Locality teams – co-design event results (July 2015)

Contents

Thank you to everyone who attended the event. We value your feedback and are glad that so many of you enjoyed it.

About the event

A pilot half day Integrated Local Health and Social Care Team co-design event was held in the Eastbourne area (3 June 2015). It enabled conversations between health and social care practitioners (including the independent and voluntary sectors); members of the public; and patients, clients and carers.

Presentations and four ‘real life stories’ illustrated current challenges in health and social care and the experiences of a range of people; and asked how integrated health and social care teams could operate to improve outcomes in future. Questions enabled participants to design ‘measures’ against which this progress can be gauged.

The East Sussex Better Together (ESBT) Engagement and Communications Advisory Group fed into the design of the event, including the stories and how they were used.

(See Appendix 2 for the four stories and the questions asked.)

Event feedback summary

Locality teams co-design event

Held 3 June 2015 in Eastbourne

Four ‘real life stories’ illustrated current challenges in health and social care and the experiences of a range of people

61 people attended the event, with a good mix of representation across health and social care, voluntary organisations and patients/clients and carers

The majority of attendees live in the Eastbourne area (27 of 40 who answered the question)

People were very positive about the event, with at least three quarters rating the event as 5 or 4 (5 being excellent) across all categories. Comments included:

> “Lots of expertise in the room both professional and lived experience value the feed back.”

> “I think these events are really useful to break down barriers between voluntary sector health and public more of these are needed.”

> “Enthusiastic round table discussions well facilitated.”

What worked?

- The group discussions were popular with people
- The facilitators was praised for their role in the process
- The mix of people at the tables was seen as a positive

What could be improved?

- Some people didn’t like the picture presentation
- People wanted a Q&A session at some point
- There needs to be feedback and a clear follow-up after the event

Themes from the story discussions

Themes that came up more than once for the questions discussing who people might talk to about their situation and what might be done differently (Q1&2):

- Communication – across professionals and with patients/clients and supporters (11 comments)
- There is a key role for the voluntary sector and informal support (9)
- Key contact or care coordinator needed (7)
- 24 hour access to local support (a telephone helpline) (6)
- Knowledge – what is available and how to access (4)

Themes that came up more than once for the question discussing barriers to access (Q3):

- Have a 'minimum offer' and targeted approach to understanding need (5 comments)
- Communication needs and methods of communication (4)
- Services and networks to support equality of access (4)
- Whole-person/personalised approach (4)
- GP surgeries need to be more accessible and have an expanded role (3)
- Isolated people may need

• Vulnerable or people who are isolated may need more support (3) • Whole person approach (3) • Availability of local services (2)	more/different support (2)

What should be measured (Q4)?

(Suggestions mentioned more than once included are included in this summary)

Service accessibility (4 comments)	Access to services is easy. People have a single number to call to access all services and are directed to the right service at the right time. Access to support is available 24 hours a day and every day of the week.
Accessible information about services to aid patient/ client decision making (4)	Information is easily accessible in the format and language that people need it in. People are empowered by knowledge to understand their rights and responsibilities and make decisions.
Organisations knowledge of patients/ clients and information sharing (4)	Providers will be joined up, sharing the lead role and working seamlessly. People's key information is shared easily between services.
Having services/ support that make people feel supported and safe (4)	How the services make people feel will be a key measure. People should feel safe, supported and in control. Isolated people may need more support to feel this way.
Communication is targeted and appropriate (4)	Communication needs to be good and trustworthy. Understanding different needs and using appropriate and efficient technologies will support this. For example, British Sign Language (BSL) patients or clients should have direct access into the Locality Team through suitable methods such as video phone or email.
Role for lead worker in the new teams (3)	The lead/key worker will be identified early, maybe through a basic assessment of need which would identify the best person to coordinate the involvement of all services. For example, for BSL clients getting the right professional support would mean family/friends can give appropriate types of help.
Whole person/ personalised approach (2)	People to feel they have a choice: to choose their lead worker and support network or on being a carer.
Proactive approach being used (2)	A focus on prevention, rather than waiting for a crisis. For people with ongoing or changing support needs this means building up their network of support before illness occurs or worsens.

Appendix 1: Analysis summary

Who attended?

Including organisers and facilitators, 61 people attended the event. The table below shows that the biggest group were representing an organisation, but there was a good mix of people including clients and carers. Ten people didn't provide this information.

Table 1: The capacity people attended in

What capacity attended in	Number
Representing an organisation	21
Work in health and social care	14
Use health and social care	9
Look after someone (carer)	5

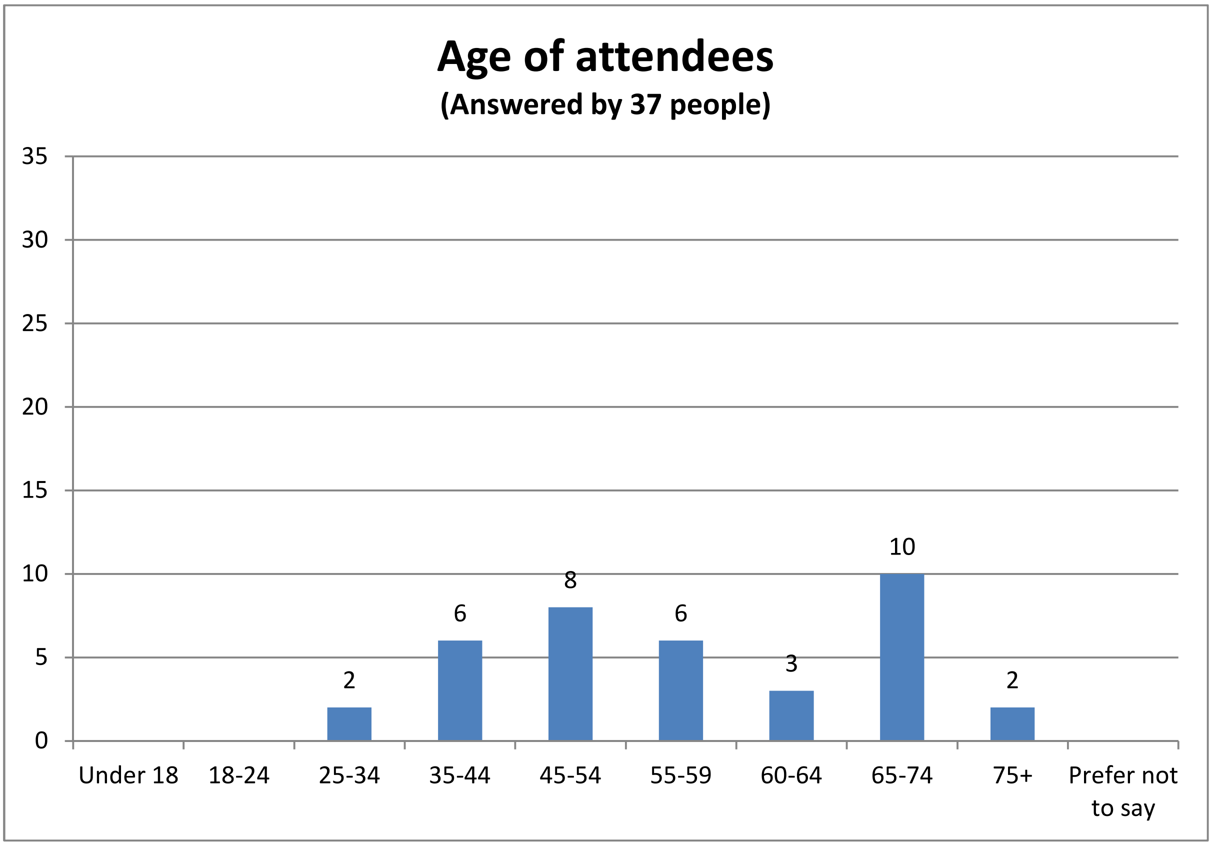
About you summary

People were asked to fill in an 'About you' form which collects details about the protected characteristics. 40 people completed a survey, although the number answering each question varied. (See appendix 1 & 2 for full details.)

The main points were:

- The majority of attendees (27 of 40 who answered the question) live in the Eastbourne area.
- The majority of attendees were female (33 of 39 who answered the question).
- Over half of the attendees are aged 55 plus (21 of 37 who answered the question). See chart below for more details.
- The majority of attendees were White British (31 of 37 who answered the question). The others were White other, Mixed White and Black African, Black or Black British Caribbean and Chinese.
- A small number consider themselves to be disabled (5 of 38 who answered the question). Three attendees are Deaf BSL users and two have a physical impairment.
- Over a third say they have a religion or belief (16 of 39 who answered the question), with all 16 saying they are Christian.
- Over three quarters identify as Heterosexual/Straight (32 of 38 who answered the question). Although five of the remaining six people chose prefer not to say.

Chart 1: Age of attendees



Analysis: Themes from the event

Table 2: Question 1 themes

The table below shows the overarching themes, related notes and how many times they were noted down as a key point from the group discussions about question 1.

Question 1: In your area today, who might the people in the story talk to about their situation?		
Overarching themes	**Notes from the group discussions**	**Number of times**
There is a key role for the voluntary sector and informal support	Key role – VCO – eg Care for the Carers. Networks, family etc. Key people – have good body of knowledge, eg Care for the Carers, voluntary sector, social care coordination. Befriending, Venton Centre. Carers and young carers groups will be most helpful and most likely to be able to help. Issue that may not be talking to 'services' and might need advocate or befriender etc to help them engage with process. DeafCog – deaf signposting service.	6
Communication – across professionals and with patients/clients and supporters	Better communication between care professionals. Failing to communicate appropriately with client and carer – in communication. To address cultural and communication needs – need to break this cycle. GP had been rung in the day – needs flagging at an early stage to integrated team. Methods of communication – media, campaign, overall understanding. Lack of communication/interpretation availability for the deaf/hearing impaired.	5
Other (only mentioned once)	Role of school important but he may not want to talk about it or be different there. Relationship with GP will affect how they are thinking and planning. GP is often used as the default point of contact – not always appropriate. Availability of services locally – hospitals, pharmacy, social care etc. Professionals going in not recognising their responsibility to sort wider problems.	5
Knowledge – what is available and how to access	Knowing what is available/how to access them. ODH – availability and understanding of where to go. Lack of local community networks and contacts.	4

	Lack of awareness of services available to talk about.	
24 hour access to local support (a telephone helpline)	Having resources available 24/7. 24 hour contact point needed. Specific phone number. Local responses – not 111. Staffed hotline.	3
Vulnerable or people who are isolated may need more support	Where people have no-one – GPs need to register that there are vulnerable, isolated people. Anxiety will escalate the situation. Where people have no-one – GPs need to register that there are vulnerable, isolated people.	3
Key contact or care coordinator needed	Key contact person – someone who is in charge. No single point of contact/coordination – access to services difficult.	2

Table 3: Question 2 themes

The table below shows the overarching themes, related notes and how many times they were noted down as a key point from the group discussions about question 2.

Question 2: What can be done differently to avoid this situation getting worse: a) by the integrated health and social care teams? b) by other partners or local people?		
Overarching themes	**Notes from the group discussions**	**Number of times**
Other (only mentioned once)	Kim and Phil should have connection to Lifeline – cost implications – and other services within the community – emphasis on service providers to catalyse this. Flexible roles for people in the team. Support and strengthening of Pas and others – all are part of the team. Clear guidance despite financial affected care. Prevention and planning ahead. Local pharmacy and prescribing practitioner – 24 hour – who can deliver. More joined up working across providers (all). Interventions that has biggest impact are not always a health solution, eg housing.	8
Communication - across professionals and with patients/clients and supporters	Appropriate assessment – consistent transfer of information to right person/team. Vulnerable, frail people – the information available out of hours to other agencies. Sharing information electronically. Understanding people's needs, preventing	6

	duplication of work and activity. Communication is key and needs to be better. First point of contact/key worker needs to be able to understand communication needs and cultural needs to ensure correct referral made. Either trained or interpreter provided. Communication and coordination.	
Key contact or care coordinator needed	Someone taking ownership. A professional responsible to understand key issues including cultural needs; preferred communication methods; existing support networks. Needs a single person to co-ordinate. Having a key worker to do all around assessment (doesn’t depend on finances). Avoid overload and too many professionals. Continuity of care: key worker should communicate and connect into service. The most appropriate person should be identified at the start.	5
24 hour access to local support (a telephone helpline)	HSC should be 7/7 and 24/7. There needs to be a single no. that makes a range of services available to everyone all of the time. 24 hour contact point – telephone number. Staffed helplines which people are sign posted 24/7 (health social care connect).	3
There is a key role for the voluntary sector and informal support	Increase use of and emphasis on voluntary/3rd sector. Groups/organisations to support, particularly important for dementia, mental health. Increase use of volunteers to provide additional resources/support to CCGs, hospitals and social care. Using a service such as Deaf Cultural Outreach Group who can support BSL patients be signposted to the correct service.	3
Whole person approach	Remember it is a person’s life. Person co-ordinating/chairing needs to take partnership approach – equal partners. Whole holistic system approach – assess whole person and whole family.	3

Table 4: Question 3 themes

The table below shows the overarching themes, related notes and how many times they were noted down as a key point from the group discussions about question 3.

Question 3: How can we make sure everyone can benefit equally?		
Overarching themes	**Notes from the group discussions**	**Number of times**
Have a 'minimum offer' and targeted approach to understanding need	Targeted approach to the percentage which has the higher need and demands. Keeping on top of measures – keep monitoring. Keeping aware of the changes in population. The minimum offer: this is what you can expect. This will stay consistent. Understand level of need as ESCC do not know how many people speak BSL as first language. Planning in advance for older age. Can this be piloted by ESBT?	5
Other (only mentioned once)	Make sure – no assumptions. Willingness to ask for help. Could be barriers within family. Building trust in services through communities (clear barriers). ‘Culture’ of older people – do it yourself, self-sufficient, wait to access services when in crisis.	5
Communication needs and methods of communication	Deaf people (either deaf or BSL users) need clear methods of communication (example of older couple who did not receive vital information – struggling for an extended period – very distressing). NB: Deaf and blind people’s needs too. Internet-based information – not everyone can access this. Awareness and communication. BME people – won’t know about all these necessarily – need for clear and simple information and promoting understanding.	4
Services and networks to support equality of access	Higher level of BSL language courses available locally. Deaf awareness available to clinicians and health and social care providers. Would include: culture, language, communication tools, different types of deafness. Working together with other services to be prepared for the language and cultural barriers. Do we require translators? Skilled key worker.	4
Whole-	Put the individual at the centre – and look at	4

person/personalised approach	all their cultural and communication needs. Professionalization and processes – not person-focused. Personalised/holistic care. Assessment – what is the person interested in? What are their needs?	
GP surgeries need to be more accessible and have an expanded role	Greater emphasis on GP/primary care communicating what is available. Format and structure of communications – eg apps on PC may work but probably won't on mobile. GP – needs to be more holistic. Surgeries need to look different /have different people in them – and promote what is available within, to all patients. Free 'circumstance check' to establish who can get what and how. Can this be piloted by ESBT? Build on annual health checks and medication review.	3
Isolated people may need more/different support	Social isolation – identification of best way to support people. Different reasons for being isolated – need different interventions. For example, language barrier will enhance isolation. Not everyone has family – or other informal support to draw on.	2

Table 5: Question 4 themes

The table below shows the overarching themes, related notes and how many times they were noted down as a key point from the group discussions about question 4.

Question 4: If the people from the story needed help in three years time, how might this story be different? What changes should there be?		
Overarching themes	**Notes from the group discussions**	**Number of times**
Other (only mentioned once)	One person (senior) who is appointed to take responsibility for locality. Early assessment is needed – whole person. Housing issue needs sorting as future planning needed. Transparency on what is free and is not. Transparency on how it operates. Connects in the community to support process. Reassurance that the locality teams are working well. Consistency of approach.	7

Service accessibility	One number to call that gives them access to 'everything' – directed to right service at the right time. 7 day GP access. Doctor's surgery – out of hours support, 24 hours. Access to services easy.	4
Accessible information about services to aid client decision making	Have information accessible – appropriate format/translated – knowledge of service and supported to make the best and ask for right support to manage self- care. Not down to luck. Marketing and promotion is public knowledge. Education – young people, knowing about issues. Young people understanding rights and responsibilities. Rachel/Tony knowing the support networks and using community services wisely. Awareness of range of services/support and self-help techniques.	4
Organisations knowledge of patients/clients and information sharing	They will already be on the radar and known to service providers that are joined up, known to each other, sharing the lead across structures, working seamlessly. Crisis team should have been for an agreed period – prevent hospital admission. And then refer back to 'Team Eastbourne' for on-going support. People's key information being shared easily between services: information being given once.	4
Having services/support that make people feel supported and safe	Family feel safe and supported. Feeling in control. Relationships take time to build. Isolated people – work to understand their networks, circumstances and their choices – do they want more connection – especially in crisis situations – anticipate.	4
Communication is targeted and appropriate	Direct access for BSL patients into integrated team, eg video phone, email. Appropriate and efficient technologies with 24/7 sign language provision. Understanding of culture and different types of deafness. This will lead to correct referrals and ultimately less wastage of money. Communication and links are good and trustworthy.	4
Role for lead worker in the	Basic assessment of need – who is best person to support need, co-ordinate and see	3

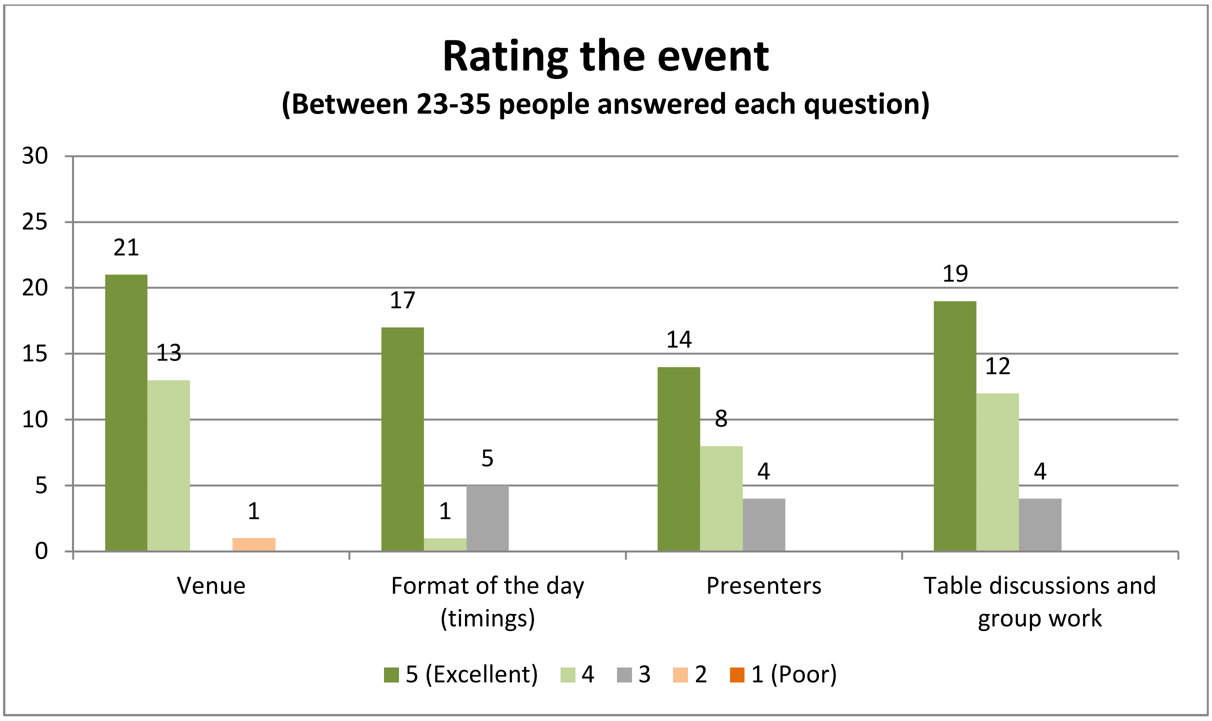
new teams	it through? Coordinate – practice planning; early identification of key worker. Family and friends are less/can be less involved in support BSL family and instead there is direct access to the key worker and PA for the patient, eg through DeafCOG.	
Whole-person/ personalised approach	Graeme to have choice to care and carer assessment and how to care. People feel they are the centre of their 'team' – choose their key people eg. Informal support is at the centre of the team.	2
Proactive approach is being used	Proactive intervention happens before a crisis. Work on networks of support before illness occurs.	2

Analysis: Evaluation surveys

The chart below shows that people were generally positive about the event, with at least three quarters rating all aspects of the event as 4 or 5 (with 5 being excellent). There was only one negative rating for the venue and none for the other three aspects, although four to five people rated the other aspects apart from the venue as 3 out of 5.

In addition, 32 people said they would attend a similar event in future, although one person said they would only attend again if they saw things change as a result of the 3 June event.

Chart 2: Rating the event



What people liked or wanted more of?

The table below shows topics covered by more than one person (there were also 11 topics mentioned by a single respondent which can be found in Appendix 2). The main thing people liked about the event were the group/table discussions. There were also quite a few positive comments about the event and the facilitators.

People would have liked more time for questions and more discussion time.

Table 6: What they liked or would like more of

Topic	Number of mentions
Liked group/table discussions	6
Positive about the event generally	6
Q&A after presentations/would have liked Q&A	4

Facilitator good	4
Liked mix of people on the tables	4
More discussion time	2

What people didn’t like?

The table below shows topics covered by more than one person (there were also 12 topics mentioned by a single respondent which can be found in Appendix 2). The main thing people didn’t like about the event was the picture presentation. Some people also said it was hard to hear and that the presentations were too quick.

Table 7: What they didn’t like

Topic	**Number of mentions**
Didn't like picture presentation	5
Hard to hear (during discussions or for interpreters)	3
Presentations too quick	2

Suggestions for future events

The table below shows topics covered by more than one person (there were also 4 topics mentioned by a single respondent which can be found in Appendix 2). The main thing people suggested was that follow-up events are held and that a question and answer session is included. Other suggestions related to the information provided about ESBT and locality teams, making the event more interactive and giving more time to the presentations.

Table 8: Suggestions

Topic	**Number of mentions**
Follow up events needed	4
Q&A needed	3
Video presentation for ESBT	2
Event needs to be more interactive	2
More information/visual information on how locality teams will work	2
Presentations too quick	2

Other comments

The table below shows topics covered by more than one person (there were also 11 topics mentioned by a single respondent which can be found in Appendix 2). The main thing people said is that they are keen to see how the feedback from the event is used and the impact it has.

Table 9: Other comments

Topic	Number of mentions
Keen to see how the feedback from the event is used	4
Positive comment about the event	4

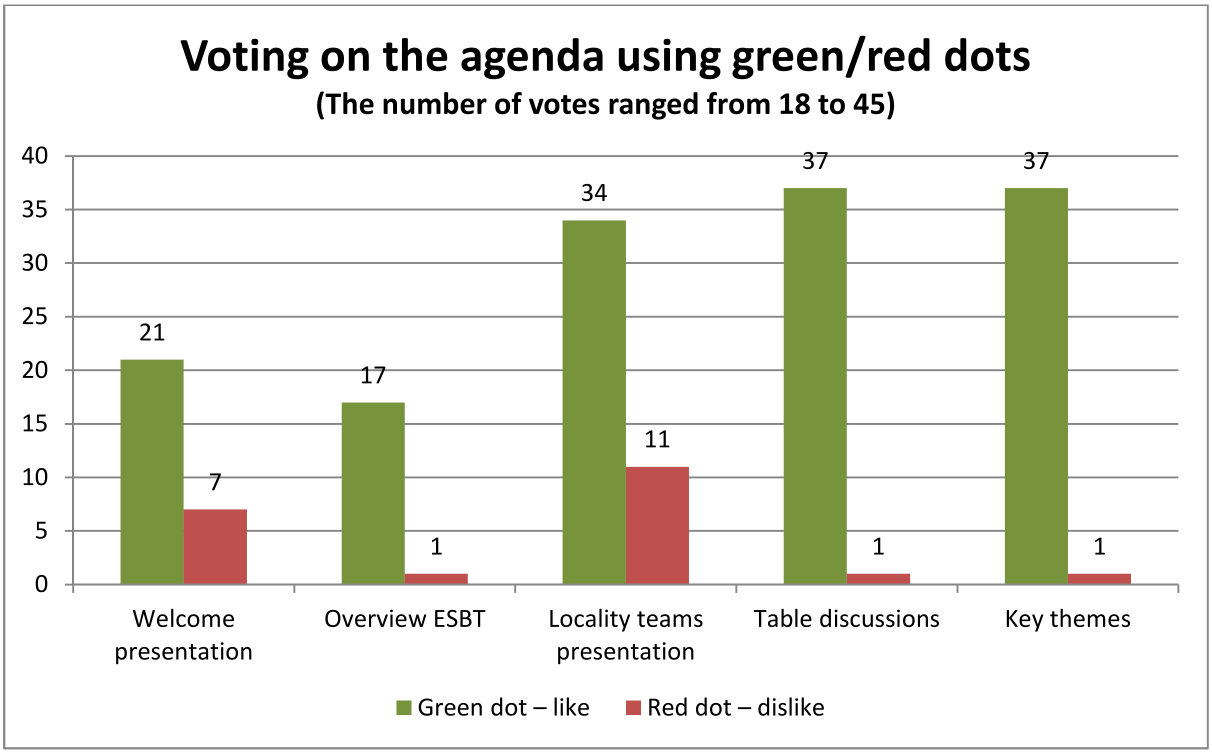
Analysis: Evaluation discussions at the event

Voting on the agenda

People were asked to vote on the event agenda with a green dot for sections they liked and a red dot for those they didn't like. It should be noted that a few people said they didn't feel comfortable voting in front of everyone else.

People were most positive about the group discussions and the feedback session (37 likes and 1 dislike for both), while they were least positive around the presentation on locality teams (34 likes, but 11 dislikes). It should be noted that the overview of ESBT got a positive response here, but there were some negative comments about it in the evaluation surveys.

Chart 3: Voting on the agenda using green/red dots



Key themes from table discussions about the event

The main comments made during the table discussions about the event reflected what came out of the survey. Namely, that there were mixed views about the photo presentation and that people would have liked a Q&A session at some point. People were positive about the event overall and particularly the group discussions. There were also some comments about avoiding jargon.

Appendix 2: Raw data

The four stories

Kim and Phil

I’m Kim. We have had a terrible few weeks – I’ve been in shock and then really feeling down. I know that Phil has been too. Changed our life completely. It all started when Phil called the doctor because I was a bit under the weather.

I wasn’t that worried at that point. We weren’t sure what the matter was – just knew I needed to see someone. The doctor is usually very good about getting out to see us, because although Phil and I take care of each other we are both quite frail.

They said the doctor had finished her visits but one of the others would call the next day. They did say to ring back before then if I got more poorly.

We don’t like to make a fuss, but in the end we had to ring that 111 service. It got to about 7.30pm and I was feeling terrible – all drowsy. Phil says I was getting very confused.

The 111 people called an ambulance – they were very nice. They took a sample and said I had a urine infection and maybe a chest infection.

The ambulance people said I didn’t need to go to hospital – I was very pleased as that was the last place I wanted to go. Instead they rang the doctor again and asked for a doctor to come and see me.

Phil says…

It was midnight when a doctor called. He told me that Kim did have a urinary tract infection.

I was panicking by that point. Kim was so poorly and couldn’t get up to go to the toilet. The bed was soaked and it was terrible.

I was so frustrated by not being able to help. I was at my wits end. There was no one else to ask either at that time of night.

The doctor said Kim couldn’t stay at home and would have to go to hospital. The only hospital that was available was miles away in Brighton.

Graeme and Sarah

I’m Graeme. I’m at senior school. Since Dad left 4 years ago, I look after my younger sisters and also my Mum, Sarah, because she has MS.

Usually things are fine because she is OK but sometimes she can’t manage to walk much or get up stairs.

This time last year, I missed a lot of school. There was a lot of pressure. I was getting the meals, helping mum get up, getting my sisters to school. After school I help with cooking (mum can’t lift heavy pots) and there is always running about to do and when she goes up the stairs for bed.

Sarah says…

Right now, I’m not very well, but we now have my care plan with the health and social care team. We agreed it last month. We had a meeting and everyone came, including Graeme’s school.

This means that I am getting some extra help in the mornings to get up and help for Graeme to get breakfast and the girls out.

It means so much to me as he gets to school in time for register and he doesn't need to worry about me. Where we still struggle is making sure he can get out and about with mates and to do his football. When he is stuck indoors with the girls all the time it really brings him down.

The end of the day is still a problem at times. I want to make sure it doesn't affect his exams – and his happiness. I worry all the time. That's my life!

Maria and Esperanza

I'm Maria. I am 78. I grew up in Portugal and although I've lived in Sussex for many years we've always spoken Portuguese at home.

I'm feeling very weak at the moment. My health has been bad for years. I have kidney problems and a heart problem. The doctor says I have diabetes too now.

Believe it or not, all this didn't stop me working until just a few years ago. I have always paid my way.

And don't feel sorry for me. I am lucky now as I live with my niece Esperanza and her family. I am not lonely.

I know my niece worries about me. Now I have ulcers on my leg too and the doctor is sending a nurse to visit us. He sent her before. I don't understand why she puts bandages on both my legs though. It doesn't make any sense to me.

Esperanza says…

I love my Aunt very much, but I worry about her. Looking after her has changed our lives completely.

I can't make sense of a lot of what the doctors and social services tell us or what they are trying to do. My main problem is that Maria cannot get up the stairs any more. We got a stair lift, but it is broken and we cannot afford to repair it.

My Aunt is living in our front room with a bed she falls out of and a commode in the corner. No one comes to visit us any more.

We are really struggling. I feel anxious all of the time. I am not sure how much longer we can keep looking after her. I have to go to work and it's getting harder to manage.

I dread the idea of my Aunt having to go back into hospital or being somewhere she can't speak Portuguese. And all the information we are given is in English.

Rachel and Tony

I'm Rachel. I have a pretty full on life as I work full time and I have three children. We are a Deaf family – me and my husband Isaac use British Sign Language. Our kids are hearing and speak English too.

My Dad, Tony, is Deaf too. He lives on his own in a bungalow in Uckfield, which is about 24 miles from us. I worry about him all the time at the moment.

Dad is getting a bit forgetful and confused. I don't think he is eating well.

We keep in touch a lot, but it's not easy to really know how his life really is unless we visit. It's hard to do that every week.

A few weeks ago Dad had a fall. It wasn't bad – no bones broken Dad tells me. He texted me that evening, but he didn't know why he fell over. One minute he was crossing the road and then he fell. Luckily no traffic was coming.

I am worried in case his health is going downhill. I do wonder how much the doctor understands about how well he is. I am taking a day off work to go to see his GP with him next week.

Tony says…

I always look forward to Rachel coming down. I don't see enough of her or anyone much.

My wife died four years ago and life is a bit of a struggle these days. I find it hard to keep my spirits up sometimes. I am a bit lonely. I am not bad for an 83 year old though.

I have arthritis, but I don't think there's much else wrong with me. Rachel thinks I am too frail. She goes on about what I am eating (and drinking!) all the time.

The facilitated discussions and questions

The facilitator noted down key themes during the discussion. These were then used by the group to agree 3-5 key points for each question.

The questions used to discuss each of the four stories were:

1) In your area today, who might Maria and Esperanza talk to about their situation?
2) What can be done differently to avoid this situation getting worse:
    a) by the integrated health and social care teams?
    b) by other partners or local people?
3) How can we make sure everyone can benefit equally?
4) If Maria and Esperanza needed help in three years time, how might this story be different? What changes should there be?

Raw data: Facilitator key themes

The notes below show the key themes agreed by each table.

Group 1: Discussed Kim and Phil’s story

Question 1

1) Having resources available 24/7.
2) Knowing what is available/how to access them.
3) Better communication between care professionals.
4) Availability of services locally – hospitals, pharmacy, social care etc.

Question 2

1) HSC should be 7/7 and 24/7. There needs to be a single no. that makes a range of services available to everyone all of the time.
2) Increase use of and emphasis on voluntary/3rd sector. Groups/organisations to support, particularly important for dementia, mental health.
3) Increase use of volunteers to provide additional resources/support to CCGs, hospitals and social care.
4) Kim and Phil should have connection to Lifeline – cost implications – and other services within the community – emphasis on service providers to catalyse this.
5) More joined up working across providers (all).

Question 3

1) ‘Culture’ of older people – do it yourself, self-sufficient, wait to access services when in crisis.
2) Free ‘circumstance check’ to establish who can get what and how. Can this be piloted by ESBT? Build on annual health checks and medication review.
3) Greater emphasis on GP/primary care communicating what is available. Format and structure of communications – eg apps on PC may work but probably won’t on mobile.
4) Planning in advance for older age. Can this be piloted by ESBT?

Question 4

1) One number to call that gives them access to ‘everything’ – directed to right service at the right time.
2) They will already be on the radar and known to service providers that are joined up, known to each other, sharing the lead across structures, working seamlessly.
3) 7 day GP access.

Group 2: Discussed Maria and Esperanza’s story

Question 1

1) Failing to communicate appropriately with client and carer – in communication. To address cultural and communication needs – need to break this cycle.

2) Professionals going in not recognising their responsibility to sort wider problems.
3) Key contact person – someone who is in charge.
4) Key role – VCO – eg Care for the Carers. Networks, family etc.

Question 2

1) Someone taking ownership. A professional responsible to understand key issues including cultural needs; preferred communication methods; existing support networks.
2) Interventions that has biggest impact are not always a health solution, eg housing.
3) Appropriate assessment – consistent transfer of information to right person/team.

Question 3

1) Assessment – what is the person interested in? What are their needs?
2) Social isolation – identification of best way to support people. Different reasons for being isolated – need different interventions. For example, language barrier will enhance isolation.
3) GP – needs to be more holistic. Surgeries need to look different /have different people in them – and promote what is available within, to all patients.

Question 4

1) Basic assessment of need – who is best person to support need, co-ordinate and see it through?
2) One person (senior) who is appointed to take responsibility for locality.
3) Have information accessible – appropriate format/translated – knowledge of service and supported to make the best and ask for right support to manage self- care.

Group 3: Discussed Kim and Phil’s story

Question 1

1) 24 hour contact point needed. Specific phone number. Local responses – not 111.
2) Where people have no-one – GPs need to register that there are vulnerable, isolated people.
3) Anxiety will escalate the situation.
4) GP had been rung in the day – needs flagging at an early stage to integrated team.

Question 2

1) 24 hour contact point – telephone number.
2) Local pharmacy and prescribing practitioner – 24 hour – who can deliver.
3) Vulnerable, frail people – the information available out of hours to other agencies.
4) Flexible roles for people in the team.
5) Support and strengthening of Pas and others – all are part of the team.
6) Needs a single person to co-ordinate.

Question 3

1) Deaf people (either deaf or BSL users) need clear methods of communication (example of older couple who did not receive vital information – struggling for an extended period – very distressing). NB: Deaf and blind people's needs too.
2) BME people – won't know about all these necessarily – need for clear and simple information and promoting understanding.
3) Not everyone has family – or other informal support to draw on.
4) Internet-based information – not everyone can access this.
5) Put the individual at the centre – and look at all their cultural and communication needs.
6) Make sure – no assumptions.

Question 4

1) Early assessment is needed – whole person.
2) Crisis team should have been for an agreed period – prevent hospital admission.
3) And then refer back to 'Team Eastbourne' for on-going support.
4) Isolated people – work to understand their networks, circumstances and their choices – do they want more connection – especially in crisis situations – anticipate.
5) Work on networks of support before illness occurs.
6) Doctor's surgery – out of hours support, 24 hours.
7) People's key information being shared easily between services: information being given once.
8) People feel they are the centre of their 'team' – choose their key people eg. Informal support is at the centre of the team.

Group 4: Discussed Rachel and Tony's story

Question 1

1) Key people – have good body of knowledge, eg Care for the Carers, voluntary sector, social care coordination.
2) ODH – availability and understanding of where to go.
3) Befriending, Venton Centre.
4) Methods of communication – media, campaign, overall understanding.
5) Staffed hotline.

Question 2

1) Having a key worker to do all around assessment (doesn't depend on finances).
2) Staffed helplines which people are sign posted 24/7 (health social care connect).
3) Sharing information electronically. Understanding people's needs, preventing duplication of work and activity.
4) Clear guidance despite financial affected care.

Question 3

1) Targeted approach to the percentage which has the higher need and demands.

2) Working together with other services to be prepared for the language and cultural barriers. Do we require translators?
3) Keeping on top of measures – keep monitoring. Keeping aware of the changes in population.
4) The minimum offer: this is what you can expect. This will stay consistent.
5) Building trust in services through communities (clear barriers).

Question 4

1) Not down to luck. Marketing and promotion is public knowledge. Education – young people, knowing about issues. Young people understanding rights and responsibilities.
2) Rachel/Tony knowing the support networks and using community services wisely.
3) Reassurance that the locality teams are working well.
4) Transparency on what is free and is not. Transparency on how it operates.
5) Proactive intervention happens before a crisis.

Table 5: Discussed Graeme and Sarah's story

Question 1

1) Role of school important but he may not want to talk about it or be different there.
2) Carers and young carers groups will be most helpful and most likely to be able to help.
3) Issue that may not be talking to 'services' and might need advocate or befriender etc to help them engage with process.
4) Relationship with GP will affect how they are thinking and planning.

Question 2

1) Communication is key and needs to be better.
2) Person co-ordinating/chairing needs to take partnership approach – equal partners.
3) Remember it is a person's life.
4) Avoid overload and too many professionals.

Question 3

1) Professionalization and processes – not person-focused.
2) Willingness to ask for help.
3) Could be barriers within family.

Question 4

1) Graeme to have choice to care and carer assessment and how to care.
2) Housing issue needs sorting as future planning needed.
3) Relationships take time to build.
4) Connects in the community to support process.
5) Communication and links are good and trustworthy.

Group 6: Discussed Rachel and Tony's story

Question 1

1) Lack of communication/interpretation availability for the deaf/hearing impaired.
2) Lack of local community networks and contacts.
3) DeafCog – deaf signposting service.
4) Need to consider that those who are deaf struggle with communication tools, eg email text as English is their second language.
5) Have a different culture.

Question 2

1) First point of contact/key worker needs to be able to understand communication needs and cultural needs to ensure correct referral made. Either trained or interpreter provided.
2) Using a service such as Deaf Culture Outreach Group who can support BSL patients be signposted to the correct service.

Question 3

1) Higher level of BSL language courses available locally.
2) Deaf awareness available to clinicians and health and social care providers. Would include: culture, language, communication tools, different types of deafness.
3) Understand level of need as ESCC do not know how many people speak BSL as first language.

Question 4

1) Direct access for BSL patients into integrated team, eg video phone, email.
2) Appropriate and efficient technologies with 24/7 sign language provision.
3) Understanding of culture and different types of deafness. This will lead to correct referrals and ultimately less wastage of money.
4) Family and friends are less/can be less involved in support BSL family and instead there is direct access to the key worker via and PA for the patient, eg through DeafCOG.

Group 7: Discussed Graeme and Sarah's story

Question 1

1) GP is often used as the default point of contact – not always appropriate.
2) No single point of contact/coordination – access to services difficult.
3) Lack of awareness of services available to talk about.

Question 2

1) Communication and coordination.
2) Whole holistic system approach – assess whole person and whole family.
3) Continuity of care: key worker should communicate and connect into service. The most appropriate person should be identified at the start.
4) Prevention and planning ahead.

Question 3

1) Personalised/holistic care.
2) Awareness and communication.
3) Skilled key worker.

Question 4

1) Family feel safe and supported.
2) Feeling in control.
3) Access to services easy.
4) Consistency of approach.
5) Coordinate – practice planning; early identification of key worker.
6) Awareness of range of services/support and self-help techniques.

Raw data: Evaluation survey

Table 10: Please score elements of the event on a scale of 1 to 5:

	5 (Excellent)	4	3	2	1 (Poor)
Venue	21	13	0	1	0
Format of the day (timing)	17	1	5	0	0
Presenters	14	8	4	0	0
Table discussions and group work	19	12	4	0	0

Any comments regarding your scores:

- Facilitator - great.
- Very profitable to have attended. Excellent network opportunity too.
- It felt slightly rushed no time for questions after the presentation to seek clarification.
- Would have liked some choice about which scenario to discuss - options given in advance. Didn't capture my knowledge or experiences.
- Glad the parking was free.
- Presentation 1&2 could have been amalgamated. Differentiation unclear, table discussion great but feedback could be shorter.
- Very well organised thank you.
- It was better than many similar meetings but could have allowed more time for the complexity of the issues.
- Everything.
- It felt slight rushed. No time for questions after the presentations to seek clarification.
- All the time table discussion.
- It was quiet difficult at times to hear what was being said on our table due to noise from other tables.
- I found the day very interesting.
- Most was very good.
- Good venue and timings. Would not have worked if it been any longer it was a bit small break would have been good.
- Very productive format.

Was there anything about the event that you particularly liked or would have liked more of?

- Facilitator
- Table discussions.
- It would have been good to hears from users of services. How it is for people.
- Facilitator – great.

- Group exercises – case studies.
- Group discussion was useful. Would have preferred Q & A session.
- Good organisation.
- The event was very informative maybe more time for discussion.
- Was there adult social care representation.
- Question/answer session after speakers.
- Mix of peoples on the table very good.
- Mix of people at the session. Well organised. More interaction. Facilitator (Cathy) was extremely good.
- Opportunity to discuss but one case study was constraining. No time for questions when others fed back.
- Would have preferred to be in a group that I had knowledge of.
- 5-10 minute break would have been good. Question time after talks. Mixed disciplines essential.
- Helpful to have contacts for professionals to go to after.
- Small number of people on table.
- Very well organised. Thank you.
- More opportunity to question presenters.
- Would of liked to of also received more information and updates on progress on BT change.
- Enthusiastic round table discussions well facilitated.
- Everything.
- The mix of people on the tables.
- Table discussions very informative.
- Discussions of questions.
- Was very interesting need to make sure there is feed back.
- The relationship with others was good so useful to get an understanding how other sectors.

Was there anything about the event that you didn’t like?

- First point of talks too quick – notes required throughout.
- Timings – felt rushed- particularly for interpreters with communication.
- Video.
- Initial presentation with photos on screen.
- Visual presentation at the start.
- No.
- Maybe a coffee break would have been nice.
- I would like the blue print presentation – examples of the plans the date of October 2015 very specific but no descriptions of how this will take place – practicalities.
- Scoring with colours on the agenda. Difficult to put red on after a lot of greens or with speaker at the table. I am not keen on scripted presentations.
- Difficult to hear during the table discussion would have been good to have a breakout room (although realise this would increase costs).
- Helpful to have contacts for professionals to go to after.
- Presentation – too quick.
- Very limited selection of case studies we had 7 tables but only 4 case studies bit of a waste of opportunity.
- Amplification was having problems.

- Would have liked to also have received more information and updates on progress on BT changes.
- Table size was difficult to talk across the table.
- Was not impressed with initial presentation—power point by Paula.
- I did feel the discussion was a lot over facilitated and stifled.
- Not clear on feed back.

Do you have any suggestions for how future events should be run or topics/formats that could be considered?

- Punchy, dynamic video/cd presentation.
- I would increase the time on local health and social care teams and plans so far.
- Potentially use graphics/models to help people imagine and focus on how things work and might work differently.
- Question time and follow up meetings to know how things are coming along.
- As planning continues to keep meeting and checking that we are heading in an agreed direction until agreed outcomes.
- Give participants more opportunity to express thoughts and comments - eg post-its, flipcharts. This felt fairly passive – not interactive enough.
- Guest speakers- different disciplines with Q&A session.
- Follow up event to maintain momentum, to see influence/impact.
- Presentation too quick.
- Opportunity for questions and answers.
- Use post-its for comments. Be more interactive.
- Smaller table in size so could hear what each other was saying.
- Some extra time for the presentation so that they are not so rushed with their presentation which at times ended up garbled.
- Domestic care and help, dentist and optician.
- I like the format but I would say their events need to frequent and regular.
- Easier access by those who needed help.
- Could the ESB7 overview been delivered as a video.

Would you attend similar events in future?

Yes: 32 people

No: 0 people

One comment written next to question:

- Not unless I see some follow up.

Do you have any other comments?

- Make it work – essential.
- Q & A session.
- Thank you very much for organising.
- The event suddenly ended 25mins early no time for debate after discussion as a whole room. Shame and strange.
- Need smaller more focused groups now – more about co-design rather than general consultation.

- Lots of expertise in the room both professional and lived experience value the feed back.
- Well organised.
- Good event and interesting.
- Smoking/drinking/obesity (talk 1) = include housing, include isolation.
- Amalgamation of health/social care - would have been preferred.
- Looking forward to seeing how the information will be used/applied.
- Interested to see the outcome2.
- Would like to know how the project board will draw from today's event and take forward some of the suggestions today.
- Brilliant.
- I think these events are really useful to break down barriers between voluntary sector health and public more of these are needed.
- What difference will these workshops actually make partially in light of the huge funding issues facing health and social care.

Raw data: Voting on the agenda

Table 11: Voting on the agenda

Time	**Topic**	Green dot – like	Red dot – dislike
10:00	Welcome and introductions	21	7
	Overview of ESBT	17	1
10:25	Locality teams: the plan so far	34	11
10:40	Table discussions	37	1
11:45	Key themes	37	1
12:15	How has the event worked?	2	0
12:45	Summary and next steps	2	0

Raw data: Group discussions about the event

Comments about the integrated team:

- What is the difference between reablement support workers and social care resource officers?
- Co-ordinate community assets – jargon.
- Crisis intervention and admission avoidance: preventing people from going into hospital.
- Needs everyday language! Especially older people – a priority!
- Telehealth and telecare – what if people are deaf.

Comments about the presentations:

- Didn't like presentation: old couple. To make old people look silly. Too many words. Came over as stereotypical. Not punchy or dynamic. Too quick.
- A lot of information – a handout of key points.
- Like to take notes away.
- Language to be simple for all people – co-design means need this to get best results.
- Good to have questions after the presentation.
- Need to have more time on what teams will be like before discuss the stories.
- Did not co-ordinate slides.
- More time for slide show.
- Shorten text.
- Was stimulating.
- Some slides were stereotypical.
- Make message clear – this was focussed on older people.
- Opportunity to ask questions following each presenter to clarify issues raised there and then.

Comments about table discussions and key themes feedback:

- Case studies – good a real story really works.
- Confirmed what we had said.
- Good to hear the consulting and ideas people had.
- Good to hear from a variety of people.
- Person in the centre at the top of the tree. Spider diagram – person in the middle.

Comments about the event overall:

- Chance to talk – people of different backgrounds.
- Useful to see the other case studies.
- Brief paragraph and simple information on ESBT.
- Event was really good – more needed.
- More opportunity to attend events and ensure meet diverse groups of people.
- Very useful to be involved.
- Something needs to happen with all of the views – action please.
- Realisation of just how many agencies are out there.
- Enjoyable discussions.

- Would like time to network.

Additional comments:

- Table was too big – not always able to hear.
- Too much background noise.
- Too structured – too many questions. Keep to one case and ask table to look at specific aspects of it.
- Would have helped to have a copy of the other case histories from other tables.
- Room layout on feedback could have been in rows.
- Time – felt rushed.
- Useful to have discussion like this to support service design.

Raw data: About you information

Table 12: The Council area they live in

Area	Number
Eastbourne	27
Hastings	0
Lewes	0
Rother	2
Wealden	8
None of these	3

Table 13: Gender

Gender	Number
Male	6
Female	33
Prefer not to say	0

One person said they identified as transgender, while 30 said they didn't and one chose prefer not to say.

Table 14: Age

Age	Number
Under 18	0
18-24	0
25-34	2
35-44	6
45-54	8
55-59	6
60-64	3
65-74	10

75+	2
Prefer not to say	0

Table 15: Ethnicity

Ethnicity	**Number**
White British	31
White Irish	0
White Gypsy/Roma	0
White Irish Traveller	0
White other	1
Mixed White and Black Caribbean	0
Mixed White and Black African	2
Mixed White and Asian	0
Mixed other	0
Asian or Asian British Indian	0
Asian or Asian British Pakistani	0
Asian or Asian British Bangladeshi	0
Asian or Asian British other	0
Black or Black British Caribbean	1
Black or Black British African	0
Black or Black British other	0
Arab	0
Chinese	2
Other ethnic group	0
Prefer not to say	0

Table 16: Disability

Whether they have a disability	**Number**

Yes	5
No	31
Prefer not to say	2

Three attendees are Deaf BSL users and two have a physical impairment.

Table 17: Religion or belief

Whether they have a religion or belief	**Number**
Yes	16
No	15
Prefer not to say	8

All 16 who said they had a religion or belief described themselves as Christian.

Table 18: Sexuality

Sexuality	**Number**
Bi/Bisexual	1
Gay woman/Lesbian	0
Gay man	0
Heterosexual/Straight	32
Other	0
Prefer not to say	5