



# **DEVELOPING A STRATEGIC COMMISSIONING PLAN**

## **PUBLIC CONSULTATION**

# **QUESTIONNAIRE RESPONSES**

# INTRODUCTION

The comments, suggestions and concerns that you raised during the public consultation: Developing a Strategic Commissioning Plan have all been collected together in this document.

To ensure continuity and to enable you to follow the threads that run through each person's comments, we have utilised a very simple system. Numbers were allocated to individuals to ensure anonymity and then used throughout the document. For example this means that number one is the same person throughout the whole document and so on.

Thank you for taking the time to complete our questionnaire or attend one of our four locality events. Your comments will have had an important part to play in developing a plan that will support the delivery of local services for the people of Angus.

During the early part of 2016 we will again be encouraging you to give us your comments on the draft strategic plan. Please continue to take the time to tell us what you think and help shape the future for the people and communities of Angus

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## Q1. Supporting people to be as active and as healthy as they can be

### What support do you think people will need to help them stay as active and as healthy as they can be?

1.	Education, e.g. about diet, not smoking, walking, hobbies and benefit of these. Information about any local activity/exercise group available. May need transport if they have a disability. May need a befriender to take them along at the beginning. Need posters/adverts/public meetings.
2.	Assessment by G.P.s etc. and the right people put in place, plus self help programme put in place to help people self manage.
3.	Good carer support by: formal - family; informal - voluntary.
4.	Backup from agencies who can advise on health issues, eating/cooking, integration into local amenities (if any), a contact/s who can be accessed in crisis/emergency/frightening situations. Financial advice, when living on a basic/low income.
5.	Most people don't need support per se. They need to continue to access those community facilities they have always used and good transport and access are generally priorities. The promotion through the voluntary sector of groups to maintain active life styles is also important. Access to health monitoring and prompt response to minor illnesses will maintain good health.
6.	Same accessibility as the mainstream public to high end fitness. Classes need specialist support and accessed through general groups for fuller integration. More accessibility and knowledge tailored for the service user's understanding; leaflets and guidance etc. Accessible information to healthy lifestyle at a level that is understood and achievable - information is mainstream without taking account of deficits. Longer term strategy to support the practicalities of long term changes in dietary changes. Preventative support e.g. wellness clinics.
7.	Good local services. Good community support. Good health care locally - local health centre and community hospital.
8.	Good medical facilities. Exercise group with exercises to fit their activities. Exercise classes - bowls - golf- tennis - walking.
9.	Health providers introducing individuals to seated exercise to give them confidence that they can improve their lifestyles, meet others and not be so isolated.
10.	Communication. Different activities to suit the person (as everyone has different needs).
11.	An awareness and understanding of their conditions. Knowledge of services available to enable them to self manage their condition/s.
12.	Local activities. help with funding for e.g. local pools/gyms etc.
13.	Someone consistently encouraging them to get out, walk, and join a group/club to meet people.
14.	Physio to give exercises. Going to Daycare. Advice from Dietician about healthy diet.
15.	Social support/daycare. Physiotherapy/Occupational Therapy. Medical support.
16.	Access to daycare. Social Care input. District Nurse/Doctor. Access to transport.

17. Promotional days or events at leisure centres, community centres.
18. Going to daycare, craft group etc. Physio. Dietitian. Going in to help with exercises.
19. Access to information of what is available within their area via letter drops, G.P. surgeries or local paper. If people live alone, encourage Community Alarm or similar - they won't use it unless they must, but it's there if help is needed - regardless of cost - it can save a life.
20. Keep all current resource centres open. Provide funding for C.A.F.E. in Arbroath.
21. To keep them focused on doing exercise and activity to keep them healthy. Giving them help with doing their exercise. Also ensure that they participate in daily or weekly exercise.
22. More healthy living information.
23. Access to efficient and effective health care and social care.
24. Education - make it fun and sociable. Positive encouragement.
25. Inform of resources available to them eg. exercise classes, walking groups etc. Advice on eating for health. Transport to classes/centres if required. Volunteers to go walks etc/transport.
26. Good diet, exercise, having fun, joining in groups doing dance, swimming, gym etc.
27. Activities within their community, ease of access, eating a healthy diet.
28. Support with social aspects of their daily living along with personal care. Support to maintain health by supporting medication administration safely, along with nutrition support if required to maintain healthy balance.
29. Clubs and groups. Befriending service. SOCIAL care access. Key worker and Getting to know you approach ... someone that recognises when a person is not 'themselves'.
30. Good and dependable Public Transport. Good and dependable National Health Service. Good and dependable Social Care.
31. Better care and support in the community. I recently experienced this 'care' for my elderly mother and was appalled at what was available to her to assist her to continue living independently.
32. Access to good nutrition and sufficient physical activity including good access to free facilities, access to good sexual health services and support, access to smoking prevention and cessation, substance misuse support and pharmaceutical support, opportunities for improved oral health, and prevention of obesity, access to mental health and well-being support and health protection services and all supported targeted at our least affluent communities.
33. Access to transport to get them to the various classes. Financial support to attend these classes. Extending THAT so it can run in various towns.
34. Assistance with compliance of advice. Regular reminders of benefits etc. from every person making contact. Enabling people ++.
35. Provision should be life long. For example, provision for the tiniest to the oldest is required. Provision for most age groups is in place except for the YOUTH. They are a vulnerable group and need much more support than they get in Carnoustie at the moment. Any provision for them (Skatepark) has been subscribed and fundraised by themselves. More needs to be available for that age group.

36. Good health educational facilities from a young age. Opportunities to participate in physical activities. Good diversionary opportunities, music, art, sport, etc. Fewer fast food outlets, better food choices, more dietetic advice. Mutual aid/self-help groups. Purposeful and focused activity in their lives.
37. <b>Being Active</b> <ul style="list-style-type: none"> <li>• Continued funding of leisure services and sports centres etc by the local authority</li> <li>• Information about leisure activities being widely available</li> <li>• Support for "walking clubs"</li> </ul> <b>Staying Healthy</b> <ul style="list-style-type: none"> <li>• Focus health resources on doctors and nurses not managers and huge inefficient management structures</li> <li>• End the NHS funding of public health staff especially directors and focus resources on GP practices and local community health centres</li> <li>• Keep funding of NHS resources as local as possible to stop people getting ill and stressed by forcing them to go to Dundee.</li> </ul>
38. Where someone may have a particular health condition, support to manage their own condition through access to information from G.P. health services. For those who do not, access to information and activity programmes - gym, swimming at Council centres for instance. G.P.s to encourage take-up, help to give up smoking, tackle diet, as much information to encourage.
39. Support when leaving hospital or reaching a certain age.
40. Help them with activities, take them out for the day, doing things that they love doing.
41. Take them out for a coffee and take them for a walk.
42. Physical and emotional support.
43. Find out what activities they enjoy and create/inform of opportunities.
44. Home carers.
45. Continued access to local exercise groups, such as walking football, walking, seated exercise, gym referral classes. Making these affordable and accessible to all. Perhaps transport links, such as a community bus, to help people access activities. Community cafes in locations across Angus would be a good way of helping people to stay connected with others. Could have affordable healthy food on offer. Similar to Wellbeing Café currently running in Montrose. Use of support services to help adults with mental health difficulties access social activities and engage with others in their local community.
46. A support worker that can set up a plan to suit the individual - sometimes it is an effort to cook for one so suiting a plan to the individual and meeting their needs. Encouraging them to go to fitness class or groups that can help them be part of community.
47. Information on healthy eating, exercise information, support groups/classes, on-line information.
48. Drivers to attend exercise classes, dementia cafes, carers support. Need to support GPs to ensure everyone is able to access appointments on a timely basis - GPs are overloaded and some patients have difficulty accessing appointments. Need to ensure all professionals coordinate their services to maximise effectiveness of available resources. Bus service timings should be changed to suit elderly so they can get to health centre or to places where they can access leisure pursuits e.g. Carnoustie leisure centre.
49. Day-care.
50. Ensure that basic needs are met, such as nutrition, hygiene and exercise.

51. -
52. Prevention first and cultural shift away from passive, dependent attitudes the right help at right time to avoid preventable problems. Effective response when attending GP etc.
53. Access to nutritional information, health information, exercise facilities.
54. Physio Classes in doctors surgery.
55. Access to information and services which allow people to take responsibility for their own health and activity. A telephone or internet service might be all that people need.
56. Opportunities to maintain activity levels, roles important to them, particularly if in caring role when own health needs can suffer.
57. Make sure that there are competent services directly managed by the local authority or even the NHS NOT a voluntary organisation that can guarantee a commitment to increasing people's personal incomes. It is very hard to get help from Angus Voluntary services, as they don't understand how to go about things and the Citizen's Advice is even worse. If you want to stay active you have to pay for it if you don't want to get hurt. If you want to stay healthy either you eat well or you keep warm but can't do both and if you do one and no the other, then you can't keep healthy. I don't want young strangers coming to give me advice on what to eat or do, I know what to do with these things but can't afford the simple things because of my age.
58. Access to community supports and information on self managing their health conditions.
59. They need to know what is available locally to help them with this. Safe areas for cycling. Adult playground????
60. That depends on the individual and their assessed need. Whatever support needs to be tailored to them as much as possible within the constraints of available services and resources.
61. Keep services as local as possible, both social and medical.
62. Patient education via media, carer input, HSC input. Exercise encouraged.
63. -
64. Appropriate timely information about services available and transportation to take them to groups if not within walking distance.
65. -
66. Give them economic freedom (thomas sowell / milton friedman) - your question requires the assumption that 'people' require state involvement / intervention in order to be 'active' or 'healthy' - in order for the question to have any logical consequence. and by what barometer can you determine those things?, you can't there isn't one, you therefore are asking a critically unsound / illiterate question of me. People should be free to choose - opt in or opt out - being free to disengage with services is critical. Everyone likes a free lunch – but this isn't free – people are too stupid to realise that you simply inflate the currency / tax (steal). The state is naturally interested in this subject since it has created dependency in the healthcare arena. When provided publicly it removes the competition required to make these services efficient / cheaper / affordable since people do not demand inefficient / poor quality healthcare they demand the opposite of that. Look at the booming charity / third sector in this country. people look after their own - and taxing them to death has taken this capacity away - see Bastiat. As there is no choice people are ultimately at the mercy of the infrastructure currently in place - and surveys such as this are less influential than, say, the whim of an upper management egotist. In my view focus

<p>should be in assisting with increasing an individual's financial situation. Focus should be given to teaching people about how the state is a predator and should be used sparingly and advising them against dependence. If you are to remain socialist - then at least admit that your own corruptions have caused the lack of funding in health (et al) services. Your corruptions that have caused the economy to fail and for people to be less free. And, importantly, your own corruptions have caused the heightened expense to provide services. I mean this about both local authority (see for example) upper management wage increases) and of course for central government.</p>
<p>67. Accessible and affordable activities. Heard it many times "I would like to go to the gym but cannot afford it". Also I don't think that the many positive activities out there are publicised well enough, so regular reminding about services would be good.</p>
<p>68. Increased services to fully support individuals i.e meal prep, district nurse support, social work support, shopping service etc.</p>
<p>69. Easier access to supported exercise classes.</p>
<p>70. Occupational and physiotherapy rehabilitation to maximise independence are crucial, however, resources are very limited at present. Increasing SCO input also needed to support people.</p>
<p>71. Suitable housing. Education and local access to exercise and activity groups.</p>
<p>72. Nail cutting service. Housebound exercise routines. Regular visits by one professional who can coordinate care.</p>
<p>73. Opportunities to take part in a variety of activities. Help to get there if they need it. Lots of activities locally many of which should be free to allow participation for all.</p>
<p>74. Facilities that are within easy reach of their locality.</p>
<p>75. A big question. Depends on who we're talking about? I think we need to educate, help people make better choices about their health earlier. Deal with the inequalities and focus on prevention.</p>
<p>76. More information on local services available, and support to attend these. Less emphasis on medication. Encouraging people to take responsibility for their own health. Making good use of the groups and sessions which already run in the community.</p>
<p>77. Affordable, accessible, welcoming facilities.</p>
<p>78. A wide variety of different local meeting places and events which they can access. Better and more tailor made activities within sports centres and local halls for older people.</p>
<p>79. Need health promotion events that are in accessible environments and must be worker friendly. All persons should be able to access health promotion/education and they should be held out of normal working hours for those that work.</p>
<p>80. Locally based, one stop, contact point that can give comprehensive and accurate information and make onward referrals for both health and social care needs as well as voluntary sector clubs, activities, financial advice. etc.</p>
<p>81. Local and low cost access to fitness, health and sport facilities, good advice and easy access to health checks and advice.</p>
<p>82. Preventive interventions and engagement- reaching people before there is a crisis, e.g exercise classes and befrienders.</p>
<p>83. Having access to holistic teams who regular communicate through structured teams.</p>



84.	Access to affordable activities like gym classes, organised outdoor activities, support to attend activities - transport and physical support if they require it. Activities have to be well advertised in a wide manner to reach everyone - can't rely on people having internet access.
85.	Appropriate social, health and community services. Accessible community facilities including Changing Places to enable people with profound and multiple learning disabilities (PMLD) to help them stay as active and healthy as they can be. Carers must be supported appropriately to enable them to carry on caring and have a life outside of their caring role.
86.	Care and services to support them in the community: help to manage tasks of daily living such as personal care, meals as well as support to participate in community activities / socialising.
87.	Regular contact with others, ability to socialise without being penalised by where you live.
88.	They will require the knowledge and information about the benefits of keeping active. They need to know where to find the activities are held e.g. Leisure Centres, Support Groups and the Voluntary Sector who can provide home support.
89.	Organised groups to socialise with information regarding diet. Workout groups with gentle exercise sessions.
90.	Access to advice, information and activities across communities.
91.	Access and availability of services, healthcare to enable this. If a Carer then will require support/ respite.
92.	Access to doctors when needed.
93.	They need good back after they leave hospital after they have a stroke for instance in the hospital they get intense speech therapy and physiotherapy but when they get home it all stops or get very little. I am not saying that they need it five days week ,sometimes they forget how to walk or talk plus they need pushed to do the exercises or speaking. As they say, prevention is better than cure - if you put money to that you would save with then not having to go into hospital .
94.	More accessible, affordable activities. Workshops on healthy eating etc.
95.	Maybe a meeting place that can give a few exercises, or a small walk or Bowling club.
96.	Possible assistance with personal care, shopping/eating, medication, encouraging mobility, mental and physical stimulation. Sense of purpose.
97.	More support and activities for children in wheelchairs and local facilities that meet their needs. Very disappointing that the new high school plans do not include proper disabled toilet facilities for children in wheelchairs in main part of the school not changing places toilet in the community campus
98.	More help with their care at home, more exercise, poly pharmacy, integrated support and one point of contact.

## Q2. Supporting people to be as independent as possible and living in the community in their own homes

**What support do you think people will need to stay independent and live as long as possible in their own homes?**

1.	Need a contact person who can make checks to make sure they are O.K. and to monitor any changes in presentation. Need to assess if person is managing and if not, introduce any support gradually in conjunction with person + carer.
2.	The right people put in place. People living in the right home with any adaptations put in place for them.
3.	Personal Care. Food. Assistance. Befriending. Medication. Professional support. Formal support. Voluntary support. Family support.
4.	NHS/GP input, not necessarily a weekly visit, but maybe a telephone call to find out if patient is OK. Having meals delivered; shopping; emergency cord. If person has home help etc. trying to ensure same person turns up each time, as this can have a detrimental effect on someone who is unable to get out. Building up a trust in a carer is paramount.
5.	Practical support and health support to maintain them and prevent health deterioration. Ease of access and prompt response from the likes of nursing, podiatry, physio. and O.T. when the need is identified, rather than waiting weeks or months which has the effect of further deterioration for the individual, plus loss of confidence in the service and any benefit it may potentially provide. People also need to know that you can come easily in and out of contact with services that are beneficial is a major plus.
6.	More appropriate accommodation with support needed. Community resources and O.T. adaptations available to support high level of independence in the long term. Support to manage budgets and daily life skills. Provision of aids and services prior to discharge - more emphasis on discharge planning meetings. This can be sketchy/non-existent at times. Greater understanding and shared responsibilities across main agencies.
7.	Good sports/exercise facilities - links with the sports centres. Good local services. Good community support. Good health care locally - local health centre and community hospital.
8.	Nursing support. Help with dressing, bathing, toileting. Day centres. Respite care. Meals on wheels and help with eating and drinking.
9.	Good links with medical services. Family/friends. Home help services, although to be disbanded in Angus, a similar service to support them locally. Also good transport links.
10.	More help with Social Services. Ask people what they need. Monitoring services if possible.
11.	A care co-ordinator (named) who can monitor and report/involve other professionals as required. Thorough initial generic assessment of physical, mental, emotional and home circumstances.
12.	Gardening/housework/shopping support. Perhaps some sort of central service supporting home repairs etc.
13.	Someone assigned to keep person active physically and able to cope with home and cooking, as far as possible.
14.	Support from family, social work and district nurses if needed. Community meals.

15.	Support with personal care. Shopping support. Meal support. Rehabilitation. Domestic support. Social support/daycare. Support with finances. Respite.
16.	Support with personal care. Support with meals. Support with shopping. Support with laundry. Community alarm. Befriending service. Support with housework. Access to daycare/respite.
17.	Points of contact where information can be accessed re the above.
18.	Support from family and healthcare people and social care officers. Community meals.
19.	Being advised what is available, where to access it, and what the voluntary sector can provide or need support to provide while people are still independent - pre-services. Services they can trust, are reliable, and providers actually care about what they do.
20.	Good, quick O.T. support, fully funded (no penny pinching). Support community meals/outside provider e.g. Wiltshire Foods. Everyone in own home has a named District Nurse who visits/calls regularly.
21.	To ensure that they can manage independently. Ensuring that you continually check up on them and help them out when they require your help.
22.	More support to be independent. More information. Services available to them and knowledge via internet - easy to read and follow with guidance of local social work and NHS team members.
23.	Access to efficient and effective health care and social care which includes house visits by the various professionals when required.
24.	For all needs to be fulfilled physically, mentally, socially, spiritually.
25.	Rehab. support following health crisis - provision of aids and adaptations, community meals - lunch and tea. Information re how to employ support if required e.g. home help.
26.	Help them prepare food, shop, access community activities. Check they are receiving and taking their medication, G.P., Dentist appointments etc. are in place.
27.	Reliable carers that are trained in all aspects of the job, affordable daycare centres, amenities close by. Support for individuals caring for a relative.
28.	Better community support - particularly with dementia. Raising community awareness. Accessible care packages - diverse and highly motivated services required. Maintain rapid response support when people become unwell.
29.	Enablement approach. Joined up working with health service and social care if there is a hospital discharge. Honesty at discharge ... not just discharges to free up a bed. If social care cannot meet the identified needs then the person will be re-admitted quickly.
30.	Continuance of Angus Care & Repair Service. MEALS ON WHEELS was a good thing and the service could be brought back.
31.	100% improvement needed.
32.	Support for physical activity for those of increasing age, making healthy aging the norm. Community engagement in supporting age allowing people to stay in their own homes longer with support from those around them. Excellent social care with continuity of carers meaning that patients can be confident about who is entering their home.
33.	Flexibility in the service - trying as much as possible to accommodate the person and not trying to get the person to accommodate the service. Practical support - gardening,

<p>decorating, odd jobs around the house, shopping. Carers being able to administer medications following some form of education. Having 1 link person they can turn to or who is responsible for overseeing their social care that links in with G.P. Being clear who has overall responsibility for that person's social care. Having one central health record that is used by primary care and secondary care and also social services. Trying to have the same carer going in, not having a different person every single time. Routine and regular assistance in terms of finances and benefit check, assistance with completing forms. Discounted legal advice in terms of completing Power of Attorney. Having and documenting discussions around what they wish for in the future in terms of their care whilst they still can. Trying to future proof their house - what can be done while they are well that might make it easier in the future - ? shower room, ramp. if they can apply for help with insulation/boiler, heating system etc.</p>
<p>34. As above. More time with patients = establishing a rapport to help empower them. Give them choices - not set in stone. Consistent carers - not changing all the time. More staff?</p>
<p>35. The elderly have the services they need already available - carers, health support, home helps etc. and all these need to continue to be available without conditions.</p>
<p>36. Individuals are assessed to enhance their strengths and enabled to maximise their abilities. A single point of contact to help address issues as they arise. Provision of occupational therapy and associated aids, benefit advice and budgeting advice, choice of food supply options, good heating and home insulation. Access to smart technology and assistance to use this effectively. Community alarm, personal contact when required. Good GP and District nursing services, social care at home. Adapted bathing options. More property which is level access. Shared support services where others can utilise similar resources. Laundry facilities. Hearing and visual aids. Mobile banking. Social activities and associated transport/escort facilities.</p>
<p>37. Well funded high quality home care. Full buy in by all staff in the local authority and NHS to the full implementation of the Adult Support and Protection (Scotland) Act 2007. More home visits by doctors and nurses.</p>
<p>38. The right people going in to help where required. Adapting the relevant areas of the home as required. Making the home environment safe and secure.</p>
<p>39. Visits by the same recognisable person who they can build up trust with. Assessing them and possible dangers in their home.</p>
<p>40. Having carers and nurses going into their homes, helping them with support and helping them be independent.</p>
<p>41. Do their washing and housework and pay their bills.</p>
<p>42. Ongoing support, core services. Family support - support for families.</p>
<p>43. Individual personal care programmes. Easy access to the help they require.</p>
<p>44. Food, warmth, visitors.</p>
<p>45. Promoting a culture of self-management and empowerment. Helping people to learn skills they require to live independently and have continued support from community groups, such as CLD cooking groups. Perhaps expanding on these type of 'life skills' groups and encouraging individuals with mental health problems to live independently by supporting them to self-manage and maintain a healthy wellbeing. Having low level, informal support groups within community, which people can access longer term (e.g. Wellbeing/Hope cafes). Also introducing life skills modules into schools, to help young adults learn appropriate skills to life independently when leaving school.</p>
<p>46. People need a support worker that they can be able to contact as and when they require -</p>

someone that they are comfortable with and can call any time as the need arises.
47. Suitable council accommodation, available service to make existing property disabled friendly, home help facility for helping with house cleaning, gardens, maintenance of property, etc. mobile healthcare facilities for rural areas. Health care in the home for toilet, medication and physical assistance around the home.
48. Need to ensure that the current work with enhanced care continues with assurance that staff are looked after so they stay and it continues to be resourced. Need to start thinking about those who are younger with complex needs - need support for those in residential care, living with ageing parents. Need to ensure health and social services are adequately resourced to prevent avoidable hospital admissions, link with carer supports, ensure respite etc. Respite also important for elderly ?could develop services where trained carers go in to peoples homes overnight, ?linked to for example 7 arches unit so staff are experienced. Need to utilise local high expertise to train local carers. Need to break down the barriers between NHS and independent sector working - independent sector nurses to prescribe and train others.
49. Adaptations. Support from Social Work, Day care services, voluntary organisations.
50. Ensure that basic needs are met, such as nutrition, hygiene and exercise.
51. They need to know they are valued and not just an encumbrance to society to be got rid of.
52. Community support, networks, avoiding loneliness and isolation, befrienders, practical help. Discuss early and work out your own priorities- ACP.
53. Care packages in situ for assistance when required.
54. More SCOs.
55. -
56. Develop OT role as consultants for independent living, using their problem solving approaches to help people make decisions about how and what they do (or don't do) on a daily basis. A daily management approach to independence. (akin to pain management classes etc). Pre-retirement planning, preparing self and environment for changing future needs, rather than crisis intervention post illness.
57. I would say get me my home help back. I could just about pay her now, but she no longer works for the Council and someone else took over and is not even allowed to make me a cup of tea because she has other people to go and see at the same time. I can't move or think as fast as her, so I have asked my daughter to get me into a home, I have to give up living on my own which I like, but I also want to live a bit longer and it is a struggle without someone near you can rely to help you.
58. Information and reliable services.
59. Access to services who can visit them at home if needed. They need any necessary equipment/adaptations done in a timely manner.
60. Co-ordinated approach at the right time and developed to meet their needs. This needs to include help to access appropriate community supports and to encourage their involvement in the community.
61. More care workers to implement the care that is required for our ageing population to stay at home.
62. More carers especially night time, training for carers/GP/DNs in fact all involved in care. More engagement with voluntary sector and negotiating more flexibility on their part eg

	Marie Curie night carers faster response? More suitable housing.
63.	-
64.	A generic check agreed by all agencies to then refer on to specific agencies as required (not multiple visits by different people). Information about services for all people to remain independent not just those already known to social work. Preventative work instead of late reactive interventions.
65.	I think the work of the enablement teams assists greatly with keeping people at home for longer, also ESD as they are assisting people when they are discharged from hospital.
66.	Well, again an unusual question - are you asking me about the barriers facing people who would like to own a home? in which case the answer is obvious - the state has inflated the currency to death via fiat / reserve banking making it more difficult to purchase - look at the value of the currency plummet since we left the gold standard in '72. 'Independent' means then 'free from interventions' / self reliance. Well this isn't possible given the liberal socialist agenda, thank you for that. If you are looking for advice on how to establish communities – well these are usually homogenous and so not worth an agenda. If you are asking about unwell people – then clearly a market that offers choice in what types of accommodation that people can live in would be a start; be it to instigate more sheltered housing options / building more homes. However again, increasing the financial capacity for people to afford such accommodation / service is another problem entirely. As with my first paragraph here – it is as John Milton said in Paradise Lost: 'They who have put out the people's eyes reproach them of their blindness.'
67.	Ensure they are adequately housed. For instance, appropriate aids/adaptions, appropriate support, keep family members involved and ensure they are more involved in the SU's care when appropriate. Ensure the person can afford to live in their home, ensure their income is maximised and all relevant benefits are applied for, help SU's dispute decisions. Can any other sources of income be explored (eg - benevolent funds? Some funds can provide grants for equipment to enable them to remain at home - ease the financial pressure on NHS/SW !?!?. Some provide additional grants for heating costs, some funds pay regular payments to help with daily living costs). Can the SU apply for fuel efficiency assistance? (new boiler? insulation?). Does the person have debt concerns?. As a Welfare Rights Officer I see people on a regular basis who have health problems which deteriorate when their income is affected, then when their benefit issue is resolved/income is maximised their health improves, reducing pressures on NHS / Social Work services. If you have time please read the report at the following link : <a href="http://www.thelegaleducationfoundation.org/articles/health-outcomes">http://www.thelegaleducationfoundation.org/articles/health-outcomes</a> .
68.	Increased services to fully support individuals i.e meal prep, district nurse support, social work support, shopping service etc.
69.	Longer visit times from support staff.
70.	Physio, OT, SCO and carer support.
71.	Recognition that an individual may be facing a/some problems either after an acute episode or slowly developing. Appropriate support being offered and available after assessment.
72.	As above. Money - the money paid to keep a person in a nursing home should instead be allocated to relatives willing to take on the care.
73.	A variety of help to live at home services to meet individual needs and ensure good outcomes. The most important part of this is having the right information when people need it, varying professionals working together and ease of access to services and short times from referral to getting help.
74.	Services that can be brought to them in their homes will allow them to stay independent for

as long as possible.
75. As above. The answer to this question is highly complex.
76. I have found SAMH and Richmond's input invaluable for those who need support to manage to stay in their own homes. I think we miss a long term support organisation, such as AMHA, because Penumbra are now moving people on quickly. For those with more chronic conditions, this type of intervention does not work, and the CMHT have seen people referred back, after Penumbra. Appropriate long term support in the community is better than ill health and hospital admissions.
77. At least minimum support packages, community integration, affordable, safe housing.
78. More and better trained support and care for people with dementia within their own homes. More easily accessible respite opportunities for carers of people with dementia (within their own homes rather than institutionalised respite in care homes).
79. Think that there needs to be more analysis of what services are available to support people in their own homes. It is no use there being health services if social services are not available as the two go hand in hand.
80. As above. Regular assessments of need every five years for those over 65 taking place in their own home - with their consent!
81. Support in the home to ensure medication is taken as required and good nutrition and activity are promoted.
82. Community services. Multidisciplinary/ Multiagency teams where issues are highlighted, again, before it reaches crisis point. Engaging with people and their families so they are aware who to contact when, patients being able to self refer to services for assessment so they don't have to go on several waiting lists before reaching the appropriate person.
83. Having access to equipment and services that are individual to their needs.
84. Avoiding people getting isolated in their own homes by providing companionship and stimulating, worthwhile activities that they can join in. Providing equipment that will help them with everyday living and help them to stay independent with things like cooking and housework. Help if required to get out of the house on a regular basis to attend social activities or just go shopping.
85. Appropriate adapted housing that meets individual needs with staff that have appropriate training to support people with PMLD to live independently.
86. Help with personal care housework meals and shopping.
87. Support at home from a reliable service be it home care, cleaning with professional standard of staff.
88. Providing people with the necessary services to do this, meals on wheels, community alarms and where necessary visited by health professionals to ensure their fitness and capacity to remain at home. Use of the Voluntary Sector to provide befriending services.
89. Access to any help they may require, people need to know what help is available to them firstly. Social groups organised near the area they live in.
90. More investment on services which promote enablement and skills maintenance. Staff must have the required training to ensure they have the right skills and knowledge to support more people with complex needs such as Dementia.
91. Appropriate housing, access/ availability for adaptations to current housing, help with

activities of daily living, possible financial advice/ support.
92. Access to doctors when needed. Promote good quality sports clubs. Use care homes for help and support, like drop in centres.
93. They need someone to talk to, take them out, get them to exercise and eat properly, keep clean and tidy, take pride in their self. A lot of elderly people have no one. Maybe even cooking lessons.
94. Support tailored to meet the needs of the person not the person fitting into services.
95. Shopping / Showering / Cleaning / Meal deliveries/or cooking /Transport to Hospital appts/Dr appts/podiatrist appts/optician or clubs. Dressing and undressing a.m.& p.m. Bubble packs for tablets. Assisting if a second person in the home is elderly as well.
96. Where necessary personal care, monitor/personal alarm systems, food shopping, prompting to eat/meal preparation assistance with laundry. Social contact.
97. More information about what social work can provide for families with disabled child.
98. Home AIDS readily available through care and repair as well as a good variety of support from local peer support groups and health and social work.



### **Q3. Having choice and control over the Health and Social Care services people receive and having access to the right information to help make decisions**

**What needs to happen to ensure people continue to have choice and control over the service they receive and access to the right information to help them make decisions?**

1.	Need to give people relevant information about the types of support available to them so they can make choices about services they wish.
2.	The right services in place. Access to the right information at the right time. Make it as local as possible. A one stop shop. The right person. Tell the story once.
3.	Clear, accurate information. Professional support.
4.	Speaking to people on a one to one basis, asking them what their choices are instead of family/friends/outside making the decisions for them. Even if people have no verbal communication, or are unable to make decisions concerning their welfare, maybe a 'process of elimination' tactic could be of benefit. Having your privacy taken away is a massive issue for people who find themselves unable to cope, and strangers coming in and taking over your care can also be detrimental to their health. Final choice should be theirs.
5.	This assumes that people have choice and control currently. In the majority of situations, people do not have control or choice due to a range of factors. The resource options are limited or unknown to them, there aren't the resources, or people wait for the one option available. Seeking out information is difficult and time-consuming and sometimes depends on going through procedural hoops.
6.	Appropriate support provided by services which have knowledge and skills pertaining to the client group. Support to transition and co-ordination within services. Continued joint working organisations with less emphasis on service restrictions; more person centred. Readily available and accessible information at critical points.
7.	Good local information on local websites - people are more computer literate and looking there for information. Involve general public in focus groups - Social Work and health bodies etc.
8.	More finance for information and people to disseminate it. Consultation with self help groups. Informing G.P.s of problems.
9.	Make information of what is available more accessible. Approachable service providers and in understandable language.
10.	All services to work together and listen to what the people have to say.
11.	Information on innovations/progress in health & social care. Welfare Rights check to ensure maximum income. Information regards Independent Living Allowance.
12.	?
13.	Consistent care worker who gets to know them, their ability to cope, and willingness to make decisions.
14.	Regular meetings with care managers and Team leaders.
15.	Transparency. People given all the details on how to choose their own services.

16. Must be given all information about their options to allow them to make an informed choice. Good communication.
17. Involve more people in decision making issues and events.
18. Adequate staffing as when people leave now they are not being replaced.
19. Access Offices - to hold information, fliers available when people go to pay council tax or rent. Really for anyone who holds a bus pass. Information - not only accessible on computers!! G.P. surgeries must have a huge role in this.
20. Explanatory leaflets for all benefits available. Visits from/easy availability of Benefits Department of Angus Council. Keep First Contact system - it works well.
21. Ensuring that they are kept up to date with all the correct information on services that they are entitled to.
22. More information. Services available to them and knowledge via internet - easy to read and follow with guidance of local social work and NHS team members.
23. Information readily available about the services being provided. One point of contact at the end of a phone 24/7 who can access the necessary and relevant information and support without any major delays.
24. For them to be listened to.
25. Allocated support workers?/assessors - provide contact information for support/helpline. Inform families/G/P/s/nurses etc.
26. Information needs given and explained in a way the service user understands. Support and choices given.
27. There is a lack of care managers in the Angus area. If people don't have the information to know where or who to contact it can be very frustrating. The Council needs to make accessing services easier.
28. Raise public awareness of services and support available. Use of G.P. practice, media etc. to share this. Road shows - public media.
29. More Care Management or Home Care Assessors to be available to give meaningful information. Not just a quick phone call or a leaflet in the post. More services need to be made available. There can't be a choice without services to choose from?
30. Visitations to be made to the houses by appropriate professionals from the Health and Social Care services and a plan agreed upon both the providers and the receivers of the various services.
31. Improved liaison with patient/relatives/friends involved. Ensuring support is in place prior to discharge from care and proper assessment of the person's needs prior to discharge.
32. Individuals, families and communities, especially in our most deprived areas, need to be supported to co-produce services taking an asset-based approach.
33. People being aware of what is available, what can and can't be done. Linking in with previous, ? having an advocate or nominated family member. Also having 1 record so it is clear who did what and when and who is responsible for any actions.
34. Very regular reviews. Know who and where to contact. Improve communication and encourage people to contact agencies if problems.

35.	Assistance from family and/or health workers to make sure the elderly understand the implications of their choices.
36.	They are supported to seek the most appropriate options, that this is reviewed and adjusted in accordance with need. There is acute awareness of adult protection issues and vulnerability. There are mechanisms in place to counter poor or dangerous decision making regarding care and support.
37.	Having a variety of services state and public especially home care services. An end to the Assumption that everyone is IT/Computer/E-mail literate as this excludes so many people who are none of these things because of age, infirmity or disabilities. Again supporting infrastructure based around GP practices would be a very helpful way forward. Ensure that the welfare rights team is part of the Integration Authority.
38.	Be clear with people what their choices are. Make sure all information is clear and easy to understand (plain English). Services wherever possible as local as can be. Know who they need to go to.
39.	People receiving the care have to be listened to.
40.	Let them talk and have a say and a choice and control by making their own decisions about the service provided.
41.	The right information about health and social care.
42.	People need to know that they have the choice. They need to have a positive experience to believe.
43.	Community care. Coming together to make sure improvements/changes/needs are heard.
44.	We need to listen to them and provide what they need.
45.	Promotion of SDS is Mental Health Services. Also, low level informal services to provide longer term support for individuals with mental health difficulties. This would support people to stay connected and have access to self-help materials and information to signpost them to appropriate support services. A recent report developed by Penumbra (Angus Nova Project) based on supported people's feedback, demonstrated a gap within Angus service provision, for people who require minimal support but find some contact with mental health services beneficial.
46.	Communication with a support worker that can identify needs suited to the individual.
47.	Information needs to be easily accessed and not hidden away in small print and not only available to the people that know their way around the benefits or the social support system. It shouldn't be a case of people having to ask for the information it should be made available by medical staff, council staff, at the earliest opportunity as a situation arises for an individual and also provide easy access to online information.
48.	Good patient partnership groups in health centres. Good support for locally run services - VAA support of home help service locally is excellent and the right ethos. People receiving the services wanted this. Need resource to health and social care in enhanced care model as without resource staff put up barriers to access and do not give enough time to those most at need for help with making decisions. Need to remove unnecessary barriers to patient choice - risk adverse culture so admissions to hospital recommended, concerns regarding resource in the overall pot so admissions to hospital. POA campaign is an example of work in this area at population level.
49.	Ensuring the individual has the information provided to them. Needs assessment.

50.	Clear concise information about what can be offered, and what is practical for them.
51.	Make it known how to contact someone for advice/help. Nobody will tell you who you can turn to. GP/district nurses/hospital should pass on info on who can advise you.
52.	Effective meetings with clear plan and joint decision making. Reality checks and supportive challenges - you say you want to be independent but you can manage stairs and live in flat etc.
53.	One point of contact who are able to advise on all service options available.
54.	SCOs to advise what info they need.
55.	Clear information, the ability to source this information by looking at different ways to do this and not through usual channels.
56.	Services that are truly flexible to meet needs of people at the time they need and also not dependent upon where they live. Useful for some people to have support on how to manage this as not all can or want to do this independently. Greater use of self referrals for health professionals, and single point of contact for health and social care. Useful to have health and social care info on one website rather than multiple websites to be navigated as this can be confusing for both users and professionals.
57.	Give them choices. Like if you need help with bathing and getting in and out of the bath find out if that can be done in 30 minutes and then for getting dressed, it can take me the whole morning without help. So I can make myself my first cuppa of the day after midday. Tell me what is out there where I can phone for help and give me the time to get me some help with what I need.
58.	Services require to be reliable and flexible in their approach to provision.
59.	Information in an easily understood format, people with time to explain things.
60.	Development of appropriate advice and access to relevant supports.
61.	Make the process to access services simpler.
62.	People need to be aware of their choices and for there to be sufficient resources to offer these equitably. Info needs to be internet/hard copy/TV/radio.
63.	Online information regarding help available - inc cost, hours of business, geography, priority groups MUST be available to residents in a much more user friendly interface than is presently used. This information should form the basis of any discussion regarding a persons services. Where appropriate, family members and carers should be involved in this discussion from the earliest point and their contribution valued.
64.	A shared vision between statutory and voluntary services to provide the best most affordable service regardless of tenure and regardless of who provides the service. Do not try to make statutory services take over voluntary services that already work. Independent advice is crucial.
65.	Ensure you continue to engage with people.
66.	Show me choice and I can comment on this – there is no choice. I again offer that economic freedom ie. Increasing the wealth of individuals is the most obvious way of creating choice. Since services can then compete. I think that a phased monarchic reduction (heading toward full relinquishment to the private sector) of the entire healthcare service is required. Since, and as with all government agencies, big wig upper managers end up slaking their personal accounts with money and quality and standards slip since operational funding gets hit. In the private sector hard workers are valued and are

promoted (I gracefully await the ability to alight) – in the public sector (don't I know it) your hard work is not more valuable than the lazy bastions that have clawed their way to their level pulling hair and pomping their way up the gravy train.
67. Ensure that the SU is equipped with all the relevant information to enable them to make an informed decision.
68. To be made more aware of what services are on offer and liaise with same.
69. Decisions are financially driven - it makes little difference what older people want - they are told what they can have and I don't believe this will change.
70. Skilled key workers with a holistic, people-centred approach.
71. Regular reviews with the care givers and the individual.
72. Information. Someone to explain in simple terms the complexities of the bureaucracy.
73. Good and timely information and communication with all professionals working together.
74. People need to have access to the right information within their own locality to help them make choices.
75. Embrace the principles underpinning self-directed support.
76. Hopefully CMHT and SW staff who can discuss options with individuals, and ongoing evaluation of services.
77. Information on what can be available and the means to acquire it.
78. The available services need to be well advertised and easily accessible. If people have forms to fill in and assessments to complete before accessing services they will not do it.
79. People need to be able to have their social needs met at a time that is suitable to them. This is not the case at the moment, most users cannot get social care that suits their time/needs.
80. See above.
81. Patient groups and their advocates need to be part of process when deciding about local service provision.
82. -
83. Choices need to be user friendly.
84. Clearer information, more one-to-one contact with health and social care staff and less form filling.
85. SDS processes and it's ethos ensures that people continue to have choice and control. Clear communication and information needs to be conveyed in a transparent and accessible way.
86. Services need to be available from private providers that give an efficient and cost effective service you can rely on.
87. Clarity on what is available, reassurance that quality is maintained, continuity of services.
88. A personal assessment of what individuals require at an early stage to enable them to make informed decisions as to what their personal needs are. To do this they need to know

	where to obtain the information and where the services are in their community.
89.	People need to have a means of contacting the relevant person to discuss their needs on an individual basis.
90.	Information in a variety of formats across different locations. Access to advocacy services for the more vulnerable.
91.	Advertising campaign, open meetings, help with understanding, filling out forms.
92.	Simplify the websites, finding anything on any form of government website is very difficult, it needs to be simplified.
93.	They need someone they can trust who will give them the proper advice and actually tell them clearly what they are entitled to. Treat them with respect.
94.	Evaluations. Informed literature of service available.
95.	Must keep updated regularly and remember not everyone can work a computer via Access office/GP surgery/Chemist/ Library/attached to invoice, if any sent out to clients.
96.	Individuals should receive help and support in a way appropriate to each person via care workers, social work departments, care centres. Collaboration and communication.
97.	They are involved in all discussions.
98.	There needs to be a co-ordinated approach gather local information, this needs to be done by one organisation within Angus and it must be simple to read and understand not like the Internet, it should be widely published through various means and locations like GP surgeries, local groups, library and council, also the right approach would be to have a one to one interview with the person and their family and questions like what would you like, or what matters to you should be asked and not told this is all that's on offer as that approach is humiliating and what's on offer may not meet the needs, but something simple might be the answer like going to the pub or the gym or even just someone visiting!

#### **Q4. Preventing problems from developing into a crisis so we reduce the number of hospital admissions and the time people stay in hospital**

**We know that problems can develop into a crisis very quickly and may result in people being admitted to hospital needlessly.**

##### **(a) How can we all work together to support people in a crisis situation?**

1.	Any potential problems need addressed very quickly to prevent these becoming a crisis. We need the correct agency(s) involved to deal with crisis and at the right time of day.
2.	The right team working together to access quickly. Put the support in the home. Only admit as a last resort.
3.	Share information. Timely assessment and information. Regular support (by phone if necessary).
4.	Backup from agencies who can advise on health issues, eating/cooking, integration into local amenities (if any), a contact/s who can be accessed in crisis/emergency/frightening situations. Financial advice, when living on a basic/low income.
5.	Those who are first points of contact with the public must have a knowledge of the resources that can be brought to bear and those resources must respond promptly, preferably when assessments show that things are likely to escalate, rather than when a full crisis has developed. By and large, professionals have and do work together when situations demand it.
6.	Early intervention. All of the above. Preventative measures.
7.	Good local services. Good community support. Better joint working between health and social care. G.P.s need to be part of the local team - they don't liaise with social care as often or as well as they should.
8.	More flexible G.P. appointments. More use of District Nurse to see consultation in the home and hep assess what help is needed. More social services personnel.
9.	I personally self manage disabilities and am very pleased that I can now go to doctor's without appointment system previously in place. Very off-putting speaking to receptionist when you need to talk to doctor or other professional. Make a red dot on notes for long term conditions - if contacted you can get medical advice immediately.
10.	Find out from the person what their needs are and get the right help for them.
11.	Patients know their bodies best. Make home emergency medication available to people. Risk assessment. Telephone contact for advice (local). Availability of G.P./emergency beds in local hospital/nursing homes.
12.	Local phone contact. Local drop-in service. Local home helps. Local meals on wheels.
13.	Have <u>good</u> communication links between doctor/medical services and social carers.
14.	Communication between all services. Extra support if needed.
15.	Clear communication. Make sure all information is passed on to the right people. Choice.
16.	By reporting any changes in service user's condition. Contacting District Nurse and Doctor. Extra social care put in to support the person. O.T. and Physio support. Keep them

informed.
17. Having a core group of professionals who can be contacted as a first port of call for advice.
18. Communication between all relevant services and family. Proper documentation of daily occurrences. Extra support if needed.
19. Education is the key - even at schools - children will take home the message. it will be very difficult as lots of families are fragmented and children pre-decease their parents. G.P. surgeries have lists and if people have not been in touch this could be flagged up. More Health Visitors - not Social Workers or G.P.s but general support - like a good neighbour scheme - only more formalised.
20. Regular District Nurse visits (see above).
21. Communication plays a big part in this. Ensuring that all relevant information about the person is passed on to the correct people. Ensure that if problem arises then it is dealt with there and then and not allowed to get out of hand.
22. -
23. Everybody involved in providing the care and support talking to each other without one service provider feeling they are more important than another service provider. Openness and transparency across all service providers.
24. Ensure there is enough staff available in the event of crisis or to prevent.
25. Provide crisis monitor system by G.P./Nurses and provide support/assessment through Prevention of Admission team/social care officers or allocated assessment nurse. All involved in care of person to communicate concerns.
26. Share information. Get the correct help and advice. G.P., Nurse, O.T., Physio. Good care. Report and record. Team work. Speak to the client, ask how they feel.
27. In my experience, admissions or visits to A&E have been down to lack of knowledge and training on individuals caring for elderly people i.e. falls, bruising, knock to the head.
28. Locally integrated working making vulnerable people known to the multi-disciplinary teams. Improved health visits. Again raise public awareness to look out and refer for family/friends if required.
29. Joined up working with Health service and Early Supported Discharge and Prevention of Admission. The criteria for these services needs to be reviewed so that people are not discharged straight back into mainstream services without proper assessment.
30. Instilling in the populace of Angus the belief that prevention of crisis comes from making the problem known in its infancy and that the Health and Social Services will be approachable in such cases.
31. COMMUNICATION AND IMMEDIATE ACTION to any request/suggestion ... instead of sitting on a desk for weeks awaiting action.
32. Joined up health, social and other services allowing those approaching crisis to be identified and supported before hospital or care home admission is required.
33. Trying to identify people at high risk of admission before it gets to a crisis. Again back to getting the service to work with the person and being much more flexible. Almost having a service before they hit ECS planning. if someone is at high risk of admission, could there be more capacity for respite beds or local hospital admission? Can carers go in more than 4



times a day and for longer than 5 minutes - social interaction is just as important as having tea made.
34. Timely assessment and probably medical led to then refer to appropriate people. Good communication and have numbers available. Properly co-ordinated.
35. By making sure that all the services work together and know the patient's needs and what is happening in their care.
36. Good communication between and within services and thorough understanding of the relevance of each individual's role. Effective preventative work. Stop prioritising delayed discharge from hospital and start looking at the reasons people are unable to return home! Move funds to better support those in the community.
37. Lack of resources is clearly not the only important issue but it is an issue. <ul style="list-style-type: none"> <li>• If you look at the top salaries for Directors and Service Managers on NHS and Angus Council there is huge scope for savings.</li> <li>• The plan to cut home care whilst continuing to fund massive salaries for top officials is likely to divide people.</li> <li>• Currently in Adult Services 2 people doing the same job can get a 20% salary differential with NHS employees getting far more for the same work. This is madness and should be stopped with salaries being rounded down to the lower grade.</li> <li>• Cut down on the number of people doing "planning" tasks. In Adult Services at present just in the local authority there are 2 service managers, and at least 4 others people doing planning work. Meanwhile operational staff struggle. This is out of balance.</li> <li>• If in the new Integration Authority, every effort to focus resources on services rather than on salaries for top officers and planning staff it would be most welcome.</li> <li>• If management is structures in such a way that the same people managing hospital beds also managed home care, day care and alternatives to admission this would provide an incentive and stop one manager blaming another.</li> <li>• Try to break down lines of demarcation. Make it a "taboo" for Integration Authority staff to say "that's not my job". Keeping people safe at home should be everybody's job</li> </ul> <p>Make certain high quality welfare rights services continue to be available</p>
38. Have a team of people whose job it is to go in to support the person (G.P., nurse, physio., if required mental health person), all working together, communicating, and no duplication. Share the information so crisis can hopefully be resolved.
39. Different care groups have to interlink together.
40. Being supportive and lots of encouragement and help they need.
41. Make sure they're safe in their own home, and from trips and falls.
42. Look at society, try and prevent crisis from happening. Looking at trends etc., awareness, information. Inform the communities and workers.
43. Multidisciplinary teams in communities.
44. Keep people well for longer. G.P.s, community teams share information about people.
45. Having clear care (and discharge) plans in place, which allows smooth transition from in-patient to living back in the community. Improved pathways of service provision, for example community hubs where various services are located and can work closely together to support individuals.
46. Having a number that can be contacted - and the confidence and being comfortable with the person allocated to the worker.
47. Information providing early intervention details to prevent illness becoming a hospital trip

would help, provide GP facilities over weekends and evenings, mobile community health care, being unable to obtain a GP appointment for weeks to resolve a medical issues not helpful!
48. This needs continued investment in General Practice. Community nurses need to start taking an increased role in disease prevention. This has historically been blocked by management with no recent community nursing experience playing the lack of resource card. GPs to do this well are still carrying out tasks which would be better done by nurses including I currently dementia patients who have not been seen for some time and don't come up to the surgery to check on their care needs. Invaluable work to prevent crisis but would be better done by a nurse (they are better at this). HCA working with DNs need to check bloods/BPs and have a system for coordinated GP management of the results. QOF has resulted in tick-box exercises without the GPs acting on results taking into consideration co-morbidity. We need to ensure that future systems allow co-morbidity coordinated assessments to take place. I have adapted QOF tools for this purpose and have developed a system but this needs to be spread out as good practice.
49. -
50. Ensuring that care that is offered is delivered as a given, and not left until a crisis happens.
51. Communicate.....Both Brechin Infirmary and Ninewells discharged a man in his 90s back to his home without making sure there was someone to care for him or even if he had the right facilities at home to get a bath! Disgusted at the attitude of get them out of hospital as soon as they can without support - bring back almoners - at least they cared!!
52. Many crisis are avoidable but plans should and could be in place, eg if carer becomes ill.
53. As above. One contact who can access all necessary services to support in crisis situation.
54. Better access to GP appointments.
55. Have IT systems that speak to each other, and actually talk to each other without feeling the need to defend each others service.
56. Self referral to prevention of admission, OT/PT being part of the GP team and responding to crises earlier than point of referral to POA. Admissions being questioned as to whether they are truly appropriate due to medical needs rather than the social admissions that still occur. Also some low level medical needs moving to care at home rather than being admitted due to a simple fall or UTI with access to diagnostics from home or seen as day case.
57. What I have just said, if you know where to call for a service when you need it without causing bother anyone and knowing that someone can give you help makes you feel more confident that you can cope with what you have left in yourself to stop having to be rushed to hospital because of a fall trying to get dressed or because you can't eat what is left for you if you drop the cutlery.
58. Good communication between sectors and different services in the sectors. It development would help, so health and social care can speak to each other over It systems which are integrated.
59. Who do we contact in this situation? Especially if out of hours.
60. Remove boundaries and duplication and provide responses that are developed to meet peoples needs not organisational needs.
61. Put effective resources into Primary care, and increase funding available for respite care.
62. Don't let the crisis happen using better ACP and resources to carry these out. Integrated IT so all know. ACP, urgent response approach eg respite available.

63.	One crisis intervention action plan, signed up to by all of the services that might need to be. As far as possible, small scale meetings with the person, or their advocate, present. Clear decision making and accountability. Creative solutions and bravery in terms of action planning.
64.	Just that - work together. GP's, Social Work, Health and Vol services need to share information and act quickly to avoid falls and deterioration of conditions. Waiting lists at different referral points do not work. Home Safety checks can identify immediate issues that can then be resolved however preventative adaptations are better than larger reactive adaptations.
65.	-
66.	We can talk and mandate a structured plan to work together. Government policies and a lack of accountability are usually the root cause of problems in society today so I would suggest looking at how much freedom can be given back / how many laws regulations that prevent movement in the market can be ripped up. Remove state control of finance and eventually simply delete the government allow people to spend THEIR money (no one else's) on the things that THEY need/want and through freemarket forces and voluntarism health will increase. A failing company stops trading because no one wants it – a failing government department gets more funding. Your pound is your vote (see Mises) I intimate that you should not simply treat the symptom (ie increased hospital admissions) without knowing the cause. Increased government is not the answer when government is the problem / cause. Tell that to the bribery imbued voter.
67.	Having a clearer understanding of what teams/services are out there. The NHS Crisis App is a good example, but ALL staff need to know about it, need regularly reminded about it. Move away from the 9-5 culture so we can deal with issues outwith office hours, maybe it would suit some staff to work 8-4 or 1-9pm? I would personally be open to such suggestions, also fits in with agile working agenda (wouldn't need so many desks!).
68.	Make sure all services and help are singing from the same hymn sheet i.e communicating fully with each other.
69.	Need immediate response teams that can be easily contacted to put in short term support without a few days delay. This two or three days delay can make the difference.
70.	Shared IT systems so everyone has appropriate level of information about people and to enable communication. Team meetings. 7 day services eg OT and physio.
71.	Maintain and Improve the POA scheme.
72.	24 hour care by social care.
73.	Quick access to services when they are needed by individuals and family members, particularly getting to see your GP or having a way of doing this quickly. Again, having the right information of where you can go for help when you need it is crucial.
74.	Medically qualified people should visit people who have been identified by their GP or other medical professional as needing more support within their homes.
75.	Engage better with communities. Create innovative systems and approaches (see Buurtzorg).
76.	Ensuring that individuals know who they can phone, and when. Might be an idea to think about a handout/leaflet, which individuals can get at their first appointment, which lists numbers, times, who their case holder is, and some staying well tips?
77.	Good neighbours/family support.

78.	More availability of nursing and medical staff in the community. In particular 24hr access to dementia assessment and treatment by qualified nurses experienced in dementia care.
79.	Cut down on the paperwork that has to be completed in order to prevent admission to hospital. There is a lot of red tape needed and this is time consuming for the professionals involved.
80.	Having basic information on over 65s about their supports, That people have knowledge of how to access emergency services and services have contact number for next of kin.
81.	Regular multidisciplinary meetings can ensure plans with contingency management are in place for patients who are in this group where deterioration is a risk.
82.	Multiagency/ multidisciplinary teams that can respond same day/ next day to get the appropriate people and services in place to support the person and home and develop a joint plan to enable the person to stay at home.
83.	Robust community MDTs meeting regularly to prevent problems but if they arise being able to access POA services quickly and easily.
84.	Better communication between health and social care staff. Earlier intervention from health care professionals to prevent the crisis situation developing. Better support for older people and carers at home to keep them healthy and reduce stress, particularly for carers.
85.	Ensure that any early intervention is considered in holistically to prevent unnecessary crisis developing. Ensuring that family carers have access to information to enable them to understand any process involved and who to contact regarding this process. Relevant information should be shared appropriately to enable any process to be seamless.
86.	Services for support have to be available in an emergency and easily accessible with a quick response from assessors or the people who know you need help.
87.	More community networking build up support groups whilst still having a core professional service available to call on at short notice.
88.	Encourage vulnerable people to have the Community Alarm installed where suitable. These vulnerable people should be encouraged to have a friend/neighbour look on in them and check on their well-being on a regular basis.
89.	Better communication between all the relevant carers.
90.	We need to have staff who can work with people with very complex needs. The correct training is imperative. The number of people with Dementia is increasing globally and we need people who understand the complexity of these diseases.
91.	Help in the community, early access to support before things reach crisis point, people knowing who to contact and when.
92.	Use beds in care homes as small community hospitals, most people in hospital would be more than adequately looked after in a care home, at a fraction of the cost, and in the community where they live. When the crisis is over they can return home.
93.	Listen to them - work with them - don't talk down to them and don't feed them with drugs. Get them to help their selves.
94.	Inter agency partnerships can alleviate this to some degree and enable the person to stay out of hospital.
95.	Keep a tight grip on the situations. Make sure back-up is in place before hospital discharge, especially if a Friday discharge. Talk to each other via GP, District Nurses and

Multidisciplinary Teams.

96. Collaboration and communication. Families/carers/link workers may observe change(s) in behaviour, feed this information on asap to try to deal with situation before crisis.
97. Provide quick access to services at home to support people staying at home regardless of time or day.
98. Better support at early stage of diagnosis so that both the client/patient/ carers/family all know what to do if things get worse, who to contact, what help is available, some sort of clear concise dialogue and not a one way conversation from the statutory sector with blanking monosyllabic answer full of jargon that no one understands!

**(b) What can we do to prevent problems from developing into a crisis?**

1.	Good communication, early intervention and correct support at the time required.
2.	Early intervention by the right person or team.
3.	Support. Assessment. Intervention. O.T./Physio.
4.	Previous answers.
5.	-
6.	All of the above. Availability of supports in the short term. Not being bound by constraint, paperwork etc. Joint working. Background knowledge and open communication with all involved/sharing knowledge. Trust and confidence in the response from external agencies in service provision and delivery. Grater understanding of each other's role.
7.	Team available to assess and put in emergency support very quickly. PoA has never been resourced as well as it should - should have a team of assessors, not rely on busy District Nurses. Team to have access to emergency services at home or short term assessment in an assessment centre - 24 hour care e.g. local care home/unit.
8.	More care for single people who live alone, especially when leaving hospital. Many of whom have no family nearby.
9.	Six monthly checks by medical professional. Easy access to prescribed drugs necessary. Health Visitor checks/home visits.
10.	All work together. Speaking to the person involved.
11.	Crisis intervention plan. Involve carers and relatives. Encourage everyone involved to note any change in condition/s and report to co-ordinator promptly.
12.	Local availability to support services - and people need to know how to access.
13.	Carer/befriender should be consistent and get to know person - if possible - to see impending problem/crisis.
14.	Deal with issues promptly when they arise. Keep family members informed.
15.	Pass on all relevant information. Have things in place to prevent crisis e.g. community alarm, care manager.
16.	Good communication. Extra help given. Review of services with social and medical input. Work together as a team.
17.	Set up a support network whether there is an initial point of contact to gain advice and help.
18.	Communication has to be good between all services and shared information for e.g. between social services, nurses etc. and family.
19.	Sometimes nothing - we must accept that everyone is an individual and may prefer privacy to any sort of intervention, especially those who have no family or have what they may perceive as interference from 'Do Gooders'. Education - local groups - classes - Dorothy Dobson.
20.	Emergency plans for all in receipt of care - contacts, drug regimes, access to NHS records

(GP etc.)
21. De-escalate all problems to ensure that they don't develop into a crisis.
22. -
23. Service providers to talk with each other openly and honestly. Involve and keep informed the person needing the care and their family members. Don't keep people hanging on.
24. What does the person need? Take appropriate action quickly.
25. See previous.
26. Look, listen, record, report and get the help needed from professionals. Good support network.
27. Give the people going in to tend to these individuals the adequate training. If they have the knowledge they are less likely to panic and deal with the situation appropriately.
28. Input care immediately if required. Knowledge of people at risk in community localities. Promote joint working to observe people at risk through MDT meetings. Involvement of voluntary sector to support this?
29. As Section 1. Key worker approach so that small issues are not being dismissed. Communication between all agencies is key.
30. Covered pretty well in the above section. The confidence by the users that they can phone with confidence and that the person they contact will deal with them professionally and sympathetically and will talk with them reasonably slowly and in a clear voice, and spend time with them in their problem.
31. Act immediately.
32. Allowing better communication between agencies so that a problem identified in one area can be addressed rather than overlooked. Empowering carers and friends to voice concerns.
33. Having the capacity to respond quickly. If there is a plan in place already then could be actioned quickly.
34. Early detection. Listening to carers and family of fears and worries. Reacting timely with appropriate interventions. <u>Envalue the patient.</u>
35. The agencies to talk to each other, to the patient and to the patient's family as soon as the problems arise.
36. Clear contingency planning to offset crises. Resist the urgency to remove people from hospital settings until they are fully ready to return home. Establish rehab services to enhance confidence and reassure carers of someone's ability to manage more independently. Avoid the 'revolving door' of home/hospital. Fund community based services appropriately.
37. Careful multi agency decision making and good links with GP practices is crucial. Having a multi agency team attached to each practice with social workers, and nurses with a single manager working together would be one way forward. Poverty is a major contributor to crisis. Enhancing the current welfare rights service is the one really sure way of aiding a preventive strategy.
38. Early intervention if someone sees something - a relative/friend. A conversation can perhaps follow to prevent a crisis? G.P.s might spot something early on and can do

something?
39. Talk with client and family, friends, carer etc. and put in place regular checks.
40. Same as other question - giving them plenty support and encouragement and help that they need is provided for them.
41. Look at their care plan.
42. Try to reduce the likelihood of these crises occurring, intervention, communication, education.
43. Get help at the beginning - recognise the signs - get help earlier.
44. Act on the information that we have.
45. Preventable measures. Services being flexible, accessible and efficient in supporting people to self-manage. In addition, having low level, longer-term support (where required).
46. Constant communication suited to the needs of the individual.
47. Early intervention and support, more support at the front end of the process, which would mean more community nursing/care/GP along with extended periods for these services availability during the day and weekends to prevent unnecessary hospital trips. Also correct time for appropriate staff to spend with individuals to resolve a medical issue and to make individuals feel understood and cared for.
48. Need good GP and community nursing co-morbidity assessment with MDT working. Need IT/recall systems to support this. Community nursing management need to get over the hurdle of not wanting to provide resource to support GP practice QoF box ticking - need to change culture into something else. ?one for Margaret Cairns to look at in her current role. We can show her what we are doing in Monifieth regarding this if she wishes.
49. Assessing each individual as a whole. Ensuring that those living alone and recognising little support from family/carers, are at greater risk from a crisis developing.
50. Good consistent basic care, routine offered at home.
51. Employ staff who actually care and it is not just a job to them. Someone who will use their initiative to ensure the health and safety of the elderly or vulnerable.
52. Let people know warning signs and when to get help. Share information cross sector with permission. Highlight at risk situations early.
53. Support as above.
54. Better access to GPs.
55. More of the above from 4.
56. Culture shift in expectations of how health and social care can be delivered with more medical needs being met at home (as above). More reliance on care at home rather than always expecting hospital admission with minor illness/incident.
57. As I said, if you are on your own and you don't have anyone to call to help you with your problem, like not being able to open the pills container one day, then you just miss the pill and that can cause a problem become a crisis.
58. Good communication and quick response times to provision of services which are needed.



59.	Monitor how people are doing. Seeing the same GP so they understand how we are and see any deterioration.
60.	Earlier intervention.
61.	Invest in local services instead of putting so much of the budget into secondary care.
62.	Don't let the crisis happen using better ACP and resources to carry these out. Integrated IT so all know. ACP, urgent response approach eg respite available.
63.	As above, start these types of conversations early. Have a Wellness Recovery Action Plan in place for all people known to services so that early identification of problems and subsequent plans are in place. Ask people and their families what they might need to help them to remain at home. Consider the use of things like telecare to support people to remain at home.
64.	Home Safety checks - available in the Voluntary sector and funded by Council already available. GP's need to give advance warning of people going in to hospital or experiencing difficulties so that they can be addressed at the earliest point. Hospital staff need know about and utilise services rather than waiting for community staff to deal with them on discharge.
65.	-
66.	You could actually work together / adopting one strategy amalgamating all involved services seems plausible. Less passing the buck etc. But if you are going to cut operational services and instead maintain the increase in big wig salaries then you can't pretend to be able to operate at a higher level. (facepalmingly obvious no?). Admit that poverty is a health concern... and mandate it. By maintaining the welfare rights service you can cheaply remove the situational financial pressures which are very likely a major contributing factor to declining public health. If you have any influence then it seems very clear to me that removing the 'minimum wage' would allow people to negotiate wages / pay rates (in the way other prices are negotiated) – this would allow for more disabled people to enter into the workforce would significantly reduce mental health instance since work is fulfilling and a huge social resource – when otherwise those people have very little. - I know that you disagree though and even though it will mean huge lay offs and company closures (less workers) AND MORE HEALTH DETERIORATION you actually think the opposite; you want to INCREASE the minimum wage.
67.	Respond promptly
68.	Not sure.
69.	Staff should be better able to assess whether even if a client is saying they don't want a doctor/ambulance that they may in fact need one.
70.	Enhanced community support meetings working well to share information on vulnerable people, but staff very stretched. Agreed screening tools eg for frailty.
71.	Timely and appropriate intervention which currently is not well enough resourced and does have a patchy take-up.
72.	Will always be unplanned crises. But clear SIMPLE care plans that everyone including relatives are aware of. As simple as - if admitted, neighbour on left can take cat.
73.	Quick access to services when they are needed by individuals and family members, particularly getting to see your GP or having a way of doing this quickly. Again, having the right information of where you can go for help when you need it is crucial.
74.	Awareness and communication should be the top priorities to prevent problems from

developing into a crisis.
75. Mobilise communities, 3rd sector, private sector. Move resources from institution to prevention.
76. Ensure that a good therapeutic relationship is developed with the individual, however, for some individuals, crisis happens, and we need efficient systems to deal with quick response, or admission. The paperwork around hospital admission can be a time consuming process.
77. Stay in contact.
78. Good information sharing between NHS and social work staff. I think NHS and SW should all use the same assessment and information systems. ie care first or MiDIS (or its successor).
79. Be more pro-active and provide services before they reach a crisis. Evidence shows that cost of providing early social care interventions reduces admissions to hospital is financially viable.
80. See above answers!
81. Contingency plan and management - involve the widest possible support network to ensure early warning signs of deterioration are addressed.
82. Effective communication- if everyone knows who to contact in which situation. Communication between services to highlight any vulnerable people who need interventions before it reaches crisis where possible.
83. Ensure good communication.
84. Closer contact and monitoring with vulnerable people in the community, providing physical and emotional support to them to keep them well.
85. Again, Communication and appropriate information provision is crucial to prevent problems from developing into crisis. Provide appropriate early intervention support. Family carers' knowledge expertise and skill base should always be considered when assessing care needs. Working with family carers as equal partners in care reduces the risk of problems developing.
86. Get services and help in quick, no hassle.
87. Be proactive in anticipating possible areas or identifying vulnerable people and reducing risk as much as possible to minimise crisis points when or if they do occur.
88. People with LTCs should be provided with a personal care plan and where appropriate they should be provided with a home supply/rescue of antibiotics and steroids. This works well in COPD patients, could it be or is it utilised in other LTC?
89. All services involved need to talk to each other on a regular basis. Ensure the clients have contact details for reaching the appropriate person in the event of a crisis.
90. Ensure the right staff with the right skills are in place to support people and invest in prevention of admission services or intensive care at home.
91. Increased awareness, health literacy, health plans.
92. Doctors appointments when needed. And as above use of local businesses.
93. Train your people to look out for the start of the problems. If you have a dedicated officer they would get to know the habits of the person and maybe stop the problem before it

starts.
94. Ensure the person has a tool kit and coping strategies and plan in place.
95. We must have a strong support group at all times. Qualified and quality staff in each category.
96. As above, work together. Report and share information. Listen to people who know individuals and have regular contact with them. Identify and employ appropriate resource to support the change.
97. Rapid response from relevant parties.
98. Early diagnosis, good two way communications, good support from healthcare staff as well as social work staff, good management of the conditions/conditions by healthcare, social and the person themselves by self management and general good care by their family.

## Q5. Further promoting the safety and respect for everyone within our community

### What needs to happen to further support communities to respect each other and maintain their own safety and wellbeing?

1.	Need to do a risk assessment covering all areas e.g. mood, wandering behaviour, safety at home and outside, finances, falls risk, self neglect.
2.	Communication about what is there to be accessed.
3.	Timely access to information. Clear information. Connection with support services.
4.	Police Scotland and Fire Service could be involved in assuring people their home is safe and secure, and checking fire risks, especially people who have mobility issues. A council department who liaises with people on a regular basis to find out if people require assistance with agencies etc.
5.	I think this is more a philosophical question than one to produce concrete practical answers. It's like asking what kind of society are we and what kind of society do we want to be.
6.	Using trading standards more. Community Police - joint working with services. Prevention strategies. Fire safety awareness. Promoting public duty to protect vulnerable members of society.
7.	Real joint working - health, G.P.s, social care, housing, community planning, independent sector and voluntary sector. Locality working with powers to develop what is needed locally with less red tape and paperwork.
8.	More exercise projects tailored to the abilities of people.
9.	Trust and confidence in our Policing system - with recent amalgamation of Police Forces, local/beat bobbies thing of the past. Local safety officer who can be contacted. Youth and older people maybe meeting together to bring up issues they both have.
10.	Communicate with each other.
11.	Better understanding between generations to improve mutual understanding/empathy. Talks, visits, social events etc. involving all age groups, Police, Fire Service etc.
12.	Depends on the community!
13.	Again, consistency in care/support worker assigned, and ability to gauge how much responsibility each person will take for their own wellbeing.
14.	Communicate with each other.
15.	Diversity. Respect and dignity. Neighbourhood Watch. Sheltered housing. Safety checks on housing e.g. fire alarms.
16.	Treating people with respect and dignity. Be non-judgemental. Ensure information is given to everyone. Join neighbourhood watch groups. Look out for each other.
17.	Periodic meetings with key organisations and professionals to discuss issues.
18.	Communication with each other, and support from relevant agencies.
19.	Perhaps via Church groups, W.R.I., Information in local stores. People who can help being

more visible i.e. stalls in local supermarkets i.e. Fire Brigade, Police, Care & Repair etc. Building trust, being reliable.
20. No comment.
21. Ensure that the correct services are in place to meet the specific needs of the person.
22. -
23. If respect, openness and honesty amongst service providers is clearly evident to the public in the delivery of care, this will have a positive impact for good. When people feel that they are of worth and not a nuisance, respect will blossom.
24. Respect has to be given by everyone. Also positive regard. Empower people to maintain own lives.
25. Provide information on resources available to them - advice line. Develop a 'help a neighbour' scheme! Develop volunteer groups to monitor community and provide support to those most in need.
26. Educate, communicate, get information out to people. Report any concerns
27. The community being aware of who they could contact if they suspected a problem. Drop in centres, public awareness sessions for clubs, etc.
28. More information sharing of what is available and services offered. Working Groups in locality areas to work with communities.
29. Work is already being developed within Accommodation (older people) services and schools to bring the 'old' and the 'young' together. This has been a huge success.
30. Respect for others, looking after your own safety and wellbeing and that of others are aspects of life which should be engendered in the home and in the Education system. In the work day situation, perhaps employers, foremen and others with responsibility should be encouraged to look after the workforce and everyone make every effort to contribute to a happy and caring community.
31. Communication and proper assessment.
32. The NHS and Angus Council need to engage with our communities, particularly in our least affluent areas, in a very different way from what is currently the norm, by co-producing all service planning and delivery wherever possible. This needs to be followed by action genuinely reflecting the needs of those communities.
33. Not sure about this - is it the health care communities or in general?? Possibly promoting volunteering to school kids. Having community events open and accessible to all.
34. All of the above. Communication +++ . Know what's available, especially more obscure services and pathways.
35. I don't know!
36. Promote improved community spirit. Encourage attendance at locally based events. Provide data for service users in a range of formats. Ensure all communities of interest are included.
37. This smacks of social engineering and also an idea that if resourced will shift even more resources from front line health and social care services to development officer type posts, of which there are far too many already. We get ludicrous situations where people cannot get their ulcerated legs treated properly whilst advice workers are harping on about the

danger of too many "Big Macs".

**"further support communities to respect each other"** superficially sounds good. However it is really a meaningless phrase which 99% of Angus residents would have no understanding of. I have just done a straw poll of people in my office, all qualifies staff. None knew what this phrase meant. If consultations are to be serious the use of plain English is essential. Who says communities do not "respect each other"? Which "communities" are you referring to? Some efforts again via GP practices - a natural hub for many people – has scope. There are already community councils, these can be used. The idea of supporting prevention in the community can be best supported by freeing up care managers and social workers to utilise local services and businesses to support vulnerable people in the community.

Allowing people to **"maintain their own safety and wellbeing"** sounds like an attempt to opt out of providing services. Generally people do support each other in Angus, especially so in rural areas. The problem is people are too slow to come forward to get the services they have a right to. The one really major thing that would do most to prevent people needing admissions and seeking services etc would be to protect and even enhance the roll of the Welfare Rights Service. The links between poverty and sickness/ill health/misery/depression etc is long since demonstrated. Making quite sure that everyone entitled to benefits gets them is the one single thing that would achieve most in this regard. The embracing of the welfare rights team and proper funding of it is the crucial test of the commitment of the new Integration Authority to keeping people as safe and well as they can.

38. Communication, information in whatever form - leaflets - events, encouraging people to be good neighbours. Taking responsibility for ourselves in our communities and neighbourhoods. Engaging through Council, Community Safety Groups, the Third Sector?

39. Community support groups have to make themselves more available in communities. Not everyone knows what help they can get. More funding.

40. Work as a team.

41. They need more social care in our community.

42. Communities need to be encouraged to come together, to look out for each other. Again awareness, education etc.

43. Education specific to the area.

44. Having a safe community helps, good neighbourly actions.

45. Education and preventable measures.

46. Communication - I feel that a person feels more able to live independently if they have sufficient support/contact to assist at times of need.

47. Community events/gatherings/workshops/information drop-in sessions

48. Good inter-disciplinary working setting a good example of the type of relationships we wish to foster throughout our interaction with the public. Need to ensure those who are frail or with dementia are seen to be valued. Increasing role of volunteers. Need to clamp down quickly on the rogue callers in Monifieth by good liaison with the police.

49. Promoting enablement within their own homes Promoting independence, adaptations.

50. Education and clarity about what is available.

51. There is no respect any more. It used to be if you were old you were valued. Now you are a bed blocker. How respectful is it to discharge a 95 year old at 2am ??? I am so angry that people are treated like this in this day and age and I dread old age myself now. Have planned my own way out when the time comes rather than be treated like that.

52.	Challenge when people behave inappropriately or don't respect their surroundings. Clear discussion what you can do to help and what we can offer. Mutually respectful partnerships.
53.	Education/training.
54.	Community team of multi disciplinary workers.
55.	-
56.	Not sure.
57.	Make more places to cross the roads safely and cut the speed at which everyone seems to drive around, specially the young ones. It is very hard to go out without a car passing by at all speed, even in small towns and villages.
58.	Information, advice, access to interventions such as classes for coping with long term health conditions.
59.	Being neighbourly. Tackle quickly those that scam the vulnerable. Call blocking from unknown phone numbers.
60.	Work with communities to develop capacity and understanding.
61.	Maintain a community spirit. Keeping services local.
62.	Cultural shift which should come to some degree via all above.
63.	The promotion of community cafes etc i.e. the old community centres that offer things that community members would be interested in - this would be a first step to creating communities rather than just people living in the same area. Respect is built in relationships. Support and facilitate people feeling part of something.
64.	Information needs to be available about all local services. Mapping currently underway by VAA. More generic instead of specific OTs and Physios.
65.	-
66.	This makes no sense at all. I am intrigued by the word 'further' in this sentence – it is as though you agree with anarcho-socialist Noam Chomsky on matters relating to 'necessary illusions' and 'manufacturing consent'. We have enough government to dodge without the implementation of the thought police as well. You can have community without unity – trade is mutually beneficial – I want your money you want my goods (and the less prejudice the more customers I access and value I accrue) otherwise my time is wasted and my time is the most valuable thing to me (see Bertrand Russell (in praise of idleness)).
67.	I don't particularly understand the meaning of this. There will always be an element of disrespect and danger in our communities, perhaps earlier engagement with school aged children? Introduce into the curriculum something which ensures pupils engage and understand that people can be different for a variety of reasons (mental health/cultural reasons, etc)
68.	Not sure.
69.	Don't understand the question.
70.	Infrastructure designed to encourage activity and independence. Support networks to promote socialisation throughout the community and reduce isolation.

71. Education. Regain/ build neighbourliness.
72. No idea.
73. Encouraging community connections. Building community capacity. Having ways that different groups in the community know about each other and each others needs and can help each other out. Having schemes like they do in Dundee such as the scheme where you bank your time and services free e.g. doing someone's laundry - you get points for how much you do and can then spend it on a service you want like a few hours gardening from some one else in the scheme.
74. Many people feel and are isolated within their own communities. Work should be done to reduce loneliness, eg building complexes specifically for older people to allow them to live independently while living safely.
75. Support communities to understand each other, embrace differences, become aware of how much they can contribute. Not sure I really understand the question. are we talking about different communities working to support each other...or what happens within a community?
76. I liaise with a lot of community agencies, I think this is a positive thing. Events like the Recovery event, but maybe more community and less health type events? Maybe Callum Whitelaw's role will help with this? I would like to organise an art event at some point, but getting the time is the issue. Anything that helps to de-stigmatise mental health.
77. Visible community policing, local accessible services.
78. Not sure what this is asking?
79. -
80. Ensuring the fabric of the towns are well maintained eg: roads, pavements, litter removed and roads are safe by enforcing no parking on double yellow lines. If the local areas are well maintained this has a knock-on effect on people's morale.
81. There needs to be further work to address the stigma associated with some groups e.g. alcohol and drug services users. Person centred care where the person is supported to take control of their own recovery.
82. -
83. -
84. More initiatives to help people engage with all members of their community, making them feel part of something. Involving them in consultations and making them feel proud of where they live.
85. Appropriate equipment and aids need to be available to people with PMLD to ensure that they maintain maximum safety and wellbeing within their local communities. Also appropriate physical and intellectual access to their community will enable them to fully participate in a meaningful and fulfilling way.
86. People need to take responsibility for their own health and wellbeing as much as possible and provide care to family friends and neighbours as they can.
87. More education of local communities, more raising awareness of the community as a whole and why people should respect and care for each other.
88. Identify the communities who need the help to give respect to each other respect to each other and maintain their safety and well-being. Once identified use the services necessary



to provide the information and support.
89. More community groups to be encouraged. Neighbours to be more involved with each other.
90. ???????????
91. Trust, group support, recognised support.
92. Break down illness barriers, like stigma of dementia, educate children at schools, go and deliver education at sports clubs etc.
93. You need to try and get people together like meeting rooms, tea rooms. If you get people out of their homes they will make friends and start watching out for one another. A lot of people just sit in their homes and never see anyone.
94. Educating communities.
95. Talk to each other and respect what they do.
96. Continue community alarm systems. Maintain communication links. Report changes to appropriate individuals with health and safety in the home responsibility. Information should be accurate, updated and shared with all health and social care contacts.
97. Everyone treated equitably and have equal access to facilities and activities.
98. More local communications and let's bring back the good neighbour who was once there at every occasion, promote wellbeing in the communities, bring services to the people, not people to the services. Most villages have an underused hall, why not have monthly poly clinics there involving local pharmacists, healthcare and social work to allow the local community to ask questions, get help about conditions, alcohol and drug abuse and stopping smoking or Diabetes checks. This could be run with a social cafe and cooking demonstrations etc!

**Q6. Supporting carers to have a life outside caring and enable their health and wellbeing to be improved.**

**(a) What needs to happen to ensure that carers are supported in their role as a carer?**

1.	Need carers assessment. Need support to do the job. Need some time to themselves - respite. Some form of sitter service to look after the one they care for. Need emotional and financial support.
2.	G.P.s to offer health checks and have lots of information for them to access.
3.	Clear information re support and how to access. Listen. Time away hard if only 1 carer/cared for person.
4.	Is it possible to contact carers of the person they are caring for requires doctor/hospital help, and someone from social services contacts them to find out if they need help/advice/respite, or just someone to talk to, but difficult if carer does not want outside intervention.
5.	Funding of carer support initiatives and organisations, and initiatives to inform those who are developing a carer role, funding of supplementary care and respite in a range of forms.
6.	Carers assessment. Adequate and robust service provision. Adequate equipment to manage daily life skills better. Good maintenance in service provision. Appropriate care packages. Angus Carers support. Time spent listening and recognising the caring role.
7.	Carers centre is doing a good job. Social Care, under SDS, are appreciating carers more. Valuing carers - better benefits, financial support.
8.	More Daycare service. Respite care to allow carers to recover. Help with expenses for family and friends who help.
9.	Respite care to give carers a break. Accessible medical advice, maybe phonenumber, so that if carers stressed, can talk through with professional and trained person similar to Samaritans.
10.	They don't suffer financial hardship. If needed they can get help when they ask for it.
11.	Carers save health & social care services an immense amount of money. The current payment is a pittance. carers need regular free time and a realistic remuneration for personal loss of income.
12.	Support - needs to be known support - not just random - trust issues.
13.	Care workers need adequate time off to refresh their energy and emotional balance. So relief person is needed and briefed.
14.	Someone to talk to and get advice from. Respite care regularly. Someone to come in and sit with family member so they can go out.
15.	Respite for carers on a regular basis. Support groups.
16.	Support from medical and social care staff. Keep them informed. Include them in the setting up of personal plans and care packages. Flexibility.
17.	Contact with carer organisations and information available to read re what support is out

there.
18. Respite care. Support from all relevant people etc. Information from relevant sources.
19. Ensure workers advise of Angus carers - Charities who can provide support, both pastoral and practical. Regular meetings with Care Managers and other family members. Adequate respite for carers.
20. Accurate, timely information on Carers SDS entitlements. Regular visits by Social Work staff for reviews (start enforcing the 'annual review' rule). Automatic regular check-ups by G.P. for depression and any long term conditions caused by caring (muscular problems etc.) Quick, timely and positive support from O.T. to provide aids in the home to reduce physical difficulties as carers grow older.
21. Ensure that the carers are given correct information regarding health and wellbeing. Also that they know how to make use of day care facilities and also respite.
22. -
23. Regular contact with the carers by the service providers to let them know they are not forgotten. Provision included for times away from their caring role.
24. Positive regard and respect from their managers. Managers to undertake further training on managing people.
25. Provide information re resources available e.g. groups/advice lines/reduced rates for classes/gyms etc.
26. Time out. People to talk to. Fun time. Not to feel they are alone. Information on help available. Find new interests and hobbies just for them.
27. Given the appropriate help they need, have access to support networks, befrienders, someone to let them go shopping etc., volunteers, daycare centres.
28. Again awareness of services available to them. Drop in centres, one to one consultations. Link groups. Media information sharing/publications.
29. Make day care services more accessible. More places and also more respite bed availability. Care at home type service. A carer finds it almost impossible to attend any carer support groups if they don't have access to a respite service or carer.
30. Angus Carers Centre already contributes in this problem area and, from all reports, are doing a very good job. It's integration into Social Care??
31. Communication and proper assessment of carers' needs.
32. Better identification of those in a caring role. Wider dissemination of information about existing support and creation of new ways of working which are co-designed with carers.
33. Ensuring they identify themselves as carers so can access the support if they wish it. Can be difficult for people to see themselves as carers. That they are listened to and their knowledge and views are respected by health and social professionals.
34. Their needs must be met and discussed early so they are understood. They should have appropriate information on prognosis etc. and what services they can use.
35. Respite provision should be more available and be cheaper. Those needing the respite (the carers) are often the poorest in the town because they are unable to work and the work they do is unpaid.

36. Carers are encouraged to self identify. There are respite options widely available. The support available can be flexible. There is opportunity for carers to meet with others in similar circumstances.
37. Ensure Carers assessments are undertaken. Ensure carers are always offered a welfare rights benefits check/income maximization check by the welfare rights team in Angus.
38. Regular health checks offered when the cared for person is having theirs? Carers Groups to offer support and activities to encourage the carer to have a break. Befriending schemes to care for the person while carer gets a break.
39. Regular supporting checks on how they are coping and more respite if required.
40. Giving them plenty of support.
41. Have time off and more funds.
42. Support for carers, respite, more information. Carers recognised as needing support too.
43. Helplines. Code of Conduct. Training.
44. Information about Carers support groups. Having someone to listen. Getting a break sometimes.
45. Easy referral routes. Flexible services given circumstance. Advice and information being readily available to support carers. Peer support beneficial also.
46. Recognise and support the needs of carers - communication and advertisement of groups and support that can be given.
47. Community care groups, supported help to allow life outside caring.
48. Continue role of Angus carers, they are fantastic. John Gibbs work in post-diagnostic services for those with dementia is invaluable, he is only one man - we need this type of work for everyone and for it to continue past 1 year.
49. Carer needs assessment. Opportunity to meet with others in a similar situation.
50. Carers should be consulted as well as the client, often they may have different opinions about what is needed.
51. Provide respite care or even someone to take on the burden for a few hours so they can get away to reduce stress.
52. All staff need to make it part of normal practice to identify, listen, guide and support carers to have a life- what are their goals? More attractive and flexible respite options. Clear communication between teams.
53. Services available to give carers 'time out'.
54. More SCOs.
55. Carers services continue to develop their role and raise awareness of what is available to help them. Make sure that once a carer is identified that they are not just left to 'get on with it'.
56. Use and access to respite. Carer support training to include the importance of own role maintenance and activities important to the carer - literature emphasises how caring impacts negatively on self esteem etc.

57.	Some carers can't go away on holidays because there is no one who can check that their old parents or relatives are ok when they are away.
58.	Respite needs to be made possible more frequently at home or in a day setting.
59.	Let them be aware of what is available support wise, spend time with them ensuring they are ok as well as person they are caring for.
60.	That depends upon the individual carer and how they see themselves and their caring role.
61.	Funding of respite care or respite carers.
62.	Carer support, eg Angus carers, respite, information and empowerment to allow them to improve caring skills and know who to contact if necessary.
63.	An actual understanding of the pressures on carers. Empathy with their situation. Respite. Support to engage with "Angus carers" and respite to allow them to do this.
64.	Additional respite support to ensure they stay happy and healthy. Earlier intervention and support for people living with dementia and their carers to stop it becoming a crisis.
65.	More respite options.
66.	I think supporting carers is an excellent idea! Charitable monies would one day see them right, if you are to invest then I think that a similar approach to Steiner's schools could be drawn up – ie that the same care provider is given throughout the experience / touching base for the social benefit and elimination of confusion of both the carer and the cared for. I think that appeasing the financial trouble of carers would be the best bet – maintain the welfare rights service would allow them to have access to expert advice on access to funding for carers – for which there is a lot. Princess Royal Victoria Trust et al. each person has their own difficulty / specific requirement I would support a malleable funding plan in approaching this area. My close friend is a full time dad / carer of 2 severely disabled children (autism & PKU) and he is absolutely exhausted whenever we talk – his experience with the care services has been that they are only interested in his financial situation / costings and whether he is outright capable – redress the balance here, don't be so antagonistic – these people save you such a massive amount of money when otherwise infrastructure & facilities (or euthanasia) would be required. He needs a holiday; it's a 24/7 job and no break – access to respite would really enhance his life (whether he takes it is up to him – an autistic child would probably not cope well with abandonment) – even an hour here and there could really help.
67.	There are a lot of unidentified Carers in our community. So who is best placed to identify such people, I would say GP's/Nurses/Support Staff. These professionals are best placed to ask Carers if THEY need support, if so then actively make referrals to appropriate agencies such as the Carers Centre, etc, etc.
68.	If services were increased carers might have more free time, or if respite care was available this would give carers a break.
69.	Where do you even begin with this? Carer centres and agencies are good in so far as they do well to support non working carers. Many of us can't get the time off work to look after ourselves and can't afford to give up work to care for someone. Better financial support for full time carers would help some people be able to make that difficult decision to go from employment to full time caring.
70.	Carers need to be identified and given information. More awareness of how it feels to be a carer.
71.	Increase carer's support, more funding, more resources.

72.	Family carers should be paid to care. And should receive regular, planned respite.
73.	Again - it is knowing what help is out there, where they can go to get it when they need it and raising the local community's awareness of local carers needs so they can help and support.
74.	Carers need to feel valued; they may have their own health issues which can go ignored as the cared for person takes precedence. Giving carers an open door to services and allowing them to communicate with medical professionals on an equal footing would improve their well being and outcomes for them.
75.	Carers are respected and valued. Offered support and opportunities to recharge. Encouraged to design and develop the services around them...to be at the centre of that.
76.	I think Angus Carers Centre and Charlene Kenny do very good work in this area.
77.	Carer welfare.
78.	As above re more accessible and better respite services. More support groups and opportunities for carers to support each other.
79.	That they are provided with respite regularly and referred to other agencies that can offer them support, in other words there should not be a waiting list for carer assessment, this includes speedy financial assessment.
80.	Ensure Angus Carers Centre receives sufficient finance to maintain existing services and extend into areas in Angus which ACC cannot yet comprehensively cover.
81.	Support networks and services are developed such as Angus carers.
82.	-
83.	-
84.	They need to be identified for a start. They should have easy access to regular, reliable short term respite like the Short Breaks service that was cut last year. They also need to be able to get together with other carers to get support from people that can understand the stresses of their caring role. Social events that involve both carers and the person they care for are also very beneficial to their wellbeing. Mainly carers need regular breaks from their role to enable them to have some me-time, and relax without worrying about the person they care for.
85.	Appropriate assessment and support will enable carers to continue to care for their son or daughter. Also, the time taken to complete the assessment process is a crucial factor in both supporting the carers and preventing crisis.
86.	Acknowledgement of the vast amount of care they provide and help and support like respite and financial assistance so they are not living in poverty whilst saving the taxpayer a fortune by looking after their own.
87.	Give them back the short breaks service which allows them more freedom and time or themselves - don't keep giving then taking away - build a core support group for them to call upon at short notice.
88.	Firstly identify all people who are carers with the community. Encourage these carers to register themselves as carers. Provide them with the information to make them aware of what is available to them.
89.	All services need to be in place and any problems need addressed immediately. Carers need a specific person they can contact in an emergency.

90. Regular respite breaks, money advice, access to support groups.
91. Financial, respite support, feeling valued as a Carer, health/ well being of carers.
92. Use a system where a person can have a break from the person they are caring for, it can be a day or a week's holiday, again day care and care homes could help with this.
93. They need some training and info on what to look out for and situation that could happen and how to handle them. I know you don't know it all. Its a shock to the system when you become a carer.
94. Separate services dedicated to carers.
95. Tell them from the beginning of what is available to help ease the stress they will be under, don't wait for them to call and back up the information with a well developed set up.
96. Ensure that they know how to contact someone if the need to. Continue to keep them informed via Website, newsletters. Encourage meeting/outings with other carers. Support and value them as they save costly resources time and money.
97. Active log of carers, more ready available information.
98. Good carers support from all sectors, specific support from organisations, the ability to ask questions about the person they care for without all the red tape around. Gaining access to medical information or the expense of being power of attorney. The carer has to be involved in all parts of the care planning as they will be the vital link to the persons wellbeing at home and also the contact person etc.

**(b) What needs to happen to improve the health and wellbeing of carers and ensure they have a life outside of their caring role?**

1.	Regular support for carer and one being cared for. May need information about carers' support groups. Need regular support, probably on a daily basis, not just once a week.
2.	Offer support and group activities and respite for carers.
3.	Sharing information. Quick, clear access to support - who, what, when, how. One stop shop.
4.	A break, maybe twice a week for an hour, with help from social services, again with financial constraints. Where will funding come from for implementations to be carried out.
5.	As above, plus a recognition of the need to develop partnerships over the long term to cope with ongoing changes in circumstance and need.
6.	As above. Respite as required. Peer support and service support.
7.	Real services to give carers a break - external market in SDS needs to improve.
8.	As above + more money.
9.	That they are not left to own devices. Maybe computerised information of carers with visits from professionals on fortnightly basis to discuss any problems.
10.	They can have respite if needed. Someone to turn to if it is getting on top of them (to talk to).
11.	Initial assessment of physical, mental, emotional state, independent support, care plan to clarify time off, crisis plan if carer is ill. Knowledge/understanding of how condition/s affect person they are caring for.
12.	They need to know what support is available and that they can trust the support.
13.	As above - time off to live their own lives and come to work refreshed.
14.	Take care of themselves. Support.
15.	Support given to carers from NHS and social care staff to set up a care package that leaves them with time to themselves on a regular basis.
16.	Support carers by giving them time off similar to Short Break service. Giving them access to respite beds on a regular basis. Good communication/information about support groups.
17.	Breaks for carers and more professional support for carers.
18.	Support from relevant agencies.
19.	Let them know how valued they are - too much emphasis is put on the person they care for and not enough on the carer until 'burnout' is reached. Crisis ensues and everyone is the worse for it.
20.	Fast response to assessment, and payment, of Carers' SDS. Minimise paperwork. PROVIDE OUT-OF-HOME RESIDENTIAL RESPITE CARE TO ALLOW CARERS TO RELAX AND LIVE - FOR A WHILE AT LEAST - LIKE NORMAL PEOPLE. Establish and implement transparent and fair method of calculating respite care for all carers. Abandon the farce of calling attendance at a Resource Centre 'respite' - it isn't.



21.	Giving the carer the correct support and also ensuring that they are given rest periods.
22.	-
23.	Provision included in their package of support for times away from their caring role.
24.	Listen to them and get help that is required. Carers, short breaks, befrienders etc. Many are at breaking point and there are no services for them.
25.	As above.
26.	They need relaxation time. Fun, chat and time to be themselves. They need help and support. Spa weekend.
27.	As above. If the carer has some time out, they are more likely to cope with their situation better. If they have the necessary structure and support networks in place.
28.	Services available to offer time to regenerate and 'make time for me'. Awareness of support available.
29.	Make day care services more accessible. More places and also more respite bed availability. Care at home type service. A carer finds it almost impossible to attend any carer support groups if they don't have access to a respite service or carer.
30.	Again, the existence of Angus Carers Centre is widely known and that Centre takes into consideration the lives of carers outside of their caring role.
31.	SUPPORT.
32.	Access to good nutrition and sufficient physical activity including good access to free facilities, access to good sexual health services and support, access to smoking prevention and cessation, substance misuse support and pharmaceutical support, opportunities for improved oral health, and prevention of obesity, access to mental health and well-being support and health protection services, and all support targeted at our least affluent communities.
33.	Responsive flexible service which is tailored to their needs at that particular time.
34.	Regular review of carers' needs as things change. Establish supportive network within the community for them.
35.	Their needs must be listened to and somehow supported.
36.	Employment opportunities or volunteering is an option. They can plan time with their friends or family whilst knowing their 'cared for person' is being appropriately cared for. They can have time to do nothing (if they wish) or attend appointments for themselves etc.
37.	Ensure Carers assessments are undertaken. Ensure carers are always offered a welfare rights benefits check/income maximization check by the welfare rights team in Angus. Ensure home care/respite care and daycare are available. Develop (respite) fostering scheme for vulnerable/dependent people.
38.	Giving as much information as possible to carers on maintaining health and wellbeing and the choices available on life outside their caring role.
39.	Regular supporting checks on how they are coping and more respite if required.
40.	-

41. Have a good social life.
42. -
43. Support from management. Regular catch-ups.
44. Improved health of the person they are caring for.
45. Respite and short breaks accessible to carers. Person centred support for carers and information on what they are dealing with.
46. Take some of the strain of caring for a relative via communication and a support worker that can be contacted as and when required.
47. Information made available to give awareness of support for carers, mechanism to bring like minded people doing the carer role together.
48. Continue work already going in this area. Need to think about adults living with ageing patients needing respite. Carers coming into home often more acceptable and may even be cheaper than having specialised units. Need to be very good and accredited if going into folks homes, I think 7 arches staff could have a role in supporting training for this.
49. There may be a need to combine work or education, hobbies and caring, therefore services such as day-care, short breaks at home, or a befriending service may help.
50. Increase in services, should they need to have a break.
51. There is no possibility of a life outside their caring role - it engulfs you 24/7.
52. Community hubs for caring, short breaks, valued in their role, payment for their role.
53. Carer's health checks and keeping them informed of options available.
54. Better support from social services.
55. Funding to allow appropriate respite.
56. Use and access to respite. Carer support training to include the importance of own role maintenance and activities important to the carer - literature emphasises how caring impacts negatively on self esteem etc.
57. I don't know.
58. Carer groups perhaps online or telephone support to provide peer support if this would be accepted by carers who often feel isolated and do not define themselves as carers as they look after a partner or similar.
59. Let them be aware of what is available support wise, spend time with them ensuring they are ok as well as person they are caring for.
60. That depends upon the individual carer and how they see themselves and their caring role.
61. More support.
62. Plenty staff/
63. As above + provide a "back-up" so that all of the responsibility does not fall onto one or two people. Value their contribution in the same way that paid staff are valued.
64. Additional respite support to ensure they stay happy and healthy. Earlier intervention and

	support for people living with dementia and their carers to stop it becoming a crisis.
65.	-
66.	Again economic freedom – if private centres were able to compete standards could be such that parents of disabled people and carers could leave their loved ones in the hands of another person. See above. But there isn't any quality due to the lack of choice and so they don't have a competent service. I would strongly advise approaching carers for the answer to this - otherwise how can you know if you even have a role to play.
67.	The Carer first of all must have the desire to receive help, some are actually content with their role. So as above, identify the ones who wish support, make sure they are given a comprehensive review. There is opportunities for the third sector to expand in this field, social enterprises can be expanded/created. Find out what interests the carer has? eg if its Golf then organise a golf day for Carers while the person they are caring for is looked after. I'm sure this could be done cheaply as golf clubs would benefit from some free publicity on the back of donating a few rounds of golf.
68.	If services were increased carers might have more free time, or if respite care was available this would give carers a break.
69.	Get real, carers don't have a life outside the caring role because the government does not want to fund enough care and care homes are inadequate in acceptable standards of care that carers expect.
70.	Ensuring their needs are identified and addressed.
71.	Increase access to respite, educate that this is a need to provide care not a luxury to the carer.
72.	Family carers should be paid to care. And should receive regular, planned respite.
73.	A much greater range of flexible short breaks and respite and easier access to this - less bureaucratic ways of accessing that.
74.	Providing good quality respite care is imperative; this would allow carers time to themselves and the extended family.
75.	Create significant capacity to offer choices and options for carers to lead a fulfilling life outwith their role.
76.	Possibly more promotion of the above organisations? Clinicians being willing to liaise with carers, with permission, if possible?
77.	Respite.
78.	As above re respite care.
79.	Appropriate and timely referrals to others.
80.	As above. Ensure that all carers are eligible for respite care at least once a year if needed. Presently there is no respite care provision for carers of young adults with mental/physical or combination of both in Angus.
81.	There are local low cost fitness/ sport facilities. That their health needs as a carer is prioritised by services as supporting carers has a positive health economics impact.
82.	-
83.	-

84.	Reintroduce a Short breaks service! Regular, reliable support with someone who knows the cared for person so the carer can relax and not feel guilty having a life outside their caring role. Affordable day care for people who require full time carers needs to be re-introduced to allow carers a day at home if they want to relax and spend time alone or with friends.
85.	The time taken to complete the assessment process is currently detrimental to family carers' health and wellbeing both emotionally and financially. E.G. family carers returning to work currently experienced difficulties when accessing appropriate support to enable them to return to work.
86.	Respite care and support groups - a good understanding of the impact this caring role has on the carer and their health, that no-one can manage 24 hours per day, 7 days a week and that they need support before the situation breaks down.
87.	Ensure they get continued support to allow them time to themselves and have time to develop and meet their own needs.
88.	Ensure carers are offered the appropriate respite. Provide the support needed and encourage participation in the social events that are available for them.
89.	Respite needs to be available for carers if they want it.
90.	Respite, financial support, support groups and activities for carers.
91.	Respite.
92.	As above and I can't stress how important it is to be able to get a doctors appointment when you need one, having to wait a week causes stress and no doubt ends with people being admitted to hospital.
93.	A break would be good, just a day or two, and someone to ask the question like "how are you managing?", "do you need any help or any devices to help make life easier?"
94.	Support, breaks from caring role.
95.	Tell them from the beginning of what is available to help ease the stress they will be under, don't wait for them to call and back up the information with a well developed set up.
96.	When appropriate, respite time. Outings/meetings/trips. Some carers may prefer support visit/phonecall at home as a support.
97.	Support.
98.	Respite care needs to be offered, a good care plan in place for the person being cared for, the availability of local services to support them and an understanding that communication is the key issue and the dissemination of good information is essential as most people are unaware of what's available to them, as are most of the staff involved in care!

**Q7. Any other comments you would like to make or questions you would like to ask?**

1.	-
2.	-
3.	-
4.	I have completed the questionnaire and hope any comments will be taken into consideration along with others. As a relative of a 94 year old lady who resides in Angus with her daughter, I can see how lack of communication with outside agencies can have a detrimental effect on the elderly and those who have mobility and communication issues. They do not want to 'bother' anyone, and will put up with pain and discomfort, rather than 'be a nuisance'. I realise there is not a pot of gold, but look forward to what comes out of the consultation. Thank you.
5.	I am particularly interested in how the new partnership will put in place mechanisms to show how things have improved with regard to efficiency and effectiveness. What will be done to develop a public understanding of this new model of service and care? The structure will be no less difficult for the public to understand than the current local authority and health services.
6.	-
7.	-
8.	-
9.	I feel anyone with long term condition should be introduced to exercise of some sort to give them confidence and meet others with similar conditions, and maybe G.P.s and hospitals could incorporate into services.
10.	-
11.	Communication, consistency and diligence can make or break the best laid plans. Duplication and confusion wastes time and resources. Professionals have to break down barriers between each other and make patients priority.
12.	Funding must be tightened up and local services need to be available to all - many services are just too expensive for people to access.
13.	As a person in category under discussion, I very well understand the need for trained, <u>caring</u> carers. I looked after my mother with Parkinson's so have first hand knowledge.
14.	-
15.	-
16.	-
17.	-
18.	More staff to replace people who leave or retire. If shifts are getting split etc. there can be a danger of a service user being overlooked. Also more communication from other services for e.g. being told when people are taken into hospital or discharged.
19.	I have been a carer for my parents in excess of 60 hours a week prior to their deaths. I

<p>never asked for support then I had a collapse. I had a Community Alarm installed after that for a year until I regained my full strength and confidence. I think I used it 2-3 times but I felt safe! Due to restraints on budgets and lack of adequate service provision, carers are forgotten to a large degree - but without them - we would all sink!</p>
<p>20. How and when will we receive feedback on all the comments made in this consultation, those which have been accepted, and the action plan for implementing them.</p>
<p>21. -</p>
<p>22. -</p>
<p>23. -</p>
<p>24. I have seen/experienced the system from a personal perspective as well as professional, and find it very frustrating and disheartening to see carers struggle through lack of services and support.</p>
<p>25. -</p>
<p>26. -</p>
<p>27. I looked after my mother for 14 months in my home while working full time. I found the current system to be very flawed. I had to access most things myself due to the lack of care managers, or they started the job then left within a few months.</p>
<p>28. Better monitoring systems for older people would be a great advantage (use of smart technology to monitor the safety of people). Educating the local communities would help - particularly for people with dementia.</p>
<p>29. -</p>
<p>30. I have been a carer all of my married life - since 1958. My daughter has lived at home since birth and continues so to do. Jean has learning difficulties, impaired sight and impaired co-ordination. We are very thankful for the services of Rosehill Adult Resource Centre.</p>
<p>31. -</p>
<p>32. Integration of health and social care needs to be used as an opportunity to promote the co-production of service planning and delivery, the promotion of health and well-being, the prevention of ill health (including protection against communicable disease and environmental hazards) and the pursuit of health equity.</p>
<p>33. Just seems that when trying to prevent a crisis, if respite is mentioned there is a financial cost - doesn't seem right that person has to pay as not coping at home but doesn't need hospital. Feel there could be more step down facilities from Ninewells, sometime going straight home is too much and ping back into hospital even though has ESD in place. Could be a failed discharge, but could be just need a few more days to recover, emotionally as much as physically.</p>
<p>34. Communication from NHS to Social Work has to improve, especially the SCOs, as patients are becoming more complex so care plans change often. Workshadowing NHS might help.</p>
<p>35. -</p>
<p>36. -</p>
<p>37. -</p>

38.	I am extremely interested in health matters and I am connected to a number of health groups in Arbroath and Angus and beyond. I have been connected for a number of years to quite a number of groups. For example - member of the Care Inspectorate (Involving People Group). So I was unsure if to respond 'yes' to the question 'Responding as a professional working in an organisation that provides ..... etc. Cannot class self as a professional in these terms.
39.-	
40.	-
41.	The social care workers should have a bit more time to do their work.
42.	-
43.	-
44.	Integration sounds like a good thing.
45.	-
46.	-
47.	-
48.	The ideas are out there in the community, need to move balance of power to those working and living in localities in order to ensure that good ideas flourish, I am not sure that management mind-set is quite there yet.
49.	-
50.	I work in health, and I am also a carer for my increasingly frail mother, at the moment I am trying to get more input for her, but am finding the process slow and confusing.
51.	Please change things so that people are treated properly.
52.	-
53.	-
54.	More help for social workers who are under to much pressure with case load.
55.	-
56.	-
57.	Is there a telephone number to ring if you need help one day but not every day, if you live in Kirriemuir?
58.	-
59.	-
60.	I hope the results of this survey will help to develop a good and responsive strategic commissioning plan. I am not clear that these questions will do that.
61.	-
62.	More staff, more training, cultural shift, more investment.

63.	-
64.	-
65.	-
66.	Please learn the critical tools needed to both express and question other people efficiently. This was a very confusing and poorly composed questionnaire. Please forgive then any invalidity that you recognise since my position has resultingly been compelled by intuition.
67.	-
68.	-
69.	I am both a professional and a carer and I am exhausted despite my parent having twice daily care. It is always the crisis moments at weekends that cant be managed, they always want to punt to hospital because can't manage at home but hospital is not going to do anything clinically that can't be done at home so it is inappropriate "social" admission.
70.	-
71.	-
72.	-
73.	-
74.	I am responding as a former carer of my mother who died recently. The services she received were good most of the time, however she was let down at times which was upsetting for her and the family who were caring for her. She was fortunate enough to be able to stay at home, but this was not without difficulty with services.
75.	-
76.	I work in CMHT for 16 - 65s, so my responses will reflect this.
77.	-
78.	-
79.	-
80.	It is essential that communication within departments and between agencies is fast, honest and efficient and with the person enquiring about or needing services.
81.	-
82.	-
83.	-
84.	-
85.	-
86.	Never underestimate the effect caring has for someone on the carer and their families, while I care for the person I am not spending this time with my children, there is always a price to pay.
87.	Consult with staff at ground level - they're the experts on what works and what doesn't - not

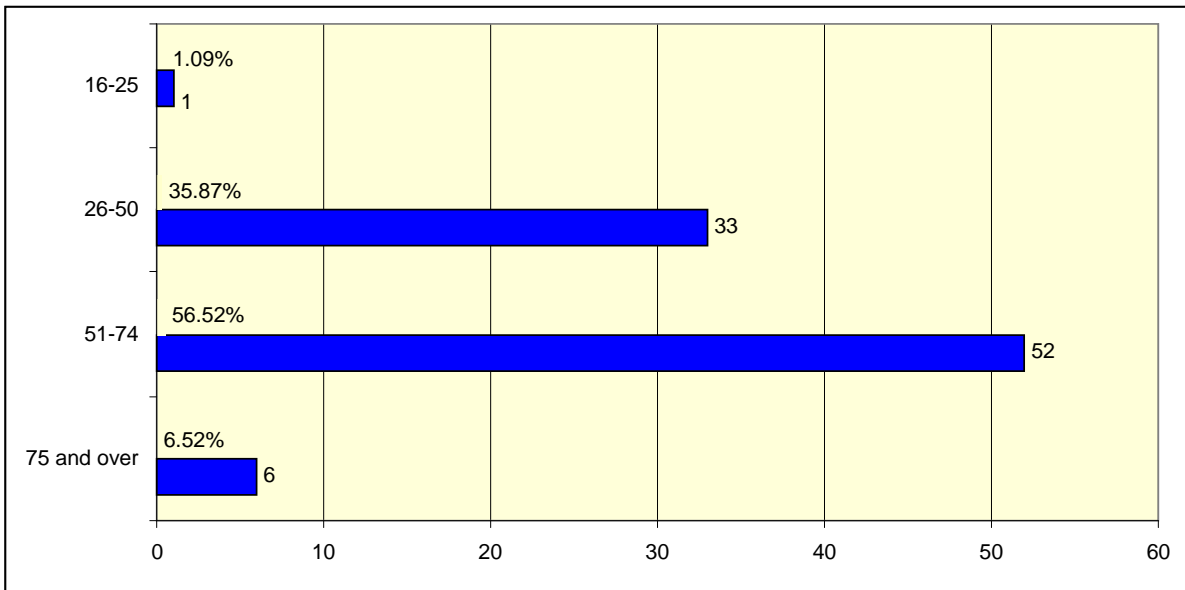


the people who hide away in think tanks.
88. Not at this time.
89. -
90. -
91. -
92. I believe more services should be run by the private sector, in my opinion they are better value for money. I have been involved with charitable organisations over the years and find councils can throw money at them because it is politically correct, and some of these charities (not all) do not deliver value for money, but talk a good game.
93. I think you should let your SCO talk to their customers and not give them a tight time scale - I don't mean like thirty minutes, just ten or so. People talk to your officers and are more open than they are to the carers or relatives.
94.
95. Answers supplied above are based on previous situations with my mother and mother-in-law over a period of 10 - 15 years where I have seen a marked difference in the system. I also have a friend who is a carer and can see her difficulties. I also have a relation in Fife who was a carer years ago and feels as I do that the system is not there at present for the ones who require it.
96. Thank you for this opportunity. This is very important to not only me, but many others in the community. Supporting and caring for others and vulnerable people is to me, the point and being of life.
97. -
98. I'm hoping this major change makes things better and there are no more arguments as to who is responsible for the patients needs and that a more robust support system for care is put in place as well as more information is made available to everyone about what is available and not just the little bits that Angus Council want people to know about to save money by not providing a service which should be available. I hope there is better planning for care and communication is far better than it is at present and a one point of contact would be brilliant and save me lots of calls to different people and departments to get information. I would also like to see the better use of local voluntary organisations utilised to their best and also funded where needed, like Angus Care and Repair who lost their council funding and are now unable to do as much as they could before to help people stay in their own homes, the council service isn't as good as it takes ages to get something done!!!! Organisations like Angus Carers are also vital to the wellbeing of both areas and the person they look after and they are a very well respected organisation, but again underfunded!!

### What is your age?

Answered: 92

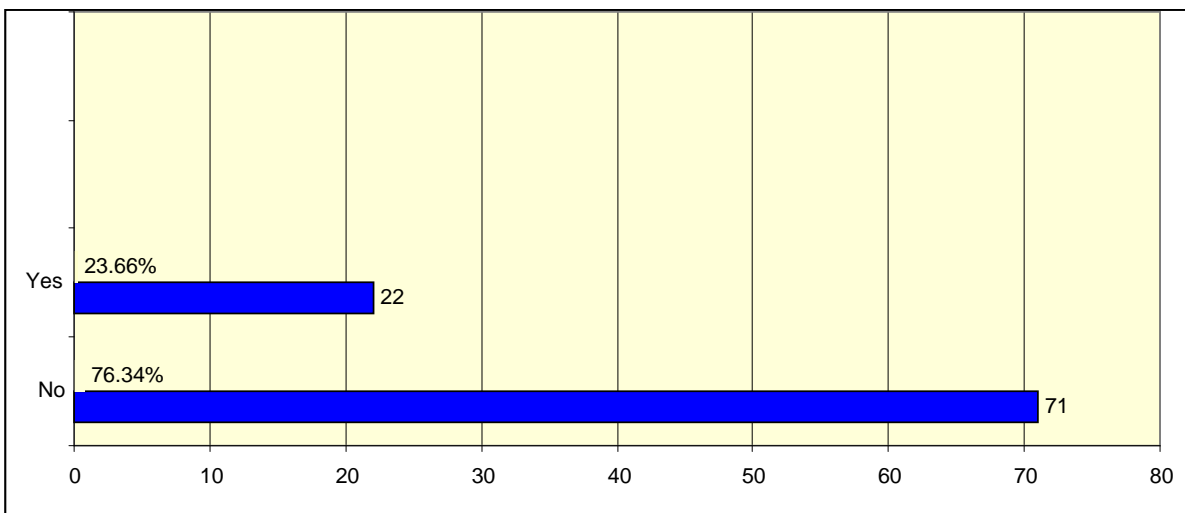
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### Do you receive health or social care services?

Answered: 93

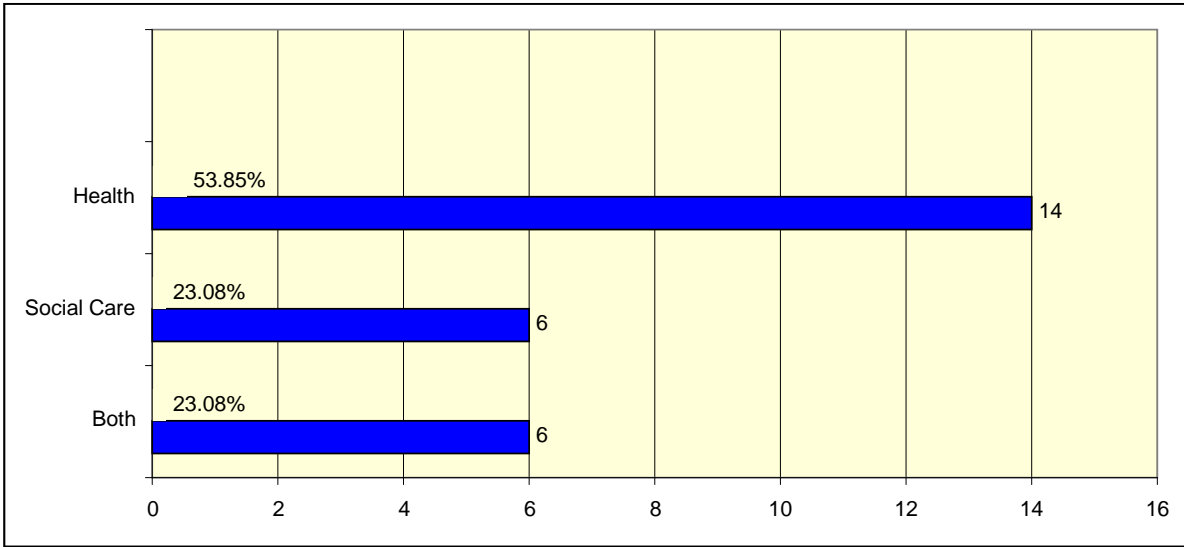
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**If so, what services?**

**Answered: 26**

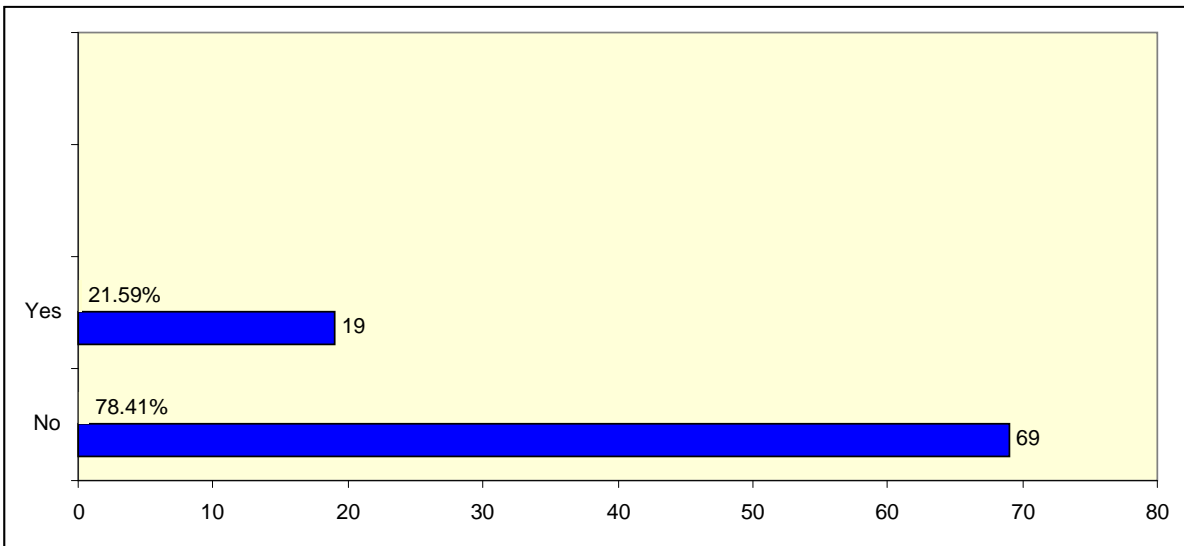
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**Do you use local community or voluntary services?**

**Answered: 88**

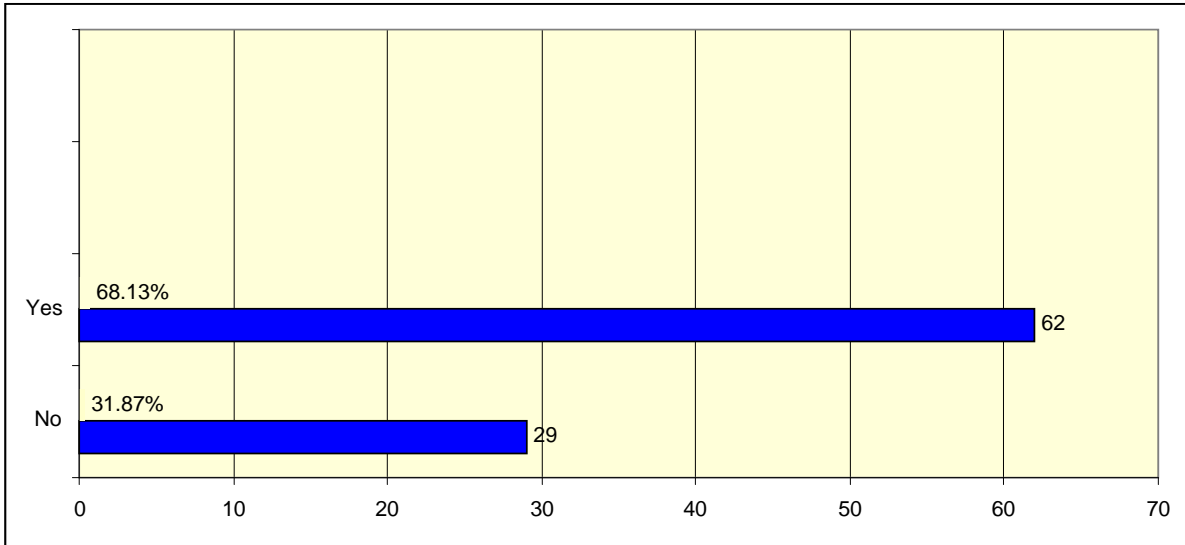
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**Are you a family member or friend of an older person?**

**Answered: 91**

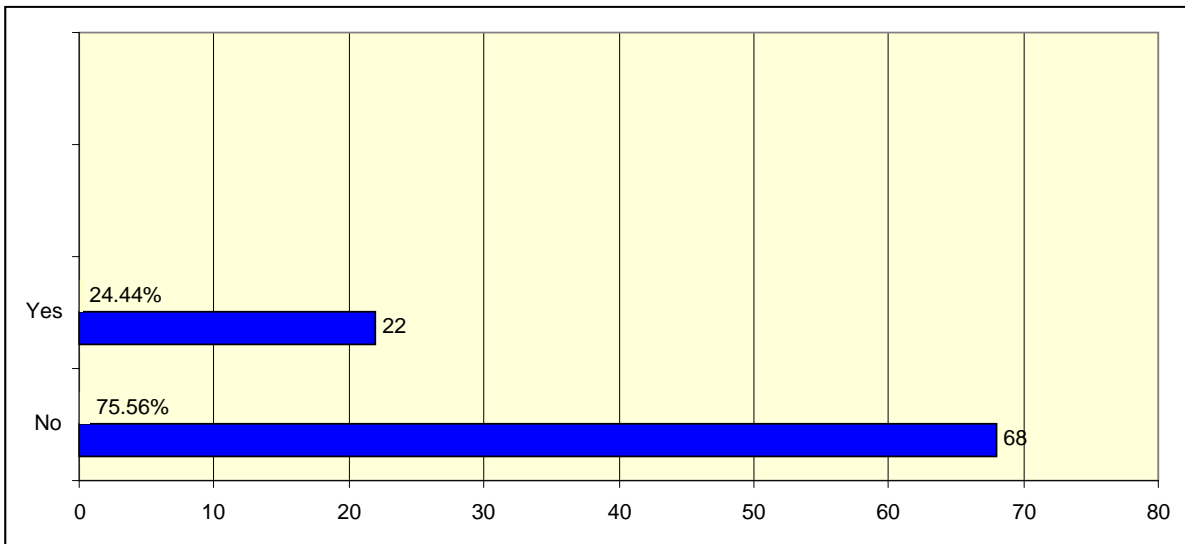
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**Are you an advocate for an older person?**

**Answered: 90**

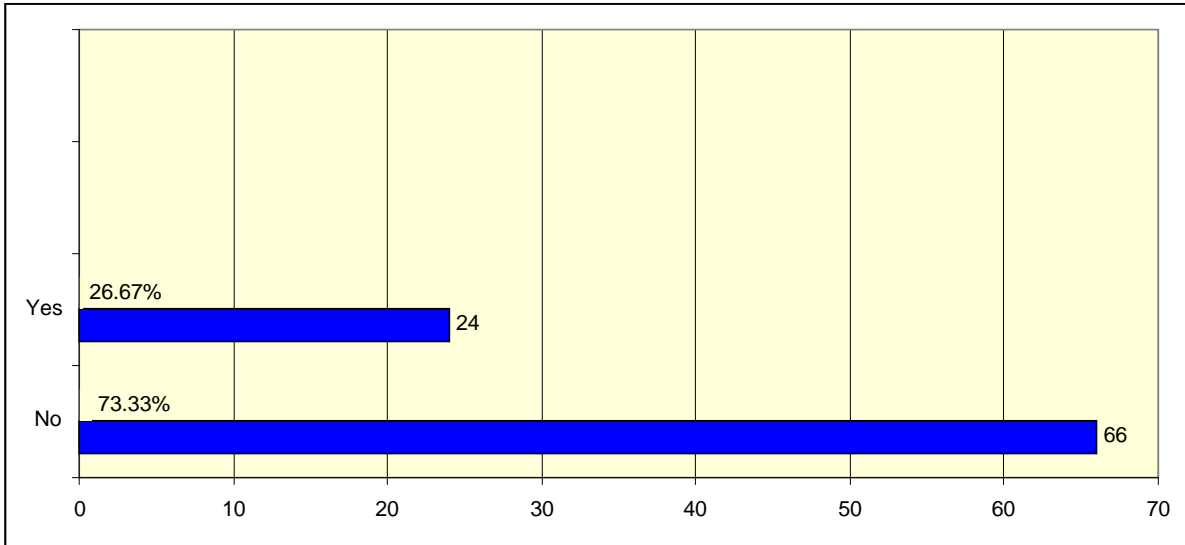
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**Are you an unpaid carer?**

**Answered: 90**

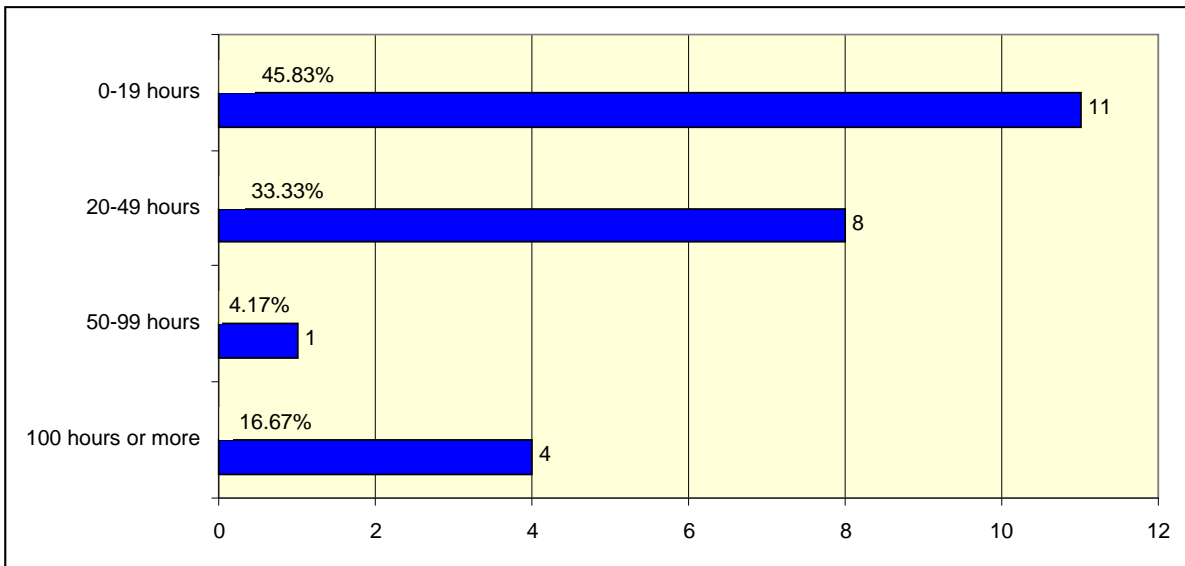
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**Please tell us how many hours a week on average you provide unpaid care.**

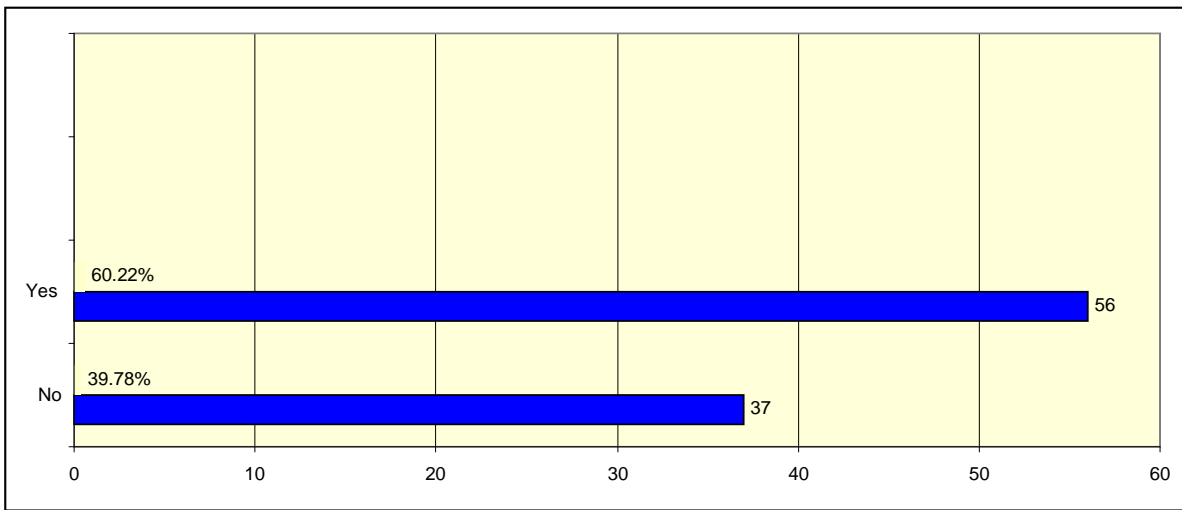
**Answered: 24**

**Skipped: 79**



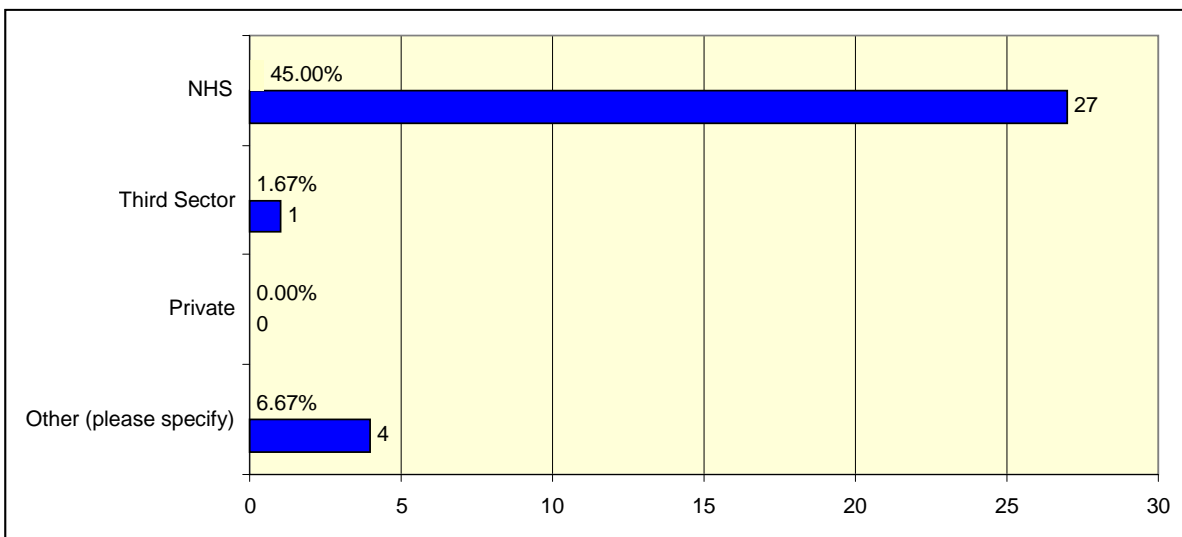
Are you responding as a professional who works in an organisation that provides social care, health or support to older people?

Answered: 93  
Skipped: 10



What type of organisation do you work for?

Answered: 60  
Skipped: 43



**Other**

G.P. Practice
Retired Pharmacist
Public participant, Angus CMRR Programme (South Angus Sub Group)
Voluntary work for Brechin Infirmary and attend local COPD seated exercise group in Stracathro