APPENDIX 4

NHS
Medway
Clinical Commissioning Group

Improving Adult Community Health Services in Medway

Draft Health and Adult Social Care Overview and Scrutiny Committee consultation and public engagement summary document

Public Engagement by NHS Medway CCG

3rd September – 26th October 2018

This document provides a summary of our proposal to improve adult community health services in Medway. Background information providing the detail behind our plans, reports on public engagement carried out so far, as well as this information in alternative formats is available at [weblink will be added when live]

The public engagement is open for eight weeks, from 3rd September to 26th October 2018.

Why we are consulting on these services

NHS Medway Clinical Commissioning Group (CCG) is responsible for planning and commissioning (buying) healthcare services from providers, based on the health needs of our local population.

Over the last year we have been working with patients, the public, clinicians, local communities and Medway Council to see how we can improve adult community services in Medway, to keep people well and cared for close to home. This, in part, will contribute to some of the key changes needed to deliver Medway's Local Care Sustainability and Transformation programme – the Medway Model – which involves moving a proportion of health funding from secondary (hospital) care into primary and community care. This would reduce unnecessary activity in the hospital setting, instead supporting people at or nearer to home and helping them to take more control of their own healthcare needs. More information about the Medway Model can be found here.

Currently, community services are mainly provided by Medway Community Healthcare, with a few services provided by Kent Community Health NHS Foundation Trust, the voluntary and community sector, and other organisations offering specific services. These contracts end on 31st March 2020.

The CCG has a legal obligation to go through a formal procurement process for a provider from April 2020 and we'll be looking for organisations to submit proposals describing how they would develop the model, within the constraints of the money and resources available. We will consider the detailed proposals in the final stage of procurement and we aim to have a new contract or contracts in place by April 2020.

We are now consulting on this and the feedback will be used to refine our proposed model. It will also be taken into account when evaluating bids, alongside our criteria for selecting a preferred bidder.

Our proposal

The aim is to reconfigure adult community health services in Medway so that they are less fragmented and more joined-up. This will allow us to provide more services within local communities closer to people's homes with improved access hours. We are proposing a system of multidisciplinary teams – where multi-skilled community nurses and therapists provide the majority of care, backed up by a small number of specialist teams. We will also create a single point of contact – email and telephone of them all.

We propose introducing senior community clinicians working with people with three or more long-term or complex conditions, so that these patients can be provided with integrated (more joined up) care in the community. This will help them avoid unnecessary admission to hospital. There will be a rapid response mechanism so that the service can respond quickly to patients with urgent needs. Where appropriate, there will also be more use of technology for people to manage their own conditions.

We are asking patients, families, residents and staff to tell us whether you agree that these changes will bring about an improvement to people's experiences of adult community healthcare in Medway.

About community services

Community health services help people get well and stay well – either in their own home or close to home – in settings other than hospital. 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 healthcare professionals, such as nurses and therapists, coordinate and deliver care, working with other professionals including GPs, social workers and the voluntary sector. The services include community nursing, palliative care, community phlebotomy and community rehabilitation such as specialist stroke rehabilitation services.

Services that fall within the adult community services model redesign and procurement*

- Anti-Coagulation
- Cardiology and Arrhythmia
- Cellulitis
- Clinical Assessment Service
- Community Nursing
- Community Rehabilitation
- Continence Care
- Cruse Bereavement
- Dementia Crisis Support Team
- Diabetes
- Epilepsy
- Hand Therapy
- Learning Disabilities
- Lymphoedema
- MSK Physiotherapy
- Neuro physiotherapy
- Nutrition & Dietetics
- Phlebotomy *(except GP phlebotomy)*
- Podiatry
- Respiratory
- Specialist Palliative Care
- Speech and Language Therapy
- Stroke services (community)**
- Tissue Viability and Wound Therapy

* *A public facing description of each service is on the website – this will be included in the consultation document*

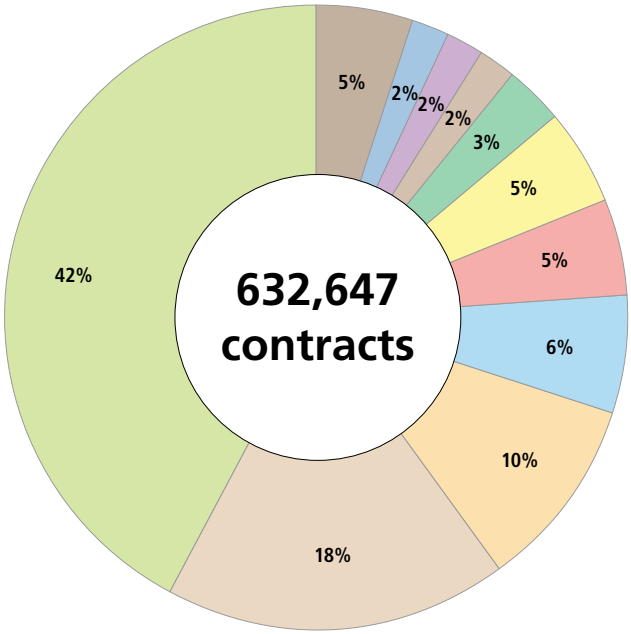
** *Stroke services are currently under review across Kent and Medway which will determine whether these are included in this procurement*

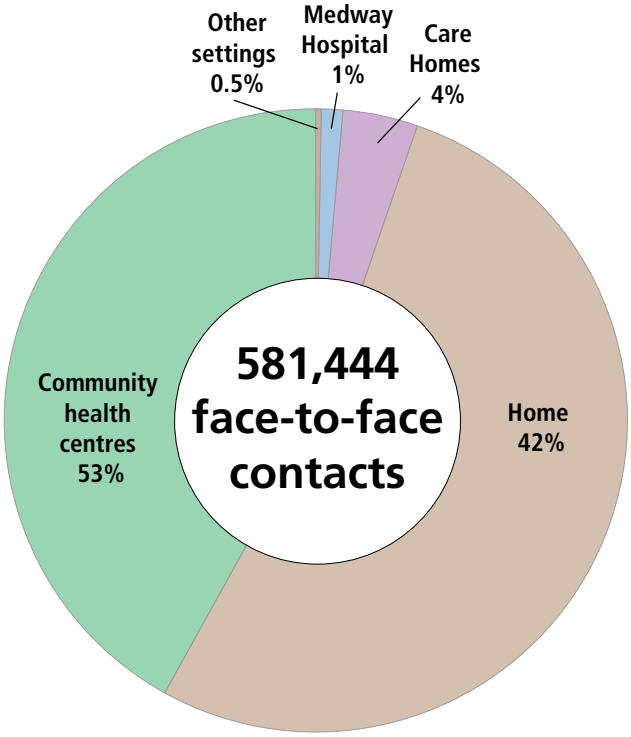
It is national policy to make the provision of care outside of hospital a much larger part of what the NHS does. This includes providing care locally, with health systems built around the needs of the local population, not individual organisations.

Local challenges and the improvements needed

In Medway, in 2016-17, we spent £44 million on community services for adults and children: about 12% of our total expenditure. More than 90,000 people received these services: about one in three people in Medway. There were approximately 632,647 contacts and the majority of these were face-to-face (91%).

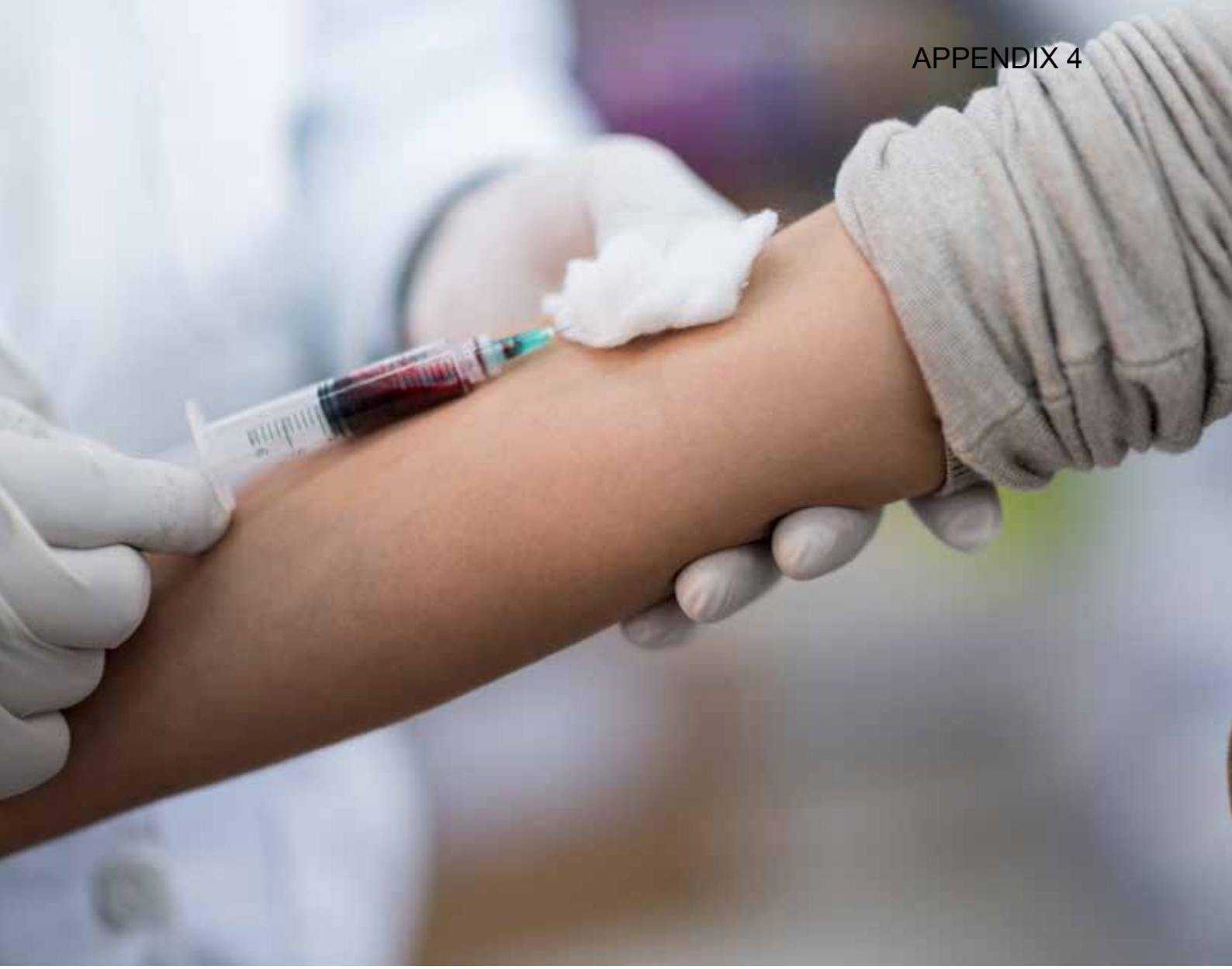
▽ Breakdown of contacts by service.





- Community Nurses
- Phlebotomy
- MSK Physiotherapy
- Anti-coagulation
- Palliative Care
- Community Rehabilitation
- Clinical Assessment Service
- Podiatry
- Cardiology
- Respiratory
- Other

△ Community services are provided in a variety of settings across Medway



Around 80,000 (approximately one quarter) of face-to-face contacts in the community are provided in settings such as smaller clinics, GP practices, leisure centres and community centres, not in one of the four existing Health Living Centres (HLCs) in Gillingham, Rainham, Rochester and Lordswood.

Around 278,000 people live in Medway and this is estimated to grow to around 330,000 by 2035. While Medway has a relatively young population, the number of older people is increasing – people over the age of 70 will rise by 20% in the next five years. Older people use health and care services much more than other age groups, particularly hospital admissions and community services. More than half the contacts for community services are estimated to be for people aged 65 or over. Local data shows as many as four in ten emergency admissions to hospital could be avoided if the right care was available in the community.

In Medway, more than 40,000 adults live with a long-term condition or disability that limits their day-to-day activities. On average, a person with a long-term condition requires six times more health and social care support as a generally healthy person. There are around 12,500 adults in Medway who have three or more long-term conditions – such as respiratory, cardiology, diabetes, rheumatology – who account for approximately 10% of all adult A&E attendances and 19% of adult emergency admissions. Approximately 16% of people in Medway have a common mental health disorder, such as depression or anxiety (around 31,000 people). These conditions often go hand-in-hand with physical health conditions.

We know that most people, when given a choice, want to stay out of hospital and receive care either in their own home or in their neighbourhood. In line with national and local strategy, our revised model for community services must also help relieve pressure on secondary (hospital) care. We will need to change where some of the services and workforce are now located, to provide more resources nearer to local communities. This will include moving some contact which people have with hospital services into community settings, where appropriate.

This is a real opportunity to forge stronger links between secondary care (such as hospitals), primary care (the first point of contact for healthcare, mainly the GP) and community services and to provide more co-ordinated and integrated care across all organisations involved in a person's health and care.

Healthy Living Centres in Medway

The Medway Model groups services around six localities in Medway – Gillingham, Rainham, Chatham Central, Lordswood, Rochester and Strood. Four of these currently have purpose-built Healthy Living Centres (HLCs) which are being updated to be fit for future requirements. Medway CCG is working with partner organisations to build new HLCs in Chatham and Strood, expected to be completed in 2020-21. Existing sites will be used until then.

Our review of community services to date

A series of reviews carried out in Summer 2017 showed that, while there were many areas of good practice, there were also areas needing improvement, for example:

- Services are not equitable across Medway, meaning some people have to travel further than others for the same service
- Current services are not designed to truly promote a patient-centred, holistic approach
- There is inconsistent use of digital technology, for example for referrals, care programmes, self-care
- How quickly people get seen varies from service to service
- People are being admitted to hospital unnecessarily, due to lack of community support, putting pressure on hospital beds and resources
- Once admitted, it can be difficult to get out of hospital and back home, due to lack of appropriate local community services
- Improvements are needed to make sure care is available in the right location, at the right time – whether this is in clinics, people's homes or care homes
- The way in which professionals work together – within and between organisations – could be improved so people have a better experience of care
- Community services could work more closely with GP practices in actively seeking, identifying and treating people who are most at risk
- There needs to be stronger links to other services and organisations that support people's overall wellbeing, such as voluntary and community sector, to address psychological and social needs as well as physical support

Throughout the review we have engaged with patients, the public, clinicians and other stakeholders to gain their views and involve them in developing the future model. Key areas of feedback included the need for: ***greater involvement, collaboration and integration between services and organisations*** including the voluntary sector; ***one shared IT system***, with ***one assessment and care plan*** and ***one named point of contact*** and ***care navigation; person-centred services***, looking at the whole person, with a greater ***focus on prevention***; better ***patient information and communication*** and ***greater involvement and support of family carers; a 'one-stop shop' approach***, with a range of services, on one site, locally; ***greater consistency and equality of care*** and services across locations; ***improved access*** and ***more flexible appointments; strong community engagement*** with community services and groups; better use of the clinical workforce through ***upskilling/skill sharing***. Reports on our engagement activities and feedback can be found at http://www.medwayccg.nhs.uk/getting-involved/involvement-projects/adult-community-services.

The proposed changes

Having looked at all the evidence and given careful consideration to clinician, patient and public feedback we've identified ***seven key changes*** to adult community services that we believe will, together, improve the patient's experience of care and lead to more successful health outcomes.

KEY CHANGE 1: The most common services will be provided locally in each Medway town, with specialist support provided centrally

Currently, 46% of face-to-face contacts take place where people live (including care homes) and approximately 54% of community activity takes place in a clinical setting – about half of which isn't provided in the same locality as where the patient lives. Approximately 72% of clinic appointments for community services (excluding phlebotomy) currently take place in just two localities, so a large number of patients have to travel much further than others for the same service.

In the future, where possible, care will be provided closer to home, in HLCs in each of the six Medway Towns. This will allow for more joined-up working between a range of local services, including health and care services, voluntary sector and community groups.

We expect the most common services (such as wound therapy, respiratory, cardiology, diabetes, phlebotomy, community rehabilitation) to be provided in each of the HLCs, based on the level of need in each area. This will mean moving some clinic appointments across the six localities, but people will have more equitable access to services, reducing travelling time for some. For example, approximately 60% of wound therapy appointments currently take place in one locality and two of the localities don't hold any clinics at all. In the revised model, this will be provided more consistently.

The average distance patients currently travel to appointments in the community is around 5.8 miles. This will reduce to around 3.6 miles where services are provided in all six HLCs.

Looking at the whole population, in peak travel times 94% of Medway residents will be able to reach a HLC by car within 15 minutes, 78% will be able to reach it within 20 minutes by public transport, over half of the population will be able to walk to their local HLC within 25 minutes.

Where there is low demand or specialist staff, equipment or clinic space is needed, services will be provided across two adjacent localities – Gillingham and Rainham; Chatham Central and Lordswood; Rochester and Strood. This will ensure a more equal distribution of services across the whole of Medway. For example, pulmonary rehabilitation sessions currently only take place in Chatham and Rainham. The revised model will ensure sessions are also available in Strood or Rochester.

The most specialist services – for example, specialist nursing for continence care, tissue viability and epilepsy, hand therapy, musculo-skeletal assessment and triage – will run less frequently but, wherever possible, staff will travel to the relevant HLC (based on the level of demand) or be available through better use of technology.

The four existing HLCs are being updated to be fit for these future requirements. They are all close to local bus service routes and have access to nearby public car parking. We are working with Medway Council to build new HLCs in Chatham and Strood, expected to be completed in 2020-21. Existing sites will be used until then.

***Example**: A Rainham resident had 75 appointments last year at the day rehabilitation centre in Rochester. The travel time from their home in Rainham to the site is 28 minutes by car each way (off peak) and 1 hour 45 minutes by bus (including walking to and from bus stops).*

In the new model, more appointments will be available at the HLC, Rainham, which is nine minutes away by car, off peak (19 minutes less travel time) and 17 minutes by bus (1 hour 28 minutes less travel time). Alternatively, for a service provided across two localities, Gillingham HLC is 14 minutes away by car, off peak (14 minutes shorter) and 46 minutes by bus (1 hour 18 minutes shorter).

KEY CHANGE 2: More multi-skilled community nurses and therapists supported by specialist teams

Currently community services are provided in a range of settings, with little integration and coordination across teams or organisations.

In the future, services will be reshaped to provide fewer, larger community teams, with a shared set of skills, supported by smaller, highly specialist teams in each of the six HLCs. These community teams will consist of more generalist, multi-skilled community nurses and therapists, treating and providing support and basic education on a range of conditions.

The level of services will not be reduced, but they will be provided differently. Each locality will have the necessary skills – and more shared skills – to provide a wider range of treatments; to better co-ordinate care; and reduce duplication of appointments, records and treatment – with the specialist team providing support where it's needed.

***Example**: At the moment, a patient who has active chronic obstructive pulmonary disease (COPD) and diabetes receives treatment from the respiratory team (including lung function tests and medication review) and the diabetes team (including an annual review and self-care education) at separate locations and on separate days.*

Under the new arrangements, this patient will receive the same treatment by the locality team who offer a single appointment to provide treatment and support for both conditions. The locality team will be supported by the relevant specialist team. If either condition worsens, the specialist team will either provide the locality team with specialist advice for further treatment or will arrange to the see the patient themselves as necessary.

KEY CHANGE 3: Extending the hours and days of larger services in each of the six localities

Currently most community services run from 9am to 5pm, so patients have limited choice of appointment slots outside these hours.

Future operating hours will be agreed as part of the procurement but service hours will be extended to align with the planned hours for primary care services (such as GP practices), where possible. For example 8am to 8pm Monday to Friday, 9am to 4pm Saturday and where demand exists on Sunday too. This will apply to larger services, such as the core nursing and therapy services. It may not be clinically possible or financially viable to extend the hours for some of the smaller specialist services.

Improving Community Health Services in Medway Consultation and Public Engagement Document

Seven Key Changes Prepared for the Health and Adult Social Care Overview and Scrutiny Committee consultation and public engagement summary document

Our proposal is to reconfigure adult community health services in Medway so that they are less fragmented and more joined up, and that more services take place within local communities, closer to people's homes with extended periods of access.

We are consulting on seven key changes to adult community health services and are asking patients, families, residents and staff to tell us whether you agree that these changes will bring about an improvement to people's experiences of adult community healthcare in Medway.

Please ensure you read the consultation and public engagement summary document before answering these questions [with link to summary document]

questionnaire

1. Firstly, please could you indicate if you are responding as a patient/member of public, a clinician or a member of staff?

☐ Patient or member of public ☐ Clinical staff ☐ Non clinical staff

2. Please could you write in the name of the organisation that you work for?

1. To what extent do you agree or disagree that the following changes will improve the experience of those using adult community services in Medway:

    1. Moving some of the most commonly-used services so that there is more equal access for residents across all six Medway towns (Gillingham, Rainham, Rochester, Lordswood, Chatham, Strood), reducing travel for some and improving access to and integration across services and organisations in each of the localities
    2. Fewer and larger community teams in each of the six localities, consisting of more generalist, multi-skilled community nurses and therapists – who can do a number of things in one appointment – supported by smaller, highly specialist teams
    3. Extending the hours and days of the larger services – such as Core Nursing and Therapy Services – provided in the six localities
    4. A central booking and co-ordination function, including a 24/7 phone number to arrange and manage appointments, timed and better coordinated appointment slots and an online patient portal where people can see specific aspects of their health information
    5. Investment in Senior Community Clinicians who will case manage and co-ordinate the care of all patients with three or more long-term or complex conditions (approximately 12,500 patients)
    6. People with three or more long-term or complex conditions who are in crisis or need urgent treatment/ support and who contact the central telephone number will receive a response within two hours
    7. Greater support for patients to lead healthier lifestyles and manage their own conditions, including use of healthcare technology, information about health and wellbeing, education programmes and signposting to relevant services

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

2. If you disagree with any of these changes please explain your reasons below.

In a survey conducted at the end of last year patients, public and staff identified the following top three priorities for the review of community services:

- **There are shared records across services and one care plan for each patient**
- **People who are frail, or who have a number of different health conditions are supported at home or in the community and any risk of getting unwell is spotted early on**
- **One access route into services, so it's quicker and easier for patients and professionals to access the right service**

3. In your opinion, to what extent will the key changes outlined in the consultation and public engagement summary document address these three priorities?

☐ Fully ☐ Partly ☐ Not at all

4. Please add any comments to support your answer

5. Which of the seven key changes outlined in the consultation and public engagement summary document, do you think will be the most important to people receiving community-based care? (TICK ONE ANSWER ONLY)

- ☐ 1. Moving some of the most commonly-used services so that there is more equal access for residents across all six Medway towns (Gillingham, Rainham, Rochester, Lordswood, Chatham, Strood), reducing travel for some and improving access to and integration across services and organisations in each of the localities
- ☐ 2. Fewer and larger community teams in each of the six localities, consisting of more generalist, multi-skilled community nurses and therapists – who can do a number of things in one appointment – supported by smaller, highly specialist teams
- ☐ 3. Extending the hours and days of the larger services – such as Core Nursing and Therapy Services – provided in the six localities
- ☐ 4. A central booking and co-ordination function, including a 24/7 phone number to arrange and manage appointments, timed and better coordinated appointment slots and an online patient portal where people can see specific aspects of their health information
- ☐ 5. Investment in Senior Community Clinicians who will case manage and co-ordinate the care of all patients with three or more long-term or complex conditions (approximately 12,500 patients)
- ☐ 6. People with three or more long-term or complex conditions who are in crisis or need urgent treatment/support and who contact the central telephone number will receive a response within two hours
- ☐ 7. Greater support for patients to lead healthier lifestyles and manage their own conditions, including use of healthcare technology, information about health and wellbeing, education programmes and signposting to relevant services

6. Please explain your reason

7. Having read the consultation and public engagement summary document do you think that the changes overall will improve the experience of those using adult community services in Medway?

☐ Improve significantly ☐ Improve to some extent ☐ No improvement

8. Please explain your reason

9. Are there any other comments you would like to make about our proposals?

ABOUT YOU

We know people from different age groups, ethnic groups, religions and sexualities access healthcare services in a variety of ways, have differing health needs and sometimes experience services in dissimilar ways. If you are able to tell us a bit about you, we can try to get feedback from as many people as possible.

If you prefer not to answer any of the following questions please select "prefer not to answer". This information will remain confidential and will not be passed on to any healthcare professionals. Your individual information will not be linked to your responses and all data will be collated to ensure no individual is identifiable.

10. Please write in the first part of your postcode (e.g. ME9):

11. Please indicate which of the following age groups you fall into?

☐ 16-24 years ☐ 25-34 years ☐ 35-44 years ☐ 45-54 years

☐ 55-64 years ☐ 65-74 years ☐ 75 years or more ☐ Prefer not to answer

12. Are you:

☐ Male ☐ Female ☐ Transgender ☐ Prefer not to answer

13. Please indicate your ethnic group? Choose 1 option that best describes your ethnic group or background.

- ☐ White - English/Welsh/Scottish/Northern Irish/British
- ☐ White - Irish
- ☐ White - Gypsy or Irish Traveller
- ☐ Any other White background, please write in below
- ☐ Mixed / Multiple ethnic groups - White and Black Caribbean
- ☐ Mixed / Multiple ethnic groups - White and Black African
- ☐ Mixed / Multiple ethnic groups - White and Asian
- ☐ Any other Mixed / Multiple ethnic background, please write in below
- ☐ Asian / Asian British - Indian
- ☐ Asian / Asian British - Pakistani
- ☐ Asian / Asian British - Bangladeshi
- ☐ Asian / Asian British - Chinese
- ☐ Any other Asian background, please write in below
- ☐ Black / African / Caribbean / Black British - African
- ☐ Black / African / Caribbean / Black British - Caribbean
- ☐ Any other Black / African / Caribbean background, please write in below
- ☐ Other ethnic group - Arab
- ☐ Other ethnic group, please write in below
- ☐ Prefer not to answer

Please write in if you selected any "other" option above

14. What is your religion, belief or faith?

- ☐ No religion
- ☐ Buddhism
- ☐ Christianity
- ☐ Hinduism
- ☐ Islam
- ☐ Judaism
- ☐ Sikhism
- ☐ Prefer not to say
- ☐ Other (please specify):

15. What is your sexual orientation?

- ☐ Heterosexual (straight)
- ☐ Bisexual
- ☐ Gay/Lesbian
- ☐ Prefer not to say
- ☐ Other (please specify):

16. Are your day to day activities limited because of a health problem which has lasted, or is expected to last at least 12 months?

- ☐ Yes, limited a little
- ☐ Yes, limited a lot
- ☐ No
- ☐ Prefer not to say

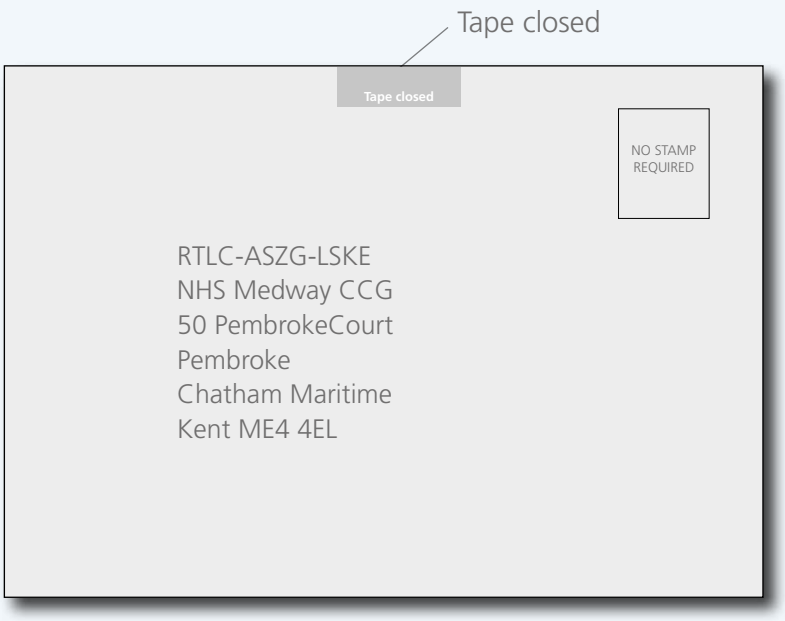
Tape closed

APPENDIX 4

NO STAMP
REQUIRED

RTLC-ASZG-LSKE
NHS Medway CCG
50 PembrokeCourt
Pembroke
Chatham Maritime
Kent ME4 4EL

Once you have completed the survey, simply fold in half and tape as shown below.
Then post it back to us (no stamp required).



KEY CHANGE 4: A central booking and co-ordination function

A central phone number exists for general enquiries but individual services have different phone numbers and arrangements for making appointments. The revised model will include a single 24-hours-a-day, 7-days-a-week phone number for all patients being referred to, or already using community services, to help them to arrange and manage their own appointments, should they need support to do this. Patients requiring a home visit will be able to use this to arrange appointments in set time slots, so they know when someone will be coming, rather than having to wait in all day.

The central booking and co-ordination staff will have access to patient records, so it will be easier for them to respond to queries or manage bookings. The new provider of community services will be expected to have a system in place where a trained clinical staff member is able to respond to urgent queries or concerns where necessary.

The central booking and co-ordination function will be linked to a web-based patient portal where people will be able to see their own health information – such as their care plan, test results, letters from health professionals, notes and appointments. This will enable patients to manage their own care where necessary and appropriate. The provider will be required to adhere to NHS confidentiality requirements alongside the General Data Protection Regulations that became enforceable on 25 May 2018.

In the revised model, administration staff who currently support the many different community services will be supporting the larger multi-skilled teams in each of the six localities alongside staffing the central booking and co-ordination function.

KEY CHANGE 5: Senior Community Clinicians will case-manage the care of all patients with complex or three or more long-term conditions

There are approximately 12,500 patients with more complex conditions, including people who are frail and elderly and people living with three or more long-term conditions. Patients who have three or more conditions such as diabetes, chronic obstructive pulmonary disease or heart conditions would fall into this category. Although these people only make up about 4.5% of the Medway population, they are likely to have 34% more A&E attendances and 24% more emergency admissions than those with no long-term conditions.

For this group of patients, the revised model will provide much greater support in the community and there will be an investment into community services of approximately £1.5 million to increase the number of Senior Community Clinicians (SCCs) – qualified professionals with additional training and development in a range of conditions, who will be the named key professional for a number of these patients.

They will be responsible for managing and co-ordinating their patients' care, working with the patient in agreeing one joined-up care plan, taking into account all aspects of their health and well-being needs – physical and mental health, social, economic, educational, cultural – and liaising with other professionals and services to ensure the plan is followed. This will ensure greater continuity of care, better communication and information-sharing across professionals and services involved in the person's overall care. They will manage a team of community clinicians who will be providing core care in that locality but will also provide support to the SCC's patients, as requested and overseen by the SCC.

We are currently testing this approach on a small scale and hope to have SCCs in each of the six localities by December 2018, with further refinement and development in 2019. We envisage there will be around 70 SCCs in total – the actual figure will be confirmed before formal procurement.

***Example**: In her previous role Sarah managed a team of nurses, caring for people with respiratory problems. While she was an expert in her field, she found it difficult at times to link with other professionals involved in other elements of her patients' care, often leading to multiple assessments and care plans and duplication of care.*

In the revised model, Sarah's assessment skills are more advanced, she has greater in-depth knowledge in other areas, such as lymphoedema and nutrition, so she can work with her patients and their carers more holistically, still seeking more specialist advice from colleagues where necessary. She works with patients with other long-term conditions, such as diabetes and cardiac problems so can provide more support for people with multiple long-term conditions. She is now able to refer a patient with their consent, for an integrated review so that other professionals can provide their support and advice and agree one care plan which reflects all of the patients' needs. As the named key professional she will co-ordinate the agreed care and oversee completion of agreed actions.

KEY CHANGE 6: Speedier response within two hours for people with complex or three or more long-term conditions who are in crisis or when they need urgent treatment or support

Our analysis has shown the majority of current community services can't respond urgently to patients in crisis, which means those patients may attend A&E or be admitted to hospital.

In the new model, the 12,500 people living with more complex or three or more long-term conditions who find their health has worsened; are in crisis or need an urgent response; and who contact the central telephone number, will receive a response within two hours where necessary. Wherever possible the response will be from their SCC or a member of their local team. If they are not available, the response will be from a clinician appropriate for the patient's needs.

The patient's records will be shared across the system by the SCC and held at a central point, so any staff responding to someone's urgent care need will have access to their information and existing care plan.

Evidence from elsewhere shows this approach can reduce the number of inappropriate attendances at A&E or hospital admissions. We are currently testing this on a small scale and we aim to have testing in each of the six localities by March 2019, with further development and refinement taking place during 2018 and 2019. We will work with the new provider to ensure this is available across all six localities from April 2020.

APPENDIX 4

KEY CHANGE 7: More opportunities and support for people who use community health services to lead healthier lifestyles and to manage their own conditions

In the future there will be greater emphasis on education and activities that support people to follow healthier lifestyles. Staff will be trained to talk to people about how they can make healthy lifestyle changes and will help them to find out how they can get further support (e.g. health improvement services).

People, particularly those with long term conditions, are often the experts in managing their own conditions but are not always heard or involved in care plans and actions. Staff will work with the patient to understand their individual level of knowledge, skills and confidence in managing their own conditions, so the most appropriate options can be offered to them.

There will be stronger links with a range of organisations and services – including public health and care navigation – to support people in taking control of their health and changing their health behaviour (for example, programmes to help stop smoking, manage weight).

Many people may already use technology – the latest government figures suggest more than 90% of people in Medway have been online in the last three months. However, not everyone wants or knows how to use technology related to health care and currently the use and availability of technology to support people to manage their own conditions is limited.

In the future model we expect the new service to use the latest technology, such as self-care apps, telehealth, telecare, teleconsultation and telecoaching, and to provide training and support for people to use these. Staff will carry out routine assessments to find out what tools people are able and willing to use and will be trained to show patients how to use them.

The seven key changes outlined above will, collectively, change the way we deliver community health services.

Providing the most commonly-used services in each of the 6 Medway towns, reducing travel and improving access to and integration across services and organisations in each of the localities 1

Fewer and larger community teams in each of the 6 localities, consisting of more generalist, multi skilled community nurses and therapists,supported by smaller, highly specialist teams 2

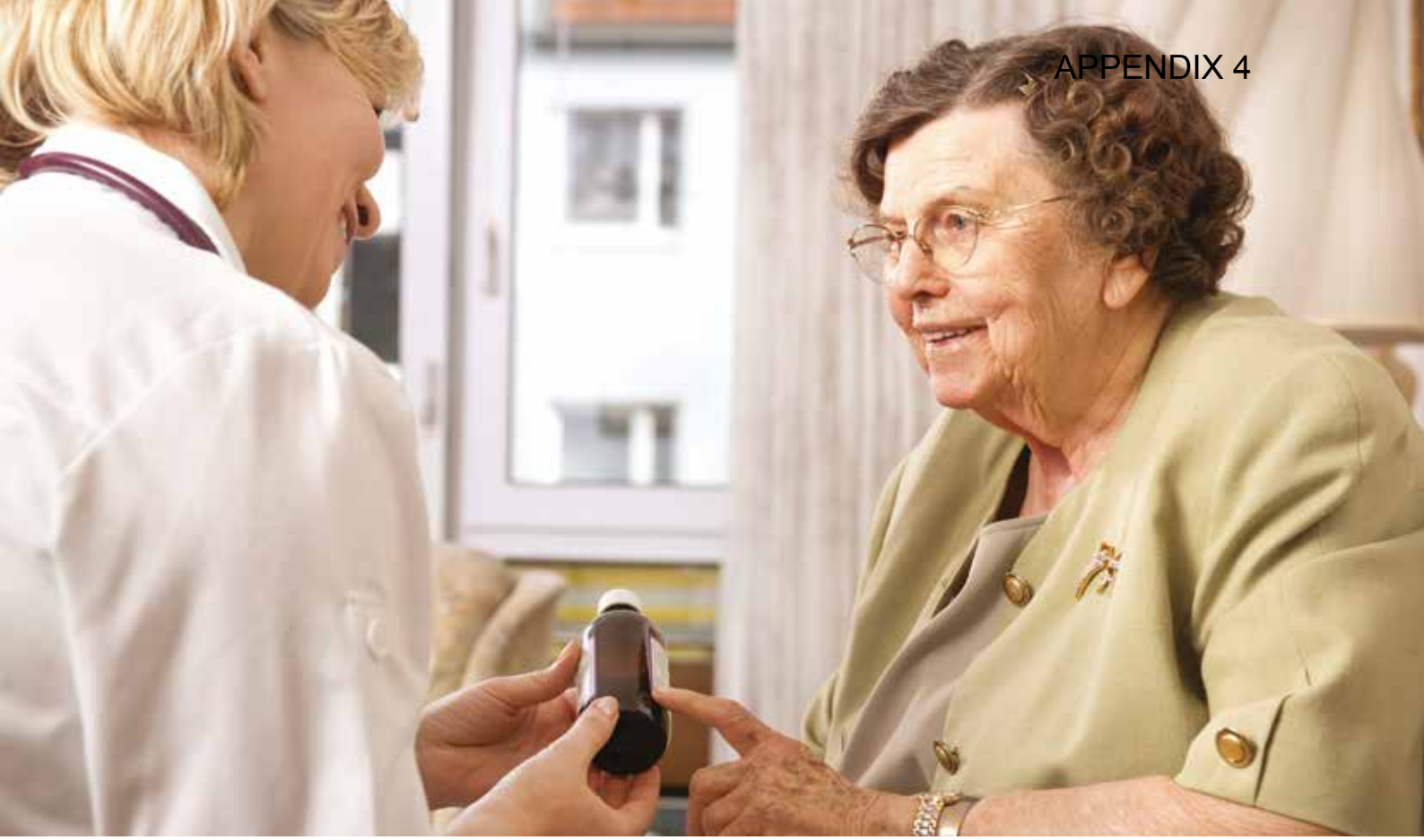
Extending the hours and days of the larger services – such as Core Nursing and Therapy Services - provided in the 6 localities 3

A central booking and co-ordination function, including a 24/7 phone number to arrange and manage appointments and a patient portal where people can see their health information 4

Investment in Senior Community Clinicians who will case manage and co- ordinate the care of all patients with 3 or more long term or complex conditions (approximately 12,500 patients) 5

People with 3 or more long term or complex conditions who are in crisis or need urgent treatment/support and who contact the central telephone number will receive a response within two hours 6

Greater support for patients to manage their own conditions, including healthcare technology, information about health and wellbeing, education programmes and signposting to relevant services 7



The benefits

We want to ensure people in Medway receive the best possible community care that meets local needs within the available resources.

The following shows some of the key benefits if the proposed future model and key changes are supported:

- More care provided out of hospital and closer to where people live
- More joined-up working between services and organisations, including non-clinical support
- Better information sharing, improving integration, reducing duplication and improving the patient's experience – making use of digital means of support
- More resilient, multi-skilled local teams in each of the six Medway towns
- People accessing more services in the evenings and weekends
- People accessing services through a single point
- A more responsive community service for people with more complex or three or more long-term conditions when they are in crisis
- More consistent scheduling of appointments, within agreed timeslots
- People having greater understanding and control over their own care
- People more able to remain well through a greater focus on prevention and self-help within community services
- Greater use of online support to help people manage their own conditions
- Patient-centred care, where people are treated in a holistic way, taking into account all aspects of their health and wellbeing

Potential disadvantages and concerns

There have been a few potential disadvantages and concerns about the proposed changes raised by patients, public, staff and other stakeholders during the earlier stages of our review.

These include:

- Potential fragmentation, if multiple contracts are awarded
- Perceived and actual ability of people to self-care
- Over-reliance on technology
- Inequity of access to transport
- Governance issues around shared IT systems and information-sharing
- Lack of GPs and wider staffing and recruitment problems in health and care
- Lack of communication and joint working between health and social care

These should also be taken into account when considering your response to our proposals.

Illustrative case studies

The following fictionalised case studies draw on the experiences of real people. They show how the revised model will improve care and patient experiences.

Laura

Laura is 72 years old and lives alone in a bungalow in Rochester. She has a history of heart attacks, heart failure and chronic obstructive pulmonary disease (COPD) and she now suffers from swollen legs and cellulitis. Laura recently tripped on the step at her front door. With the help of her neighbour she managed to stand but she cut her leg and knocked her side which resulted in hip pain. Her neighbour called an ambulance and contacted her daughter who lives in London. Once in A+E she was treated for a urine infection and the wound on her leg. Laura was discharged home with a temporary care package, home care in the mornings and in the evenings, to help her get in and out of bed.

Current community services	Community services in the revised model
• Whilst housebound, the community nurses looked after her wound. The wound does not improve. • She was referred to the wound clinic as soon as she is able to leave the house and had regained her confidence. • Services were not always well designed for patients with co-morbidities. • Laura had to juggle several appointments – to visit the wound clinic, to see the respiratory team for the COPD, and the cardiology team for the heart failure. Often these were in different settings and on different days.	• Laura will be pro-actively identified through risk stratification and clinical assessment as someone with long-term conditions who is at risk of falling and may be socially isolated. • Laura will be seen by the Rochester area Local Care Team, receiving a holistic assessment taking into account her health needs alongside a range of other issues that are important to her (like remaining independent in her home for as long as possible). The team will receive input from a heart failure specialist which helps with the treatment of her swollen legs, reducing the risk of Laura developing cellulitis. • Laura will receive a copy of her care plan which continues to be updated by all the professionals she comes into contact with. Laura will get to know her named key professional who will coordinate her care, supported by a central appointment booking system and coordination function. • In the event of a fall where Laura calls an ambulance, the ambulance service will be able to see her care plan. If clinically appropriate, the coordination function will arrange for an urgent response from her Local Care Team instead of a conveyance to hospital, and will alert the named key professional. • The coordination function will manage Laura's subsequent appointments to ensure that, wherever possible, she receives the minimum number of contacts (home visits or clinic appointments) necessary, reducing her anxiety and giving her more control over her care. In most cases, these will be in the Rochester Integrated Health and Wellbeing Centre. • All the health professionals with whom she is in contact will have a greater understanding of the services available in the community that help reduce social isolation. They will either advise Laura of these or refer her to a care navigator who will help her to access services to support her wellbeing.

Bill

Bill is 66 years old and lives in Rainham with his daughter Barbara, and two dogs. They moved from Glasgow 18 months ago into a two-storey semi-detached house with two bedrooms and a family bathroom. Barbara doesn't drive, so they both rely on public transport. Bill has early stages of dementia and is waiting for further tests at the Memory Clinic. Since Bill was diagnosed, he has attended a day centre once a week. This allows Barbara time to get things done that she can't when looking after her father. Two months ago Bill suffered a stroke and is currently receiving rehabilitation at home. Since the stroke, Bill's dementia has deteriorated. He has lost strength on his right side and bladder control. He now has a catheter but the nurses have said that it might be possible, one day, to recover the function in his bladder and he might not need it any more.

Current community services	Community services in the revised model
• Barbara finds it difficult to look after Bill's catheter. • Barbara has needed to call the ambulance several times when Bill get disorientated and aggressive. Every time Barbara calls, she needs to go through everything again which is very stressful. • The stroke rehab workers struggle with Bill's behaviour and Barbara fears they might discharge him from the service. • The Dementia Crisis Support Team has been supportive but can't help with all of Bob's needs which means other teams have to visit too. • All the workers are caring and professional but Barbara feels that nobody understands the whole picture and all the different faces make Bill very confused.	• Bill has developed several long-term and complex conditions his GP (or any health or social care professional) will refer him to the Rainham area where nurses and therapists work with Bill's GP and are supported by mental health and social care workers to provide him holistic support under one shared care plan. • Specialist input to the MDT, from a specialist consultant, a dementia nurse, and the specialist stroke team will be easily accessible – recognising the level of acuity and risk in this case. • Bill will have a named key professional who will be responsible for making sure that he and Barbara know what is going on with his care and is a friendly face to go to with concerns. • The health professionals Barbara and Bill are in contact with will have a greater understanding of the services available in the community that may help improve wellbeing, both for Bill and Barbara as his carer. They will either advise of these or refer to a care navigator who will help her to access services to support their wellbeing – such as carer information and advice. If she is willing, Barbara will also be referred to Adult Social Care for a formal carer assessment to see if she is entitled to support. • Anyone who visits Bill will understand and feel confident in dealing with his dementia and will also be able to sort out his catheter. • If Barbara feels she cannot deal with Bill, instead of calling the ambulance, she uses the coordination function, and if appropriate, they will provide an urgent response. If an ambulance is called, the ambulance service will be able to see Bill's care plan and Barbara will not need to explain the situation all over again.

Find out more and give your views

Read more about the proposed changes
Visit [weblink] for all related background information, including the Case for Change, engagement reports and frequently asked questions including further statistics

Come to our events
We are holding public events where you can learn more from the CCG and give us your views. For more information on these events please go to [weblink]

Invite us to your meetings/groups
We are also meeting with a range of community groups to talk through our proposals. If you'd like us to come to your group, please contact us on [email & telephone no.]

Complete the consultation questionnaire
Please complete the questionnaire in this document and return to us using [FREEPOST] or complete it online at [weblink]

Contact us
If you have any queries or would like to give us your views directly then please do contact us, either by emailing [email address] or calling [telephone number]

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