Report from the 'Culture of Change and More than Medicine' Workshop

Wednesday 13th February

ALLIANCE, Venlaw Building, 349 Bath Street, Glasgow, G2 4AA

1. Introduction

The aim of Scotland's House of Care Programme is:

To promote and establish the adoption and spread within Health and Social Care Partnerships of care and support planning as normal care for people living with long term conditions; linked with community self-management support and help build the Scottish capacity for a rights-based approach to person centered care across integrated health and social care communities.

As part of a programme of activities supported by Scottish Government funding for 12 months from November 2018, a 'Culture of Change and More than Medicine' workshop was held bringing together General Practice staff, House of Care implementors, third sector representatives, HIS and Scottish Government. This workshop was the first of three network workshops to be held in 2019 which will cover topics pertinent to spreading and supporting care and support planning within a House of Care framework in Scotland.

The aims of the 'Culture of Change and More than Medicine' were twofold:

- Maintaining the ethos and principles of care and support planning to support self-management and living well with long term conditions:
    a) Consider what we mean by the culture of care and support planning and the House of Care framework
    b) Highlight what this means for the role of the practitioner in a care and support planning conversation
    c) Share an example of how the ethos of care and support planning has been strongly promoted within a general practice.

- Explore ways in which practitioners can see the value, easily access and promote more than medicine activities to support self management and living well with long term conditions:
    d) Consider what we mean by more than medicine
    e) Share knowledge and learning about approaches to more than medicine, including national work around the Links worker programme
    f) Explore barriers and solutions around promoting more than medicine as a key component of the House of Care framework

This report contains a summary of the workshop content and discussion sessions, and provides the full feedback from around the tables in the appendices.

2. Themes and Recommendations

The discussions on the day revealed the following themes and recommendations:

- Broad agreement on the key purpose of Care and Support Planning, in terms of the conversation being patient-led, supporting people's self management and underpinning a therapeutic alliance between healthcare professional and person.
- Identification of need to support greater partnership working between primary care and the third sector and interest in proposed ways of doing this, e.g. Links Workers, ALISS, More than Medicine events, etc.
- Going forward an appetite to explore other solutions to fostering a partnership between third sector and primary care, e.g. exploring potential of proposed Treatment Hubs as community anchors.

3. Workshop Sessions

The day was broken into six main sessions:

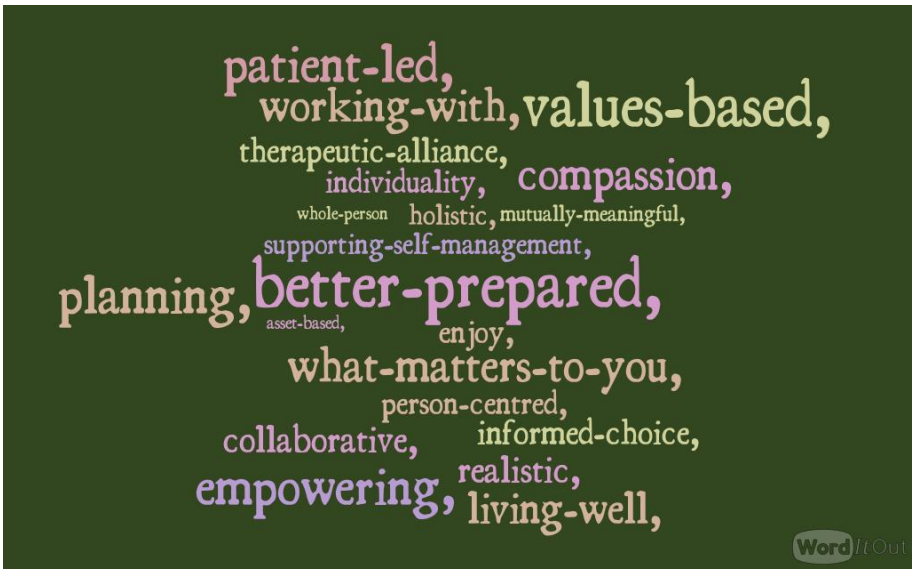
a) Care and Support planning - what are we trying to do?
b) The role of the practitioner in a care and support planning conversation
c) The St Trids story – "Keeping with the philosophy"
d) 'Thank you for the Petunias'
e) Barriers and enablers to More than Medicine
f) Presentations on the Links Worker Programme, More than Medicine event in Renfrewshire and the role of a Third Sector Interface (TSI)

The full agenda for the day can be seen in Appendix 1.

The session was opened by William Griffiths, Development Officer for House of Care at the ALLIANCE and Dr Graham Kramer, Clinical Lead for House of Care. They invited attendees to introduce themselves and say what they hoped to get out of the day. These hopes were captured to be discussed in closing remarks and can be seen in Appendix 2.

a) Care and support planning – what are we trying to do?

Lindsay Oliver, National Director of Year of Care Partnerships, led the discussion on 'Care and support planning - what are we trying to do?'. Working around the tables, attendees were invited to write up what they thought was the key purpose of a care and support planning conversation. The full set of notes can be read in Appendix 3. Following discussions, the below word cloud represents the key phrases chosen by attendees.



(https://worditout.com/word-cloud/3616126/private/781f2f3bcfac405a0845b602517f296b)

b) The role of the practitioner in a care and support planning conversation

This session explored the role of the practitioner in a care and support planning, and started with inviting attendees to complete a reflection sheet. This was followed by an activity around the tables where attendees were invited to consider six cards and lay them out from most to least suited for a care and support planning conversation. This allowed attendees to explore in more detail the role of the practitioner in a care and support planning conversation.

This led into an exercise exploring the barriers and enablers to supporting a change in role for the HCP. The responses from the tables can be read in Appendix 3.

c) The St Trids story – "Keeping with the Philosophy"

Dr Graham Kramer presented on St Triduanas practice, using it as an example of an exemplar site of implementing care and support planning within a House of Care framework. He highlighted the importance of a whole team approach, allowing for time to properly embed care and support planning and the benefit of linking to the local third sector. Year of Care Partnership have previously gathered a case study on St Triduanas practice.

d) 'Thank you for the Petunias'

After lunch attendees were invited to play 'Thank you for the Petunias', a game developed as part of a suite of resources supporting the implementation of care and support planning developed by the national Year of Care Programme. The game helped participant to consider the lifetime of people with a range of LTC and how different

types of support may be useful as different issues and conditions arise. It encouraged participants to reflect upon their view about the therapeutic values of non-traditional interventions for people with LTCs and how care and support planning is an opportunity to review the medical and psychosocial aspects of health and can act as an opportunity to identify "more than medicine" activities which enable people to live well with their LTC(s)

e) Barriers and enablers to More than Medicine

William Griffiths led a discussion around the tables on More than Medicine, asking attendees to think about their experience of partnership working between primary care, what difficulties had been encountered, what solutions to those difficulties were and what had worked well. The full responses from around the table can be found in Appendix 5.

f) Presentations on enablers to More than Medicine

- **Links Worker Programme – Gerry Mitchell and Phil Donnelly, Links Workers in Pollock and Ibrox, Glasgow**

Gerry and Phil presented on their role as Links Workers in Glasgow. They highlighted their role in one to one support with people, practice education and wellbeing, and developing community resources. They argued for the importance of the Links Workers role in supporting people in accessing community resources to help them live well.

- **More than Medicine event – Sandra McGuire, HoC Programme Manager, NHS GGC**

Sandra presented on the 'More than Medicine – Lunch and Learn' workshop held in a GP cluster in Renfrewshire in September 2018. This event was a partnership between the ALLIANCE, NHS GGC and Engage Renfrewshire and invited the local third sector into a GP cluster to present on their projects to GP practice staff. A video and a learning report of the event were produced following the event.

- **Third Sector Interface (TSI) – Karen McIntyre, Community and Partnerships Manager, Engage Renfrewshire**

Karen presented on the role of a TSI and on her work with Engage Renfrewshire developing volunteers, community capacity and social enterprise and their role in community planning and public policy engagement. Karen highlighted the benefits of primary care and third sector working together – she has previously written an opinion piece for the ALLIANCE highlighting the importance of cross-sector working to support people's self management.

Jamie Begbie, Senior Policy Officer at Scottish Government closed the workshop by checking in with attendees that their hopes for the day had been met and summing up the day.

Appendix 1

Culture of Change and More than Medicine

Wednesday 13th February

ALLIANCE, Venlaw Building, 349 Bath Street, Glasgow, G2 4AA

10 00	**Welcome and Introductions – Dr Graham Kramer, Clinical Lead HoC and Will Griffiths, ALLIANCE**
10 15	**Care and Support planning what are we trying to do – Lindsay Oliver, Year of Care Partnerships**
10 40	**Coffee break**
10 50	**The role of the practitioner in a care and support planning conversation – facilitated workshop discussion, Lindsay Oliver, Year of Care Partnerships**
11 30	**The St Trids story – "Keeping with the philosophy" – Dr Graham Kramer** • Presentation of an exemplar site
12 00	**Lunch in ALLIANCE kitchen**
13 00	**The House of Care and More than Medicine – 'Thank you for the Petunias' – game and what we mean by more than medicine – Lindsay Oliver, Year of Care Partnerships**
13 30	**Reflection on game and fit within context in Scotland - Will Griffiths, ALLIANCE** • Introduction of Links Worker Programme
13 35	**Links Worker Programme – Gerry Mitchell, Links Worker, Pollok Medical Centre and Phil Donnelly, Midlock Medical Centre**
13 55	**Coffee break**
14 05	**Barriers and enablers to MTM – facilitated workshop discussion, Will Griffiths, ALLIANCE**
14 55	**More than Medicine event in Renfrewshire – Sandra McGuire, House of Care Programme Manager, NHS GGC**
15 05	**Role of a Third Sector Interface in Linking third sector to primary care – Karen McIntyre, Engage Renfrewshire**
15 15	**Summary and next steps – Jamie Begbie, Scottish Government**
15 30	**Close**

Appendix 2 Attendees' hopes for the day:

Flipchart notes

Interact with other healthcare professionals and share experiences Demonstrate impact of More than Medicine Explore fit of House of Care with Links Worker model Overcoming barriers to More than Medicine Explore what More than Medicine means in terms of communities Getting clarity on how to support House of Care practices with More than Medicine Foster partnership working Opportunity to network Hear thoughts on House of Care and More than Medicine A feeling the process has stalled in Ayrshire and Arran and some tips on how to tackle this. Increase knowledge of what's available in their community Overcome difficulties with the process (e.g. administrating care planning and data sharing between agencies) See how the third sector interacts with people Spreading adoption of a model that's been pump-primed Gain traction for care and support planning – "Get going" Gain traction in primary care reform and General Practice reform Conversations with people on barriers and solutions Hear what's going on in future workshops Barriers around engagement and solutions Hear how to embed an infrastructure, gain traction and make it matter to everybody Spread House of Care and Care and Support Planning across Scotland

Appendix 3 – Purpose of care and support planning

Flipchart notes

Support people's self management
Give patients autonomy
Develop a culture of 'prepared patients' and 'listening practitioner'
More time to understand condition and personal impact
What does the person want out of it/ what concerns them
Person centred improve literacy share information
Ways to improve our engagement and openness with patients
More patient centred care. Can we improve?
Enjoy the interaction
What the patient feels is important to them and how dealing with/ supporting that could help them achieve a better quality of life/help mood/mental health.
See the whole person not the condition
Listening is key to person centred care
Empower
To bring out the best in my patients
Finding out what is important to the individual – planning their care
Enable opportunity for informed conversation – patients are able to make decisions to change in a different way
Provide advice and information to allow patients to make informed decisions.
To find out what matters most to the person with a long term condition
For an equal dialogue to take place in a protected environment between an HCP and a patient that is meaningful to patients and will help them on their journey to manage living with their condition.
Agreement going forward on care plan and goals
Build relationship
Achieve better outcomes
Non-judgemental
Valued conversation
Link theory with practice
Holistic approach – best way forward
Prepared person
Individualised
Balanced/equal conversation (power shift)
Co-design self management strategies/goals
What matters to me? (Active listening)
To be more involved in my care with professionals (lead partner)
Having professional info which can inform self management
Individualised person-centred care
Empower patients to take control of their disease
Partnership – prepared patients
Culture change of seeing the whole person
Actively involved in decisions relating to own care = partnership
More than Medicine conversation
Patient centred approach
Put the patients at the heart of their care planning

What matters to you
Conversation is a valued holistic approach in treating the 'whole person'
Facilitate self management – recognise issues
To support the patient in what matters to them
What else is on offer in the community to help living with the long term conditions – self manage
Give people the tools to cope when not with the healthcare professional
Personalisation – patient at the centre
Let patients have a say on their treatment
Patient led
To understand the patient's needs and potential barriers
To give the patient relevant information about their conditions to make a more informed decision about their treatment plan
To understand the patient's needs and potential barriers
Person centred care
Therapeutic alliance
Get an overall picture of the needs of the individual (more holistic)
Working with
Meaningful discussions
Build strong teams
Patient centred – individualised
Creating a partnership between patient and practitioner
Make healthcare relevant to patients
Elicit what matters to me
Opportunity to identify peer support opportunities
Learning from each other
Creating more compassion

Appendix 4 - Exploring the barriers and enablers to supporting a change in role for the HCP

Flipchart notes:

Barriers
Time
Perception
Process
Relationship
Identity
Attitudes

Enablers
Being human
Relatable
Roll out of HoC/MtM should free up professional time
Manage agreed targets (smart)
Peer support opportunities ("Adopt a GP practice – Programme Days")

Barriers
Long complicated emails
Referral criteria/ processes
Culture
Poor knowledge of services in your local area (both professional and public) hierarchy

Both barrier and enabler
Time
Motivation

Enablers
easy access to link workers
more than medicine, GP cluster events etc
accessible buildings
ALISS etc
Conducive environment
Benefits to confidence through accessing new services
Co-location of hcps and third sector
Reaching out into the community
Effective MDTs – proactive meetings

Barriers
Time constraints
Existing/historical practice
Competing priorities
Patients understanding

Willingness
Health literacy
Philosophy
Attitudes
Hard not to give solutions
Nothing new?

Enablers
Marketing pitch

- Cost effectiveness
- Appointments
- Outcomes
- Evaluation

Allow people to reflect on practice, it's not new, it's lived experience
Join the dots/instead of
Allow time/ familiarisation
Clinical skills for PN (GP has as part of training) consultation
Infrastructure to be tested pre-introduction
Whole practice approach/ Primary car contract GMS
Transforming nursing roles
Training opportunities/ HoC being built in (NES)
Professional development

Barriers

HCP knowledge of self management support options
3rd sector sustainability
Guidelines
Sustainability of 3rd sector – funding
Poor health literacy
Culture "doctor knows best", this is how we've always done it.
Colleagues not agreeing
Time
Patients 'wants' some patients want to be fixed

Both barrier and enabler
Time
Culture – patient expectation
IT

Enablers
Speed-networking
ALISS, NHS Inform, etc
Competency framework
Community Links Workers

More than Medicine events – engage practices with the third sector services and ALISS – HoC/CSP approach
Building on existing successful infrastructure

Barriers
Time
Transition into CSP
Resource
Target-driven
QOF gone, but new targets introduced
Buy-in – resistance to change, challenging to get whole practice buy-in
Lack of information - lack of comms within and outwith practice 'just another initiative' breads scepticism
Funding
What does HoC mean?
Siloed for those doing CSP

Enablers
Better resourced
Community engagement – "do people know what's happening in practice and system?" and "Do GPs/GPNs know what is happening in the community?"
Inviting 3rd sector into GP practice leads to staff and public knowledge
Promoting services in community e.g. supermarket stalls

Appendix 5 - Discussion of difficulties, solutions and what worked well in terms of More than Medicine

Flipchart notes:

Barriers (difficulties)
Time
Capacity
Resilience
Team buy in
Enthusiasm
Competing prioritisation
Data/ improvement – no quick wins
Complexity
Patient may not be willing to have a CSP conversation – buy in
Not priority in complex environment
Choose/not choose to do it
Funding – training capacity – training all, supporting practitioner -external support
CSP -MI/BC skills

Enablers and solutions
Consistent funding to support change
Top down approach – policy (strengthen to support change)
Education/training -undergrad and embed and all practices to reduce variation
+++More than Medicine
Share inspiration/change – locally, board level, nationally
More Links Workers/Social prescribers
More than Medicine APP – easily accessible, ALISS, up to date info at fingertips
Easy access to local solution/asset builders

Barriers (difficulties)
Knowing what's out there and keeping up to date
"Not my job"
Community Links Workers are all different – role and remit
Lack of feedback from how patients got on at community resource

Enablers (solutions)
Dashboard with hyperlinks to what's known about
GP websites linking to community resources, generated by ALISS
Community Links Workers to support
'Locator' website (Lanarkshire) and equivalent in other areas
Adding website links to CSP Prompts/Results letter
Community boards

Worked well
Sharing knowledge of links workers more widely
Networking

IT support put tools/links/shortcuts on PCs
Practice driven campaigns e.g. Beat the Bulge campaign, walking GPs

Difficulties
Constraints of current model – e.g. construction
Lack of links workers
Lack of connections, communication and relationship building
Transient nature of 3rd Sector

Solutions
Care support planning
Links workers
Health fairs
Skilling up admin staff
Community champions
Community participation groups
Practice participation groups
Clusters

Worked well
Links workers
Health fairs

Barriers (difficulties)
Lack of knowledge of what is out there and how to tap into it
Funding and temporary support
Communication
Resources
Better partnerships with providers of services
HCP's lack of education on social prescribing, diet and exercise

Enablers/solutions
Funding on 'more than medicines' focus on charities and organisations out there already established
Better promotion of social prescribing
Wider community understanding more about social prescribing
Managing patient expectations
House of care patient champions
Third sector interface engaging more with HCPs to educate them on what is out there
Training for HCPs on the fundamentals of diet, exercise, etc

Difficulties
Lack of knowledge on what's available
Short-term funding
Competing priorities

Lack of buy-in from professionals/patients

Solutions
Embed CSP in undergraduate training
More cross-sector working
Regular PLT sessions on what's available locally

Worked well
GPs job-shadowing voluntary organisations