NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Integrated Locality Teams Specification Development Workshop

A specification development workshop in Weston Super Mare on the 18th October 2018 welcomed more than 60 people from across the region. These included clinicians, patients and carers, members of the public, general practices, third sector groups, community services providers, local authorities, sustainability and transformation partners and many others. The summary presented here reports themes in people's feedback. It does not necessarily represent the opinions of every person or group involved, or the CCG's views.

Providing care – what does good look like?

Most people thought that adult community health services should revolve around the needs of the person and their family.

Workshop participants said that it can be hard to understand how the NHS is split into different groups and organisations, making getting to the right help and support more difficult at times. Most people said it is a priority to make community services easy to contact. Community navigators might help to signpost people to support.

People said that a patient should be seen by the right person, with the right skill, at the right time, in a convenient location for the patient.

Participants also identified that historically, patient trust has traditionally sat with the GP, and that this trust needs to be spread out into the community to enable a range of staff with the necessary level of skill to meet the needs of the patient and be trusted to do so.

Most people felt that voluntary and community organisations should be included when considering adult community health services.

What could the referral process look like?

A single referral form and point of access was thought to be a good idea by participants. People said that technology should be used to support this and enable links between GPs and adult community services, acknowledging there may be different sensitivity of data.

Communication was a key theme from participants and the need to only 'tell a story once'. When being referred and transferred between services within the community, people said that a person's story should follow them and be communicated between staff within community services.

Participants strongly felt that there should be a range of methods available to be referred and that this should be appropriate to the person who is accessing the service. The main methods mentioned were the ability of a person to self-refer to the service and contact via telephone and talk to someone. Professionals who attended workshops felt they should have these options as

well and in addition be able to access electronically via a standardised form, email and messaging through a common electronic system.

Most participants also requested that when there are any referrals between adult community services that this is clearly communicated to themselves and also their GP. It was felt that this would ensure people would know what was happening and why.

What about follow-up and care after discharge?

Most people felt the need for a multi-skilled team around each patient. This should include providing other types of care which may not be directly related to the original injury or illness.

Most participants said that the patient should be kept up to date and be fully aware of which professionals are involved in their care. They should also know who they are able to contact with questions or to ask for further support.

People said that they would like to be enabled to perform checks themselves where appropriate, to support monitoring their own health and self-care. They also said there should be links with other healthcare services, including mental health where appropriate.

What role could digital solutions play?

It was widely suggested by participants that using technology would benefit patients and health professionals that are time pressured. However, not all users are comfortable with technology or have access to accessible technology, such as screen readers. Therefore, continuing to provide access to face-to-face and other traditional options is important.

A key theme from participants was the need for a directory of services that is centrally managed and up to date due to the amount of services available, including health and social care and charitable organisations.

Summary of key points

Key points raised by participants were:

- There is a need to ensure that services work more closely together in the future to best support people to remain independent
- Community nursing is valued
- Working in partnership with mental health services would be beneficial
- Care navigators can help signpost to other services
- There could be access to therapies to ensure people are supported more holistically
- The voluntary and community sector could be included
- There is a need to recognise the value of a range of staff to work in the service including apprenticeships
- Identifying the workforce at a younger age and giving them opportunities in health environments would enable them to gain on the ground experience and support future staffing
- The needs of vulnerable groups need to be considered, including the frail elderly transgender, autism, Asperger's and many others