Local care networks in Southwark: patient and carer engagement
October 2016 – January 2017
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# Acknowledgements

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Additionally we would like the following people:

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Executive Summary

Local care networks (LCNs) bring together a range of health care professionals working together as a team in the community including doctors, nurses, social workers, housing support workers, home care workers and therapists who work with a patient to achieve the goals that are important to the in a clear jointly agreed way.

In 2016/2017 local care networks across Lambeth and Southwark are prioritising the delivery of co-ordinated care to people with complex needs; i.e. those people with three or more long term conditions.

In September 2016 GP practices in Southwark were in the process of identifying all their patients who had three or more long term requiring coordinated care in order to start reviewing their care. A letter was sent to each of these patients asking if they would like to get involved in the project to try and make care better and more joined up for local people.

We engaged with local people with three or more long terms conditions in a number of ways:

1. Patient films
2. Collecting patient stories
3. Workshop to look at care planning
Recommendations

The following recommendations are based on what local people have told us as part of the engagement described in this report. Local care networks should consider how:

- appointments could be better streamlined for patients
- people with complex needs should have a named GP they should be able to see at each appointment
- people with complex needs often need longer GP appointments to discuss their conditions
- written and verbal information is made accessible and in plain English and health and care providers should check understanding with their patients and give them the opportunity to ask questions
- health and care providers should establish how actively involved in their care an individual wants to be and this should not be assumed. People will be more confident to make decisions and be informed if this is aimed at the level of involvement they are comfortable with
- people are informed about how their information is shared with others involved in their care
- people can have a choice in who is coordinating their care – people form different relationships with different professionals and this is based on trust and how well people know them – it is not always the professional who is most involved in their care
- families and carers are supported by the system – people value the support their families and carers give them
- health and care professionals can give people information about opportunities in the community for socialising and getting out and about - it is important for people to be able to carry on doing what they liked doing before they were ill
- health and care professionals can understand what is important in people’s lives as this may impact on their ability to better manage their health - this might be financial or housing issues, family situation, as well as what they like doing
- the condition often most worrying for people is the one that impacts most on their daily or social life and this might not be the one that professionals think it is
- people do not always recognise the emotional impact of being ill on themselves and it is important that clinicians are able to recognise this, point it out to the individual and refer them to the appropriate support services
- often people and their families feel that they are coordinators of their own care and this needs to be recognised and supported

Specifically in terms of care planning LCNs should consider:
• developing a visually accessible profile section as part of a care plan so that people can be supported to think about what is important in their lives and what they need in place to support them to do these things
• one page profiles could be used as part of future training on care planning for professionals
• developing resources to help people think about what they want to talk about as part of a care planning process
Background

Southwark has a shared vision for health and wellbeing services, building on the principles of better and more co-ordinated care across organisations so that local people feel in control of their lives and that services and professionals work better together around people and their families. This vision will be achieved through groups of providers coming together to deliver services in a more joined up way to deliver services working with people to support them to do what is important in their lives.

Fundamental to achieving this vision and enabling agencies to work better together around the needs of local people is an understanding of what matters to local people, how they live their lives, what works for them and what does not.

In Southwark we are supporting the development of two local care networks (LCNs) to help deliver this vision; the north LCN and the south LCN.

Southwark’s vision is described more fully in the Southwark Five Year Forward View.

The development of the LCNs across Lambeth and Southwark is one of the key priority areas of the Lambeth and Southwark Strategic Partnership which is a partnership of Lambeth and Southwark clinical commissioning groups (CCGs), Lambeth and Southwark councils, the GP federations, King’s College Hospital NHS Foundations Trust, Guy’s and St Thomas’ NHS Foundation Trust and the South London and Maudsley NHS Foundation Trust.

Care co-ordination

In 2016/2017 local care networks across Lambeth and Southwark are prioritising the delivery of co-ordinated care to people with complex needs; i.e. those people with three or more long term conditions. They are using the service specification developed as part of the work to transform primary care across London and which is laid out in chapter three of Transforming Primary Care in London: a Strategic Commissioning Framework. This specification builds on work carried out by National Voices, a collection of health and care charities, working for strong patient and citizen voice and service built around people. They have done a lot of work in this are including developing a narrative for patient centred co-ordinated care.

The key elements of these pieces of work are summarised in the table overleaf:
### Transforming primary care in London

| **1. Case finding and review:** Practices will identify patients who would benefit from coordinated care and continuity with a named clinician, and will proactively review those that are identified on a regular basis. | **National Voices – patient centred co-ordinated care**

“I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes [goals] important to me.” |

| **2. Named professional:** Patients identified as needing coordinated care will have a named professional who oversees their care and ensures continuity. | “I tell my story once.”

“The professionals involved with my care talk to each other. We all work as a team.”

“I always know who is coordinating my care”

“I have one first point of contact. They understand both me and my condition(s). I can go to them with questions at any time.” |

| **3. Care planning:** Each individual identified for coordinated care will be invited to participate in a holistic care planning process in order to develop a single care plan that can be shared with teams and professionals involved in their care. | “All my needs as a person are assessed.”

“Taken together, my care and support help me live the life I want to the best of my ability.”

“I work with my team to agree a care and support plan.”

“I know what is in my care and support plan. I know what to do if things change or go wrong.”

“I have as much control of planning my care and support as I want.”

“I can decide the kind of support I need and how to receive it.”

“I have regular reviews of my care and treatment, and of my care and support plan.”

“When something is planned, it happens.”

“I can plan ahead and stay in control in emergencies.” |

| **4. Patients supported to manage their health and wellbeing:** Primary care teams will create an environment in which patients have the tools, motivation and confidence to take responsibility for their health and wellbeing. | “I have information, and support to use it, that helps me manage my condition(s).”

“I am supported to understand my choices and to set and achieve my goals.”

“Taken together, my care and support help me live the life I want to the best of my ability.”

“Information is given to me at the right times. It is appropriate to my condition and circumstances. It is provided in a way that I can understand.” |
| **5. Multidisciplinary working** | “Information is given to me at the right times. It is appropriate to my condition and circumstances. It is provided in a way that I can understand.”
“When I use a new service, my care plan is known in advance and respected.”
“When I move between services or settings, there is a plan in place for what happens next.” |
---|---|
Patients identified for coordinated care will receive regular multidisciplinary reviews by a team involving health and care professionals with the necessary skills to address their needs. The frequency and range of disciplines involved will vary according to the complexity and stability of the patient and as agreed with the patient/carer. |
How we involved local people

In September 2016, the LCNs invited the engagement leads from the partner organisations in Southwark and Healthwatch Southwark (the independent health and care consumer champion who sits on the LCN Boards) to plan engagement with local people who have three or more long term conditions and/or their families/carers to understand their stories and experiences of how they live their lives. This was to build up a local picture of what is working well and what might need to improve to help the LCNs understand what needs to be put in place to make joined up care better for local people.

By the end of September 2016 GP practices in Southwark were in the process of identifying all their patients who had three or more long term conditions requiring coordinated care in order to start reviewing their care. The engagement leads and Healthwatch wrote a letter in every day English asking people if they would like to get involved in the project to try and make care better and more joined up for local people. The GP federations in Southwark sent the letter out on behalf of the GP practice. A copy of the letter is attached at appendix A.

<table>
<thead>
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<th>Numbers of patient contacts and responses</th>
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<tr>
<td>Letters sent out to patients</td>
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<tr>
<td>Total patient responses, of which</td>
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<tr>
<td>Interested in attending workshop</td>
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<tr>
<td>Interested in giving a story</td>
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<tr>
<td>Declined involvement</td>
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<td>Awaiting further contact</td>
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In many cases it seemed that people welcomed receiving a letter from or on behalf of their GP practice and were happy to talk over the phone about their health and their experiences as well as becoming further involved in the project. The CCG referred three people after this initial phone conversation as it appeared that they had responded to have immediate situations sorted out rather than take part in wider engagement. Twenty people declined further involvement due to being too ill, not having time (carers) or not being interested. Two family members contacted the CCG to say that the person who the letter was addressed to had died – this was due to the time lag between the details being drawn from GP lists and the federations sending the letters. One carer has since contacted the CCG to say that his wife had died since expressing initial interest in the project and he no longer wants to be involved. The 38 for whom the CCG is awaiting further contact have been left telephone messages or have been sent emails with further information about the project.
Engagement methods

We engaged with local people with three or more long terms conditions in a number of ways, which are described below.

1. Patient films
In addition the CCG made contact with three people with multiple long term conditions interested having their stories filmed, along with two people identified through general practice. The film was shown at the learning event for GPs, practice nurses and other medical practitioners from LCN partner organisations in October 2017. You can see this film of what people said about living with multiple long term conditions on the CCG YouTube channel.

The CCG also made five separate shorter films of the individual people who contributed to the longer film. You can also see their stories on the CCG YouTube channel.

2. Patient stories
During November and December 2016, 16 in-depth people’s stories were completed by the CCG (5), Healthwatch Southwark (5) and Revealing Reality (6). Revealing Reality is an organisations working with the LCNs across Lambeth and Southwark to support them to understanding the wider context of a person’s life when colleting patient stories, including using storytelling, flexible questions, observation in real life settings which is often a person’s home. This is called an ethnographic approach to engagement.

The 16 people’s stories were usually conducted in people’s homes; two were conducted at the individual’s GP surgery, one at the day centre the individual attended and one at the CCG’s offices.
The pictures below represent the visual analysis that the CCG carried out on the patient stories they carried out.

Healthwatch Southwark wrote up the stories they collected on one page profiles as shown below. Names of all individuals have been changed in above photos and in the below one page profiles. Stock photos have been used in three of the above analyses rather than photos of the individuals.
3. Patient workshop

26 local people living with long term conditions and carers attended a workshop on the 16 January 2017. The vast majority had not attended a NHS engagement event previously and LCN partner organisation engagement leads and Healthwatch Southwark were very conscious that we wanted people to feel comfortable and be able to participate. With this in mind, we wanted the workshop to be interactive, stimulating and easy for people to take part.

We started by showing the patient film that we had previously used at a clinical training event (see page 10) and highlighting some of the emerging themes from what people had told us both as part of the films and part of the stories.

We had a graphic artist to draw a picture of the ideas that came out of the day and we had an exhibition of photos taken by Revealing Reality when collecting patient stories.
We then moved into small groups to look at what is important to people in their lives and what their goals are and what they need to have in place to achieve these goals. We used a fruits (goals) and roots (what needs to be in place) tree for this exercise and the groups were facilitated by engagement leads from across the LCN partner organisations and Healthwatch Southwark.

Dr Lauren Parry, clinical director of Improving Health (IHL – the south Southwark GP federation) brought the morning session to a close explaining care planning and that the exercise we had just done could be seen as the goal setting part of a person centred care planning process. She explained that care planning is equal conversations between you and the people involved in your care to identify what’s important to you, what you can do to live as well as you can and what support you need from others and that a good care planning process takes place in four stages:

1. Preparation / getting ready
2. Talking with the person most involved in your care
3. Writing it down (and doing it!)
4. Future updating

In the afternoon we were joined by GPs, nurses, colleagues from hospitals, adult social care and the voluntary sector and we started the session by feeding back the emerging themes from the morning session.

**Joint afternoon workshops**

In the afternoon, we asked GPs, nurses, pharmacists, colleagues from hospitals, adult social care and the voluntary and community sector to join our discussions to explore what needs to be put in place to support a person centred care planning process after having heard what people had said was important to them.
in the morning session. We also had example copies of different care plans to see what people thought of these in terms of lay out style and whether they would use something like that.

Themes from the afternoon session are enlisted on pages 26 – 28.
Themes from the patient stories

This section presents what people told us about their lives, their experiences of using health and social care services, and what it is like living with three plus long term conditions.

Appointments

- people have a lot of medical appointments which can be tiring and sometimes confusing
- appointments can be in a lot of different places which also can be tiring and confusing
- sometimes there is not enough time within a medical appointment to talk about all your symptoms and issues when you have more than one long term condition, though some people might prepare for their appointment with internet research and come armed with questions
- some people have difficulty making appointments and getting to the GP surgery.
- some people talked about going for appointments at hospital, and experienced long delays with the transport system - “I don't ever want to go to hospital. Almost never ask for hospital transport. You have to be ready 2 hours before and you don't know when they will collect you. I was once waiting for 6 hours after an appointment in the transport waiting room.”
- one person talked about hospital departments attempting to coordinate appointments so they only had to visit once – this didn't work well for them as they were collected early in the morning and were kept waiting a long time at both clinics, so it was a long and tiring day.
- people said that seeing a locum can be difficult as they do not know you or your health conditions – “You don’t see the doctor like when you were young. The GP knows you by looking at the screen.”

Relationships with medical professionals and care providers

- many people were generally were very grateful for the services they has received; “I have nothing but love and gratitude [for the NHS] as I wouldn't be alive without it.”
- everyone felt that trust was very important in establishing relationships with health and care professionals, and having consistent professionals who know you well is important to people - “A person should have their own GP. I don't talk to another doctor. They don't know you. It's all down on paper but they don't know the person. They can read through but haven't seen you before.”
- some people noted small human interactions can make a large difference. For those that don’t see a lot of people, a smile from a receptionist can mean a lot and being treated as an individual makes them feel visible in a world where they may otherwise feel a bit invisible and lonely
- people talked about wanting better and/or more consistent relationships with the professionals that support them – people were grateful to be offered phone consultations and home visits
- some people found it hard to know when to challenge – whether about their diet, their health, or their independence. There is a fine line between
letting people have their quality of life and doing what they want (e.g. their diet) and telling them how to make change

- some people see their relationships with their GP and/or consultant as a partnership in which they are equal decision makers
- some people see their GP and/or consultant/nurse as the expert in their particular speciality and do not ask questions
- some medical professionals do not see the whole person and give advice about for example, exercise, not recognising the impact of other long term conditions on the person’s ability to exercise
- a few people in particular noted that their pharmacists were key in their care and they have known their pharmacists for a number of years
- a few people noted their GPs were particularly important and they have known their GP for a number of years and, in one case, they had had the same GP when a child so the GP knew them and their family situation very well; “[My] GP was amazing when all this was kicking off and I was terrified …the way she handled my medication and that fear was brilliant.”
- one person told us that they had a good relationship with their GP and felt that he really took the time to get to know them and understand their situation - “This latest doctor he really feels for us. Every time he sees me. He’s like my friend. Never met doctors of this sort.”
- a few people noted that the Community Psychiatric Nurses (CPNs) provide an important on-going relationship and that their CPNs knew them, visited them at home, listened and helped them with other issues such as helping them get out of debt; “I am so lucky. I’ve got a fantastic CPN at my GP surgery. I don’t think I would be as anywhere near as together as I am sometimes without here.”
- one person said that their hospital consultant was particular important to them at the point of diagnosis (as a fairly young adult of working age) and they saw them very regularly over a period of a few months and contacted them in between appointments via email and were responded to, for which they were grateful as the person knows how busy the consultant was
- wider GP staff were also important for one person as they know the person very well and they are able to go and sit in the practice without seeing the GP if they want as the person was lonely and frightened of being alone
- some people talked about wanting better and/or more consistent relationship with the professionals that support them – some said they would like to be able to see the same GP each time, but understands that this is difficult and appreciates phone consultations to keep connected. One was very grateful for their GP who made home visits to them when requested
- some people talked of regular appointments at clinics in the hospital and at GP practice – they spoke of the importance of getting to know the staff there
- one person had particularly enjoyed having a laugh with their care workers support them after coming home from hospital in addition to the support they gave with practical tasks and they missed this
- one person said that the care worker finished all the designated tasks very quickly and spent the rest of the allotted time on her phone on the sofa
one person who was confined to bed when they came out of hospital said it felt strange having someone else in the house and they wanted them to come into the bedroom to say what they would be doing

**Relationships with wider community, neighbours and family**

- many people are lacking in human contact, and the fact that so many people want to take part in the project and comment on the fact they have had a lovely time, shows the need for some more human contact. People often attach a lot to small interactions such as a smile, or a visit from a care worker or volunteer, and the long weeks can often stretch ahead when they barely see or talk to anyone else.
- some people felt that their (voluntary sector) support worker had been particularly important in their care and support in terms of providing care and support after a hospital stay for a physical health condition but also provided emotional support in addition to the physical support and this was particularly important in terms of being able to leave the house as well as proving support in writing letters to try and sort out housing issues.
- many people talked of the relationships with neighbours and local people were important to them – they were a source of supportive and regular contact and made people feel like they were part of a community.
- a lot people talked of community and voluntary sector clubs and visits made a difference to them – relationships built with volunteers coming to visit in their home and supporting people to participate in club activities. “It [singing] uplifts me after my husband died… it really did get me over it. They are such a jolly lot [at the choir].”
- two people talked about their art and how this was an important part of their life
- four people talked of the importance of faith and the relationships they have made with clergy and others with the same faith, this supports feelings of hope and recovery, though it can be difficult to leave the home to go and worship.
- one person could no longer easily get to the pub where a lot of their socialising had taken place, so they spent more time on their own now.
- a lot of people said that there is a lot going on in Southwark but it is difficult to find out about activities sometimes. Two people were member of the choir for those with chronic obstructive pulmonary disease; one person had been given the information by their GP and one person had seen a notice on a community noticeboard. They were spreading the word though.

**Carers**

- carers spoke about requiring support to be able to carry on looking after their family member at home and not wanting their family members to go into a care home; “Providing I can manage I wouldn’t put her into care.”
- there is often an emotional impact on caring, you can become lonely and isolated particularly if you are looking after your spouse and growing older together; “I took my vows when we got married (65 years ago) … in sickness and in health. Well, I’ve had the good and now …”
- carers can sometimes ignore their own health needs and sometimes have to cancel health appointments due to the needs of their family member.
- many people talked of family support is important to them –caring and support to do day to day tasks such as shopping, is being taken on by
family members. This both puts pressure on the families but also keeps the family connected with the care of that person. “I have the whole team [family] around me. They are helping me because I am helping nobody.”

- the idea that someone that is currently the ‘stronger’ of a couple slips under the radar if the most ill person passes away

Self-management and motivation

- there was a wide range of attitudes towards taking ownership of one’s health and condition from those people that totally deferred to a healthcare professional and taking little ownership over health, to feeling as if you know yourself well, and you want to know about medication changes etc. Those that defer to healthcare professionals often don’t even know all of their conditions, and have resigned to ‘being ill’; “I can’t think of all my health conditions … my heart isn’t as strong as it was.”
- some people, particularly when they received a diagnosis when younger (either as a child or as a working age adult), allowed themselves to be only defined by their illness and how others saw them was important; where people took more responsibility for looking after themselves it seemed that they were less likely to only define themselves by their illness
- for one person with mental health needs their focus was on their mental wellbeing rather than their physical illnesses
- sometimes the overriding condition which impact’s on someone’s life the most is not the most serious medical condition, for example losing your hearing impacts on your daily life as does IBS but these might not be the most serious conditions from a medical point of view; “It is so embarrassing. I don’t even want to take the bus or invite friends around.”
- some people said that they lost their confidence with being ill and they needed more personal support to get going with some self-management activities such as going to the gym as it can be intimidating, although they recognised that “the system is here to help me to take personal responsibility … I need something that is tailored to me … is going to give me a sense of purpose.”
- one person had taken a lot of self-management courses such as DESMOND (for diabetes) and cardio rehabilitation
- people lose confidence when they are ill and can become more frail and may need extra support to get going in doing activities that support self-management; “I am grateful I have free gym, but there’s nobody there to help me … it’s pretty intimidating … and I feel pretty vulnerable.”
- one person felt that self-management courses need to be more inspiring and stimulating especially when addressing foods and eating as this is a pleasurable activity for most people “I felt like I had gone back to kindergarten … there was valuable information but … a little too broad and too general. Make it interesting, get people excited about the stuff they put in their tummies.”
- people do not always recognise the emotional impact of being ill on themselves and need a clinician to point this out to them and refer them to appropriate services such as counselling
- one person felt that one course of six counselling sessions is not enough to address the emotional impact of living with multiple long term health conditions
• one person had adapted to being less physically able by no longer going to the gym but playing golf and using some of the outdoor gym facilities at their local park

• five people talked about being able to mobilize and manage around the home – some did say that going out is far more of a challenge to them but they manage at home. Adaptations in the home have helped to keep independent, manage steps, use the shower etc.

• two people talked about their commitment to staying fit – talking about getting out and about, doing as much exercise as they can to maintain their current health

• many people don’t see themselves as ‘old’, and sometimes it means that they are avoiding many of the truths that come with getting older, and ignoring the fact they are vulnerable – this is then also about how healthcare professionals frame the things they say

Impact of being ill on your life

• being ill with many long term conditions can get you down and you can become depressed, although you do not always recognise that you might be depressed

• being ill mean you can no longer do all the activities or hobbies that you used to do and this can mean that people become more socially isolated or bored. Not being able to do hobbies is often the first of many things that begin to stop in a person’s life. That one thing can often be a lifeline to the rest of the world so stopping it can be really damaging to a person’s wellbeing

• one person used to play team sport when they were younger and found it more difficult and somewhat lonely to do solitary exercise but was not well enough to participate in team sport any longer; “playing team sport was a big part of my social life and I can’t do that now and that leaves me isolated.”

• getting out and about is important for people – people are often stuck at home (stairs are often to blame) as their mobility is too bad to walk down stairs or go too far and this can get you down

• some people are worried about the future and who will support them as they become older “People get lonely and often don’t find life worthwhile anymore. [They] only get picked up when they have gone down so far.”

• people of working age are often worried about not being able to work and what this means for their future in terms of finances and were often concerned about perceived stigma of receiving welfare rights; “What I had to go through to get benefits …what I had to go through to get housed … where’s the humanity gone?”

• there are financial implications to eating healthily

• being ill can mean you are living in constant pain

• the impact on of one illness or condition on your life can have more of an impact than others and this is often the one the person focusses on even though it might not be the most serious in medical terms

Care planning and co-ordination

• there were many examples of the miscommunications / lack of coordination in people’s experiences of healthcare, that may seem small but can really effect someone
only one person knew that they had a plan in place and this was their crisis plan which they had helped to develop and which they thought was good as it contained key contact details and information about themselves

whilst most people hadn’t heard of a care plan, they thought that professionals were already sharing notes about their care.

some people felt that not all information and messages between different parts if the system are shared. - “Do they work together? I don’t think so…I have a separate person each time I think they just read my notes. Think the clinics send a letter to the GP. It’s up to the GP to read the letter. Not sure if they do. They must get thousands of letters.”

a number of people felt that they are already actively co-coordinating their own care but felt it would be good to link this up with professionals better “I am responsible for co-ordinating my care”

some people felt that they had family members who co-ordinated their care

not all messages between different parts of the health system are shared and this can happen with results

some people said that they did not feel that they need a care plan

some people scan all their letters and appointments so they have an electronic file on their computer with all their details in and they also carry out internet research on their conditions, medications and side effects; they prepare for their appointments by writing everything they want to speak about down. They had not heard of a care plan but thought that what they were doing would contribute to it and thought that joining up everyone’s views and thoughts would be very useful, although they were not aware of what happened behind the scenes amongst different professionals

some people keep a paper folder of all their letters and appointments and hadn’t heard of a care plan. When it was explained, they thought it might be useful to have one in place as they had had frustration at the perceived lack of communications between the GP and the hospital but they were concerned that they would not lose control over their own care

one person talked about hospital departments attempting to coordinate appointments to allow the person to have one visit to the hospital to attend both. This did not seem patient friendly as they had to be collected early in the morning and was waiting a long time to be seen at both clinics.

one person actively wanted all their hospital appointments on one day

one person thought that a care plan would be a good idea to help them not have to repeat themselves at appointments.

one person felt that their named GP is their care coordinator.

Communication and information

some people had had appointments not made by medical professionals even though they had written it on the card and it took them a lot of time and effort to walk to it to then be told it was not happening

some people do not understand medical terms and do not ask

some people do not understand the medical terms in letters but some people might research on internet or have a family member who might do this on their behalf

some people prepare before going to medical appointments and night have a list of questions to ask
Medication

- people have a lot of medication to take, often at different time of the days and don’t always understand what it is for or what the side effects might be
- three people talked about fully understanding the medication they take – they could talk about why they were taking each tablet
- a few person talked about going to talk with the pharmacist if they are not clear about the medication
- many people talked to us about taking a lot of medication – but not always understanding what it is for or what the side effects might be - “If a doctor puts you on a tablet they usually tell you how (to take it), but after that you are on your own.”
Themes from the morning workshop: roots and fruits exercise

The table below summaries what came out of the ‘roots’ (the things people said that they needed in place to achieve their goals) and ‘fruits’ (the things that are important to people, their goals) activity at the engagement workshop in January.

In summary, what was most important to people (the ‘fruits’) was their hobbies, receiving person-centred care, being mobile and independent and stating connected with people. What people felt they needed in place to achieve these things (the ‘roots’) was knowing about all the different services available to them and being able to access them.

### Fruits: what’s important to people and their goals

<table>
<thead>
<tr>
<th></th>
<th>Mentions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hobbies</td>
<td>16</td>
</tr>
<tr>
<td>Person Centred Care</td>
<td>12</td>
</tr>
<tr>
<td>Mobility, freedom to go out, be independent, places to be accessible</td>
<td>9</td>
</tr>
<tr>
<td>Stay connected with people</td>
<td>8</td>
</tr>
<tr>
<td>Improve, be and stay healthy. Self-management</td>
<td>7</td>
</tr>
<tr>
<td>Information sharing, communication with health professionals</td>
<td>5</td>
</tr>
<tr>
<td>Taking Medication</td>
<td>4</td>
</tr>
<tr>
<td>Volunteering / Learning</td>
<td>4</td>
</tr>
<tr>
<td>Socialising and keeping support system</td>
<td>4</td>
</tr>
<tr>
<td>Want to be taken care of by health professionals</td>
<td>4</td>
</tr>
<tr>
<td>Losing weight, having an active life</td>
<td>3</td>
</tr>
<tr>
<td>Improving confidence</td>
<td>2</td>
</tr>
<tr>
<td>Wanting holistic care</td>
<td>2</td>
</tr>
<tr>
<td>Seeing the same GP each time</td>
<td>1</td>
</tr>
<tr>
<td>To be able to use hospital transport without long wait</td>
<td>1</td>
</tr>
<tr>
<td>Doing things in their own pace</td>
<td>1</td>
</tr>
<tr>
<td>Wanted health professionals to be more flexible</td>
<td>1</td>
</tr>
<tr>
<td>Wanted health professionals to know that illness does not define who they are</td>
<td>1</td>
</tr>
<tr>
<td>Faith</td>
<td>1</td>
</tr>
<tr>
<td>Understanding clinical problems</td>
<td>1</td>
</tr>
</tbody>
</table>

### Roots: what people need in place to achieve their goals

<table>
<thead>
<tr>
<th></th>
<th>Mentions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to find services e.g. befriending</td>
<td>15</td>
</tr>
<tr>
<td>Services to be easily accessible, efficient and innovative e.g. a one stop shop for several specialisms</td>
<td>11</td>
</tr>
<tr>
<td>To offer person centred care</td>
<td>9</td>
</tr>
<tr>
<td>Services and staff to know how to support people (including health, social care, voluntary, busses, education settings)</td>
<td>8</td>
</tr>
<tr>
<td>GP to develop a more efficient appointment system</td>
<td>5</td>
</tr>
<tr>
<td>Clear information about the conditions I have, a care navigator/coordinator would help, to have someone to ask questions</td>
<td>5</td>
</tr>
<tr>
<td>Services to be joined up more and streamlined</td>
<td>5</td>
</tr>
<tr>
<td>Open dialogue between patients and professionals</td>
<td>5</td>
</tr>
<tr>
<td>Timely care planning</td>
<td>4</td>
</tr>
<tr>
<td>A service to help me get out to socialise and be active</td>
<td>4</td>
</tr>
<tr>
<td>Southwark Council to improve access e.g. pavements uneven, better lighting</td>
<td>3</td>
</tr>
<tr>
<td>Hospital transport to review and improve service for patients</td>
<td>3</td>
</tr>
<tr>
<td>To see the same professional each time for consistency</td>
<td>2</td>
</tr>
<tr>
<td>For people to include the physical and spiritual side of patients, mindfulness</td>
<td>2</td>
</tr>
<tr>
<td>GP to keep better records</td>
<td>2</td>
</tr>
<tr>
<td>Joined up care, especially with health and social care services</td>
<td>2</td>
</tr>
<tr>
<td>Time keeping of professionals visiting my home</td>
<td>1</td>
</tr>
<tr>
<td>Protected green space, to help me keep active</td>
<td>1</td>
</tr>
<tr>
<td>Volunteering</td>
<td>1</td>
</tr>
<tr>
<td>A service to help me learn new skills</td>
<td>1</td>
</tr>
<tr>
<td>Need to change my expectations of GP, I know I can’t see the same person each time</td>
<td>1</td>
</tr>
<tr>
<td>A system to help me have my medication on time</td>
<td>1</td>
</tr>
</tbody>
</table>
Themes from care planning afternoon workshop

The table below summarises the conversations that took place at the workshop between patients and health care staff. The purpose of the session was to explore what needs to be put in place to support a person centred care planning process.

This exercise was captured by people writing their thoughts on post-it notes. We colour coded these so we could see what the different groups of people had said:

- Green patients and carers
- Orange primary care
- Blue secondary care
- Pink voluntary and community sector
- Yellow adult social care

### Needing more time with patients

"How do we make patients more active and involved when you have a short amount of time with them, we also need to explain things in plain English to help people understand their conditions?" – Nurse practitioner

"Having time to talk to patients is key = we spend more time with people on a weekly, monthly basis" – Adult social care

"We need time and information about services to be able to support patients and to link them in to groups and activities that would help them reach their goals" – Southwark Council – Learning Disability Service

"Communication within the right timeframe and the patients know that the timeframe is. There are different communication systems in place – across organisations (doesn't help smooth communication) - GP"

### Linking into the community / signposting

"As a clinician it is hard to know what is available as service change so you want to be able to send patients to current services" – Nurse practitioner

"We need time and information about services to be able to support patients and to link them in to groups and activities that would help them reach their goals" – Southwark Council – Learning Disability Service

### Communication

"Communication within the right timeframe and the patients know that the timeframe is. There are different communication systems in place – across organisations (doesn't help smooth communication)" – GP

"Patients will always come into contact with us so let’s make it easier for them" – Community pharmacy

"The professionals have an opinion of you and you have to try and tell them your side of the story. You have to sometimes battle with them around medication, but there might be a time when I can’t battle and that worries me” – patient

"Can the doctor feedback what was talked about at the appointment? This would help me follow up on what I am supposed to do" – patient

"We need to be able to have a dialogue with patients to offer meds as and when they need it” – Community pharmacy
| “I can’t see so it is far more difficult for me to access things — people need to be mindful of this when working with me.” — patient |
| “We look at individual needs and the things that people want to achieve. It is about listening to see what would be the best support for them.” — Adult social care |

| Care plan document |
| “Stay Well Plan is an example which works well. It’s a massive document but the person has a copy too” — GP |
| “Passport used in learning disabilities services is good.” — Adult social care |
| “It needs to be flexible, be completed together and include achievable or realistic goals and be accessible and user friendly” — GP |
| “It needs to be a balanced document – not too much information but enough for a thorough assessment of the person’s progress/situation” — GP |
| “GP’s need to have the right skills to plan / agree goals.” — GP |
| “Patients need several visits to develop goals.” — Community rehabilitation services |
| “It’s important to have something everyone can input into” — Nurse practitioner |
| “There is a learning disability health plan which works well” — Hospital doctor |
| “I wouldn’t want to take control of a care plan — I want a professional to look after it and update it for me” — patient |
| “I need to have a copy so I can remember what we agreed.” — patient |
| “It needs to be done in my own time and not at GPs.” — patient |
| “If we were to have a shared template to allow everyone to add to the care plan notes, that could work – this would need to include the patient, GP, hospital, community pharmacy etc. to be able to access it” — Nurse practitioner |
| “A formal care plan can go out of date quickly – digital version allows it to be updated quickly and easily” — Southwark Council, Learning Disability |
| “It is hard to engage with patients with care planning, we have tried many methods. We also need to input the information twice onto our computer system and then onto a patient facing document” — Nurse practitioner |
| “A care plan is fluid and dynamic. It might not be a single document. Some goal setting might be quite specific.” — Community rehabilitation services |
| “Things important to me need to be in it.” — patient |
| “It needs to be clear and easy to read with broad sections.” — Adult social care |
| “People’s goals change – there needs to be a clear way to update it.” Southwark Council – Learning Disability Service |
| “Care plans need to be reviewed regularly.” — Community rehabilitation services |
| There are difficulties incorporating various professionals’ views / information within the plan.” — GP |
| “In diabetes when care plans have been used it would be good to know what the impact has been to see if this is a method to put more effort into” — Nurse practitioner |

| Multi-disciplinary working / information sharing |
| “There are difficulties incorporating various professionals ‘views/information’ within the plan” — GP |
“information with the right people (to implement quicker care planning)” - GP

“information sharing with the right people (to implement quicker care planning)” - GP

<table>
<thead>
<tr>
<th>Named person</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Some people want a third person who is not a professional to help with creating a care plan” – Adult social care</td>
</tr>
<tr>
<td>“My GP” – Patient</td>
</tr>
<tr>
<td>“An advocate – someone who is impartial, I wouldn’t mind if this was a volunteer” – Patient</td>
</tr>
<tr>
<td>“I would prefer it to be my brother but if I couldn’t have him it would need to be my GP or my Community Psychiatric Nurse” – Patient</td>
</tr>
<tr>
<td>“The GP is not always the best person to set the goals. It needs to be someone who the patients trusts and has a good relationship with.” – Community rehabilitation services</td>
</tr>
</tbody>
</table>
Next Steps

Members of the local care network boards across Lambeth and Southwark held a decision making event on 1 March 2017 to develop a care pathway for patients with multiple long term conditions that provides more co-ordinated care.

The care pathway describes what support people with multiple long term conditions will receive and how they move between different service such as general practice, community services and hospital services as well as looking after one’s own health.

The London high level service specification (see page 8) outlines the key elements of care that are important for providing patient care that is co-ordinated: case finding, having a named professional, care planning, support for self-management and multi-disciplinary working.

Health and social care professionals at the event in March agreed a number of actions under each of these areas which will be tested over the coming months and local people and their families will be involved in this. In early summer, the local care networks will contact everyone who took part in the engagement that over winter and invite them to help the LCNs shape communication approaches including templates for letters and care planning so they are useful and make sense to local people. These will then be tried out as part of normal ways of working later on in the year and adapted in response to any further feedback before being made part of contracts with the organisations that make up the local care networks (GP federations and local hospital including South London and Maudsley NHS Trust) from April 2018.
Dear insert title and name of patient

RE: Opportunity to help us improve local health and care services so they work better for you.

Improving Health (IHL) / Quay Health Solutions (QHS) is a group of all south / north Southwark GP practices working together to provide extra GP appointments from 8am – 8pm, seven days a week. We are writing to you on behalf of your general practice.

We know that health and care services don’t always get it right for patients and we want to make this better. We are working with local services, but we need to understand your views and experiences to do this. We are focusing on how care and support is planned and organised for people such as you who have a number of health or care conditions. Your care often involves a number of health and care professionals and this is why we have written to you.

The services we are looking at include hospitals, GPs, pharmacy services (from your local chemist), community health services (e.g. district nursing, therapies), social care services. (e.g. help getting out of bed or washed, help with meals or seeing friends and family) and / or services from local voluntary sector providers (e.g. from local charities such as befriending groups, peer support groups or lunch groups etc.).

You can get involved in different ways:

You could tell us your story or experience
We can speak to you (and/or your carer) about your views and experiences (either on the phone, at your home or at your GP surgery). We would like to do this in November/December. If you do choose to share your story this can be anonymous and will not affect the care you receive. However, we would also like to film some stories with permission. You have the choice of how you tell us your story.

You can take part in a workshop
On 19 January 2017 we are organising a joint workshop involving patients (and/or carers) and staff (e.g. doctors, nurses). At the workshop we will be thinking up ideas to make services better for patients.

You can take part in other/more specific meetings that will help shape our plans
We would like patients (and/or carers) to be part of discussions about different aspects of planning and receiving care. We will provide you with support to do this (such as, support before, during or after meetings).

If you are interested in finding out more: Please get in touch with Rosemary Watts who works for NHS Southwark Clinical Commissioning Group. You can either fill in the form over leaf and send it back (you do not need to use a stamp) or you can telephone or email her. Rosemary will happily call you back to discuss this more with you and answer any questions you might have.

Telephone: 020 7525 1686
Email: rosemary.watts@nhs.net

Thank you for your time in reading this letter, we hope you would like to get involved.

Yours sincerely,

Add name of GP Practice
On behalf of all GPs in Southwark
If you would like to know more about this you can contact Rosemary Watts directly by emailing Rosemary.Watts@NHS.net or by phoning 020 7525 1686. Alternatively you could fill in this form and send it to this free post address (no stamp required):

Communications and Engagement Department
FREEPOST RSCY-ACYH-CAZL
Hub 5, 1st Floor,
NHS Southwark CCG,
PO Box 64529
London SE1P 5LX

You name:_____________________________________________________

Your GP practice:______________________________________________

Your phone number:____________________________________________

Your email address:____________________________________________

Preferred method of contact: □  email  □  phone
Appendix B: roots and fruits table discussions write up

I want to be able to get out on my own
I want to use my computer to stay connected, it is currently broken
I want to be healthy and stay healthy
I want to carry on going to my choir and taking part in activities
I want to keep on top of my medication which allows me to do the things I want
I want to feel confident about walking on the pavements – they are sometimes very uneven
I want to do things in my own pace; I don’t want to get breathless
I want to stay on top of my medication and go out to do the things I want to as I do now – Go out with friends to have a meal, do my shopping
I want to lose weight
I want to be able to use the hospital transport and not be waiting around for hours
I want to be able to use a mobile phone to text and keep in touch

I would like to go out walking and have support to go
I want to continue travelling with my wife
I want to continue walking each week, but the hospital tells me not to do too
I want to be able to see the same doctor each time when I go to the surgery
I want to carry on travelling with my wife
I want to continue walking each week, but the hospital tells me not to do too
I need to change my expectations of my GP as it won’t always be possible to see the same GP each time I go to the surgery
I need Southwark Council to improve pavements for people with access needs.

I want to be able to get out on my own
I want to use my computer to stay connected, it is currently broken
I want to be healthy and stay healthy
I want to carry on going to my choir and taking part in activities
I want to keep on top of my medication which allows me to do the things I want
I want to feel confident about walking on the pavements – they are sometimes very uneven
I want to do things in my own pace; I don’t want to get breathless
I want to stay on top of my medication and go out to do the things I want to as I do now – Go out with friends to have a meal, do my shopping
I want to lose weight
I want to be able to use the hospital transport and not be waiting around for hours
I want to be able to use a mobile phone to text and keep in touch

I need green space around me to allow me to get out, socialise and be fit
I need support for people to have assistance to go out
I need the hospital transport service to review and improve the waiting times for patients
I need a service that will send a person to sit with me and show me how to use my mobile phone
I need services to understand that my conditions are not the things that make me who I am. I have family, friends and things I like to do and my conditions don’t impact on that
I need Southwark Council to improve pavements for people with access needs.

I need support for people to have assistance to go out
I need a service to help me exercise, to go for a walk in the park each day
I need to find ways to do the things I want to, like continuing to carpool to get to choir.
I need services to understand that my conditions are not the things that make me who I am. I have family, friends and things I like to do and my conditions don’t impact on that
I need Southwark Council to improve pavements for people with access needs.

I need support to find other activities I can do that won’t impact
I need my GP to develop a more efficient appointment system
I need Doctors to use computer systems so it does not matter that I don’t see the same GP each time it is all updated
I need support to find other activities I can do that won’t impact
I need my GP to develop a more efficient appointment system
I need Doctors to use computer systems so it does not matter that I don’t see the same GP each time it is all updated

I need to have easy access to transport such as Dial-a-ride and to link up with people and services to know what is happening nearby to get involved with
I need support to find other activities I can do that won’t impact
I need my GP to develop a more efficient appointment system
I need Doctors to use computer systems so it does not matter that I don’t see the same GP each time it is all updated
I need Southwark Council to improve pavements for people with access needs.

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I need support to find other activities I can do that won’t impact
I need my GP to develop a more efficient appointment system
I need Doctors to use computer systems so it does not matter that I don’t see the same GP each time it is all updated
I need Southwark Council to improve pavements for people with access needs.

I need to find services that would help to fix computers or to help people get to a library where there are computers – this includes transport
I need support for people to have assistance to go out
I need the hospital transport service to review and improve the waiting times for patients
I need a service that will send a person to sit with me and show me how to use my mobile phone
I need services to understand that my conditions are not the things that make me who I am. I have family, friends and things I like to do and my conditions don’t impact on that
I need Southwark Council to improve pavements for people with access needs.

I need to know about services to support me to get to classes, learn to cook healthy food, be able to talk about my mental health and the voices in my head, including how this affects me when I am out
I need support for people to have assistance to go out
I need a service to help me exercise, to go for a walk in the park each day
I need to find ways to do the things I want to, like continuing to carpool to get to choir.
I need services to understand that my conditions are not the things that make me who I am. I have family, friends and things I like to do and my conditions don’t impact on that
I need Southwark Council to improve pavements for people with access needs.
I want to be better managed in the system.

I don't want to be socially isolated.

I want to be healthy and stay healthy.

I would like professionals to be more flexible.

I would like more communication between health and social care services.

I don't want to be socially isolated.

I want to go on a London tour on a mini-bus.

I don't want to be taking 22 pills a day.

I want to go out more and going for walks.

I want to be involved in decision-making about my care.

I want to be independent and get on with my life.

I need to have clear and simple information about my conditions.

I need consistency – I need to see the same people.

Pharmacy reviews are important to understand whether I still need the same medicines.

Joined-up care is really good for me.

I would like someone helping me navigating the system.

Mindfulness helps me a lot.

I would need a bus pass to move around.

Volunteering activities keep me going.

I would need professionals to talk to each other.

I would like a care navigator – the right person advising me at the right time.

I would love to speak to a care coordinator regularly.

I would like to be confident enough to ask the right questions.

I would love to have some honest conversations with professionals.

I would need to understand clearly what's going.

I would like my surgery to do something about people that don't attend appointments.

I would like health professionals to have some common sense and ask me what I need.

I need my GP to develop a more efficient appointment system.

I would need someone helping me navigating the system.

I need someone helping me navigating the system.

I would need professionals to talk to each other.

I would love to speak to a care coordinator regularly.

I would like my surgery to do something about people that don't attend appointments.

I would like health professionals to have some common sense and ask me what I need.

I need my GP to develop a more efficient appointment system.

I would need a bus pass to move around.

Volunteering activities keep me going.

I would like to be confident enough to ask the right questions.

I would love to have some honest conversations with professionals.

I would need to understand clearly what's going.

I would like my surgery to do something about people that don't attend appointments.

I would like health professionals to have some common sense and ask me what I need.

I need my GP to develop a more efficient appointment system.

I would need a bus pass to move around.

Volunteering activities keep me going.

I would like to be confident enough to ask the right questions.

I would love to have some honest conversations with professionals.

I would need to understand clearly what's going.

I would like my surgery to do something about people that don't attend appointments.

I would like health professionals to have some common sense and ask me what I need.

I need my GP to develop a more efficient appointment system.

I would need a bus pass to move around.

Volunteering activities keep me going.

I would like to be confident enough to ask the right questions.

I would love to have some honest conversations with professionals.

I would need to understand clearly what's going.

I would like my surgery to do something about people that don't attend appointments.

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I need my GP to develop a more efficient appointment system.

I would need a bus pass to move around.

Volunteering activities keep me going.

I would like to be confident enough to ask the right questions.

I would love to have some honest conversations with professionals.

I would need to understand clearly what's going.

I would like my surgery to do something about people that don't attend appointments.

I would like health professionals to have some common sense and ask me what I need.

I need my GP to develop a more efficient appointment system.
I would like to join a knitting group.

Singing in the choir for COPD and asthma.

I am interested in photography.

Mobility – getting out and about – feeling confident.

I enjoy reading and would be interested in joining a reading group.

To be listened to and looked at.

I would like to attend evening classes.

I need it to be easier to cancel appointments.

Everyone should know how the system works.

Working with you at your stage of readiness.

Care at home needs to be planned before leaving hospital.

Knowing what the care workers are doing and what they are there for – Care workers to treat you with respect.

Computer course at St. Thomas Apostle provided by Southwark Council. There are many events taking place. They are doing a lot for us.

You feel like you are living to go to hospitals. Your whole life has become hospitals.

Need more personalised patient transport. Differentiate between needs.

Care workers need to turn up on time.

Being given information about COPD choir, movement and balance classes, computer classes.

Pharmacists being well placed – longer term relationships so they know you and may need to be involved – know your goals and can sign post.

I want to continue to attend church.

I need for hospital appointments not to be first thing in the morning. The transport calls for me very early and I have to sit in the waiting room for hours. I need it to be easier to cancel appointments.

Someone to talk to about non-medical things – general practice to be more proactive in identifying people to refer to SAIL if lonely.

Time in hospital or surgery to talk to someone about issues related (though not directly) with medical condition.

Care workers need to turn up on time.

I need for hospital appointments not to be first thing in the morning. The transport calls for me very early and I have to sit in the waiting room for hours.

I need it to be easier to cancel appointments.

Everyone should know how the system works.

Working with you at your stage of readiness.

Care at home needs to be planned before leaving hospital.

Knowing what the care workers are doing and what they are there for – Care workers to treat you with respect.

Computer course at St. Thomas Apostle provided by Southwark Council. There are many events taking place. They are doing a lot for us.

You feel like you are living to go to hospitals. Your whole life has become hospitals.

Need to streamline and have fewer appointments.
Keeping healthy so that I can lead an active life. I like walking and going to the gym.

Social contact gives acknowledgement that I exist.

At some point, understand what my clinical problem is.

Would like to lose more weight and not crave sugary foods. I want to be supported in my diet choices.

I would like to jump out of bed and get straight into the shower without waiting for back pain to subside.

Could do with a mental health support worker to visit once a week to give to give you the support you need.

To improve my wellbeing and health.

Being able to meet up with my friends and family keeps me happy and socialising.

I like walking in the summer and singing in the church choir.

To have the same carer that visits regularly.

Timely care and support planning before leaving hospital or care environment.

Need urgent appointments when you need them, not be left for weeks. Your condition could deteriorate.

Need to agree key components of a care plan – not a one size fits all format.

Employers need to be sympathetic to time off for carers to go to appointments.

Timely care and support planning before leaving hospital or care environment.

Access to technology. IT classes to help people stay in contact.

Good street lighting and safe pavements to prevent falls.

Using Face time.

Having an advocate to help – who may not be a relative or carer.

Befriending/carer schemes, regular district nurses.

Community help – getting residents association or other services to help link people.

One stop shops and multi-disciplinary working so that patients can see ‘one team’.

The bus driver needs to help the elderly and frail onto the bus.

Timely, appropriate medical services for diagnosis and treatment.

Technology needed for even larger print books. Lack of audio books.

Support to ensure sensory impairment is addressed.

Better facilities at libraries e.g.

Maintaining mobility, exercise classes, weight reduction support, mobility aids. Hearing and eyes being connected.

To support my mum so that she can enjoy this stage of her life.

I want a statement at the beginning of my care plan saying who I am as a person (RCN dementia form) my interests, work level of education, my family and community. My named person or professional who the patient can relate to, to help.

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Appendix C: Equal opportunities monitoring

Of the 26 people who attended the workshop, 24 filled in equal opportunities monitoring forms.

**Ethnicity**
- 62% identified as White
- 19% identified as other
- 10% identified Black or Black British - African
- 5% identified as mixed – White and Black Caribbean
- 5% identified as Black or Black British - Caribbean

**Gender**
- 70% identified as female
- 30% identified as male

**Age**
- 29% were aged 45 - 59
- 19% were aged 60 – 64
- 24% were aged 65 – 74
- 29% were aged 75 – 79

**Gender reassignment**
- 5% identified as having a different gender to their birth sex

**Sexual orientation**
- 5% identified as being gay

**Religion or belief**
- 78% identified as being Christian
- 17% identified as having no religion
- 5% identified as being Muslim

**Marriage or civil partnership status**
- 38% identified as being single
- 29% identified as being married
- 17% identified as being widowed
- 8% identified as being separated
- 5% identified as being divorced
- 5% identified as co-habiting

**Illness and disability**
- 1% identified as being deaf or hard of hearing
- 13% identified as being blind or partially sighted
- 25% identified as having mental health needs
- 79% identified as having a long term illness
- 42% identified as having a physical disability
- 17% identified as having other disabilities
- 13% identified as having no disabilities
Appendix D: Workshop evaluation

24 people filled in an evaluation form from the morning session.

- 63% rated the session as excellent
- 34% as good
- 4% as OK
- 50% stated that they understood everything
- 50% stated that they understood most of the session
- 48% rated the roots and fruits exercise as excellent
- 43% rated it as good
- 4% rated it as OK
- 4% rated it as poor

- “Enjoyed the discussions and sharing ideas. Very informative session”

“I thought it was a very mixed session and we talked about things I wasn’t expecting”.

“I enjoyed the "tree" activity. It was nice to see some people I knew.”

“Learnt a lot about organisations that help health-wise and therefore the session was very interesting with all the various discussions”

“A little noisy at times, sometimes missed comments. Very informative. Also very reassuring meeting others with problems and listening to how they meet and cope with them. It was good to explain my point of view, problems and "ambitions" and have them listened to sincerely.”

“I found the event useful and informative. I feel more involved with the support by the NHS for my mother. Thank you.”

“I was unsure of how to participate initially. Was made to feel comfortable and able to share my thoughts with the support of the facilitators. Thank you.”

“The session was very good, very useful and a lot of fun (for all the right reasons).”

19 people filled in an evaluation form for the afternoon session.

- 53% rated the session as excellent
- 37% rated it as good
- 11% rated it as OK
- 37% stated that they understood everything
- 63% stated that they had understood most of the session
- 58% found the task excellent
- 37% found it good
- 5% found it OK

“Wasn’t able to hear what everyone was saying, especially people directly opposite me. Nice to listen to what I could hear, sounds like things will happen in the future and it was very purposeful.”
“Thought provoking. Good to meet up with professionals. Well done!”

“There could have been more interaction between patients and GPs.”

“It’s very hard to say all that you want to in a short time and with so many around the table.”

“Was extremely good to have such a good mix of all services.”

“Interesting, informative. I feel this will really help to support all patients with health issues, long term ones as well as short term.”

“Please accept, and convey to all your colleagues involved, my thanks for what felt a very well thought out, considerate and comfortable patient engagement event and I hope the outcome will make a meaningful contribution to improving peoples’ lives.”