HEALTH NEEDS ASSESSMENT CONVERSATION CAFE

Wednesday 31st May 2017 - the Quaker Meeting House

Introduction

A conversation cafe was held as the final process of consultation with strategic leads and service providers for the health needs assessment. The aim of the event was to bring together key stakeholders who work with PWID to

- Update them on the evidence and results of the health needs assessment
- Provide the opportunity to review the recommendations and
- Agree key actions and a potential framework for implementation

Background

Sixty three people attended the event from a wide range of services and organisations which represented both Third and Statutory sectors. Invites were targeted at agencies which are essential in the provision of harm reduction interventions at locality level such as Recovery Hubs, Substance Misuse Clinical teams, GPs, Social Work and Pharmacists plus city wide services such as Streetwork, Harm Reduction, the Scottish Prison Service and Police Scotland.

Process

To enable discussion between locality teams and wider, participants were grouped as far as possible with others from the locality they work in. Those who are city wide were allocated across groups where it was felt their experience and expertise of particular approaches or services would contribute to how recommendations might be implemented at a locality level or links to specific services made. For example the Wound Care Nurse suggested ways to upskill staff across the city without the need to replicate the central wound clinic and Pharmacists highlighted their role with drug users in relation to general care and drug treatment.

The concept and principles of the world cafe (aka conversation cafe) supported the aim of engaging the stakeholders in a way that open and honest discussion was had to consolidate the draft recommendations. There were six main recommendations so each one featured on a separate table. The groups rotated around all the tables to enable them to consider each recommendation and the evidence base from which it was developed. There were two facilitators at each table who stayed there for the duration. This enabled them to hear ideas or themes from the start which became richer as the session progressed. Prior to the event they were given a brief about the key principles and how to host each conversation.

The following seven World Café design principles are an integrated set of ideas and practices that form the basis of the pattern embodied in the World Café process

1. Set the Context
2. Create Hospitable Space
3. Explore Questions that Matter
4. Encourage Everyone's Contribution
5. Connect Diverse Perspectives
6. Listen together for Patterns and Insights
7. Share Collective Discoveries

World Cafe Design Principles (http://www.theworldcafe.com/key-concepts-resources/design-principles/)

Participants were encouraged to actively contribute verbally or through notes and/ or doodles on the paper tablecloths. The same questions were posed for each recommendation and collated after the event.

1. Which recommendations do you think are the most important?
2. What might the next stage of development be and who do you think might lead on the work? (which partners should be involved? SU involvement)
3. What do you think are the opportunities/ challenges with providing some of these recommendations? (do we need to change the way we work, where we work from, skill set of the service provider)
4. In relation to this area (e.g. OST) is there anything missing?

Following six rounds of facilitated discussion the groups were asked to spend 20 minutes reflecting on the morning without a facilitator and to define three things that had emerged from the information and/ or event for them. Any emerging issues or gaps were then fedback by each group after lunch.

Feedback

Overall the feedback was positive about the content of the recommendations with suggestions of what should take priority, what could be implemented immediately, where bits of work could be directed and which agency could lead.

Gaps that were identified were

a) Lack of interventions that would impact on drug using cultures- nothing to address stigma of injecting or attitudes towards injectors.

b) The involvement of active drug users as influencers.

c) There are no gender specific recommendations.

d) The person's experience and measurement of widespread adoption of a person-centred approach.

e) Retention in OST does not mention discharge from services of complex service users

The following table sets out the recommendations and the facilitators, along with the key headlines from each table drawn from the participant responses.

Table no.	Recommendation & facilitators
1.	**Improve access to & retention in opiate substitution therapy (OST)** (Tracey Cochrane & Paul Novak)
	• Local system standards & KPI's are important to base further work on improving access to & retention in OST. • Review standards which should include the discharge policy. • Non medical prescribing should be the next stage of development • Meeting the HEAT targets is becoming detrimental to the care of the patient. Person centred care should be provided not one size fits all. More opportunities need to be provided for rapid access. Learn more from service users. • Safer injecting rooms & heroin assisted treatment is still missing from this discussion
2.	**Provide harm reduction as part of all service contacts with PWID** (Jim Shanley & Jill Smith)
	• Support for services to do more outreach to ensure they are reaching the service users in places that they are accessing regularly (e.g. enhanced pharmacy project) • More integrated working across services, including the liaison role for the acute sector • Harm reduction interventions can be provided better with more consistent training for staff, protected learning and access to appropriate equipment and locations from which to provide it safely for the staff, service users and the general public. • Person centred approach to meet the needs of all PWIDS e.g yp, IPEDS & those only accessing pharmacy
3.	**Reduce losses & missed opportunities for the testing, care & treatment of BBV** (David Williams & Hilda Stiven)
	• A BBV dashboard would provide a way of pulling information together. Currently not much interest but if it can be shown to be effective in

	feeding back data & highlighting the needs of patients then it is considered to be useful. • Lack of information and understanding amongst service providers and service users about services that are currently available to support people into HCV treatment and what HCv treatment now involves. Not all practitioners are prioritising HCV testing. This all demonstrates the need for training and information to be made available across hubs to reach workers and the patients. Targeting people in long term recovery should also be considered. • Relationships with key workers are key, so priority should be given to build capacity in current workers to engage SU with testing & into treatment as they already have the relationship with the SU instead of bringing in new services (e.g. RIDU outreach, phlebotomists) • The BBV team are useful for testing but its hard to co-ordinate patients with the BBV team especially when hubs operate across different locations. Regular focussed sessions like HRT do might be a good way forward as intense bursts seem to be better than little and often. • Explore non medical prescribing of HCV treatments within pharmacies
4.	**Provide more opportunities for clients to access support for general health & wellbeing** (Claire Glen & Sheila Wilson)
	• Increase the skill mix- There is a recognition that staff in the hubs need to be upskilled to offer more support for general health in current services as service users are lost when referred on. Ideas such as respiratory assessments, smoking cessation and wound care were given as these were the main concerns along with poor mental health • There should be flexibility within teams where there are vacancies to look at staff who can provide basic health care such as a healthcare assistant who can rotate between locality teams. If a “Keep Well” model was used it would need to be reinvigorated & tailored more to the needs of PWID and ensure the workers proactively engaged with SU not just waiting for appointments. • There was support to make the wound care nurse a substantive post who would remain a central post. This would increase capacity to facilitate wound care training for locality staff across areas. • Use the SMD quality improvement group to develop ideas. • Have better links with services who will be seeing PWID regularly, especially pharmacists or receiving specialist areas such as

	Respiratory. Lots of support for outreach to pharmacies to provide an enhanced service.
5.	**Strengthen services for vulnerable groups** (Dave Carson & Sabina McDonald)
	• Service provision needs to be reviewed – can NOT offer one service to all – it must be flexible and suit need • Data collection needs to be improved and/ or better shared/ communicated as well as better understood • The role of peers needs to be further explored/ expanded • Integration services, in particular Addictions Services and Mental Health Services is required – can NOT work in isolation of each other – need to join up/ communicate/ information share as appropriate • The needs of older drug users and female drug users needs to be further explored and understood as do the needs of children and families of people who inject drugs
6.	**Establish a multi- disciplinary & multi-agency plan for quality** (Nick Smith & Chris Stothart)
	• There is support for a dashboard, the development of service standards & KPIs to ensure quality services are provided. This should include competencies for non-clinical staff to ensure everyone is working to a high standard. **There needs to be a central service/ person who oversees this- an overarching group with the 4 Edinburgh localities, 3 Lothian localities, and 2 prisons – who can represent all areas and share resources/information across the areas would be useful**. Service standards should be flexible enough to support innovation and be patient centred because the PWID population is not a homogenous group. • A skills based/ workforce audit should be conducted to look at the assets we already have in the workforce & determine what the gaps are. • Data collection and dissemination should be a two way process. Service providers and SU should have an understanding of why the data is required to improve buy in. Data should also be fedback to services to enable quality improvement. • Coordinated Learning & Development sessions; protected learning time for a range of stakeholders to attend: multi-agency, city-wide/locality, GPs; specific training • A challenge exists with how systems currently don't talk to each other.

	Is it possible for them to interface somehow to inform the development of a dashboard? • Need for a new system across all agencies, or just a central place that compiles all the data? • Need to ensure we are consistently collecting the right information whilst keeping in mind how this will improve the patient journey and how we measure the impact of the dashboard and the training that is provided.

Evaluation

The event evaluated very positively and the majority of participants found the conversation cafe useful. All respondents apart from one agreed that a similar event in a years time would be helpful to bring everyone together again and review progress against the agreed actions.

All of the evaluations said that the conversation cafe updated them on the evidence and results of the health needs assessment.

41% completely agreed that they had been given the opportunity to review the recommendations, 25% partly & 33% not sure.

Participants were less clear that key actions and a framework for implementation was agreed on the day with the majority saying they only partly agreed with this statement.

It was clear from feedback that having the time and headspace away from work to network with others was valuable for most, alongside hearing about the evidence base and stakeholder feedback.

"I really liked that there was a broad cross section of staff from across services. This bought with it a wealth of information and many ideas to discuss. It was a pleasure to be part of this process."

It was a new experience for some and the opportunity for all of the key stakeholders to come together happens infrequently. Participants also valued the opportunity to comment on the recommendations and share their ideas for moving forward.

The main areas for improvement that were suggested were to reduce the size of the groups and use a bigger room as space was restricted. Providing the questions before the event was also felt to be a more efficient use of time & enable participants to formulate better answers.

All of the evaluations indicated a willingness to be involved with the implementation of the recommendations with some work already underway.

"*I would like to get involved with putting suggested harm reduction improvements in to the voluntary provider services that CGL provides."*

"*Any way you like. Currently supporting the take home naloxone programme. Would like to do some data capture with that."*

"Would be keen for Waverley Care to be involved in how we can support any of the recommendations relating to our work with people living with or at risk of BBVs."

The main ways in which people would change their practice as a result of discussions at the conversation cafe were knowing where to refer clients and training they would access or ask to be provided.

Next steps and actions

- Finalise the recommendations based on the feedback at the conversation cafe
- Collate the feedback from the conversation cafe
- Establish plans & leads agencies for the work going forward
- Implement small tests of change & evaluate