

ADULT COMMUNITY HEALTH SERVICES

MEDWAY CLINICAL COMMISSIONING GROUP

RESPONSE TO THE PUBLIC ENGAGEMENT, SEPTEMBER – OCTOBER 2018

YOU SAID – WE DID

1. Purpose

NHS Medway Clinical Commissioning Group (CCG) wants to transform the way adult community health services are delivered across Medway, so that they are less fragmented, more joined up and with more services provided within local communities, closer to people's homes. From 2020 a new contract will be in place to provide these services.

We would like to thank all the patients, staff and local residents who have worked with us to develop a new model of care. This document sets out our response to the public engagement we carried out in September and October 2018.

2. Background

In 2017, the CCG engaged widely with patients, families, residents and staff on their proposals for future adult community services and the feedback informed the development of the proposed model.

In January 2018, the CCG ran a day long 'Whole System Planning Workshop' involving more than 100 patients, staff, voluntary sector representatives, commissioners, and other services in Medway. Participants tested the emerging model using a series of case studies and worked with other stakeholders to suggest solutions to any problems identified within the model.

2.1. The adult community services model – seven key changes

Medway CCG used the feedback from the Whole System event to create a document detailing seven key changes to improve patients' experience of adult community services. These are:

1. The most common services will be provided locally in each Medway town, with specialist services provided centrally.
2. More multi-skilled community nurses and therapists supported by specialist teams.
3. Extending the hours and days of larger services in each of the six localities.
4. A central booking and co-ordination function.

5. Senior Community Clinicians will case manage the care of all patients with complex or three or more long-term conditions.
6. Speedier response within two hours for people with complex or three or more long-term conditions when they need urgent treatment or support.
7. More opportunities and support for people who use community health services to lead healthier lifestyles and to manage their own conditions.

2.2. Public Engagement September – October 2018

From 3 September to 26 October, a programme of engagement events was organised to share the seven changes and to gain feedback on the proposed model. Engagement activities comprised:

- An online and a paper based survey available from GP practices, council offices, libraries, community and acute health services.
- Four public engagement events were held across Medway at a range of dates, venues and times.
- Discussion at the September GP monthly meeting.
- Focus groups were run by the Involving Medway Community Engagement Team.
- Community Health Researcher Volunteers conducted face-to-face interviews with people who use community health services.
- Community nurses also helped to target feedback from housebound patients by distributing surveys on their caseloads.

The survey was completed by 270 people including patients, public and staff. A total of 195 people including staff, local councillors, members of the public, patients and family carers attended four public meetings held across Medway. Involving Medway conducted 18 focus groups – targeting those less likely to attend public meetings – and spoke to 226 Medway residents. Community Health Researcher Volunteers conducted 18 in-depth interviews with users of community health services.

3. You said – We did: Medway CCG's response to the public engagement September – October 2018

Most of the people who responded to our survey or who took part in discussions agreed that the proposed changes will improve the experiences of those using adult community health services in Medway. People told us that these proposals would mostly be an improvement as current services are fragmented and, for many, difficult to access. They welcomed the focus on multi-skilled teams, better co-ordination, improved access and prevention and education. However, there were some concerns raised particularly around whether there would be the resources to deliver the model fully.

A full report of the findings is attached as an appendix to this document, as well as published on the CCG website.

3.1. Key comments from the engagement events

Set out below are key comments from the engagement events held in September and October 2018, together with the CCG's response.

You Said	We Did
<p>“Mostly the proposed seven key changes will bring about improvements for patients and should be put into place as soon as possible”</p>	<p>We have started to implement some of the changes already.</p> <p>For example, in line with key change 4, the central booking and co-ordination function – Kent Community Health NHS Foundation Trust (KCHFT) – which currently provides three of the existing community services in Medway has implemented a new central co-ordination centre. All the administrative processes are now based within a single team which manages all calls and referrals, performs basic triage and allocates appointments. Medway Community Healthcare (MCH) which currently provides the majority of community services in Medway is also setting up a similar central booking system, which will be complete in the spring of 2019.</p> <p>Clinical teams are already starting to work differently, testing and finalising models for example, to support Integrated Locality Reviews (ILRs), which have been in place in the Rainham locality since June 2018, with other localities following from January 2019 onwards. ILRs are regular structured discussions between clinical staff from the full range of health and social care services across Medway. The aim is to discuss patients with multiple long term conditions and to ensure their care is being well managed.</p> <p>We are also working with NHS Property Services and Community Health Partnerships, the landlords of the premises, to gradually change the services that are offered locally. This includes reviewing rooms in the Healthy Living Centres to make sure we get the most out of the buildings; making sure the space is suitable and that rooms are more fully utilised.</p>

<p>“The model will only work if there is enough funding”</p>	<p>Analysis has been undertaken of workforce requirements to support the revised model which demonstrated that additional investment was required. We are investing approximately an extra £1.5 million, over and above current funding levels, into community services. This is to increase the number of Senior Community Clinicians – qualified professionals with additional training and development in a range of conditions to ensure the most complex patients are better supported in the community.</p> <p>The proposed changes in these services will create efficiencies through providers working better together, using developments in technology and working differently and more efficiently as a whole. For example, there will be larger community teams aligned to each locality. The workforce within each Community Locality Team (CLT) will have a shared set of skills and be supported by specialist teams which means care will be better co-ordinated, with fewer appointments and less duplication.</p> <p>The joined-up approach to care planning and improved collaborative working with a range of clinical teams are all essential components of the revised model; as they will help patients to stay well for longer and avoid unplanned hospital admissions; which will be better for patients as well as reducing expensive hospital admissions.</p>
<p>“If we haven’t got enough staff now, how is this going to change by 2020/21?”</p>	<p>We have 43,500 staff working in health and social care in Kent and Medway but we have some challenges across the system. To deliver our plans we need the right staff, in the right places with the right skills.</p> <p>The Kent and Medway Sustainability and Transformation Partnership (K&M STP) is working collaboratively to ensure our local workforce is able to deliver sustainable, high-quality, patient-centred care.</p> <p>Some of the actions undertaken focus on:</p> <ul style="list-style-type: none"> ○ Online and social media recruitment campaigns. ○ Canterbury Christ Church University, and the University of Kent’s bid for a medical school for Kent. ○ Detailed work to identify what types and numbers of staff, with what skills, we need for the future. <p>Across Kent and Medway the workforce will also gradually be</p>

	<p>deployed differently to support the realignment of resources from the hospital into primary and community services.</p> <p>In Medway, we are working with current providers to identify training needs, as well as holding discussions on recruitment and retention to ensure initiatives address current gaps. A local workforce lead has been recruited to support this.</p> <p>In early 2019 we will be finalising our local workforce strategy with our partners, including primary, community and acute sector representatives as well as community and voluntary care and social care. This will dovetail into the K&M STP workforce developments.</p> <p>The strategy will also focus on upskilling the current work force to ensure staff are able to provide a wider range of treatments; empowerment and self-care will be important.</p>
<p>Upskilling staff:</p> <p>“Will having multi-skilled staff in the community dilute some of the specialist skills and access to specialist teams?”</p>	<p>Specialist advice and opinion will still be available to all where necessary. Core nurses and therapists will work alongside – and be supported by – specialist clinicians who can provide advice and education, as well as more complex care when required.</p> <p>The model of having a core team, with access to a specialist team when needed, will support core staff and give them exposure to a range of experience and learning that may not previously have been possible.</p> <p>We will make it a condition of the contract that the core nursing and therapy staff are a more resilient workforce, with a shared set of skills. The provider will have to ensure they are appropriately trained in the most prevalent health conditions to support people with long term conditions. This means that because nurses and therapists will have a wider skill set, they will be able to help patients with several long term conditions, such as diabetes and Chronic Obstructive Pulmonary Disorder (COPD) rather than managing patients by separate disease groups.</p> <p>We are also working with local universities to ensure training programmes are tailored to meet these needs. Work is under way with our wider education stakeholders i.e. Health Education Kent, Surrey and Sussex, and our local Community Education Provider Network (CEPN) to ensure workforce</p>

	<p>plans are aligned and funding is allocated to support this.</p> <p>We are already working with MCH to upskill current staff to be able to better support patients with the most common long term conditions. A gap analysis is planned for early 2019, to identify workforce areas for training and development.</p> <p>Going forward the focus will be on ensuring staff are appropriately trained with the right skills and competencies across all sectors including primary, community and acute organisations.</p> <p>As soon as the contract is awarded we will be working with the provider to continue staff development where necessary.</p>
<p>Numbers of staff:</p> <p>“Does the new multi-skilled teams and the upskilling of some staff mean there will be fewer staff over time?”</p>	<p>We do not envisage there to be a reduction in the numbers of staff in services. We are investing approximately an extra £1.5 million, over and above current funding levels, to increase the number of Senior Community Clinicians.</p> <p>As part of the bidding process, we will be assessing the resilience of any providers’ proposed workforce model. The CCG will not stipulate the number or type of workforce required but will expect the provider responsible for the revised model to be innovative and efficient in their approach to ensuring outcomes are met.</p>
<p>“Alignment with other strategies and plans is important. How will this proposal link with other ongoing activity, such as the Sustainability and Transformation Plan (STP) and plans for Local Care?”</p>	<p>We are continually ensuring we are aligned with the K&M STP and have ensured that the newly proposed clinical model fits well. The revised model for adult community services is a fundamental element to delivering these changes, which is known locally as the Medway Model.</p> <p>Our case for change, which is available on the CCG’s website, provides details of research we have undertaken to ensure alignment with other strategies. For example, The King’s Fund research into community services. Their report includes examples of good practice from across the country, which we have considered.</p> <p>As well as this, we have carried out a review of other areas where similar projects have taken place, for example, Bromley CCG’s recent procurement of community services;</p>

	<p>and learning from Encompass in Whitstable (Vanguard site for new models of care).</p>
<p>“There needs to be better integration, closer working relationships between GPs and community services (including practice nursing teams).”</p>	<p>The model is designed to make sure GPs and community services work better together.</p> <p>It will be the provider’s responsibility to encourage working in an integrated way, by building successful Community Locality Teams, actively participating in the Integrated Locality Reviews (ILRs) and working with social care, secondary care specialist services, mental health providers and other partners, to deliver good support in the community.</p> <p>It will be a key requirement that Community Locality Teams establish close, formal links with professionals with other organisations, such as primary care (GPs and practice teams), social care, public health, the voluntary sector, mental health and the secondary sector. Providing care closer to home in Healthy Living Centres will also allow for much closer and more joined-up working between a range of services.</p> <p>We believe this move towards core teams of multi-skilled nurses and therapists will provide care much closer to patient homes and will improve the co-ordination of care.</p>
<p>“There is a need to simplify the referral process.”</p>	<p>We have designed a central co-ordination function, which will provide access for patients, members of the public and partner agencies to services, in a more straightforward way.</p> <p>It will signpost patients to appropriate care, acting as a one-stop shop.</p> <p>Patients will be clinically reviewed and prioritised and then they will be seen in relation to need.</p>
<p>“How will you ensure the central booking system works well and what assurance will be given that it will be better than similar systems previously tried?”</p>	<p>We have made it a requirement for the provider to report on how well the central co-ordination function is working.</p> <p>Based on feedback from the public engagement responses, we have added a section to our reporting requirements on response times. This means the provider will need to report</p>

	<p>on how well they are responding and we will be reviewing this on a regular basis. We will know if any patient is not seen within the planned time.</p> <p>Some of the areas that the provider will be reporting on are:</p> <ul style="list-style-type: none"> ○ Availability of the 24/7 Single Point of Access, 365 days a year. ○ Average waiting time for calls to be answered. ○ Percentage of dropped calls (i.e. when a patient does not continue with the call). <p>As part of the bidding process we will also be assessing the providers' proposed approach to the way the function operates. Once in place, through the checks above, we will be able to make sure it is working well.</p>
<p>“The NHS needs to invest in IT networks and technology to support sharing information and records.”</p>	<p>We agree that good IT and the sharing of information are crucial to the successful transformation of adult community health services in Medway.</p> <p>We have strengthened our requirements of IT and have made the following mandatory for the revised service model:</p> <ul style="list-style-type: none"> ○ The provider must ensure their IT systems are integrated and fully compatible with those used by GPs, to improve communication and the flow of information, and reduce the need for paper based files. ○ The provider must work with GPs and other partner organisations to ensure data sharing agreements are in place to support this work.
<p>“How will you engage with other organisations – voluntary/charitable – so that we know what’s happening and how will you keep communication open between the different systems and involve organisations beyond the NHS?”</p>	<p>We know how important Medway’s community and voluntary sector is in delivering good quality care and what importance local people place on it. Following feedback, we reviewed our documentation and strengthened the process that we expect the provider to use in engaging with other organisations, such as the Voluntary Community Sector (VCS).</p> <p>We have now outlined that the provider must ensure their workforce has a good knowledge and an understanding of the roles, responsibilities, and services provided by other organisations, including the VCS, i.e. wellbeing navigators. The wellbeing navigation service sits outside of the scope of</p>

	<p>this model being described but the provider will establish strong links with this service as one of the key stakeholders. They will be able to do this using the ILRs that will be regularly taking place.</p> <p>The provider will be asked to supply information based on the number of referrals made to the wellbeing navigators and the number of referrals that require ongoing health input.</p>
<p>“Mental health and learning disabilities need to be built in as they have a strong impact on physical health.”</p>	<p>We agree, there are strong links between mental and physical health and staff need a good awareness of mental health issues even if they are not delivering these services. This is already described within the professional code of conduct, as part of a clinician’s professional registration.</p> <p>Based on your feedback, we are now asking that the provider ensures:</p> <ul style="list-style-type: none"> ○ Staff have the relevant skills and awareness training to identify those patients with mental health needs, learning disabilities and dementia. ○ The workforce is appropriately trained in talking about and undertaking brief advice and signposting around mental wellbeing. ○ Staff work collaboratively with mental health services, in particular with talking therapies. ○ They expand on the work currently taking place with an aim to provide an integrated service for patients with long term conditions for their mental health needs, including talking therapies. <p>We want to ensure staff have the right levels of expertise to provide emotional and wellbeing support for patients with more common mental health conditions, particularly those linked to the presence of physical long-term conditions or disability e.g. anxiety and depression. Work has begun for patients with diabetes; we will look to expand on this, with the aim of providing a joined-up service for patients with long term conditions for their mental health needs that includes talking therapies.</p>
<p>“Healthy Living Centres are not always easy for me to get to. They are not easy for me to</p>	<p>Our revised model spreads community health services more evenly across Medway. At the moment too many people have to travel long distances to clinics. One of our</p>

<p>access by public transport and there are also issues with parking at them.”</p>	<p>requirements is that the most commonly used services are made available in every Medway town – using Healthy Living Centres and other locations where appropriate.</p> <p>The Healthy Living Centres were purpose built to serve the Medway population in terms of spread and equitable access.</p> <p>We will be making sure the provider plans their demand and capacity for each Medway town or area, to avoid any of the sites being used significantly more than others. This means demand on clinic spaces is well managed and, as a result, parking for patients can be planned for.</p> <p>There are public car parks near to all the Healthy Living Centres including the two new-builds being planned.</p> <p>Of the current Healthy Living Centres – Rochester and Lordswood currently provide free car parking. Rainham and Balmoral Gardens both have fee-paying car parks. We expect that the new-builds planned for Chatham Central and Strood will have fee-paying parking, this is being taken into account as work progresses.</p>
<p>“The services for people in rural areas, especially the Hoo Peninsula, are inadequate.”</p>	<p>Medway Council’s Local Plan will see the development of additional homes on the Hoo Peninsula in the near future. Hoo is included in the Strood locality but we are looking at options to create a new locality, just for the Peninsula.</p> <p>We feel this locality will eventually require a Healthy Living Centre of its own. We will work with the council and other stakeholders to make sure plans are developed.</p> <p>Meantime, the Walter Brice Centre will be utilised by the provider for care in the Strood locality. It is planned to develop this centre to ensure it is better equipped to offer community health services.</p>
<p>“You need to ensure that once the revised model is rolled out, people are clear about how they can access care.”</p>	<p>We will ensure there is a clear communications plan that will take effect nearing the ‘go live’ date with the provider, to ensure patients and the public, as well as clinicians are clear on the changes.</p>
<p>“Will my patient record be safe</p>	<p>The provider will be required to adhere to NHS</p>

<p>if it is shared across services?"</p>	<p>confidentiality requirements alongside the General Data Protection Regulations which came into force in May 2018.</p>
<p>“Providing enough support for self-care – we have heard before about plans for self-care – how are you making sure this will happen this time?”</p>	<p>We will ensure the provider empowers patients to self-care through the use of practical exercises, education and advice. This might include education about their COPD or self-care exercises for muscular-skeletal conditions. There are a number of new technologies available to help people manage and control long term conditions and to remain independent.</p> <p>We are aware that not everyone is able to use new technology in relation to healthcare. The provider will assess patients to find out what tools such as self-care apps, telehealth and teleconsultations people are able and willing to use and will be trained to show patients how to use them if needed. Telehealth involves remote monitoring of patients in their own homes to help them manage their own condition and spot changes early. Teleconsultations can mean remote consultations between patients and clinicians. Where a patient is not happy using a technology they can still be supported either with continued face-to-face visits or through other simple to use devices e.g. telehealth can be supplied by the NHS and installed into the patient’s home – which can include video-conferencing facilities.</p> <p>The provider will share information relating to the number of patients adopting self-care technologies and those who have maintained or improved their health and wellbeing as a result.</p>

4. Next Steps

Medway CCG has used the views of patients, staff, GPs and other clinicians to develop a new way of delivering adult community health services in Medway. The procurement of the revised model is taking place in 2019 and will go live in 2020. Our patient panel is involved in the assessment process over the coming year. We will publish updates on our website during the procurement and make sure we continue to engage with local residents and stakeholders over the coming years to find out how people think the revised model is progressing.