

B&NES Health and Wellbeing Network Meeting



the care forum
voluntary sector service

Wednesday 9 February 2011

Attended:

Pamela Akerman, NHS B&NES;
Sue Bateman, Action For Blind People/Rnib;
Harriet Bosnell, Somer Community Housing;
Sam Brinn, NHS B&NES;
Anthony Clarke, B&NES Council;
Betsan Corkhill, Stitchlinks;
Greyam Crowl, B&NES Council;
Janet Dabbs, Age Uk - B&NES;
Joan Davison, B&NES Carers' Centre;
Neil Drinkwater, B&NES Carers' Centre;
Corinne Edwards, NHS B&NES;
Helen Erswell, NHS B&NES;
Philippa Forsey, Creativity Works;
Richard Foulkes, BMI Healthcare;
Jackie Gore, B&NES Council;
Diana Hall, B&NES Link;
Janet Hall, Bath People First;
Helen Hanney, B&NES People First.;
Wendy Harris, B&NES Council;
Nicky Hayward, NHS B&NES;
Claire Hicks, Rethink;
Joel Hirst, NHS B&NES;
Damaris Howard, Freeways Trust;
Mary Ivey, Action For Pensioners;
Teresa Johnson, NHS B&NES;
Philip Kirby, Avon Local Medical Committee;
Charlotte Krezel, NHS B&NES;
Karen Lamb, Avon Local Medical Committee;
Wendy Lovell, Bath Care And Repair;
Isla Meek, Four Seasons Health Care;
Richard Merrett, NHS B&NES;

Mary Jane Middlehurst, Family Information Service;
Carole Pullen, B&NES Link;
Jane Pye, B&NES Link;
Karen Reid, Care South;
Ben Rogers, B&NES LINK;
Janet Rowse, NHS B&NES;
Paul Scott, NHS B&NES;
Sarah Scott, B&NES Health & Wellbeing Partnership;
Sarah Shatwell, B&NES Council;
Joanna Sheldrake, Intermediate Care;
Jo Spinney, NHS B&NES;
Pauline Swaby-Wallace, Bath Ethnic Minority & Senior Citizens Association;
Chris Taylor, B&NES Council;
Derek Thorne, NHS B&NES;
Jill Tompkins, B&NES Link;
Joan Travis, Action For Pensioners;
Janice Vincent, ICAS;
Karen Webb, Four Seasons Health Care;
Patricia Webb, NHS B&NES;
John Whapshott, B&NES Council;
Sarah Whitfield, Dorothy House Hospicecare;
Connie Wright, B&NES Link;
Dee Stainer, Bath People First;
Howard Wreford-Glanvill, B&NES LINK;
Emma Borowski, RUH;
Jo Reed, The Care Forum;
Ronnie Wright, The Care Forum;
Katharine Gonzales, The Care Forum.

Apologies:

Joly Babu, ICAS;
Melina Buckling, Mendip Care And Repair;
Denice Burton, NHS B&NES;
Tracey Cox, NHS B&NES;
David Donaldson, Bath Care And Repair;
Julie Evans, Somer Community Housing Trust;
R A Gardiner, Dunkerton Parish Council;
Meryl Gaskell, Living;
Sue Green, B&NES Social & Housing Services;
Alison Jackson, NHS B&NES;

Philip Kelley, Bath NHS Healthcare Centre;
Zoe Kelly, Care South;
Kevin Lake, Mendip Care & Repair;
Peter Lennard, Dorothy House Hospicecare;
Jerry Long, Lloyds Pharmacy;
John May, Corston Parish Council;
Hester McLain, B&NES Council;
Brenda Michael, St Mary's Surgery;
Chris Mordaunt, B&NES Council;
Malcolm Patterson;

Shirley Reynolds, B&NES Council;
Lorraine Rhodes, B&NES Council;
Rhiannon Richards, Royal United Hospital;
Naomi Rutter, Intermediate Care;

Dusty Walker, NHS B&NES;
Tom Watson, DHI - Developing Health &
Independence

Presentations:

Janet Rowse:

<http://careforum.pixillionserver.co.uk/assets/files/Volunatry%20Sector/Presentations/Banes/Janets%20presentationv2.pdf>

Pamela Akerman:

[http://careforum.pixillionserver.co.uk/assets/files/Volunatry%20Sector/Presentations/Banes/Healthy%20Conversation%20-%20Public%20Health%20Changes%20\(2\).pdf](http://careforum.pixillionserver.co.uk/assets/files/Volunatry%20Sector/Presentations/Banes/Healthy%20Conversation%20-%20Public%20Health%20Changes%20(2).pdf)

The workshop discussions are detailed later in these meeting notes.

Corinne Edwards and Sarah Shatwell:

<http://careforum.pixillionserver.co.uk/assets/files/Volunatry%20Sector/Presentations/Banes/Healthy%20Conversations%209th%20Feb%202011%20Re-ablement.pdf>

Key Points:

- 1** There is a lot of interest in and enthusiasm for the Health and Wellbeing Partnership Board - the balance of representation and accountability on this is crucial, as is the effectiveness of communication to and from the Board.
- 2** To ensure a wide range of providers, creative commissioning is needed that focuses on a social model of provision based on excellent strategic information about local needs and existing local services.
- 3** Commissioning programmes need to be inclusive, clear and systematic. That includes good feedback and monitoring and evaluation of services using an outcomes focus.
- 4** Accessibility of evidence in public health is very important. We need to be sure we are all effectively joined up in terms of the evidence we all have and consider how evidence and information is shared, including people's experiences of services.
- 5** The reablement service is of great interest and people are keen to hear more. In particular people wanted to know how the service would work for people with long term conditions and how it related to carers. They stressed the importance of links between the reablement service and other services.

Question and Answer Session – Corinne Edwards and Sarah Shatwell

Q: There are anxieties about working with Wiltshire: Wiltshire is in debt, B&NES is not.

A: Each local authority and PCT received some of the money. We have a natural relationship with Wiltshire, particularly around RUH, therefore we are doing things together, but we have different approaches to how we use the funding. We can use each other's learning.

Q: I am concerned about people with long term chronic conditions in older age. Suitable care will be there even if it means hospitalisation.

A: Our intention is to say that reablement is a good offer. If we reach more people and at an earlier stage, we can help people manage their long term conditions. It is not about saying that is the only offer.

Q: When someone has Alzheimer's, they immediately try to put people in an Alzheimer's unit or institutions. Families may prefer the home environment, so a specialist is needed with knowledge of Alzheimer's to go out regularly in the community.

A: One of the focuses of our work is looking at people with dementia. People are being admitted to hospital for social reasons. We are looking at a dementia pathway and at supporting people as long as possible in their own home. We are also looking at people who fall frequently and keeping them well in their own home.

Q: It is the same with mental health.

A: Another change in health and social care is around mental health services. There is a move towards reablement in mental health also.

Q: Can you outline how you will work with carers? You could have a support worker working with carers in house in a multi disciplinary team.

A: Sonia Hutchinson, Carers Centre, has been in contact about how we can be more involved, particularly supporting carers in hospital. We are having conversations with RUH, too. It is very much part of these plans. We are doing scoping work for identifying different issues. In the gapping work, an occupational therapist (Yvonne Thompson) is doing work based at the RUH and is capturing the needs of carers.

Q: How long will a service be provided, for example, dementia?

A: There is a distinction between reablement and a window of opportunity during which there is an emphasis on re-skilling people, a short term intervention. It should be free at the point of delivery. There are guidelines. Reablement is six to eight weeks.

A: There is a benefit as we have an integrated commissioning body and are looking at funding more broadly and using it more flexibly. We are looking at doing things creatively. This year we have non-recurring funding and are trying to think strategically about how to use it.

Q: We have an online support group for people with a long term illness. Many patients are demotivated and through the website we have 500 narratives. Social isolation negates treatment. There are cheap solutions, such as the social knitting group at the pain clinic.

A: We will get in touch and capture that information.

Q: I work with people who are deaf/blind. Communication is very different. Reablement services need to be extremely streamlined. Joined up thinking is needed. At assessment, people need to understand how to communicate effectively. Having the right service in place to start with is important. There could be a brokerage system in hospitals, so people know which organisations they can tap into.

A: We are on a journey and are learning. The RUH has a service called DATE which helps to coordinate people's discharge and makes links with community services. Yvonne is part of the DATE service. She is building a resource of knowledge.

A: One of the benefits of integration is that the reablement services enhances the social model, including inclusion.

People also recorded the following comments on post-its which Corinne and Sarah subsequently replied to:

Q BEMSCA would like a conversation into local progress – How are you going to develop the service in relation to ethnic minority people?

A We would be happy to talk to BEMSCA to get members views on how we might best ensure the inclusion of B&OME people - we would also ensure that any services commissioned as a result of the gapping and mapping work had a strong focus on equality and diversity

Q Will there be funding for training for providers to be able to train staff in reablement?

A The gapping and mapping process will highlight the need for training and we will invest in this if necessary.

Q Will providers be asked to pilot the reablement? If so, how will they be selected?

A There will need to be some sort of application process for providers as there is a limited amount of resource and we need to be able to evidence capability, capacity and outcomes, so careful monitoring during a pilot stage would allow us to do this.

- How would the reablement service work when the person falls into more than one category eg mental health, physical or long term chronic health conditions
- Ways to use resources for re-enablement
 - integrated computer services eg RIO, Carefirst accessible to social services/physical and mental health service. Health/hospitals/district nurses/community teams
 - mental health worker within intermediate care – to provide care and support to people with mental health difficulties and carers
 - increased amount of staff to provide a wider service. So clinicians can spend time on assessment
 - A need for mental health worker with intermediate care/ or re enablement teams –to work on people who have progressive conditions vulnerable to mental health conditions or dementia
 - Carers within re-enablement must look to professional for appropriate equipment use, before using equipment in order to safe guard service user i.e. to avoid use of hoists before it's use has been assessed for that particular service user by the appropriate professional

Closing Remarks – Derek Thorne and Janet Rowse

Derek noted the enthusiasm for the health and wellbeing board and the interest in it. The request for accountability and membership being thoroughly considered in the design had been noted. There is a strong message from provider to commissioner to have clarity about what is being commissioned and good arrangements in place for contracts. With evidence, research and the JSNA, the request had been made that people's experience is recognised as well as statistics. The point had been made that in future, thinking on reports from people using the service should be prioritised.

Janet thanked everyone for coming to the event and for their input. She added that she had heard very fair and appropriate challenges. She had also heard good connections being made to help them move forward quickly.

Workshops

Question 1 - Is the health and wellbeing board the right place to bring together ring-fenced public health and other budgets?

What is needed for the Board to be effective?

For example what information do they need and where from?

How would you like to see the board working?

Who do you think needs to be on the board?

Discussion

Who is on the Board?

- Good balance of representation e.g. between local authority and GP commissioners
 - include VCS representation
 - have to balance between effective decision making and hearing all information needed, mustn't be unwieldy
 - lines of accountability for all reps
- Where does community nursing fit? - relationship with GP consortium
- Healthwatch important partner - not just one place for 'public': needs more
- Role of VCS in identifying issues on behalf of patients, and identifying gaps
- Healthwatch and VCS need to be on PB - also must reflect capacity
- Planning need to be represented on PB
- Education a vital partner on PB. Role of schools.
- Social representation, rather than medical model. Right people on board to represent.
- What will be the balance/proportion of elected members?

What information needed?

- Patient scrutiny – not traditionally done so well by NHS: Board needs good data that is scrutinised, clear and transparent
- Accessibility to information and decision making crucial
- For Board members to make effective decisions they need information about quality of services
 - board monitoring spending
- Qualitative as well as quantitative data. Qualitative needs to be high priority and unbiased

Accountability and Structure

- Who decides who's on the Board? Representing wider public health interest. Elected members now involved as well – opening up to public scrutiny.
- Does the board have to make all the decisions? Could be made by subgroup
 - has to be range of different sub structures for PB to be effective
 - those links must be transparent
 - effective leadership from PB
 - JDs for all those on PB and subgroups: support influence of local people
- Concern about those who might want to challenge: scrutiny by others crucial. Commercial issues muddy water
- Social enterprise locally – need clarity between relationship between social enterprise and external providers
- GP skills around commissioning – some reps on Board representing local people/GPs accountable to NHS Commissioning Board: conflict? - Lines of accountability crucial
- Scrutiny – who is Board accountable to?- clarity needed about Board accountability
- Patient participation groups important
 - likely all GP practices will have to a patient participation group
 - line of accountability from PP groups through Healthwatch?

- All members of board to be equal: VCS, Healthwatch and GPs
- It is important that local people shape the makeup of the board
- Accessibility, accountability. Closed meetings? Will people be aware of how ring fenced decisions are made? Can people attend the meetings to hear what goes on?
- Trust with decision makers
- Care Quality Commission (CQC) – where do they fit in? CQC will have clout, but less resource
- CQC will probably want to see outcomes of work done as a result of the board i.e. evidence of outcomes
- Board must be a strategic group with small subgroups that research thoroughly and drill down. Subgroups produce researched, ethical outcomes that can be discussed by board
- What other places are there? Another tier might be created
- Concern that local politics might interfere

Board Considerations

- How assess quality of service received? From patient perspective - relationship of Board within clinical governance, complaints. How to capture patient experience - quality processes and relationship to PB
- Information available to patients - communication with patients crucial
- Training as people may not be professionals. Training for people on the board and others who are contributing
- Shadowing of people in their roles and jobs for the commissioners
- How will decisions be made? Some will be unpopular. Not yet thought out.
- Everything should be done to make the meeting as open and public as possible
- Preconceived ideas from health wellbeing board – think laterally

Communication and Access

- Different ways of communicating – choice of accessible formats
- Communication: the public are not always aware that things are open to them
- Communication needs to be transparent
- Council website not easy to navigate to get meeting papers. There needs to be signposting that the papers are there.
- Information about the meeting could go on PCT postmaster
- You can't always submit questions and often don't have the question until you get there
- Does the current board contact third sector people on the ground for comments when budgets are to be discussed? It might improve the profile of the board. They could go out and say: your budget will be tabled on such a date and what are the views of your organisation? It would stop the wrong messages filtering down and make the process transparent. *(NB to request an agenda is emailed before a meeting contact democratic services)*

Local Strengths

- How pilot of partnership looked at and taken forward important
- B&NES integration a bonus: are already involving good cross section of different groups. Good foundation
- Healthy conversation good event to link with PB

Question 2 - What can be done to ensure the widest possible range of providers are supported to play a full part in providing health and wellbeing services?

What are the barriers to such involvement and how could they be reduced?

Discussion

Commissioning Processes

- Good commissioning – clear vision. Open, honest and straightforward
- Knowing where to look and go to find out about what commissioners are intending to commission
- Knowing who to contact – link officers within the new organisations
- GPs not focussing on the medical model – more focus on social model (social prescribing)
- Social model vs medical model – need to understand both sides
- Client centred practice unconditional regard/multi media delivery of information for all people (social model)
- Consider the medical model and social model
- Taking a holistic approach
- GPs commissioning services require a tremendous understanding of all services and professionals available in order to make appropriate referrals
- GPs will require a lot of support and less pressure
- Staff with no expertise in procurement and commissioning need training

Develop the Market

- Need for 'creative commissioning' – working/supporting providers (business link) to develop skills within the sector – long term
- Supporting voluntary providers in the face of financial cuts. Considering time constraints. Not discriminating smaller providers – and reach all providers not just the known ones
- Need to engage with providers on the periphery of B&NES
- Impact of not knowing the impact of financial savings on the motivation of staff working in the voluntary sector. Can damage confidence with service users/clients
- New commissioning bodies to provide training to voluntary sector

Strategic – Service Needs

- Providers involved in the development of strategy
- Development of networks of providers
- Importance of providers knowing or being based in their local communities
- Development of a forum with the voluntary sector
- Not merging services who have different remits
- Keep areas of expertise, services to deal with what they know
- Is there a danger of watering down the services you provide if the specialism is not there?
- Time to be allowed to engage
- Disabilities in particular 'hidden' disabilities e.g. dyslexia
- Intervention services working with the voluntary sector who deal with vulnerable people e.g. stop smoking service. Delivering brief intervention training for staff working in vol sector.
- Understanding the roles of all professionals before you can appropriately commission services.
- Registration of GPs across board e.g. incident
- Funding pressures are affecting public and private sectors

Monitoring - Outcomes

- Financially astute and monitored
- Monitoring needs to be appropriate and reasonable for the size of the contract value

- Moving to measuring quality/outcomes, rather than activity/numbers

Marketing and Communication - Information

- Impact of the market and competition
- Communication across service provider
- Effective marketing of services
- Need to engage in different ways for different needs/age/cultures/geography (rural/urban)
- Involvement of patients/supported to take responsibility. Good information in simple form.
- Knowing how and where to get information
- Use of Well Aware database – not everyone has access to internet

Question 3 - The council will take on the lead responsibility for commissioning public health programmes in B&NES. National work, such as cancer screening programmes, will be commissioned by Public Health England or the NHS Commissioning Board. What do you think needs to happen, and how might we support commissioning programmes that:

a) ensure the best possible outcomes for the population as a whole, including the most vulnerable;
b) reduce avoidable inequalities in health between population groups and communities.

Discussion

Information – market intelligence

- Council will need excellent expertise, knowledge and information in order to make good commissioning decisions
- Collection of good quality information to inform strategic board
- Risk to be aware of = threat to voluntary/independent sector user led organisations
- Talk to people who do the work at the moment and also include a range of other providers who have something to offer eg voluntary organisations, independent sector etc
- Decision on funding distribution should be based on client centre collaboration and unbiased research and evidence (independent of company and agendas)

Inclusion

- Support for smaller interest groups which 'feed' board
- Voluntary/independent sector reps on Board
- Making contact with people who aren't in touch with statutory organisations
- Getting out to the community i.e. commissioners rather than inviting people in
- Pro-actively stimulate development of group/voice for people who aren't networked
- Join up public health with housing, children's planning, schools etc
- Include key vulnerable groups in the sub analysis of the public health outcomes framework
- 'minorities within minorities'
 - including people who have specific access needs when planning public information
- Remember social model of disability
- Better bespoke provision of services for people with specific needs - capturing equalities information
- Prevention across all disciplines
- May need 'additional interventions above the norm'

Systematic

- Strong systems, pro-active, bespoke, to ensure accessibility for all – different formats
 - giving time for this
- Ensure feedback mechanisms to support accountability
- Support for a range of feedback mechanisms so we can learn from this and what went well e.g. PALS
- Get the health and wellbeing board right – right kind of representation – funnel effect
- External oversight and supervision – scrutiny framework

Mechanisms

- Audits and surveys eg housing used as planning tools, better strategic planning
- Use of newer media might widen inequalities
- Capturing better outcomes data on provider monitoring returns
- Use parish councils to highlight local priorities

Clarity of Purpose

- Agree what we mean by 'vulnerable' and 'best possible outcomes' e.g. carers/young carers
- Carers – identifying people who don't consider themselves vulnerable

- Is there a prototype we can adopt?
- Having courage to keep investing when outcomes are long term
 - evidence base
 - creative – try different approaches
- Looking ahead and sharing knowledge/good practice

4 What can local partners contribute to improving the use of evidence in public health?

(Evidence can be information about local needs or information about programmes that are known to be effective)

What evidence do you gather?

How is it shared?

How do you think evidence should be used?

What information would you find useful? What information do you use?

Discussion

Changes

- Financial constraints and back function reduction/information
- Ensure transitions don't lead to loss of information e.g LINK changing to Healthwatch
- Loss of vital evidence when funding for a post cut – make use of evidence already provided/available

People and Services

- Don't have evidence/information to deliver services to carers
- Informal carers: isolated/don't understand needs
- Families don't feel empowered, particularly in health
- Information presentation more attractive and meaningful to communities
- Emerging issues/what does it mean for local communities
- Mental wellbeing: complex arrangements for measuring performance
- Service user evaluation of SVCS – consider the point at which service users are asked to complete form

Being Joined Up

- Expand university links
- Supporting public health to carry out evidence based analysis
- More joined up analysis/performance measures for providers
- More thought/synergy approach to indicator analysis/evaluation
- Ensure providers of information can see evidence of use to make it feel valuable/relevant
- 'no free lunch' teams to encourage unbiased research and not manipulation based on hidden agendas. Good outcomes measures that are accessible/client centred
- Public health largely numbers driven - how to incorporate anecdotal information and make it meaningful
- Feedback loop to information providers is key
- Strategic outcomes clearly accessible to providers
- Different data/information interesting/useful to different people – is anyone interested in 'the lot'?
- Nationally available data from locally based organisations
- Central portal for holding key data
- How can we share between 3rd sector and public organisations i.e. data protection/?
Governance
- Recognition that information sharing is compromised by non-communicating data systems i.e. GP practices, hospitals
- Improved interprofessional working by one compatible data/record base i.e. RIO. Holistic care. Social/medical

JSNA

- JSNA to clarify greater role for third sector

- JSNA: develop needs better
- Integrated marketing and communications to raise awareness of JSNA. Consider user friendly microsite similar to home office site
- JSNA useful in funding applications
- How to make JSNA accessible? - easy read version acceptable to all readers and checked by a panel

Access and Accessibility

- Accessible leaflets/docs
- Avoid use of jargon in shared information
- Use 'find and replace'
- Social model of disability – what information – accessible – two way
- Use existing experts in accessible information
- Difficult to collect information
- Information/evaluation overload

Evaluation

What was the most significant outcome of the event for you?

- Info about reablement and how it will reduce re-admissions
- Greater understanding of reablement and ITC plans for the future
- Finding out about local plans and health and wellbeing board - more on reablement
- Discussed reablement
- Intermediate care and re-enablement plans
- Information given - comprehensive and informative
- The grand setting and discussing and sharing a wide topic new to me
- Understanding the enormous project in hand
- Possibility of making good use of the voluntary sector. Cost effective funding needed.
- The need for better use of the voluntary sector. Funding is needed and will be cost effective.
- To hear the proposals for change
- Hearing about the new health and wellbeing board
- That B&NES seem to be in the forefront of planning for new provision
- Hearing how B&NES are planning to take these initiatives forward and engage as today in future provision
- Future plans of B&NES PCT
- Knowledge sharing
- Opportunity to input to discussion
- To learn more about new developments in public health
- It helped with a talk I have to give next week. Something here about how roles link and how we all can contribute to improving health
- Good chance to have an input into changes that will happen in B&NES. Very useful meeting
- More information about what is happening locally and plans for the future
- Better understanding of the topic
- Confusion
- New developments and more information about health and wellbeing board
- Listening to members of wider network
- Hearing view points of other providers and organisations
- Meeting others - link to safeguarding board
- To meet other people
- Information and contribution

Do you have any suggestions regarding topics/speakers for future meetings?

- Monitoring and development of the reablement process
- How the ICT and re-enablement service will be integrated and advertised and assessed for
- More on enablement
- More detail on reablement and how the programme will link to RUH DATE team
- Opinions as to where resources given to re-enablement may be directed from service users and service providers
- How do we get 'customers' ie service users to become more of a part of the health and wellbeing network
- How all the new systems will be made known at the "grass routes". Positive effort to get health and wellbeing promoted. Patients participating groups. Parish Councils so that the community is more informed.
- Group funding. How is it decided.
- Explanation of how group funding was decided
- In the not too distant future, a follow up meeting describing the suggested plans.
- More opportunity to help shape the new structure/framework for PH

- More on the public health role of B&NES council. More on reablement in practice
- Keeping us updated on changes
- Progress in both areas discussed today. Mental capacity - still often misunderstood by NHS professionals and key to health and wellbeing
- How to make it accessible for people with learning disabilities/other learning disabilities e.g dyslexia
- How will you make sure and continue to explain to the public all the changes being made

Are there any other comments you would like to make?

- Excellent meeting and discussion and meeting others. Many thanks to those who led us on our tables.
- Very useful morning. Good networking.
- Very useful overall - good to have time for discussions, and to be able to network with others
- Very useful
- Networking with others always useful at these type of events.
- Very interesting to listen to wide range of views and perspectives. Excellent PPI contribution
- Access in terms of my specific need was well catered for, thank you.
- Less going up and downstairs - not enough time. Much better to move facilitators than delegates.
- Questions for discussion not always clear.
- DDA compliance for all disabilities to have the ability to join in with these discussions. It would have been useful to have a list of attendees - helpful afterwards. The room was totally inadequate for group work
- Problems hearing in the room
- Room made it very difficult to hear what everyone was saying - the screen could have been pulled across? Morning presentations went on a bit too long which made the groups very short. Not everyone was able to have their say.
- Very difficult to hear all conversation when working in groups as background noise loud.
- More time to discuss things
- Needed more time/better acoustics for discussion
- It was too quick as I have dyslexia and only just understood the question before we moved on which affected my confidence to contribute. Thank goodness for post its.
- No labels on food. No plates or serviettes until too late. No water.
- Refreshments were too alternative (sandwiches) and not labelled. No plates, no serviettes, no water.
- There were no drinks at lunch time – just water would have been welcome and tea and coffee preferred.
- The need of better knowledge of front line care and outcomes has been highlighted – such increase in information will greatly help in planning care provision.

Content	Average mark (out of 5)
Understanding of subject at start	3.0
Understanding of subject at end	4.0
Sessions	
Speakers	4.0
Other elements	4.0
Organisation	
Pre-event information	3.8
Facilitation	4.2
Organisation on day	4.2

Venue	
Access	4.1
Refreshments	3.7
Standard of room	3.9