Connected Care Audit
Owton Ward
January 2006

An interim report of the Connected Care audit conducted by residents of Owton Ward

Supported by The University of Central Lancashire,

Turning Point, Hartlepool Primary Care Trust, Housing Hartlepool

Hartlepool Borough Council and the Department of Health

FORWARD

Liam Byrne
Parliamentary Under Secretary
of State for Care Services

We are embarking on a new direction for community services in this country. The White Paper "Our Health, our care, our say: a new direction for community services", published after the completion of the connected care audit demonstrates this government's determination to deliver services which are fair for all and more responsive to individual needs. Our reforms are modernising the NHS to introduce more choice and more personalised care. The next challenge is to revolutionise social care services, putting people in the driving seat. We need a radical shift to emphasise care outside hospitals and closer to people's homes. We need to focus on preventing ill health and delivering healthy communities.

Many people who use the NHS have long term conditions and complex needs. They have both health and social care needs and receive care from different agencies and services, including local authorities, GPs and hospitals. These people want services that fit around their lives. They do not want to have to fit their lives around the services they need. That is why it is essential that we integrate health and social care and get people working together across service boundaries to be more responsive to people's individual needs. We will revolutionise the way people are trained to break down the barriers between different professions. We will put people in control of their healthcare. This means better information about how to access care so that people can make more informed choices. It means putting people in control: involving people in designing and delivering local services.

All too often those people with the most need often find themselves living in areas with the poorest levels of service. Problems can be compounded by shortages of key staff, poor transport links and the difficulty of finding good enough buildings in the right places. People find it difficult to get the support they need and want help

to navigate the system. The White Paper sets out a clear direction for primary care trusts and local authorities to work together to tackle these inequalities and target our efforts on those areas with the most deep-rooted problems.

I congratulate the community of Owton, local agencies, Turning Point and the University on developing the connected care blueprint for change. Connected care is a totally new way of delivering services which are flexible enough to tackle a range of complex problems and tailored to fit individual needs. It is a bold and ambitious project, but rightly so. The people of Owton Ward have told us that they want the whole system to change. They want services which are joined up and easy to access. They told us they want better information on how to navigate the system. In the twenty first century we need to build a society where services work together to provide a web of support to hold people with complex needs, instead of forcing the person who needs help to knock at several doors to try and turn their life around.

Connected care is designed for the most deprived estates in England, where there is a high level of need for social care services. Connected care is unique in that it begins with the community it will serve. The connected care audit ensures that local communities are fully engaged in the process of developing services for their area. The services are delivered within the community and developed by the community.

The last few years have seen major improvements in the health service as we aim to provide a patient-led NHS: free for all and personal to each. The challenge now is to topple the divide between health and social care and deliver social care services which tackle complex needs and turn lives around.

INTRODUCTION

Iain Wright MP
Member of Parliament
for Hartlepool

There is a lot to be proud about in Hartlepool. Our superb new marina; the fascinating history of the area and of course its people. Yet we cannot ignore the fact that in the past this area has had its share of difficulties. The decline in heavy industry during the 70s and 80s led to high unemployment in the area which has led to many social, economic and health related problems. Although we have made real progress in the past few years, there is much more to be done to make people proud of this area again and to make sure everyone gets the support and services they need.

I was honoured to be elected as Member of Parliament for my hometown in September 2004. My job is to work together with everyone in the constituency to make Hartlepool a better place to live and for its people to have a better quality of life.

That is why it gives me great pleasure to contribute the introduction to this interim report of the connected care audit conducted by residents of Owton Ward. People living in Owton Ward are working very hard with their councillors and service representatives to change things in their neighbourhood. They have a tremendous amount of energy and enthusiasm for change. We need to listen to the views of people who live in communities like Owton Ward so that we can support them to make life better for themselves and their neighbours.

Connected care provides an excellent blueprint for change. It involves services working together to fit around people's needs instead of forcing people to try to navigate their way around a confusing system. It is designed and developed by the community and reaches out to support people in need. This audit is a very thorough and in-depth exploration of the problems facing Owton Ward and some of the solutions that people living here would like to see. The challenge now is to make sure that the good ideas in this report are turned into reality.

The Prime Minister has pledged that by 2010, no-one should be seriously disadvantaged by where they live. Britain is one of the richest nations in the world. We must strive to make sure the benefits of that prosperity are felt by everyone in this country. That is why this government is shifting resources into services delivered closer to peoples' homes. It is why we are investing in preventive health and social care to tackle the root causes of ill health. We are striving to close the health gap and targeting our efforts on the most deprived areas of the country. Together with the people who live and work in Owton Ward, we can make a real difference to people's lives and deliver the right services, in the right place, at the right time.

ACKNOWLEDGEMENTS

CONTENTS

SECTION 1

WHY DO WE NEED CONNECTED CARE?

Two case studies are presented below. These are summaries of just two interviews that took place during the audit. Each gives a 'real life' sense of how and where things can go wrong, and helps to remind us what the goals of Connected Care ought to be. Each illustrates the way in which care can sometimes be delivered in a disjointed manner and can, quite simply, fail to meet even the most basic client needs. Simple things, such as knowing where to go for help or advice and having workers whom you know you can rely on, can make all the difference. The way that an organisation operates, or the constraints that systems sometimes put in place, can mean that the client slips through the net. Connected Care is about trying to deliver services in a more effective and joined up way. It is about putting the client first: making sure that they have the information that they need about services to enable them to make informed choices; that systems are easier and more

straightforward so that clients can find their way around them, and ensuring that those who need help to do this receive it; that the right services are offered, at the right time and in the right location; and ensuring that services work together consistently and coherently so that even where needs are complex and multi-faceted, the client still gets the support and help that they require.

Sarah

'Generally service provision for my son has been very poor – he is a client of an out-patient service and is supposed to have a key worker but the key worker never turns up – he never gets to see him. The workers have changed, so you never see the same person twice.

We don't know what is on offer or what should be happening. He gets promises to take him out, but then no-one turns up. As a mother I don't know who was supposed to turn up, or where they were supposed to take him, so I can't follow it up. I don't know who to complain to.

From time to time things have been arranged for him but when he doesn't turn up once, that's it. No-one attempts to get him back into it.

He couldn't live on his own – he did once, but the house was a complete tip. He would need someone to go round and get to grips with it. He would be too vulnerable…like the two men who live over the road. They are taunted by the local kids… and the house is a tip.

Shared accommodation would be no good either – he has a history of drug use and would just end up being led back into use. If he was to live independently he would need a high level of 1:1 support.'

'If I was the key worker…what would she say to me?'

'Turn up. I want to see the same worker every time. Do what you say you are going to do. Take him out.'

Joan

'My basic care needs are not being met. I need a walk in shower which I can 'man handle' and a carer to help me to use it. I haven't had a shower for a month. I apologise for smelling. I feel awful. I feel dirty and I have itchy skin. I am sorry. I have been told that I can't have my own shower as there's one down the corridor that I can use. But that's a communal one and I don't like using it. I want my own.

I need help with cooking. I can't use a conventional oven – I'm prone to fits and might burn myself. I have a microwave, but I need help getting hot dishes out of it.

I have been told that I can't use an electric wheelchair as I may fit and might not be able to control it. So I need a carer to take me out. I would like a carer to help me to shop, to help me do the things I want to do, to help me shower.

I once paid for a private carer. I paid them £7 per hour on a Sunday to clean up. But she only turned up twice.'

David

'If she doesn't have someone to look after her, this means more work for me. I worry about her and I have to look after her. Social Services are slow. We had an assessment for direct payments 18 months ago. But we have never heard anything back. I guess we could do more to chase it up, but why should we have to?'

SECTION 2

HOW HAS THE IDEA OF CONNECTED CARE COME ABOUT AND HOW DOES ITS DEVELOPMENT SIT WITH CURRENT NATIONAL POLICY DRIVERS?

This section identifies some of the external forces and drivers that may affect the operating environment and influence the strategic options and choices in the development of Connected Care in Hartlepool.

Tackling inequality and social exclusion are a central part of this Government's public service agenda. In health and social care, this manifests itself in the form of a desire to see reductions in different access to care and health outcomes. A recent report, published by the Joseph Rowntree Foundation[1] evidenced how poverty is the determining factor within health and social care. Areas with the highest level of poor health have the lowest number of doctors and health professionals and its populations are more likely to have a limiting long-term illness. Poor people with the greatest need for healthcare, education, jobs and housing have the worst access to opportunities and services. Connected Care aims to bridge the gap between health and social care and reverse the inverse care law. The one-size fits all approach of the public services fails more deprived communities because their needs are specific and usually hidden. Connected Care's vision is for services to be bespoke around their needs and designed and delivered by the local community. Although health has improved dramatically over the last century, health inequalities have persisted and, according to the government's white paper on public health "remain a considerable challenge."[2]

In their report on mental health and social exclusion[3], the Social Exclusion Unit (SEU) picked up the importance of an understanding of complex needs. The SEU advocated that the National Institute for Mental Health in England pilot new forms of social support in deprived neighbourhoods, drawing on Turning Point/ippr's model of Connected Care Centres[4]. The Social Exclusion Unit's report, *Transitions: Young Adults with Complex Needs[5]* outlines new cross-government action to help young adults (aged 16-25) with complex needs - such as homelessness, drug misuse and mental health problems - to give disadvantaged young adults the opportunity to break out of a downward cycle of social exclusion and make a successful start to adult life. It talks about blurring the artificial age boundaries and advocates one-stop holistic services so that young adults get the help they need when they need it instead of stopping or starting services and help because they have passed a particular birthday. It cites Connected Care, stating that the pilot not only presents one possible way of addressing the complex needs of 16 to 25 year-olds but also that it offers a way of bringing together support for the wider needs of the whole community, from cradle to grave.

Choice and personalised care are also central to the

Government's health and social care agenda. In 2003, the Department of Health carried out a national consultation[6] with the public on how to create more choice and personalised care within the NHS, whilst promoting equality. It concluded that measures had to be taken to ensure choices and services genuinely reach everyone, including the most disadvantaged and marginalised groups, and above all that the NHS had to listen to what patients and the public are telling it and then act. This required a culture change to make services more responsive to people's needs, to treat people as whole persons rather than a collection of symptoms and a process of decentralisation to pass power outwards and downwards to put patients in control. Only then will the NHS deliver the best possible care to everyone. Central to this is the extension of patient information, power and choice.

On the commissioning side, increasingly, there will be opportunities for communities to have a voice and to influence the pattern of services within their locality. The Connected Care audit provides a transferable model for gathering the views of the community and letting them have real and meaningful input into the planning, design and delivery of services. Alongside the themes of choice, equity and personalisation is a commitment to expand capacity and encourage greater diversity in the range of services and support on offer, both of which are preconditions to enabling people to choose.

A common theme across health and social care is that users lack choice over how and when services are delivered, and have to fit in with service routines rather than having their individual needs met. They are denied both power and control over their own lives. **Payment by results** is intended to ensure by use of a national tariff that there is consistency across the country in the cost of care and that funding follows the patient, so that services are delivered and funded where the patient accesses them, making commissioning more responsive to people's needs and choices.

Practice based commissioning is a new process for GPs to develop an effective commissioning role, most likely through clusters of local practices, while monitoring referrals at practice level. It was announced in the recent NHS Improvement Plan (June 2004)[7]. It has two main aims. First, to involve GPs and practices more directly in the whole process of commissioning, including giving them a central role in planning what services their patients' need and deciding how these services will be provided. This will enable local agencies to deliver services that bring about better health outcomes, tackle inequalities and provide an emphasis on health prevention. Practice based commissioning will provide an opportunity for GPs to shift the emphasis from treatment and move

1 Joseph Rowntree Foundation (2005) The Relationship Between Poverty, Affluence and Area.
2 Department of Health (2004) Choosing Health: Making Healthy Choices Easier.
3 Social Exclusion Unit (2004) Mental Health and Social Exclusion. Office of the Deputy Prime Minister.
4 Rankin J, Regan S (2004) Meeting Complex Needs: The Future of Social Care. IPPR and Turning Point.
5 Social Exclusion Unit (2005) Transitions. Young Adults with Complex Needs. A Social Exclusion Unit Final Report. Office of the Deputy Prime Minister.
6 Department of Health (2003) Choice, Responsiveness and Equity in the NHS: a National Consultation.
7 Department of Health (2004) NHS Improvement Plan 2004: Putting People at the Heart of Public Service.

resources from the acute sector to improving the health and well being of the local population to construct "care packages" that reflect the needs of each patient. Secondly, it will also help to strengthen commissioning with local partners, especially social care commissioners. Practice-based commissioning provides the driver for more responsive and joined up support within Hartlepool, and the prospect of treatment that is more convenient, more appropriate, closer to home and more often provided by a member of their local team. It can also encourage primary care to extend into a wide range of services at the interface of primary and secondary care and further reduce the demand for secondary care through managing referrals and reducing unscheduled admissions.

Given the developments within primary care, more and more health care can be delivered outside of hospital. Connected Care can assist with this by enhancing the capacity of services to provide immediate engagement through a range of interventions, assessment, supported referral onward and ongoing low-level support.

The Green Paper on the future of adult social care[8] saw that there were considerable challenges not only in terms of improving the design and delivery of services but also in improving the strategic commissioning of services. Connected Care was cited as an innovative model of service delivery with the potential to bridge the gap between health and social care while ensuring at the same time that local communities are directly influencing and assisting in the redesign of services. The subsequent White Paper[9] in turn, cited Connected Care as an example of commissioning responsive services in the poorest neighbourhoods.

The Government has clearly signaled its commitment to promoting greater independence, more choice and higher quality services based on a firm understanding of the aspirations of each local community and of bringing about a sustained re-alignment of the whole health and social care system. It envisages services delivered in settings closer to home, giving people real choice in primary, health and social care services that are integrated around the needs of individuals. It sees a new direction for the 'whole system' of health and social care.

There will also be a greater focus on **joint commissioning** between healthcare and social care and better integration between healthcare, social care and other local government services. The Government will develop guidance on joint commissioning for people with complex needs and a model contract for health and social care services. The Government wants to encourage more diverse providers, with more freedom to innovate and improve services that will support a patient-focused NHS. This will include introducing more providers from the voluntary sector. Collaboration with the voluntary sector is an effective way of building community relationships, and delivering integrated health and social care. Connected Care aims to reduce the fragmentation

of service delivery experienced by individuals being sent elsewhere by removing the division between health and social care through the development of joint commissioning and funding arrangements. This should be backed up by integrated teams with a shared strategic vision, shared information protocols and single assessment and care management arrangements. Connected Care will need to bring this arrangement together locally, and also bring in a range of other services across housing, employment and transport.

Reforms to the health and social care workforce will also be a preoccupation of the Department of Health. There has been significant investment in new contracts for almost all NHS staff, and a move away from traditional occupational roles towards defined competencies is supporting greater flexibility. One of the main discussions in the Department of Health is how to create interlinked career pathways in health and social care. There is some work already under way in exploring an interlinked workforce strategy to straddle the division between health and social care. In delivering an integrated health and social care agenda, this will need to develop a health and social care interlinked qualifications framework, to enable movement between health and social care and between different provider sectors. It will have to set core competencies as well as be value based and take account of the new type of workers needed to deliver the new agenda building on existing philosophies of person-centred care and having a patient-led NHS.

There has been some discussion on a shared curriculum for practitioners in health and social care in pre- and post-qualifying education and training, with shared competences and, when appropriate, qualifications across current streams and an inter-linked career pathway that enables movement between jobs and sectors. In the Connected Care pilot, it has been argued that if we are to deliver truly responsive health and social care services, the needs of the community must determine the core competencies of the local workforce. The community should be actively and positively engaged in identifying its needs and the services to meet these.

8 Department of Health (2005) Independence, Well-being and Choice.
9 Department of Health (2006) Our Health, Our Care, Our Say: A New Direction for Community Services.

This will help to achieve healthy communities as well as healthy individuals.

In the most deprived areas, special efforts will be needed to engage service users and carers in this process. This will involve an analysis of workforce supply and demand across public, commercial and non-profit sectors, recognising that a mixed economy of social care delivery already exists, backed up by procurement approaches which value quality and the outcomes users want as well as cost factors. It will also be important to encourage new providers into the market and stimulate more flexible and innovative deployment of appropriately skilled, trained staff. Connected Care advocates that different models of engaging with the community should be piloted to determine what works and what is transferable to health and social care.

Connected Care will require a skilled and professionally coordinated workforce willing to do things differently. Staff will be skilled in working across different services and acknowledging their interface with other services by making the links between those services already accessed by the individual and other universal and specialist agencies.

The Government wants to encourage greater take up of **direct payments** in under-represented groups. In addition, there is an existing project called **'In Control'** which is developing individual packages of support for people with a learning disability. This project uses brokers to work with the individual, their family and local authority to develop an individual package of support. This may be funded through a direct payment or other mechanisms. The key is that the support is truly personalised. The Government wants to develop an evidence base for **individual budgets** through the creation of pilots with a view to introducing them for people with disabilities by 2012. The enhanced options that are made available through direct payments and individual budgets will ensure that the user's views and wishes form the basis of the assessment process enabling self-directed support and independent living, a key component of Connected Care.

The success of individualised budgets will be dependent on partnership working across the statutory and voluntary sector. Different partners will need a genuine commitment to collaboration and a willingness to explore new ways of working together. This

will involve agencies working creatively across different service boundaries and budgets. There must be a recognition that this may lead to very different forms of service provision as well as a convergence of priorities and goals between different agencies and sectors.

Direct payments for those who can take total charge of their social care needs are one solution, but the Green Paper recognises that many people with complex needs will not achieve this. They will need assistance in developing a more powerful approach to meeting their own social care needs. Connected Care could provide a collective method of assisting adults with health and social care needs gain more control over their provision.

SECTION 3

THE LOCAL CONTEXT FOR CONNECTED CARE – A COMMUNITY PROFILE OF OWTON MANOR

Owton Community Neighbourhood Action Plan[10]

The Owton Community Neighbourhood Action Plan was prepared in conjunction with the community of Owton in 2005. As well as detailing the demographic and socio-economic features of the area, the Action Plan sets out a number of ideas for improving the quality of life of the people of Owton and narrowing the gap between Owton and other areas of Hartlepool around seven key themed areas. Owton has a relatively young population (28% of residents are under 16 years old). 6757 people live in a fairly large community made up of around 2905 households. These are made up of predominantly social housing which is now largely owned by 'Housing Hartlepool' or 'Right to Buy'. Owton is ranked as being within the 5% of the most deprived neighbourhoods nationally according to the multiple indices of deprivation.

- The unemployment rate in Owton is 6.7% compared with the borough average rate of 3.9%.
- Owton is home to a high percentage of lone parents (19.6%).
- A high proportion of people not working are unable to work through disability or long-term sickness.
- 56.9% of people aged 16-34 have no qualifications, compared to the borough rate of 39% making it the worst out of all the NRF areas.
- There are very low levels of literacy within Owton. South Owton is within the worst 2% and North Owton within the worst 5% nationally for education and skills. This is despite the fact that Owton houses 2 Primary schools (Grange and Owton Manor) and the Manor College of Technology. A particular weakness cited is the transient nature of the population within the areas served by the primary schools.
- Health care is within the worst 1% nationally for health and deprivation.
- Owton mortality for all ages is 119 per 1000, compared with a borough mortality rate of 114 per 1000.
- Carers represent 11% of Owton compared with 7% for the borough, representing the highest in all the NRF areas. 10% of the population provide unpaid care.
- Owton has high rates of teenage pregnancy (97/1000 Owton, 73/1000 borough rate).
- Drug supply in Owton (3.8%) is the highest of all NRA's and compares to a borough average of 0.7%
- 8.1% of housing stock is overcrowded compared to a 5.1% borough average. Despite housing being more overcrowded in Owton than borough rates, satisfaction with landlords is high and housing conditions and local environment satisfaction has improved.

The seven key themed areas for improving the quality of life for the people of Owton are:

- Jobs & Economy
- Lifelong Learning & Skills
- Health and Care
- Community Safety
- Environment & Housing
- Culture & Leisure
- Strengthening Communities

Under each section, the NAP highlights the strengths and weaknesses of the area, which in turn could either contribute to the success of schemes or present barriers or obstacles to effective service provision. Also listed are all the projects and schemes which are being developed or undertaken by various agencies including schools, housing, community and residents associations, Sure Start, the PCT, Connexions, the Police, Neighbourhood Renewal Fund, Borough Council, sports centres, youth centres and services, the church, in order to address many of these issues.

Owton Fens Community Association Owton & Rossmere Wards Community Audit[11]

This audit was funded by the Community Empowerment Fund and carried out by Owton Fens Community Association (O.F.C.A.). The resulting report is the culmination of a series of community audits and a number of additional one off rapid response surveys. The study targeted 1 in 16 households in the area of Owton & Rossmere and covered 8 themes on which the views of a 'wide cross section of the community' were canvassed in order to demonstrate need. The 8 themes covered were similar to those in the Neighbourhood Action Plan with the addition of one on 'Residents Information':

- Housing and Environment
- Crime and Safety
- Health and Care
- Learning, Training, Education and Employment
- Culture, Leisure and Sport
- Community Facilities/Community Involvement
- Business Activity
- Residents Information

Under the theme 'Housing and Environment', there are results recorded for how satisfied people feel about many issues including street lighting, public transport, noise levels, air quality, parks, trees & plants, appearance of buildings, upkeep of property, all of which only around 20% of people were dissatisfied or very dissatisfied with. However specific problem areas of over 30+% dissatisfaction were litter, vandalism, quality of footpaths, provision for cyclists, road safety and parking.

10 Hartlepool Partnership/Hartlepool Borough Council.

11 Owton Fens Community Association: Owton & Rossmere Wards Community Audit. Hartlepool: OFCA (March/April 2003).

When asked what would most improve their living environment, the most frequent response was activities for young people followed by repairing pavements and better play areas for children. When asked, 84% of people thought that the area would be the same (50%) or worse (34%) in 5 years time. Interestingly, 90% of respondents were happy with the area; the most frequently cited reasons for unhappiness with the area were car parking (6/56) and drug use (7/56).

Under the theme 'Crime and Safety' there are results recorded for how safe people feel in different environments including; at home in the day time, local streets in the day time, local parks in the day time and local shops. During the day less than 18% or respondents felt unsafe. However, at night- time these were common areas of concern where over 40% of local people did not feel safe: specifically, local shops after dark (52%), local streets after dark (43%), and local parks after dark (60%). Interestingly, 23% of people also feel fairly unsafe (15%) or very unsafe (8%) at home after dark.

123/264 people had been a victim of crime in the past 12 months. 74 people had been a victim of youth nuisance but 34 % of people did not report crimes, often because of too little or too fragile evidence, 158/258 respondents were not aware of the community- policing programme.

Under the theme of 'Health and Care', 80% percent thought their health had been 'good' or 'fairly good' over the last twelve months, whilst 20% considered their health to be 'bad'. 210 of 273 respondents reported doing things to maintain good health, for example healthy diet (122), regular exercise (100) and not drinking too much (104). However, 43 people reported that an injury or illness prevented them from exercising and 119 out of 258 respondents smoked.

When questioned about the performance of primary health care services in the town, 179/223 thought they were excellent (4), very good (42), good (38), fairly good (11), overall good (2) or Ok (82). Out of the 44 other responses, 22 were negative. Responses ranged from 'poor' to comments focusing on appointment systems, waiting lists, GPs not caring/listening, the need for permanent doctors rather than relying on locums and modernisation of current services. Several suggestions were made on how improvements could be made: 4 people wanted more care for drug users, 4 called for the introduction of a smoking cessation programme and 4 wanted more doctors and nurses. A number of gaps were also identified, including more work with children and families and the need to improve access to information on health.

Under the theme 'Learning, Education and Employment', 193 respondents from 254 had not received training or attended any courses in the last 2 years but 89/238 would consider attending Adult Education and quite a lot expressed an interest in 'computing' (45). Only 65 of 228 respondents held an up to date CV but only 27 of 232 would have liked professional help preparing one.

Under the theme 'Culture, Leisure and Sport', there was a big desire by respondents for youth clubs (107), Saturday clubs (94), after school clubs (81), play schemes (75) and mother and toddler groups (50). 87 out of 206 respondents did not think the school sites were being fully utilised and 81 from 206 thought sport and leisure facilities were either unaffordable and/or inaccessible.

Under the theme 'Community Facilities/Community Involvement', 23 of 255 respondents utilised community type centres. Of those that did the largest purpose was for sport activities/keep fit (29%). Only 17 out of 233 respondents expressed an interest in joining a community or voluntary organisation.

Much of the reported community involvement that respondents had undertaken over the previous 12 months was around performing some sort of caring role, either baby sitting (66), visiting an older person or sick person (63), or shopping for someone (54). Only 23 of 240 respondents said they would be interested in some form of volunteering. However 85 of 220 thought there was considerable community sprit even though 178 out of 240 did not feel involved in their community.

Crime and safety (39%) topped the list of things that people in the area feel concerned about followed by housing and environment (20%), with education, learning, training and employment (13%) and health and care (15%), still being significant.

Under the theme 'Business Activity' O.F.C.A. looked at the most popular shopping areas and people's level of satisfaction with these areas. In addition some ideas about how Seaton Carew (coastal area) could be improved were also highlighted. This section also provided information on what additional amenities people thought were required. Whilst a post office was the most frequent response (20 of 69 respondents), a significant number required health care services (38 of 69) including dentists (13), doctors (8) and chemists (17).

SECTION 4

USING A COMMUNITY ENGAGEMENT APPROACH TO ESTABLISH THE PRINCIPLES OF A CONNECTED CARE SERVICE IN OWTON

Approach

The Connected Care audit was based on the University of Central Lancashire (UCLan) Community Engagement model[12]. The model provides a framework that enables communities to directly influence the type of services that need to be commissioned by engaging and capacity building individuals drawn directly from the community. Utilisation of the model ensured that local residents, including service users and carers, were able to directly influence the pilot development and the specification for the Connected Care service.

A local community organisation was selected to recruit, co-ordinate and host a team of Community Auditors. 9 Community Auditors were recruited from the local community. The Community Auditors were tasked with developing a tool to measure satisfaction levels of existing services and identify expectations and aspirations regarding a new model of delivery.

A training package was delivered by UCLan to develop the skills of the team in research methods, interview techniques, facilitating focus groups and recording and analysing data. These workshops were accredited, giving the Community Auditors the opportunity to gain a university qualification.

The process was overseen by a local steering group comprising of local residents, statutory, community and voluntary sector agencies, and others who have a stake in how health and social care services are delivered in the area. The steering group was also established to ensure any proposed development integrated with current and future developments in the area.

The Pilot Tool

The initial process involved the use of a questionnaire developed by the auditors for use with participants on a one to one basis. The questionnaire was beneficial in building the confidence and skills of the auditors in engaging community members in the audit process and in providing basic data regarding general concerns relating to health and social care provision. However, the auditors recognised that more in depth data needed to be collected especially from those in 'seldom heard' groups

Developing The Tool

A further tool was developed in light of this which supported a less structured approach and allowed for a more free flowing conversation to gain depth to the information collected. The data collated from the initial questionnaires identified key areas of focus for the audit framework:

- Awareness and understanding of service provision and level of need
- Access to services
- Information about services
- Continuity and co-ordination between services
- Quality of provision

The subsequent audit framework was developed to reflect these areas. The questions were defined to provide insight into the communities and individuals actual experiences and their opinions of how services should be configured to best suit their needs. The framework included a set of core questions aimed at all respondents with follow up prompts to gain further detail and promote the respondent to expand on their answer. The framework also provided an indication of the type of information sought under each section, thus enabling interviewers to adapt the line of questioning appropriately and gain consistency of information.

Methods

Three methods were utilised supported by the audit tool:

- One to one interviews: to provide in depth data from individual sources including those with specific issues or complex needs.

- Focus groups: in order to elicit information from a group discussion between individuals brought together due to shared experiences and providing the flexibility of exploring unanticipated issues as they arise during conversation and the ability to discuss and check possible conclusions within a group setting.

- A Community 'Have Your Say' Event: to provide access to the audit process to the widest sector of the community including those not accessed through other methods.

In total, 251 people participated in the audit process through the variety of methods. This included those identified by the community as seldom heard including:

- Drug users
- Single parents
- Older people
- Offenders
- Carers
- Young people
- People with disabilities
- People with learning disabilities
- People with mental health problems

We have learned a lot from carrying out the Connected Care audit. We will be refining the methodology following the audit process. This will be published separately.

[12] Winters, M. and Patel, K. (2003) Community Engagement: Report 1 the Process. University of Central Lancashire.

SECTION 5
FINDINGS

The Use Of Data To Inform Connected Care

The emerging data from the various tools and methods provides the basis for the development of the principles of Connected Care outlined in this document. Where possible, data is presented in the form of direct quotes and illustrated by case studies and examples provided by members of the community[13]. Using this approach ensures that the community can directly identify how their experiences have influenced service design and delivery and essentially, how any new approach will meet the expressed needs and the aspirations of those it is designed to serve.

The key findings are presented thematically under the following headings:

Information
Choice
Access to Services
Continuity and Co-ordination between Services
Workforce and Quality Provision

Each section or theme is followed by a discussion of the possible key implications for Connected Care based on the community's solutions.

Information

In order to enable people to make informed decisions about their health and social care, the community needs to have up-to-date, accessible information about the service options open to them. This needs to include information about services, the support that they can get from each of them, and how to access them. They want to be treated as full partners by public agencies. Their expectations are often disappointed.

The community highlighted problems with information at many different levels. Although there was good information made available by some agencies, overall individuals felt that much more needs to be done if the community are to be able to get the information that they need at the time they need it.

There was a perceived lack of proactive information provided about health and social care leaving people having to ask for information with little awareness of the assistance that they could receive or the availability of outreach support in the community. The community wanted general health and social care information about the kinds of help they can expect and specific information tailored for specific client groups, such as disabled people and benefits, drug users and information on treatment.

People complained that they often didn't know where to go for help, or what kind of help might be available. They said that they

wanted to be directed to people who had the right kind of information and who could help them. They felt that information should be made available to them at whatever point they engaged with services and that they should not have to run around looking for it. There were also concerns on how different services join up the information and support available.

'You don't know about it (what help is available). They don't tell you…if you could go and find out about your money situation… you don't get to know of any benefits your entitled to.'
(Older Person 1:1)

'You need to know what is on offer and how to get it.'
(Have Your Say (HYS))

'My parents needed help and information to cope with my drug use. But none of us have got a clue where to get it.'
(FG Drug user group)

'I went to see my doctor – but he wouldn't treat me or refer me on. He just said "I don't deal with that". But didn't tell me where to go.' (FG Drug user group)

'People will get information from many different sources. You need to be able to get the information wherever you are.' (FG Parents of Children With Learning Disabilities)

'What about the smoking cessation clinics…? I didn't know there was one.' (FG Disabled group)

'I need somebody who knows about pensions, who can talk about pensions because when I lost my husband I didn't know where to go, who to talk to, and I got no help at Social Services. I was on sick at the time, they had explained it all to me, I would have been better going on a widows pension and coming off sick and then I could have claimed but I can't now.' (Older Person 1:1)

'I don't know where to go (for advice about council tax). I am sure it is not right but they (the council) just keep sending me away all the time.' (Single parent 1:1)

'If you are having problems with the council they should be able to send you somewhere else I think. They can't expect you to know where to go.' (Single parent 1:1)

This report also highlights a failure by agencies to act on information from people about how they want services delivered, even when they themselves have sought out the information. This inevitably affects the choices they have and the motivation of the community to come forward for help.. In some instances it might actually lead to people refusing to engage with or becoming disengaged from services. People need to be given full information about what services do and what roles different services play.

'I don't know what different people are supposed to do. What are people's roles and responsibilities?' (HYS)

'They (social services) only deal with kids who are naughty at school and children who are getting abused and things like that, don't they?' (Single parent 1:1)

'People feel disempowered to make things happen and often don't know the process' (HYS)

'How do you transfer to another doctor if you're not happy?' (FG Drug user group)

People told us that it can be difficult to understand the information they receive. Sometimes leaflets are not in plain language, or they are not well distributed within the community. Providing the right information in the right ways and communicating it effectively and in accessible formats remains a significant challenge across all services.

'We need better information about benefits and rights of disabled people.' (HYS)

'The information is not easy to understand. You get half way through a leaflet and then you have to go back and start again.' (Carer 1:1)

'There's about 50 different leaflets? How do you know which leaflet to read?' (FG Disabled group)

Implications for Connected Care

- **It is hoped that increased involvement of the community, combined with high quality information about their health and social care, will increase community satisfaction, improve trust and build better relationships with professionals and positive health. It would also support individuals to make contact with services earlier, improving opportunities for prevention and early intervention.**

- **A key finding is people did not know what was available, where or when. They did not have the "know how" they need to find and use services effectively. Better information about health and social care services will help the community understand and make best use of the options available. It will also enable people to take more responsibility for their own health and social care.**

- **Connected Care needs to provide the portal for information within the community that informs the local population on what services are available, the eligibility criteria, information on health promotion, and how they can access help easily and quickly. Connected Care needs to provide more support to help people interpret information and what it means for their health and social care needs. The consultation showed that some people might prefer more one-to-one support than more information or choice.**

- **Specifically, there should be better information about what different services across the NHS, local authority and social care have on offer, in signposting services and informing people of their entitlements.**

- **Information needs to be up-to-date, to cover all the areas that matter to people, to be accessible, and in one place. It needs to include print and web-based information campaigns and booklets, as well as telephone advice, face-to-face work and outreach work. In the community, some people clearly preferred to be able to get their information face-to-face at local meetings that people could attend to find out what's available, rather than from leaflets or other forms of written information. They did not want automated information. At present, the range of options is not available to them.**

- **Information needs to be integrated across agencies so that people don't have to struggle through the system or give the same information time and time again. It will also support a single assessment procedure and avoid repeat assessment and referral (see later section).**

Choice

Offering people more choice was a key issue raised by the community. A number of people wanted to see more choice available across health and social care. Once again, the community felt that they must be provided with the information and advice to enable them to make their choice. Well-informed people making active choices will be more satisfied and confident about service quality. Some people wanted choice in relation to the professional they saw; others regarded choice as being able to choose from a menu of services.

It was clear that choice of service was often limited. The choice to take it or leave it is no choice at all. Some people wanted more services to be provided in the local community. In other cases, people saw more choice as an essential component of being able to access better quality services. Where it is not possible to offer individual choice, the audit highlights that communities and groups of users should be encouraged to take decisions collectively about their local services. A key finding is that agencies should respond to needs and aspirations in ways that make sense to the community, as that will provide a new incentive to improve performance.

'Housing Hartlepool just offered me a house over in Headland which is miles away from anywhere. I didn't get any choices because I was going to be homeless. Even though I said what I wanted they just offered me the total opposite.' (Single parent 1:1)

'If I had stayed with the same GP I would probably still be in the same boat. As soon as I seen another GP…she acted a lot quicker.' (Single parent 1:1)

'I have no problems getting to see a GP. If it's an emergency you just ring up and they tell you come in and wait. But you can't choose who you see.' (Single parent 1:1)

'He used to go to the day centre, but he was just so bored. Now he's moved into his own flat. But he just sits at home all day because there is nowhere else for him to go.' (Carer 1:1)

'My nanna ended up in a home. It worked out OK. She was in a nice place. But others were not so good. There was no choice though. It was "go and live here or sort yourself out". There was no offer of a bungalow or a warden flat.' (HYS)

'How do you get a choice of doctors?' (FG Drug user group)

'The service we use is good - but there is only this one – there's no choice – nothing else.' (FG Parents of Children With Learning Disabilities)

Economic status, poverty and unemployment were often key factors that restricted choice. This was particularly identified by the single parents who were interviewed. Many complained that they had insufficient money to get by on a day- to- day basis, and that this lack of economic power seriously restricted their choices.

'I want permanent work' (Single parent 1:1)

'It's money worries…' (Single parent 1:1)

'I wasn't working. We had no money. Nothing. No savings. We got by day by day.' (Single parent 1:1)

'Keeping a roof over our head worried me. Paying the bills. Normal things that everyone worries about.' (Single parent 1:1)

'I need to be out of debt. Since I went back to work I am much worse off because I am paying higher council tax rate.' (Single parent 1:1)

'I have a problem with catalogues, and I get credit really easy and I can't help myself. With me being depressed I always order loads of things.' (Single parent 1:1)

'Mostly money…not having enough of it. A better paid job… I am constantly borrowing money to keep myself right' (Single parent 1:1)

Implications for Connected Care

- **A lack of choice can lead to low aspirations and acceptance of poor quality provision.**

- **Connected Care needs to empower people to make choices. Central to this is the ability to provide people with the right information to enable them to make informed choices.**

- **Connected Care also needs to develop appropriate mechanisms for flagging up gaps in services: where no choice is available. Connected Care cannot exist at the operational level alone – it must also operate strategically with appropriate links to service planning and commissioning structures.**

- **Direct payments and in the future, individualised budgets, offer the potential for people to have greater choice and control over the services they receive. Most people need assistance in identifying the care they need; assistance should be accessible to all people, including those with specific needs.**

- **Connected Care is not separate from the wider social and economic contexts in which people live their lives. Connected Care needs to be delivered within this wider context. Initiatives that tackle poverty and create employment and prosperity are an important component of Connected Care.**

Access to Services

Key to Connected Care is service accessibility. People need to be able to get into services easily. The right kinds of services need to be available, in the right locations, and at the right times - that is when people need them and when they want to access them. Appointment systems need to be designed around the needs of the service user, and waiting times (whether for an initial appointment, or to be seen when you turn up for an appointment) kept to a minimum.

The audit also highlighted considerable existing variation and inconsistency in both the availability of services, and their quality. Services were not sufficiently convenient or designed to fit around people's lives. For members of the local community, issues on poor access focused particularly on getting access to doctors with some services not being available locally, finding your way once contact with services was made and the continuity of support and aftercare on leaving services. Overall, most concerns centred on the shortage of local health and social care amenities, spanning primary care, hospitals and care homes, and the need to travel long distances to get the support that people needed. In contrast, local innovations, such as the health bus for health checks and the drop in clinic were positively received. However, access to these services and awareness of their availability were not universal.

People should be able to access Connected Care services from wherever and whichever service they first touch base with: whichever service a person chooses to approach is the right service for them, and that service should work to fully engage them with Connected Care.

The lack of out-of-hours services were causing problems in many parts of the community. Many people complained that services were not available when they needed them, or that they were delivered from locations that were too distant. Others felt that out of hours services needed to be more responsive to people's needs and take more account of their lifestyles. There were calls for a single telephone access to out-of-hours health and social care services:

'There's no out of hours services if you're working. So if I did need any I wouldn't be able to access them.' (Single parent 1:1)

'The kids need somewhere to go. Somewhere that's open until 10 o'clock at night.' (Carer 1:1)

'Something after hours…drop in for instance. I often can't get to the ones during the day.' (Carer 1:1)

'We actually have to make appointments for the doctors for our neighbours. You have to phone at 8.30am. They both work so they would never get in.' (HYS)

'Low-rider buses are great, but there aren't enough of them in the evenings.' (HYS)

'You need an out of hours service – after 5pm. 7 days a week. Services that are open when you've got a problem. A telephone service at least. I mean, it's no good saying to me come and see me in a couple of days…like my problem is going to wait. I need help now.' (FG Drug user group)

'She works as a volunteer. People phone her up at 3 in the morning. She doesn't say, "I'm sorry, I'm asleep". She just gets on with it. Doesn't even get paid for it.' (FG Drug user group)

'Everything is down the town. You always have to go to the civic centre all the time. Something like a clinic that was here, something here like a centre' (Older Person 1:1)

'The home she is in is on the other side of town. There isn't anything locally. Not for the 24 hour care she needs.' (Carer 1:1)

'I go quite often (to the doctors). The only thing is the buses. You have to get one bus to the town and another one to Seaton. His surgery used to be on this estate but they've closed it down.' (Carer 1:1)

'I wouldn't mind seeing someone somewhere nearer, because you know you have to get over to the hospital. I got two buses…and it was cold. We could do with say maybe not even a hospital, say a medical centre here, you know closer in our area.' (Older Person 1:1)

'It costs me to get to the doctors and back. About £8. It's a taxi. There is no bus route.' (Single parent 1:1)

'If we didn't have the car we'd have real problems…we would end up sitting in the house wasting away then end up in the cemetery.' (HYS)

'Services are located too far away and are difficult to get to.' (HYS)

'The Health Bus is good. It means we can get basic health checks without having to travel.' (HYS)

'The service is a 6 or 7 mile bus journey.' (FG Drug user group)

Often people complained that service availability and appointment times seemed to be designed around the needs of the service rather than those of the service user. Services should have appointment systems that suit the client not the services. Services need to be available when service users want them:

'You go in to the chemist one day to get your script at 11.00am. You go back at 11 the next day and they say, "Oh, the pharmacist won't be back until 2.00pm". I mean fair enough if he's got to nip out, but why didn't they tell you that the day before. You have to come back later. And meanwhile I'm starting to rattle and all that.' (FG Drug user group)

'You need to be able to access as and when you need them.' (FG Parents of Children With Learning Disabilities)

'The care worker comes to take my daughter out twice a week. I can't take her out... I have angina She might come on a Thursday and then not come again until the following Wednesday. It's not fair on her as a teenager. (FG Parents of Children With Learning Disabilities)

'If it's an out-patients clinic, they shouldn't really have waiting

times. You can understand it in casualty or accident and emergency, but not in out-patients.' (Older Person 1:1)

'You can phone your doctor day after day, they will only allow you to make an appointment within the same day so they can say they've seen you within 24 hours. If there are no appointments left for that day then just start again the next day.' (HYS)

'You can get an appointment for another day but it has to be made as a repeat appointment from your GP, the problem is getting to see him in the first place.' (HYS)

The community called for a single point of entry for accessing information, advice and service provision. People strongly felt that they needed to be able to get into services easily, so that they can access an entire system of integrated support, health and social care as well as housing and benefits advice.

Discussion with the community generated strong support for mechanisms that could link people into different services, but people were wary of having another building or for its own sake.

People also favoured a system, which enabled them to access the same level of Connected Care service, whatever the entry points within the community. This would ensure that people could be referred to Connected Care services 'wherever they first touched base'.

'I know you have one (a benefits clinic) at Manor Residents, but I think they should be spotted about in different places for different residents.' (Older Person 1:1)

'We don't need another building. You can only do so much with bricks and mortar. There needs to be information at Manor Residents, Manor West, and all the other community centres, readily available to the residents. They need to be able to walk in and say, 'Right, where do I go for this' and people should have the information to hand, and that's what we haven't got. We don't need another building.' (Single parent 1:1)

'Wherever they touch base we will need to be able to deliver services to them otherwise they won't return.' (Anon 1:1)

'Make it as easy as possible for them to dip into any services that are available.' (HYS)

'Services should be made available within communities at the places where people go.' (HYS)

'You just want one place to have to go to…where you can just drop in. A lot gets done in a place like this. Even though you just come in for a cup of tea or a game of pool.' (FG Drug user group)

'The Practice Nurse runs a drop in clinic all over the place. I think there's one run out of the centre near the library. It frees the

doctors' surgeries up. There's one on in most areas three times a week if you can get to know where it is. I didn't know about it though until someone said you can go there for your flu jab.' (FG Disabled group)

'Well I dare say, if I needed help, it would be resource centre up here.' (Older Person 1:1)

'If I needed help with anything I would most likely ring the council and ask them if they could give me the address.' (Older Person 1:1)

'A single point of access for advice and guidance.' (HYS)

'Well I dare say, if I needed help, it would be resource centre up here.' (Older Person 1:1)

'There should be an NHS directory where you can phone them up and tell them your needs and they will provide you with advice on where to go.' (Carer 1:1)

'If I was somebody that needed to know where everything was, I would like to be able to go to one person somewhere and say, "Right where do I find this information out?" Even if they couldn't tell me everything I needed to know they could point me in the right direction. That would make a difference. Because even if you go to the civic or you go to the health service they just pass you from one department to the other. And by the time you get through, you end up talking to a machine. People get sick and put the phone down. Talking to a face would make a difference.' (Single parent 1:1)

Many members of the community were not in contact with services, or accessing care. They felt that they did not have the confidence and the 'know how' to navigate their way around public services and get the most out of them. Others were not in contact with services at all and were fearful of approaching them and admitting that they could not cope without help. Some people wanted more support if they are to make meaningful choices about public services.

There was an impression that some people were frightened of engaging with services. It was felt that services needed to reach out to community members on their terms and move away from the expectation that people will automatically know how to or want to engage with them. They need to work hard to engage and retain potential service users when they approach them by creating warm and inviting environments. It was felt that services needed to identify individuals whose needs are unmet and are not necessarily presenting to services and establish contact with them through outreach. More is needed to help those not in contact to come in.

'They (Social Services) knocked on my door one day because my child had a couple of weeks of screaming at night and not settling down so somebody had actually rang social services, so they came out to see me…they chatted to me for a while and they went

away happy and they sent me a Health Visitor…and she came to see me and she helped me to talk about settling him down and gave me advice on that.' (Single parent 1:1)

'For some there appears to be a real fear of admitting they can't cope and need help.' (HYS)

'Some people will need to have their hand held to help them get into a service.' (HYS)

'If you're not the kind of person to go and ask how do you find out about services.' (FG Parents of Children With Learning Disabilities)

'Specialist people need to come out to you and tell you.' (FG Parents of Children With Learning Disabilities)

Services need to make clients feel safe and at ease:

'I was put in a refuge. I was there with my daughter who was four years old. The place was full of 'smackheads'. Below me, and up above me. And I was on the middle floor so I couldn't escape them. It was awful.' (Single parent 1:1)

Part of feeling safe is about addressing some of the wider issues of community safety, crime and the fear of crime. Older People, in particular, raised concerns about crime and the fear of crime. For them, community safety and anti-social behaviour were major issues. Many expressed concerns about the appearance of the area and about the lack of visible policing. Many were afraid to go out, especially at night, and cited the lack of adequate street lighting as a problem. Such fears can prevent people accessing the kind of help and support that they need.

'We have a few unruly kids where we live, and we have drug dealers and you can see them waiting on corners and that's frightening. Very frightening.' (Older Person 1:1)

'We're starting to get graffiti again on the shutters here…graffiti getting sprayed all over.' (Older Person 1:1)

'I have never seen a policeman since…I have been here for thirty eight years and I have maybe seen two policeman and wardens are supposed to come round and I have never seen a warden at all.' (Older Person 1:1)

'I think we should have more resident wardens…the only time we see any police is if they are raiding a house or on duty.' (Older Person 1:1)

'Since the break in I don't go out. Even in my house on my own now the doors are all locked. All the deadlocks are on.' (Older Person 1:1)

'I would like a light outside, more street lighting.' (Older Person 1:1)

'But the lighting at the other end of the Grove, where it backs on to Midlothian Road…it's like the black hole of Calcutta.' (Older Person 1:1)

'It's so dark you can't see anybody, you have to be right on top of them before you can recognise who it is.' (Older Person 1:1)

Services need to be sure that they are offering the right kinds of services. Services need to consider whether they are delivering the kinds of things that clients actually want, or whether they are simply offering what they have always historically delivered. There were calls for the development of more services in the local community rather than relying on hospitals. A number of gaps were identified including difficulties in accessing home care, day care, and general follow-up support once people leave hospital, as well as new services for people who are more reluctant to access current services, such as women with substance misuse problems. Many respondents called for more assistance to help people with caring responsibilities, for example more respite care.

'She was getting carers coming in twice a week to bathe her and then each morning to get her dressed and on an evening to get her undressed…but she could have done with more care during the day, instead of like morning, night and that was it.' (Carer 1:1)

'Finding day care is sometimes hard.' (HYS)

'I had broken my ankle. I was in and out of hospital very quickly. As soon as I could hobble I was on my way. I was never asked if I needed any help to cope. I needed all kinds of help. Help with the children. Help with getting up and down stairs. Help with standing. Luckily I had my parents to help and I could stay with them.' (HYS)

'There is nowhere to go if you have very small children. More coffee mornings and places to go with small children would be useful.' (HYS)

'My daughter (who has learning disabilities) went to live in independent accommodation. They put her in a place promising that they would move some other young people in. But they never did. It was just full of old people. It wasn't suitable at all.' (HYS)

'If my family hadn't been locally based I don't know what I would have done. Without them to help I would have had real problems accessing any type of social activities or employment. (HYS)

'There's a gap between what you want and what services can do.' (FG Drug user group)

'There's not enough respite beds. There are 60 people wanting to use them and only 10 beds and they have to keep 2 of them for emergency.' (FG Parents of Children With Learning Disabilities)

'There's nowhere for women.' (FG Drug user group)

When asked about health and other essential services, a number of people commented that they found it difficult to access a hospital building or clinic in the course of a visit or appointment, and others cited difficulties in accessing local amenities more generally. A number talked about the shortage of accessible transport and saw that as the biggest barrier in accessing services. The focus of the concerns centered more on physical access rather than the attitude of professionals. This applied as much to universal services (such as leisure services, education services and shopping centres) as it did to specialist health and social care services:

'The town centre is wheelchair friendly…but then you get shops putting baskets in the aisles and you have to go back out.' (Disabled 1:1)

'I think MPs should be fastened in a wheelchair for a couple of days and sent out into the town and see how they cope. Shopping is either too low so you can't reach or too high on the shelves.' (Disabled 1:1)

'Take our doctors surgery. The doors are too narrow to get into his room.' (Disabled 1:1)

'The local authority spent money on providing access ramps on pavements but I still can't get access to the shops, there's a step up.' (HYS)

'The greatest problems are to do with the accessibility of places. Steps, pavements, narrow doors, layout of shops, width of shopping aisles, disabled parking.' (HYS)

'The GP is good, but I have to get a taxi there which I have to pay for.' (HYS)

'I dropped out of college. To get there I had to go round the back to use the ramp. Then I had to go through six lots of heavy glass doors. I had to wait for random people to walk past to open them for me. The disabled toilet was locked, because it was being used as a store cupboard.' (FG Parents of Children With Learning Disabilities)

'I want my child to have the same opportunities as every other child – rainbows, brownies. I want her to access normal schools and colleges and training centres. It wouldn't work her staying at home every day. She'd just watch DVD's every day. That's not real life.' (FG Parents of Children With Learning Disabilities)

'There is not enough disabled parking.' (FG Disabled group)

'Dial A Ride won't guarantee a time. It's no good if you have an appointment.' (FG Disabled group)

'There's not enough wheelchair taxi's.' (FG Disabled group)

Implications for Connected Care

- **The emerging vision is to develop more services in the community, rather than only in hospitals or outside the local community, so that they are more convenient to access. This would involve the expansion of the range of services available across primary and health and social care. It is important that strategies enable the community to access the support they need (for example, there were spontaneous calls for more respite for parents of adults with learning disabilities and other carers) including those members who currently do not access provision at all.**

- **There was support for high quality, integrated, multi-disciplinary out-of-hours services. These services also need to offer more general emotional support for people's broad needs. This would need to be backed up by strong links between primary care and appropriate health and social care professionals and seamless pathways for people accessing those services.**

- **Given that variation exists across different areas, more work is needed to help improve the availability of a range of suitable services, and ensure fair and equal access. To do this effectively, there would also need to be better information systems to facilitate communication and transfer of data between services and collaborate on referral processes, subject to addressing issues of confidentiality.**

- **Services need to be delivered as near to people's homes as possible with convenient access with Connected Care providing integrated support across agencies so that people don't have to struggle to find their way through the system or give the same information time and time again. Older people and disabled people will have specific access requirements.**

- **Crime, and fear of crime, can prevent people from accessing the kind of help and support that they need. It can also have a negative effect on quality of life for both the individual and wider community. Issues surrounding community safety and tackling anti-social behaviour need to be addressed fully and incorporated as part of the overall Connected Care response.**

- **Connected Care needs to provide a point of entry into joined up health and social care provision, targeted support and access to wider support by mainstream agencies. People felt strongly that information and access should be in one place to remove the chance of missing things and to improve the patient–professional relationship with services. There was not support for a new building, however. It is important to ensure that Connected Care services are not more difficult to navigate where there are also multiple information, access and referral points in the community. It is also important to ensure that, upon entering any service, whether a GP's surgery, housing support or job centre, the person is referred to Connected Care provision, where appropriate.**

- **There were specific calls for same day appointments and for the availability of non-appointment sessions, as well as for services opening later in the evening and at weekends.**

- **A Connected Care service will need to have its own team and office base. This means that every person should be able to be referred to integrated support provided by Connected Care, whatever the point of access. For example, a person may get help with drug rehabilitation but is then unable to find employment. Similarly, another individual may get housed locally, but does not access appropriate mental health services at a later date, and so ends up abandoning their flat and not get appropriate support. Connected Care will need to address this by providing integrated packages of support. It is also critical to embed Connected Care firmly within every service. In the long term, every worker in every service should become familiar with the concepts and ideas that underpin Connected Care.**

- **Services need to reach out to the community rather than always expecting them to come to services, particularly for marginalised groups. There are already excellent examples of good practice, such as health buses, but these are in small pockets and need to be expanded. Through outreach work, services should identify individuals with unmet need in their areas, or whose health is deteriorating and ensure contact is made, not just wait for them to present to services. This will involve Connected Care offering integrated support and provide a referral to other agencies.**

Continuity and Co-ordination Between Services

Continuity, co-ordination and communication between services was an issue that was raised many times. Some of the difficulties that people had encountered were relatively basic and should be fairly straightforward to sort out. For instance, people complained that they never saw the same worker more than once, that they didn't know who was in charge of their case, that workers didn't get back to them when they said that they would, or that their details were not been passed on and acted upon as they should have been. These issues are fairly basic, but can have a huge impact on how people experience services.

At the other end of the scale were some far more complex and strategic problems. Some people complained that, for example, while they were seen as a priority and had their needs acknowledged by one service, they were not necessarily seen as a priority by another. The fact that one service identified a client as having a particular need does not necessarily mean that the service that is responsible for meeting that need accepts that assessment or attaches the same weight or priority to it.

Services are complicated and complex. Many people felt that they needed someone to help them navigate their way through the system or to have access to someone who could represent them or fight their corner, or help them to make a complaint. A clear need for more support and a dedicated worker to enable people to understand service pathways, and to facilitate ongoing participation was identified. Some people wanted a key worker to fulfil this role.

Another theme was the alienation experienced by some members of the community in having to make contact with different professionals and re-telling a difficult story, often many times over or moving between different agencies for repeat assessments by professionals who then poorly responded to their needs. Many people felt frustrated that information did not appear to be passed effectively from agency to agency, or even within agencies. Having said this, others were very concerned that information about them should not be shared (e.g. especially around drug use and offending) for fear that this would jeopardise their access to other services.

Many people wanted to have a single named worker who they knew they could turn to for help. They wanted someone who could advocate for them and help them find their way through the system. This would be someone who they knew they could go back to if they got stuck, and someone who could help them to pursue complaints when necessary.

'Whether it was health, housing, crime, education, they are not going to know all the answers but they should know the referral points. That would make a difference.' (Single parent 1:1)

'You need someone to sort it all out.' (HYS)

'No one ever gets back to us.' (HYS)

'If you are working full time you don't have time to sort everything out yourself. You need someone who you can trust to do it all for you.' (HYS)

'We got what we wanted because we were very pro-active. We knew our way around the system and we didn't give up. Really you need someone to represent you.' (HYS)

'My husband is disabled. He is going to be moved into accommodation more suited to his needs with higher support. Although it has been identified that he has a high level of need we, the family have been left to co-ordinate his move. This involves a variety of tasks including paperwork, moving furniture, etc. and no-one in the family feels clear about how to do this.' (HYS)

'You rely on services to guide you on where to go. You have to know who to go to. I've got a good social worker who points me in the right direction when I get stuck. You need to know which benefits you are entitled to…what services are around.' (FG Parents of Children With Learning Disabilities)

'I didn't know where to go until the Health Visitor told me.' (FG Parents of Children With Learning Disabilities)

People wanted to see the same worker and saw this as one way of ensuring that their needs were understood and that they got a consistent response:

'The workers keep changing so you never get to see the same person twice.' (HYS)

'You need to see the same person every time otherwise they do not know your needs.' (HYS)

'You keep seeing different workers – you have to explain your story every time.' (FG Drug user group)

'They keep rotating the venue, so I never know where I'm supposed to be going.' (HYS)

Another cause for concern was that services did not work together to meet people's complex or multiple needs. Often services did not have shared priorities and goals and often had conflicts between what they were trying to achieve. Some people complained that services seemed to be inconsistent:

'My old doctor was prescribing for me. But when I moved into the area and got a new GP he just said, "You're not getting anything like that off me".' (FG Drug user group)

'I was told last October I would need a follow up appointment in about a year. So I went along to see my doctor in October and they said "Oh well, you seem OK so it'll probably be in January".' (FG Disabled group)

People wanted information to be passed on effectively to those that needed that know so that their needs could be met.

'There is no communication. You can go and talk to one down that housing office and it goes in one ear and out the other. They don't write anything down or type on the computer to say you have been saying this about this. You ring up and say nothing is being done and they say, 'Well, we haven't heard about it.' It should be wrote down as you're telling them what you're complaining about. Nothing gets done.' (Older Person 1:1)

'The hospital couldn't deal with her having Alzheimer's. On a night she wouldn't get much care because people on the ward didn't know much about Alzheimer's. So we would say "Have you changed her?" and they would say "We'll change her later"; we said "You have to feed her because she can't feed herself". Many times we've gone in and her food was just left beside her.' (Carer 1:1)

'A network of service providers should be established which would pull together GPs, housing, health, probation, police, social services, sure start, children's fund, voluntary sector etc…' (HYS)

'Case workers could draw on information held by network partners which would be utilised in putting together multi-needs assessment plans and work with individuals in order to address multiple needs.' (HYS)

Some particularly marginalised groups felt that having information about them shared might not be in their best interests however. The drug user group in particular recognised some of the tensions that might exist in trying to make Connected Care work if information about them was shared:

'If you are looking for somewhere to live you don't want the council to know that you are a drug user and that you have a history of offending. I mean, if you piled my offences up they would reach the ceiling. The council aren't going to house me.' (FG Drug user group)

'Some people don't want other people to know their business. They think that organisations are all inter-linked and others find out like social services.' (Single parent 1:1)

Some people experienced health and social care operating as two systems rather than one and there was poor communication or signposting between the two, which made it difficult to know where to go for help. Services were working to different goals and priorities. They did not always share information between each other (although there were some good examples) and this contributed to a poor understanding of a person needs across an

area and meant that information did not follow the individual between services.

The community felt that services were not currently organised in such a way that they can deal with people who have more than one problem. In practice, support often tended to focus on health needs, with other needs taking secondary place and not always being sufficiently or clearly reflected. There were examples in which people felt that services had not co-operated together effectively and so did not deliver the identified services, particularly for people who have complex and interlinked needs that cut across health and social care.

It was considered that effective care co-ordination needed to take the broadest view possible and include health and social care needs as well as bringing in wider support in relation to housing, education, caring responsibilities, employment, benefits advice and leisure.

'My child has disabilities. We've had real problems in having adaptations made to the house. They came and did an assessment regarding what equipment we would need but the work hasn't been co-ordinated. There are so many different people from different departments involved, it's hard to know who should be doing what. You don't know who to complain to. In the end it's up to family members to provide support.' (HYS)

'My son has dyslexia and everything. He gets one to one at school and I didn't want to take him out of school - he'd had enough upheaval – this and that and the other. But they still offered me a house that was miles away.' (Single parent 1:1)

'Getting somewhere to live…getting housed is impossible. If you're single…male… homeless…a drug user…with a criminal record. You're not a priority. No chance. Probation say they'll get you somewhere to live when you come out of jail. You just get housed with other drug users.' (FG Drug user group)

'It tends to be "Oh, that person needs a place to live, lets put him in there." Fitting someone in where there is availability rather than what's best for that particular individual. By putting them in just any old place where they are not going to progress, if anything they will go back over.' (Carer 1:1)

'Her (my daughters) school was in Owton Manor. My work was in Owton Manor. But this place (refuge) was right in the middle of town.' (Single parent 1:1)

Implications For Connected Care

- **The community advocated bringing together a network of professionals including a range of NHS, social services and voluntary professionals to come together to meet people's whole needs. In practice, for Connected Care to work effectively, commissioning will need to be strengthened across health and social care boundaries, with commitments from all agencies to jointly plan and integrate personalised packages of support and services as far as possible. This would need to be underpinned by other strategies such as multi-needs assessment plans and ways of sharing information between agencies. It will need to remove the division between health and social care through exploring the development of joint commissioning and funding arrangements, backed up by integrated teams with shared strategic vision, shared information protocols and single assessment and care management arrangements.**

- **The community wanted a dedicated Connected Care workforce who would be clearly accountable for supporting the person to find their way through the system of health and social care from initial contact at the assessment stage to long-term support. This would mean that services would need to take responsibility for helping a person to navigate complexity of need - a real issue for the local community.**

- **The workforce delivering Connected Care would have knowledge of all mainstream and specialist services and work with an individual to offer a sustained package of care to meet that individual's needs. They would have an advocacy remit and help people represent themselves (or make a complaint) to professionals and reduce current inconsistency of support from other professionals. They would need to be solution focused by finding out the right form of intervention and support and co-ordinate the delivery of services.**

- **There will need to be buy-in from current services and mechanisms in place to make sure Connected Care works effectively in practice so that required services co-operate and deliver appropriate support. To that end, the Connected Care workforce will need to have sufficient authority and status to negotiate or require compliance where a clear need has been defined. This may mean linking workers with budgetary control.**

- **Support should be developed through a single assessment process. This should assess a person's health, social and emotional needs. It would act as a one- stop shop assessment instead of lots of appointments and processes. This will remove the hassle of having to repeat information or experience repeat assessments. It will also reduce overlap and ensure a more consistent approach from professionals, and enable a person's support to be directed more effectively and more consistently reviewed and evaluated.   This assessment will be then be used to plan an integrated package of support and form the basis for referrals to other agencies.**

- **This level of reconfiguration needed to deliver Connected Care will be a major challenge locally, and will necessitate new forms of collaboration between existing services, and the creation of relationships with new partners.**

- **Connected Care services will need to develop mechanisms for aligning different organisational and agency goals where these differences present an obstacle to the provision of joined up and coherent care packages.**

- **For Connected Care to work, agencies will need to develop clear and consistent protocols around information sharing and confidentiality to ensure that information is able to flow quickly and freely when it needs to, whilst respecting the clients rights to privacy.**

- **All groups wanted easily accessible services and integrated support. Some people from specific groups such as drug users and carers of people with learning disabilities more strongly advocated for an individual to take responsibility for overall care and support and provide a continuity of support from initial assessment onwards.**

- **Connected Care will not be as straightforward as making sure that services do what they currently do better. The community were looking for a more radical solution. How services can meet people's whole needs should be a driving force in the delivery of services. This needs to be embedded in every stage of delivery from assessment and treatment to aftercare and service providers need to be flexible and creative to deliver this.**

- **Connected Care might also include putting together individual budgets for specific groups, such as older people and people with learning disabilities.**

- **It will be a challenge to ensure that each person receives a consistent response from Connected Care and a consistent response within and between services, without losing the flexibility of services to respond to local needs.**

Workforce And Quality of Provision

Service users want staff who are professional and in whom they can feel confident. They want to see staff who are knowledgeable about services and who can demonstrate that they understand the types of needs that clients might have. Staff need to be properly trained, both in their own specialist areas and in how other related services work and operate and can contribute towards meeting client needs. Service users want to be treated as an individual and not to be labelled or stereotyped. They want to be treated with dignity and respect and to be afforded basic rights such as privacy.

Service users expect to be listened to and to be actively engaged

in their own treatment. A number of people emphasised the importance of having somebody there to talk them through what their options were, what was likely to happen and the possible consequences of the different decisions that they might take. They stressed how important it was to have a say in what happened to them and not just to have decisions taken on their behalf.

Services need to be of sufficient quality to meet real needs - this includes offering practical help and treating people holistically. It is not acceptable to have to wait for a long time before anything happens.

Clients need to feel that they can trust services and that they can have faith in them. Services need to make clients feel safe and at ease. A number of people said that they felt that some services appeared to put the needs of the system or the agency first and that the needs of the client seemed secondary. Some people complained that services seemed to favour one group over another and commented that services need to be seen to be fair.

The importance of having properly trained and skilled staff who were equipped to do the job was raised by many:

'You want staff who know what they are talking about. I've spoken to people who don't know anything about heroin or crack. All they know about is cannabis. But 90% of the people who are in there are on heroin or crack.' (FG Drug user group)

'People talking to you on your level – not using jargon.'
(FG Parents of Children With Learning Disabilities)

'How can you know what I feel? You don't have a 12 month old child with Down's Syndrome.' (FG Parents of Children With Learning Disabilities)

People want to be treated individually and with respect and dignity. They don't want to be pre-judged, labelled or stereo-typed:

'They (doctors) just give you anti-depressants, that just made everything worse and I stopped taking them. I don't think that was helping me. Really they are just dishing out tablets. It's not going to help you in the long run. It just puts a haze over all your problems.' (Single parent 1:1)

'They assume that because you are a single parent that you all get labelled the same. You're a single parent who is trying to get as much as you can out of the system. But we're not all the same.' (Single parent 1:1)

'The problem is that doctors process people. They only allow a certain length of time to see a patient, in and out they don't care…' (HYS)

'I think they need to take into account that everybody is different… If there is a group of 12 single parents they are not all in the same circumstances they are all different.' (HYS)

'You don't want to be judged on your past.' (HYS)

'If you have an issue they assume you are lying because you are drug user.' (FG Drug user group)

'They just think you are blagging because you are a drug user.' (FG Drug user group)

'Not all Down's Syndrome children are the same.' (FG Parents of Children With Learning Disabilities)

'When they told me what was wrong with me I thought I was going to die. I mean it was nothing to them, but I was petrified. Where's this heart disease come from? There's no history in the family. To them it's just an everyday thing.' (FG Disabled group)

Privacy was important for many, but especially for those from stigmatised groups:

'With that supervised consumption there's no privacy. They've got a boxed off area but everyone knows what you are going into that bit for. Everyone knows what the box is there for.' (FG Drug user group)

'The pharmacist shouts out, "Have you got X's methadone there…?".' (FG Drug user group)

'They call your name out, and then they ask you to confirm your address. They don't do it quietly. Everyone knows who you are and where you live.' (FG Drug user group)

A common theme for quality service provision was that clients should feel listened to and properly engaged in the decision making process:

'You need people to listen to you when you go and complain.' (Older Person 1:1)

'You need somebody there to be talking you through it all the time, rather than them rushing by.' (Single parent 1:1)

'Sometimes a big problem is a little problem really, and if you can just get someone to sit, get that out, just get someone to listen.' (HYS)

'The social worker is very helpful. Like clockwork. He is there for any problem. You've never known such a helpful guy. Any problem. He just sits and chats.' (FG Disabled group)

'I said to them my treatment isn't working…and they just said it is…' (FG Drug user group)

'I asked to speak to the pharmacist but he said "I'm too busy".' (FG Drug user group)

'It's important to have a say in what happens to your children… not just to have decisions made on your behalf. (FG Parents of Children With Learning Disabilities)

'They just say we need these tests. They don't tell you what they are for. You have to ask.' (FG Disabled group)

'When I had my hip done I went to physio. I was told that I didn't need any. I was told that I was fit enough. I could hardly walk.' (FG Disabled group)

Services need to do things that are meaningful to the client. They need to meet real needs and treat people holistically, not simply tick a box.

'Some of the activities are boring and not stimulating at all.' (Carer 1:1)

'It's the form filling. If you're not used to filling forms in, it's a minefield.' (Single parent 1:1)

'It is no longer acceptable that service providers tell us what they can deliver. It's up to them to deliver services that we need at a time and location that fits our needs.' (HYS)

'Social services have always been great – asked what I needed, easy to talk to, sorted everything out quickly.' (HYS)

'Housing and social services were excellent. When I got a chair lift installed they just got on with it and when the handrail was installed the council just took care of it.' (HYS)

'Where you've been assessed and recommendations have been made to improve your quality of life these should be followed up.' (HYS)

'Probation are only interested in keeping you out of trouble. "Are you keeping off the drugs?" You get your prescription and that's it. They don't address any of the other issues.' (FG Drug user group)

'You can see them down town…one carer shuffling around the shops with a group of Down's Syndrome people – it's not what I want for my child. It's not using their brains. Groups of 30 year old plus. I can 'shuffle' around with her (my daughter) anytime. They're not doing enough. They need to do something that you can't do with them.' (FG Parents of Children With Learning Disabilities)

Services need to be seen to be taking client problems seriously and to respond promptly. They will need to be adequately resourced to do this:

'The roof tiles blew off months ago. You put in for repairs. They still haven't been replaced.' (Disabled 1:1)

'I rang the social worker and left several messages. I never heard anything back.' (Carer 1:1)

'My 93 year old grandmother had a broken gas fire. It took 7 weeks to sort it out. Why the wait? First someone had to come out to assess it. They put a tag on it to say 'Do Not Use'. Then someone had to requisition a new one. Then someone else had to purchase it. Then someone had to deliver it. Then someone had to install it. The person who installed it in the end was a private contractor and he said that he had loads of that type of fire in stock.' (HYS)

'Services are too stretched. You can get an appointment – but they say they have other clients to see – you'll have to come back tomorrow – but I'm in trouble now.' (FG Drug user group)

'…some services are so full and short-staffed nobody has time to do anything.' (Carer 1:1)

'People keep coming back into the system. They are helped into independent living accommodation, but then the support that they need isn't there. They are left out on a limb. There is no one to support their needs.' (Carer 1:1)

'The trouble is we haven't got enough supported living centres.' (Carer 1:1)

'There are lots of people who need more than the hours they get. It's about negotiating with social services to see how much you can afford.' (Carer 1:1)

'Most social workers are crap. I'm not saying it's their fault. But they have too many people on their books and obviously, say I had an emergency and I phone them up and they are not in their office then what am I supposed to do?' (Carer 1:1)

'I had to wait for an hour to see the doctor.' (FG Drug user group)

Above all people need to feel that they can have faith in services: to feel that they can trust services to do what they are supposed to do and that their needs will be put before the needs of the organisation:

'They (the job centre) won't go looking for things (courses). They have to have them in place already set and running. They can't find anywhere else to help you.' (Single parent 1:1)

'Funding dictates the number of hours support you can have. It could only be three hours a day which means you are left alone for 21 hours with only 3 hours support each day.' (Carer 1:1)

'The way we have to pay rent has changed. We now have to pay through direct debit, at a post office or at a housing office as the alternative to the previous system where someone would collect the rent in person. What if you don't have a bank account, or if you have problems getting about?' (HYS)

'The chemist gets paid more for supervised consumption… so that's all they do. They say, if you don't want it, you'll have to go to (names another pharmacist). But that's miles away.' (FG Drug user group)

'It would depend on who that person is…whether I felt I could trust them.' (Carer 1:1)

'I felt he (my granddad) was just neglected and left there in bed. I don't think they were aware that he was almost more or less blind. He was depressed and everything from having a fall and he eventually died in hospital. He never came back out…I think what it's more to do with…these days…is with the lack of people caring…They might sort of tick the right box to say that he's had that medication…but then they just walk away.' (Single parent 1:1)

'You need somebody that you feel is professional, that you know is giving you the correct advice and maybe steering you in the right track.' (Single parent 1:1)

Sometimes different groups of people will have different entitlements. Where this is the case the reasons for this need to be made transparent so that services are seen to be equitable and fair:

'The older you are the better off you are. If you are over 70 or 80 I think you get £300 (towards your gas bill) but we get £200. But we are going to use the same amount of gas so therefore why don't they keep it straight and give us all £300.' (Older Person 1:1)

'He (ex husband) gets loads of help. That's another thing, he gets more money because he's on the sick, and they know he smokes cannabis all the time and I thinks it's scandalous. He gets all his rent…all his council tax, and he doesn't pay any maintenance or anything and there's me trying to do the best for my son.' (Single parent 1:1)

'I have to pay for everything because I am working. All the carpets – everything. And the house was a mess when I moved in. Other people just get everything paid for.' (Single parent) 1:1

'Look at my daughter. She was pregnant. She was in a two bedroom flat when she fell pregnant. The flat was damp. She went to Housing Hartlepool to get on the list. She couldn't go on the list until she had had the baby…they couldn't give her any points even though the flat she was in was unliveable because it was damp in the bedrooms. Drug users get a house when they like, and they are provided with stuff my daughter had to go and ask for a grant' (HYS)

'You work all your life, and then when you need a home they make you pay for it. If you don't work and save anything, they pay for it for you.' (HYS)

'She (worker at drugs service) definitely has her favourites. If she likes you, you can get what you want, but if she doesn't…no chance.' (FG Drug user group)

Implications For Connected Care

- The workforce will need to be highly responsive to user and carer needs if it is to deliver high quality, user-led health and social care. Better outcomes for the community depend on the NHS, local authority and the voluntary sector working in new and different ways together to reshape and integrate services that are focused on the needs of that community.

- The role of the Connected Care workforce will be defined by the functions and skills, rather than by professional labels.

- Staff will need to be trained and educated in methods of involvement and they need to understand the benefits of engagement with the community. Services need to be engaging and non-stigmatising. They will need to challenge the process on behalf of the individuals and challenge other colleagues if the values of respect, dignity and fairness are not followed.

- In relation to Connected Care, better service commissioning will stimulate demand for a more appropriately skilled workforce.

- Under the Connected Care model, professionals are committed to sharing expertise and listening to local people to find what people themselves want, to co-ordinate services and negotiate the system for people with more complex needs.

- Staff will also be expected to be skilled in working across different services and making the links between those services already accessed by the individual and other universal and specialist agencies. The workforce will be encouraged to have a good understanding of how others work, a shared vision for integrating health and social care and strong inter-team relationships.

- Connected Care Staff will need to have sufficient status and seniority to command respect across a wide range of traditional professional boundaries.

SECTION 6
NEXT STEPS

The process by which this audit has been undertaken has brought together members of the local community in Owton with a range of service providers, commissioners and other key stakeholders to help decide the future direction and shape of health and social care services in the area.

A number of community members have been trained and supported to identify and articulate the thoughts, concerns and ideas of the local community. A model for engaging the local community actively in the process has been piloted and tested and a number of key lessons have been learned.

This report does not identify all of the answers about where to go or what to do next. It does provide a framework for moving forward however. The next stage is to design a service specification based on this Connected Care audit. As future ideas about developing Connected Care in Owton develop they can be checked back against this report as a way of ensuring adequate accountability to the local community.

As part of this process the report will be shared with the local community at a conference on 28th February 2006 where the 'next steps' will be discussed. It will also be shared with a wide range of service providers and commissioners as part of a process of ensuring adequate buy-in to what will be a period of change.

The community have identified a range of solutions to deliver better, more responsive services for Sarah, Joan and David, whose stories were featured at the start of this report. It is hoped that Connected Care will build community capacity with services designed and delivered by the local community. Services should be flexible and easy to access and meet the whole needs of Owton. Services also need to be outcome driven and delivered by a professional and coordinated workforce willing to do things differently.