MEDWAY COUNCIL
Gun Wharf
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Health Overview and Scrutiny

Assessment of whether or not a proposal for the development of the health service or a variation in the provision of the health service in Medway is substantial

A brief outline of the proposal with reasons for the change

Commissioning Body and contact details

NHS Medway Clinical Commissioning Group

Current/prospective Provider(s)

Current providers – Medway Community Healthcare, Kent Community Healthcare Foundation Trust. Prospective providers – to be determined after a procurement exercise.

Outline of proposal with reasons

A strategic and clinical case for change has been developed and agreed by the CGG Governing Body, which presents the rationale for redesigning and re-procuring adult community health services in Medway. It draws on findings from recent due diligence stocktake review of local services, best practice case studies, stakeholder feedback gathered to date, and aligns with national direction to meet Sustainability and Transformation Plans (STP) expectations for local care. It highlights the following reasons for the change:

- To abide by procurement regulations – the CCG must re-procure services by April 2020.
- To align with national, regional and local strategic direction.
- To refocus resources where they have most impact.
- To improve access by ensuring services are provided in the right place and at the right time.
- To realign a highly competent and resilient workforce.
- To treat the person, not the condition – ensuring a holistic approach to care planning.
- To ensure prevention and patient empowerment is at the centre of community services.
- To make better use of technology to support the delivery of community services.
- To make better use of intelligence (data and feedback) to constantly develop the system.

The document has been used to develop a high-level revised model for community services, which is outlined below. This will be tested at a whole-systems stakeholder event on 10 January 2018 which will, in turn inform the outline business case and outline service specification.

The revised model

The Medway Model and the developing Primary Care Homes are centred on general practices grouped around six defined localities working with health, social care and the voluntary sector to develop and provide services closer to the patient's home.

The six localities are as follows:

- Rainham
- Gillingham
- Chatham Central
- Lordswood
- Rochester
- Strood

Within these six localities, services will be provided to populations of between 30,000 and 50,000, either in their own homes or in Integrated Health and Wellbeing Centres (IHWC) where health and social teams will be co-located forming a multi-disciplinary team that works together to achieve the four key components of a revised community services model.

Redesigning the community services provision is fundamental to ensuring alignment with the developing Primary Care Homes and the Medway Model.

Key components of the revised community services model

The key components of the revised model are as follows:

Realigned and upskilled workforce

- Primary Care professionals doing more or different things – including the development of GPs with specialist interests (GPSIs) and ensuring community pharmacists are used to their full potential.
- Improving access to consultants in community settings within or alongside community teams.
- Improving core and generalist skills to make the most efficient use of the workforce and to reduce duplication.
- Increasing the number of prescribers within community services to ensure more timely access to medication.
- Developing a knowledge base and directory of services to enable a proactive approach to sign posting to services.

Improved access and simplified services

- Making better use of current estate to ensure equity of provision across Medway. This will involve moving some clinics and team bases to mirror demand in each locality.
- Ensuring that people are seen at the appropriate location, including at home only when needed.
- Extending access where appropriate in line with 8-8 working, and ensuring that services can respond more quickly in times of crisis.
- Developing central point for booking appointments and general enquiries.
- Developing patient portals and self-care apps to provide information in one place.

Improved co-ordination of care

- Reducing fragmentation of services - reducing hand-offs between teams and duplication, and breaking down professional silos to facilitate professionals working together more closely.
- Using integrated case management to improve continuity of care.
- Ensuring that care plans are agreed with you and take a holistic approach and are goal focused - asking “What matters to you?” and not “What is the matter with you?”
- Improving information flow – within and between teams, organisations and different parts of the system and multi-agency partnerships.
- Develop shared care plans that interface across the health and social care system and have been agreed with the patient and their carers.
- Proactively identifying and managing people via multi-disciplinary teams (MDTs), who are most at risk, for example people with multiple and complex long term conditions who have a greater demand for secondary care services.

Strong prevention and empowerment ethos

- Recognising that mental and physical health, often go hand-in-hand. Services and the staff within it need to promote people’s emotional wellbeing.
- Creating stronger links to the voluntary and community sector.
- Using peer groups and support networks to improve people’s experiences and wellbeing outcomes.
- Recognising and supporting informal and family carers.
- Improving self-care tools and technology enabled care.
- Creating stronger links with public health to ensure that all opportunities to prevent ill health are embedded across the local community.
- Providing a patient portal/ website that enables patients to self-care.

Arrangement of services and teams

The revised model will have fewer and larger teams in order to facilitate a reduction in unnecessary contacts and to improve coordination of people’s care.

The revised model groups services into three tiers. These tiers are based on learning from ‘NHS New Models Vanguard’ sites, this will mean that local service provision will be aligned to one of the three tiers in the revised model.

The services will be developed as locally as possible around geographical localities, populations and health and social needs. Staff will be expected to move across the localities to deliver services. Services will only be ‘centralised’ if it is not clinically or financially viable to provide them locally. E.g. specialist diagnostics undertaken in the community, or there is a requirement for larger numbers to run group learning events or requirements for gym facilities.

Level 1 services

The revised community service model will provide some services at Primary Care Home Level (population of 30,000 to 50,000). These services will be the most common services that serve the highest number of patients. These will include:

- Community nursing – including wound clinics, non-bed-based end of life care and long term condition management e.g. cardiology, respiratory.

- Urgent response element – professionals that will respond urgently and in times of crisis.
- Integrated case management (ICM) – including older people and patients with complex needs. This includes case management and care coordination.

ICM and care coordination is key to achieving co-ordination and access to services. This approach is proactive and aimed at increasing anticipatory care planning, admission avoidance and keeping people well at home.

Within each locality ICM will build relationships between health and social care professionals mental health and encourage Multi-Disciplinary Team working. This will help to improve health and wellbeing outcomes and patient experience.

The MDT will be responsible for the care of individuals that are identified at risk of their condition deteriorating without intervention and support. These patients will be identified via their GP surgeries by combination of risk stratification (a score generated by the GPs clinical system identifying patients) and clinical judgement. These patients are reviewed at a multi-disciplinary meeting and an agreed set of interventions will be recommended by the clinicians and social care providers, this may include geriatric or other specialist review, rehabilitation, education, social prescribing.

Patients referred for ICM will receive 24 hour, 7 days support from the care coordination centre a single point of contact (SPOC) that will coordinate their care and support them and their carers to maintain good patient outcomes and experience.

An urgent response team will also be available via the care coordination centre that will be able to respond to emergencies.

Level 2 services

Less common services requiring more specialist input will be provided for populations of around 100,000 across two adjacent localities: Gillingham and Rainham, Chatham Central and Lordswood, and Rochester and Strood. Services at this level will include:

- Community therapy including, physiotherapy for the housebound, gym-based exercise rehabilitation, and pulmonary and cardiac rehabilitation.
- Dermatology.
- Long term condition educational support for diabetes.
- Podiatry services.
- Musculo-skeletal physiotherapy.

Level 3 services

The most specialist community services will cover the entire CCG population and will have input into ICM as required. These services will include:

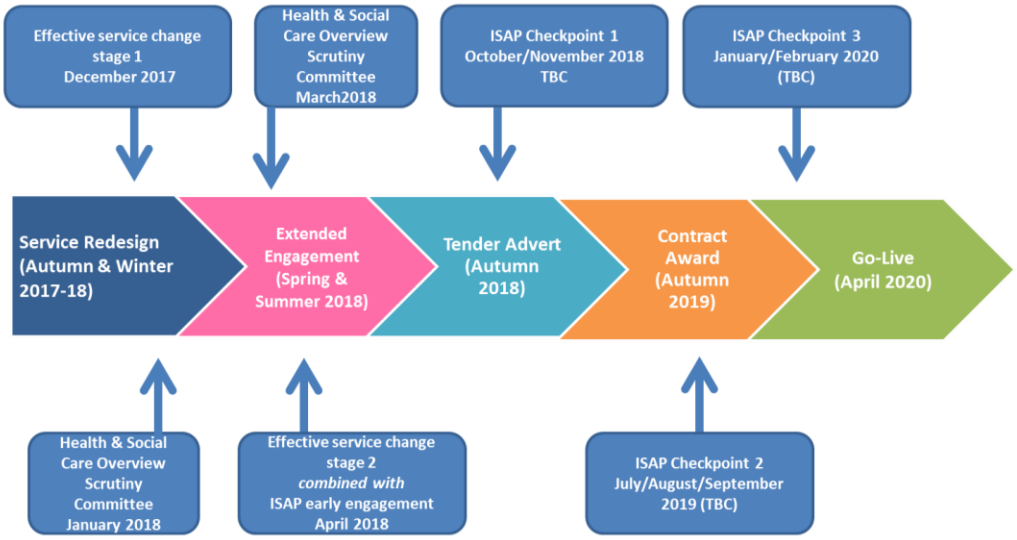
- Tissue viability and lymphoedema, and continence care
- Specialist palliative care, including inpatient services.
- Learning disability health services.
- Musculo-skeletal assessment and triage, and specialist hand therapy

Location of services

The location and accessibility of current community services is not equitable across the localities resulting in some patients having to travel further than others for the same services. As described above, the revised model will address these inequities, reflecting the needs of the local populations. This will require the relocation of a range of services into the IHWCs (current and proposed) and is explained in the sections below.

Intended decision date and deadline for comments (The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 require the local authority to be notified of the date when it is intended to make a decision as to whether to proceed with any proposal for a substantial service development or variation and the deadline for Overview and Scrutiny comments to be submitted. These dates should be published.

The Community Services Re-Procurement Programme includes the following stages:



The CCG recognise the significance of community services in alignment to the Medway Model and the impact on acute and primary care and feels that an extended engagement approach will offer the opportunity for the public to shape their local services. Therefore, the programme has time allotted to carry out a full extended engagement.

The outline business case, outline service specification, and engagement documentation will be completed in February 2018 ahead of agreement by the CCG Governing Body in March 2018. This will be followed by the extended engagement.

Alignment with the Medway Joint Health and Wellbeing Strategy (JHWBS).
Please explain below how the proposal will contribute to delivery of the priority themes and actions set out in Medway's JHWBS and:

- how the proposed reconfiguration will reduce health inequalities and
- promote new or enhanced integrated working between health and social care and/or other health related services

The revised model for community services aligns to the following JHWBS priorities:

Giving every child the best start

The majority of services in scope of the revised model are for adults. However, the revised model will take into account young people and their transition between specialist children's services and adult community services.

Enable our older population to live independently and well

Older people have a higher usage of health and care services use compared to other age groups, particularly hospital admissions and use of community services. Medway has a lower than average life expectancy for both males and females. The revised model will take these changes into account, building in good practice from recent pilots for frailty; enhancing support to care homes; increasing the use of technology enabled care; improving links between community services and services that enhance general wellbeing.

Prevent early death and increase years of healthy life *and* ***Improve physical and mental health and wellbeing***

In Medway, healthy life expectancy is below average. For males, the average healthy life expectancy is 61.8 compared with an average of 63.4. For females, the average health life expectancy is 59.7 years, compared with an England average of 64.1.

In Medway, 16.4% of adults (all ages) have a long term condition or disability that limits their day-to-day activities. This is based on adults of all ages, with the prevalence of long term conditions increasing in older population groups, with many people also having more than one long term condition.

People are living for longer with long term conditions with males living for around 16 years of life not in good health and females living over 20 years in poor health. During these periods people are more likely to make use of services to support them with their health. On average, a person with a long-term condition requires six times more health and social care support as a generally healthy person (from Kent Integrated Dataset (KID) (2015-16); Carnall Farrar Analysis, reported in Kent and Medway STP).

The revised model recognises the impact of long term conditions and complex health needs on the health and social care system. It includes a greater focus on the proactive identification and treatment of people most at risk of requiring intensive treatment. It will include the use of ICM, named workers, and shared care plans that enable better coordination of care for people with long term and complex conditions.

It is estimated that approximately 16% of people in Medway have a common mental health disorder – such as depression or anxiety. Mental health problems disproportionately affect people living in the most deprived areas and often go hand-in-hand with physical health conditions. The revised model will ensure that there are improved links to mental health services and talking therapies.

Reducing health inequalities

In line with the Medway Model the revised model is based on the provision of community services at a local level – either in the home or in out-of-hospital settings close to home. Community services will be provided locally within the localities, supported by the development of (current and proposed) IHWCs. Public Health analysis of the needs of the six locality populations has informed the revised model which realigns services based on the identified local need.

In developing the revised model, detailed service specifications will be written that ensure providers are more proactive in identifying and addressing health inequalities:

- A requirement that providers collect and report data regarding access to and outcomes of services against person characteristics such as age, gender, ethnicity, and post code.
- A requirement ensuring that services hold regular equity audits and addressing any findings.
- A requirement that services are appropriately targeted to address differing levels of need in different populations. This may include specific targeting to groups experiencing worse health outcomes.
- That services work towards reducing the variation in health outcomes across different groups which could include targets on specific areas.
- Consider how community services can signpost/refer to preventative/public health services, particularly for groups experiencing disadvantage/inequalities so risk factors for poor health can be reduced in these groups.

The revised model for community services will enhance integrated working between health and social care, primary care, and secondary care.

- The reconfiguration of Adult Social Care service by Medway Council also aligns staff within the six localities across Medway. It is important that patients and their carers are supported in a holistic way which considers the factors that they feel are important in maintaining their independence.
- The Medway Model recognises the central role of GPs, practices have come together to form Primary Care Homes based on the same six localities.
- The revised model will ensure that future services break down the barriers between in-hospital and out-of-hospital care by ensuring strong links to consultants working in the community.

Please provide evidence that the proposal meets the Government's four tests for reconfigurations (introduced in the NHS Operating Framework 2010-2011):

Test 1 - Strong public and patient engagement

(ii) Have patients and the public been involved in planning and developing the proposal?
(iii) List the groups and stakeholders that have been consulted
(iv) Has there been engagement with Medway Healthwatch?
(v) What has been the outcome of the consultation?
(vi) Weight given to patient, public and stakeholder views

During 2017, the CCG has been involving a range of stakeholders in our initial planning for redesigning and localising community services in Medway. The Communications and Engagement Plan sets out who we will engage and involve in this and how we will reach all relevant audiences. The plan outlines the desire to ensure that:

Those who use community health services and those who deliver these services as well as the wider public in Medway have been involved at every stage of revising the local community services model, and that the CCG can demonstrate what has been done to respond to their views and that we have been fully transparent about the decisions we have taken.

We know that engaging with service users in this area is challenging as most of the care takes place in people's homes or in local community settings and, while many people in Medway use community health services, public awareness about them is low. We are also aware that there may be unmet need in some communities which we need to target. It is essential that we work with family carers and also with those who deliver services on the ground.

Medway Healthwatch sits on the programme steering group and has advised us on our engagement. In addition, the services of an expert organisation, the Public Engagement Agency (PEA), has been commissioned to develop the approach and support stakeholder engagement.

The following groups of stakeholders have been involved in developing the model to date

- Patients and public
- Patient representatives
- Voluntary and Community Sector representatives
- Current and potential provider clinicians
- GPs
- Acute sector clinicians
- Mental Health clinicians
- Medway Council representatives, including social care

Specific engagement activities have included:

Review of existing provider patient experience information

Friends and Family Test results and complaints and concerns have been reviewed. People tend to be positive about the care they or their families have received but the take up of these feedback mechanisms is low.

Questionnaire

In the autumn of 2017 a questionnaire was launched to gain more information about current experiences of care from stakeholders (patients and clinicians). 150 people responded to the questionnaire.

Involving Medway – Focus Groups and community health researchers

The CCG has been working with the Involving Medway partnership in a series of workshops and focus groups with patients and community groups. Involving Medway is helping the CCG ensure that a wide range of communities are reached and involved in shaping a revised community services model. The partnership has carried out 14 focus groups or drop in sessions in local community settings and also trained 15 'community health researchers'. These are volunteers from local community groups who have interviewed 36 family carers and patients for the programme to gather their stories directly into the programme, some of which have been used as examples in the stakeholder events listed below.

Community services stakeholder events

A series of stakeholder events have taken place. Findings and feedback from each session have been collated and used to develop subsequent events to ensure that stakeholders can see how their views have informed, and are shaping the developing model.

- General Principles launch events (10 and 15 November 2017)

100 attendees at our launch events to develop a set of high-level principles on which to build the revised model.

- Self-Care and Empowerment (30 November 2017)

Self-care and empowerment: 25 people helped us examine how to incorporate prevention into the model, how to empower people to take more control over their own care, and how to encouraging stronger local communities in the model.

- Person-Centred and Co-ordinated Care (5 December 2017)

At this event, attended by 49 people, we asked a panel of patients to tell us their stories which were then used to focus discussions around how to make sure that the revised model of care is joined-up in a way which works for patients.

- Clinical Priorities (12 December 2017)

At this final workshop 44 clinicians and members of the public helped us to develop the practical components of a model of care, advising on how they would work and the potential barriers to delivery.

In addition to the above the CCG took the opportunity to engage stakeholders through existing meetings:

- GP Protected Learning Time (15 November 2017)
- STP Workshop (27 November 217)
- Informal CCG Governing Body Workshop (29 November 2017)

The Patient Panel

A Patient Panel has been formed and was present at two of the community services stakeholder events (Person-Centred and Co-ordinated Care, and the Clinical Priorities) where it was the focal point for discussions. The panel includes representation from three members of the public (past and present service users), Healthwatch Medway, and Involving Medway. The Panel is independently supported by PEA to participate in events and to challenge with confidence.

The Patient Panel has/ will:

- Ensure that communication is patient-centred and uses plain English.
- Told their stories as real life case studies – to see where improvements may be needed and to test new ideas.
- Be involved in subsequent stages of the procurement programme, including evaluation of bids.

Next Steps

A draft summary report of all the findings so far has been compiled and is appended to this report.

Bringing together all the findings of the initial engagement and the clinical case for change a 'Whole System Design Workshop' on 10 January will test the revised model for effective community services including examining specific patient journeys and pathways of care. We will make sure that the event includes representatives from each of our key stakeholder groups so that they can work together to review the revised model of care.

During this period we will work further to engage with patients and with communities who may not attend events; through further written survey work and targeted visits and outreach work. We are exploring engaging with housebound patients directly through nursing teams.

Further to agreement with the Health Overview and Scrutiny Committee and through the NHS England assurance process, the CCG will undertake a series of activities to promote, run and analyse a 12 week extended engagement on the proposed options or models for delivering community services in Medway. This is likely to take place between May and July 2018.

We will publish our extended engagement findings as we move along the process and show people what we have done as a result of their feedback. We will publish a full report on the findings and continue to engage with patients as we move into procurement. We will continue to involve and consult the Patient Panel throughout the procurement process, including mobilisation and monitoring the implementation of the revised model. The latter of which was raised and asked to be addressed through one of community stakeholder events.

Test 2 - Consistency with current and prospective need for patient choice

The revised model will enhance equality of service provision and patient choice. The location and accessibility of current community services is not equitable across the localities resulting in some patients having to travel further than others for the same services. The revised model will not limit choice of access to services such as phlebotomy and wound clinics which will be provided across each of the six localities.

The service specification will ensure that, in line with clinical guidelines, people are offered informed consent and choice of treatment options where appropriate. This will be enhanced by better links to a range of self-care options and services that enhance general wellbeing.

The operating hours of the majority of current community services is 9-5 Monday to Friday. In line with national policy for extended hours, the revised community services model will ensure more timely more convenient access.

Test 3 - A clear clinical evidence base

(ii) Is there evidence to show the change will deliver the same or better clinical outcomes for patients?
(iii) Will any groups be less well off?
(iv) Will the proposal contribute to achievement of national and local priorities/targets?

The revised model will enhance community services and does not reduce service provision. Whilst there may be some movement in the location of services, the revised model will ensure that, in line with the Medway Model, provision is based on the needs of the six local care areas. The case for change has drawn on the following to show how redesigning services will lead to better patient outcomes.

Review of other CCGs, vanguard sites and best practice research

A review of other areas has also taken place in order to learn from similar redesign and re-procurement projects for example Bromley CCGs recent procurement of community services, vanguard sites (national new models of care) for example learning from Encompass in Whitstable, and learning from the Carnell Farrar STP local care research. Other key national best practice research has also been reviewed including:

- Community services: How they can transform care (Kings Fund, 2014)
- Specialists in out-of-hospital settings (Kings Fund, 2014)
- Co-ordinated care for people with long term conditions (Kings Fund, 2013)
- Case Management (Kings Fund, 2011)

Latest clinical guidelines

All current community services have been subject to a review as part of the stocktake and due diligence stage of the Community Services Re-Procurement Programme. This has included a review of service standards, such as NICE guidelines. The final service specification will ensure that the revised model adheres to the latest best practice guidelines.

Strategic Context – national and local priorities

The new model fully supports the following key areas of policy and strategy:

- The NHS Five Year Forward View
- Kent and Medway Sustainability and Transformation Plan
- General Practice Forward View
- The Medway Model
- Health and social care integration
- Medway Council – Medway Local Plan
- Local estates strategy
- Kent and Medway digital strategy
- Medway Urgent Care Redesign
- Medway End of Life Care Strategy for Adults

Local tests for change

The CCG has begun or is developing small tests for change, findings from which will/have informed the revised model. These include a range of interventions for elderly patients and adults with complex needs:

- Proactive Care for the Elderly - clinics are being rolled out across Medway to provide a multi-disciplinary approach to care of frail older patients through a geriatrician-led multi-disciplinary team.
- Frailty Flying Squad - provides an extended hours service, operating 7 days a week, 365 days a year to supporting patients in their usual place of residence in urgent situations.
- Technology enhanced single point of access – A central monitoring point for frail older people who are at high risk of admission to hospital or high intensity users of GP's by using telecare and other technology enhanced care services.
- Care Homes – Dedicated nursing, end of life, and pharmacy support to care homes, recognising the impact of the care home population on health services.
- Primary Care Home Programme – population health management in support of MDTs.

The CCG, alongside Public Health, have developed health profiles for each locality and Medway as a whole. These health profiles, the public engagement work carried out in partnership with Involving Medway, and the developing model will inform a Combined Impact Assessment (including equality and diversity). This will inform the next stage of development of the revised model.

Test 4 - Evidence of support for proposals from clinical commissioners – please include commentary specifically on patient safety

The CCG Commissioning Committee has agreed the Case for Change (clinical and strategic) which is appended to this report.

In addition, the CCGs Governing Body has been kept informed at various stages of progress including a workshop on the 29 November 2017. The CCGs Governing Body fully supports the Community Services Re-Procurement Programme.

The Clinical Priorities stakeholder event, which took place on 12 December 17, was a specific session focussing on developing the clinical model, and involved a range of clinicians from across acute primary and community services. The session tested the key component parts of the proposed model and was broadly supported by all participants including patients who recognised that the revised model represented an opportunity to improve patient experience and outcomes.

The GP listening event, which took place on 15 November 2017, identified key themes, please see the attached draft summary findings of Public Engagement report. Themes included the need to wrap community health services around primary care and to have better integration across services and better inter-agency communication. The group also suggested that there has been a drop in effectiveness of some services with some services experiencing long waiting lists.

Commissioners are aware that the transition of services and mobilisation may have an impact on patient safety. The Community Services Re-Procurement Programme Steering Group will ensure that an appropriate transition and mobilisation plan is in place to mitigate against any impact on patient safety and continuity of services.

Commissioners will work with providers to ensure that any potential impacts on interdependent services are managed and mitigating actions put in place.

All services will be working to the existing quality standards and monitored by the Quality and Safety team at the CCG. The Chief Nurse, who leads on Quality and Safety, also is a member of the Steering Group and the Programmes Clinical Lead.

The Community Services Re-Procurement Programme Steering Group regularly monitors the Programme Risk Register and these are subsequently shared with the CCG Commissioning Committee and Governing Body.

Effect on access to services

(a) The number of patients likely to be affected
(b) Will a service be withdrawn from any patients?
(c) Will new services be available to patients?
(d) Will patients and carers experience a change in the way they access services (i.e. changes to travel or times of the day)?

In 2016-17, approximately 38,000 people received community services (excluding community phlebotomy, which brings the total to 94,000 people). This represents a significant proportion of the Medway population (approximately 1 in 8 people, excluding community phlebotomy). A larger proportion of people aged 65 and over use community services (approximately 1 in 4).

There is no intention to withdraw any community services that that CCG currently commissions. The Kent and Medway Referral and Treatment Criteria will continue to be used as a guideline for treatment options.

The revised model will improve current services by:

- Realigning and upskilling the workforce
- Improving access and simplifying services
- Improving co-ordination of care
- Ensuring a stronger prevention and self-empowerment ethos

The revised models will take advantage of technology enabled care, including telehealth, teleconferencing and self-care apps, which will improve accessibility for those patients who are able to take advantage of these tools, while recognising that they will not be appropriate for everybody.

The operating hours of the majority of current community services is 9-5 Monday to Friday. In line with national policy for extended hours, the model will ensure more timely more convenient access.

The location and accessibility of current community services are not equitable across the localities resulting in some patients having to travel further than others for the same services. As described above, the revised model will address these inequities, reflecting the needs of the local populations and providing care closer to home.

(Calculations below are based on the majority of community services but currently exclude community phlebotomy, MSK Physiotherapy and some smaller services. Figures will be adjusted in the business case.)

In 2016-17, of the total contacts for community services (≈ 425,000):

- approximately 12% were telephone contacts.
- approximately 62% of contacts were in the patient's place of residence.
- approximately 26% of contacts were in community health settings.

The revised model recognises the importance of the provision of services in people's place of residence (including care homes) and will continue to provide visits to housebound people and those in care homes when required. Housebound patients will be clearly defined and an efficient model of care will be implemented to ensure that there are not multiple visits from separate members of the MDT and that appointments are planned and timely.

Of the 112,000 face to face contacts in community health settings:

- approximately 42% (≈ 46,700) were in an IHWC (currently healthy living centres)
- approximately 58% (≈ 65,400) were in alternative community settings.

The revised model recognises that the current community estate is not fully utilised and, in order to support the co-location of multidisciplinary teams, the majority of the services currently provided in alternative community settings would move into the local IHWC (currently healthy living centres).

There is variation in the utilisation of IHWCs between localities. This can be illustrated by comparing the number of community health setting face to face contacts by Primary Care Home location (a proxy for residence) to the number of contacts held in that location. The revised model will address these discrepancies by moving services, for example clinics, to a closer location.

This would mean over 65,000 additional face to face contacts in community health settings moving into an IHWC – an increase of 40%.

Locality	All community health setting face to face contacts in 16-17 by Primary Care Home	Percentage of community health setting face to face contacts by Primary Care Home	Number of community health setting face to face contacts in 16-17 in healthy living centre	Revised model – shift in community health setting face to face contacts by location
Gillingham	19,580	17.48%	5,199	+14,381
Rainham	21,889	19.54%	8,771	+13,118
Rochester	12,501	11.16%	21,222	-8,721
Strood	28,721	25.64%	0	+28,721
Lordswood	19,679	17.57%	11,616	+8,063
Chatham	9,647	8.61%	0	+9,647
Total	112,017		46,808	+65,209

In total, approximately 82% of community health setting face to face contacts activity would move.

- 75,900 community health setting face to face contacts (approximately 68% of non-home-based face to face contacts in the community) would shift between localities to support contacts in a location closer to people's homes.
- An additional 15,800 contacts (14%) would move into an Integrated Health and Wellbeing Centre from alternative settings in the locality, supporting a 'one stop shop' approach.

Revised model – changes required	Community health setting face to face contacts	% of contacts in community	% of all contacts
No change	20,297	*18.1%*	*4.8%*
Move into IHWC from local area	15,801	*14.1%*	*3.7%*
Move between localities	75,919	*67.8%*	*17.9%*
Face to face contacts in community	112,017	-	*26.3%*

Demographic assumptions

(a) What demographic projections have been taken into account in formulating the proposals?
(b) What are the implications for future patient flows and catchment areas for the service?

The CCG, alongside Public Health, have developed health profiles for each locality and Medway as a whole. These profiles include future projections and these will be complimented by the Medway Local Plan. This will inform the next stage of development of the revised model, the outline business case to ensure that the services are delivered locally take into account the needs of local populations.

Diversity Impact

Please set out details of your diversity impact assessment for the proposal and any action proposed to mitigate negative impact on any specific groups of people in Medway?

The Combined Impact Assessment, which includes equality and diversity, is a developing document that will be informed by the implications on changes to where people access services, the locality health profiles, and the outcome of extended engagement.

The final model will ensure that all appropriate action has been taken to mitigate negative impact on any specific groups. This is being developed and will be completed alongside the outline service specifications and business case.

Financial Sustainability

(a) Will the change generate a significant increase or decrease in demand for a service?
(b) To what extent is this proposal driven by financial implications? (For example the need to make efficiency savings)
(c) What would be the impact of 'no change'?

The revised model will make better use of existing resources through better coordinated care which will reduce duplication and overlap between services. A key component of the revised model is ensuring a stronger prevention and self-empowerment ethos which will be achieved by improving patient education, improving access to self-care tools and greater use of technology, and improving links to community-based resources that enhance general wellbeing.

As with all public services, there is an inherent drive to ensure value for money and effective outcomes in all services that we deliver. Our Case for Change is underpinned by the following:

- To abide by procurement regulations
- To align with national, regional and local strategic direction
- To refocus resources where they have most impact
- To improve access by ensuring services are provided in the right place and at the right time
- To realign a highly competent and resilient workforce
- To treat the person, not the condition
- To ensure prevention and patient empowerment is at the centre of community services
- To make better use of technology to support the delivery of community services
- To make better use of intelligence (data and feedback) to constantly develop the system

The impact of no change would be as follows:

- Inability to prove best value for money in a health social system that is under financial pressure
- Lack of opportunity to redesign services in line with national, regional and local strategic

direction
- Lack of opportunity to systematically redesign, localise and improve services, and improve patient outcomes.

Wider Infrastructure

(a) What infrastructure will be available to support the redesigned or reconfigured service?
(b) Please comment on transport implications in the context of sustainability and access

The revised model is underpinned by the Medway CCG Local Estates Strategy which is currently being updated. The four healthy living centres in Lordswood, Gillingham, Rainham and Rochester are already established. The CCG is working with Medway Council through the One Public Estate programme to identify equivalent high calibre estate in the Strood and Chatham locations. The six Integrated Health and Wellbeing Centres will be at the centre of the locality-based model.

Recognising that there will be a time lag in all the estate being ready, existing sites within the relevant locations will be used in the interim.

Each of the Integrated Health and Wellbeing Centres (currently healthy living centres) are undergoing infrastructure upgrades to ensure that they are fit for purpose to enable the future ICT requirements. By 2020, the CGG would require the community services provider to support internal efficiencies and to operate in a paperless environment; including diagnostic requests and results; and shared care plans with other health and social care providers.

The future model will provide care as close to home as possible. Initial analysis demonstrates that currently approximately only 32% of patients are seen in their local area. This will significantly reduce the need for non house bound patients to travel.

There will be a positive environmental impact assessment with the provision of care closer to home resulting in fewer car trips.

The Community transport provision and bus routes will be reviewed as part of this process. Lack of public transport of Sundays will be taken into account when looking at demand for services.

Is there any other information you feel the Committee should consider?

The local health and social care system has developed the Medway Model in partnership. The redesign and re-procurement of community services presents an opportunity to fully embed this localised model across Medway within the next three years.

Please state whether or not you consider this proposal to be substantial, thereby generating a statutory requirement to consult with Overview and Scrutiny

The CCG recognise the significance of community services in alignment to the Kent and Medway Sustainability and Transformation Plan, the Medway Model and the impact on acute and primary care and feels that an extended period of engagement would offer the opportunity for the public to shape their local services.

Following initial discussions with NHS England as part of their assurance process, the CCG is suggesting that the revised model will not constitute major service reconfiguration and

therefore, does not constitute a substantial variation. This is based on the following reasons:

The revised model for community services will enhance integrated working between health and social care, primary care, and secondary care. It aligns to the Kent and Medway STP expectations for local care, and to the Medway Model.

- There will be some changes to location of services. However, the location and accessibility of current community services is not equitable across the localities resulting in some patients having to travel further than others for the same services.
- The majority of community service contacts (62%) take place in the patient's place of residence. Approximately 26% of contacts take place in a community health care setting, the remaining 12% of contacts are telephone contacts. In summary of all community service contacts the proposal will only affect approximately 22% (approx. 92,000 contacts) and it is envisaged that this will have a positive impact in providing care closer to home (noting the exclusions as detailed in the effect on access to services section above).

The CCG intends to significantly engage and test the revised model in more detail. As a result this programme has time allotted to carry out an extended engagement to further refine the model.

The CCG now seeks HASC recommendation on whether this constitutes a substantial variation.

Supporting Documentation

- Case for Change – clinical and strategic
- Communication and Engagement Plan
- Draft summary findings of Public Engagement report