health and Clinical Excellence Clinical Guidance on Diabetes *CG15: Type 1 diabetes: Diagnosis and management of type 1 diabetes in children, young people and adults and CG66: Type 2 diabetes: the management of type 2 diabetes (update)*

people aged 65 years and over. Currently there are 3,618 people who have between 3 and 8 long term conditions

- Hypertension, depression and Diabetes are the most common conditions, with the highest incidence being seen in GP practices in Knutsford, Handforth, Macclesfield, and Congleton, which correspond to the areas of high deprivation[19]
- Variation in Life Expectancy in Eastern Cheshire shows startling variations. For example, a woman living in Macclesfield Town South is expected to die on average almost 13 years earlier than a woman living a couple of miles away in Tytherington (Office for National Statistics, 2010)

3 Outcomes

3.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely
Domain 2	Enhancing quality of life for people with long-term conditions
Domain 3	Helping people to recover from episodes of ill-health or following injury
Domain 4	Ensuring people have a positive experience of care
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm

3.2 Adult Social care Outcomes Framework

Domain 1	Enhancing quality of life for people with care and support needs
Domain 2	Delaying and reducing the needs for care and support
Domain 3	Ensuring that people have a positive experience of care and support
Domain 4	Safeguarding people whose circumstances make them vulnerable and protecting them from harm

3.3 Public Health Outcomes Framework

Domain 1	Improving the wider determinants of health
Domain 2	Health Improvement

[19] Eastern Cheshire CCG Risk Stratification tool April 2015

Domain 3	Health Protection
Domain 4	Healthcare public health & preventing premature mortality

3.4 Local Defined Outcomes (Diabetes)

The locally defined outcomes for Eastern Cheshire CCG are as follows:

- Reduction in the rate of mortality for people who have diabetes and are <75 years of age
- People are empowered to take responsibility for their own health and wellbeing (mental and physical)
- People have a healthier lifestyle resulting in improved quality of life
- Families/carers are supported and able to maintain their desired quality of life
- Reduction in unplanned admissions for Diabetes associated complications
- Care is delivered closer to home
- Access to services and improved outcomes for those at greater risk of poorer health outcomes including people who are vulnerable and marginalised
- Ensuring seamless transition between services for people aged 16 years+ to adult and across multidisciplinary teams

A number of contractual outcomes have been identified in the ITT which can be refined and agreed as part of contracting process.

4 Scope

4.1 Aims and Objectives of Service

The aim of this service specification is to commission Integrated Diabetes Care for the population of Eastern Cheshire. The service will provide:

- High quality, cost effective care for adults aged 18 years and over including a smooth transition for young people aged 16 years to adult services
- Care as close to a person's home as is practical for people who are registered with a GP within Eastern Cheshire CCG
- Appropriate service components to be accessed 7 days a week (to be agreed with service providers during the procurement phase)
- Outcomes based on the standards, principles and ambitions of the Caring Together Transformation Programme

Service / care providers will be required to work innovatively and collaboratively to ensure that care is joined up and focused on improving outcomes for people who are at risk of Diabetes or who have a diagnosis of Type 1 or Type 2 Diabetes.

4.2 Objectives of Integrated Diabetes Care in Eastern Cheshire

The objectives of Integrated Diabetes Care in Eastern Cheshire are as follows:

- To empower people who are at risk of or have a diagnosis of Type 1 or Type 2 Diabetes to take responsibility for their own health and wellbeing, to self-manage their care and are confident in understanding how to avoid or manage a crisis
- To identify people who have Type 1 or Type 2 Diabetes are provided with guidance, access to the right level of care and educational support at the right time
- To support, educate, coach and empower people who are at high risk or who have been diagnosed with Type 1 or Type 2 Diabetes to achieve personal HbA1c and lifestyle goals. These goals will be achieved through a range of approaches including educational programmes and/or the use of technology and virtual learning.
- To support, educate and empower families and carers of people who are at high risk or who have been diagnosed with Type 1 or Type 2 Diabetes
- To delivering high quality affordable Diabetes care that meets national and local standards and guidance
- To providing equitable access and reduce inequalities through ensuring people are treated with dignity, respect and are fully informed about their care and through working in partnership with care professionals

4.3 Financial Resources and Contracting

The financial resources available to invest in Integrated Diabetes Care has been identified and an indicative figure for the total of the 3 components is presented in the 'Invitation to Tender' (ITT) document in section 4.4 The Contract Activity and Prices section.

Eastern Cheshire CCG requires prospective providers and suppliers to propose the funding required in order deliver Integrated Diabetes Care.

A new contracting model to support integrated diabetes care has been adopted to support outcome based commissioning, using the Year of Care capitated approach full details are presented in the ITT document in section 4.4 The Contract Activity And Prices. This model takes an approach of transitioning from payment by performance to payment based on outcomes over 5 years. These percentages are indicative and providers can suggest an alternative phasing.

4.4 Eastern Cheshire Integrated Diabetes Care Model (Figure 1)

Integrated Diabetes Care in Eastern Cheshire will deliver an outcome based care model, which has been co-designed with colleagues and partners from the NHS, Local Authority/Public Health and Third Sector organisations. Included also in this co-design of the Integrated Care Model are people who have diabetes and people with an interest in diabetes. Eastern Cheshire CCG have further utilised its Risk Stratification Tool, throughout the design process, (see appendix 5A and 5B) which has enabled Eastern Cheshire CCG to review the level of risk of unplanned admission for people with Diabetes and attribute an appropriate level of care.

Through our approach, it is envisaged that the Integrated Diabetes Care Model will enable a proactive service approach, which is tailored to the needs of individuals. A person's level of care will therefore change during a crisis or escalation of their health problems (e.g. ketoacidosis or hypoglycaemia or complications such as cardiovascular or neuropathic acute event) with the ability to 'step up' to the next level of care as appropriate. The model also allows people to 'step down' for continuing care once stable. This innovative model of care will be measured through a series of high level outcomes, key interventions and key performance indicators, but is fundamentally underpinned by the notion of an integrated approach to service delivery. Thus the model aims to move away

from a traditional service model to a model whereby providers can inform interventions, inputs and outputs and outcomes delivered.

The Eastern Cheshire CCG Integrated Diabetes Care System is the output of a co-design project and will be the foundation for the delivery of care. Figure 2 outlines the components that make up the system that will support people with diabetes and describes:

- Overarching the model highlights the importance of the **empowered person**, taking responsibility for their own health and wellbeing
- Community Care delivered close to home with support of **Integrated Community Teams and STAIRRS**
- **Specialist Diabetes Service** delivering Super 7[20] + local requirements Including Review of people post discharge from hospital in community setting. Review of people who are at high risk of admission or in crisis (step up of care to specialist services). Education in Primary Care re Virtual Clinics, Case Reviews
- **Primary Care** outlines primary care contract for diabetes care. With some practice in Eastern Cheshire CCG delivering a higher level diabetes service than included in the general practice contract, this may be at GP Practice or Neighbourhood Team level and provider of the specialist team is required to work with local general practice to agree how this level of care is provided
- **Public Health** – supporting prevention of diabetes and lifestyle interventions
- Access to **Mental health and Psychological Services** for people who have diabetes
- **Third sector** opportunities including services that are already commissioned such as wellbeing coordinators, 'healthy eating and cooking on a budget' courses, local diabetes support groups
- Underpinning the model highlights the importance **clinical and professional leadership** and includes; **Structured Education** for people with Diabetes including **Technology Enabled Care** to support hospital admission avoidance, earlier discharge from hospital and information sharing

The Integrated Diabetes Specialist Team will support the wider multi-disciplinary team and a graphic outlining the interdependencies is included in Appendix 6.

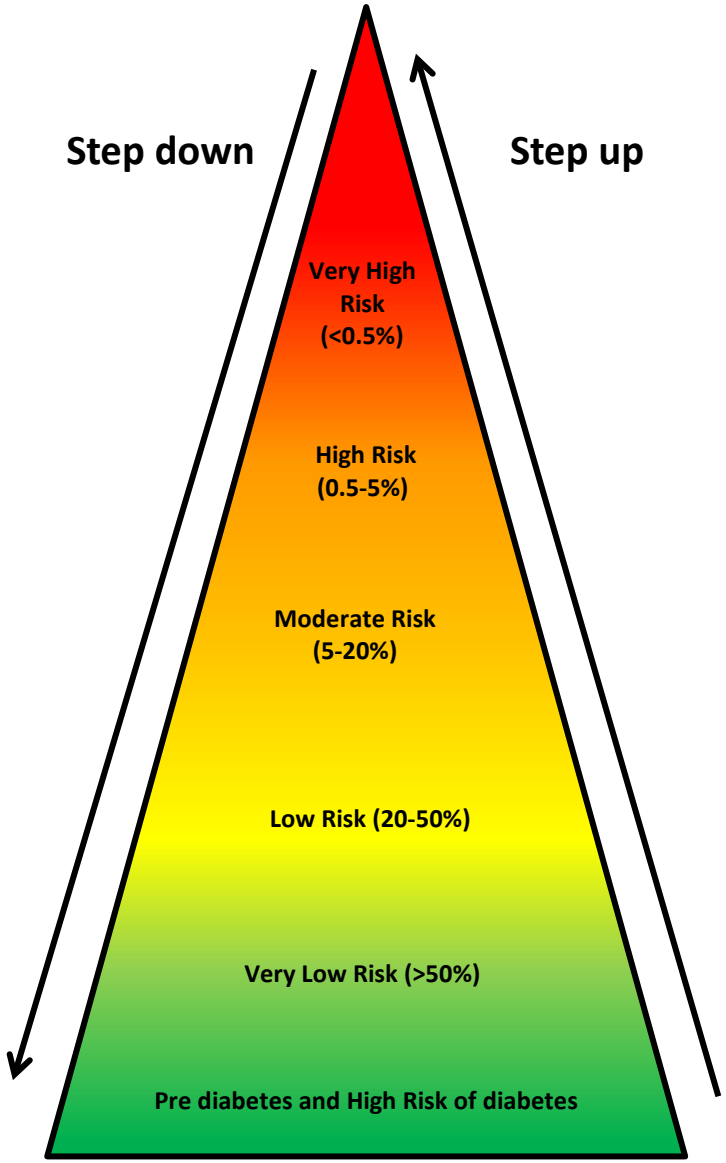
The specification includes a range of short and long term high level outcomes. The focus for the contract period is to deliver the following outcomes:

- People are empowered to take responsibility for their own health and wellbeing (mental and physical wellbeing
- Increase update of diabetes education/lifestyle/behavioural interventions
- Enhance/maintain quality of life for people with diabetes and carers/family
- Maintain good blood pressure and glycaemic control
- People feel supported to manage multiple long term conditions
- Reduced avoidable hospital admissions for:
    - Hypoglycaemia
    - Ketoacidosis
- Reducing inappropriate time in hospital

[20] www.leicestershirediabetes.org.uk/982.html.

Providers and commissioners will agree the baseline, outcome targets and measurement indicators, which will support the evaluation of service delivery as a whole and be part of reporting of Eastern Cheshire CCG transformation programme and STOPandGO project monitoring.

Figure 1 Eastern Cheshire Integrated Diabetes Care Model – Levels of Care The co-design work used Eastern Cheshire CCG Risk Stratification Tool (see Appendix 3) throughout the design process.
Figure 1 outlines the levels of risk of unplanned admission and highlights the appropriate level of care. The model promotes the ability for people to step up to a higher level of care and step down a level of care as appropriate.



Level 3: Complex Care: People who have Type 1 or Type 2 Diabetes, who are at High to Very High Risk of unplanned admission in the next 12 months
Population: approximately 2,258 people
Lead Provider: Specialist Led Consultant and Diabetes Specialist Nurse, GP Primary Care,
Care based Close to where a person is; at home, in hospital, in care home or community setting
Strategy: Diabetes Management, Case Management
Technology: Motivational lifestyle coaching, Disease Specific Education, Telehealth Monitoring, Supported Discharge, Applications that support health and wellbeing, Support for Integrated Working

Level 2: Management: People who have diagnosis of Type 1 or Type 2 Diabetes who are at Moderate Risk of unplanned admission in the next 12 months
Population: approximately 4,291 people
Lead Provider: GP Primary Care, with virtual support from Diabetes Specialist Team
Care based: Close to where a person is; at home, in hospital, in care home or community setting
Strategy: Supported Self Care, Diabetes Management
Technology: Motivational lifestyle coaching, Disease Specific Education, Telehealth Monitoring Supported Discharge, Applications that support health and wellbeing, Support for Integrated Working

Level 1: Prevention and Very Low Risk: People at High Risk of developing Diabetes, People who are registered Pre-Diabetes, People who have diagnosis of Type 1 or Type 2 Diabetes who Low to Very Low Risk of unplanned admission in next 12 months.
Population: Approximately; 24,560 people
22,000 High Risk of Diabetes – Undiagnosed
2,000 Pre-diabetes Register
2,975, Type1 or Type 2 Diabetes Very Low Risk >50% of unplanned admission.
Lead Provider: Cheshire East Council Public Health, GP Primary Care
Care based: Close to where a person is; at home, in hospital, in care home or community setting
Strategy: Prevention and Wellness Promotion, Diabetes Management
Technology: Motivational lifestyle coaching, Disease specific education, Applications that support health and wellbeing, Support for Integrated Working

Figure 2

Eastern Cheshire CCG-Integrated Diabetes Care System

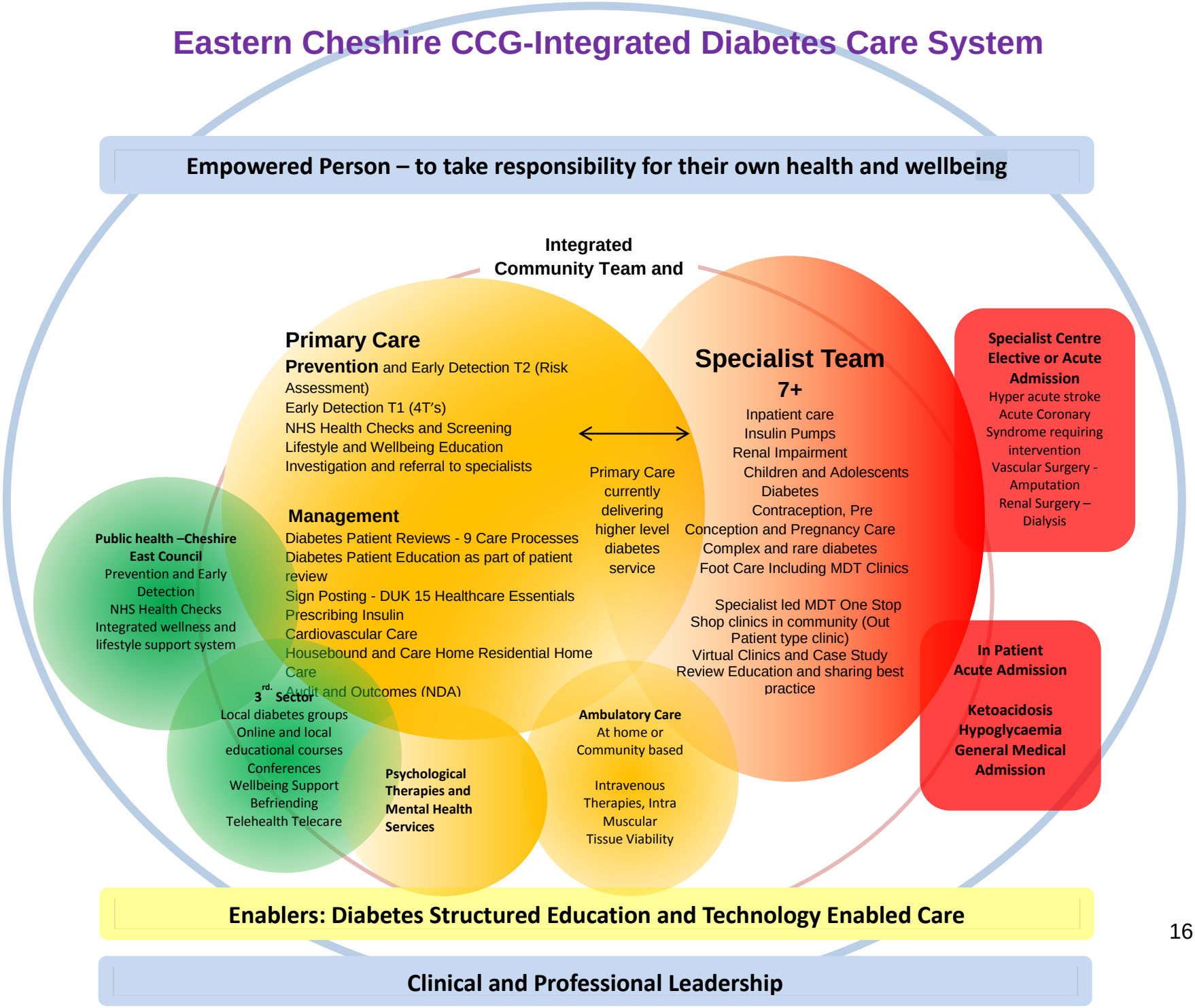


Figure 3 Eastern Cheshire Integrated Diabetes Care Model – Outcomes, Key Interventions and Quality Standards, High Level Key Performance Indicators

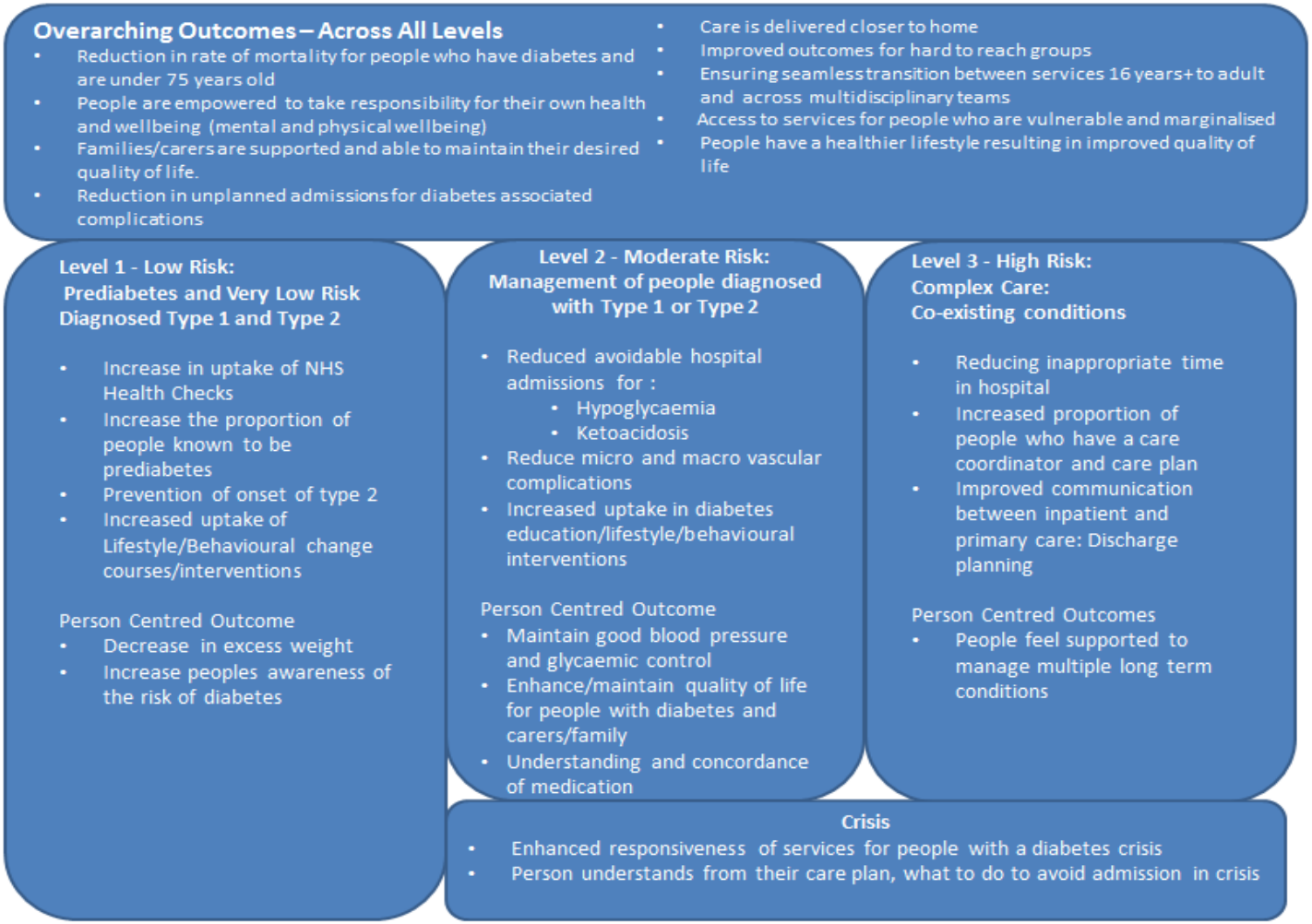
The levels of care reference high level outcomes, key interventions, quality standards and high level key performance indicators which are aligned to a specific level of care, some of these are applicable to other levels of care i.e. support for families and carer's will apply to all 3 levels. **This is not a definitive list and a number of contractual outcomes have been identified in the ITT which can be refined and agreed as part of contracting process.** Outcome model is outlined further in Figure 4.

Morbidity	Outcomes	Key Interventions and Quality Standards	High Level Key Performance Indicators
	• Care is delivered closer to home • Reducing inappropriate time in hospital • Increased proportion of people who have a care coordinator and care plan • Improved communication between inpatient and primary care: Discharge planning Person Centred Outcomes • People feel supported to manage multiple long term conditions • Families and Carers are supported and are able to maintain their desired quality of life Crisis Management - Enhanced responsiveness of services for people with a diabetes crisis - Person understands from their care plan, what to do to avoid admission in crisis	• Support for families and carers • Specialist Team provide 'one stop' multidisciplinary clinics (Outpatient type clinic) in the community neighbourhood teams or GP practice level including foot MDTs • Care Co-ordination and Individual Proactive Care Plan with an agreed goals and action plan including admission avoidance /crisis management plan. Including access to single point of contact • Provision of services currently delivered in hospital setting to persons home or community setting (ambulatory care) • People with diabetes admitted to hospital are cared for by appropriately trained staff, provided access to Specialist Diabetes Team and given the choice of self-monitoring and managing their own insulin, to enable early discharge • People with diabetes who are at risk of admission to hospital are given the choice of self-monitoring to prevent avoidable admission • People with diabetes with limb-threatening or life threatening diabetic foot problems are referred immediately to specialist services and MDT foot care service. • Ambulance Service implementation of diabetes pathway • Devolving care back when the health of a person is stabilised – Step down • End of life pathway as appropriate	• Number of years of life lost >75years • Proportion of people identified through risk stratification who have a jointly developed care plan and care co-ordinator where appropriate • Proportion of people diagnosed with diabetes admitted to hospital as a result of microvascular or macrovascular complications of diabetes • Length of stay for people admitted with diabetes
	• Reduced avoidable hospital admissions and A&E Attendance as a result of : • Hypoglycaemia • Ketoacidosis • Reduce micro and macro vascular complications • Increased uptake in diabetes education/lifestyle/behavioural interventions Person Centred Outcomes • People are empowered to take responsibility for their own health and wellbeing (mental and physical) • Maintain good blood pressure and glycaemic control • Enhance/maintain quality of life for people with diabetes and carers/family • Understanding and concordance of medication	• People with diabetes with active foot problem that is not limb threatening are referred to MDT foot care/protection service within 1 working day and triaged within 1 working day • Trained health care professional initiate and manage therapy with insulin a within a structure programme that includes dose titration by the person with diabetes • Biochemistry support through diagnostic testing, reporting and attending MDT meetings or case reviews. • Access to high quality, structured education for people who have Type 1 and Type 2 Diabetes that fulfills nationally agreed criteria from the time of diagnosis, with annual review and access to ongoing education • Specialists Team provide support and education at neighbourhood or GP Practices – Case Review, Virtual Clinic, Skype, and EMIS Vydio. • Access to specialist team advice through dedicated email, telephone advice	• Proportion of people diagnosed with diabetes, completing the 9 care process • Proportion of newly diagnosed people who have diabetes (Type1 or Type 2) completing education programme • Proportion of people diagnosed with diabetes being admitted to hospital as a result of Hypoglycaemia and Ketoacidosis, National Indicator • Proportion of people diagnosed with diabetes attending Accident and Emergency Department

	• Access to services and Improved outcomes for difficult to reach or marginal groups	• People with Diabetes have access to technology enabled care to support self-management • People admitted to hospital with ketoacidosis receive educational and psychological support prior to discharge and are followed up by Specialist Diabetes Team • People with diabetes who experience hypoglycaemia requiring medical attention are referred to a Specialist Diabetes Team • People with diabetes receive an annual assessment for the risk and presence of the complications of diabetes, and these are managed appropriately • People with diabetes at risk of foot ulceration receive regular review by a foot protection service in accordance with NICE • People with diabetes are assessed for psychological problems which are then managed appropriately • Provide access to for difficult to reach or marginal groups including transition to adult services and transition to specialist services • Completion of National Diabetes Audit • Risk stratification tool is used to identify a person with diabetes risk of unplanned admission and level of care	
	• Increase in uptake of NHS Health Checks • Increase the proportion of people known to be prediabetes • Prevention of onset of Type 2 • Increased uptake of Lifestyle/Behavioural change courses/interventions Person Centred Outcomes • Decrease in excess weight • Increase people's awareness of the risk of diabetes • Ensuring seamless transition between services 16 years+ to adult and across multidisciplinary teams • People have a healthier lifestyle resulting in improved quality of life	• People with diabetes agree with healthcare professional a documented personalised HbA1c target and receive an ongoing review of treatment to minimise hypoglycaemia • People with diabetes agree with their healthcare professional to start review and stop medications to lower blood glucose, blood pressure and blood lipids in accordance with NICE guidance • Women of childbearing age with diabetes are regularly informed of preconception advice and care or offered contraception, pregnancy advice as appropriate • People with diabetes receive personalised advice on nutrition and physical activity from an appropriately trained healthcare professional or as part of a structured education programme • Assessment of patient activation; measure of a person's skill, confidence and knowledge to manage their own health • Use of Technology to support health and wellbeing i.e. health guardians, fitness and lifestyle apps, Coaching and self-monitoring devices • People at risk of diabetes have access personalized advice on nutrition and physical activity from appropriately trained healthcare professional or part of structured education (signposting to lifestyle course, coaching • Early identification of Type 2 Diabetes, through NHS Health Check and opportunistic risk assessment • Promotion and awareness of early identification of Type 1 Diabetes (4Ts campaign – Thirst, Toilet, Tired, Thinner)	• Prevalence of people registered with pre diabetes • Variation of prevalence and incidence of pre diabetes • Proportion of people on pre diabetes register completing lifestyle courses • Proportion of people with a BMI >30 who have had a 5% reduction in weight since last review National Indicator • Increase the number of people who are physically active • Increase the number of people who east healthily – 5 a day

Figure 4 Eastern Cheshire Integrated Diabetes Care Model – High Level Outcomes

The **overarching high level out comes are applicable across all levels of care** and consistent for the life course of diabetes care. The 3 levels of care Low, Moderate and High Risk, have specific high level outcomes that are most relevant to the specific level of care these are also applicable to other levels of care which includes crisis intervention. **A number of contractual outcomes have been identified in the ITT which can be refined and agreed as part of contracting process.**



5 Procurement

To ensure that our vision for the Integrated Diabetes Care System (Figure 2) is truly realised, providers and suppliers are encouraged to work innovatively and collaboratively from the outset the following Caring Together Principles:

- integrated care cannot be delivered by organisations working alone or in isolation, it must be delivered through collaborative working

- it must ensure seamless care so that people who have diabetes, families and carer's when moving from one care setting to another experience no gaps, do not need to repeat their history or any unnecessary tests or treatments and feel that everyone involved in the care process are well informed and working together as a team

- the development of very different relationships are at the heart of integrated care, with professionals from different organisations, professional groups and teams understanding one another and developing mutually respectful and collaborative relationships with those who require their professional expertise

- the skills, knowledge and experience of staff is respected and their willingness and ability to work across boundaries is valued and rewarded

- information and required data on people and service users and their carer's is readily available and utilised as required across all relevant service providers through an effective and safe IT system

- staff, people and carer's are able to suggest and access different kinds of solutions and models of care that are bespoke to their needs and that inspiring and innovative working is supported and rewarded appropriately

Eastern Cheshire CCG is therefore looking for partners (both current and potential providers and suppliers from all backgrounds) who are interested in continuing the co-design work with the focus being empowerment of people to take responsibility for their own health and wellbeing.

This procurement focuses on 3 component required to deliver Integrated Diabetes Care System; Specialist Integrated Diabetes Service, Technology Enabled Care and Diabetes Structured Education.

Eastern Cheshire CCG wishes to highlight the interdependencies between all elements in the Integrated Diabetes Care System and the opportunity to collaborate outside the specified areas, for example services commissioned and provided by public health and the 3rd Sector. To ensure the opportunity to join up care for individuals is fully realised.

A key interdependency is the collaboration between the specialist team and primary care. In the design of the integrated diabetes care system we have highlighted the

opportunity for primary care to deliver a higher level of diabetes service than included in the general practice contract (Figure 2). The provider of the specialist team is required to work with local general practice to agree how this level of care is provided.

To assist a range of bidders to collaborate in response to the specification, Eastern Cheshire CCG's requirements for Integrated Diabetes Care are divided 3 components which are outlined in the following sections.

The components are partly funded by the European Sustainable Technology for Older People–Get Organised (STOPandGO) Project21 which is a Public Procurement of Innovative solutions (PPI) Pilot project co-funded by the Information Communication Technology Policy Support Programme (ICT PSP) of the European Union (CIP ICT PSP 2007-2013), Grant Agreement No 621013. In addition the procurement of this component complies with all the key directives as outlined in Appendix 10.

Eastern Cheshire CCG Integrated Diabetes Care

The aim of this service specification is to commission Integrated Diabetes Care for the population of Eastern Cheshire. The service will provide:

- High quality, cost effective care for adults aged 18 years and over including a smooth transition for young people aged 16 years to adult services
- Care as close to a person's home as is practical for people who are registered with a GP within Eastern Cheshire CCG
- Appropriate service components to be accessed 7 days a week (to be agreed with service providers during the procurement phase)
- Outcomes based on the standards, principles and ambitions of the Caring Together Transformation Programme

Service providers and suppliers will be required to work innovatively and collaboratively to ensure that care is joined up and focused on improving outcomes for people who are at risk of Diabetes or who have a diagnosis of Type 1 or Type 2 Diabetes

5.1 Specialist Integrated Diabetes Services (including STOPandGO)

The requirements of Specialist Integrated Diabetes Service are;

- Specialist Integrated Diabetes Services will provide care close to where a person is; Close to where a person is; at home, in hospital, in care home or community setting.
- Providing specialist diabetes care at Level 3 Complex Care will be provided at a GP Practice or Neighbourhood Team Community setting, which shall include a MDT

[21] http://stopandgoproject.eu/

'one stop shop' review for 'step up' care of people for crisis intervention or post admission follow up (Out Patient type clinic) and 'step down' to primary care for continuing care once stable.
- Specialist Diabetes Care to Primary Care/Neighbourhood Teams and Community at Level 2. Management of less complex diabetes care through virtual clinics, case study review at Neighbourhood MDT meetings, email or telephone access for specialist advice
- Specialist Integrated Diabetes Service will provide specialist clinical leadership across the Eastern Cheshire CCG's Integrated Diabetes Care Model. Collaborating and supporting primary care and the community based integrated teams to achieve the objectives, outcomes and key performance indicators
- Specialist Integrated Diabetes Services will comprise of a range of health care professionals and support workers who will provide additional support to Primary Care/Neighbourhood, Hospital Acute Care, Community Services, the Integrated Community Teams and STAIRRS to achieve the system-wide outcomes and cost savings.

5.1.1 Population Need

Diabetes Specialist Services will be organised to meet the specific needs of the population at a Neighbourhood Team level. Appendix 5 A/B outlines diabetes data at EC CCG and Neighbourhood Team level and includes data on prevalence, registered people who have diabetes and at risk groups, numbers of people at high, moderate and low risk of hospital admission and admission rates.

5.1.2 Referral Criteria

Referral will be direct from General Practitioner, Practice Nurse.

Providers are required to;
- Set out in the bid the process for referral into the service
- Set out a referral criteria to maximise outcomes and response time
- Set out equity of service to enable access and provision of suitable assistance for people or families and carers needs
- Set out equity of service to enable access and the provision of suitable assistance for people who are vulnerable and marginalised
- Develop a communication plan to ensure uptake of the service is maximised and 'did not attends' (DNA) are minimised
- Outline how referrals will be monitored and outcomes measured

5.1.3 Exclusion Criteria

Children and adolescents with Type 1 or Type 2 Diabetes, however young adults 16 years and above are included through smooth transition to adult services.

5.1.4 Outcomes

The service should support the delivery of Eastern Cheshire's Integrated Diabetes Care models overarching objectives. The provider/s shall provide activity and outcomes data that demonstrate how the individual components have contributed to Integrated Diabetes Care objectives and outcomes outlined in this specification.

A number of contractual outcomes have been identified in the ITT which can be refined and agreed as part of contracting process.

5.1.5 Workforce
The expectation is that the specialist team will include a range of care professionals including;

- Consultant Endocrinologists/Diabetologists
- Consultant Biochemists
- Diabetes Specialist Nurses (adult)
- Dieticians
- Ophthalmologists
- Podiatrists
- Link workers – Transition to adult services, complex care management

- The Provider must ensure that staff is employed in appropriate numbers and with the necessary skills, qualifications and competence to deliver the service
- The Provider is expected to demonstrate that employees' competencies and skill levels are in line with any national guidance and that these are assessed on a regular basis
- The Provider will be required to demonstrate how they ensure the maintenance and development of the relevant clinical skills of their staff
- Where staff is required to be registered with professional bodies it is the responsibility of the Provider to check compliance
- Ensure all staff new to the Service has an induction programme to ensure that they are familiar with policies and procedures
- All staff must be aware of the Clinical Commissioning Caring Together objectives and values and support the delivery of these within the service
- The Provider will undertake annual appraisals for its employees where it is the main employer

5.1.6 Implementation
There are 2 planned phases to the implementation of Integrated Diabetes Care, although this will be further informed and developed with the selected providers during contract negotiations.

5.1.7 Phase 1 – Commencing April 2016
- Appointment of Clinical Lead GP – Oversee implementation, chair project meetings, attend/chair Cheshire Diabetes Clinical Network Meetings
- Appointment of a Peoples Diabetes Champion to oversee implementation and to attend Cheshire Diabetes Clinical Network Meetings, Healthvoice meetings and Patient Participation Group (PPG) Meetings
- Implementation of Integrated Diabetes Specialist Service
- Community Services delivered as care at home or in the Community i.e. management of ambulatory care such as diabetes complications e.g. infected diabetes foot care, hypoglycemia, ketoacidosis where clinically appropriate

5.1.8 Phase 2 – Commencing April 2017
- Appointment of Peoples Diabetes Champion for each integrated community team
- Social Prescribing initiatives developed and implemented

- ‘One stop Diabetes information portal’ - an on line directory of services, advice and information portal linked to Cheshire East Council Citizens' Portal and CCG intranet
- Social Marketing Campaign
- Establishment of Diabetes Peer/support Groups for people with diabetes and their families or carer’s

5.2 Technology Enabled Care (including STOPandGO)

Eastern Cheshire CCG is procuring Integrated Diabetes Care that is enabled by a broad range of technologies that are tailored to each person’s needs, goals and situation. The technologies should range from everyday technology using applications to Telehealth monitoring for people with a range of complex needs. In addition we are looking for technology solutions that support integrated care by increasing communications and efficiencies in working between care providers and between people and services.

This component demonstrates Eastern Cheshire CCG’s commitment to implementing a large-scale adoption of innovative technology enabled solutions targeting people with Diabetes or pre-diabetes across all the levels of risk in our population. Figure 5 provides information on the population and indicates the range of technology support that should be provided.

More information on the EU STOPandGO project can be found in Appendix 6 and benefits which the STOPandGO will deliver can be found in Appendix 9.

5.2.1 Population Need

Technology will be part of the Integrated Diabetes Care System and available in all the levels of care within the system and therefore the population need is all adults with Diabetes or identified as pre-Diabetic.

Technology support will be offered to all adults with Diabetes or identified as pre-Diabetic as part of their “joined up” or integrated care and support. The focus of STOPandGO is on older people and technology will be offered to all those older adults with Diabetes, which in April 2015 were 5,859. The STOPandGO project requires a minimum of 1,250 older people to use technology as part of their integrated care and their daily lives.

5.2.2 Referral Criteria

People can be considered for technology support if they fulfil the following criteria:

- Registered with a GP in Eastern Cheshire
- Is over 18 years old or young adults 16 years and above for transition to adult services
- Person has consented to consider the use of technology in their daily lives
- Person has primary diagnosis of diabetes (Type 1 or Type 2) or pre-Diabetes

And must also fulfil **one or more** of the following criteria:

- have attended A&E, 1 or more times in the last 12 months
- have had 1 or more emergency unplanned admissions *for their condition* in the last 12 months

- are wishing to improve their symptom control due to poor compliance
- are wishing to improve their self-management and understanding of their condition
- require support for the optimisation/titration of new or existing medication
- are newly diagnosed or require additional support their self-management

Referrals are will be accepted into the service from all professionals involved in provided Integrated Diabetes Care including Integrated Community Teams, General Practitioners, Practice Nurses and staff in the Specialist Team.

5.2.3 Exclusion Criteria

Children and adolescents with Type 1 or Type 2 Diabetes, however young adults 16 years and above are included through smooth transition to adult services.

5.2.4 Outcomes

Technology will be an integrated part of Eastern Cheshire's Integrated Diabetes Care model and the provider needs to demonstrate how it supports the delivery of the model and the overarching objectives. The provider/s shall provide activity and outcomes data that demonstrate how the technology support has contributed to Integrated Diabetes Care objectives and outcomes outlined in this specification.

It is anticipated that technology will support people to be able to self-manage and take responsibility for their own health and wellbeing with the intention of reducing their reliance on services such as Accident and Emergency and hospital admissions. Eastern Cheshire CCG invites technology suppliers to work as collaboratively as partners with care providers to develop innovative approaches that deliver the following outcomes:

- Empower people to manage their health more effectively
- Provide community based care to enable people to live well and maintain/maximise their independence
- Reduce avoidable attendances, appointments and hospital admissions
- Address people's physical and mental health needs to ensure parity of esteem
- Support integrated working across multidisciplinary teams

A number of contractual outcomes have been identified in the ITT which can be refined and agreed as part of contracting process.

5.2.5 Implementation requirements and timings

5.2.5.1 Phase 1 – Commencing April 2016 – August 2016

Eastern Cheshire CCG wishes to implement technology enabled Integrated Diabetes Care as quickly as possible, particularly for the older adult population as the STOPandGO project concludes in April 2017. However it is recognised that a period of co-design and collaborative working is required in order to facilitate the delivery of Technology Enabled Care. To this end, it is expected that part of the first Quarter of the contract will be spent establishing the service including confirmation of the

clinical protocols and technologies that will be utilised respectively. The contract expects that the:

- Providing partnership identify ways to develop the service and improve care through the introduction of a innovative, flexible, tailored and dynamic menu of care

- Philosophy underpinning technology enabled care is outcome-based and cannot be delivered independently from Diabetes care and other care services in Eastern Cheshire.

5.2.5.2 Phase 2 – Commencing August 2016

Expansion of the delivery of technology enabled care to all adults with the requirement to achieve the STOPandGO requirements of 1,250 older people being supported by 31.3.17

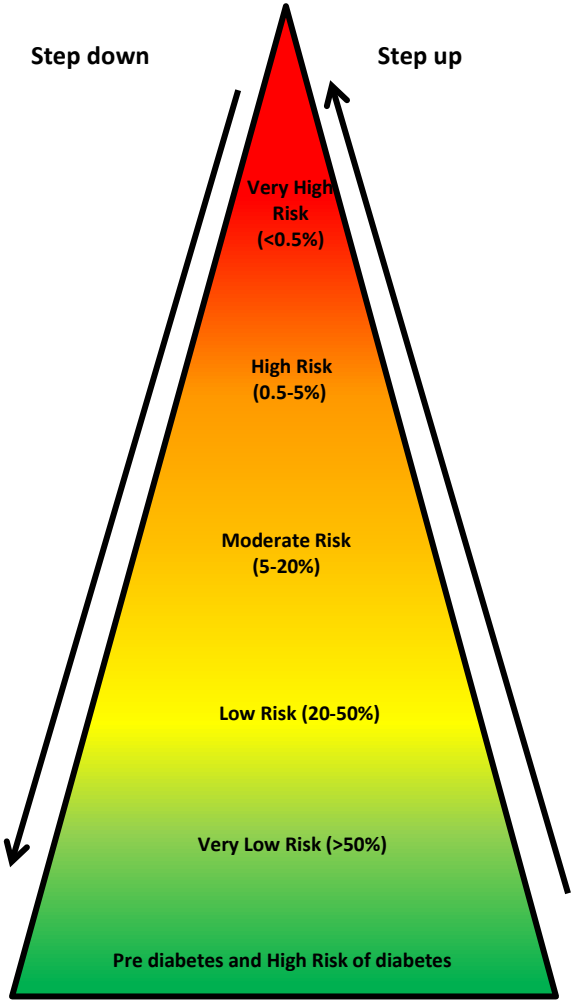
It is expected that by the close of the STOPandGO project in 31.3.17 the data provided will demonstrable evidence of the benefits of implementing the service (as defined by Eastern Cheshire CCG) will include:

- A reduction in people within the technology enabled care experiencing unplanned attendance or admission to hospital through early identification of any signs of deteriorating health
- Technology enabled care having had a positive impact on the care experience and quality of life of people with diabetes, their carer's and wider family – promoting independence, treating people as participants in their care and increasing person confidence in managing their condition, reducing anxiety and increasing person empowerment.
- Demonstrable evidence that the technology enabled care supports the promotion of the effective use of existing community resources and a positive staff experience

Section 5.9 outlines the reporting requirements and that providers and commissioners will agree baseline data and reporting requirements to support measurement of outcomes. This will support evaluation of service delivery as a whole and be part of reporting to Eastern Cheshire CCG and STOPandGO project.

Figure 5. Technology Enabled Levels of Care

These are the services to be provided to the population of Eastern Cheshire as part of Technology Enabled Care including STOPandGO under the Integrated Diabetes Care service. It is our aspiration to offer services to a minimum of 1250 people and the numbers below illustrate the services by type and target numbers per intervention in order to reach this aspiration.



Level 3: Population approximately 4,549

Telehealth Monitoring – The delivery of healthcare at a distance using electronic means of communication. This involves remotely monitoring objective data such as persons' vital signs, (e.g. oxygen saturation/BP/weight/HbA1c) and subjective data such as symptoms/knowledge/behaviour with continuous health-risk assessment via automated evidence based and validated question sets. Breaches of rule-sets for individual people and disease cohorts, set by healthcare professionals, triggers a timely intervention. This is also known as Telemonitoring.

Disease Specific Education – tailored and specific advice on the management of a diagnosed long term condition in order to better support self-management and overall condition control

Motivational Lifestyle / Health Coaching – a process that facilitates healthy, sustainable behaviour change by challenging users to improve their health and wellbeing through a structured educational programme or programmes which focus on the needs of the individual users. Example topics could include smoking cessation, managing weight, exercise, healthy eating etc.

Supported Discharge – aims at helping people to leave hospital more quickly and return to their own homes whilst continuing to be monitored (length of monitoring to be defined) in order to maximise independence as quickly as possible after being admitted

Applications that support health and wellbeing through self –management of health and wellbeing

Technology to support integrated working - virtual clinics, remote meetings

Level 2: Population approximately 4,412

Supported Discharge – as outlined in Level 3

Disease Specific Education – as outlined in Level 3

Motivational Lifestyle / Health Coaching – a process that facilitates healthy, sustainable behaviour change by challenging users to improve their health and wellbeing through a structured educational programme or programmes which focus on the needs of the individual users. Example topics could include smoking cessation, managing weight, exercise, healthy eating etc.

Applications that support health and wellbeing through self –management of health and wellbeing

Technology to support integrated working - virtual clinics, remote meetings

Level 1: Population approximately 24,560

Disease Specific Education – as outlined in Level 3

Motivational Lifestyle / Health Coaching – as outlined in Level 3

Applications that support health and wellbeing through self –management of health and wellbeing

Technology to support integrated working - virtual clinics, remote meetings

5.2.6. Principles of the technology enabled care

Eastern Cheshire CCG aims to implement technology enabled care based on the following principles:

- Procuring services enabled by technology
- Procuring based on outcomes
- Focussing on cultural changes e.g. integrated care and/or person empowerment and activation needed to tailor the services to individuals
- Provide the possibility to up-scale promising innovative solutions
- Provide continuous assessment, disease management and a proactive care approach
- Encourage empowerment supporting self-management

The service provider(s) should ensure that technology enabled care links to collaborative working, supporting multidisciplinary teams' decision making and enabling information sharing through correct governance to access to appropriate care.

It is intended that through technology enabled education and an appropriate menu of care, people will be able to self-manage and take ownership of their own health and wellbeing with the intention of reducing their reliance on more traditional point of care services such as Accident and Emergency.

Technology enabled care will be achieved through the following routes which are not exhaustive:

- Adapt the processes and train professionals towards user activation[22].
- Assure the availability of an adequate number of properly trained staff to deliver the service, including training, activating, installation, and monitoring of technology
- Assure the availability of fully trained facilitators, facilities and tools to support the sharing of experiences within communities of people and caregivers
- Produce and maintain material to support the management of the activities by people and carers
- Design a multi-channel distribution of the educational material and the practical instructions (e.g. via the portal of the organisation, through apps on mobile devices, by short videos on YouTube).

Generic requirements that technology and providers should:

- Improve the quality of life
- Improve people's knowledge through structured education and coaching
- Collaborate with other providers, people and carers to promote the "expert patient" approach
- Promote healthy behaviours and lifestyles
- Support self-care activities
- Improve people's independence in activities of daily living
- Involve families and carers, where agreed with the person receiving care

5.2.7 Service description/care pathway

The component is based on the management of the following service components which providers and suppliers are expected to deliver:

[22] http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/supporting-people-manage-health-patient-activation-may14.pdf

- Supply management
- Access to a contact centre
- Management of any links with other services and onward referrals
- Data reporting and training programmes for staff groups, people and carers

Eastern Cheshire CCG would not wish to identify any strict correlations between disease types or stage and particular interventions. The ability to provide 'menu of care' technologies to enable care professionals to provide varied responses based on individual user needs and preference and providers experience and opinion.

The expectation is for a high level of personalisation dependant on clinical judgement and the willingness and activation of each person.

5.2.8 Whole System Relationships

Services delivered must be interoperable with a range of existing information systems used by our local health providers, including the EMIS System used by general practice and community services, Cheshire Care Record, and hospital systems.

5.2.9 Key deliverables expected are as follows

- Technology supply management – equipment warehousing, delivery into people's home (where appropriate) including unloading, unpacking, installation and configuration of all equipment and software including wiring. Warranty cover that is responsive to need including replacement of consumables, regular maintenance and testing. Removal and decommissioning of equipment from people's home, to include re packing of equipment and putting people's home back to its original state if requested e.g. removal of wiring

- Access to a Contact Centre– a single point of contact that is responsible for; first contact and selection of the peoples' 'Menu of Care', technical support, clinical triage of alerts, one to one telephone consultations with clinical staff (e.g. follow ups and prescribing), motivational support specialists and the analysis and response to peoples' trend data. (Potential for 7 days a week service)

- Management of all interfaces between the technology-enabled care and other local provider services, including receipt of referrals into the service from Primary, Community and Secondary Care and onward referral of appropriate clients to other services

- Provision of agreed data sets for statistical/management reporting on the levels and quality of service delivery and Daily Person / User Trend and Outcomes

- Provision of training programmes to people, carers, health professionals, Contact Centre and Installation Personnel to include the production of materials

5.2.10 Days/Hours of operation

The service will provide an agreed level of service based on need:

- People must receive a response from the service to alerts 7 days per week, 365 days per year, for agreed pathways and parameters

The proposed route for people benefiting from this service is outlined below:

5.2.11 Care pathway

- Once a potential person has been identified, a health professional will evaluate if the person is suitable for the technology enabled care and gain consent from the person to be referred for technology support with a guide to the level and type of intervention required
- The expectation is that people identified Level 1 might be offered a “Light Touch” intervention such as Telecoaching, internet services and mobile technology applications
- People who are at Level 3 and are case managed are likely to benefit from a Telemonitoring approach, they will have their needs fully assessed by the health professional currently managing their care who will specify what needs to be monitored and put in place a care plan before referral
- In all cases the technology provider receives the clinical information/needs of the person and they decide what menu of care / equipment is the most suitable in discussion with the person and health professional

5.2.12 Response time and detail and prioritisation

The technology provider will include in their bid the response times for technology enable care for the different levels including urgent referrals to enable a person to continue living at home safely and for supported discharge.

5.2.13 Discharge Criteria and Planning

Where appropriate, discharge from the technology enabled care will be considered and communicated to the person at the point of commencement to the support. Each episode / menu of care will end when the condition of the person has been optimised or after a standard length of enrolment. At the end of the episode re assessment of person need will establish whether continuation of the current support, a move onto another menu of care or discharge from the service altogether is appropriate.

5.2.14 Interoperability requirements

5.2.14.1 General Interoperability

Eastern Cheshire CCG will ensure that health information systems work together within and across organisational boundaries in order to advance the effective delivery of healthcare of individual and communities through ensuring:

- That the privacy of people and the confidentiality of information provided by the tendered services is maintained
- That the CCG works within it’s the legal framework about data exchange and protection

5.2.14.2 Legal Interoperability

Eastern Cheshire CCG will ensure that the assimilation of standards and regulations regarding medical systems and treatment of personal information is a key point in designing a robust and reliable solution for ensuring the ethical and deontological underlying aspects compliance in the health and social care provision services by telematics ensuring that:

- The adoption of the Directives 95/46/EC and 2002/58/CE
- That there will be a mechanism to update the data when it is necessary

- That the service provider must take the necessary appropriate technical and organizational measures to preserve the security of data
- That the service provider supplies the tools to ensure confidentiality of data.
- That the service provider must guarantee the appropriate system safety
- That if there is risk of security violation customers should be informed by the provider of the electronic communications service. The confidentiality of traffic data through public networks should be guaranteed. The responsibility of the service provider in case of data leaks should be clearly defined

5.2.14.3 Organisational Interoperability

Eastern Cheshire CCG will ensure that that all organisations delivering services as part of the Integrated Diabetes Care will share a common environment to develop their activity correctly as outlined in EN ISO 13940. The consecution of that environment is enabled by the use of a common set of concepts that permits the interchange of information and knowledge having the certainty that the receiver understands the same as the transmitter. The EN ISO 13940 standard is necessary to use in all documentation as it defines a set of concepts to give support to continuity of care, in a way such that all the concepts appearing in the documentation generated by the process have the meaning specified in the standard. The table in Appendix 1.

5.2.14.4 Semantic Interoperability

Eastern Cheshire will ensure that systems are able to export information which can be stored in common repositories and that willing systems can read it preserving all its original meaning and context. The necessity of keeping the information in a standardised way for being accessible for others, or secondary use, is an obligation of all parties involved in the delivery of this component.
In relation to semantic interoperability, Eastern Cheshire CCG will ensure that each procurer can choose between the following strategies:

1) Integrating the 13606 information provided by the procured services
2) Ask for a development in the tenders to adapt the normalized information provided by the procured services to their own systems
3) For a specific development to adapt the procured services to their own systems, independently of the normalised information provided.

Therefore with reference to data exchange schema and standards, Eastern Cheshire CCG requires adherence to all relevant standards and protocols.

5.2.14.5 Technical Interoperability

Eastern Cheshire CCG will ensure that technical interoperability will be in line with the decision made about semantic interoperability. The overall aim is that the solution procured offers the ability of two or more systems or elements to exchange information and to use the information that has been exchanged, e.g. via the implementation of the extracts in XML compliant with the XML-Schema published by the EN 13606 Association or via any other.

With reference to inclusion, it is proposed that all providers and suppliers both large and small come together to form partnerships to deliver parts or the whole Integrated Diabetes Care Service solution.

5.2.14.6 Legislative Compliance

With reference to legislative compliance, this procurement exercise adheres to the: -

- Directive 2014/23/EU on the award of concession contracts
- Directive 2014/24/EU Directive 2014/25/EU
- Directive 2014/25/EU
- Directive 95/46/EC
- Directive 2002/58/CE

Where the new laws have not been adopted, this procurement exercise will adhere to the:

- 'Classic' Procurement Directive 2004/18/EC
- 'Utilities' Procurement Directive 2004/17/EC

Other directives to be considered can be found in Appendix 10.

5.3 Diabetes Education for people with Type1 or Type 2 Diabetes, Carer's and Families including STOPandGO

The requirements of Diabetes Structured Education are to:

- Provide high quality affordable diabetes education that meets national (NICE) and local standards and guidance
- Providing equitable access and reduce inequalities, ensuring people are treated with dignity and respect and fully informed about their care, working in partnership with local care professionals
- Promote healthy lifestyle, including psychological and mental wellbeing
- Enable people who have Type 1 or Type 2 Diabetes and their families or carers to work together with the required support to achieve their lifestyle goals
- Develop the necessary confidence and skills to feel empowered to take responsibility for their own health and wellbeing
- Empower people with diabetes can make informed decisions about their lifestyle choices, aware of the risks of diabetes and importance of good glycaemic control

5.3.1 National Context

The National Institute for Health and Care Excellence (NICE), Diabetes in adults quality standard 1 (2011) states: "People with diabetes and/or their carer's should receive a structured educational programme that fulfils the nationally agreed criteria from the time of diagnosis, with annual review and access to ongoing education." The National Service Framework. NICE Clinical Guidelines (CG66, CG87) endorse five standards for structured education programme see www.nice.org.uk/guidance/qs6/chapter/quality-statement-1-structured-education

5.3.2 Local Context

Eastern Cheshire CCG has empowerment at the centre of the integrated care model and highlights; "Everything we do will seek to empower people to take responsibility for their own health" and "People will be supported to self-care. This will involve the use of web – based resources, disease specific or lifestyle education and public health programmes".

5.3.3 Population Need

To provide high quality structured diabetes education for adults (18 years +) who are registered at a GP practice in Eastern Cheshire. Education to be provided to individuals or groups as appropriate;

- People who are newly diagnosed Type 1 diabetes
  Approximately 50 people annually would be eligible
- People who are newly diagnosed Type 2 diabetes
  Approximately 500 people annually would be eligible
- People who have established Type 1 diabetes, who would benefit from participation in structured education
    - Eligibility would include people who are having difficulty self-managing and control of their diabetes resulting in frequent attendance at health care services
- People who have established Type 2 diabetes, who would benefit from participation in structured education
    - Eligibility would include people who are having difficulty self-managing and control of their diabetes resulting in frequent attendance at health care services
- Families and Carers of people who have Type 1 or Type 2 Diabetes who would benefit from participation in structured education as above

5.3.4 Referral Criteria

Referral will be direct from General Practitioners and Practice Nurses.

- Provider will set out in the bid the process for referral into the service
- Provider will set out al referral criteria to maximise outcomes
- Provider shall set out equity of service to enable access and provision of suitable assistance for people or families and carers needs.
- Communication plan to ensure uptake is maximised and did not attends (DNA) are minimised
- Provider shall outline how the service will be audited and outcomes measured

5.3.5 Exclusion Criteria

Children and adolescents with Type 1 or Type 2 Diabetes

5.3.6 Outcomes

The service should support the delivery of Eastern Cheshire's Integrated Diabetes Care models overarching objectives. The provider/s shall provide activity and outcomes data that demonstrate how the diabetes education programme has contributed to Integrated Diabetes Care objectives and outcomes.

A number of contractual outcomes have been identified in the ITT which can be refined and agreed as part of contracting process.

5.3.7 Workforce

- The Provider must ensure that staff is employed in appropriate numbers and with the necessary skills, qualifications and competence to deliver the service
- The Provider is expected to demonstrate that employees' competencies and skill levels are in line with any national guidance and that these are assessed on a regular basis
- The Provider will be required to demonstrate how they ensure the maintenance and development of the relevant clinical skills of their staff
- Where staff is required to be registered with professional bodies it is the responsibility of the Provider to check compliance

- Ensure all staff new to the Service has an induction programme to ensure that they are familiar with policies and procedures
- All staff must be aware of the Clinical Commissioning Caring Together objectives and values and support the delivery of these within the service
- The Provider will undertake annual appraisals for its employees where it is the main employer

6 Implementation of Integrated Diabetes Care

Commencing July 2016

7 Population Covered

The service will cover all people registered at a GP practice in Eastern Cheshire CCG

8 Interdependencies of Integrated Diabetes Care with other services/providers

The providers and suppliers shall ensure that they work collaboratively to maintain continuity of care, through information sharing with the following organisations; (this is not an exhaustive list)

- GP Practices and Neighbourhood Teams
- Proactive Care Co-Ordinators and Wellbeing Co-Ordinators
- Secondary Care Services including Specialist Centres
- Health and Social Care Community Services including Integrated Community Teams and STAIRRS
- Maternity Services
- Public Health – Health and Wellbeing Boards
- 3rd Sector and Voluntary Sector Organisations
- Technology Suppliers
- Care and Residential Homes
- Health and Social Care Commissioners
- Medicines Management and Neighbourhood Integration Medicines Optimisation Team (NIMO)
- Diabetes and Age UK
- Community Pharmacists
- Patient Participation Leads – Health Watch and Health Voice
- People with Diabetes, their families and carers
- Cheshire and Merseyside and Cheshire Diabetes Network
- Single Point of Access
- GP Out of Hours Service
- NWAS 999 and 111 Services -
- Improving access to psychological services (IAPT)
- Proactive Care and Wellbeing Co-ordinators
- Care Co-ordinators
- Podiatry, Dietetics, Retinal Screening, Tissue Viability.
- Ambulatory Care Service

9 Integrated Diabetes Care Outcomes – Including Monitoring and Reporting

The outcomes for Integrated Diabetes Care are outlined in section 4.3 (see figure 3 and figure 4) have been developed by the Eastern Cheshire Integrated Diabetes Care project team, through workshops and project meetings

- The overarching outcomes are applicable to all 3 levels of care
- High level outcomes for Level 1
- High level outcomes for Level 2
- High level outcomes for Level 3
- High level outcomes for people who experience a crisis at Level 2 or 3

The outcomes for Level 1 – 3 are not repeated and may apply to more than one level. Providers and commissioners will agree baseline data and reporting requirements to support measurement of outcomes. This will support evaluation of service delivery as a whole and be part of reporting to Eastern Cheshire CCG and STOPandGO project.

10 Applicable Standards Requirements

10.1 Applicable Standards set out in guidance and or issued by a competent body (e.g. Royal Colleges)

- Royal College of Physicians
- Royal College of Nursing
- GMC guidelines
- NMC guidelines

10.2 Applicable National Standards (e.g. NICE)

The service shall meet the National Standards within the following;

- NICE quality standards for Diabetes QS6 (2011)
- NICE Quality Outcomes Framework for Diabetes
- All NICE Guidelines Diabetes (2011 – 2015)
- All NICE Guidelines Mental Health (2014 – 2015)
- Diabetic retinopathy guidelines (2012)
- Advancing Quality Measures for Diabetes http://www.advancingqualitynw.nhs.uk/condition/diabetes/

10.3 Applicable local standards

- Caring Together Integrated Care Ambitions Standards and Outcomes Framework 2015/16
- Local Diabetes Guidance (2012) CECPCT – Updated DRAFT 2015
- CEC Medicines Management Team – Guidelines (2015)
- Joint Strategic Needs Assessment
- Director of Public Health Annual Report
- Foot Check - Standards and Local Guidance re CECPCT (2012)

10.4 Relevant Publications

- NHS Diabetes Commissioning without Walls (2009)
- NHS Atlas of variation in healthcare for diabetes (2012)

- NHS Commissioning Excellence in Diabetes (2012)
- Our Health, Our Care, Our Say (2006)
- NHS Confederation Healthy Mind, Healthy Body (2009)

10.5 Further Guidance and Information

- The National Service Framework for Diabetes (2001)
- Diabetes Quality Indicators (2011) Yorkshire and Humber Observatory
- The National Diabetes Audit (2014/15)
- National Pregnancy in Diabetes Audit. England, Wales and Isle of Man 2014
- NHS Diabetes Commissioning without Walls (2009)
- Minding the Gap: The provision of psychological support and care for people with diabetes in the UK – A report from Diabetes UK
- Emotional and Psychological Support and Care in Diabetes: a report by Diabetes UK
- Think Glucose – NHS Institute for innovation and improvement
- NHS Atlas of variation in healthcare for diabetes (2012)
- NHS Commissioning Excellence in Diabetes (2012)
- Our Health, Our Care, Our Say (2006)
- NHS Confederation Healthy Mind, Healthy Body (2009)
- NICE Technology Appraisals (2002 – 2014)

11 Applicable Quality Requirements

Providers shall audit the impact on people's quality of life, experience of service and diabetes outcomes through use of PROMs, PREMS and QOL assessment tools;
For example:
National Diabetes Audit
SF-36
EQ-5D
ADD QOL

12 Information Governance

- The Provider is required to comply with all IT and information governance standards and requirements
- All documentation made must be in accordance with the organisation's policies and good practice to ensure they are accurate, contemporaneous and legible
- The Provider IT equipment must meet the standard policy on confidentiality and also be compliant with N3

13 Risk Management

- Comply with appropriate statutory regulations (including, but not limited to Data Protection Act, Health and Safety at Work Act, COSHH Regulations)
- Actively promote an Open Culture of incident reporting and risk awareness among all staff
- Implement Eastern Cheshire CCG incident reporting policy and ensure that all incident and near misses are reported in line with the CCG's policy

- Participate and co-operate in incident investigations as appropriate
- Have a robust system in place whereby families, other professionals and the public can raise concerns about the quality of care and have adequate arrangements in place for the investigation of such concerns
- Have robust evidence based policies, procedures, guidelines and standard operating procedures in place for staff to follow in delivering the service
- Ensure that the service complies with the NHS Litigation Authority Risk Management Standards and the Care Quality Commission Healthcare Regulations 2010
- Provide information in relation to risk assessments undertaken, incidents and complaints

14 Location of Provider Premises

The providers shall have a centralised point of contact. Localised access to the services across Eastern Cheshire CCG shall be aligned to the 6 Integrated Community Teams or Neighbourhood Geographies to ensure people are easily able to attend the service for MDT (one stop shop) clinical review.

Appendices

APPENDIX 1: Caring Together Vision, Values, Principles and Ambitions

Caring Together

All care organisations in Eastern Cheshire have agreed to work together to drive forward the development of integrated care across the health and social care system, to ensure we have a sustainable care system that meets with needs of local people within the available resources. Caring Together commenced in 2012 and members of the public, local politicians, representatives of local health, social care commissioners and providers have all been involved in the co-design of the programme.

All health and social care services commissioned for the population of Eastern Cheshire from April 2015 onwards will be part of this programme and providers are expected to work together to deliver care in line with the programme vision, values, principles and behaviours.

The vision for the Caring Together programme is:

‘ C a r i n g T o g e t h e r ’

Joining up local care for all our wellbeing

For the public it means:

‘I am supported to live well and stay well because I can access joined up care and support when I need it’

For the organisations involved in commissioning and providing care this means,

‘Supporting our customers to live well, by enabling them to access joined up care when it is needed we support them to stay well’?

People from Eastern Cheshire developed Quality Standard Statement which includes the following statements:

The Caring Together programme will…

- Enable me to be actively involved in decisions about my care
- Ensure that I am supported by care staff to make fully informed choices about my care
- Help me to access effective and helpful joined up care and support when I need it

As a carer …

- I can balance my caring roles and maintain my physical, mental and emotional wellbeing
- I am valued, involved and informed throughout the care process

The Caring Together programme means…

- I will receive the highest quality care regardless of the time of day or day of the week
- I will receive assessment and recommendations for care based on current best practice

Values:
To empower people and carer's, promote collaborate working and encourage Innovation:

- Promoting self-care and management, health promotion, education and individual
- responsibility where appropriate, and for care workers and people and their carer's
- to work together with access to the required support and facilities to make this
- happen
- Ensuring collaborative working between health and social care workers and
- colleagues in private, voluntary and third sector to meet the needs of people, and
- respecting the needs of staff to achieve this
- Promote innovation, and encouraging new ideas from local people, carer's and staff

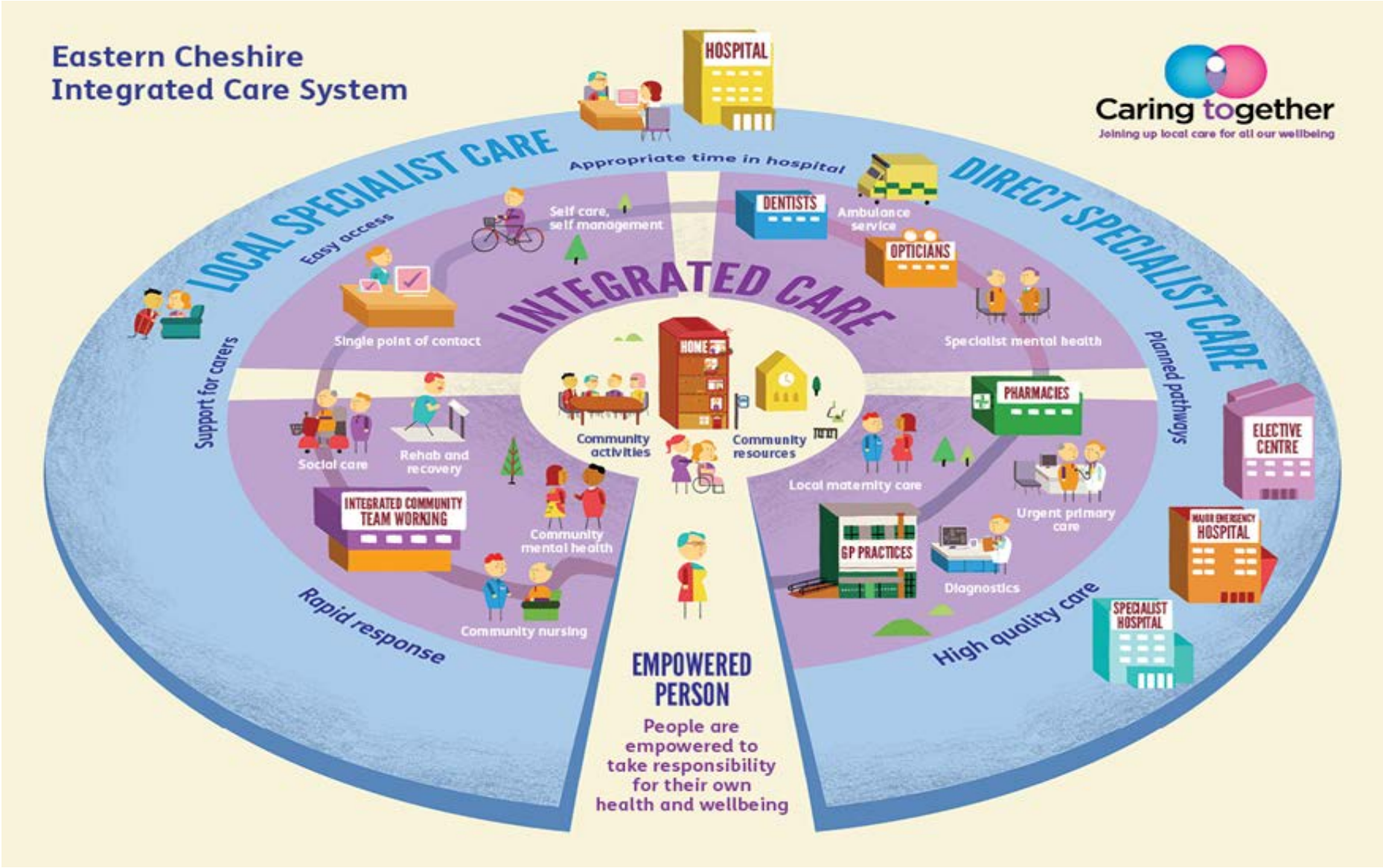
Caring Together Principles

- Be organized around the needs of individuals (person centered)
- Focus always on the goal of benefiting service users
- Be evaluated by its outcomes, especially those which people themselves report
- Include community and voluntary sector contributions
- Be fully inclusive of all communities in the locality
- Be designed together with the users of services and their carer's
- Deliver a new deal for people with long term conditions
- Respond to carer's as well as the people they are caring for
- Be driven forwards by the commissioners
- Be encouraged through incentives
- Aim to achieve public and social value, not just to save money
- Last over time and be allowed to experiment

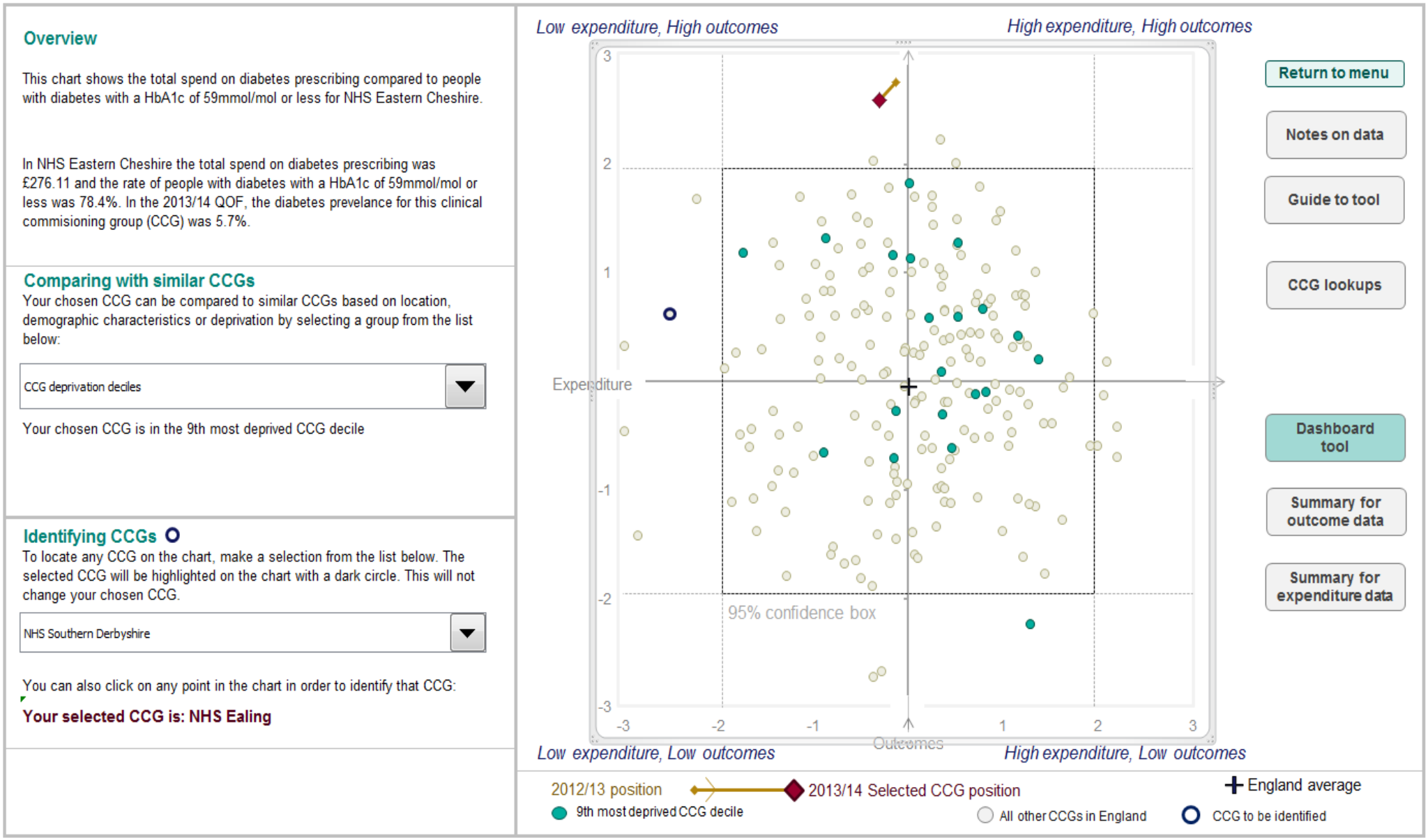
Caring Together Ambitions:

- **Integrated Care** – Staff working together with the person at the center to proactive manage long term physical and mental health conditions
- **High Quality Care** – The highest quality care delivered by the right person regardless of the time of day or day of the week
- **Support for Carer's** – Carer's are valued and supported
- **Easy Access** – Access that is designed to deliver high quality, responsive services and information
- **Appropriate time in hospital** – Appropriate time in hospital, with prompt discharge into well organised community care
- **Rapid Response** – A prompt response to urgent needs to that fewer people need to access urgent and emergency hospital care
- **Planned Pathways** – Simplified planned care pathways delivered as locally as possible

APPENDIX 2: Eastern Cheshire Integrated Care System



APPENDIX 3: Eastern Cheshire Diabetes Outcomes versus Expenditure (DOVE) Tool



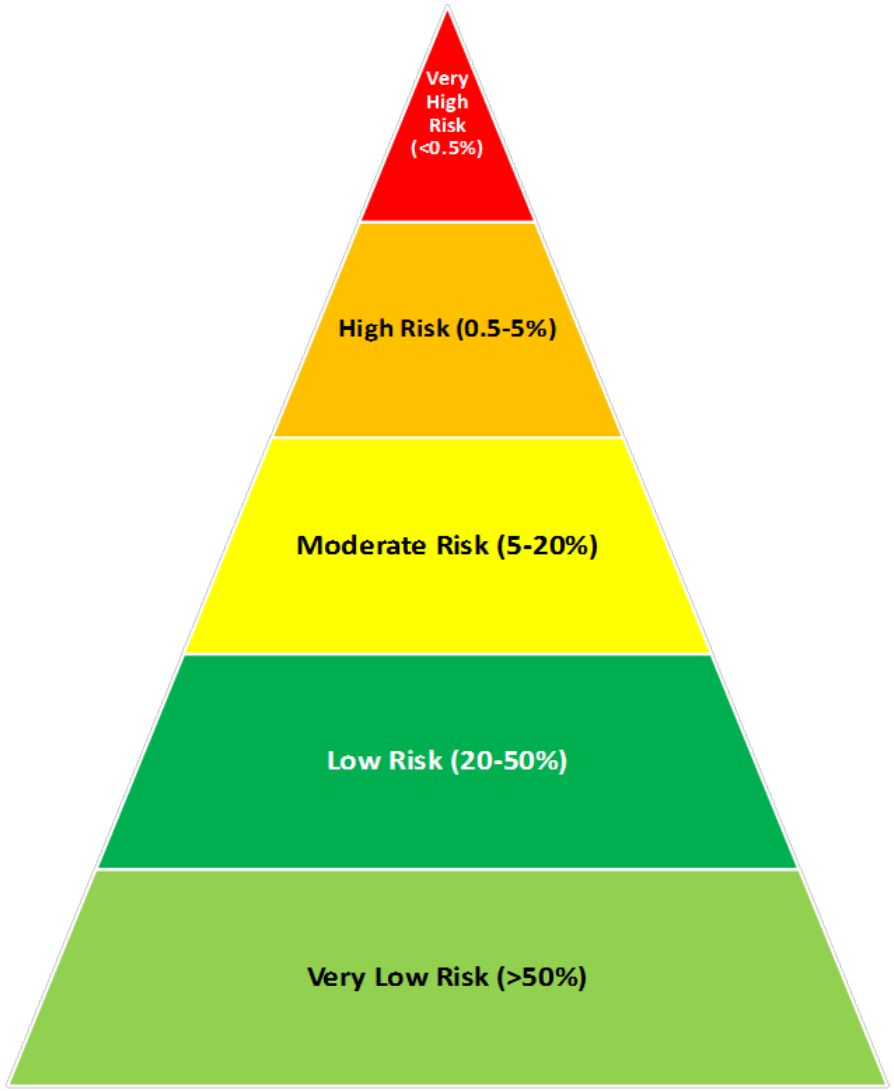
APPENDIX 4: Risk Stratification Data and Proactive Care Co-ordination in Eastern Cheshire

Eastern Cheshire uses a combined predictive risk stratification tool, to identify people who are at risk of an unplanned admission in the next 12 months. This calculation is based on their previous use of health care resources. GP practices use the data to identify people at high risk of admission and take a proactive approach to personalised care. People who are identified as high risk are assigned a Care Co-coordinator, who works under the leadership of the GP or Specialist.

The Care Co-coordinator completes a proactive care plan with the person and where appropriate carer or family member. The proactive care plan includes information to support crisis management to avoid unplanned admission. The information and advice may include understanding symptoms of hypoglycemia, hyperglycaemia, blood and ketone testing and monitoring, following an insulin regime or carbohydrate guidance, a single point of access number and when to call 999 or go to A&E.

The Risk Stratification Tool can also support providers and commissioners to plan services to target specific needs at practice, neighbourhood and CCG level.

APPENDIX 5A : Eastern Cheshire Risk Stratification Data at EC CCG and Neighbourhood Team Level



Risk Stratified Population - April 15	Age Band	Total Popn In Age Band	Number of Patients, by Age Band, categorised as having DIABETES: CHAW	CHC	PDB	KNUT	MACC	ECCCG
997	0-19	53	1	0	0	0	1	2
	20-39	44	2	1	0	0	0	3
	40-54	102	1	2	4	2	15	24
	55-64	61	6	0	2	2	7	17
	65-74	124	19	10	6	5	8	48
	75-84	252	12	15	17	16	26	86
	85+	361	0	8	16	14	31	69
	Total:	997	41	36	45	39	88	249
8,973	0-19	393	2	0	0	0	9	11
	20-39	336	2	3	4	3	14	26
	40-54	517	23	11	5	3	42	84
	55-64	629	23	33	24	19	73	172
	65-74	1,408	84	71	66	42	159	422
	75-84	2,915	157	146	131	116	238	788
	85+	2,775	91	84	81	71	179	506
	Total:	8,973	382	348	311	254	714	2,009
29,924	0-19	4,324	12	10	11	6	17	56
	20-39	2,268	11	13	13	6	49	92
	40-54	3,164	76	94	53	34	197	454
	55-64	3,474	125	148	107	74	264	718
	65-74	7,077	271	320	238	163	483	1,475
	75-84	7,052	200	295	181	164	371	1,211
	85+	2,565	52	82	52	28	71	285
	Total:	29,924	747	962	655	475	1,452	4,291
	Top 20%:	39,894	1,170	1,346	1,011	768	2,254	6,549
60,038	0-19	20,739	8	9	4	1	15	37
	20-39	9,282	34	28	31	15	64	172
	40-54	9,257	108	134	90	48	185	565
	55-64	7,797	124	195	130	70	225	744
	65-74	9,241	123	253	101	83	166	726
	75-84	3,248	30	55	20	25	29	159
	85+	474	2	3	2	1	1	9
	Total:	60,038	429	677	378	243	685	2,412
99,508	0-19	17,141	1	0	0	1	0	2
	20-39	30,794	6	18	2	9	23	58
	40-54	32,686	45	99	26	28	59	257
	55-64	13,185	24	64	18	27	38	171
	65-74	5,179	11	37	12	6	8	74
	75-84	523	0	0	0	0	1	1
	85+	0	0	0	0	0	0	0
	Total:	99,508	87	218	58	71	129	563
	Grand Totals	199,440	1,686	2,241	1,447	1,082	3,068	9,524

Appendix 5B: Eastern Cheshire CCG Neighbourhood Team Data for Diabetes Care
Note that the new Neighbourhood Team geography is split into 6 Teams – Macclesfield is split into 2 teams

PEER GROUP	Number with Diabetes	Prevalence	Obesity (2013/14 QOF)	Obesity (2014/15 QOF)	Obesity Prevalence (2013/14 QOF)	Obesity Prevalence (2014/15 QOF)	People High Risk Score	People Medium Risk Score	People Low Risk Score	14/15 Unplanned Admissions	14/15 Unplanned Admissions /1000 weighted popn
MACC	3,104	5.08%	3,944	3,651	6.45%	5.98%	784	1,456	864	212	2.98
CHC	2,248	5.22%	3,182	3,176	7.43%	7.38%	461	1,060	727	106	2.36
CHAW	1,689	3.70%	2,192	2,089	4.86%	4.58%	394	753	542	88	2.02
BDP	1,440	4.34%	1,623	1,546	4.89%	4.66%	334	649	457	63	1.86
KNUTS	1,085	4.79%	1,785	1,567	12.64%	6.91%	283	474	328	40	1.63
ECCCG	**9,566**	**4.66%**	**12,726**	**12,029**	**6.21%**	**5.86%**	**2,256**	**4,392**	**2,918**	**509**	**2.33**
England		*5.13%*			*7.69%*	*7.37%*					

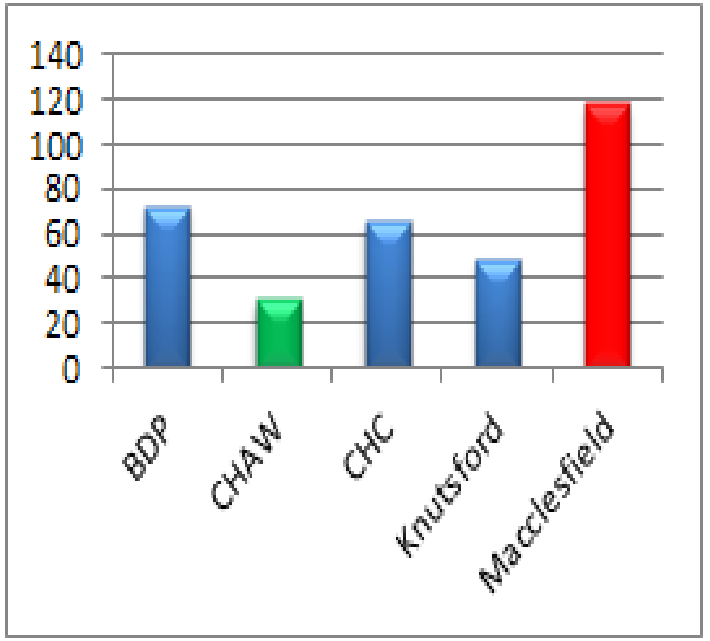
T1+T2 From April 2015 Risk Stratification

Primary or 1st Secondary ICD10 code for Diabetes

A&E Attendances - Diabetes

Baseline data (2014/15 data has been used)

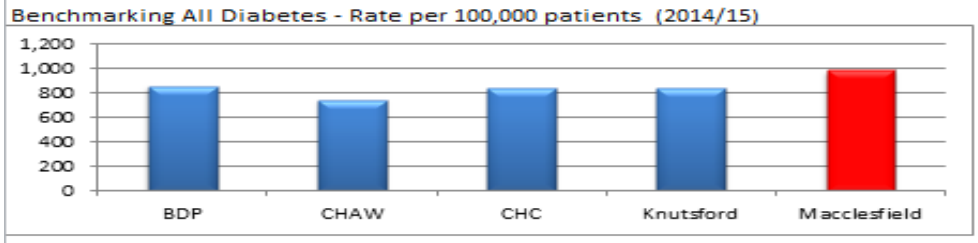
Peer Group	Actual	Population	Rate per 100,000 patients
BDP	24	33,216	72
CHAW	14	45,591	31
CHC	28	43,036	65
Knutsford	11	22,668	49
Macclesfield	72	61,050	118
Eastern Cheshire CCG	149	205,561	72

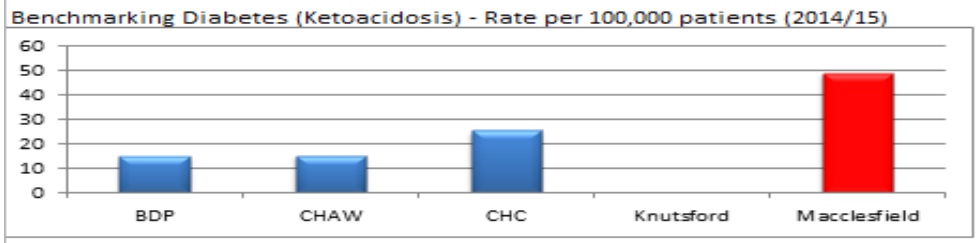


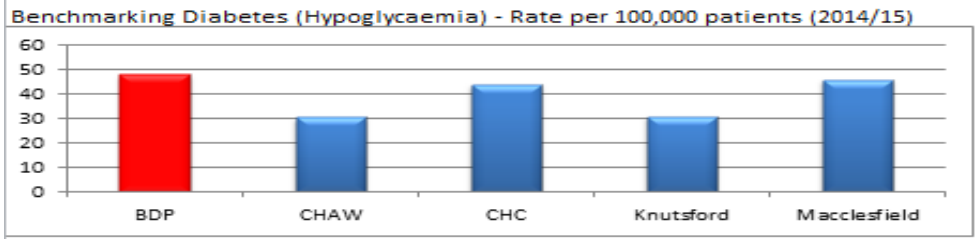
Emergency Admissions

Baseline data (2014/15 data has been used)

Peer Group	Emergency Admissions - All Diabetes	Emergency Admissions - Diabetes (Ketoacidosis)	Emergency Admissions - Diabetes (Hypoglycaemia)	Population	All Diabetes - Rate per 100,000 patients	Diabetes (Ketoacidosis) - Rate per 100,000 patients	Diabetes (Hypoglycaemia) - Rate per 100,000 patients
BDP	285	5	16	33,216	858	15	48
CHAW	338	7	14	45,591	741	15	31
CHC	359	11	19	43,036	834	26	44
Knutsford	189	0	7	22,668	834	0	31
Macclesfield	603	30	28	61,050	988	49	46
Eastern Cheshire CCG	1,774	53	84	205,561	863	26	41



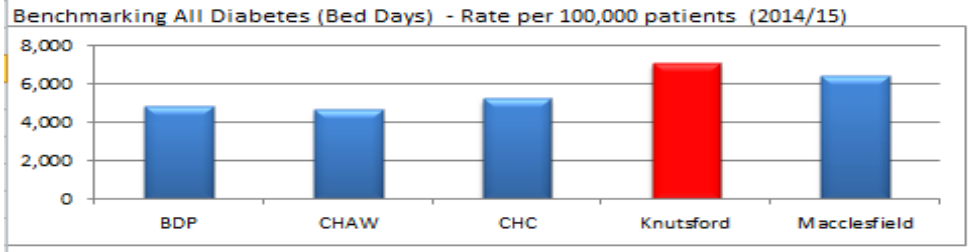


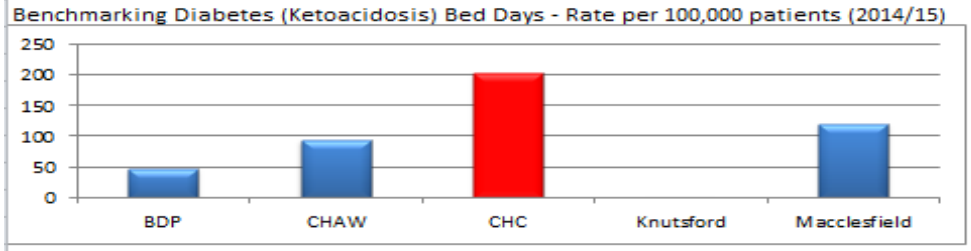


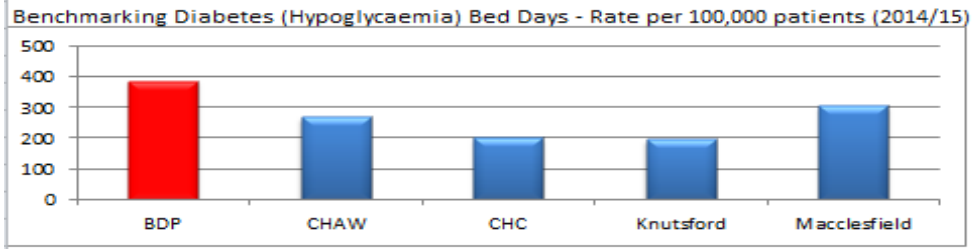
Bed Days – Diabetes

Baseline data (2014/15 data has been used)

Peer Group	Emergency Admissions - All Diabetes	Emergency Admissions - Diabetes (Ketoacidosis)	Emergency Admissions - Diabetes (Hypoglycaemia)	Population	All Diabetes - Rate per 100,000 patients	Diabetes (Ketoacidosis) - Rate per 100,000 patients	Diabetes (Hypoglycaemia) - Rate per 100,000 patients
BDP	1,620	16	129	33,216	4,877	48	388
CHAW	2,116	43	123	45,591	4,641	94	270
CHC	2,265	88	87	43,036	5,263	204	202
Knutsford	1,607	0	45	22,668	7,089	0	199
Macclesfield	3,953	74	187	61,050	6,475	121	306
Eastern Cheshire CCG	11,561	221	571	205,561	5,624	108	278



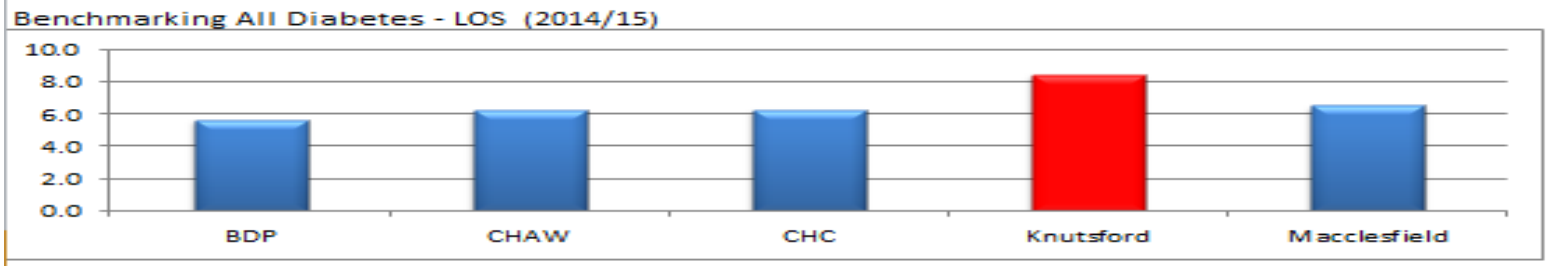


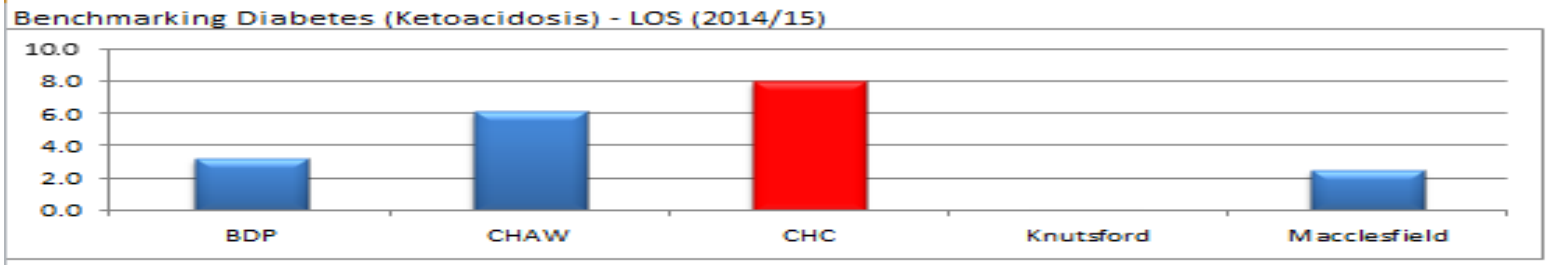


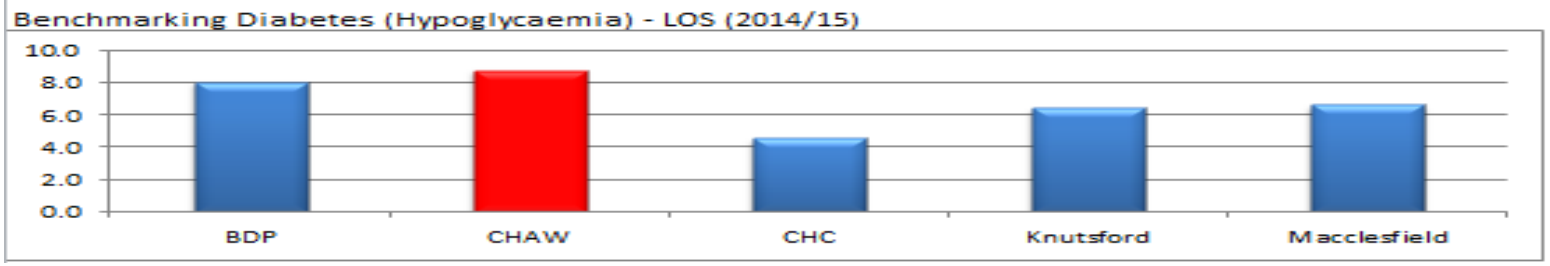
Length of Stay - Diabetes

Baseline data (2014/15 data has been used)

Peer Group	LOS - All Diabetes	LOS - Diabetes (Ketoacidosis)	LOS - Diabetes (Hypoglycaemia)
BDP	5.7	3.2	8.1
CHAW	6.3	6.1	8.8
CHC	6.3	8.0	4.6
Knutsford	8.5	0.0	6.4
Macclesfield	6.6	2.5	6.7
Eastern Cheshire CCG	6.5	4.2	6.8







APPENDIX 6: STOPandGO Project

European Context to STOPandGO

The European Sustainable Technology for Older People – Get Organised (STOPandGO) Project, a three year project, was established to support the European priority of supporting innovative solutions and purchasing health care to ensure cost effective care and enhanced wellbeing for the aging population. Eastern Cheshire CCG is a core partner in this project, committed to procuring innovative technology at scale in order to help meet the objectives laid out by the EU. Further details on the European and National context of the STOPandGO Project can be found by the following links: **https://www.easterncheshireccg.nhs.uk/About-Us/stopandgo.htm** and **www.stopandgoproject.eu**

There are four UK based partners involved in the European STOPandGO Project: The UK partners are working together with all European partners to support best practice procurement of technology enabled care. UK based Partners are;

- Eastern Cheshire Clinical Commissioning Group
- North West Coast Academic Health Science Network
- Telecare Services Association
- Knowledge Transfer Network.

Eastern Cheshire CCG

Eastern Cheshire CCG's primary role is overseeing the procurement exercise of this project and to ensure that all organisations which have been successful in securing a contract and deliver all outcomes expected for the target population. Further information on the CCG can found at: **https://www.eastcheshireccg.nhs.uk/**

North West Coast Academic Health Science Network

The North West Coast Academic Health Science Network's objective is to create an environment where innovation and best practice can be diffused at pace and scale, across healthcare systems to people and population, NHS, as well as industry and the economy at large. The organisation has a commercial role and provides advice to industry and SMEs on NHS engagement. The NWCAHSN provides generic advice across the STOPandGO Project in particular for procurement activities. Further information on NWCAHSN can be found at www.nwcahsn.nhs.uk

Telecare Services Association

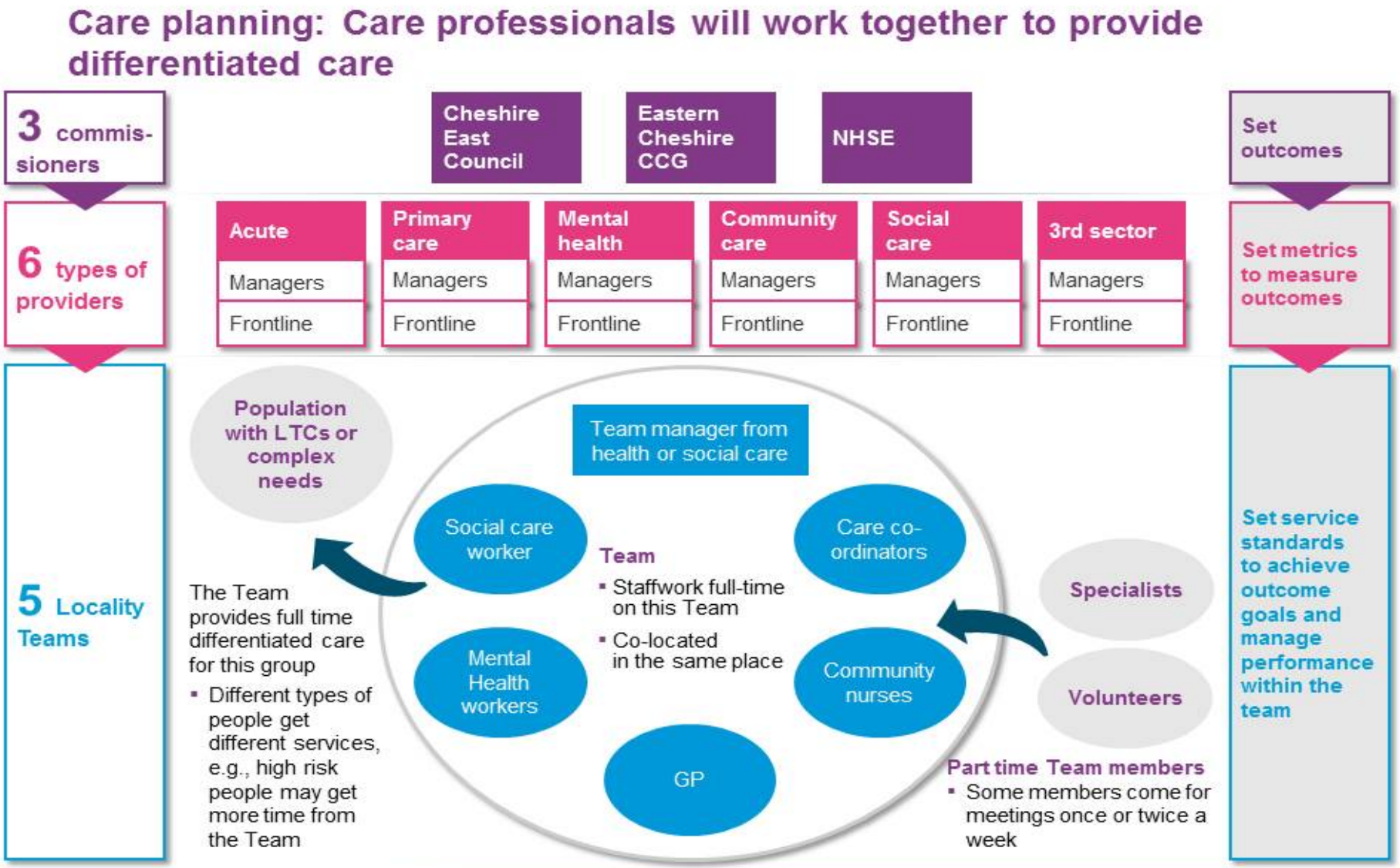
Telecare Services Association (TSA) is the industry body for telecare and telehealth, and the largest industry specific network in Europe. TSA promotes and supports the telecare and telehealth industry, highlighting the benefits of telecare and telehealth for commissioners across health and social care, service users, their family and carers. Further information on TSA can be found at www.telecare.org.uk

The Knowledge Transfer Network

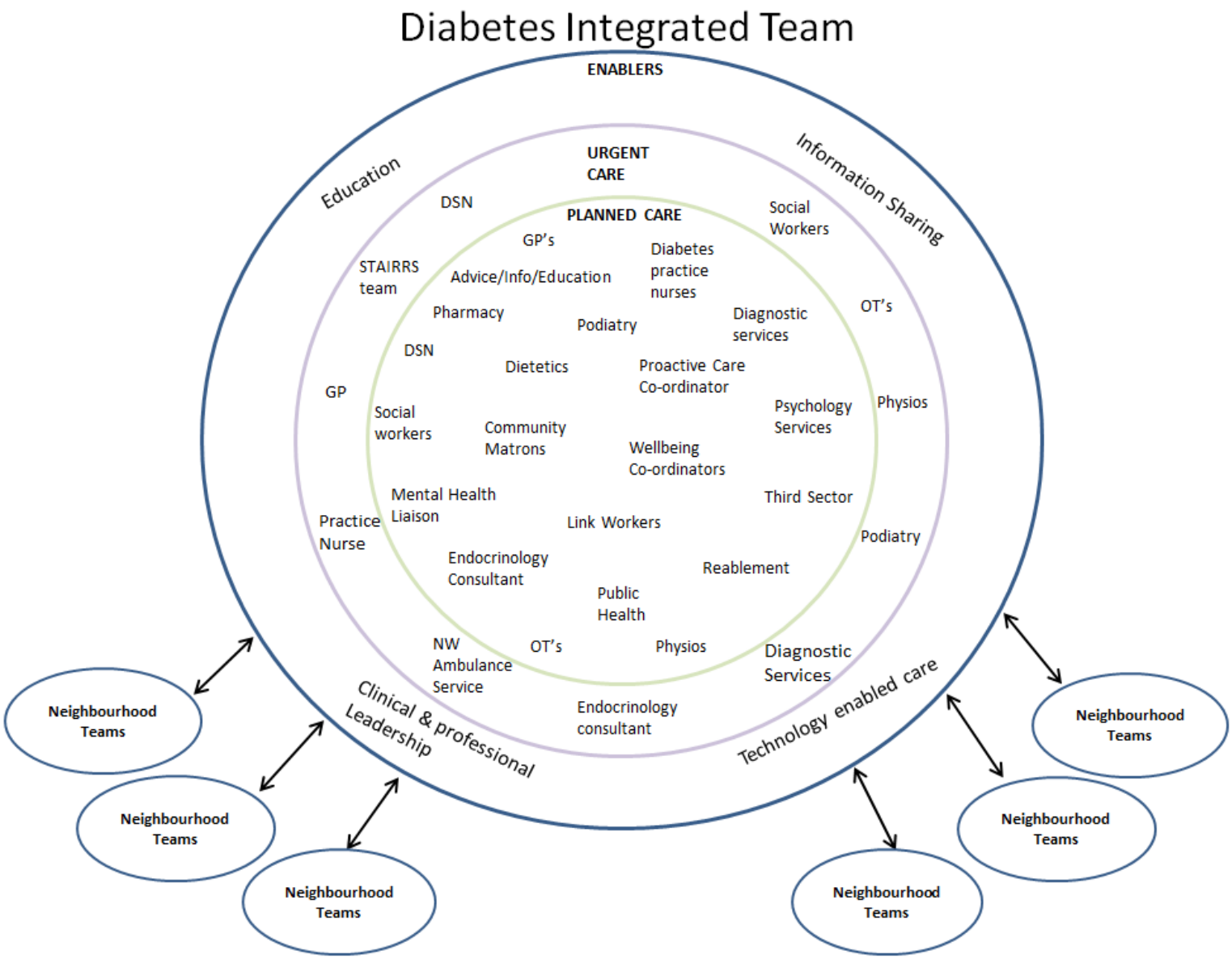
The Knowledge Transfer Network is the lead dissemination partner in the STOPandGO Project. The Knowledge Transfer Network exists to support business innovation and believes the outputs of STOPandGO will lower barriers to the procurement of innovative solutions in health and care, accelerating the adoption of new services that better meet peoples' needs and creating business opportunity for innovative companies across Europe. Further information on KTN can be found www. Ktn-uk.org.

Collectively the four partners will work together to ensure that through Technology Enabled Care Services procured, the project delivers on all the targets and outcomes set through evidence which is based on quantitative and qualitative data.

APPENDIX 7: Integrated Community Teams model



APPENDIX 8: Eastern Cheshire CCG - Integrated Diabetes Team



APPENDIX 9: Benefits Technology Enabled Care

Benefits for users could include:

- Technology Enabled Care Services being congruent with people's lifestyles and solutions tailored to their health needs. This may mean educating people and providing motivation to people with Long Term Health Conditions the benefits of using Technology Enabled Care. Access to equipment may need to be not only universal but also multilevel. In addition bidders will need to determine the level of technology awareness of people and provide this a part of service offered.

- To improve access to healthcare for people living with diabetes across the Eastern Cheshire health economy, through the application of a menu of remote technological services. This will be carried out as part of the Eastern Cheshire transformation initiative.
  - All people and carers should be seen as equal partners in the delivery of their care and should be given the opportunity to feedback their experience. Users should be engaged in decisions relating to their care.
  - Language should not be a barrier to people using the service achieved through the utilisation of interpreting services.
  - Devices must be in-obtrusive, reliable and easy for users to incorporate into their home and have a reasonable level of functionality including wireless and mobile operability.
  - People must receive a response from the service to alerts 7 days per week, 365 days per year, for agreed pathways and parameters.
  - The system must be flexible and allow for the use of multi users in community settings, such as nursing homes and extra care schemes.

Potential benefits for the hospital

- To introduce a formalised and integrated approach for delivering and implementing Technology-enabled models of care.
- To maximise and demonstrate the benefits and efficiencies sought through introducing this innovative service.
- Add value to the diabetic community by:
  - *Supporting the cost effective deployment of technology.*
  - *Enabling scalable deployment of technology devices.*
  - *Reduction in admission by ensuring that navigation into other Health and Social Care provider services take place e.g. appropriate signposting through NHS 111.*
- Ensure feedback from target audiences is reflected in the way the service is configured.
- To ensure that project objectives are met within the timescales and criteria set out in this document and its supporting documentation.
  - Maximise opportunities for joint working and use of resources with local organisations.
  - A flexible open system design that can communicate with other partner networks across acute, community and primary care to allow for informed decision making and supporting a seamless model(s) of care.
  - Clinical risk management must be in line with Eastern Cheshire CCG structures to respond to user complaints and incidents.

The remote nature of the technology-enabled service should reach people who historically do not engage with mainstream NHS services. This will allow the inequality gap to be tightened by encouraging people to become engaged in health and social care at an earlier stage particularly in deprived parts of the health economy. Thus the provider will ensure the service delivered is:

- Acceptable to people, staff and commissioners
- The service must be committed to equal opportunities and equality and diversity. It will not discriminate against staff or people regardless of gender, race, sexuality, religion, faith, age, marital status or disability
- The service will use appropriate interpretation services when required
- The service will be sensitive to the needs of the population of Eastern Cheshire
- People will be treated with dignity and respect

APPENDIX 10 Directives for considerations as part of the component for Technology Enabled Care including STOPandGO

ACCESIBILITY recommended

1. **CEN/CENELEC Guide 6 / ISO Guide 71(Good Practice Guidelines) (new draft: Mandate M376)**
   This sets out the guidelines and framework for Stop&Go, laying down European Accessibility requirements for public procurement of products and services in the ICT domain. It aims to give an incentive to the market and public organisations to take accessibility into consideration and to give an incentive for manufacturers to develop and offer accessible products, applications and services.

   In addition, **EN 301 549 is** a standard giving a complete set of technical requirements for Accessibility of ICT products and services in Europe. It is intended to give access to mainstream ICT for users with the widest range of characteristics and abilities and minimising conflicts with existing accessibility requirement both in Europe and the Americas.

Protection for Service users and carers

EU Directives on Equality in Employment covering contracts and laws

There is a requirement in Employment Law that the actual contract for the worker does need to state they are expected to undertake this work, mention this includes offsite working etc. Many contracts also state that the individual must be trained for specific aspects of the work, e.g., Health and Safety on and offsite. During the project we will identify issues through our checklist and address these.

Data collection requirements

- Directive 95/46/EC of the European Parliament and of the Council of 24 October 1995 on the protection of individuals with regard to the processing of personal data and on the free movement of such data
- Directive 2002/58/EC of the European Parliament and of the Council of 12 July 2002 concerning the processing of personal data and the protection of privacy in the electronic communications sector (Directive on privacy and electronic communications)

Information technology security

- ISO/IEC 27001:2013: Information technology — Security techniques — Information security management systems — Requirements
- **ISO/IEC 15408:** The Common Criteria for Information Technology Security Evaluation

Product safety

- **CE Marking Directive (93/68/EEC**)

  This offers a presumption of conformity with the relevant Directives. This EU regulation requires that checks be made about specific equipment used whether this has identified CE Marking or is research model stuff only, etc. It is known that when some equipment is used for slightly different purposes, e.g. A Mobile phone used to gather healthcare data that possible additional checks and agreements are needed. Each Member State has a Regulatory Body (MRHA in UK) dealing with these matters and may have variable requirements.

Medical devices

- **EU Medical Device Directive 98/8/EC (EN60601-2)**

  This covers a family of standards whose scope covers some of the safety, essential performance and electromagnetic compatibility of Medical Electrical Equipment and Systems. This is another EU Directive where the work may include emergencies with accident/injury work included. Each Member State has a Regulatory Body (MRHA in UK) dealing with these matters and may have variable requirements. Again, if the use or main purpose of the equipment is changed from that it was designed for, specific approval maybe required.

- **EU Medical Device Directive (EN60601)**

  This covers a family of standards whose scope covers the safety, essential performance and electromagnetic compatibility of Medical Electrical Equipment and Systems. This is another EU Directive where the work may include emergencies with accident/injury work included. Each Member State has a Regulatory Body (MRHA in UK) dealing with these matters and may have variable requirements. Again if the use of main purpose of the equipment is changed from that it was designed for specific approval maybe required.

Informed consent

Part of the evaluation will involve collecting personal data from users, families, and carers on their experiences of using the innovative mobile services. Data will be gathered through questionnaires administered either by post, by telephone or face-to-face. In most instances, Procurers will manage these data but, in some instances, sub-contractors and service providers may be involved (e.g. in respect of local assessment and data gathering). Again there is a cross management data issue and any ethical aspects must be met.

EU Guidance for Applicants Informed Consent Directive 2001/20/EC

UK:

UK Government Digital Inclusion Strategy (2013) has been developed around the needs of users and people who do not have the capability to use the internet. It promotes digital inclusion for all. Making local councils more transparent and accountable to local people (DCLG 2013) sets the scene for greater local accountability and transparency.

During the running of the S&G Project, Procurers can add relevant information according to their own national Digital Inclusion Policies and how these effect the options for service provision.

Ethical Standards for Providers of Public Services (DCLG 2014a) makes recommendations to Government to ensure that proportionate ethical standards are made explicit in commissioning, contracting and monitoring arrangements for all those delivering public services. The **Local Government Transparency Code** (DCLG 2014b) sets the context for greater democratic accountability. Regulatory advice for an innovative product can be found at the Innovations Office at the MHRA.

http://www.mhra.gov.uk/Howweregulate/Innovation/index.htm

GLOSSARY OF TERMS

CCG	CCGs are responsible for implementing the commissioning roles as set out in the Health and Social Care Act 2012.
NICE	National Institute of Clinical Excellence
PREMs	Patient Reported Experience Measures
PROMs	Patient Reported Outcome Measures.
HbA1c	Glycated haemoglobin is a form of haemoglobin that is measured primarily to identify the average plasma glucose concentration over prolonged periods.
Delivery of Technology Enabled Care	Management of people from receipt of referral to discharge utilising a variety of interventions, devices and hubs through the provision of a complete end to end technology enabled service in a common health management service platform that includes acute, community and primary care.
Risk Stratification	Uses data from primary care and hospital such as history of admission, number of GP Visits, Number of Long Term Conditions, A&E Attendances and other factors that predict risk of unplanned admission. This data is then taken through an algorithm that predicts risk of unplanned admission over a 12 month period.
STAIRRS	Short Term Assessment Integrated Response and Recovery
STOPandGO	Sustainable Technology for Older People Get Organised
Telecare	Through remote technologies such as pendants, bed sensors, fire alarm alerts and heat sensors (not an indicative list), people can be continuously, automatically and remotely monitored in real-time. This is a way of managing social care emergencies and lifestyle changes over a *24 hour period* in order to manage the risks associated with independent living.
Telecoaching	The provision of motivational coaching to support service users / people wishing to make lifestyle changes in order to *improve health outcomes* and prevent deterioration of health.
Telehealth	Encompassing term for various types of technology assisted healthcare delivery
Telemedicine	To enable clinical care consultations outside of hospital using remote video links. In particular installation in care homes to allow clinical consultations to take place without the need to admit into hospital and in key primary care premises to provide people with an opportunity for review (MDT) consultations closer to home.
Telemonitoring	The delivery of healthcare at a distance using electronic means of communication. This involves remotely monitoring objective data such as persons' vital signs, (e.g. oxygen saturation/BP/weight/HbA1c) and subjective data such as symptoms/knowledge/behaviour with continuous health-risk assessment via automated evidence based and validated question sets. Breaches of rule-sets for individual people and disease cohorts, set by healthcare professionals, triggers a timely intervention