APPENDIX 2

Wellbeing: Enhancing quality of life for people with care and support needs	
▪ Financial support/wellbeing	Access to benefits and financial advice
▪ Responsive overnight care service (covering both external and internal providers) ▪ Better incontinence support ▪ Flexibility in services ▪ Pool/register of Pas ▪ Personal budget freedom	Stimulate the market to provide more personalised services
▪ Emotional and practical support through life and support changes ▪ Listening service ▪ More frequent “check ups”/“check up” service ▪ Emergency low-level support availability ▪ Combatting isolation ▪ Use of technology to alleviate lonliness ▪ feel isolated due to limited activities in area for someone with my condition	Emotional support
▪ Support with and information relating to lifestyle changes ▪ Education and awareness programmes ▪ Access to and availability of information and services ▪ Appropriate training for all professionals	Information and Awareness (with Training as necessary)
▪ Accessibility/full use of existing property ▪ Help to maintain independence at home ▪ Suitable housing to meet needs	Supporting independence at home
▪ Accessible sports/wellbeing classes ▪ Better disabled facilities/toilets	Supporting independence in the community
▪ Build community capacity ▪ Encourage collaborative working with the individual and partner agencies ▪ Improving engagement/consultation	Community engagement/involvement & Partnership work
▪ MS OT	Specialist services
▪ More day care and respite availability ▪ A place or support group of mutual understanding	Community support
▪ Allocated professionals for consistency	One point of care management contact
▪ Work (FPH) do not undertstand that staff have long term conditions that may affect your working pattern - this keeps changing	Supporting employment

Recovery: Delaying and reducing the need for care and support	
▪ Ensuring installation and not just delivery of equipment ▪ promises made by OT not fulfilled - equip did not materialise	Ensuring seamless, end-to-end support
▪ Empowering and understanding own needs ▪ Knowing how and when to access support before crisis ▪ Education/respect for conditions to enable more appropriate practitioner support (not just medication for symptoms) ▪ Help to find the right support ▪ Correct information given at the onset/diagnosis of condition	Education / Information around Self-care
▪ More sheltered housing/supported living accommodation to enable independent living ▪ More accessible housing	Supporting independent living
▪ Holistic approach to care and health including dietary needs	Consideration of the whole individual
▪ Responsive OT for Stroke ▪ after stroke - leaving hospital it was a few months before speech therapy started	Specialist services
▪ Timely interventions	Right support, Right time
▪ Easier system to access non-critical services and support	Access to services

Experiences: Ensuring that people have a positive experience of care and support	
▪ Support the individual and not the condition ▪ Equality in treatment of different conditions ▪ Mutual understanding and management of (realistic) expectations ▪ More flexibility in the availability of care management adjusting communication methods to suit the individual (preferred contact methods) ▪ Easier navigation of the system (less need for "inside knowledge")	Fair/consistent access and support
▪ Increased knowledge and awareness of conditions at all levels	Awareness / Training
▪ Remove "postcode lottery" of services ▪ More choices of services	Stimulate the independent care market
▪ Accessible directory of services ▪ One point of contact for all help and advice ▪ Access to information (not just via the internet) ▪ Promotion of support/services ▪ Correct information given at the onset/diagnosis of condition ▪ Appropriate signposting ▪ Experts by Experience and more independent information	Access to information
▪ Joined up/seemless service approach between LA/NHS/VCS ▪ Greater strategic partnership work ▪ Easier transition from health to social care ▪ More opportunities to share experiences and understand practitioner/individual/organisational viewpoints ▪ Greater strategic community involvement ▪ Want to feel valued and listened to	Partnership work / Community engagement
▪ Continuity of care management ▪ Concerns regarding continuity of care management provision from part time staff	One point of care management contact
▪ Enabling and aiding planning for the future	Future proofing support plans
▪ Mobility concessions ▪ Access in to older buildings	Supporting independent living
▪ Help developing confidence	Personal development
▪ More freedom on fundamental decisions	Personalisation

Safety: Safeguarding people whose circumstances make them vulnerable and protecting from avoidable harm	
▪ Timescales from diagnosis to support to avoid unnecessary risk/deterioration	Timely interventions to reduce risk/escalation
▪ Greater engagement of hard to reach communities	Partnership work / Community engagement
▪ Greater support and information regarding PAs (legal, financial, etc)	Support around Personalisation
▪ Issues arising through confidentiality where communication difficulties arise for main/informal carers where not NOK	Information / guidance for informal carers or friends who are not NOK
▪ Anticipation of future needs when planning care	Future proofing support plans
▪ Concerns about competancy/standards of available support	Quality Assurance Assessment
▪ Mobility scooter speed restrictions	Community safety
▪ people need to be made aware of their rights	Awareness
▪ lost home help while being married ▪ Language difficulty - interpreters not always available	Protecting equalities