SCHEDULE 2 – THE SERVICES

CALDERDALE ASSISTIVE AND DIGITAL TECHNOLOGY SERIVCE SPECIFICATION

Service Specification No.	**Final**
Commissioner Lead	**NHS Calderdale Clinical Commissioning Group**
Provider Lead	**Unknown – Procurement Process**
Period	**1 April 2017 – 31 March 2020 (3 year contract)**
Date of Review	**1 April 2019**

Service Specification Contents

1.0 Population Needs

1.1 National/ Local Context and Evidence Base

Health and social care providers are facing difficult choices, with a responsibility to ensure that the services we commission are high quality, safe and sustainable and that in doing so we manage our budgets efficiently and effectively.

In the last 15 years there have been great advances in medical knowledge and technology and the increasingly sophisticated and specialist treatments and procedures. This has enabled more services to be provided outside hospital, in GP practices and community settings, while hospitals increasingly focus on the most seriously ill people. We need to make sure that our health system has adapted to meet these and future advances if we want our patients to be educated to be able to self-care, get the latest treatments and have the best chances of good outcomes when they become very ill.

Alongside these advances there has also been a rapid development and adoption of technologies that change the way people live. The *NHS five year forward view*, published in October 2014 by NHS England, echoes this, stating that future solutions will involve rethinking how health care is organised and delivered.

Technology unlocks personalised support and care for illnesses. We know that diseases like cancer and dementia are not single diseases but infinitely complex variations on a theme; however technology can also unleash a revolution in prevention.

NHS Calderdale CCG's Care Closer to Home (CCTH) approach provides a blue print for earlier intervention, prevention, greater independence and wellbeing for patients through community and primary care services. This vision is an inherent part of the design and delivery of our pathways, reflecting the aim to integrate and join up primary, community and secondary care provision for the benefits of patients. It is based on addressing the challenges of reducing health inequalities, engaging with groups at risk of poor health and increasing the use of technology in the community.

This vision is crucial in the development of safe and effective pathways, and supports the national direction of travel in terms of integration, earlier intervention, prevention, patient choice and jointly agreed shared care plans.

As part of this vision we have already tested and explored the use of assistive technology to allow people to maintain their independence wherever possible and by helping and supporting people to understand and manage their own needs and illnesses. As part of this testing it is clear that a multi-disciplinary approach is critical to the successful implementation of assistive technology and digital information systems as it inspires new ways of working to optimise the benefits available (N.B: NHS Calderdale CCTH specification must be read in conjunction with this specification in order to provide the story, vision and detail for Calderdale)

National guidance for urgent and emergency care services has emerged following a comprehensive review launched in January 2013 by the NHS Medical Director, Professor Sir Bruce Keogh. For more information go to www.nhs.uk/nhsengland/keogh-review. This has involved NHS England working with expert clinicians, patients and partners from across urgent and emergency care systems to develop an evidence base for a set of principles to underpin change.

Locally, over the past three years we have gathered views from more than 4,000 people on hospital and community services. This has included engagement and stakeholder events on the Care Closer to Home programme in Calderdale. We have also developed an animation 'The Future of Health and Social Care Services in Calderdale' to capture what people told us - full details can be found at https://www.calderdaleccg.nhs.uk/your-health/care-closer-to-home/ including some real life animations illustrating people's experience of using services in Calderdale. Two case stories in particular (Gerald and Tarique) provide a view of how services will be provided in the future through the increase of assistive and digital technology.

The key findings from both national and local people about the way they would like to be helped to live their lives, and the type of technical support that could be offered to help them live independently in the community were:

- IT innovations and developments, where appropriate, be utilised to support patient care
- Promote primary prevention, such as general physical activity, healthy diet, good emotional wellbeing and resilience
- Promote supported self-managed care and proactive early intervention services
- Services coordinated and focused on an individual person's needs
- More information about health conditions and more communication about what is available
- Technology that people can use to reduce travel times and unnecessary journeys, particularly for young people

A key goal in the development of the assistive technology programme is to ensure we create an inclusive approach where we will listen and involve the people of Calderdale, through the delivery of the key findings above.

2.0 Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

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

2.2 Local Defined Outcomes

2.2.1 Outputs

- Equitable access to technology for the registered population of Calderdale
- Quality of life for clients is improved
- People feeling better cared for and supported
- People can self-test in the comfort and convenience of their own home
- Enables people to further understand and manage their condition
- Reduce the need for people to travel to appointments
- Improved monitoring reduces the frequency of appointments

2.2.2 Outcomes

Full outcomes will be explored and agreed against each of the 5 elements described in scope with the provider(s). We will expect to adopt different approaches for data extraction based on the conditions selected.

Quantitative

- Reduce calls and visits for GPs in hours and out of hours
- Reduces repeat visits for community nurses and other clinicians
- Reduces non elective admissions through detecting deteriorating health early
- Reduces emergency ambulance call outs and dispatches
- Supports early hospital discharge by giving clinicians more confidence that needs will be met in the home
- Reduces outpatient attendances and planned admissions

- Reduces bed days and length of stay
- Increases medication compliance

Qualitative

Qualitative thematic synthesis will be used including: maintaining a healthy diet, engaging in exercise and physical activity, monitoring of blood glucose and other bio parameters; adherence to medication; reducing risks by avoiding health damaging behaviours, monitoring the condition and participation screening; healthy coping and motivation

- Improve the visibility of residents' health, meaning community nurses can better monitor patients without the need for travel
- Increases long-term positive outcomes with daily tasks and greater self-efficacy. For people who are frail outcomes such as; reduce fear of falling, fewer home hazards, decreases reliance on personal assistance or replaces it where possible
- Increase the acceptance and adherence to its optimal usage, greater attention to users' and caregivers' goals and preferences
- decreases caregiver burden and increases independence for older adults
- Enables community matrons to monitor trends and work in a proactive/ preventative way with patients on their case load
- Improve co-ordination between the providers through better sharing of information
- Enabling individuals to seek information online, increasing their ability to self-care
- Enhance and improve patient care/experience and patient outcomes via patient surveys, case studies etc.
- Create more efficient, connected and cost effective bespoke care pathways

2.2.3 Monitoring

Services will be monitored on an individual basis and are required to meet Key Performance Indicators. These will be agreed between the provider(s) and NHS Calderdale CCG. Dashboards will need to be completed on an agreed, regular basis as part of performance and contract monitoring. A data collection package including questionnaire/checklists for care and outcome reporting a data collection form for costs and resources, effectiveness and utility instruments and guidelines. Each service will be expected to provide information such as:

- How many people have used the technology on offer and if options were offered, which options were used
- How many people were trained to use the technology (staff/individuals)
- How many people were offered promoting tools and resources to help them manage their health
- How many champions have been trained
- What impact the technology has had on people e.g. how many people feel more informed about their health, how many are more confident using online tools to manage their health
- How many people feel less lonely or isolated and happier as a result of the technology offered
- Regular collation and evaluation of staff and service user experience

3.0 Scope

3.1 Aims and Objectives of Service

The purpose of this document is to provide an outcome-based service specification for the delivery of an assistive technology service offering a consistent and sustainable model of care for the people of Calderdale; a truly person centred approach which would best meet the needs of people with long-term needs, and help to make efficient use of NHS resources.

This service will support and enable people to take increased responsibility for monitoring their own conditions through technology. It will help people to further manage and understand their own

condition, promote independence and help them lead active lives in their own home/care home, thus reducing dependency on hospital and avoid the need for more costly interventions.

To be most effective, such technologies need to be embedded into provision, and form part of a mainstream service delivery, supporting an array of pathways. Hence this project being a key link to vision of growth and direction set out in the CCTH programme/specification.

The service will ensure:

- People will be treated as individuals with choice, dignity, privacy and independence, recognising people's individuality and personal preferences
- All staff/workers are made aware they are visitors in people's homes or workplace and should act accordingly
- Provide support to carers, whether relatives or friends and recognise the rights of other family members
- They provide protection to people who need it, include a safe and caring environment
- People's self-care abilities and independence are maximised
- People understand their condition and are encouraged to self-manage to improve their own outcomes
- People feel more informed about their condition and feel more confident using on line tools to manage their condition
- People receive messages promoting resources that could help them manage their condition
- Provide high levels of support, care and advice to people whilst empowering them to take increased control of their condition(s)
- Help with the transition of patient care from hospital into the community and care homes
- All patient readings to flow into the patient record on EMIS or SystmOne with a click of a button (this is does not apply for Apps)
- Enhanced patient care and outcomes
- Technology is tested clinically and where applicable supplied in accordance with NICE guidelines
- They can define and provide assurance of the appropriate levels of data security provided – quoting the required standards
- Cost effectiveness without compromising people's needs. Maximises value for money and remains within the allocated budget aligned to performance indicators, efficiency targets and financial outcomes.
- Consistent improvement of health outcomes for people with long term conditions
- Quarterly surveys are carried out to capture the benefits and outcomes of the service
- Where necessary, any providers involved in the deployment of technology obtain consent as required their Safeguarding and Information Governance policies

3.2 <u>Service Description and Requirements</u>

The provider will ensure the key roles are provided to deliver the service outlined below and achieve the service standards and outcomes.

This specification relates to the provision of a range of Telecare, Digital Health Solutions and Digital Apps. To be most effective, such technologies need to be embedded into an array of existing pathways and provide a platform to build digital solutions that will work for the people of Calderdale.

It is our vision to enhance our approach and direction in technology by putting people at the heart of what we do and integrating care pathways in social care, education and other parts of service delivery.

There are five elements to this specification, these are:

1. The supply and installation of Telecare equipment into all care homes in Calderdale
2. The supply and installation of digital health solutions using applicable devices or technology to monitor/test vital signs for people residing in care homes in Calderdale
3. Call Centre/Monitoring Centre facilities for care homes out of hours – from 6.30 p.m. to 9.00 a.m. 7 days a week, 365 days a year
4. The supply and installation of digital health solutions for people with long term

conditions to help monitor their vital signs remotely from home (in the community) and using applicable devices or technology (such as base units, mobile apps, online devices etc.)

5. Digital apps available to people of all ages with a long term condition or mental health problems, for example we are looking for apps that will help individuals with diabetes, heart failure, chronic pain, autism spectrum conditions, mental health problems etc to allow people to monitor their vital signs remotely from home and work using appropriate devices or technology (such as base units, mobile apps, online devices etc.)

3.2.1 The requirements of the five elements are outlined below.

3.2.1.1. <u>Telecare in Care Homes</u>

A range of innovative telecare sensors/detectors/alarms etc. for people residing in care homes in Calderdale that can automatically detect incidents such as someone falling, having an epileptic seizure or leaving their bed, chair or room and alert staff to these events. Telecare is currently being provided in 24 Calderdale care homes, and this specification is to facilitate the provision of telecare to the remaining care homes in Calderdale (approx. an additional 17 but this is not a definite number as more homes may open within the time of the contract).

The design, installation, modification and support of products and services required are listed below.

Base units - connection to be identified as part of initial assessment per care home

Personal Telecare (numbers will be dependent on the current levels of provision within the homes and on the individual's needs). Calderdale currently offer the following types of Telecare devices:

- Activity monitors/movement detectors
- Bed/chair occupancy sensors
- Care assist
- Epilepsy sensors
- Enuresis sensors
- Fall detectors
- Light dimmer
- Medication dispensing and reminder devices (ensuring there is no duplication with any equipment already in the homes)
- Movement detectors
- Pillow alert
- Pressure pads/mats
- Property exit sensors e.g. door use sensors and automated exit messaging systems
- Pull cords
- Sirens, beacons, pager
- Smoke detectors
- Wireless nursecall system or equivalent (either deployment or liaise with current provider to sub contract existing systems in place)

In line with innovation and improvement, alternative and better devices that may be easier for individuals to use, be more reliable and are cost effective is being sought from bidders.

N.B. All products described above must comply with all relevant health and safety requirements.

The Provider will be responsible for:

i. A thorough risk assessment of the recipient's place of residency to be undertaken by appropriately trained staff. Referrals will indicate the urgency of the referral which will be:
    - Urgent install within 2 working days
    - Medium install within 3 working days
    - Low urgency install within 5 working days

ii. Installation of all equipment by appropriately skilled and qualified individuals. Providing written instructions/training of devices to the individual, their carer and staff/professionals
iii. Content Provision – development (in conjunction with local clinicians) of health and wellbeing questionnaires and/or adaptation of existing ones
iv. Training and on-going education to professionals and staff in the care homes
v. Effective and efficient repair and maintenance of all equipment under warranty. This includes maintenance and repair of all equipment under the contract and against agreed Service Level Agreement (SLA) targets. This will include temporary supply of a replacement unit where a unit needs to be taken/sent away for maintenance. The maintainer/installer will install all equipment required regardless of the provider of the equipment.
vi. Withdrawal and reconditioning where necessary. Arranging for the devices where possible to reuse to be sterilised and stored until re-issued and the safe disposal/writing off of items that cannot be reused.
vii. Review of installation within 6 weeks to ensure it meets the individual's needs.
viii. Calibration and PAT testing of all equipment in accordance with Health and Safety regulations and as agreed in the SLA.
ix. Monitoring (call centre) equipment in the care homes. The service is required; 24 hours, 7 days a week, 365 days of the year. It will provide a response as required dependent on the alarm raised and the issue.
x. Decontamination (relating to re-usable products. To be carried out in line with policies and procedures)
xi. Maintaining sufficient stocks of all devices and providing storage of all devices and relative equipment and accurate live records
xii. Provide call out arrangements for wireless nurse call system, this will include:
    - Initial telephone support from service engineer to establish the extent of the issue
    - 4 hour urgent engineer response time to visit the home and establish the extent of the fault
    - Repair to be carried out within 1 hour (this can be a temporary or permanent fix)
    - Where temporary fix is applied, follow-up support is required within urgent timescales defined above

The provider shall be responsible for risk assessment, hazard control and other health and safety matters affecting its staff in the delivery and installation of the equipment and services. The provider will do all that is reasonably practicable to prevent personal injury and damage to property and to protect staff, individuals and others from hazards.

The Provider will provide proactive advice and guidance to professionals and advise on the types of Telecare devices available and potential opportunities for using Telecare devices effectively

3.2.1.2 Digital Health Solutions in Care Homes and People's Own Home

Provision of digital health solutions providing diagnostic information for:

a) People residing in care homes to monitor/test vital signs using applicable devices or technology
b) People with long term conditions monitor their vital signs remotely from home and using applicable devices or technology (such as base units, mobile apps, online devices etc.)

To be most effective, such digital solutions need to be embedded into an array of existing pathways and provide a platform to build digital solutions that will work for the people of Calderdale.

A summary of the requirements for these projects are:

a) NHS Calderdale's flagship project 'Quest for Quality in Care Homes' trialled the use of telehealth in care homes. Different approaches were tested during the pilot with the most successful option being the roll out of telehealth to all residents.

The digital care home service coordinates the monitoring of vital signs, weight and hydration. It acts as an early warning system, highlighting changes in health which may otherwise go unnoticed. The service includes a digital patient record which integrates directly with GP systems, meaning it can be accessed by the designated teams. Provider(s) must show how apps are interoperable with the current GP systems

The units include set tasks for care home staff to following and carry out each day. Readings are collected by the care home staff as part of their daily routine and assessed, this supports proactive care planning within the homes. This service enhances care within the care home, improving the visibility of residents' health, reducing non-elective admissions and supporting early hospital discharge by giving clinicians the confidence that needs will be met within the home.

It is expected that the Provider offers telehealth devices and peripherals to care homes in Calderdale for use of all residents in the home. The Provider is expected to encourage the take up of the telehealth units in as many care homes as possible, providing support, training and education to staff and professionals.

b) Deployment of digital devices that offer remote vital signs monitoring for people (children/young people and adults) with long term conditions in their own home.

It is our aim to build on the existing service provision for people with COPD in the community. Using an easy to use self-monitoring device, vital signs such as blood pressure can be measured by the individuals/their carers. An automated system at a pre-agreed time, will notify the individual daily when they are due to take their reading.

The individual is asked questions around their general health and well-being and will record their reading.

An app/web option with peripherals will be the preferred option, however, it is recognized this will not be suitable for all individuals, therefore the following options will also need to be available:

- a tablet with peripherals
- portal and peripherals
  (The Provider is expected to list the peripherals included and excluded as part of this service).

Provider to identify number of units to be deployed against the value for this section of this element.

It is expected that the Provider works closely with the community nursing teams and locality navigators who will be identifying the individuals suitable.

The Provider will be responsible for: (areas indicated with a * are the same requirements as those described above for Telecare)

i. Risk Assessment – as described in Telecare with the exception of the referral timeframe. Referrals for the digital solutions will indicate the urgency of the referral which will be:
   - Urgent install within 1-2 working days (for telehealth at home this urgent referrals will include early supported discharge)
   - Medium install within 3 days
   - Low urgency install within 5 days

ii. Installation*
iii. Content Provision*
iv. Training and ongoing education *
v. Effective and efficient repair and maintenance*
   Maintaining sufficient stocks and storage*
vi. Technical Support
vii. Stock Control*

viii. Patient Registration – ensuring all people registered and details/information is shared with the care navigation team through a secure network. Network and methodology must be defined by the provider(s).
ix. Review*
x. Monitor and Response – remote transmission of data, and capture of data on secure website (including development of an agreed suite of reports that can be run from the website by authorised users). Monitoring of readings and investigation of alerts in a timely manner to deal with any non-clinical issues, sending on clinical alerts according to local protocol
xi. Decommissioning*
xii. Decontamination*

N.B: Care Navigation is not required as part of this specification. Providers must work with the Care Navigation team in place locally.

3.2.1.3 Call Centre/ Monitoring Centre Facilities

An out of hours call centre/monitoring centre is required for care homes in Calderdale.

This provision will work in conjunction with the 'Quest for Quality in Care Homes' Service (for further details refer to the Calderdale 'Quest' specification) and will provide assurance and support to homes outside of 'Quest' service hours (times stated below).

Through a secure video link, staff in care homes will have immediate access to a call centre/ monitoring centre, service. This will be provided by a single point of access to expert opinion, diagnosis and support. Triage and assessment will be carried out by a senior nurse who will provide direct support and advice or arrange for other services to respond as deemed appropriate. Staff will talk to care staff and residents and identify the required response and management.

The senior nurses will have a wide range of acute and community experience (particularly experience of caring of the elderly, emergency medicine, ICU, respiratory and cardiac care). Nurses will monitor people on screen providing immediate assessment, advice, support and assurance to staff at night in care homes.

This service will link with local pathways and services, such as local 111 and Local Care Direct aligned to local pathways, such as head injuries/falls. The aim of the service is to offer peace of mind for staff, residents and relatives, avoiding transfers to hospital at night where preventable and avoid the stress associated with a hospital admission. It will also ensure efficiencies through the reduction of out of hours GP visits, ambulance dispatches, hospital attendances and admissions.

A digital summary of the consultation including the problem encountered, level of support/ care provided and any ongoing care/support required will be captured in the individual's case notes to be accessed by GPs, Quest Team and members from the MDT.

The service is required out of hours – from 6.30 p.m. to 9.00 a.m. 7 days a week, 365 days a year.

3.2.1.4 Digital Apps

Provision of digital apps available to people of all ages with a long term condition or multiple long term conditions or mental health problems, for example apps for health promotion activities such as ways of helping people with diabetes, heart failure, chronic pain, epilepsy, autism spectrum conditions, mental health problems etc. to manage their condition, to allow people to monitor their vital signs remotely from home and work using appropriate devices or technology (such as units, mobile apps, online devices etc.)

This is a relatively new area for NHS Calderdale CCG and as such, we are seeking both best practice and innovative ideas from Providers. We would like providers to provide digital solutions tailored to the needs of the Calderdale population. This will need to link with Active Borough Calderdale in the development of the local digital platform. The apps will be used to monitor health and wellbeing in

people, empowering and enabling them to understand their condition(s) by assessing personal information against known risk factors and providing information, advice, and support on how to manage their condition. This will lead to better treatment outcomes, reduced accidents and an overall increase in health and wellbeing. Apps can also help inform medical professionals, thus encouraging a more productive appointment and, ultimately, leading to better medical care and reduction of risk.

Providers will be expected to share and demonstrate their digital solutions with local people, staff and professionals as part of the procurement process.

The Provider is expected to:

- List the digital solutions options included in their tender including a differentiation between "live "apps and those which could be developed
- Describe the digital solutions on offer, clearly indicating the platform, the condition covered and target audience where services are available to a specific age range or conditions only
- Suggest a condition for testing the app approach before fully integrating apps for people with long term conditions
- Develop a plan on how to advertise the apps to the public and how to monitor usage and outcomes

3.2.2 Business Continuity

All service providers are expected to have a business contingency plan which will demonstrate how they would continue to provide, prioritise and plan services in the case of events that have a major impact on access or staff availability and/or IT equipment and/or Premises. These will include major disaster, severe snow/weather, unprecedented levels of staff absence/sickness etc. This plan will be shared with NHS Calderdale CCG.

Providers are also expected to have a mobilisation plan setting out their plans for implementing the service. This will include a plan on service continuity and risks identified if existing technology is to be removed by the current provider and the mitigating risks in avoiding disruption to people and staff.

3.3 Population Covered

The service is available to the whole population of Calderdale.

3.4 Interdependence with Other Services/ Providers

NB This list is not exhaustive :

- Primary Care Services
- 111
- Quest for Quality in Care Homes Service
- Gateway to Care
- Adult Health and Social Care – Digital Solutions
- Secondary care services – related to any services providing urgent and planned care for long term conditions, frailty and pain. i.e. District Nursing/ EOL/ Palliative Care team
- Community services – related to any co-morbidities
- Public Health –staying well programme, better living service, and any projects involved self-care and prevention across all ages
- Other specialist services as required – e.g. stop smoking, alcohol, mental health services Care Closer to Home Programme

4.0 Applicable National Standards

4.1 Applicable National Standards (e.g. NICE)

Standards not identified in the Care Closer to Home Specification are noted below:

- NICE Guidance – Social Care for People with Multiple Long Term Conditions
- NICE Guidance – Technology Appraisal Guidance

5. Applicable Quality Requirements and CQUIN Goals

Applicable Quality Requirements (See Schedule 4A-D)

The service provider is expected to be aware of all changes in legislation which will affect the provision of these services.

Service providers are expected to work to the following documents not stated in the CCTH specification:

- Telecare Services Association (TSA) standards of operations
- Calderdale Safeguarding Policies and Procedures

The provider will comply with the NHS Calderdale CCG safeguarding standards relevant to the organisation. The provider will ensure that all staff receives the appropriate level of safeguarding training every 3 years. The provider will have an organisational safeguarding policy which references and complies with the West and North Yorkshire adult safeguarding policy and procedures (detailed in the CCTH specification).

Provider(s) are not directly required to obtain consent as part of this service. However, it is expected that the technology provider(s) are assured that consent is obtained by the care providers in the deployment of any technology in line with Safeguarding, IG, Deprivation of Liberty Policies (detailed below and in the CCTH specification)

In order to have the assistive technology either someone must have capacity to decide if they want to have the equipment / arrangements. If they lack capacity to make this decision, a decision must be made as to whether it is in their best interests – (there are a range of factors to be taken into account when deciding if something is in someone's best interest. This is a sentence that is used in other service specs: "When a patient lacks the mental capacity to make a decision about entering a programme or any other decisions during the programme, professionals should be able to evidence this with a mental capacity assessment, make a best interest decision and follow guidance from the Mental Capacity Act Code of Practice" Equipment like sensors may contribute to someone's care amounting to a deprivation of liberty and this must be recognized, assessed and if appropriate an application made to authorise the deprivation of liberty.

Applicable CQUIN Goals (See Schedule 4E)

Not applicable for this specification

6. Location of Provider Premises

Not applicable for this specification

7. Individual Service User Placement

Not applicable for this service specification