NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Adult Community Health Services Procurement

Protecting high quality healthcare services for the long term

January 2019

What are we doing?

We are advertising for one organisation to provide community health services for adults across Bristol, North Somerset and South Gloucester. Community health services are the services provided in local areas, outside hospital. They work alongside general practices to help people stay well and independent in the community. Examples include physiotherapy, speech and language therapy and community nursing.

Why are we doing this?

Historically, three different organisations have supported adults with community health services in each of Bristol, North Somerset and South Gloucestershire. Contracts with these organisations come to an end over the next few years. We are advertising for an organisation to provide adult community health services across all three areas from April 2020 onwards. This will ensure that care is joined-up and consistent across the area.

We already have a fantastic community health workforce, helping people to live independently at home for as long as possible. We want to build on this and link up with other services that promote wellbeing, including exercise, diet and mental health, helping people to get consistent care, no matter where in Bristol, North Somerset or South Gloucestershire they live.

Who has given us feedback?

Between October and December 2018, more than 500 local people, healthcare professionals, and voluntary and community groups and others had their say to help the NHS understand what is most important to them.

We held workshops in Bristol, North Somerset and South Gloucestershire, with patients, carers, health and care professionals, local authorities, voluntary groups and NHS organisations. We spoke with local patient groups and carers' forums and we invited people to take part in a survey. We also filmed people who had used community health services talking about their experiences.

You said	We did
Local people should be at the centre of community health services. It is important to see local people and their carers as experts about their health and encourage independence.	Patients and carers are at the heart of plans for future community services, designed on the principle that the best bed is your own bed. Each person will have a care plan which gives information on the type of support you need and how this support will be given. This helps people stay as independent as possible and understand their condition. There will also be one single point of contact – one person that a patient will have a relationship with, to keep communication as clear as possible and to ensure that there is one person that knows someone's whole care plan, rather than just fragments of it.
Communication could be better – both with patients and between healthcare professionals.	A priority for planning adult community health services is to develop approaches where people will not have to tell their story more than once. We are promoting digital records that can be shared by healthcare professionals so people do not have to repeat themselves. We are also planning an online directory of all services, so people know what is available to them and where.
Healthcare professionals could work more closely together.	Care works best when healthcare professionals work together so we will introduce 'Integrated Locality Teams' which are teams of healthcare professionals working in a defined area. This will include GPs, community nursing, occupational therapy, mental health services and others working as a multidisciplinary team.
It is important to keep people using services and their families involved in developing services and in their own care.	We are making sure that information about services is provided in many formats using easy to understand language. We are making sure that people have opportunities to be involved in planning and monitoring services as a whole, so that community services can continue developing for the benefit of local people.

You said	We did
It needs to be easier to access community health services.	A Single Point of Access (SPA) is a service that manages patient referrals from health professionals into all community health services. This will be available 365 days a year. A lack of transport can be a barrier to getting treatment and attending groups and appointments. We are looking at ways to address this. One possibility is having hubs of services working together in the community, placed near to transport links.
People wanted to make sure that they could access good quality services wherever they live.	The service will ensure that everyone gets access to the same high quality care, whatever their postcode.
Response times are currently slower than you would like them to be.	There will be a rapid response depending on a patient's condition and this will be in place 24 hours a day, seven days a week. Our aim is to have people seen within two hours if there is a crisis; within four hours if it is urgent and within seven days if not urgent.
There should be better link with voluntary sector organisations.	We are encouraging more joint work with the voluntary and community sector, including suggesting allocating some budget towards these services every year.
There should be a better link with mental health services and support.	In future, it is planned that community services will work closely with mental health professionals to make sure patients are able to access mental health and physical health support in the same place. We aim to encourage stronger links between health and social care and voluntary groups to ensure people are referred on to other organisations that can support them when and where needed.
There should be help for homeless people.	The homeless have often been unable to access community healthcare. We want this to change. We are encouraging community healthcare professionals to attend hostels and support people without a fixed address.

You said	We did
There needs to be a strong relationship between hospitals and community care, so people are discharged from hospital into the right services and avoid staying in hospital for longer than they need to.	We are planning an in-hospital liaison service to make sure people are discharged from hospital into community services as quickly and efficiently as possible, to avoid unnecessary hospital stays. There will also be support in the community for those who need more specialised care, including beds in community hospitals and things like catheter care and IV therapies (where you might need to be on a 'drip'). This should help people to get out of hospital and back into their communities much more quickly.
Frontline staff (for example GP receptionists) could better signpost people to the community services available.	We want to develop more community navigators which are trained individuals who are able to signpost to a variety of non-clinical services to help improve someone's health and wellbeing. We will also ensure there is an up to date directory of services that anyone can access.
There should be more support in place for carers.	Carers have an important and tough role. In future, community health services will look at how best to support carers, including a sitting service to give carers respite. Hubs in the community might also help reduce time spent attending multiple appointments and could mean carers are able to access support groups in the same place that patients receive treatment.
Engaging with patients and carers	Equalities will be taken into account when engaging with patients and carers. Information should be in plain English and consideration given to those who do not have English as a first language including British Sign Language. We will always be aware of disabilities when engaging with people, including mental health issues and learning disabilities.