NHS KENT AND MEDWAY

ANALYSIS OF PUBLIC ENGAGEMENT TO INFORM THE KENT AND MEDWAY SUSTAINABILITY AND TRANSFORMATION PLAN

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May 2017

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Executive Summary

This report analyses a survey of residents in Kent and Medway, together with a series of focus groups. Around 1,900 people took part in the survey, and while this sample does not exactly match the wider population of Kent and Medway (for example, having a higher proportion of older people), this is a common characteristic of surveys of this kind. It does not invalidate the findings, but it does mean that they must be interpreted with care. (For more, see pages 5-8.)

Participants were in general **keen to improve their own health**, particularly in losing weight and taking more exercise. The three main barriers they gave were will-power, lack of time and pre-existing medical conditions. Many people wanted more support from health professionals to help them make changes in their lifestyles, though there were many other barriers, from the cost of exercise classes to caring commitments. People wanted more information on available services, particularly in Medway; and preferred 'free' forms of information such as emails from their GP to paid-for forms such as adverts. (See pages 10-15.)

The survey **revealed high levels of satisfaction with GP and Community Nursing services**: the main criticism was that there were not enough nurses to meet people's needs and keep waiting times down. The main priorities were for nurses to take the pressure of GPs and to provide integrated care for people in their homes or in their local neighbourhoods, particularly for long-term or palliative care. (See pages 16-19.)

A substantial number of those taking part were **concerned about health and social care** in Kent and Thanet: mainly about insufficient staff or other resources, but also about management and delivery. In particular, there was **frustration about the state of mental health provision**, including some participants saying it was letting down patients and their families; there was also **frustration with social care**, from the time it took for an assessment to the quality and amount of care available. There was, however, praise for specific services and for the professionalism and dedication of staff. (See pages 19-23.)

Bringing health and social care closer together was a recurring theme in the survey. Participants strongly backed **GP surgeries being a focus for social care**, on the model of hubs or health centres, so each patient or client could receive the support they needed in a coordinated way. The next two most popular priorities for co-location were mental health and community nursing; participants also supported having specialist clinics take place in GP surgeries; and for additional treatments such as physiotherapy to be available on-site. (Pages 28-30.)

Participants also wanted **extended opening times** for GPs and other services, particularly after work during the week and on Saturday mornings; overnight access was less of a priority. (See pages 18-19.)

Cottage or community hospitals were seen as crucial in reducing 'bed-blocking' and providing a bridge between specialist hospitals and care at home, and again a means to integrate health and social care and provide extended services such as physiotherapy. The only significant concern about integration was the time and distance to travel to larger, centralised health centres, particularly for those reliant on public transport. (See pages 28 to 33.)

There was strong support for **integrated teams** (by implication, based in the GP surgery or cottage hospital 'hubs') with clear priority given to end-of-life care (chosen by 74% of participants), followed by support for parents of children with additional needs (67%) and support for cancer survivors (60%). Integrated care was a recurring theme in responses throughout the survey, alongside enhanced support for carers. (See pages 27-28.)

Participants were generally **open to the idea of new technology** in supporting enhanced health and social care. Some options, such as telephone advice lines, were more popular than others, such as mobile phone apps, and though there were concerns about security, most participants who expressed a view did not think this should stop innovations such as electronic patient records. Participants also felt that technology should augment and not replace face-to-face contact. (See pages 24-26.)

There was support for **social prescribing and other innovations**, although also some doubt as to available resources and concern that this should not distract from getting the basics right. Exercise groups led by health professionals was the option with the most support, reflecting many people's wish to have more advice, support and encouragement to improve their health. With innovation, participants often looked outside the 'core' of NHS services, reflecting the STP's involvement of Kent and Medway councils and other partners. The most popular proposed innovation was to prioritise dementia-friendly housing developments, and other proposals with wide support included a young person's volunteer scheme. Similarly, participants' own suggestions for innovations ranged from open-air gym equipment to boosting public transport. (See pages 26-27 and 31-33.)

More widely, there was **qualified support for the STP process**: while most respondents wanted more resources committed to health and social care, they also accepted that improvements could be achieved within existing constraints.

1. Introduction

In this section we cover the background to the project, how the survey was conducted, the recruitment and demographics.

The Project

The NHS in Kent and Medway, together with Kent County Council and Medway Council, are developing a Sustainability and Transformation Plan (STP). This will guide the way health and social care services in Kent and Medway develop to take account of rising demand and changing circumstances.

In October 2016 – December 2016 the STP Programme Board ran a survey of residents across Kent and Medway to provide a strong input to the STP process for services users and residents. This followed a series of public focus groups held across east Kent and preceded the listening events held in February and March 2017. This has been supplemented throughout the engagement phase by the work of all the organisations involved with their own staff, stakeholders, patients and local communities. The Board also published a document, "Transforming Health and Social Care in Kent and Medway", that provided the background on the needs of the population and the challenges faced by health and social care, with a link to the survey.

The independent social research agency Woodnewton was commissioned in April 2017 to analyse and report on the findings from the public survey. This will help the Board to shape plans for change to health and social care services, prior to formal consultation.

The Survey

The survey was designed and managed by the NHS in Kent and Medway in association with Kent County Council and Medway Council. It was open to all residents to take part if they wished and publicised through a number of networks covering service users, staff and the wider public. It was also promoted in shopping centres and supermarkets at roadshows to help ensure the widest possible coverage of participants.

The survey consisted of 30 questions and around 1,925 people took part. The data for each question and the number who completed each one is set out in the summary or 'topline' results in Annex A.

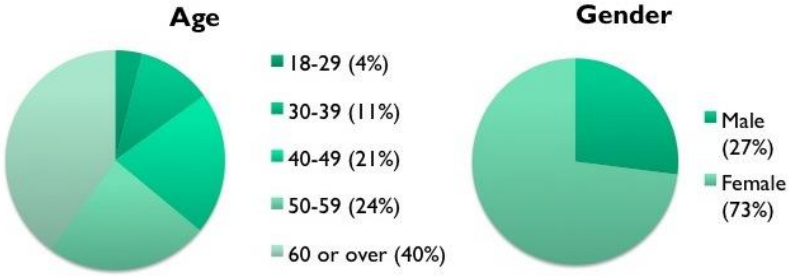
The majority of questions in the survey were 'closed': that is, participants chose from a list or rated a series of options. In many cases, these questions allowed participants to

chose more than one option – for example, selecting their top five priorities – and so percentages do not always add up to 100. In all cases, percentages have been rounded to the nearest whole number. We have set out the numeric responses, and where appropriate identified any factors which we think may affect the reliability of those numbers or help to set them in the right context.

The survey also included 'open' questions, where participants could write in their own answers. These have been extremely helpful in providing more detail and background to the numerical data, and allowing participants to make the points they want in the way that they want. The volume of material – a total of over 110,000 words – means we can analyse and explore the themes, priorities and suggestions raised by participants numerically. To do this, we have where possible 'coded' the responses – that is, identified a set of recurring themes in these responses and then allocated as many responses as possible to each of these themes. Usually this is in the form of the number of times a theme is mentioned in the responses to the open questions. We have also selected some verbatim quotes from these open responses to represent different views and give a sense of the way in which people feel or speak about services. These are anonymised, but we have included some broad demographic information for each quote to give a sense of the perspective of the contributor.

Recruitment and Demographics

The survey allowed any residents in Kent and Medway to take part, rather than being recruited against a pre-determined quota based on a demographic profile. This approach has a number of advantages, including ensuring that the survey reaches more of those who make most use of the services under discussion, compared to a random sample. It is also more cost-effective. It does, however, mean that demographics of the survey sample do not necessarily match those of the wider population of Kent and Medway. The main differences are in age, gender and ethnicity. The profile of the survey sample is older than the average for Kent and Medway. The main reason for this is likely to be that older people tend to have more contact with the health and social care system, though other factors may also be at work, including the lower propensity of young people to complete surveys.



Similarly, women make up 73% of participants who provided their gender, against 27% for men (compared to 51% women and 49% men in Kent and Medway as a whole). This may in part reflect the way in which women still tend to take more responsibility for caring and care co-ordination than men, as well as tending to live longer (for example, in the 2011 census, women make up over 60% of the population of Kent aged 85-89); again, other factors may also be at work.

In the survey, the proportion of participants reporting their ethnicity who were classed as Black, Asian or Minority Ethnic was 5%, against a BAME population in Kent of 15%. This may in part be a reflection of the age profile of the survey (the proportion of BAME residents tends to fall as age increases) but may also indicate some shortfall in reaching ethnic groups through existing communications channels of the kind used to promote the survey – a problem which public services face throughout England.

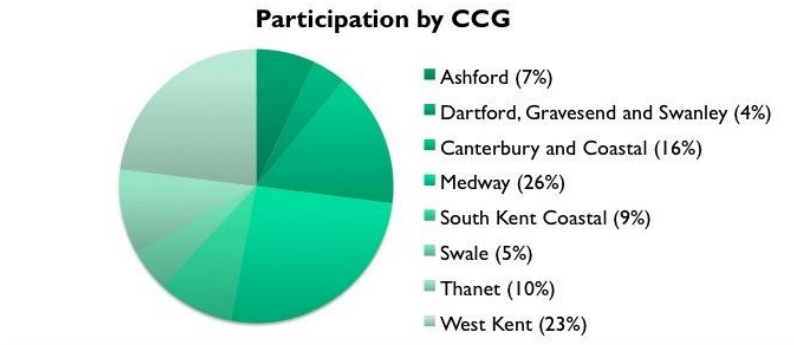
These kinds of differences are common characteristics of public consultations and do not mean that the findings of the survey are invalid: only that they need to be interpreted with care.

Regional Analysis

We reviewed the survey data to see if there were any significant differences between different areas within Kent and Medway. For this, we used the postcodes provided in Question 1 to assign responses to one of the eight Kent and Medway Clinical Commissioning Groups (CCGs). The number of responses who provided a postcode for each area was as follows:

CCG	Postcodes	Responses
Ashford	N23-27, TN30	127
Dartford, Gravesham and Swanley	BR8, DA1-4, DA9-13	79
Canterbury and Coastal	CT1-6, ME13	284
Medway	ME2-8	462
South Kent Coast	CT14-21, TN28-29	156
Swale	ME9-12	90
Thanet	CT7-12	173
West Kent	ME1, ME6, ME14-19, TN1-2, TN4, TN8-15, TN17-18	408

The proportion of responses for each CCG is shown in the chart below.



By comparing the number of responses to the total population of each of the CCGs in Kent and Thanet, we can see the different response rate to the survey in the eight Kent and Medway CCGs.

CCG	**Population**	**Response Rate (per 1,000)**
Ashford	124,000	1.0
Dartford, Gravesham and Swanley	258,000	0.3
Canterbury and Coastal	207,000	1.4
Medway	276,000	1.7
South Kent Coast	205,000	0.8
Swale	102,000	0.9
Thanet	140,000	1.2
West Kent	477,000	0.9

The most striking feature is the low response rate for Dartford, Gravesham and Swanley: otherwise, the distribution is as we might expect for a self-completion survey. It suggests that the promotion of the survey was less effective in this area, perhaps because some of the patient networks and other intermediaries in Kent would have less reach into communities closer to London.

There was some variation in age and gender profiles for the eight sub-regions in Kent and Medway. In Thanet, for example, the proportion who stated they were male compared to female was 16:57, while in Ashford it was 29:45. According to the 2011 census, there is no corresponding difference in the proportion of male and female residents in the two areas. We are not able to offer any explanation for these differences, and they may simply be a feature of the relatively small sample size for the sub-groups.

There were some small differences in the age profiles of different sub-regions, but none of these was statistically significant.

Differences in Local Views

We would not expect to see significant differences in the views of residents in a single district or county about 'national' issues such as data security. What we might expect to see are differences in how residents experience the local delivery of services and in their local concerns and priorities. For example, the issue of access to services is likely to be a higher priority for residents in a rural area, where public transport may be limited, compared to an urban area. Because these differences are often very local, they may not be statistically significant: but they have been analysed and included in the analysis of priorities and concerns below. In fact, the only question where we found a significant difference was Question 6, which asked whether people were aware or not of services in their area to help with health improvement.

The open questions allowed participants to raise specific local concerns. In fact, the proportion of people who did so was small. The individual comments have all been recorded and analysed, but did not point to common priorities or areas of concern shared by a statistically significant proportion of the survey sample. In other words, the survey did not identify 'hot spots' of widespread anxiety or concern.

Although the survey did not ask participants about any specific health conditions, some participants did mention these in passing. The most common condition mentioned was diabetes, followed by mental illness and arthritis. More significantly, around half of those who mentioned their illness had multiple, complex or overlapping conditions.

2. Healthy Living

The survey posed a series of questions about how healthy people felt their lifestyles to be, what they wanted to do to make their lifestyles more healthy; what the main barriers were; and what could help the most to overcome these.

Healthy Lifestyles

The main way in which people said they kept healthy was by avoiding some well-known unhealthy behaviours: 88% didn't smoke; 77% avoided sugary drinks; 66% kept to recommended limits on alcohol; 65% limited their intake of sugary, salty or fatty snacks and other foods; and 61% said they ate at least five portions of fruit and vegetables a day.

The proportion that exercised regularly was smaller: 51% said they worked to keep their muscles strong and 44% said they exercised until they were out of breath for at least 150 minutes a week. This is likely to be influenced by the age profile of the survey participants, who are on average older than the mean; and also by the presumed higher incidence of those with medical conditions.

Participants were also asked about their mental well-being: 73% reported they spent social time with other people and undertook activities they enjoyed; 56% got a good night's sleep; and 54% were open to talking about their feelings and asking for help.

Where people described in their own words what they did to keep fit, there was (as we would expect) a very wide range of responses, from swimming to getting an early night, and from Scottish country dancing to eating jellied eels every day. But some clear patterns emerged. Walking was the most popular exercise, mentioned by 50 participants. This particularly included dog-walking.

> *"I walk my dog - he sets the pace - he's fast!"*
> (Female, 50-59, Dartford, Gravesham and Swanley)

The second most popular action, with 27 mentions, was to avoid alcohol completely; the third, with 20, was to volunteer with charities or local groups. Twenty people practised yoga or other disciplines combining physical and mental exercise, such as tai chi and pilates. Seven mentioned different forms of artistic or cultural activity, such as dance, singing and study; and eight mentioned different forms of positive thinking. Perhaps reflecting the age profile of the survey sample, and the prevalence of existing medical conditions, sports did not feature very highly: nine mentioned going to the gym or exercise routines, seven mentioned swimming and five cycling. Six people mentioned

gardening, and another six mentioned that they were vegetarian or vegan. Participants also mentioned ways in which they could maintain or improve their state of mind, such as spending time with friends and family, which showed that 'healthy living' was not seen as limited to purely physical activities. Most of all, though, the picture was one of a wide variety in the approaches people took to life.

> *"I attend a weekly zumba class - high impact for 60 minutes."*
> (Female, 40-49, Medway)

> *"I am 93 but do exercises regularly every morning and on doctors orders have one tot of whisky a day."* (Male, 60+, Canterbury and Coastal)

A recurring theme was the impact on people's lifestyles of caring for a relative.

> *"Until my husband became unwell (falls/fractured wrist/vascular cognitive impairment) I danced Scottish a couple of times a week."*
> (Female, 60+, Canterbury and Coastal)

A number of participants also referred to the medicines or prescriptions they needed to manage their conditions, or how conditions or disabilities prevented them from exercising as they would wish – a theme to which we shall return.

> *"I go swimming as after as I can, unable to do other activities being a full-time wheelchair user. Used to do weights but health problems forced me to stop."*
> (Male, 60+, Thanet)

Participants were also asked to say one change they would like to make to improve their general health and well-being. The leading choice, cited by 38% of respondents, was to exercise more, and the next, on 21%, was to lose weight. 7% said they wanted to eat more healthily, and a further 8% specifically mentioned reducing their intake of sugary, salty and fatty foods.

> *"I try and eat 5 portions of fruit and veg a day but some days this is not possible."*
> (Male, 50-59, Medway)

A significant number of people prioritised different ways to manage or improve their mental health and sense of well-being. 5% wanted to reduce the stress or anxiety in their lives, including a further 3% who wanted to reduce workplace stress or achieve a better work-life balance. 5% wanted to sleep more; 2% wanted more free time; and 2% wanted to spend more time on hobbies or activities or socialising with friends and family.

11% said they needed more help and support to improve their health, including needing a specific operation or treatment programme, such as a knee replacement to allow them to exercise more, or better management of diabetes to control their weight.

3% said they wanted to reduce their alcohol intake, and just 2% said they wanted to stop smoking. The latter in particular in low, given that 12% of the survey participants were smokers. It is also reflected in the open question about what people did to stay healthy: while 27 said they did not drink alcohol, only three mentioned not smoking. It raises the question of whether there is a significant group in Kent and Medway who are either happy to continue to smoke, or at least resigned to doing so, and who therefore do not prioritise smoking cessation; and whether there would be cost-effective ways for the healthcare system to re-engage with such a group. It may also suggest that there is more latent demand for help or advice for those who want to cut down on alcohol or give up entirely.

A large number of other issues were raised which did not reach 1% of the total, and in some cases were only raided by a single respondent. These ranged from wanting to feel safer on the street to asking for regular health checks to needing to overcome depression. There were also a number of comments about the state of the NHS, including the role of the private sector and concerns over priorities, which have been included elsewhere in the analysis.

> *"I'd like to cut down on crisps and have more time to do more walking as work prevents anything above three miles a day. I like to do 20 miles with my dog when possible but just don't get the chance very often."* (Female, 40-49, Medway)

> *"I'd like to feel safe cycling or join a women's sport group."*
> (Female, 30-39, Canterbury and Coastal)

> *"I want accessible healthcare. The nearest main hospitals to me are miles and miles away."* (Male, 40-49, South Kent Coastal)

Overall, the picture is that participants knew what they needed to do to become healthy: exercise more; improve their diet; and think about their wider well-being, including managing stress and building up their social networks. For some, existing physical conditions were the main issue, including restricted mobility, and there was a need for a range of ways to exercise and wider support. For others, it might be stress at work or balancing competing pressures in their lives. Unlike lack of exercise or unhealthy diets, smoking and alcohol were not generally seen as the one change people wanted to make.

Barriers to Change

For participants, the main barrier to a healthy lifestyle was time, including the time they spent at work (mentioned by 21% of respondents), on family or caring responsibilities (7%), or socialising (4%), for a total of 32%. The next most cited barrier was their own lack of will-power, or motivation, or a perceived lack of self-discipline, with 16%. Costs and charges for activities were mentioned by 13%, and a lack of availability of facilities and opportunities by 4% of participants.

> *"I can't at the moment. I have to wait for my children to get old enough to leave at home."* (Female, 40-49, South Kent Coastal)

> *"Needs to be a better choice at the weekend as well as during weekday evenings. (I commute, so my working days are long and I'm either not home in time or am too tired to do a weekday.)"* (Female, 40-49, Medway)

Ongoing medical conditions or disabilities were mentioned by 4%, with a further 2% citing a lack of medical support or treatment and another 2% wryly saying that the main barrier to a healthy lifestyle was their age.

Amongst more specific barriers, 3% mentioned lack of sleep or lack of energy, and the same proportion mentioned stress or anxiety. For 2%, the main barrier was over-eating or the temptations of junk food. Another 2% wanted more information about healthy lifestyles or on what facilities were available.

The single most popular form of support that would help them overcome these barriers was access to low-cost exercise (39%), followed by one-to-one support such as a health trainer (29%) and joining a group (21%). (Access to exercise facilities – particularly swimming – was also a recurring theme amongst participants when discussing innovations in service delivery later in the survey.) 17% said they would like more information, and only 11% saw smartphone apps as a priority (though this again may reflect the age profile of those who responded to the survey). Participants also had many suggestions of their own.

> *"Cycle racks at work, shower facilities and space to change in."*
> (Female, 40-49, Ashford)

> *"Better crêche facilities of kids groups at Kingsmead - coordinating a kids activity with time for a single mum or other mum wanting to do exercise at the same time the kid is doing an activity. Child care is a big barrier for time to keep fit for mums."* (Female, 30-39, Canterbury and Coastal)

"I would like to have an exercise bike or treadmill at home as It will give me the flexibility i need to exercise anytime." (Female, 30-39, West Kent)

Information on Healthy Living

Around three in ten participants said they did not have enough information about how to access healthy lifestyle services such as stopping smoking and healthy eating, and a further quarter of participants were not sure about the information available. Only half of participants said they did have sufficient information. Interestingly, this was the only question where we found a statistically significant difference by area. The percentage saying they were aware of such services in each CCG were as follows:

CCG	Percent aware
Ashford	55
Canterbury and Coastal	50
Dartford, Gravesham and Swanley	38
Medway	36
South Kent Coast	51
Swale	44
Thanet	41
West Kent	40

We cannot say for certain that these reflect the actual views of the populations of each area, and if these are reliable figures, we can only speculate as to the causes. It could, for example, reflect differences in social class or educational attainment in the different areas: but it may also point to successes in signposting services in Ashford and South Kent Coast that could be shared with other CCGs; and certainly suggests that awareness of services in Medway and Dartford, Gravesham and Swanley should be looked at further.

The service that participants said they were aware of most was smoking cessation. There was some awareness of services to support weight loss and taking more exercise, but these tended to be non-NHS services such as those provided by Weight Watchers.

The most popular channel for receiving such information was emails from GPs or other healthcare providers (48%), followed by posters and leaflets in GP surgeries, hospitals and pharmacies (45%), leaflets through your door (43%) and adverts on screens in GP surgeries (40%). People were not so interested in paid-for promotions on Facebook (12%), articles on websites (17%), Facebook posts shared by your friends (24%), articles in council magazines (29%) and articles or adverts in local papers or magazines (29%). (The latter is interesting because in general local newspapers are a popular channel for local

information: it may be that participants were less keen on any mention of advertising, preferring that 'free' channels be used instead.) Other channels received a little more support: a health-focused website and app (chosen by 31% as most likely to help keep participants informed); text messages for your GP practice (33%); a leaflet given to you by staff providing treatment (36%); and posters and leaflets in shops and community venues (37%).

Overall, this suggests that the public prefer to receive information from a range of sources; that they are open to the use of digital channels such as email and texts; that they would not want to rely solely on these channels, and still value traditional approaches such as leaflets and posters; and that they do not favour paid-for channels such as online adverts.

Self-Management of Health

Participants who had a long-term health conditions such as heart and lung disease and diabetes were asked how confident they were about watching out for and managing changes in their condition, in their home, with support from health professionals. 27% said they were very confident and another 46% said they were fairly confident. 10% said they were not very confident and 3% were not at all confident. This is a net score of 73% confident against 13% not confident.

Similarly, in the open questions a number of participants mentioned their own ability to understand their conditions and play a leading role in managing it.

> *"I take my Parkinson's medication regularly and monitor side-effects."*
> (Female, 60+, West Kent)

Many patients and carers also called for more support to be made available so that they could do more for themselves and for those they were caring for. This indicates potential to extend this form of collaborative self-care.

3. Service Delivery

Participants were asked about ways in which GP practice and community nursing could best be delivered, and about extended opening times for GP practices. Those who had experience of the relevant services were also asked about mental health and dementia care, and social care.

GP Practice and Community Nursing

Participants were invited to choose up to five from a list of 17 services that could be provided by community and GP practice nurses that they thought would be of greatest value to their area. Three of these were chosen by over half of the respondents:

- Providing care and treatment for people with long-term conditions (66%);
- Planning and supporting end-of-life care in or near to people's home (58%);
- Providing nursing care with GP support so that the most vulnerable patients could avoid going into hospital (58%).

This reflects one of the wider messages from the survey: the priority that people in Kent and Medway give to integrated care being provided for people in their homes or in their local neighbourhoods, particularly for long-term or palliative care.

There were also other options that, although not scoring so highly, told the same story. Support for patients and carers living with dementia was chosen by 43%; recognising and supporting patients with complex, complicated and/or long-term conditions as a priority by 40%; training patients and their carers in self-management, such as taking or giving medicines themselves by 37%; and being a constant point of contact for patients on their list (34%). Participants also wanted nurses to have more control over the care provided to patients. 36% wanted nurses to be notified when they went into hospital and to be involved in their care when they came out. 30% thought it a priority that nurses should be allowed to admit patients to community hospitals or respite care.

Some other options did not score very highly. These included providing intravenous therapy and device care (11%); prescribing continence products and managing referrals to specialist services (14%); making referrals to specialist respiratory and/or heart failure teams (16%); and recognising and treating urinary tract infections when patients are housebound (22%). It may be that there was reluctance on the part of some participants for nurses to take on roles such as prescribing, diagnosis or referral to specialist teams that would traditionally be the role of a doctor (though other participants said that nurses should be given more responsibilities of this kind); or it could be that these

options related to specific conditions that were only directly relevant to a smaller proportion of the survey sample.

For other options, there was a medium level of priority. These were: care for wounds, including assessments, prescribing care and referrals to specialist services, which was rated a 'top five' priority by 28% of participants; providing health checks and flu jabs for housebound people (26%); and providing care at clinics with specialised nursing (also 26%). Though we cannot be sure why these options received these scores, it may be that they were seen as appropriate and valuable roles for Community and GP Practice nurses, but did not have the same priority as providing, say, end of life care or avoiding people having to go into hospital.

Those who had direct experience of Community Nurse and GP Practice Nurse services were asked what worked well and what needed improvement. Overall, participants were evenly split between commenting on what worked well and improvements.

The most common example given of what worked well – nearly a quarter of all responses – was the way in which GP practice nurses could deal with routine or non-urgent matters such as blood tests, vaccinations, asthma reviews or ear de-waxing, and so relieve the pressure on GPs. The next most common example was the value placed on seeing the same nurse (27) and the quality of their care and their level of expertise (25). People also valued the speed with which they could be seen (25) – by implication, in contrast to waiting for a GP appointment – and the communication skills of nurses (20). People also commented that they felt nurses often had more time for them than busy GPs, and were often more approachable or easier to confide in. Friendliness and compassion was mentioned by 16 participants, and the value of home visits by 13 participants; and there was also praise for their skill in the supervision of post-operative patients at home (12).

> *"The nurses are excellent, caring, and a credit to the NHS."* (Male, 50-59, Thanet)

> *"Following a broken hip nurses visited home as did physios for several weeks after discharge from hospital - excellent after care - also helpful fittings installed in home to aid mobility e.g. grasp handles, etc."* (Male, 60+, Swale)

> *"Nurse can often answer questions and reassure so no need to see GP, can do routine blood tests and take blood pressure etc. Also nurses appointments often run more on time than GPs."* (Female, 50-59, South Kent Coast)

The main change that participants wanted in these services was for more capacity, including more staff and shorter waiting times. These totalled 136 mentions, or almost half the total.

"Specialised nurses for specialised conditions as they demonstrate the appropriate respect, empathy and allow patient to be dignified." (Female, 40-49, Medway)

Some other concerns were common to other areas of the survey, including the need for better communications between staff, patients and carers (24 mentions), continuity, so that patients saw the same member of staff (23), spending more time with patients (16). There were also variations on these themes: as well as commenting on the need for better co-ordination amongst different parts of the healthcare system, some participants thought that there was too much overlap and duplication, leading to a waste of resources.

"Lack of continuity – we have scarcely ever seen same nurse twice."
(Female, 60+, Ashford)

"Integrating the nurses from the community and GP practice to work more seamlessly together." (Male, 50-59, South Kent Coast)

There were 28 critical comments on the quality of the service provided, including the training, skills and attitudes of some staff; though 11 participants thought that nurses should be given more responsibilities or expanded roles. There were 17 suggestions for extending cover for specific conditions or complaints, such as care for wounds and mental health.

Two other responses were of interest. Several respondents thought that there was insufficient information about Community and/or GP Practice nursing services, and they should be more effectively promoted to reduce pressure on GPs and other parts of the health and social care system. There was also interest in the better use of IT, particularly for booking and confirming appointments or letting patients or clients know about any changes or delays in booked appointments.

"Hospitals need to STOP telling discharged patients to see their GP surgeries for wound care - this is laziness! Wound clinics have been in situ for many years but hospital staff cannot be bothered to explain the system - this causes patients to be disgruntled and make complaints because they believe the GP surgery is fobbing them off." (Female, 50-59, Medway)

Out of Hours Access

All participants were asked how likely they were to make use of a range of times for out-of-hours services (that is, health and social services outside the core GP hours of 9am to 5pm). The most popular 'slot' was between 5pm and 10pm on weekday evenings (rated most likely by 56% of participants), followed by Saturday mornings between 9am and 1pm. Saturdays were generally more popular than Sundays, and over-night slots were seen as less likely to be used (19% for weekend nights and 15% for weekday nights). Overall, there was a clear preference for extending access after work and to a lesser extent at the weekends (particularly Saturday morning), but much less demand for night-time access.

Participants were given five options for contacting out of hours services: telephone, email, text, website and mobile phone app; and an 'all of the above' option. 72% gave the telephone option the highest preference, compared to only 25% for the next highest, contact by email. Similarly, only 4% gave the telephone option the lowest priority, compared to 42% who gave the mobile phone app the lowest priority. 41% had a strong preference for providing all five options. This reflects a wider pattern that extends outside health and social care: the public may have a strong preference for one channel for contacting public services (usually but not always by telephone) but they also think it right that the service should offer a wide range of channels to reflect different people's preferences and circumstances, and to provide a similar experience to other service providers such as utilities and banks.

Social Care

Around one in ten of the survey participants had direct experience of social care. This included help with personal hygiene (for example, being bathed or dressed) at 52% of those with experience of social care; help making their home safe (42%); advice and support with claiming benefits (32%); access to nutrition, such as home delivery of meals (28%); support with housing (18%); support to access work, training or other activities outside the home (16%); and help with employment (9%). (As we would expect, this profile of experience of social care differs from that of the general public, with a greater emphasis on social care linked to medical conditions and less on social services such as advice with benefits, work or housing.)

About 8% of all respondents (that is, about three-quarters of those who had direct experience of social care) made some financial contribution towards their care. Of this sub-group, 64% paid for help with hygiene; 44% paid for help to make the home safe;

40% paid for home food deliveries or other forms of nutrition; and 20% paid for support to access work, training or other activities outside the home.

In total, over 200 survey participants provided examples of what worked well or what could be improved regarding social care. The main areas that participants cited as working well were home and personal care, the commitment and professionalism of staff, and the quality of care. They also strongly valued continuity in staffing, so that they saw a familiar and friendly face who understood their needs; and for staff who showed sympathy and compassion. There was praise too for a range of specific services and treatments, such as respite care and occupational therapy; and particularly for advice and/or installation of aids to help people stay safely in their own homes.

> *"Social worker for parents. She was so supportive."* (Female, 60+, Thanet)

> *"The carers have been lovely."* (Male, 40-49, West Kent)

> *"We used [social services] for my Mum who had dementia. Personal Hygiene worked well, as did making the home safe for her."* (Male, 60+, West Kent)

However, as we would expect, there were a large number of concerns and frustrations, and plenty that people wanted to see improved. The chief of these was the need for better co-ordination and joined-up delivery between different services. People also wanted staff to be able to spend more time with patients and clients, to ensure that they had done everything that was needed and to provide a little extra personal contact. There was also frustration about the timing of visits: both reliability and the impact of late starts and early finishes on patients who were being got up from or put to bed: the latter could be as early as 6pm. There were widespread concerns about staff turn-over and retention, which linked back to continuity and the value of having staff who were familiar to patients and clients; and also to the quality of staff, including the need for better pay and more training. Other significant concerns included responsiveness in a crisis; the need for better information and communication with patients and their carers; and better support for carers. Funding was seen as a priority, as was mental health.

> *"Some services need to get better at communicating with each other and ensuring person centred care & support."*
> (Female, 50-59, Dartford, Gravesham and Swanley)

> *"More help supporting families with end of life care for relatives. Not leaving them to do it themselves."* (Female, 40-49, West Kent)

"Home visits to help with dressing, toileting, feeding etc are never long enough." (Female, 50-59, West Kent)

For some participants, their experience of social care had clearly left them frustrated and upset, reflecting the deep emotional impact on carers and family members of the conditions that social care is supposed to help alleviate.

"The whole system of communication. The system of locating places in care homes is horrid and should not be allowed. It was so distressing to know that my mother's name was put in a system to see if care homes wanted the business - disgusting!" (Female, 40-49, Canterbury and Coastal)

"Nothing actually materialises though, Life aids, wheel chairs, beds, continence products. If you do have them you constantly get called to have them taken away again! At least wait for him to die." (Female, 40-49, West Kent)

Participants did also offer suggestions for ways the service could be improved.

"Access to work - I work full time and have a PA for this, however the system is ridiculously complicated and I have to submit a massive claim form EACH month. It would be better if my direct payment encompassed any access to work payment so they're centralised rather than all these various different, and time consuming sections." (Female, 30-39, South Kent Coast)

"Social care personnel could be based in our local Hospices as part of the hub and spoke services." (Male, 60+, Dartford, Gravesham and Swanley)

Mental Health and Dementia Care

Participants were given a range of characteristics of mental health and dementia care and asked to select the three most important. The most popular choice, on 57%, was for multi-disciplinary teams, so that all a patient's needs could be considered together.

The next most popular (on 43%) was for early care and support to be given to new and known mental health patients. This aside, here was a fairly even split in priorities between mental health and dementia. Working with people who have dementia and their carers to manage their health and well-being was on 36%; and providing support for people in a mental health crisis; working with patients to manage their mental health and well-being, including crisis situations; and supporting the early identification and diagnosis of dementia were all on 35%.

29% of participants thought that GPs providing a single point of contact was a priority; and 22% wanted quick access to specialist teams covering eating disorders and drug and alcohol abuse.

Some options were given only a limited priority: supporting patients taking medicine, including requesting an urgent review if necessary (17%); recognising physical illnesses and referring to multi-disciplinary teams (13%); providing access to a wide range of support services, including leisure and employment and other non-NHS services (13%); and setting boundaries with patients and their families, focusing on choices and independence (6%).

Those with direct experience of mental health and dementia care services provided many examples of what currently worked well and what could be improved. (These are shown in Annex A, Question 27.) Overall, this was the area within the survey where participants were most negative. This was reflected not only in the proportion of those who had critical views, but also the strength of those views and the detail with which they explained the failings they had experienced themselves or seen in those close to them. It was also the area (along with social care) where there were significant concerns about the quality of care provided by professions – for example, in the number who thought that professionals needed additional training or did not provide effective diagnoses. It was also, in contrast, the area where participants were most likely to have seen recent improvements.

The most common concern was that the service had insufficient resources, leading to unacceptable waiting times and insufficient treatment or on-going support. There was considerable frustration that delays in diagnosis or in receiving treatment meant that many cases deteriorated; carers were placed under greater pressure, which could affect their own health; and the quality of life of patients and clients was significantly harmed. Specific parts of the service – for example, crisis care and the transition from children's and adolescent mental health services (CAMHS) to adult social care – were highlighted; but the most commonly expressed view was of a service under pressure, and at times failing, from start to finish.

> *"Medical staff having a more caring attitude to people they find hard to understand."* (Female, 60+, West Kent)

> "*More knowledge of self referral, longer access to therapy services, quicker access, better CAMHS."* (Female, 40-49, Medway)

> *"Offering local support to carers / families of people with dementia."*
> (Female, 50-59, Dartford, Gravesham and Swanley)

"Proper clinical psychological therapy and occupational therapy groups not just 6 weeks of CBT for people with severe mental health problems."
(Female, 60+, Canterbury and Coastal)

Against this, there was a lot of praise for aspects of the service; for GPs, Admiral nurses, occupational therapists and other health and social care staff; for the quality of care and support; and for innovations such as single-point access and online courses. Many people made the point that, once accessed, the services could be extremely effective and supportive; that some individual services were the victims of their own success; and that the support provided in areas such as respite care were much appreciated.

"*Support given by the Care Managers was invaluable at such a difficult and emotional time."* (Female, 50-59, Medway)

"I was severely depressed about 4 years ago and was referred to the Mental Health Crisis Team. For about 2 weeks I was visited on a daily basis to ensure I was safe and not at risk of suicide or self harm." (Female, 50-59, Medway)

"More person centred than it has typically been in the past - better safeguarding and more offered in terms of rehabilitation and recovery." (Male, 20-29, Medway)

4. How Services are Provided

Participants were asked about the way in which health and social care services could be provided in new or different ways, including the wider use of electronic records; new forms of communications; social prescribing; the wider use of integrated teams for specific conditions; the sharing of facilities and co-location of service; and a selection of further innovations that drew on national or international good practice.

Electronic Records

Many improvements in the delivery of health and social care depend on the integration of patient records and other 'digitally-enabled' processes. The survey asked what concerns participants had about electronic records and how the risks could best be managed. By far the greatest concern was about hacking or other malicious attempts by those outside the health and social care system to access patient records. The general view was that all systems were open to being hacked – in effect, 'the hackers will always get through' – and some participants gave specific examples of recent data breaches.

> *"Even banks (e.g. Tesco) have suffered security breaches so limits on data availability and transferability should be in place. It would only require one breach to cause substantial problems for the NHS, its patients and reputation."*
> (Male, 30-39, Swale)

There was also a significant number of respondents who felt that the benefits of integrated electronic patient records outweighed any risks and their introduction should be accelerated; and another group who were confident that the NHS would be able to provide the necessary safeguards.

> *"No, I have no concerns, I can see only benefits from healthcare professionals being able to access information on patients' health issues."*
> (Female, 60+, Medway)

Though the nature of these open responses limits the scope to give firm proportions, we estimate that the prevailing view amongst respondents was that while there was always a risk of electronic records being hacked, it was right to proceed; but that the great sensitivity of patient records meant that all possible safeguards should be in place, including the latest technology and effective staff training and monitoring of compliance with security protocols. (Note that the fieldwork took place before the major compromise of NHS IT systems in May 2017: attitudes may have changed since then.)

Other issues raised included accidental data loss, and concerns on the number of staff who might have access to records.

> *"NHS & local authority are the one of the largest employers in Medway. This is a lot of 'staff' with access to online records on a shared system."*
> (Female, 40-49, West Kent)

There was also significant concern about giving commercial firms and other third parties access to patient information, including fears this could be used to market services to them or to influence insurance cover.

There was a cluster of concerns about the effectiveness of electronic record-keeping, including the reliability of the system and the consequences of 'downtime'; whether records would be kept fully and accurately; and whether it would provide good value for money or have too great an impact on health and social care budgets, so affecting patient care.

There were also some concerns expressed about whether some groups would have trouble accessing electronic services, particularly the elderly or those with specific conditions such as loss of sight; and whether electronic systems were an adequate substitute for 'the personal touch'.

Communications Technology

Participants were given a number of ways in which they could interact with health and social care providers: a call-back from a health professional; a video call (such as Skype) in their home; a video call while in a GP surgery, for example with a hospital consultant; messaging via a website; and messaging via a mobile phone app; and an 'all of the above' option. The call-back was by far the most popular, being chosen by 80% of participants. 41% chose the video call in the GP surgery and 35% the video call at home. 28% chose the mobile phone app and 25% the website. 23% chose the 'all of the above' option, and as some of these may have consequently not chosen the call-back option, the true proportion favouring the latter option could be even higher than 80%.

Participants were shown a range of follow-up treatments that could be provided through these new forms of communications technology, and asked to choose which they would be happy to use. The most popular were follow-up after treatment (55%) and monitoring (51%), then second opinions on X-rays or other images (40%), check-ups (35%) and health screening (31%). 53% opted for 'all of the above'.

Participants were then presented with a number of ways in which technology could enhance access to services and allow patient information to be shared by health professionals, and they were asked which they would use. The most popular was a single patient record that a range of health professionals could access, which would be used by 84% of respondents. The others were: allowing patients to book appointments online (74%); access online records and test results online (both 70%); electronic referrals (64%); and electronic discharge letters and notifications (58%). The only option which was chosen by less than have the respondents was booking appointments and accessing patient records by a mobile phone app (42%). These point to considerable enthusiasm for digital channels for patient communication, particularly bearing in mind the age profile of the participants in the survey.

Social Prescribing

Social prescribing involves a healthcare professional or volunteer directing patients or clients to alternative sources of help and support in the community that could benefit their physical or mental health. Participants were given a range of possible sources and asked which they would be most likely to join. Of these, exercise classes led by a health or care professional was the most popular, with 54% of participants saying they would be likely to join up. There was also interest in walking groups led by a volunteer (35%) and exercise classes led by a volunteer (26%). Weight loss classes were of interest to 34% and health eating classes to 31%.

Peer support groups organised by healthcare professionals were of interest to 28% of participants, and support groups organised by charities or voluntary bodies by 23% (reflecting the same preference in exercise classes for professional healthcare input).

Activities that were less obviously associated with 'health' were a little less popular: 26% were interested in arts and crafts sessions; 21% in gardening and allotment sessions; 20% in community choirs or singing; and 15% in life story or local history groups or in 'memory cafes'.

Some participants questioned whether social prescribing ought to be a priority for the NHS.

> *"Are you for real? If I want to do this I will jolly well organise it myself not as a blooming prescription!"* (Female, 40-49, West Kent)

Generally, though, participants thought that it would be helpful to make such services available, even if they themselves did not have any need of it. There were also participants who might have liked to take up some options, but could not do so –

particularly because of work commitments, lack of transport, or because they were caring for a family member.

In total, 85% of participants were interested in at least one of the options. Over 100 participants also made their own suggestions about their own preferred alternatives. These covered a wide range of activities, of which the most commonly mentioned were swimming, dance, and yoga and tai chi.

> *"Relaxation/yoga/meditation group to lower blood pressure and stress."*
> (Female, 60+, Ashford)

> *"Gravesend desperately needs an indoor bowls club. We had one but it was withdrawn due to bad maintenance. I currently travel at least 18 miles to Dartford there and back. At 84 I can see that in future times this will not be possible."*
> (Female, 60+, Dartford, Gravesham and Swanley)

There were also suggestions for particular organisations that could be involved, such as U3A, Park Run and Diabetes UK.

> *"'Tipping the Balance' scheme did the trick for me.* (Male, 50-59, Medway)

> *"Therapeutic Crochet & Knitting group such as Ewe-Nique in Ashford."*
> (Female, 40-49, Ashford)

Integrated Teams

Participants were invited to say to what extent they thought that integrated teams for a range of services were a good idea or not. The areas were: home births; care coordinators or personal care managers; advice for employers of personal assistants; personal budget support; carer support and advice; end of life care; hearing loss support, advice and clinics; medication advice and reviews; cancer survivor support; and support for parents of children with additional physical or mental health needs.

Asking participants to rate each on a five-point scale allows us to see not only their overall preferences and priorities, but also the relative strength of those preferences. In other words, it can help show not only what people want, but how much they want it.

End of life care was given the highest score by 74% of participants, followed by support for parents of children with additional needs (67%) and support for cancer survivors (60%). There was also considerable support for care coordinators (54%) and care advice and support (53%). Medication advice was given the highest score by 47% of

respondents, hearing loss support by 43%, and home birthing by 41%. There was less priority given to personal assistant support (29%) and personal budget support (28%).

Another way to approach the findings is to combine the two highest scores and take away the two lowest score, to give a net score for the overall priority given to each option. This also captures the views of participants on services they think are *not* a priority. The net scores are:

End of life care	+88
Parents of children with additional needs	+84
Cancer survivors	+78
Care coordinators	+70
Care advice and support	+75
Medication advice	+69
Hearing loss	+68
Home birthing	+42
Personal assistant support	+27
Personal budget support	+26

The pattern is similar to that of the top priority scores, but does emphasise the strength of view that end of life care and support for parents of children with additional needs should be given the highest priority for integrated teams; that care advice and support may have slightly more support than care coordinators; and that home birthing is seen as a low priority by a significant number of participants (some of whom have perhaps had a good experience of giving birth in hospital). Similarly, a significant number of participants gave a priority of 'three out of five' for personal assistant support and personal budget support (28% and 25% respectively) and it may be that these options were less familiar to participants, some of whom were in effect recording a 'don't know' response.

Sharing Facilities

There was widespread support – around 67% – for the idea of GPs sharing facilities with other community health and social care services. Only 5% were opposed, though another 28% were not sure about it (and a significant proportion of the overall respondents to this survey skipped this question). The main suggestions made by participants for services that could be combined in this way were social services or social care (including social workers) with 80 mentions; mental health with 74 mentions; community or district nurses, including midwives, with 55 mentions; and physiotherapy with 53 mentions. There was a significant number of mentions for individual diseases and conditions (45 in total); for specialist clinics (33); for health visitors, including child health and school

nurses (28); and for blood tests and other forms of screening (28). There was also interest in co-location of health training and exercise classes (22); psychotherapy and counselling (21); occupational and other forms of therapy (21); and minor injury / cottage hospital facilities (21).

There were suggestions that a range of wider services could be located alongside GP surgeries, of which a pharmacy was the most popular (19 mentions), along with podiatry and chiropody (18) and dentistry (13), and extending to include schools, libraries, welfare advice and Surestart centres (all less than 10 mentions), perhaps reflecting the recurring theme of access and transport.

There were more mixed views about using other community facilities such as libraries and children's centres to provide health and social care services. Some liked the idea:

> *"I think any rooms that aren't being utilised shouldn't go to waste and they can be used for Health Checks, Stop Smoking etc. Health Education Programmes, such as healthy eating and pain management and workshops and groups to help reduce social isolation."* (Female, 30-39, Medway)

> *"It would be good to have sessions in public libraries in villages to make services more accessible."* (Female, 60+, Ashford)

The places suggested included libraries, children's centres, sports centres, village halls, church halls, schools, supermarkets and pubs. Participants also suggested integrated health and social care information with Kent County Council's "Gateway' service, and providing mobile units that could extend services to more remote locations; and stressed the importance of having car parking nearby.

Participants also proposed a number of specific ways in which this kind of integration could be achieved.

> *"Mobile clinic services where possible for health checks/screenings to be done, example, parked in a secluded superstore car park and move around the key superstores. This can be part of their social responsibility initiative. With booking online […] to support mobile clinics. Parking would be available as well. This could be extended to shopping malls like Bluewater."*
> (Female, 40-49, Dartford, Gravesham and Swanley)

> *"Do health checks at big local events, there is usually one or two every summer at the prom in Gravesend."* (Female, 30-39, Dartford, Gravesham and Swanley)

> *"We live in Hextable and we have a large community centre called The Howard Venue that we can all get to without a car but it doesn't offer any health or GP facilities."* (Female, 60+, Dartford, Gravesham and Swanley)

But there were some concerns, particularly at the idea of a venue such as a library being used for medical examinations or consultations, which raised questions about privacy and hygiene.

> *"A library is definitely not the best place to hold a clinic: much better to use local GP surgery."* (Female, 60+, Thanet)

There were also concerns about security if the general public was invited to use health facilities in a children's centre. But overall, participants were supportive of the idea, so long as the right facilities were provided at the right venue. It was seen as particularly helpful in addressing the problem of access in rural areas and for those with easy access to public transport.

Cottage and Community Hospitals

Participants had strong views about cottage hospitals. In general, those who were familiar with them were very positive, and saw them as a vital way to help bridge the gap between an acute hospital and care in people's own homes, for post-operative recuperation or for a lower intensity of medical care. They were often critical of past decisions to close or downgrade cottage and community hospitals. Those who lived in areas where there was no community or cottage hospital were often frustrated by the lack of provision.

There was less unanimity about extending the facilities or services provided by cottage hospitals. Some people thought this would be valuable, or might make cottage hospitals more viable and prevent their closure; others were concerned that it would take up valuable capacity or dilute their benefits.

> *"One thing you should do is locate the eye serve van for regular checks on eyes at another location. Parking in the ambulance bay at the [Victoria Memorial community hospital in Deal] is not helpful as it means loads of additional cars parked, as patients drive there. Why not locate these in supermarket car parks?"* (Female, 60+, Swale)

But all the discussion tended to reflect two underlying and strongly-held views: that there should be a network of local hospitals for post-operative recuperation and minor in-

patient procedures; and that there should be local health centres or polyclinics where a range of services could be brought together on one site.

> *"Similar idea of Children's Centre principles for older adults - one shared area with multiple services working together for holistic community care."*
> (Female, 50-59, Medway)

Innovations

Participants were offered a series of national and international innovations in health and social care and were asked to choose those that they thought could help improve the lives of people in Kent and Medway. The most popular innovation was to give planning priority to housing developments that are dementia-friendly, accessible and contain communal living-space and facilities and on-site care: this was chosen by 69% of participants.

The next most popular, with 57% support, was for a national scheme in which young people could volunteer to help care for others in return for reduced higher education tuition fees or priority access to apprenticeships and public sector posts. 51% supported combined, single-site day services for children under five and older adults; and 49% supported local restrictions on the sale of alcohol, including personal use limits and restricted opening hours. 45% supported care brokers who would match those in need with volunteers, and 43% help to buy or shared ownership for those who would sub-let to lone, isolated or vulnerable or elderly people. The option with the least support, on 38%, was a social care bank or cooperative, where people could exchange care services with their neighbours.

By definition, some of these innovations will have been unfamiliar to many participants and as (in general in surveys of this kind) higher familiarity leads to higher favourability, it would be reasonable to assume that if these innovations were presented in greater detail, or were piloted, there would be greater support for them. Further, it may also be that participants gave more support to those innovations that were more familiar or could more easily be imagined working on the ground, such as restrictions on alcohol sales, compared to others that were less easy to turn from a concept into reality, such as a social care bank. But even if such effects were at work, they are very unlikely to outweigh the broad picture of strong support for dementia-friendly housing developments and a national scheme for young volunteers.

Over 100 participants offered their own ideas for innovations in health and social care. The most popular was for health, social care, leisure and community facilities to be

brought together on one site, so that people could receive all the care and support they needed to live healthy lives in one integrated package.

Participants also suggested changes which, if not exactly innovations, were changes in priority or ways of delivery. The most popular of these was for enhanced health education in schools, including teaching children how to eat healthily; and making healthy food more affordable, including lessons in healthy cooking. The other recurring themes were:

- Encouraging people to walk or cycle more, including cycle lanes, more and better footpaths, and an extension of the London bike hire scheme;

- Bringing the generations closer together, including co-locating day care for the elderly and for pre-school children, and encouraging children visits to care homes;

- Discouraging unhealthy eating, including taxing sugar and salt and reducing the number of fast-food takeaways;

- Encouraging or requiring employers to provide time in the working day for employees to exercise;

- Enhancing advice and support for mental health on the same lines as for physical health, and not only dealing with serious cases of mental illness;

There were other ideas which only received one or two mentions, but were nevertheless of interest or reflect the wide range of views or priorities amongst Kent and Medway residents. These included:

- A scheme should be set up to encourage safe hitch-hiking and car-sharing, with drivers given ID and CRB checks, to help improve access to services;

- All doctors and nurses who train in the NHS should in return be required to work in the NHS for a time;

- There should be 'Tech-free' zones to reduce people's dependence on new technology and improve mental well-being;

- An employment agency should be set up specifically for older and/or disabled people to match them with suitable job or volunteering opportunities;

- Parishes should keep registers of volunteers prepared to help out in the community;

- Patients should be told the cost of their treatment to the NHS, to encourage more healthy lifestyles and self-care;

- Patients should pay a small charge to visit the GP to encourage self-care; and/or charged a larger fee for missed appointments or unnecessary visits to A+E;

- Health and social care staff should be encouraged to lodge with an older or vulnerable person, to provide informal care and reduce their accommodation costs.

5. Conclusions

There is a set of principles implicit in the evidence we have reviewed which could usefully help guide the further development of the STP in Kent and Medway. Not all participants would agree with all of these principles, or give them the same weight, or express them in the same way; but there are points on which we see majority agreement.

- First, that **there is scope to deliver better services within existing resources**. Some, perhaps even a majority, might want to see substantially greater resources committed to health and social care in Kent and Medway; but working within existing budgets does not, for most participants, invalidate the process. However, there was some scepticism about how much could be achieved – particularly in areas of innovation such as social prescribing – and a clear view that specific areas, including social care and above all mental health, needed extra staffing and other resources.

- Second, there was widespread agreement that **the system needed to be better integrated**, not only between health and social care, but with a wider set of public services, including education, transport and leisure. Grouping services around GP practices was one way to achieve this that participants could either imagine working or have already experienced; but perhaps even more important than integrated access was for services to be provided in an integrated way for individuals, taking account of their specific needs and circumstances.

- Third, people were **open-minded about innovation** and there was **an appetite for new technology** to support health and social care, but not at the expense of a service that became more remote and impersonal; it was a recurring theme that participants wanted to be listened to more, and to see a friendly face who understood them as an individual.

- Fourth, that **people wanted to do more to look after their health**, and to a large extent understood what they needed to do. They saw it as a matter of their own will-power as much as external circumstances (although many participants also had existing medical conditions that prevented them from taking exercise or participating in activities as they would wish); but that additional information and support would help them onto the right path.

- Fifth, some participants felt they had been **let down by the system** or had experienced inadequate care and support; but for the majority, the issue was not the quality of care or the commitment or professionalism of staff, but their ability to access what they needed.

Appendix 1: Topline Survey Results

Q1. Where is your home located? (Please enter the first part of your postcode; for example, TN23.) (n=1,882)

Postcodes	Number	Percent
ME1-19	839	45%
CT1-21	624	33%
TN1-25	329	17%
DA1-14	84	4%
Other	6	0%

By Clinical Commissioning Group	Postcodes	Responses
Ashford	TN23-27, TN30	127
Dartford, Gravesham and Swanley	BR8, DA1-4, DA9-13	79
Canterbury and Coastal	CT1-6, ME13	284
Medway	ME2-8	462
South Kent Coast	CT14-21, TN28-29	156
Swale	ME9-12	90
Thanet	CT7-12	173
West Kent	ME1, ME6, ME14-19, TN1-2, TN4, TN8-15, TN17-18	408

Q2. Which of the activities below do you do to stay healthy? Please tick those that you do regularly. (n=1,885)

	Number	Percent
I eat at least five portions of fruit and vegetables a day	1,142	61%
I exercise or am active until I am slightly out of breath for at least 150 minutes a week	834	44%
I carry heavy shopping, dig the garden, work out with weights or do other things that keep my muscles strong	962	51%
I don't smoke tobacco/cigarettes	1,666	88%
I choose plain water or unsweetened drinks instead of fizzy or sugary drinks	1,449	77%
I limit sugary, fatty and salty snacks and foods	1,225	65%
I know my BMI - Body Mass Index - and maintain a healthy weight	747	40%
I keep to recommended daily alcohol consumption limits	1,250	66%
I get a good night's sleep	1,052	56%
I spend social time with other people and do activities I enjoy	1,381	73%
I talk about my feelings and ask for help when I need it	1,020	54%
Other (please specify)	223	12%

Other (total number of mentions):

Walking (including dog-walking)	50
Not drinking alcohol	27
Volunteering	20
Yoga / Pilates / Tai Chi / Ju Jitsu	20
Dieting / weight loss groups	9
Positive thinking / mindfulness	8
Arts (dance / music / reading)	7
Swimming	7
Allotment / gardening	6
Vegetarian / vegan	6

Q3. What is the one change you would like to make to improve your general health and wellbeing? (n=1,652)

Subject	**Mentions**	**Percent**
Exercise more	525	32
Lose weight	388	23
Support / treatment for existing health / mental health condition	110	7
Better diet	106	6
More free time / better work-life balance	101	6
Less stress / anxiety / worry (in general)	76	5
Sleep more	69	4
More activities / socializing	62	4
Stop smoking	41	2
Less stress / anxiety / worry (at work)	39	2
Cut down on alcohol	29	2
Cut down on fats / sugar / salt	28	2
More facilities, including health and well-being counselling	27	2
Changes to NHS including role of private sector and complaints handling	25	2
More affordable activities	17	1

Q4. What is the biggest barrier stopping you making that change? (n=1,616)

Subject	**Mentions**	**Percent**
Lack of will-power / motivation / self-discipline	254	16
Time	244	15
Time spent at work	221	14
Costs and charges for activities	204	13
Disability / ongoing medical condition	192	12
Family / caring responsibilities including children	108	7

Time spent socialising	58	4
Lack of availability and opportunities	57	4
Sleeping badly / tired / lack of energy	46	3
Stress	41	3
Over-eating / junk food	38	2
Information about healthy living including available help	36	2
NHS / quality of services	26	2
Age	24	1

Q5. What would most help you to make that change? (n=1,508)

Join a group	21%
One to one support (such as a health trainer)	29%
Information	17%
Low-cost exercise activities	39%
Recommended smartphone apps	11%
Other	35%

Other mentions:

Work less / retire / work more flexibly / less stress at work	50
Receive treatment or research to find cure	49
More motivation / self-control	46
More support	34
More time	29
More facilities including affordable and local	25
More groups for support or activities	23
More support / facilities from employers	23
More health funding / staff / services	18
Points about national and local politics / NHS reforms	18
Better information and communications	16
Better-off / earn more / more financial support / win the lottery	16
Childcare / support for carers	14
Healthy eating / affordable healthy food	13
Other	10

Q6. Do you know which services are available in your area to help you with health improvement - such as diet, or exercise or managing weight, stopping smoking? (n=1,683)

Yes	48%
No	27%
Not Sure	24%

Q7. What is the best way to tell you about health improvement services which are available in your area? Please tick those which are most likely to help. (n=1,780)

Adverts on screens in waiting rooms in GP practices or hospital clinics	40%
Health-focused website and app	32%
Paid-for promotions on Facebook	12%
Posts on Facebook shared by your friends	24%
Posters and leaflets in shops and community venues	37%
Posters and leaflets in GP practice, pharmacies and hospitals	45%
Leaflets put through your door	43%
Articles in council magazines	29%
Articles or adverts in local papers or magazines	29%
Text messages from your GP practice	33%
Emails from your GP practice or other service providers	48%
Articles or adverts on websites that you use a lot	17%
A leaflet given to you by staff treating or caring for you	34%

Q8. Many people live with and manage one or more long-term health conditions such as: heart problems, lung disease (COPD) and diabetes. If you have a long-term health condition, how confident do you feel that you can watch out for and manage changes to your health condition at home, with advice and support from a health professional? (n=1,225)

Very confident – I know my body and have been managing my health for years	27%
Quite confident – I know who to ask for advice and I already know what to do for some issues or problems	46%
Not very confident – I worry things will get worse quickly and I won't know what to do	10%
Not at all confident – I want to be seen by a health professional, I would panic on my own	3%
Don't know – I've not thought about it or been asked about it before	14%

Q9. If health and social care services could be available at times when your usual GP practice is closed, when would you be most likely to need them? Please use the star rating to indicate which sessions you are likely to use - using the most stars for the one you will most use. (n=1,336)

	One star	**Two stars**	**Three stars**	**Four stars**	**Five stars**	**Weighted average**
Weekday evenings 5pm to 10pm	9%	6%	11%	17%	56%	4.06
Week days overnight	42%	18%	15%	10%	15%	2.38
Saturday mornings 9am and 1pm	13%	10%	21%	21%	36%	3.56
Saturdays 9am to 5pm	13%	12%	22%	22%	31%	3.47

Saturdays 8am to 8pm	19%	12%	18%	18%	33%	3.34
Sundays 9am to 1pm	24%	15%	21%	18%	22%	2.99
Sundays 9am to 5pm	20%	13%	19%	19%	30%	3.26
Weekends overnight	43%	14%	14%	10%	19%	2.49

Q10. If health and social care services could be contacted at times when your GP practice is closed, how would you prefer to contact them? Please use the star system to show which you would prefer to use (most stars) down to the one you at least likely to use (one star). (n=1,484)

	One Star	Two Stars	Three Stars	Four Stars	Five Stars	Weighted average
By telephone to a single number	4%	2%	7%	14%	72%	4.47
By email	21%	13%	19%	21%	25%	3.17
By text message	29%	14%	21%	18%	18%	2.82
Via a web site	26%	17%	20%	18%	19%	2.87
Via a mobile phone app	41%	15%	15%	14%	16%	2.49
All of the above	23%	6%	15%	13%	42%	3.46

Q11. We want to use technology to provide a faster more efficient service to our patients and their families. Which of these new additional services would you be happy to use? Please tick as many as you would like. (n=1,507)

A call-back from a health professional	80%
A video call (Skype or similar system) with a health professional in your home	35%
A video call (Skype or similar system) from a health professional whilst at your GP practice, for example if a hospital consultant could talk to you and your GP at the same time to give advice on follow-up treatment rather than going to a hospital appointment.	41%
Messaging via a website.	25%
Messaging via a mobile phone app.	28%
All of the above	23%

Q12. Please tell us what sort of assistance you would be happy to use via the technology-linked health services listed above? (n=1,475)

Follow-up after treatment	55%
Monitoring	51%
Specialist or second opinion on images (such as x-rays, scans, MRI) sent to another health professional	40%
Health screening	31%
Check-ups	35%
All of the above	53%

Q13. A modern approach to health and social care services requires the best technology so everyone treating or caring for you can (with your consent) see your record. Technology can also help you access health and care services more quickly and easily. Which of the methods listed below would you use? (n=1,505)

A single joint patient record that can be viewed and updated by all those providing person's care	84%
A computer system that lets people book all their health appointments online	74%
Secure online access to your medical records	71%
Ability to book appointments and view your medical records via a smartphone app	42%
Electronic discharge letters and notifications	59%
Electronic test results	71%
Electronic referrals	64%

Q14. Although the NHS and social care have secure systems and strict rules on how we protect your data, do you have any concerns about the increased use of technology? Yes / No (n=1,258)

Yes	396
No	134
Other (comments and observations)	728

If yes, please explain.

Hacking / Identity theft	173
Disclosure to insurers or other third parties	28
Unauthorised staff access	28
Accidental data loss	27
Difficulty for patients to access records	18
System downtime / crashing	18
Poor or incomplete record-keeping	15
Loss of personal touch / patient contact	8
Funding / cost / drain on NHS	7
Other	15

Q15. If you had access to 'social prescribing' – when a volunteer or professional links people to alternative sources of support in the community – which of the activities listed below would you be most likely to join? (n=1,474)

A walking group led by a volunteer	35%
Exercise classes led by a health or care professional	53%
Exercise classes led by a volunteer	26%
A peer-support group organised by a voluntary organisation or charity	23%
A peer-support group organised by staff at your GP practice or other health or care	28%

staff	
A weight loss or weight management programme	34%
Healthy eating, cooking and meal planning activities	31%
Community gardening or allotment activities	21%
Art and craft sessions	26%
A community choir or other voice-based music group	20%
Life story or local history group or memory café	16%
None	15%
Other	9%

Other mentions:

Book and other groups	9
Swimming	6
Yoga / Tai Chi	6
Dance	4
Other sports	11
Other arts	4

Q16. Below are some services that could be included as part of single teams providing health and social care of different types. For each service select a score on the scale from 0 to 4, 0 being it's a bad idea and 4 being it's a great idea. (n=1,311)

	0	1	2	3	4
Home-birthing support	11%	8%	21%	20%	41%
Care coordinators or personal care managers	3%	5%	15%	24%	54%
Personal assistant employer support and advice	11%	12%	28%	21%	29%
Personal budget support	13%	12%	25%	23%	28%
Carer support and advice services	3%	3%	14%	28%	53%
End of life care support	3%	2%	4%	18%	74%
Hearing loss support, advice services and clinics	2%	5%	19%	30%	44%
Medication advice and medicines use reviews	3%	4%	17%	29%	47%
Cancer survivor support	3%	2%	12%	23%	60%
Support for parents of children with additional physical mental health needs	3%	2%	8%	21%	67%

Q17. These are some ideas that have been suggested nationally or internationally. Which, if any, of these ideas do you think might help you and people you know to lead healthier lives? (n=1,219)

Neighbourhood social care bank or cooperative society where people can offer to swap or exchange care services with their neighbours	38%

National volunteering service where younger people volunteer to care for others in exchange for reduced higher education tuition fees or fast track access to apprenticeships and public sector posts	57%
Professional care brokers who match those who need care one-to-one with local volunteers	45%
Priority planning approval for housing developments that are dementia friendly, accessible and include intergenerational communal living space and amenities and on-site care provision	69%
Help to buy, shared ownership for younger adults sharing or sub-letting their home to lone, isolated and vulnerable elderly people	43%
Local restrictions on alcohol sales, restricted outlets and personal use purchase limits, restricted opening hours and licensing hours	49%
Combined, single site day services for children under 5 and older adults	51%

Q18. Are there any innovative ideas that you think might help you and people you know to lead healthier lives? (n=429)

Most popular ideas:

More education on health and food in schools	15
Making healthy food more affordable	13
Affordable gyms, including equipment in parks and on seafronts	10
Hubs and other ways to bring together health and community facilities	10
Employees to have time off to exercise / maintain their health	8
Using IT to provide more mental health advice and support	8
Reduce the number of takeaway and fast food outlets	7
A small charge for GP visits to discourage 'timewasters'	6
Community woods / gardens	5
Pets and young children to visit care homes	5
Taxes on sugar and fat	5

Q19. Community and GP practice nurses have a wide range of skills that are absolutely essential to giving people local care and treatment. Please take a moment to read through the list of these services then tick up to five that you think are most important for your area. (n=1,317)

Provide care and treatment for people with long term conditions, working with a team of professionals who care for people with complicated health issues and conditions	66%
Plan and support care at home or close to home for people at the end of their lives, including giving medicines	58%
Provide intravenous therapy (drips) and device care	11%
Train patients and their carers in self management such as to take or give medicines	37%

themselves	
Care for wounds including assessments, prescribing care and referrals to specialist services	28%
Provide care at clinics including specialised nursing for certain conditions	26%
Recognise and treat urinary tract (water) infections when patients are housebound	22%
Provide nursing care with GPs so that the most vulnerable patients avoid going to hospital	58%
Prescribe continence products (pads etc) and manage referral to specialist services	14%
Provide health checks and flu jabs for housebound people	26%
Recognise and support patients with complex, complicated and or long term conditions	40%
Be a constant point of contact for patients on their list.	34%
Be notified when patients on their list go in to hospital and be involved when they come out	36%
Be able to admit patients into community hospitals and respite care	30%
Make referrals to specialist respiratory (lungs and breathing) / heart failure teams	16%
Support for patients and carers living with dementia	43%
Provide an assessment of mental health and referral to the appropriate service	35%

Q20. If you have direct experience of COMMUNITY NURSE OR GP PRACTICE NURSE services please tell us in the boxes below what works well, and what needs to improve? (n=252)

What works well:

Nurses carrying out straightforward tasks (blood tests, diabetes etc)	66
Having the same nurse / knows the patient	27
Faster treatment	25
The quality and expertise of the nurses	25
Communication / take time to listen / more time than GP	20
Friendliness and compassion	16
Local service / visit the home	13
Post-operative or long-term supervision and follow-up	12
District and community nurses	10

What needs to improve:

Availability / capacity	57
Staffing	52
Coordination and duplication with health system	32
Quality / training / knowledge / attitude of staff	28
Waiting times	27
Communications with patients / carers	24
Continuity / same nurse / better record-keeping	23

Provision for specific conditions such as wounds	17
Longer time for staff to spend with patients	16
Online records / bookings / tests	12
Out of hours appointments	12
More powers / expanded roles for nurses	11
More information / publicity about what services are available	7
Other	21

Q21. Adult social care helps people live their lives comfortably, particularly those people who require extra practical and physical help, and to stay connected in their community. Adult social care aims to help individuals to improve or maintain their wellbeing and live as independently as possible. Do you or does somebody that you care for receive any of the social care services listed below? Please tick any that you receive. (n=218)

Help or support with personal hygiene (such as bathing and being dressed)	52%
Help or support with access to nutrition (such as delivery of meals)	29%
Help or support to make use of the home safely	45%
Somebody to support you to access work or training, or attend day activities and venues outside your home	16%
Benefit advice, help and support	32%
Support with housing	18%
Support with accessing employment services	9%

Q22. Do you or somebody that you care for pay for [self-fund] any of these social care services? Please tick any that you make a contribution towards or pay for in full. (n=163)

Help or support with personal hygiene (such as bathing and being dressed)	64%
Help or support with access to nutrition (such as delivery of meals)	40%
Help or support to make use of the home safely	44%
Somebody to support you to access work or training, or attend day activities and venues outside your home	20%

Q23. If you or somebody that you care for have used social care services please tell us in the boxes below what works well and what needs to improve. (n=227)

What works well (most common mentions):

Home care and personal care	21
Praise for staff	20
Quality of care, including continuity in staffing	18
Praise for specific services / treatments	17

Home aids	9
Sympathetic carers	9

What needs to improve (most common mentions):

Co-ordination / joined up deliver	31
Time spent with clients	21
Continuity including retention and pay	20
Reduce staff turn-over / training / quality	17
Responsiveness / urgency in crisis	15
Better discharge from hospital / aftercare	14
Better information and communication	8
More funding	8
Support for carers	7
Better mental health care	6

Q24. Please take a moment to read through the list of MENTAL HEALTH AND DEMENTIA CARE services. Please choose up to three that, in your opinion, are the most essential for us to provide? (n=1,248)

Work together in a multidisciplinary team so that all patients' medical needs are treated at the same time	57%
Provide support and early help to known and new patients with mental health needs	42%
Work with patients to manage their mental health and wellbeing, and crisis situations	35%
Be a constant point of contact for patients on their list	29%
Quick access to specialist teams (eating disorders, drug and alcohol services)	22%
Set boundaries with the person using services and their family/carer, focusing on choices and independence	6%
Support patients with medication including requesting an urgent review of any medication that they take to help their mental health	17%
Access to a wide range of support services including leisure, employment and other non-NHS services	13%
Recognise physical illness and refer to colleagues in multidisciplinary teams	13%
Provide support for people in a mental health crisis	35%
Support the early identification and diagnosis of dementia	35%
Work with people who have dementia and their carers to manage their health and wellbeing	36%

Q25. If you or somebody that you care for have used MENTAL HEALTH or DEMENTIA CARE services please tell us in the boxes below what works well and what needs to improve. (n=327)

What works well (Top 10 Responses)

Nothing / Not much	42
Care and support from GPs and other staff	27
Specific services such as CBT and dementia cafes	22
Quick referral / help	15
Caring / Listening staff	10
Continuity of care / same staff	9
Crisis Support	9
Assessments	9
Good when you can get it	7
Face to face / 1-2-1 care	7
Support to carers / day respite	7
Other	9

What needs to improve (Top 10 Responses):

Waiting times and the quality of initial assessments	68
The capacity of the system including staffing	62
More support for carers, including training	33
More respect / listening properly to patients / clients	25
Quality of care / need for training / poor diagnosis	24
Coordination between and within agencies	21
Post-discharge and long-term care / follow-up	19
Responding to patient / client crises	17
More communications including information on services	14
CAHMS services, including transition from child to adult care	12
Other	45

Q26. Do you think it would be a good idea if GP practices shared facilities with other community-based health and social care services? (n=1,327)

Yes:	67%
No:	5%
Not sure:	28%

If yes, which services do you think they should be? (Total number of mentions)

Social services / social care / social workers	80
Mental health	74
Community / district nurses / midwives	55

Physiotherapy	53
Diabetes, dementia, other specific conditions	45
Everything / as many services as possible	38
Specialist clinics and other health services	33
Health visitors / child health / school nurses	28
Blood tests and other diagnostics / screening	28
Health training / exercise classes / gym	22
Psychotherapy / counselling	21
Community hospital / minor surgery	21
Occupational / speech therapy	20
Pharmacy	19
Podiatry / chiropody	18

Q27. As part of the Kent and Medway plan, we want to make better use of public buildings and share space where possible, introducing health and social care services alongside others, for example regular opportunities to have health checks in your library or children's centre. Please share your ideas for how we could do this. How do you think better use could be made of our community [cottage] hospitals? For example for healthy living services and access to social care? (n=583)

Most mentions:

Don't use libraries for health consultations	14
More services in cottage hospitals	13
Libraries	10
Children's Centres / SureStart	6
Church halls	6
Supermarkets / car parks	5
We don't have a cottage hospital	5
Village halls	4
Schools	4
Sports Centres / pools	4
Mobile clinics	4

Q28. Are you male or female? (n=1,339)

Male	27%
Female	73%

Q29. What is your age? (n=1,340)

17 or younger	0%
18-20	0%
21-29	4%
30-39	11%
40-49	21%
50-59	24%
60 or older	40%

Q30. What is your ethnicity? (n=1,317)

English / Welsh / Scottish / Northern Irish / British	92%
Irish / Any other white	4%
Indian	1%
African / Caribbean	1%
Other	2%

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