

Banes Forum – 3<sup>rd</sup> November

Electronic notetakers: Trudi Oasgood and Jane Bevan

*(Trudi's uncorrected sections in italics)*

Mike McCallam – commissioning manager working for social services and the NHS.

My colleague, Sadie Webber.

First, thanks for allowing us to meet you this afternoon – two things that we want to discuss with you.

First – Your Care, Your Way. Some of you may know about this – it's our review at the moment, looking at community health and social care services in BANES.

I will explain more.

Then for the second half, Sadie will lead a short discussion about a strategy on working with the needs of people with sensory impairment.

A break between the two sessions, we will finish on time by the end of the day.

If anyone wants me to stop or to clarify at any point, please indicate and we will do our best to explain anything. There will be an opportunity to ask questions at the end of each presentation.

I will start with Your Care, Your Way.

This is a review of community health and social care services. A project that started Jan 2015 so we are 9 months into it. It will run as a review until April 2017, a two year review of community and social services.

It's to ensure that we have the right services to meet people's needs. So I will talk about why we are doing this now, what we are reviewing, some ideas of how the services might look in future and to give you an opportunity for feedback on those ideas and what you think might work well for people in BANES.

A brief explanation: what are the services we are reviewing. It's almost easier to say what they're not reviewing

Hospital services, like RUH and secondary care services.

We don't commission GPs, so it's not about doctors' surgeries in the future. It's the services in the middle, the services people receive at home or at a local setting that fit the bit between GP and primary care, and hospital and secondary care. It's a review of health and social care.

So in social care terms, it's services to enable people to remain living in their home and independently, staying well for as long as possible.

We know some people will barely use community services, they might be 'light-touch' users. But others with long-term conditions will need to use community services every day for the rest of their lives. On the diagram, we've described some things that community services do.

Help people with hospital discharge with short term support after hospital stay.

Services to self-manage and self care, eg with diabetes or Parkinsons or Multiple Sclerosis and conditions like that.

Might be services that support people to live in their own homes, like domicillary care, people who come to help with personal care and support.

One thing we want to do is ensure people who need to use one or more of those can do so in a more joined up way than they have so far.

So the project will go on til April 2017.

This is phase 2 of four.

Phase 1 was gathering up information and doing engagement with the community in BANES and providers, considering the range of services that fit the umbrella of community services.

Phase 2 is thinking about ideas of how services could look in future, based on some ideas people have given us.

Some early headlines:

Some feedback

People want health and social care to be more joined up, to work better around them as individuals. People get frustrated having to tell their story over and over to different people, so we want to find a way to address that.

We are coming to the end of phase 2 – you will see that there are ideas about models for community services in future.

Phases 3 and 4 will be taking that to more detail and talking to providers about services provided, and how to award contracts for those.

So – why do we need to change and why now?

Four clear reasons:

We know, like everywhere else, we have a changing population and know that over the next 10-15 years, more people will live longer, and with long term conditions, with complex conditions.

And we have a generation of younger adults living into adulthood with complex health needs. People who until recently would not have lived through til adulthood are now doing so. So we have changing levels of population and changing levels of needs.

National policy of Government and social services is that there is an expectation that we change how we support people to be more self-managing and to self-care conditions – for example, personal budgets to purchase support, giving people more choice and control over how to meet their support needs. That's becoming the statement of intent from Government in health and social care. An expectation that people will design their own services, not just fit with what is provided.

So this is already out there as a national idea. If you do follow this in the press, there is a lot of discussion about joining up health and social care, more joint commissioning, more pooling of budgets.

Third reason for the review – there is technology coming onto the market everyday. Technology to enable an individual to manage their own needs or conditions more independently – how to use apps and technology and software and internet to support people to be independent.

A story of a man who gets a 2 hr bus journey to the RUH, waits in the waiting room, sees the consultant for five mins. And then goes home. But perhaps he could do that from home.

And how to create opportunities for people to have a single health and social care record, over which they have more control than they have in the past. We need to ensure we use technology not just now but for that that is coming in the next five or 10 years.

The fourth reason for the review is finance. Everyone knows that public services are under pressure, with cuts to social services and NHS. We need to think about how to manage the money we have now, and how to tackle the savings we have to make locally.

So it's not about cutting services or being told we have to save money. It's about ensuring we use the money we have available in the most efficient way.

So that's the four reasons to do it now. Our aim is to ensure that as we move forward, the services are fit for purpose and meet the local population needs and reflect what people have told us they want and expect for the future, and to ensure we are not caught out by not understanding the needs of a section of the population.

A bit about the current picture: I was surprised by some of this.

We spend just under £70m on community services. So we are spending on the RUH and other aspects of social care. But if we map that out – it's just short of £70m. That sounds like a lot. But we are spending it in quite an inefficient way, with 400 contracts, for services, with over 60 providers. Some are large, like Sirona or AWP, or smaller providers doing one thing in a specialist way. Our Action on Hearing Loss services are funded from this community pot in part.

Those providers and services are commissioned by multiple people within the Clinical Commissioning Group and social services. Our providers would like to see a more joined up and coordinated commissioning structure. So we are looking at how providers deliver services and how we need to change services and think differently in the future.

One aim of the review – an example might be that we have 6 or 7 different services working with older adults with dementia, all commissioned separately. So we need to discuss how to provide their services in a more joined-up way, to meet people's needs.

*A couple of sentences – want to ensure we make services that allow living independently supporting them in their own home – in way that meets their needs. Want to make sure people have support in way and that they listened to and wishes and needs respected. So about how services support an individual rather than tell them what they get.*

*We want to make sure ... that our services focus more than they have done in keeping people well in the first place, or stopping them getting ill, or focus on services for prevention than heavy focus on supporting them when most ill. We heard that in banes people think services good when very ill, but when they recover or get better services drift away – then they need to have crisis before we involved again. Think about that, how we have services that sustainable for people whatever their level of need at time. We talk with words like enablement or empowerment – I been challenged on that word! We want change way workforce supports people and sees itself as enabling and empowered to be in control rather than experience of 'I was ill and at the hands of the nhs and I done unto!' – we want to change that.*

*Two final statements.*

*One we have 500 different providers, want make a model where you can access services at different times without barriers and things in way. Have examples of people who said, I have three different conditions, have to see three different consultants, none of you talk to each other! How we move around services in more joined up way. And through our contracts join up social care and have more*

*integrated system. Could the Clinical Commissioning Group put all its money in one pot for community health and social care?*

*So based on feedback so far, in consultation document are four ways to have community services delivered – the meaty part of talking to you today.*

*Will briefly go through the four ideas. Didn't think of titles!*

*They called model one two three and four.*

*Model one says what if focus on condition you have, example diabetes, and think of ideal pathway from onset, how prevent diabetes? Early onset? Living with long term condition and treatment pathways if severely ill. We could design services around a condition model, have great specialists who good at every stage of condition. But where that falls down, when have more than one condition. Say you diabetic and heart condition and dementia, how we join up the experts? We think pros and cons to each idea. Good and bad bits. Maybe final model a mixture of all. So under first model, we would ensure that your support and treatment/care managed by someone with expertise in that condition, and a model that brings all the specialists together and works around you.*

*Second idea – change that slightly. What if we design services that meet your needs at particular time? So if you been in hospital, had fall, and need support at home, we could look at what 'good' looks like after hospital discharge and design services at that time.*

*Or might be, if thinking about end of life care, think of those who provide good end of life care and bring them together. Like the first model, works well, but as circumstances and needs change, think about how we get those different people talking to each other – transferring your support as your needs change.*

*So good bits might be, think about what end of life support looks like and what good crisis response services look like – how we get them joined up when need to move from one to the other. That second idea.*

*So models three and four, slightly different. First models one and two about individual person and their needs at particular moment in time.*

*Models three and four more about how design services around communities or locations.*

*One thing we know, people find it difficult to travel to different places to see different people.*

*So in model three – we thought it might be possible to create a wellbeing hub in a particular geographical location. We in Bath. So could say, create hub in ... we north? Or south bath here? We could create wellbeing hub in this area, could be 2/3 in bath, one in keynsham and one Midsomer Norton and Radstock. What about a hub that works around GP practices and coordinates all the local services.*

*And with this model, opportunity to understand and map needs of local population and give more reflective services that responds to needs.*

*So with end of life, could have 2000 people with diabetes, how deliver services to meet their needs? How bring those services from RUH to locality?*

*If live in area, you could potentially have more than one need and need more than one specialist, the hub would help you do that. Some of the questions we asked, how you make sure you get access to specialists you need? Back to ways of delivering. We have talked to RUH about opportunity to work in more community focused way and deliver services in local neighbourhood and work more in partnership with community providers.,*

*So in model three, talked of possibility of giving the hub its own budget, devolve some money from council and Clinical Commissioning Group and give them opportunity to purchase own services for own population.*

*Now model four.*

*Model four an extension of three. It says could we create a community led team that aspirational in mapping strengths and needs of local community with opportunities to design and deliver local services – health and social care, housing needs, and can deal with spikes and trends – thinks about sitting health and social care in a broader idea of local community forums. Image in my head – notion of tribal elders that sit around smoking pipes! And being respected as champions of change in their area – who influence what happens. That how we think four should work.*

*What I not said. For each model we thought about who in control? And how we make sure that one area doesn't spend all money on diabetes and another on mental health. I don't have all the answers. But with all models – you are the managers of this and the decision maker! Are opportunities for me as manager in Clinical Commissioning Group to give some of that control away to local communities. I need make sure money spent wisely.*

*So I stop there ... ask, any questions you want to ask about these models?*

*Or anything that needs re explaining?*

*Q. what words Clinical Commissioning Group mean?*

*A. stands for Clinical Commissioning Group – basically its the local NHS. Used to be the primary care trust. I work for Clinical Commissioning Group – how the money comes down to local areas. We don't deliver services but hold the contracts and commission different providers.*

*Questions?*

*Alex says thanks for invitation today inviting deaf people to discuss with you – good to be invited to give different ideas.*

*Thanks!*

*All sounds good so far, says someone – but models community led? How accessible for deaf people? If hearing people running it, when deaf people arrive would struggle without interpreters, who funds interpreters?*

*A. We had conversations about how models work for those who don't need many services and can manage their support well = want make sure all models work for all in community. So if you take hub model for example, the hub work with AHL to say do we have deaf community in area? Where they living? How we access interpreters? And other information and advice services?*

*I determined that any model doesn't marginalise anybody – we reach everyone in location. Is detail to be worked out about how we do that – point earlier, we need make sure we talked to everyone, given all the chance to give views or overlook issues that people want to raise with us.*

*That sounds like I didn't answer the question!*

*Comment – I not sure, that political.*

*Frank – the problem about how to deal with deaf people particularly difficult. If local hubs won't get many deaf/hard of hearing in that area, need services. Better to get all deaf people in one location, cheaper and more deaf friendly. But such a range of hard of hearing and deaf people – we have communication overkill here! three screens, three interpreters! ... difficult!*

*Answer – in order for models, or models around wellbeing or neighbourhood teams, we recognise people from deaf community in every area. So some things common. Need make sure don't make too many mini services where delivering*

*to a similar need – how be more joined up? Take your point – can't say go live here when you deaf!!!! Would be about coordinating it.*

*Comment – talking about if you have a hub – what about those who can't physically leave home, say deaf blind people who need support. If get there, is service accessible?*

*Answer – OK when I talk about a hub, I don't mean a bricks and mortar building! Is the idea that it coordinated around a set of GP practices but understands geographical boundaries. We discussed what about people who don't live home, because too old, frail or scared? How rebuild notion of who your neighbour is. How be eyes and ears of community? We lost that over last few years. But harsh reality, we need community to do that as local Clinical Commissioning Group and council as we can't do all we been doing. Need find way that local communities want to do that and they trust it, rather than we dump it with you as we can't afford it!*

*In detail of document we talk about care navigation. How we think about supporting people who need access to services? Called it a system of navigation. For some people they don't need much support, but for some with complex needs, they might need dedicated person who care navigator who arranges all their care and support. So person who deaf blind or doesn't leave home – whatever model we have – commit to give them right support.*

*As slight aside – talking about transport, we heard that people find it difficult to get to appointments due to transport. So what we do is talk to councils, transport people! – not sure their title! – and the NHS has ARRIVA transport – council has its own, and people use taxis – can they use public transport more. How commission transport service to access services. Those in rural communities, villages, how bring them into the fold and use them more effectively. I learnt lots of stuff from transport people – and how we use the internet – interesting thing about these events, I never know what people ask me!*

*Question – She uses internet, ipad and email address, emails the hospital, if any problems she can get information that way. It really good for deaf people.*

*Answer – that good. Want to make sure we know where good practice is – and how spread that out to all depts. Or make sure if they doing something in good way – how others use it?*

*Question: how do let people know about policies in the area and what is going on?*

*I access the hospital iwth friends, but what about other people's experiences? I have someone to help me – what about other people?*

It's the same with the doctors and other services. People like health professionals need to be aware about these issues. could be the GP or the hospital – there are different issues.

Speaker: with Your Care, Your Way – it has its own website, we've been putting articles in the local press, in the Chronicle. We have a facebook page and Twitter account and an email account.

Comment: a BSL survey will be available this week.

Speaker: there will be a survey for everything I've described – that will be available on the website in BSL and we can ensure Deaf Plus and Vision Plus and AoHL know about it.

Comment: I know about that, but there are people who don't know – that community, those people, perhaps older people, like in my situation, not used to that technology. How do they know what you are planning? What you are trying to do?

Speaker: we want to think of how to work with organisations like AoHL and Deaf Plus and Vision Plus – how to make better use of those groups who know a lot of people in the deaf community that we don't know. We promote our messages through websites, usual communication channels, but the more we use our community partners to get the message out... if you have ideas on how to do that better, let us know. We've not sent a letter to every household in BANES as we didn't think that was the best way to do it, but there's always different ways of getting the message out.

And how do people know what services are available, as you asked? A lot of the professionals say they don't know what is there or how people access them. so we are wondering how to make that information more known, more accessible, how to let GPs know all the social care services. Lots of amazing volunteer organisations. An information and advice service, more accessible to all, is what we want, really.

We will try.

Any more questions?

Comment: so if I volunteer to work in a shop.... in a workshop on a Friday morning, it's a workshop group I'm involved in. they pay us.... they have to be careful with money. And then every year, you have a review of what you've done at the workshop.

Comment: my mum has diabetes and I go to the RUH and get support with an interpreter there. They also have a cafe so have different community things going on there. You see the ambulances based there, many doctors based there too, and they do blood checks and have all the different services there. That's how they achieve their goals. Fantastic to have different doctors there.

Speaker: that's really good – one thing we knew when we started the project was that a lot of good stuff happens in BANES. We are not starting from a bad point – we just need to nurture our services for the future.

One more question:

Oh, two!

Question: I wanted to clarify something. With the hub model, is that something that's every month? Every year? How regularly does it operate?

Speaker: well, it's more about a geographical location where services are. It wouldn't be a service open at a particular time or shut at others. It's like we have area forums in the council, a meeting monthly. But the geographic area exists all the time. Wellbeing hubs is a way of describing how we might coordinate local services around an area, and ensure they are delivered. It's not something that opens and shuts, or meets, at given times.

There would be people in charge ... I think in any local hub area, there would be senior representation from health services, or maybe Action on Hearing Loss if it were Twerton – senior management about how the hub works. But it would be a living thing, every day, all year round.

Lots of questions!

Comment: so all the staff that support us – they also support us with healthy living... and getting weighed. You get a health check at the GP and are weighed. And they check a lot of things, in depth, a regular thing they do. possibly you might have medication. So I go to NHS house every six months, to visit and have a chat. Then we review the medication I am on, and talk about it. And another lady, Emma, I meet her at the hospital in London. ... I talk to her about how I sleep and different things, how much sleep I have. Then it's a regular process. You know the kind of things. Then there is the GP things, checks, more regular, more often. So it's like a regular health pattern. The doctor can help with things and staff with other things.

Lots of different things – covers everything.

Speaker: that's good, that's the sort of thing that would carry on and not be any different under a new model

Just two more questions:

Comment: the timescale, getting survey done by April. But there are two phases – does that mean the feedback from phase 1 is finished?

How do you know about that once it's finished?

Speaker: we didn't run these events for phase 1 – a mistake on my part. We are now at the end of consultation in Phase 2 – hard to organise in the short timescale. So today's event – there will be a written record of the event, the feedback is fed into the next stage.

How else can you help us – slide?

A website, [yourcareyourway.org](http://yourcareyourway.org) – people can complete that. There is also a paper survey, which asks for comments on the four different models. After the end of consultation, a group of people I work with will decide if we are to recommend one particular model or another, that goes to the board of the Clinical Commissioning Group.

April 2017 is when the current services end and we need new contracts in place then.

We've been in a formal consultation period, but we are open to comments and feedback at any point. It will take at least the next year – it is late to be meeting you but the opportunity hasn't been lost to ensure views are taken into account.

We have learned SO much through talking to people and it has shaped how we want the services to be.

I will stop as we have the second half of the day to discuss. Thanks for listening to me and for the interesting questions – they all get taken back and reviewed as part of our thinking. We have notetakers today – the record will go on our website. And people can have a report on this. We will think about how to make this accessible for everyone.

10-15 mins for coffee break and then Sadie will lead discussions about the draft commissioning strategy.

**BREAK**

*Next presentation : ... by Sadie Webber*

*All got a cup of tea, ready to get going?*

*I Sadie, I work in the commissioning team for Mike.*

*The work I working on is commissioning strategy for those with sensory impairments.*

*So the strategy says what we do now, and what we do in three years.*

*We want promote independence and wellbeing, to make sure we find support early and where it needed to prevent care needs.*

*We want people be in control of their own care and have access to good advice – so that people take active part in communities.*

*Its the first one in banes for people with sensory impairment, joint plan with health and social care.*

*Why we need a plan?*

*We know are 400 people registered blind in banes, 450 partially sighted, 5000 people with moderate to severe hearing loss, 4% of population of banes. And 150 people who use BSL as first language.*

*We think all those figures are under estimated!*

*We also know we got growing population., and that they be ageing, and as they age, will be increasing number of those with sensory impairment.*

*I do recognise a few of you, met some of you a year ago – I know it while ago, I was pregnant! And ready to have my baby!*

*What people with sensory impairments were telling me then about local services, was that I need information in format you can understand. You said it difficult to book a BSL interpreter, maybe you want speak about social care or council tax, but I can't get interpreter.*

*Difficulty accessing GP – some reasons, due to lack of interpreter or understand I need longer time, and that I can't text or email my GP. These problems similar for contacting council too – I can't email or text them, I can't tell them my communication needs.*

*I was told we need more access to rehab and training services.*

*Waiting times too long between diagnosis and waiting for support.*

*Better mental health support.*

*Better communication needs – because how mental health affected.*

*More support to find employment needed.*

*More support to stay healthy.*

*(what you told her before).*

*We taken all those comments, put them in a plan. We developed six areas that main action points for our commissioning plan – will briefly tell you them then ask for your opinions – we got it right?*

*What clear to me, what you telling us, the things not specific to health and social care, can be applied widely across services.*

*So some specific to health and social care.*

*Some for speaking to colleagues in the council.*

- 1. How we engage with local people. Some of that touched on earlier – how we better find out what you think about how we improve things and local services. What best way to communicate with you? In meetings like this? Emails? Facebook page? A list that we send out to people to your address? Setting up focus groups? Speaking to you via groups you already go to ? or support providers?  
That first area – to look at.*
- 2. Increasing awareness of those with sensory impairment. This about how we raise awareness about local services, for sensory impairments. Maybe council – frontline services, if contact social services whether we know how to book interpreter, how you tell us how you communicate with us – and whether housing would know their requirements for interpreters or making information accessible. One of the action points said that important – arranging sensory impairment awareness training for front line staff.*

*Other point, working with people who known to support services, care homes, and those people, can they recognise the onset of sight or hearing loss? So support can be put in early so people can learn how to work with communication needs.*

- 3. To improve access to information and advice. This key point, comes up again and again. Raising awareness of need for interpreters and how to book them, and looking at interpreter service we have already in council, and check that people know how to book it, and it fit for purpose – are there enough interpreters?  
Also look accessibility of council website, told it difficult to use and navigate, no BSL videos – we work on that straightaway – we met with a team who do website want meet with us. If anyone wants to be involved with that, you be welcome, want your opinions on how to make it better. Also want to ensure that new accessible information standards are implemented. If you don't know – this a new standard, that health and*

*social care organisations must follow by law. I think by April next year. Aim to make sure that those with sensory loss get information in format they understand and get communication support. Work with voluntary organisations to make sure they understand the standard and implement it in time.*

4. *Improved health and wellbeing. This where work with mental health colleagues in commissioning, how those with sensory impairments receive services and raise your questions about access. Increase awareness in colleagues of those with sensory impairment. Could be access to information – alcohol, stop smoking, and access to routine screening and healthchecks. In consultation you said you didn't know how to access these services, how get information in BSL, or audio? Or Braille? Maybe we could raise those questions with people who do that work. Also want to be sure are joined up services with health and social care – ensuring that health and social care services speak to each other, and it clear for people to access – make sure everyone speaks to each other.*

*Other area, identify need and plan services. Find out locally the numbers of people with sensory impairment, including young people and childrens services, and also the numbers of older people.*

*This will give us better understanding of needs of the local population.*

*Then want to look at current services, and check that those in commission meet needs locally – of those with sensory impairment.*

5. *To improve employment chances. Came up a lot. A lot of people want employment, something about raising awareness of that. Understand those who looking for employment, and review the support available and speak to the council.*

*So really today, I want ... to ask you whether we chosen the right areas for action. And have we missed anything?*

*The strategy almost ready to circulate, will put it on website and send it out. Before that, I want to know that areas we covering are correct, and if there is anything we missed?*

*F – underscore ????*

*Yes the underscore causes confusion, some can't access that website due to the underscore after the the word sensory.*

*Any questions?*

*Q. yes I do. think you covered a lot – areas are broad. I happy with what you chosen.*

*Q. I work for Sense – support deaf/blind people, we have people who support people – so if you need any help with that or access to website let me know.*

*Comment – that great thank you.*

*Comment – I think what you just explained, you have most of the points I wanted to make. Strategy does sound good from what I heard. I suppose it does all come down to funding. I think – I looked up figures for number of blind and partially sighted people in banes from RNID they say 5,500 people with sight loss in banes, and 730 have serious impairment. I worked out that the one rehabilitation officer – if all the 730 people wanted to see him, it would take a year and a half to see them! My experience was that I needed – my sight suddenly deteriorated, I couldn't go past the front gate, took months and letter from MP to queue jump so I could get out of my house on my own. In that five months I went stir crazy – like house arrest – I done nothing wrong! When I heard of this meeting, my first thought was – services! What services!*

*My concern is that whichever model is used, its the most efficient in terms of management so that the money goes to the frontline services rather than the managers. I know we need managers, and efficient management but we need people to come to our houses and get us out! And I believe there is a council in east of England who have invested more in rehab services for blind, they saved a 146,000 pounds!!! – sorry, don't know the council name. Whatever models, whatever strategies, its a stitch in time saves nine.*

*Comment – yeah, we agree. We do work closely with, Alison Bruces team, the sensory impairment team, we need ask them – you having an increasing demand on people requiring individual rehab?*

*Rnid estimate is that over next five years, number of sight impaired people grow by 12%.*

*Comment – yes you right, in terms of getting to people early – is what we want to achieve. Getting that support to you at earliest opportunity is the best way to prevent people from deteriorating. Alison says 'learning bad habits' – easy do that when first have impairment, or coping with change in your life. Rehab can help you not be isolated, get out of your home.*

*Female – yes and impacts on rest of family*

Any other questions or comments?

Comment: how are you working with specialist services? Are you going to work with mainstream services? Reduce services? It's a big concern for me. We worked with Supporting People funding before – lots of issues of communication, they don't have the full specialist knowledge re deafness, so people have come back to us. RNID and RNIB know how to work with people with impairment – ensure you have the right support. Or are you trying to create mainstream services?

Sadie: there's no more money for any different services – we aim to work with the local providers like Deaf Plus and AoHL and to ensure that we commission the support for people that require it.  
In terms of Mike's project – it's ensuring the specialist services are involved in the planning.

Mike:

It partly echoes the discussion from earlier, about access to services. We currently commission audiology from RUH and from Sirona and then a service from Deaf Plus/Vision Plus and then with AoHL. It's piecemeal – how to work with all the providers to commission more effectively. I don't think we want to dilute specialist services – it's about how the spend the money in different ways. I mentioned earlier that an ageing population will develop complex needs; as we have more older people we will have more people with sight loss and hearing loss. We will need more access to specialist services from those working with people with sensory impairment. One rehab officer in BANES is not adequate. I was wondering how we benchmark with other authorities – I suspect we might all be failing to address that issue. There are no magic answers overnight but it's something to be aware of.

Comment: on one of your six areas – you mentioned employment. Is that with a focus on younger people – are you focusing on a specific age range?

Sadie: no – we've been told it's an area to work at, what are the numbers, younger people coming through from children's services – we'd work with AoHL and our other organisations to say that they are probably doing good stuff, and how can we ensure we are working together ?

Comment: I was just thinking about those leaving school and needing some kind of advocacy services.

In regard to awareness raising, especially around employment – is that regarding organisations, making them aware of sensory needs, so people can access and gain employment more easily?

Sadie; the first part is around us trying to figure out numbers and what happens locally, how the employment support services work, are they accessible to people with sensory impairment. There's work to be done before talking to other organisations about how they can help with employment.

Thanks for coming today. We have another one of these events in the evening, 5-7.30 pm. Could you please tell others about it, if you know people who would like to come along?

There is information at the front if you would like to take it – contact details for us.

Most of you have that sensory impairment address; you can email me with feedback on that.

Thank you for coming – it's been good to meet you all.

End of session.