B&NES Health and Wellbeing Network Meeting Notes
Bailbrook House, Bath
Wednesday 18 November 2009

Attended:
Janet Elisabeth Cowland; Malcolm Patterson; Ben Rogers; Dorothy Suckling, Action For Pensioners; John and Mary Walden, Action For Pensioners; Janet Dabbs, Age Concern - Bath & NES; Amanda Simpson, Assura Minerva; David Leveridge, Avon & Wiltshire Mental Health Partnership NHS Trust (AWP); Mike Relph, Avon & Wiltshire Mental Health Partnership NHS Trust (AWP); Luke Byron Davies, B&NES Council; Adrian Inker, B&NES Council - Councillors; Jane Pye, B&NES DEF; Jill Tompkins, B&NES LINk; Pat West, B&NES LINk; Sheila Sheppard, B&NES Older Learners Forum; Heather Bonsey, Banes Social And Housing Services; Wendy Harris, Banes Social And Housing Services; Shirley Reynolds, Banes Social And Housing Services; Kathy Sinkins, Bath & North East Somerset Council; Anne Marie Jovcic-Sas, Bath & North East Somerset Racial Equality Council; Lesley Hutchinson, Bath And North East Somerset Council; Helen Hanney, Bath And North East Somerset People First; Richard Foulkes, BMI Healthcare; Neil Drinkwater, Care Network; Andrew Evans, Care Network; Jan Westrope, Citizens Advice Bureau - Bath & District; Lorraine Warrington, Connexions; Mary Hall, Crossroads - Caring For Carers B&NES; Julie Hughes, Drugs And Homeless Initiative; Karen Stephenson, Family Information Service; Jessica Burston, Great Western Ambulance Service; Yvonne Smith, NHS B&NES; Tracey Cox, NHS Bath & North East Somerset; Corinne Edwards, NHS Bath & North East Somerset; Sue Griffin, NHS Bath & North East Somerset; Joel Hirst, NHS Bath & North East Somerset; Craig MacFarlane, NHS Bath & North East Somerset; Janet Rowse, NHS Bath & North East Somerset; Derek Thorne, NHS Bath & North East Somerset; Dusty Walker, NHS Bath & North East Somerset; Patricia Webb, NHS Bath & North East Somerset; Lesley Featherstone, North East Somerset Arts NESA; Jade French, Rethink; Rhiannon Richards, Royal United Hospital; Brigid Musselwhite, Royal United Hospital Bath NHS Trust; Carole Pullen, Scout Enterprises Ltd - Western; Myra Dow, St John's Hospital & Bath Municipal Charities; Martha Flower, Support For People With Alzheimers; Gareth Griffen, Supported Living Service; Debbie Howitt, The Care Forum; Shirley Stephen, The Care Forum, Trustees

Apologies:
Silvie Chase ; Veronica Parker, B&NES LINk; Pat West, B&NES LINk; Francine Haeberling, Bath & NES Council - Councillor; Stephen Meredew, Bath & NES Council - Social & Housing Services; Marian McNeir (Cllr), Bath And N E Somerset Council; Sarah Brown, Bath And North East Somerset Council; Meri Rizk, Bath And North East Somerset People First; James Rumsey, Bpas; Pat Daley, Connexions; Helen Storey, Crossroads - Caring For Carers B&NES; Jayne Devlin, Hanover; Michael Lennox, Lloyds Pharmacy; Lee Eborall, NHS BANES; Simon Douglass, NHS Bath & North East Somerset; William House, NHS Bath & North East Somerset; Val Janson, NHS Bath & North East Somerset; Kieran Morgan, NHS Bath & North East Somerset; Phillipa Forsey, North East Somerset Arts (Nesa); Judith Marsham, Parkinson Disease Society -Bath; Debi Amor, Rethink; Claire Hicks, Rethink; Derek Loring, Samaritans; Mike Vousden, Scout Enterprises Ltd - Western; Lisa Otter-Barry, Soundwell Music Therapy Trust

Presentation: Janet Rowse
http://www.thecareforum.org/publication_uploads/HWB_Network_181109.pdf

Questions and Answers

Q: The presentation did not reference the role of the third sector. This needs to be clear.

A: We do need to acknowledge the role of the third sector.

Q: Individual budgets are going ahead, and I don't disagree with them, but grants for small charities enables them to do a lot of preventative work. There is flexibility in the grand system. Has any thought been given to the danger for preventative services?
A: Balance is needed as there is real pressure on budgets.

Q: Not all the results are positive.
A: There is a range of answers. Having a more focussed way to invest in the third sector is the route to go on.

Feedback from First Workshop

This workshop followed the presentation on the five year plan and was made up of two elements:

The first part of the workshop gave participants the chance to talk in more detail about the presentation, the key messages and engagement process for developing the plan. People had the opportunity to discuss any ideas or issues they had arising from the presentation. The second part of this workshop looked at the broad feedback that has been heard through the many engagement activities that have taken place. Participants were given a copy of the summary document (see appendix one) that is an overview of what people have said they want from services. We wanted participants to know that it is recognised that people have already given a lot of feedback in many different forums. The workshops spent some time discussing ways in which people think this might be done and talking about the summary document and whether people feel this is an accurate summary of key issues and whether people feel there are any critical omissions from the summary.

Workshop A

- Contact is not being made with the people, we don't hear enough.
- Small talks locally would be useful.
- We need to consider the meaning of community.
- It's different here to Midsomer Norton, for example.
- We need better information. The recent "Give us a break" launch was excellent, but there was a useful phone number mentioned which most people didn't know about.
- Council Connect is overwhelmed by leaflets and people just need to know what is relevant to them.
- The importance of encouraging people to take preventative measures can't be over emphasised. Funding is the dominating factor.
- A cultural change needs to be made so people can access services that make them feel better about themselves.
- GPs can't hold that information, what about using volunteers?
- If we had a specific area where there is a gap, we could concentrate our services there.
- Mosaic is software which pinpoints specific people reliant on investment for daily living, we are now able to target those areas.
- Our volunteers go out to various places, what about combining with us?
- The GP is not the best funnel for information. In the older people's group, we are looking at village agents. In the future, there could be voluntary organisations supporting the local area to draw up rotas to look after each other.
- Loneliness is a contributory factor in people going to the GP. We need to address how to get people out to simple events.
- A study in Somerset has shown that in villages with social capital, health was better.

- In Bath's NHS health care centre, we are inundated and the main population is aged 17-24. Student populations are growing, there are isolation issues and often chaotic behaviour.
- People need to recognise early on that a range of things might happen to them.
- An education programme is needed.
- People prefer walk in GP practices as they are not intimidated.
- We have found with our toe nail cutting service that it is an opportunity to sign post people to other services.
- National surveys in GP surgeries are not picking up local issues.

Workshop B

- Microphone issues – speaker needs to be able to project voice and repeat questions from the floor.
- Email slides out. Unfortunate they were not available today.
- Key messages. Understanding the story – there are serious omissions. Mental health – did not hear much, not prominent, no-one from B&NES attending important conference in London. **Action:** Corinne Edwards and Andrea Morland to obtain information from London conference on mental health.
- Mental health actions not being well publicised.
- Next conversations to focus on mental health services.
- 20% of complaints have a mental health dimension. Should be a priority to raise the profile.
- Meetings to have specific focus – inspiring members and service users.
- Give examples of service users.
- Signposting and accessing services is still a problem. Important for personalisation budget.
- How much conversation is going on between authorities? Do not reinvent the wheel.
- Liked symbols. Very simple summary of the journey/strategy - consensus.
- Focus on communication and accessible information.
- Is this good summary? Concern that not all providers understand disability access issues. Restricts access due to parking issues in Bath.
- Rural areas very restricted.
- Not more information. Less, more specific and accessible is better. Targeted information.
- GPs surgeries have information advisers. Have access to information and signposting e.g. benefits. For example, social prescribing.
- Housing – big gap in the presentation. A resource not emphasised enough. Add to values that people support.
- Big concern is out of hours services – problem across all health issues/ages.
- Urgent care – accessing right service at the right time.

Workshop C

Q: Transforming mental health services needs to be a priority.
A: Raised in parts on sheet not just over-arching mental health
Q: Concern about what is happening in the interim – concern that voluntary sector organisations may disappear in the process.
A: Need to converse with voluntary sector.
Q: Individual budgets (IBs) are a concern – confusing where work will fall when several voluntary groups. Our view of what IB holders need.
Q: Are you feeling the impact yet?
A: No, not IBs, just direct payments.
Q: Who provides back up if PAs/IB Staff do not show?
A: In theory there should be. In reality, this is not happening – and cost comes out of the voluntary and community sector (VCS).

A: PA sacked when IB holder spent money out of bank account unknowingly.
Q: Three month gap between status quo and new arrangements. Big problem for VCS funding. Issue about sharing confidential information – so not seamless at all.
A: So lots of anxieties about IBs.
Q: If VCS is marketing well, then creating poaching from other VCS groups. And spending time on marketing, not on delivering services.
A: Recognise pitfalls that the council and NHS B&NES need to work on with VCS groups.
Q: Harder to get agencies to work holistically and collaboratively if competing for IB clients.
Q: Value for money dominates over quality.
A: Maybe people will opt for quality service rather than cheaper.
Q: If 150 clients take IBs elsewhere, how will we need to reorganise our services?
Q: Should PCT/council facilitate collaborative working?
A: We are working in competition whether we like it or not so PCT.
Q: Contestability/competition is one route, but collaboration/quality is a good outcome. What role would PCT play to encourage this?
A: Should be done now, so VCS groups can plan to provide now eg for brokerage.
A: We need to know what commissioners really want, then VCS can build specialist response within overall strategy. Statement from commissioners that want everyone to contribute.
A: VCS group of 8 orgs with CAB is looking at all of this – to have single phone lines, joining together so can collectively provide a better service – benefits outweigh the advantages but don't know how long from outcomes. BC/PCT should support collaborative working so that public get best service. Share admin etc.
Q: Is there anxiety that if insufficient investment it is hard to plan. Would PCT have funds to support VCS through transition period?
A: We don't have that pot. Will need to shift money from secondary into prevention agenda.
Q: Could you support managing mergers? To overcome fear of the unknown.
A: No training for staff to prepare for IBs organisationally. No workshops for staff.
A: VCS do the red tape, but want to work with people. The pay off for the council will come if red tape can be reduced.
A: Clarity of context, commissioning intent, encourage opportunities for collaboration otherwise silos will be perpetuated.
A: Had a cooperative approach in the past avoiding gaps and duplication. But threatened by commissioning.
A: Need to take a dialogue not top down approach then providers part of the solution and have information.
Q: How will collaborative work together between private and statutory sector in acute services?
A: We will expect providers to offer how can provide better care more effectively. Need to know how to translate provide sector expertise/quality into other settings. RUH is now identifying services it cannot provide best.
Q: What will be the process for this?
A: Providers need to plan strategically ahead and we need to capture the opportunities this identifies. Will then need to test the market and make decisions.
A: Scope for PCT to provide capacity to bring providers together and support process of forming consortia.

Workshop D

- Presentation clear – a lot to do.
- Challenges: how do we ensure continued delivery.
- Story accurate: concerned about chronic conditions.
- Expert patient programme crucial for this.
- Wish social prescribing at all surgeries – bridging VCS/statutory GP services vital.

- Challenge: ensuring all available resources used/coordinated – integrated H and SC, but more collaboration needed, eg with RUH.
- How to maintain funding for services working well?
- Need to ensure, for example, migrant communities have clear information.
- Reducing reliance on statutory services: how support communities in pulling together, for example, mental health and older peoples services.
    - Community empowerment agenda crucial
    - Recognise importance of building "social capital".
    - Social prescribing. Time banks. Gloucester work.
- MH issues: have to address, include education. Re: supporting people and mental health
    - Need to reduce stigma.
    - Baccalaureate potential.
    - Intergenerational work.

Key messages paper

- Big concern: people's expectations in relation to services.
    - Managing expectations.
- Communications: people and ESOL.
- Registration.
- Ways to encourage people to take more responsibility for own health.
    - How engage with wider population?
    - Starting and YP
    - Cultural change: think this is emerging
    - PH debate also helping and this
    - All know what should do

Workshop 2

Workshop 2 followed presentations on two particular programmes: urgent care and communications.

Tracey Cox – Urgent Care
http://www.thecareforum.org/publication_uploads/Tracey%20Cox%20Presentation%2017%2011%2009.pdf

Derek Thorne – Communications Strategy
http://www.thecareforum.org/publication_uploads/Communications_presentation.pdf

Workshop A

Urgent Care

- Walk and wait is not universal.
- When in pain, we don't always know what the matter is and where the best place to go is.
- GPs are all so different. Benchmarking of GP services is needed.
- A triage system from a nurse would be appreciated. It's there at night, but not during the day.
- The triage system provides a well defined pathway from 6pm to 8am.
- A big issue is also judgmental receptionists.
- Receptionists sometimes behave like that because they don't have any appointments. GPs sometimes hide behind the receptionists
- If you go to a pharmacist, you have to pay. What about people, such as a lone mother on tax credits, having a card for free prescriptions?

- Pharmacists are very helpful. They help to make things less medical.
- It's also about skilling people up to be able to recommend a lunch club, for example.
- People need advice and support when they are in pain and worried.
- In an acute episode of pain, there are too many gateways. The services need to be amalgamated. Riverside could be moved to A and E.
- At A and E, you know you will be seen.
- The GP led walk in centre is open every day for a year and cuts across the same hours as out of hours. Two hours every evening overlaps, which is confusing for patients.
- A lot of people don't go to GP practices. Information about which service to use needs to get to people locally and simply.
- Although someone might have gone to the wrong place, they may not be re-directed due to lack of staff and time, so the situation is perpetuated.
- Often people are going to A and E with exacerbation of a long term condition. People with long term conditions need to know that they can go to a surgery, where people know them and their condition.
- People who can't see their GPs, particularly for dressings, will come to Riverside. Commissioners could specify that nurses need to be provided.
- We need to communicate with schools, sports clubs and universities as they often send people to A and E when injuries could be dealt with by the GP or minor injuries unit.
- It's also about triage. Someone could help schools decide where to send the injured child to.

Communications Strategy

- Social marketing: Service users and the public need to be involved in this process to make sure that the language makes sense.
- A little clear, consistent information is needed, perhaps it could be provided at parents' evenings?
- We have a magazine at St Marks. I'll arrange for you to put some information in it.
- What about having a bank of volunteers to go into schools? They could be given training and support. The volunteer centre could help with finding volunteers.
- Advertising on big boards or on the back of buses is effective.
- In California, prevention is very public with social marketing on TV and there is a very detailed hand book with steps in it, provided by the insurance funded system.
- A book on how to use the NHS would be useful, as are the maternity books.

Workshop B

Urgent Care

- Why is NHS Direct not used? How to promote it.
- One first point of contact to signpost.
- Promoting NHS Direct. Must have confidence that NHS Direct will respond.
- Ensure NHS Direct has knowledge of local services.
- Target specific communities with information.
- Simple information, easy to retain in a stressful situation.
- Promote walk-in centres/minor injuries unit.
- Problem of access in rural areas.
- Access of all equality groups.
- Information needs to be simplistic. How much assessment at individual levels is required? Do we want more support for self assessment? Do we recognise some groups will need more support than others?
- Use third sector to signpost.

- Dementia is a priority.
- Older People living alone require additional support.
- "Village Agent" model to be explored.
- Issues are that people who do not already use services are vulnerable.
- Do we encourage this vulnerable group to use A and E?
- How do we know who is vulnerable?
- Different directions: Over 75 route for GP health check. Also provide card will access information. Sign up to GP – promote card.
- Target community groups to provide information to hard to reach groups.

Communications Strategy

- Greatest health need. What is this? Missing 'social need'. Do we need a priority audience?
- Priority audience – who is not accessing services? Is the area of lowest life expectancy. Is this the priority audience?
- Engagement – focus activities. Outreach investment. Go out to groups working with disadvantaged groups. Use mobile libraries for rural areas. Important aspects of signposting parish councils.
- Keep it simple. Consistent, regular messages from all providers. Is it a health and welfare communication strategy for NHS or is it for every organisation involved. Must be a partnership strategy.
- Circulate final document – people want to see it.

Workshop C

Urgent Care

- People go to GP for social contact not available at pharmacist.
- Biggest impediment to accessing health care is GP receptionist which don't face at A&E – can be seen that day.
- Receptionists behaviour/phone system needs to change.
- Responsibility falls on patient to judge if urgent is offputting – avoid this embarrassment at A&E.
- Finding correct phone number for NHS Direct. ?? is easier – needs easy telephone numbers.
- NHS Direct is "a waste of time"
- They are trained, may take a more risk averse approach.
- Definitions of thresholds e.g. minor or urgent – not clear.
- Transport is a big issue: ambulance solves that. Access issues for deprived communities.
- Is portage a good use of our money?
- Compare access solutions with for example France.
- How do we ensure equal access?
- Transport, especially for rural communities.
- Usage of A&E – Bath City practices are biggest users – so rural communities go elsewhere.
- For what conditions do people present at A&E?
- Self harm including drugs and alcohol.
- General increase across age bands.
- Students, overseas students access is an issue.
- Ambulance service – no obvious trend but many people could have gone elsewhere because quick and reassuring.
- NHD Direct helps by giving an expectation management. Amb. Finds this difficult once called out we expected to transport.

- Needs to be more integrated into alternative pathways.
- NHS ability to influence and change market is limited.
- After 6pm, I ring 999, as I can't get a doctor.
- Out of hours nurse triage.
- Drs write to patients with pattern of going to A&E.
- How would we react to this?
- Would be OK if alternative offered.
- Is increase in falls admission related to nursing homes no longer being allowed to pick up the fallen?
- Other acute area is mental health – can ring only police which is hard for carer.
- Could also go to A&E but only if co-operation. If go through SSD takes too long.
- Mental health users ring 999 perpetually despite education as they want the attention.
- Has to be an alternative signpost.
- Are GPs giving out the wrong information?
- Are NHS services giving a consistent message, for example and drs surgeries?
- Easy English laminated flowcharts for fridges.
- Choose well campaign is helpful with this – to quickly choose options.
- How do we get leaflets out without it being junk mail – through GPs has more credibility – would take time, but cost effective.
- People like individual attention – face to face or voice to voice.
- If distribute information through GPs what about people not registered with GPs?
- TV is memorable
- Info on GPs websites for new patients is important.
- Cannot assume have access to internet?
- English not first language – communities need targeting.
- In Schools – adults of tomorrow – very important to educate.
- People now ask about diagnoses, find out about it on internet – young people take more responsibility.
- Should we make it difficult to access certain services?
- No. People would get aggressive.
- Triage at the door manages demand must be able to signpost.
- Some people feel they are imposing – first presentation is crucial and may be hiding other things.
- May take a while to find underlying problem. Self harmer asks hospital not to tell GP, so back again 2 weeks later.
- No support there for self harmers to prevent them.
- Are carers signposting.
- Services are there but waiting lists or don't fit criteria or normalise behaviour by grouping them all together.
- Choose well people who can sit and chat in GP surgeries to educate also use pharmacies.
- Community options team for mental health clients signpost.
- Years ago had an introductory appointment with GP as a new patient – giving out information, this may have been lost.
- New Routes/Village Agents – both pilots, need expanding.
- GPs surgeries are pivot between secondary, primary and community care. Put more funding into signposting from surgeries.
- Different way of communication. CAB advice bus can participate.

Communications Strategy

- Priority audience: young people for a more efficient future.

- Who decides who are in greatest health needs?
- And does this amount to most effective audience for prevention.
- Find out why needs focussed geographically.
- Work jointly with council to target equalities communities and focus health messages on prevention/young people.
- All staff should be responsible for signposting – an asset to use.
- Vulnerable people trust voluntary groups and will take on information coming through, for example, age concern.
- Avoid jargon.
- Use parish councils.
- Subcontract to voluntary groups working with target groups.

Workshop D

Urgent Care

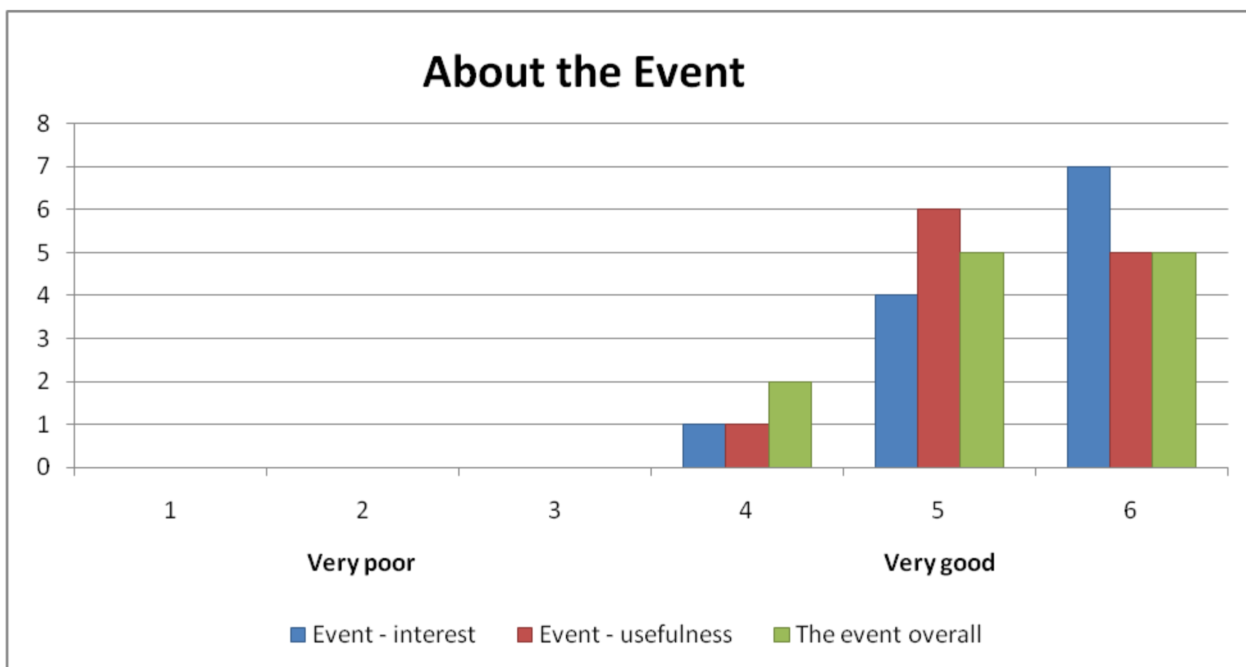
- A&E facilities: GPs don't have access to key equipment.
- Tracey's figures: does it include, for example, people from Keynsham who go to A&E in Bristol?
- Should people even be in A&E? Ambulance service does triage.
- Need easily accessible list (would this change what people do?) printed key numbers. Fridge magnet. Stroke "FAST" information useful.
- Response you get when you phone number: Expect GP to come out – go to A&E if GP doesn't come out.
- Leaflets: very tiny impact.
- Natural instinct: 999.
- Leaflets: people find them of varying use. List of numbers – difficult to decide which to use. Triage through 111.
- People have different experiences of triage through the phone.
- Discussed inappropriate 999 use.
- One possibility: physical triage at A&E.
- Consistent and repeated messages necessary: public confused. Names confusing. Consistency of marketing.
- Sometimes choice not welcome: confusion?
- Need to explain benefit in not using A&E.
- Physical triage good, for example, explain waiting time. Speak to everyone: whether people need to stay or not.

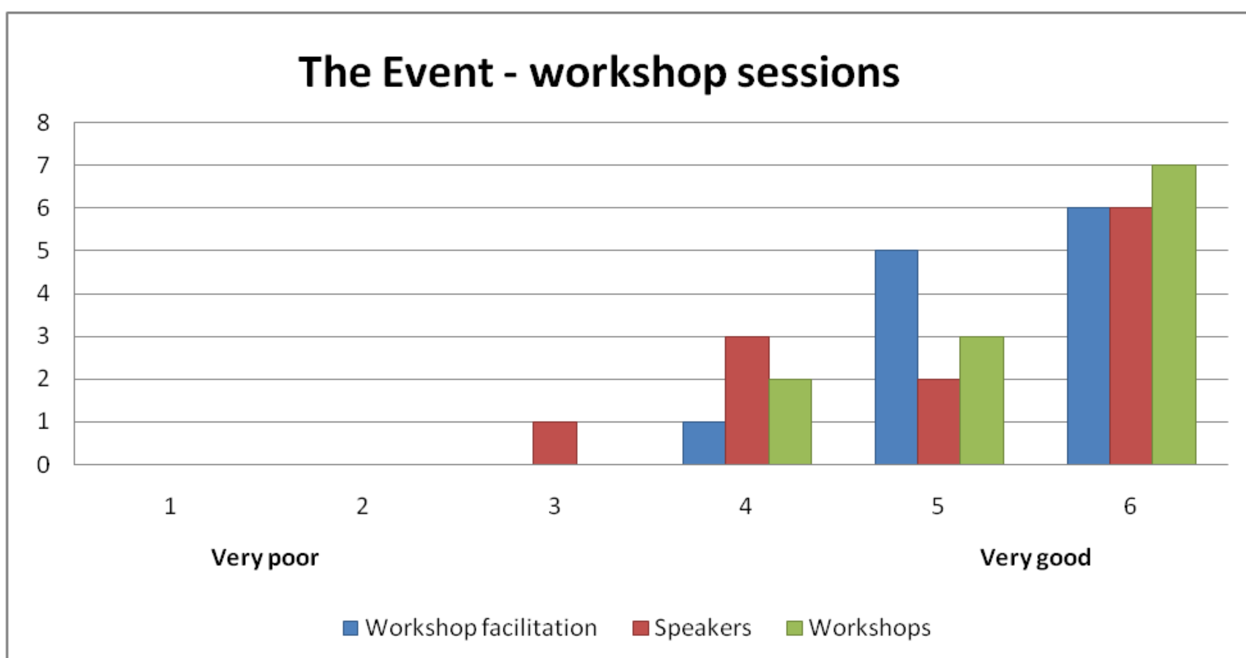
Communications Strategy

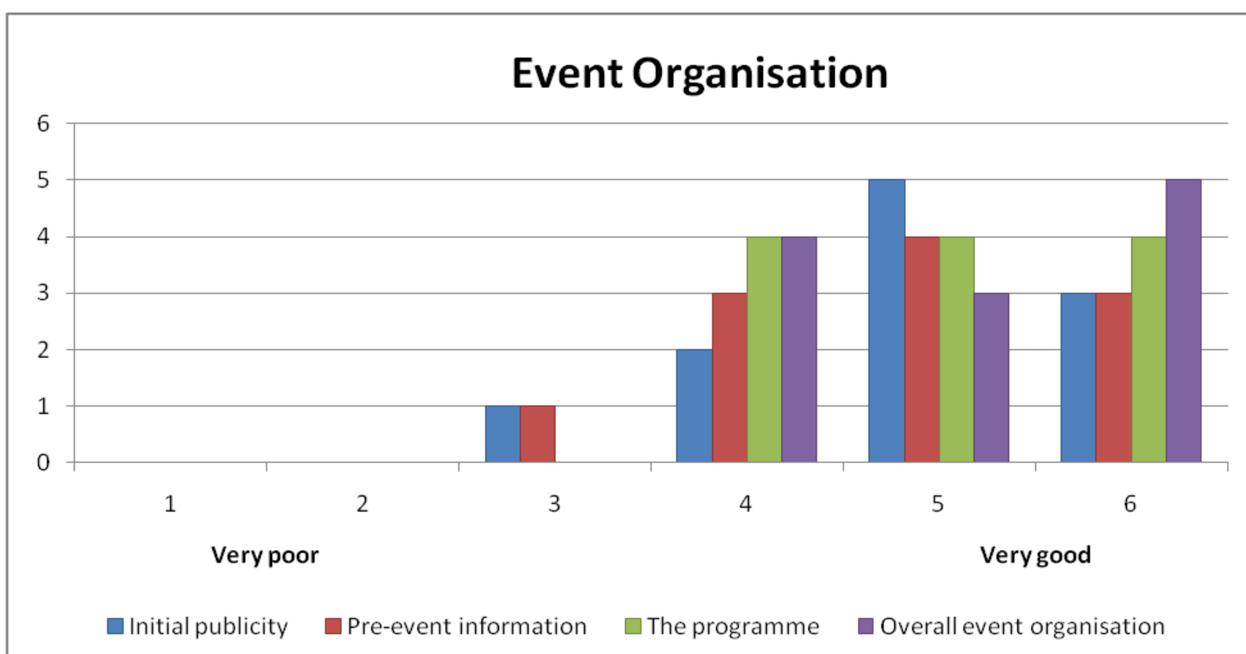
- Priority audience: thoughts?
    - Take meetings to those in need
    - Engage with local knowhow
    - Use GPs: using email?
    - GPs as hub in community. Places: understand key local focuses for sharing information
    - Need both generic and targeted info: understand where people go
    - Children's services bus
    - Map communication routes: joined up thinking
- Target audience: who? Where target info? Need cleverer ways of communicating. For example, Chlamydia information in clubs.

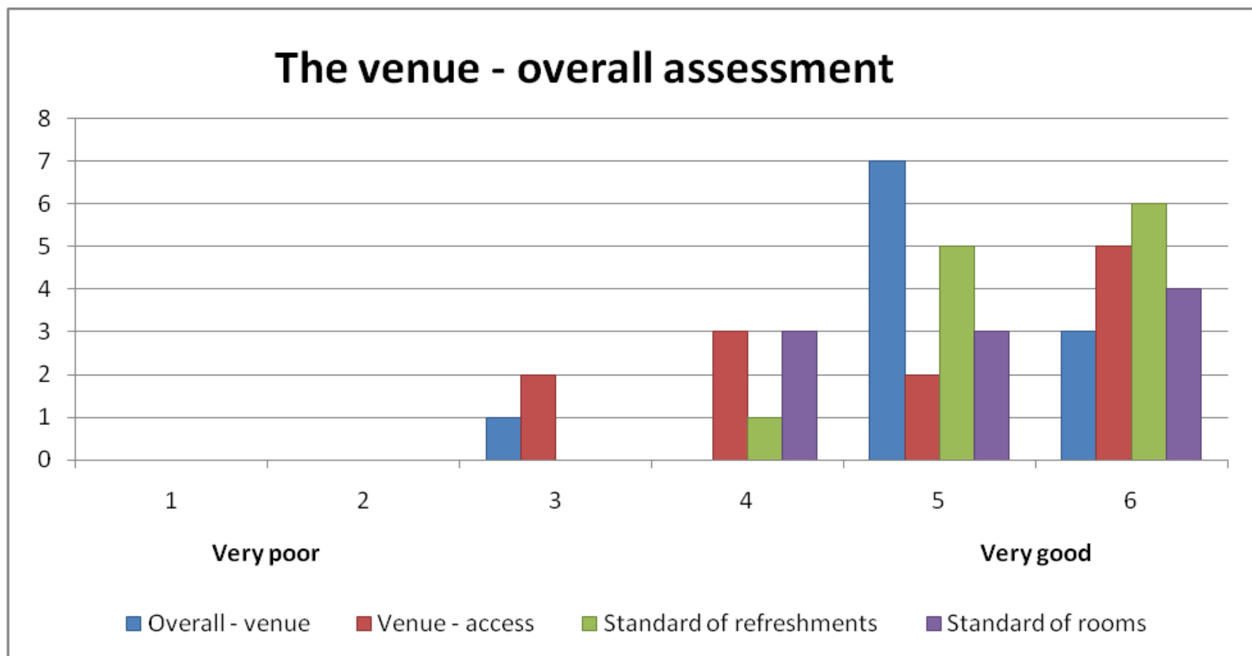
- Use existing networks better, for example, identify 1 key message a month we all circulate. People more likely to read information they have asked for.
- Start with the child.
- LINk and local universities, for example, on communication courses.
- Any suggestions of other venues? Venues for these meetings different from local community meetings – that's OK.
- Health impact equality assessments needed.
- Discharge also needs to be considered in with urgent care.
- Urgent care: also links to issue of accessing GPs.
- Bad experience of getting prescription
    - Varied experiences
    - Some GPs offer variety of means to communicate
    - How do people choose A&E or GP?
    - Argument for poly clinics?
- Referral system within hospitals.
- Accessibility of communications vital e.g. different cultures/languages
- Experience needs to be shared beyond Bristol about different communities: protocol.

Evaluations









Additional Comments

What comments do you have about participating in the event?

- Really good event. Liked the sheet (A4) what people want from services. This enabled this meeting to reflect and move forward a step. The presentations were short, to the point and gave food for thought for group work. Lots of opportunities to put forward ideas on the topics.
- This is a really useful event. Very good presentation providing useful information. Workshops relevant and well facilitated.
- I found the event extremely useful. It was organised in such a manner that members felt able to make contributions which felt valued.
- Innovative, thought provoking and very positive overall.
- Very good, interesting, met a number of well informed people.
- Good mix of statutory and third sector representatives.
- Interesting. Good to meet different people, but encourage wider participation (Children's services, education, learning difficulties, business).
- Very informative and good to meet up.
- Well organised, but not inspirational.
- I was glad to be given the opportunity to have a say in NHS and B&NES council affairs relating to health matters but had doubts, and was not alone in this, as to how much would be achieved by 'user involvement', to what extent our suggestions and comments would be taken into account and to what extent they would be acted on. Examples of the effects of 'user involvement' in terms of consequences and influence would be appreciated.

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

- Putting forward ideas on the various topics. Being asked to think outside the box and be listened to seriously by people who make those important decisions.
- Networking opportunities and sharing ideas.
- Learning more about how to manage expectations and how people are keen to ensure members of our communities know about and receive the most appropriate intervention.
- To find out that others are like minded and to see things moving in a positive direction.
- Communications strategy should be a Partnership Strategy.

- Promote use of NHS Direct.
- Networking.
- Discussion.
- Good participation in workshops, which produced some useful discussion.
- Being heard. Exchange of interesting information.
- I really enjoyed listening and participating in workshop groups. Find out other people's future needs etc.
- For me there were outcomes that were in a sense of equal significance. The good work of the NHS and the B&NES Council should not be underestimated but there's room for improvement in certain areas eg the duplication of out of hours services, particularly in this time of economic uncertainty. I became increasingly aware of the fundamental importance of preventative medicine; that the value of a good diet, regular exercise, the avoidance of smoking and excessive drinking and recreational drugs, and the need to promote these things cannot be overemphasised. Drastic action must be taken to reduce the consumption of sugar, fat and salt and legislation is required to prevent the selling off of any more school playing fields. This realisation was really the most significant outcome for me, albeit an indirect one.
- I am not in a position to evaluate this event with any degree of accuracy. I do not have sufficient criteria to go by nor am I sufficiently qualified to make comparisons. But I was very favourably impressed.

Are there any other comments you would like to make?

- Really enjoyed this event. A chance to network, meet people and speak with those who have influence.
- An excellent event – thank you.
- I would very much like to have a copy of the first presentation emailed to me. [NB All presentations are available on The Care Forum website and are sent out to those without email addresses with the meeting notes].
- Accept microphones not working but it would have helped if speakers had repeated questions before answering them.
- Cold rooms. Good lighting.
- Hard to hear in larger room and it would help if the words on the projection had not been obscured by the speaker standing directly in front of it.
- Good venue, but not accessible except by car. Public transport access is important.
- I thought Corinne was an excellent facilitator.
- The refreshments, in particular the constant supply of help-yourself coffee and the good lunch, merit comment.

Appendix 1 - What People Want From Their Services

Most people feel they receive good services and are grateful for them but sometimes the way those services are arranged and delivered can lead to frustrations. There is room to improve.

5 Principles

Through talking and listening to people who use services and to carers we know from work done both nationally and locally that the most important principles are:

Better access

Receiving services quickly and conveniently

Better information

Knowing what's happening, what to do and what's available to help me

Building closer relationships

Being involved in decisions and being treated with dignity and respect

Better cleanliness and comfort

Clean, pleasant and welcoming environments

Better safety and quality of care

Professional effective and trustworthy care and treatment

Values that people support

From our series of healthy conversations we know that people support the following values:

- Helping people to be as independent as possible
- Encouraging Individuals to take personal responsibility for their own wellbeing
- Investing in prevention
- Targeting areas of inequality
- Shaping services to be flexible and adaptable to the individual
- Helping communities to work together to help each other
- Seeing GP surgeries as a hub in the community for help and advice

The Big Concerns

Through annual surveys and ongoing work with people we have been told what people are most concerned about and would like to see improved:

- NHS Dentists
- Hospital Infections
- Time waiting in A&E
- Waiting times for hospital appointments
- Waiting times for GP appointments
- Better communication and more accessible information
- Help for carers
- Respite
- Access, parking and transport