Community Services Re-Procurement Programme
Case for Change

1. Introduction

As part of its commitment to securing a sustainable healthy future for the people of Medway, NHS Medway Clinical Commissioning Group (the CCG) has undertaken a review of adult community health services (henceforth referred to as community services) to determine how they can be strengthened and redesigned to ensure that patients remain well and cared for close to home. This is the Community Services Re-Procurement Programme.

This document presents the strategic and clinical case for change which will be used as a basis for developing public consultation documentation on the redesign and re-procurement of community services, alongside proposals for future models which are currently in development.

The document outlines the strategic context in which community services in Medway operate, highlights the local challenges and opportunities, and summarises the key areas of focus for the programme. It draws on findings of a recent due diligence stocktake review, best practice case studies, and the stakeholder feedback gathered to date.

2. Background and local context

Historic and current arrangements

The current arrangements for the provision of community services date back several years with Medway Community Healthcare (MCH)as the main provider in Medway. A small number of services are commissioned from Kent Community Health NHS Foundation Trust (KCHFT), through contract arrangements with the voluntary and community sector, and through an Any Qualified Provider contract. The CCG has worked with the providers over this period to develop and refine community service provision.

Contracts with current providers will end on 31 March 2020 which provides the CCG with the opportunity to redesign services. As a Public Sector Contracting Authority the CCG is governed by two pieces of procurement legislation: the Public Contracts Regulations 2015/102 (PCR 2015), and the National Health Service (Procurement, Patient Choice and Competition) Regulations 2013/500. The PCR 2015 places legal requirements and procedures on the CCG for awarding new healthcare service contracts above a certain financial threshold. As the current value of the current contracts is above that threshold, the programme is subject to a formal procurement.

Scope

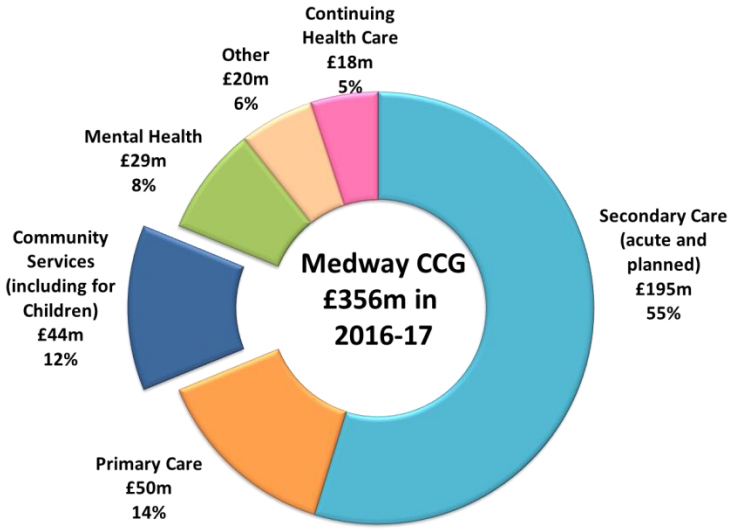
Community services are those that help people optimise and maintain their health either in their own home or other out-of-hospital settings close to home. They provide a wide range of care, from supporting patients to manage long-term conditions, to treating those who are seriously ill with complex conditions. Teams of health care professionals, such as nurses and therapists, coordinate and deliver care, working with other professionals including GPs, social workers and the voluntary sector.

A final decision on the services in scope of the re-procurement will depend on the proposed new models. Below are some of the community services provided in Medway. Specialist children's community services are excluded from this programme as it is currently being re-procured under a different programme.

- Community Nursing
- Continence Care
- Tissue Viability and Wound Therapy
- Specialist Palliative Care
- Cardiology and Arrhythmia
- Respiratory
- Diabetes
- Dermatology
- Speech and Language Therapy - Adults
- Nutrition & Dietetics
- Phlebotomy
- Anti-Coagulation
- Community Rehabilitation including rehab day centre, Falls, Physiotherapy, Neuro Physiotherapy
- Clinical Assessment Service
- MSK Physiotherapy
- Hand Therapy
- Dementia Crisis Support Team
- Learning Disabilities
- Stroke Services (Community) including bed provision and Stroke Association
- Epilepsy
- Lymphoedema
- Podiatry including Age UK Foot Care
- Cellulitis
- Pro-active clinics for the elderly

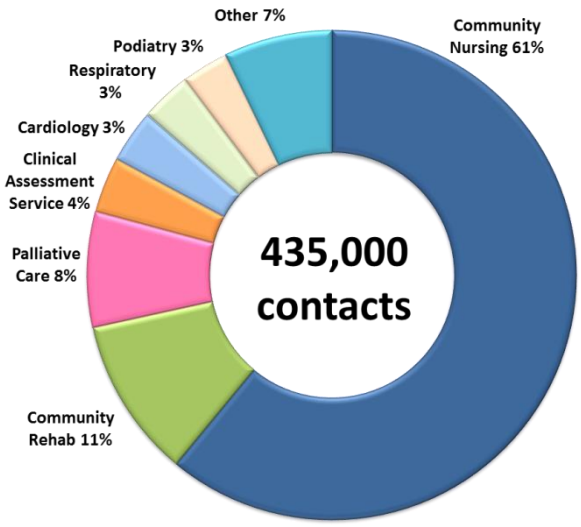
Community services in Medway contribute to a substantial proportion of CCG expenditure. In 2016-17, £44m was spent on community services for adults and children, equating to 12% of total expenditure.

Medway CCG expenditure 16-17



Community services in Medway have a wide reach. In 2016-17, approximately 38,000 people received these services which equates to approximately 1 in 8 people (excluding Community Phlebotomy, which, if included increases to approximately 94,000 - 1 in 3 people in Medway).

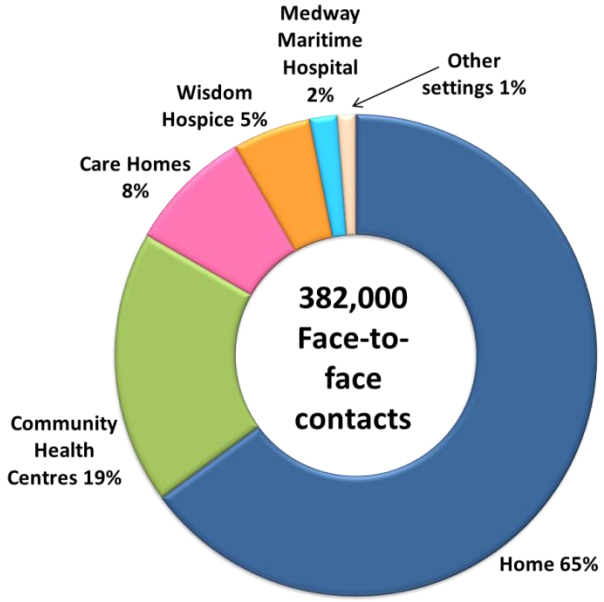
Community services contacts 16-17 (excluding Phlebotomy)



In 2016-17, there were approximately 435,000 contacts in community services (excluding Community Phlebotomy). The majority of these contacts were face to face (88%).

The Community Nursing provided 61% of these contacts as the service interfaces with many other services.

Location of face-to-face contracts 16-17 (excluding Phlebotomy)



Community services are provided in a variety of settings across the area. The majority of face-to-face contacts take place in people's homes – including care homes, this equates to almost 75%.

A larger proportion of people aged 65 and over use community services with approximately 1 in 4 accessing these services in 16-17.

Within the clinical acceptance criteria for each service, community services are open to everyone regardless of race, gender, sexual orientation, religion or belief. A full Combined Impact Assessment will be carried out once new models are proposed. At this stage there is no significant impact expected on any of the protected characteristics (outlined in the Equality Act 2010).

3. Strategic Context

The redesign of community services must take into account the national policy of the NHS and the local strategic direction. Below, the key policies and strategies are summarised with an explanation as to why they contribute to the case for change.

The NHS Five Year Forward View

The NHS Five Year Forward View (FYFV) was published in October 2014 by NHS England. The strategy recognises the dramatic improvements in the NHS since the turn of the century thanks to protected funding and commitment of NHS staff. However, it highlights the ongoing challenges and the pressures that the NHS is facing – including that the quality of care is variable, preventative illness is widespread, and health inequalities remain. The FYFV advocates the breaking down of barriers in how and where care is provided – between GPs and hospitals; physical and mental health; and health and social care. It highlights that the traditional divide between primary care, community services and hospitals is increasingly a barrier to the personalised and coordinated health services to meet patients need.

The FYFV explains that future service design should focus on managing and designing whole systems of care – not just a focus on individual organisations that provide care; and that care should be delivered locally, organised to support people with multiple conditions rather than single diseases.

The FYFV is a vision for the future of health services based on new models of care, with local areas selecting models that best suit their local area. Many of these new models of care have been trialed in vanguard projects across the country to develop blueprints for the NHS moving forward and capturing the learning to share with the rest of the health and care system.

> **This tells us: New models of care in Medway need to ensure that experiences from these vanguard projects are taken into account.**

Kent and Medway Sustainability and Transformation Plan

To deliver the FYFV on a local basis, regional health and care systems in England were asked to come together to create a plan for accelerating its implementation. The result was Sustainability and Transformation Plans (STPs) which set out how NHS and local authority organisations will sustain services and transform the delivery of care. STPs are being developed in an atmosphere of financial and operational pressures. They must, therefore, balance the need to sustain current services and use existing resources in the most efficient way, whilst developing new models of care that focus on better integration, better health and wellbeing, and improving quality of care.

Locally, Medway is a partner in the Kent and Medway STP. The list below identifies the local reasons for change:

- The local population is growing rapidly
- Local people are living longer and older people tend to have additional health needs
- Lots of people are living with long-term conditions
- Too many people are living unhealthy lifestyles and are at risk of developing conditions that are preventable
- There are unacceptable differences in health across Kent and Medway
- Many people (including children) have poor mental health, often alongside poor physical health
- If we carry on working in the way we are, we cannot meet the current and future needs of local people with our existing budgets

An overarching priority of the Kent and Medway STP is 'Local Care' which is focused on developing more and better services in people's homes and in the community by bringing together services currently provided by GPs, with the range of existing community services and others, like urgent care, diagnostic tests, mental health support, and social care. Local Care will reduce the need for people to go to hospital for treatment and services that in the future could be provided more locally. Having high-quality local care with greater capacity will relieve some of the pressure on our hospitals. It will reduce the need for people to go to hospital for treatment and increase the services that in the future could be provided more locally.

This tells us: Developing and implementing a new model of care for adult community services is an important strand of the Kent and Medway STP. The plan explains the vision to ensure that local people are at the heart of services, and that they are helped to stay well and independent in their own homes and communities and avoid being admitted to hospital.

General Practice Forward View

NHS England published the GP Forward View (GPFV) in April 2016 as a transformation strategy aimed to support GP practices and invest additional funds in: developing the GP workforce; improving recruitment and retention, streamlining workload and reducing red tape, improving infrastructure, and supporting practices to redesign services to local people.

Medway CCG published a local GPFV in December 2016 to outline how general practice in Medway would be strengthened and transformed in line with national and local strategic direction. It explains how GPs are fundamental in the co-design of the Medway Model and in setting out a vision for self-care, technology, and the wider workforce. It includes the implementation of ten high impact actions designed to give GPs 'time to care'.

10 High Impact Changes

This tells us: General practice will need to be placed at the centre of community services in the future model of care, and the new model should mirror the ten high impact changes.

The Medway Model

The Medway Model outlines our local interpretation of ways to address the challenges of the FYFV, the GPFV and the Kent and Medway STP. The model is based on the provision of out-of-hospital services wrapped around six Local Care Teams (LCTs), in local natural geographical communities. It brings together GP practices so that they become responsible for the health of a much larger population of around 30,000 to 50,000. The six LCTs will consolidate around three Integrated Care and Wellbeing Centres, bringing together a range of clinical services, wider health and social care expertise, and the voluntary and community sector all under one roof in a way that facilitates more 'joined up' ways of working for a population of about 100k.

This tells us: Wrapped around the Local Care Teams, community services will be a fundamental part of the Medway Model. Services will need to be co-located based on needs of the local population in alignment with the Medway Model.

Health and social care integration

The Better Care Fund (BCF), implemented in 2015, encourages local health and social care organisations to work together in line with the vision outlined in the FYFV. The BCF requires organisations to pool budgets and agree a spending plan to integrate health and social care services and to improve the lives of the most vulnerable. In Medway, the BCF Plan focuses on: aligning resources with the Medway Model, rationalising estate, building joint commissioning arrangements, working on the digital roadmap, and joint communications and engagement

One of the key areas of focus for Medway Council Adult Social Care in 2017-18 is the development of a 'Three Conversation' approach which will deliver more person centred care and support as well as help prevent, reduce and delay the development of longer term care needs.

Over the next few years, Medway will make a significant shift from expenditure on traditional institutional style services, such as care homes and day centres into services delivered in people's own homes and in local communities. The aim is to reduce the amount spent on residential care homes unless there is a specific, specialist need to provide care in those settings which cannot be accommodated at home.

Best Practice: Enhanced health in care homes

The FYFV includes a new model that aims to provide more support for frail older people living in care homes by NHS services working in partnership with local authorities and local care home providers to develop new way to support older people. The Framework for Enhanced Health in Care Homes (September 2016) was developed based on the findings of six vanguard areas.

The framework has a focus on quality as the driving factor for change and the use of clinical evidence to support as well as drive change. It advocates putting the needs of the resident or person with care needs at the centre of any changes whilst supporting carers and families at the same time. It argues that strong leadership and a joint shared vision for better car are needed and that a whole-system approach is needed to break down organisational barriers between health, social care and the voluntary sector. The framework acknowledges the value of the care home sector in supporting the NHS and the significant level of healthcare that is delivered in care homes by social care staff.

This tells us: Wherever possible, we must ensure that community services work alongside social care services to provide a coordinated service and a better patient experience. New models must be designed to cope with the shift of social care out of traditional–style care homes to other settings.

Estates Strategy

Medway CCG has developed a strategy to ensure that estates are key enablers - in building resilience and growth into the local system and to deliver the new models of care outlined in the FYFV. As outlined above, the development of Integrated Health and Wellbeing Centres is fundamental to the Medway Model to ensure that the scale and configuration of space is suitable for clinical work and supporting activities. The existing healthy living centres will be developed and, working with the local authority through the One Public Estate Programme, there are plans to build new facilities in Chatham and Strood.

> **This tells us: The new model for community services should support the delivery of the End of Life Strategy including a new model of care, raising the profile of end of life care and the realigning resources to support it in the community.**

Digital Strategy

The Kent and Medway Digital Roadmap, supported by a large-scale scheme of national investment into technology, outlines how IT and technology enabled care services will be utilised to support the delivery of a modern, integrated, paperless NHS which revolutionises the way patients access care from home and empowers people to take control of their healthcare needs. Areas of focus include: the standardisation of systems, consolidating ICT infrastructure, improving patient record sharing, introducing SMS text reminders, improving the ordering of diagnostic tests, patient online services, and telehealth opportunities to support patients in self-management of long term conditions.

> **This tells us: We must ensure that areas of focus in the digital strategy are incorporated into the new model of community services so that they become a key enabler to providing more efficient services. Future services should be designed to keep up with ever-developing technology.**

Urgent Care Redesign

In November 2013, the Keogh Review outlined the case for change for improving urgent and emergency care services in England. It highlighted the following areas of focus:

- Provide better support for people to self-care
- Help people with urgent care needs to get the right advice in the right place, first time
- Provide responsive urgent care services outside of hospital so people no longer choose to queue in the Accident and Emergency (ED) department
- Ensure that those people with more serious or life threatening emergency care needs receive treatment in centres with the right facilities and expertise
- Connect all urgent and emergency care service together so the overall system becomes more than just a sum of its parts

The FYFV compliments these findings and states that urgent and emergency care services should be redesigned to improve integration between emergency departments (ED), GP out-of-hours services, urgent care centres, NHS 111 services and ambulance services. NHS 111 is central to this vision – acting as a single point of access for urgent care, supported by a clinical advice hub that will assess patient needs and advise on the most appropriate course of action.

In Medway, the Urgent Care Redesign process is underway.

> **This tells us: The new model for community services must consider the interface with urgent care and ensure that they complement the new model for urgent care.**

End of Life Strategy

Medway's End of Life Strategy was published in 2017. This is aligned to the national framework, Ambitions for Palliative and End of Life Care (2008). The strategy includes the following priority areas to address the current gaps in the system:

- Ensuring professionals are supported and have the skills and knowledge to provide end of life care:
- Reviewing and developing a new model of care
- Improving systems to support consistent, efficient and effective care
- Ensuring that patients, carers and families feel supported
- Promoting local awareness of death, dying and bereavement

This tells us: The new model for adult community services should support the delivery of the End of Life Strategy, raising the profile of end of life care and the resources to support it in the community.

Community Services: how they can transform care

King's Fund research (Community Services: How they can transform care, 2014) has formed the basis for other similar redesign programmes. It is based on work with a range of community providers to determine the changes required to enable care to be provided closer to home, and to contain the growth in demand and the tight finances the NHS is facing. The report outlines the following key areas:

- Simplify services and remove unnecessary complexity which needs fundamental changes in the way primary care and hospitals are configured and commissioned
- Wrap multidisciplinary teams around groups of practices, including mental health, social care, specialist nursing and community resources – based on natural geographies
- Use these services to build multidisciplinary care teams for patients with complex needs.
- Ensure that services can respond quickly to speed up discharge and to reduce length of stay in hospital beds
- Working in new ways with specialist services to offer patients less fragmented services
- Develop teams and services to provide support to patients as an alternative to admission or hospital stay.
- Improve the information infrastructure, workforce, and ways of working and commissioning that are required to support this.
- Reach out into the wider community to improve prevention, reduce social isolation, and create healthy communities.

This tells us: Our model for community services should be based on best practice and evidence from other areas

4. Local Challenges

Demographics and population health – key facts

(Data taken from Medway Council Public Health team, the Medway JSNA, and the Kent and Medway STP Case for Change Technical document)

Growing population and people living for longer

The resident population of Medway is estimated at approximately 278,000 and is estimated to grow to approximately 330,000 by 2035. While Medway has a relatively young population, the number of older people is set to increase - those aged over 70 will rise by 20% in the next 5 years. 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. For males, the average life expectancy is 78.4 compared with an England average of 79.5. For females, the average life expectancy is 82 years compared with an England average of 83.1. Health life expectancy is also 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.

> **This tells us: We must ensure that resources are realigned to cope with the growing and aging population.**

Living with poor physical health

In Medway, 16.4% of adults (all ages) have a long term condition or disability that limits their day-to-day activities. Whilst this is lower than the England average (17.6%), it equates to over 40,000 people. In some areas, this percentage increases to almost 40%. 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.

For a number of long term conditions, including diabetes, obesity, hypertension and depression, the proportion of the Medway population registered with their GP as having these conditions is higher than the England average. This may place more demand on services relating to these conditions than average.

People are living for longer with long term conditions, males are living for around 16 years of life not in good health and females over 20 years in poor health (22.3 years). Over 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).

> **This tells us: In order to ensure that there is parity of esteem between mental and physical health, new models will need to join up services so that people with physical conditions are also supported with mental health conditions.**

Living with poor mental health (often alongside poor physical health)

It is estimated that approximately 16% of people in Medway have a common mental health disorder – such as depression or anxiety. This is similar to the England average and equates to around 31,000 people in Medway. However, mental health problems disproportionately affect people living in the most deprived areas and often go hand-in-hand with physical health conditions.

This tells us: In order to ensure there is parity of esteem between mental and physical health, new models will need to link community services that people with physical conditions to those that support people with mental health conditions.

Wider determinants

There are many wider factors that influence people's health which, for Medway overall, we are not doing as well as England. These are areas where further work would be beneficial on across the health and care system in future. We know that wider determinants of health such as homelessness and unemployment are important influences of people's health. Community services will need to have strong pathways and referral mechanisms to preventative services which will help people to stay well for longer, as well as incorporating secondary prevention and self-care within services.

Lifestyle behaviours such as smoking, alcohol consumption, physical inactivity, poor diet and being overweight cause poor health, worsening of disease, multiple illnesses and early death. These tend to be worse in the more deprived areas of Medway.

This tells us: We must ensure that preventative services are at the centre of the new model for community services and ensure that links are made to other services that support people's wider wellbeing.

Pressures in Primary Care

Primary care is often the first point of contact for people with a health problem and is crucial in health promotion, treating minor illness, signposting to other health and social care services and managing people with more complex needs. As outlined above, the Medway Model places GPs at the centre of our vision for an improved system.

There are areas in which the primary care sector in Medway is fragile. The Kent and Medway STP explains that fragility within primary care is characterised by low numbers of GPs and practice nurses per head of population - meaning that access to primary care services is difficult, high vacancy rates and high locum use – also meaning GPs and practice nurses do not know the patients or the services available locally. In Medway, the percentage of GP practices, excluding branches where the practice operates with a whole-time-equivalent of two or less is 48%

There are also very high levels of vacancies across primary care creating a dependency on locum GPs which constitute 8% of the GP workforce in Kent and Medway. The situation is likely to get worse as over a third of GPs will retire in the next five years. In Medway, there are also challenges in recruiting practice nurses, with a low number of practice nurses compared to the national average.

The Kent and Medway STP identified the following issues associated with frailty in primary care:

- Later identification of disease if early indicators of disease such as obesity and smoking are not identified and addressed in primary care.
- More complications and worsening of disease if monitoring of people with long term conditions is not comprehensive.
- Increasing activity in hospitals if local people use A&E rather than their local GP surgery for urgent care.
- Pressure on mental health services if poor mental health is not identified until it results in a crisis.

Some people in Medway are unhappy with existing GP services; on average 68% would recommend their GP surgery to a friend, compared to 78% nationally. People find it difficult to contact their GP surgery and there are long waits to be seen when they get there.

This tells us: Community services should take into account the fragilities that exist in primary care whilst recognising that GPs are fundamental in the Medway Model.

Pressures in Secondary Care

There are many pressures on secondary care, and relieving this pressure is a key outcome from the strategies listed above. Some illustrations gathered from locally collected data are:

- As many as four in ten emergency admissions to hospital could be avoided if the right care was available in the community.
- Between May 2015 and October 2017, the four-hour target for waiting in the Emergency Department had not been met at Medway Maritime Hospital.
- Diagnostic test waiting targets have not been achieved since May 2015 at Medway Maritime Hospital.

The Kent and Medway STP states that when people go to hospital they tend to stay in hospital for a long time and have difficulty getting out of hospital and back home. In addition a third of all people in acute hospitals who are medically fit have been medically fit for over a week. When people are ready to leave hospital, local services are often not ready to look after them, so they must stay in hospital longer. It costs, on average, £220 per day to care for someone in an acute hospital bed and this money could be better used elsewhere. There have been improvements in this area over the last year but we need to ensure that community services are designed to sustain this.

The Kent and Medway STP found that the level of referrals from GPs to hospital specialists in Kent and Medway are higher than other places with a similar population. This may reflect different levels of patient need, or it may be due to differences in clinical practice between doctors and nurses at any point where care is given. The STP found that if the level of referrals were the same as top performing CCGs in similar areas, outpatient activity would reduce by 9%. If planned activity in hospitals were the same as top performing areas CCGs in similar areas, it would reduce by 14%.

This tells us: In line with national and local strategy, new models of community services must help relieve pressure on secondary care and this will require a realignment of resources across the system.

Diligence Stocktake Review

Throughout summer 2017, a series of due diligence stocktake reviews took place for a range of community services. At these meetings, service specifications were reviewed to ensure that commissioners and providers had a common understanding of current service provision. The findings are broadly in line with the evidence and rationale detailed in the various local and national strategies. There were many areas of good practice which will be carried on in new models. However, there were also areas that could be improved, including:

- The way current services are designed does not always promote a holistic and patient-centred approach.
- The way in which professionals work together within and between organisations could be better to improve people's experience of care.
- There is inconsistent use of the Medical Interoperability Gateway, Electronic Referral System and other digital developments across services. Sharing of information could be better.
- Improvements are needed to make sure that care is available in the right location and at the right time.
- There is variation in how quickly people get seen from services to service.
- Ensuring that the prescription of medication is done in the most timely and efficient way.
- Working with primary care, community services could be more proactive in identifying and treating those people who are most at risk.
- There needs to be stronger links to services that support wellbeing, such as talking therapies; and to wider support networks in the voluntary and community sector, including peer-to-peer support groups.

- Improvements have been identified in the way information is recorded and reported.

This tells us: The detailed findings of the due diligence stocktake reviews must be taken into account when designing new services to ensure that inefficiencies and gaps are addressed.

In addition, detailed workforce information for each service was reviewed and findings were consistent with other areas in that the pressure on the local community workforce is increasing. Staff shortages are a recurring theme across community services. Recent data (Jul 2017) identifies that there are a number of local community services that are operating with a vacancy rate of over 5%, with the average across these services at 14%.

This is a similar picture to the findings of the Kings Fund report on workforce planning in the NHS, published in 2015. This found that a study by Foot *et al* (2014) raised serious concerns about workforce pressures within community services, with staff shortages being a recurring theme. It also highlights that the ambitions of delivering integrated community services wrapped around general practice requires a workforce that reflects the centrality of primary and community care and the need for more 'generalism', with the ability to deliver increased co-ordination across boundaries.

The CCG is working with community and secondary providers to look at improving the skill mix in the current workforce as an opportunity to deliver integrated and seamless system-wide care.

Historically, our community services have been commissioned and delivered by a large number of separate teams and groups of professionals. It is evident from the reviews we have undertaken that some services work in isolation with little integration or co-ordination across boundaries including between teams and with GP practices.

This tells us: We must ensure that the future workforce is adequate, resilient and competent, and that we need to simplify our services and improve co-ordination of care across boundaries to support new models for community services.

5. Stakeholder Feedback (Engagement Report/ You told us)

Stakeholder engagement to date

Medway CCG, working with the Involving Medway partnership, has begun to collate the views and experiences of community services. Service providers have submitted detailed reports that outline the number and details of compliments and complaints; and the results of the Friends and Family Test – the main mechanism for collecting patient satisfaction.

In addition, the CCG has been working with the Involving Medway partnership to gather patient and public insight by reaching out to local community groups through the use of focus groups and small feedback sessions.

Questionnaire

A questionnaire, tailored to both clinicians and the public, has been launched online. Hard copies of surveys have also been circulated. To date, around 60 questionnaires have been returned and the questionnaire will continue to be promoted.

Launch events

Two events were held in mid-November to launch the Community Services Re-Procurement Programme to the public and to the wider health and social care system. These events included attendance of a range of stakeholders including patients and public, GPs, representatives from current providers, Medway NHS Foundation Trust, KCHFT, KMPT, Medway Council, Patient Participation Groups, Healthwatch, and various community and voluntary sector organisations.

In addition, a separate session was held with local GPs at a recent Protected Learning Time. GPs were encouraged to feed back during the session and to attend future engagement events.

Planned future stakeholder engagement

A number of additional workshops have been scheduled, inviting a wide range of stakeholders who will be asked to prioritise a set of design principles, and asked to shape key elements for improvement for a future model of care for community services. This will help inform the service redesign process.

What have people told us so far?

- Ensure that services should be better integrated to reduce duplication and to provide a seamless experience (shared information, joined-up care plans)
- Keep up with digital technology but should not lose the human element
- Ensure that the needs of hard to reach communities are considered (some ethnic groups, homeless, and students)
- Build in flexibility for growth in demand and take into account the capacity of services and pressures on the workforce
- Ensure that prevention is a key part of the new model
- Focus on education (schools) to prevent health problems developing in later life and to raise awareness of what services are available
- Provide more services in the community instead of in hospital but need to develop the community services before going ahead with this
- Focus on workforce shortages and recruitment issues otherwise no models will work
- Develop the workforce and make sure it is properly supported in the light of changing work patterns
- Learn from experiences and best practice from similar re-procurement programmes
- Ensure that services are accessible for all and that patient transport services could be better
- Consider whether local estates are fit for purpose and the cost to providers
- Ensure that too much pressure is not placed on the voluntary and community sector as they are struggling too
- Design more proactive services and build in regular reviews for people with long term conditions
- Consider a ‘one stop shop’ model as close to home as possible
- Consider whether clinical pharmacists should go out to see people in their own homes to review and reduce medicines
- Improve the way appointment booking takes place and timings cause blocks in availability
- Ensure that mental health is not forgotten and that we cannot consider physical health without considering mental and emotional health. New models will not work if they do not include the right links to these services

What do people think a good commissioning process looks like?

- Ensure consistent and regular communications about ongoing changes to the systems and should reach out to more people
- Take into account both the cost of services and the quality
- Share more details about the current demographics and needs of the area
- Involve all organisations from start to finish
- Ensure that engagement is as inclusive as possible and that we use a range of methods
- Feed back frequently to let people know how we have used their input
- Design services based on detailed and accurate baseline information
- Consider quality in the tender evaluations
- Base service specifications on patient outcomes
- Be open, honest and transparent about services, costs and financial constraints
- Be innovative and consider new models and best practice
- Build in good contract management to ensure value for money
- Ensure contracts are long enough for providers to make a difference
- Ensure that there are concrete timelines
- Keep engaging once contracts have gone live

6. Summary of reasons for change

Drawing from the evidence outlined above, there are three overarching principles that support the case to make significant changes to the way adult community services are designed.

1. To abide by procurement regulations

The Public Contracts Regulations 2015/102 (PCR 2015), and the National Health Service (Procurement, Patient Choice and Competition) Regulations 2013/500 place legal requirements and procedures on the CCG for awarding new healthcare service contracts above a certain financial threshold. As the current value of the current contracts is above that threshold, the programme is subject to a formal procurement.

2. To align with national, regional and local strategic direction

Developing and implementing a new model of care for adult community services is an important strand of the Kent and Medway STP. New models of care in Medway need to ensure that experiences from the FYFV vanguard projects are taken into account.

General practice needs to be at the centre of community services in the future model of care and it needs to mirror the ten high impact changes. Wrapped around the Local Care Teams, community services will be a fundamental part of the Medway Model.

Wherever possible, we must ensure that community services work alongside social care services to provide a coordinated service and a better patient experience. New models must be designed with the shift of social care from traditional-style care homes into other settings.

We must ensure that the developments listed in the digital strategy are incorporated into the new model of community services so that they become a key enabler to providing more efficient services. New models must allow for flexibility to harness the efficiencies brought by continual developments in this field.

The new model for community services must consider the interface with urgent care and ensure that community services complement the new modes for urgent care services.

The new model for community services should support the delivery of the End of Life Strategy, raising the profile of end of life care and the resources to support it in the community.

3. To refocus resources where they have the most impact

In line with national and local strategy, new models of community services must help relieve pressure on secondary care and this will require a realignment of resources across the system, including coping with the growing and aging population.

Community services should take into account the fragilities that exist in primary care whilst recognising that GPs are fundamental in the Medway Model.

In order to support overarching principles, the following additional areas support the case for change:

4. To improve access by ensuring services are provided in the right place and at the right time

In line with the FYFV, the STP and the Medway Model, community services should allow care to be provided in the home, or as close to the home as possible. This includes within care homes – the NHS has published guidance in this area and this will be a focus of the Medway Care Home Steering Group.

We must ensure that community services make the most efficient use of existing and planned estate to align with our local estates strategy, which underpins the Medway Model.

5. To realign a highly competent and resilient workforce

Best Practice: Specialists in out-of-hospital settings

A Kings Fund report, *Specialists in out-of-hospital settings (2014*),
This report looks at six case studies from areas in England where specialist consultants have been deployed in community services in different ways. It highlights the evidence that shows that specialist input into the delivery and co-ordination of out-of-hospital care can improve patient outcomes and reduce the pressure on hospitals. Benefits to patients include an improved management of complex conditions, more timely access to specialist treatment, and treatment closer to home.

- The following strategies are advocated:
- Enhancing the skills of GPs and other community professionals
    - Jointly staffed outreach clinics
    - Consultant-run email and telephone helplines
    - Consultant participation in MDTs
    - Consultant-run education sessions
    - Consultants supporting staff to work extended roles
- Redesigning the workforce (redistributing roles and responsibilities)
    - Integrated consultant roles that span hospital and community settings
    - New roles for nurses and AHPs
    - GPs with Specialist Interests (GPwSIs)
- Redesigning the work (to replace rather than supplement and avoiding duplication)
- Addressing patient needs based on population-based health approach (segmenting the population and active case finding)

The report argues that in order for these changes to happen the whole-system must adapt, including shifts in culture and embracing innovation and change. System infrastructure must also change, including improving information sharing, and establishing new contractual arrangements.

We must ensure that the future workforce is adequate, resilient and competent so that it can support new models for community services. Regular monitoring of workforce data and the service review process have shown that there are currently challenges relating to vacancy rates and competency levels that we need to overcome.

There is evidence to suggest that realigning the workforce can help break down the traditional barriers between hospital settings, GPs and community services to provide more coordinated care.

6. To treat the person, not the condition

There is a wealth of evidence that shows that if a coordinated, holistic approach is taken to people's needs and desires then outcomes are better – treating the person, not the condition.

There are several ways to accomplish this

- Asking 'what matters to you', rather than 'what is the matter with you?' – ensuring consistency with the approach in adult social care.
- Improving information sharing and having joint care plans – the service reviews suggests this could be better.
- Case management can improve coordination – this does not happen across community services.
- Focusing on multiple long term conditions recognising the impact of long term conditions on the local health system and design services so that people with long term and complex conditions can stay healthy and in their own homes for as long as possible.
- Ensuring that there is parity of esteem between mental and physical health and recognising their interdependencies.

The Kings Fund has gathered evidence and made recommendations in this area.

Best Practice: Co-ordinated care for people with complex conditions

A King's Fund report, Co-ordinated care for people with complex conditions (2013, outlines the benefits of a more co-ordinated approach to treating people with complex health conditions. It is based on five UK case studies. It highlights the following:

- A holistic focus on an individual rather than treating medical symptoms helps people to become more resilient and to manage their own conditions.
- Building resilience amongst carers is important in promoting home-based care.
- Named co-ordinators of care and a single point of access can provide continuity, more timely care, and can facilitate access to multi-disciplinary teams (MDTs)
- MDTs that bring together a range of generalist and specialist staff and work toward a common set of objectives help support people to live well at home.
- Improved sharing of information and fostering collaboration between professionals can break down silo working and enable meaningful conversations about the needs of the patient.
- Proactive targeting of patients that uses intelligence to predict risk can be used to prioritise care.
- A population management approach with specific communities is required to determine the priorities in geographical localities.
- Community resources can be harnessed to support co-ordinated care and where appropriate can be formalised into the multi-disciplinary team
- Integration between health and social care and a holistic assessment can support person-centred care coordination
- Engagement of GPs and strengthening links to secondary care are important enablers to person-centred care
- Models of care co-ordination are likely to be more effective when they operate as fully integrated provider teams with some operational autonomy

7. To ensure prevention and patient empowerment is at the centre of community services

We must ensure that preventative services are at the centre of the new model for community services and ensure that links are made to other services that support people's wider wellbeing.

There should be strong links to the voluntary and community sector, recognising its value in supporting people's health and wellbeing.

People need to be better supported to access information and advice about their health and care and access to this information should be easier.

Support to Informal and family carers could be better, recognising that many people with long term health conditions are looked after by carers.

8. To make better use of technology to support the delivery of community services

Recognising that the NHS is years behind in digital services that could better enable care – in terms of access to services, sharing information, and supporting people to care for themselves at home.

We must ensure that areas of focus in the digital strategy are incorporated into the new model of adult community services so that they become a key enabler to providing more efficient services. Future services should be designed to keep up with ever-developing technology.

9. To make better use of intelligence (data and feedback) to constantly develop the system

New models and contracting arrangements must ensure that service provision is based on robust activity and finance data. Better use of intelligence, risk stratification, and proactive identification of those most in need will allow resources to be aligned more flexibly and efficiently.

Services should be better at collecting and analysing patient outcome information to gauge ongoing success and develop services.

7. Conclusion

This document has detailed the case for change by highlighting 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

This document, supported by more detailed findings from the due diligence stocktake review, other local intelligence, and best practice research will be used to inform new models development and will be used as a basis to start developing the Public Consultation documentation.