Appendix 5

Multiprofessional collaborative learning groups and faculty of facilitators

Training lead: Dr Anita Patel

Objectives

One of the HENCEL 'support for service' priorities is to improve the integration of the health and care workforce. In 2014, Barnet CEPN designed Multiprofessional Collaborative Learning Groups with this as the prime outcome.

Last year the impact of the MCLGs was evaluated by an external evaluator and shown to have produced a statistically significant increase in self-reported skills with regard to integrated working. Having created a vehicle by which to successfully deliver interprofessional education in the community, we have continued to build on this success and translate this into better integrated care for patients. This multiagency approach to the development of the social and healthcare workforce is in line with HENCEL policy, as is the focus for working across sector boundaries.

The objectives of the Multiprofessional Collaborative Learning Group programme (MCLG) for 2015/16 were to:

1. increase workers' understanding of the roles of others, leading to greater peer support and team working and appropriate delegation

2. increase workers' awareness of available local primary, secondary, community and voluntary services in order to improve access to these resources

3. increase workers' knowledge about specific substantive topics

The MCLG content was determined by needs identified by the CCG and Public Health department and previous learning needs analyses carried out by the CEPN and the Primary Care Academy. Additionally we have worked with Public Health to ensure the imparting of relevant public health knowledge where appropriate and encouraging participants to consider their roles in public health improvements

The groups focused on addressing the management of long-term conditions, in line with local and national priorities.

One of Barnet CCG's transformation strategy priorities is to improve the care of patients with such conditions as heart failure, atrial fibrillation, diabetes and chronic mental ill health. Mental disorder is responsible for the largest burden of disease in England – 23% of the total. Overall rates of individual mental health problems are higher in Barnet than London and England; (Barnet JSNA 2015-20). Within Barnet, by far the most significant element of the CCG's mental health expenditure is in secondary mental health i.e. hospital or residential settings (Barnet JSNA 2015-20).

Coronary Heart Disease is the number one cause of death amongst both men and women. As male life expectancy continues to converge with that of women it is likely that the prevalence of some long term conditions will increase in men faster than in women; (Barnet JSNA 2015-20). The priorities above are also in line with the HENCEL priority for improved care of people suffering with long-term conditions (LTC).

The meetings address the HENCEL / five year forward priorities of:

- Using education and training to deliver improved end of life care
- Ensuring all clinical staff can identify and deal with mental health conditions
- Ensuring the workforce has the skills, behaviours and training to support improved access to psychological therapies
- Increasing the ability of staff to suggest improvements in the service and drive them through
- Incentivising healthier individual behaviours
- Targeting secondary prevention

Methods to assess impact

All participants were asked to complete a survey at the end of every session.

A follow up survey was sent to all participants in April.

Facilitators have asked participants to describe what they have gained from attending MCLG sessions.

Activities

Group sessions

In 2015/16, the CEPN delivered nine rounds of eight group meetings via the MCLGs i.e. 72 group sessions, reaching 97% of Barnet GP practices and a wide range of health and social care professionals. Each GP practice in Barnet is aligned to one of the nine MCLGs. The groups were attended by over 530 people.

Each MCLG group has a lead facilitator and some have a co-facilitator. Each facilitator liaises with one of our administrators to set acceptable dates, taking note of all the other regular meetings that occur e.g. locality meetings to ensure that there is better co-ordination of meetings. Each of the facilitator is then responsible for emailing their group and also has the responsibility of ensuring that the contact database for their group is kept up to date.

The educational content has been facilitated by CEPN faculty members and some of the sessions have been supported by the North London Hospice Education Team and the Primary Care Academy. The CCG has provided backfill as they did in 2014-15. There was ongoing liaison with Royal Free NHS Foundation Trust with the cardiology department and also support for the sessions on diabetes & back pain where we had very good consultant representation

The delivery of effective integrated care requires that clinicians are able to interact and develop networks. In order to continue to support our MCLGs' further development, we monitored the attendance of practitioners to ensure that they were able to engage as part of their work-patterns. Providers of care e.g. practices, CLCH, Hospice & RFH Foundation Trust, BEH-MHT were actively encouraged to support the release of staff time. Where staffing capacity is challenged we have worked with providers to understand the methods for addressing this and the impact within the wider health economy. We have worked with our local community provider CLCH to create an arrangement that a named district nurse for an area who is encouraged to attend the MCLG meetings to ensure that they support the on-going education, training and clinical network development. We managed to secure on-going support from the RFH Department of Medicine and BEH-MHT who have acknowledged the benefits of engaging with the MCLGs.

Heart failure series

The year started with 3 meetings on the topic of heart failure and used a patient's journey to raise various issues.

The aims of the **first** case were:

- The differential diagnosis of first presentation of breathlessness in patients with medical complexities and who have difficulties in engaging with the services.
- To increase confidence in interpreting results of various tests & feel confident in communicating these to patients.
- To understand the impacts of a cardiac diagnosis on a patient and their family.

The **second** case built on the first and explored the challenges of treatment from the patient's, relatives' and health care professionals' perspective.

In the **third** case, the patient's heart failure had progressed and had developed end stage cardiac failure. In this session the aims were:

- To raise awareness in the practitioner about when to initiate palliative care conversations and care.
- To develop skills in having difficult end of life conversations for which facilitators introduced role play as a way of practising them.

long term mental health conditions & medically unexplained symptoms

The next set of meetings were on Long Term Mental Health Conditions and Medically Unexplained Symptoms (MUS). Primary Care Academy, PCA (which is the academic arm of BEH-MHT) was commissioned to run these sessions with input from the CEPN regarding the content and format of meetings.

The aim of the session on **Long Term Mental Health Conditions** was:

- To enable meaningful shared decision-making,
- To understand and coordinate the respective contributions of the primary, secondary and voluntary sector towards the recovery and care of an adult service user.
- To understand the voluntary sector resources and how they can be accessed.

Briefed volunteers from Barnet Network (a support group for short and long term mental health conditions) came to participate in the session and tell their story of how their ill health had impacted on them and what had helped them and what could have been done better.

The **Medically Unexplained Symptoms** (**MUS)** session's aims were:

- To describe the criteria for medically unexplained symptoms and its associated risks
- To help develop a management plan for medically unexplained symptoms
- To reach effective shared decision making with patients to empower them and to aid recovery.

The session had service users and voluntary sector organisations who participated. Some of the groups had a role play of a consultation between a service user with MUS and a Trust Consultant, demonstrating elements of effective communication.

Diabetes series

The two meetings on diabetes were on pre-diabetes and complex diabetes.

The aims of the **first** meeting focussing on pre-diabetes and newly diagnosed diabetes were:

- To learn about the risk factors for diabetes
- To diagnose pre-diabetes and newly diagnosed diabetes, to understand how to screen and the limitations of HbA1c
- To consider the advice given and how to keep it consistent between the disciplines
- To consider how to motivate patients to make lifestyle changes and the longer term risks of diabetes

We had patients from Diabetes UK that attended many of the meetings and shared their experiences with the group and also learnt about all the local resources that are available to patients.

The **second** meeting was about a patient whose diabetes was poorly controlled and the various choices of medication. Diabetic consultants from RFH Foundation Trust attended.

Back pain session

The aims of the back pain meeting were:

- To raise the awareness of red and yellow flags
- To consider the referral processes and the most effective management of these patients

CLCH's MSK team representative attended all the meetings together with orthopaedic consultant Mr Bajekal from Barnet site of RFH Foundation Trust to provide the secondary care perspective.

For all sessions, resource documents were sent to participants together with the learning from all the groups. This is now available on the website for practitioners to refer to.

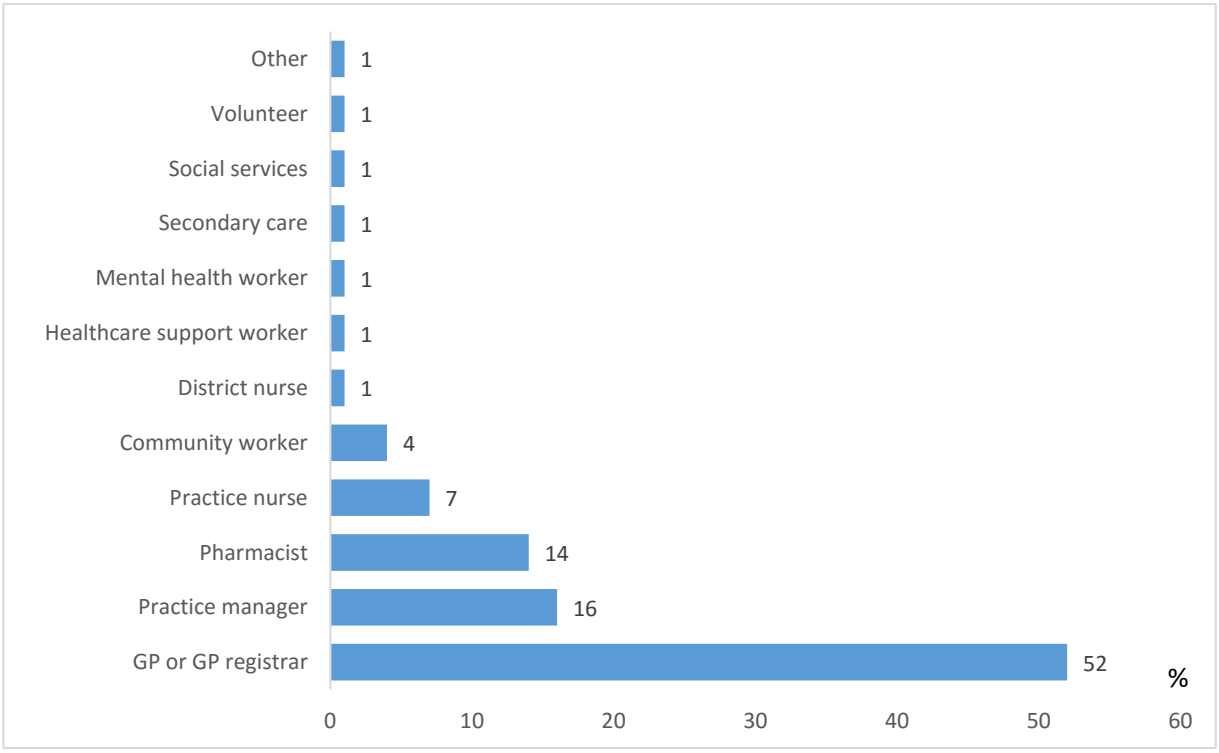
Impacts

Most information about impacts is drawn from feedback forms completed by participants. There were 538 feedback forms received from the nine MCLGs that each ran eight sessions (one group only ran seven sessions). Table A5.1 shows the number of feedback forms returned for each topic. Figure A5.1 shows the types of professionals that completed forms.

Table A5.1: Number of feedback forms available from each series of workshops

Topics	Feedback forms
Back pain	56
Diabetes 1	72
Diabetes 2	38
Heart failure 1	75
Heart failure 2	78
Heart failure 3	40
Mental health 1	110
Mental health 2	69
Overall	**538**

Figure A5.1: Types of professionals that provided feedback



Valuing the MCLG sessions

In four MCLG topics, participants were asked whether they would recommend the MCLGs to others. In all cases eight out of ten people said they would recommend the sessions to others (range 83% to 97%).

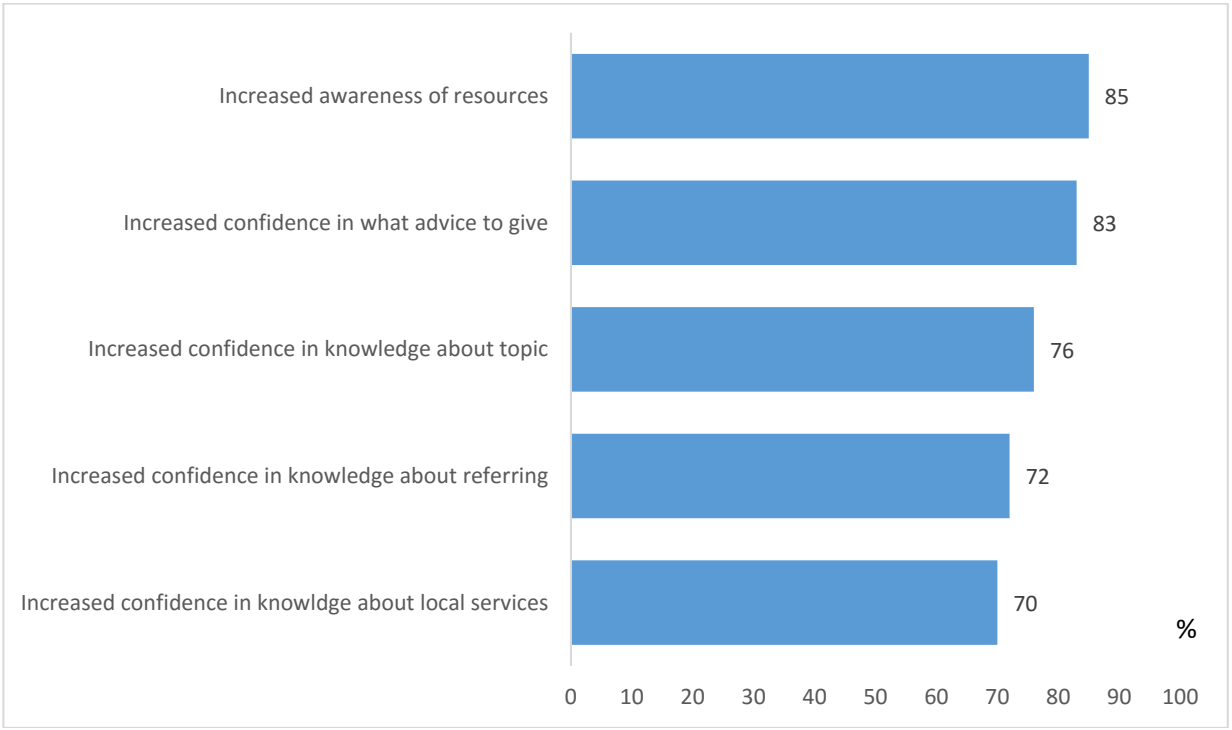
A short survey was undertaken asking about the benefits of attending the MCLG meetings. The key perceived benefits were:

- learning about local resources
- more knowledge of how to do things locally
- making new contacts
- meeting colleagues
- learning from each other
- update knowledge and skills
- improving relationships

Increased knowledge and confidence

Figure A5.2 show the extent to which people felt more confident and knowledgeable after attending groups. This shows that the participants have increased confidence in their knowledge of the topic, the advice to give to patients and also when and where to refer. They had an increased awareness of the resources available and increased confidence in their knowledge of local services

Figure A5.2: Proportion of attendees that felt more knowledgeable and confident



85% of the participants stated that they had an increased awareness of resources, supported by the quotes: *'Community dietitian referral; websites for exercise', 'Direct referral for wrist splints', 'Think about EOLC discussion'. 'Consider HF nurse', 'Pharmacy EOLC medicines. Rationalising meds'.*

76% of participants reported increased confidence about the topic, illustrated in some of the following quotes: *'Easier to initiate conversation re ceiling of care', 'Have 'the difficult conversation' earlier',' If BNP > 500 need urgent 2/52 referral. Remember to consider silent MI -> AF / HF', 'More aware how GPs can refer; be more aware of yellow & red flags', 'More aware of involving pts when it comes to lifestyle education; trying to engage and not come across as judgemental', 'More aware of most important red flags; more awareness of referring acute osteoporotic fracture', 'Review polypharmacy impact early', 'Talk about advanced care planning earlier in disease process', 'Think about EOLC discussion. Consider HF nurse. Pharmacy EOLC medicines. Rationalising meds. Conversations re empowering positive change'.*

72% of participants felt that there had been an increase in knowledge about referring. This was illustrated by the following quotes from the feedback forms: *'E-mail social work referrals with more functional information', 'Have the right access to patients. 'Confident in helping them and reduce their anxiety', 'HF Nurse referral. Ask Pharmacist to monitor. Think about BNP. More confident about making medication changes', 'I could advise patients on how to obtain help for social care /enablement packages available', 'Liaise more with voluntary services', 'Link more frequently with local GPs', 'Suggest GPs refer complex cases to MDT meetings', 'Use rapid response team more', ' Use TREAT more'.*

70% of participants felt they had increased knowledge about local services. This was demonstrated by the following quotes from participants: *'Appropriate use of rapid response services; district nurse; social services', "Consider palliative care referral services in non-cancer conditions, particularly HF'. 'Better knowledge & symptom control options will also help prescribing', Better knowledge & symptom control options will also help prescribing', 'Might use psychiatric advice line', 'Probably know more about MSK services; use CBT & acupuncture', 'Think about using the ambulatory care/treat care service; use the pharmacist more re new medication check', 'Use advice line and info sheets provided'.*

Box A5.1 provides some vignettes showing how participants benefitted from the MCLGs.

Box A5.1: Feedback about increased knowledge and confidence

"I attended the sessions on the Long term Mental Health and Medically Unexplained Symptoms and learnt a lot from the role play. Mainly about being less judgmental about people with mental health, how can I make it less stressful for patients & being aware of the anxiety that they may be experience when they come to see me. I learnt about the importance of maintain eye contact, listening & not follow my own agenda. On the results lines which I manage, one of the patients kept phoning a couple of times day for his results and this occurred several times for 4 days in a row. On the final phone call, I acknowledged that he was anxious and we had a discussion about it. He told me that his Father had died a few months ago & he was convinced he was going to die. I explained once again that his results were normal, asked him to repeat what I had said, offered to write it down & give him a hard copy. Since then he has not made contact with the practice" (HCSW)

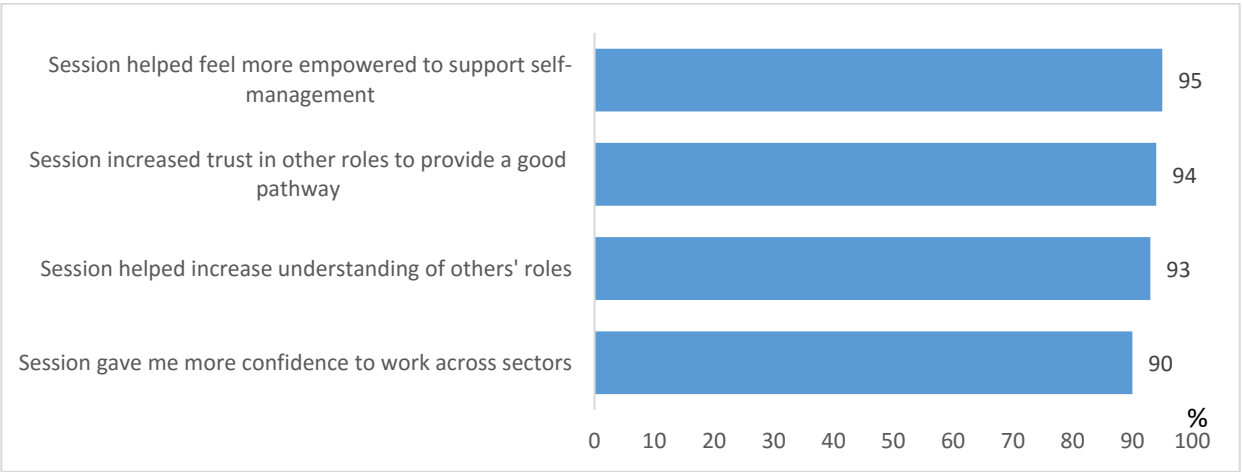
"I advise people with pre diabetes now the same as those newly diagnosed with big emphasis on need for early reversal. Rather than saying you don't have diabetes I now say you virtually do.
I also discuss with and suggest that newly diagnosed diabetes patients start metformin earlier than I used to. More of a Hit it hard early on approach." (Practice Nurse)

"I've really enjoyed all the MCLG meetings that I've attended. In particular polypharmacy in the community was very interesting. Having health care professionals from different areas of the NHS, primary care, pharmacy, hospital, district nurses is a really useful tool for networking and improving patient care. It was really interesting to see the pharmacists perspective regarding prescriptions and dosset box reviews and made me realise that I need to work closer with my local pharmacists. They often have a unique insight into patient medication issues, such as compliance, that doctors don't." (General Practitioner)

Increased multiprofessional working

Figure A5.3 shows the impact of the MCLG sessions on multiprofessional learning and working. It shows that the MCLG sessions gave participants more confidence to work across sectors, helped increase understanding of others' roles, increased trust in others' roles to provide a good pathway for patients and helped them feel more empowered to support self-management in patients.

Figure A5.3: Impact of MCLGs according to participants



95% of the participants felt that the sessions helped them feel more empowered to support self-management. This is illustrated by the following quotes from participants: *'Empowering pre-diabetics', 'Frequent follow ups of pre-diabetic pts to empower them & encourage them to continue with lifestyle modification',' More aware of involving pts when it comes to lifestyle education; trying to engage and not come across as judgemental', 'More self-help advice for pts with back pain', 'Pre-diabetic group management', 'Ways to promote recovery', ,' Provide more education & encourage exercise', 'Role of homework exercises and empowerment. Be alert to dangers of assuming that problems are automatically MUS. Avoid labels', 'Consider use of BM testing for newly diagnosed diabetics to support dietary change'.*

94% of participants felt that the sessions increased trust in other roles to provide a good pathway. This was supported by various quotes from participants: *'encouraging staff to access MSK rather than unnecessary referral to GP for rheumatology', 'Increase use of Amb Care and CNS', 'Involve HF nurse', 'Involve hospice sooner for symptom control', 'Consider palliative care referral services in non-cancer conditions, particularly HF', 'Involve social care early', 'More aware of most important red flags; more awareness of referring acute osteoporotic fracture; Use of voluntary sector. Referral pathways'.*

93% of participants felt that the sessions helped increase understanding of others' roles. This is illustrated by the following quotes: *'Being more proactive and communicate with GPs', 'Greater awareness of community teams', 'Greater awareness of the roles of DNs and Hospice team', 'I will try and use Keele Start tool; good to have MSK emails; MRIs can be accessed by MSK/PACS', 'more likely to send to pharmacy', 'community dietitian referrals'.*

90% of participants felt that the sessions gave them more confidence to work across sectors. This was illustrated by the following quotes: *'Collaborate more with palliative network in Barnet', 'Communicate any issues directly to the GP rather than just via patient',' Communicate role of comm pharmacist services',' Community Pharmacist to renew meds', 'Involve pharmacists more. Use pharmacists to diarise med reviews', ' Use pharmacists to diarise med reviews', ''More confidence in contacting GPs / other HPs if feel pt is in denial of depression of if concerns', 'More willing to pick up phone and discuss pt with GP', 'Use ambulatory care for urgent assessments'.*

There was more confidence in working with other disciplines and better relationships across the geography illustrated by the quotes:

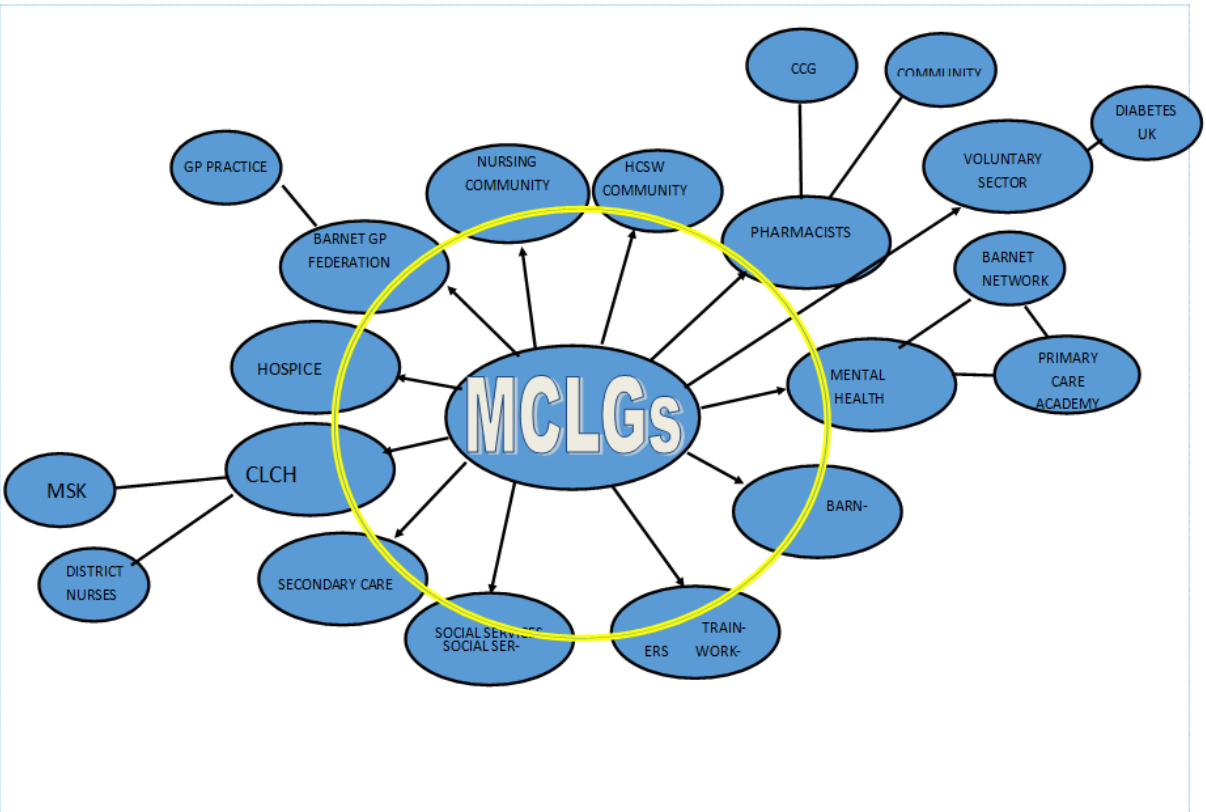
> "They (the MCLG groups) help forge collaborative working across all the MDT."

> *"It has created a better relationship amongst the professionals which gives greater confidence in reassuring the patient"* (CEPN Facilitator and Barnet GP)

Building links across organisations

Over the year Barnet CEPN has worked with numerous different groups and organisations in creating and delivering the educational programme for the MCLGs. The wide range of connections has helped to improve the connectivity of organisations in Barnet which is in line with the five year forward view. Figure A5.4 illustrates the various organisations and groups who have networked as a result of the MCLG meetings which have helped forge collaborative working across many of the organisations and groups.

Figure A5.4: Range of organisations networking as a result of MCLGs



An example of collaborative working with other providers was Barnet CEPN working closely with Pan Barnet Federation & Barndoc, particularly the practitioners involved in the referral management team to create a programme for back pain, a topic chosen due the high volume of referrals received. This pilot project for Barndoc and Barnet CEPN collaborating was a great success. We invited CLCH, RFL to participate and created the resources for the participants. Out of the meetings came a conversation with the CCG about one of the consultants being willing to run an advice service for MRI interpretations and back pain which would be very helpful for the GPs.

In North Barnet we have seen four of the MCLG network of practices become the service delivery models for 8-8. Each of the MCLG group of practices have a Hub and they are responsible for encouraging the local practices to participate in the service. There are numerous **advantages** of educational platform becoming a service delivery platform:

- Firstly there is already a relationship that has been established between the practices in the MCLG group making the setting and running of the 8-8 service easier to manage.
- Secondly, that the educational meetings can be used to update the local practices about the current news updates about the 8-8 and also the Pan Barnet Federation and
- Thirdly, some of the local pharmacists attending the MCLG groups have increased their opening hours to enable the patients attending the 8-8 service easy access to pharmacy services.

In West Barnet, the multi-professional groups have acted as a catalyst to improve collaboration and joint working between the Pharmacists and GPs. They have held separate meetings to plan how to communicate more effectively between the practices eg setting up NHS net emails, sharing direct line numbers to improve patient care and to reduce each other's workload.

Barnet CEPN had commissioned a programme for primary care staff to consider how patients with MUS can be empowered and how primary care can aid recovery. This work has been quoted in the Joint Health and Wellbeing Strategy 2015 as it is an example of further work in Barnet to address the needs of patients with MUS and to help redress the balance of supporting mental health with equal importance as physical health.

There has been increased interest in setting up multipofessional collaborative learning groups from other North, Central and East London areas. A few CEPNs have contacted us with regard to information about how to set MCLGs up.

We now have a handbook of case studies which others groups can use. They will be on the Barnet CEPN website. We have had several CEPNs contacting us regarding access to the cases to use for their educational sessions.

Costs

The total cost of MCLGs was £69,650, with an additional £50,000 provided by the CCG for backfill costs. With 778 places at sessions in total, this equates to £90 per person or £154 per person including backfill.

Lessons learnt

On the whole the MCLGs have continued to be functional and valuable to most of the participants. We have learnt to ensure that all the dates of the various meetings are taken into consideration eg locality meetings etc to ensure a good attendance. We have also encouraged the other providers of education to use Barnet CEPN website to check if the dates prior to arranging educational sessions.

The facilitation of the groups has been valued and there have been several comments in the feedback about the groups being well facilitated: 'a lot to cover but well facilitated. A nice warm welcome, thank you', lot to cover, but well facilitated. Including all participants'.

March was a difficult month as it was the end of the QOF year and also many practices had their CQC visits in Barnet together with holidays of health care professionals around Easter meant that the attendance was not as good for the last diabetic session. We will need to bear this in mind when planning dates for next year.

We have also learnt other lessons including:

- To ensure secondary care and community care are given at least 6weeks notice to attend the MCLGs as participants and a resource to ensure that clinics do not need to be rescheduled.

- To think about the structure of the sessions to make them more valuable to all attendees. One suggestion has been to have a shorter case based discussion with 'expert snippets' which could be presented by the specialists and other agencies that have been invited.

- Social services attendance has tailed off as a reorganisation has taken place which meant that the relationships that had formed were lost. We are aware that we need to work on this and have decided to try and make contact with the directors at LBBB to ensure that there is a strategic push from the management to enable social workers to be released to attend the MCLG groups.

- Improved communication with the facilitators to inform them of all the various agencies that are attending and in turn for the facilitators to send out a personalised invite to the group to with the information which will may further encourage attendance.

Challenges

The attendance in the last session, held in March had dropped off which could be for due to various reasons eg end of QOF, CQC practice visits, Easter holidays. Hence this has to be taken into consideration for future planning.

As the participation in some groups had dropped off slightly, there had been email and telephone conversations with the group participants to understand some of the reasons for this. There were multiple reasons for this but the main reason was protected time for the meetings. This was reflected in our conversations with all the providers- GP practices, CLCH, RFH Foundation Trust and so we need to think creatively about how to make it easier for all the practitioners to attend.

We had considered the possibility of holding the MCLG meetings in the evenings but a short survey revealed that the preferred time for the meetings was lunch time with a minority stating evenings would be preferable. We also looked at the attendance for the evening pharmacy meetings (attended by GP, Practice Nurses and Pharmacists) which was much the same remembering that they served a much wider area. The MCLGs are different as one of its function is to create a local community of practitioners serving a population which in the North has translated into a service delivery model.

The possible options to consider to increase the attendance are:

1. Merging 2 of the MCLGs and having half day protected time (covered by Barndoc & paid for by the CCG) & having fewer meetings but longer sessions. The localism can still be maintained by utilising group work. This would result in 4 group meeting in Barnet, enabling the same programme to be delivered. The challenge would be to find acceptable venues at a low cost.

   The **advantages** are:
   -all the practitioners from each practice can attend, increasing the attendance of Practice nurses and HCSWs
   -there would be fewer meetings for the other local providers and voluntary groups to attend making it more possible for better representation at each of the MCLG meeting.
   -There would be more time to have presentations as well as case discussions, this would meet many of the attendees needs.
   -The programme can be created to ensure that the GP community is stretched & engaged as this will ensure continued participation.

   The **disadvantage** are:
   -there would be an impact on patient access and increased workload the following day for all the practices. There are possible solutions to this eg increasing the number of Pan Barnet Federation appointments to absorb the greater demand. This will need agreement from the CCG to fund this.
   -loss of the localism & the creation of local communities of practitioners serving a population that the current arrangement of the MCLGs create. This is particularly true in the North of Barnet as they have translated into a service delivery model.
   -Pharmacist may find it more difficult to attend as it will be in the afternoon.

2. Regular change in days of the week that the meetings are held so that different members of the team can attend, this could help to increase participation. However in the last report, the more meetings that the participants attended, the more they felt they benefitted from them.

3. There could be more regular changes of the venues to enable different practitioners to attend as it reduces travel times for different teams

4. To acknowledge the length of the meetings (one and a half hour long) creates stresses for the practitioners who attend due to high levels of work load for the practices. However, the length of the sessions are controversial as some participants stated that the sessions are too long and others stated that there was not sufficient time. Shorter sessions would also restrict the amount covered and reduce the participation in small groups.

The MCLGs are most heavily attended by GPs. One option would be to be explicit with the practices that there is an expectation that they send their PNs and HCSW to the meetings rather than only GPs. This would increase the PN and HCSW attendance which is less than 10% overall. This would also improve balance of professionals within the groups.

One of the other challenges is to get greater engagement of the voluntary sector and to have more patient representation. We recently had a very positive meeting up with Age UK and are hoping to involve them in the delivery of the educational sessions. With regard to patient participation, we have used patient volunteers from Diabetes UK for our series on diabetes as well as the series on mental health and they were well received. In the future we need to ensure that they are aware of their role, the structure of the meeting and feel well supported during the session. Recently, we have been in conversation with Hackney CEPN who have done some work around patient participation & have planned a meeting to discuss this.

We have had challenges engaging with Secondary care involvement to ensure that they are able to send their consultants to attend the MCLG groups. More recently we have met with met with Antony Senner, Andrew Harrington and Louise Schofield from the RFL and so hope that there will be better attendance in the future.

Faculty of facilitators

Overview

The faculty of facilitators was created to support the multi-professional collaborative learning groups and other educational events staged by the CEPN.

The faculty comprises 17 facilitators in total. Thirteen are experienced Barnet GP trainers, three are nurses with an educational background and one is a pharmacist. Initially there was an explicit focus on working with multi-professional facilitators, however this is now being extended to include small group management skills for nurse mentors and also practice managers.

Each of the nine multi-professional collaborative learning groups is supported by one or two trained facilitators. The purpose of facilitation was to help people focus on planned content and activities, manage group dynamics and identify differences around language and terminology. Facilitators do not act as 'content experts' and 'teach' about specific topics. Their role was to guide the process, rather than to provide content.

Last year, there was a 'lead facilitator', a retired local GP and GP trainer who worked with Barnet CEPN to develop a facilitator training programme for the multi-professional collaborative learning groups. Facilitators took part in two development half-days, which included discussions about facilitation skills, practising role play and troubleshooting issues and this year we no longer have a 'lead facilitator'.

Activities

There have been three facilitator development half days this year. The first one focussed on awareness of the current developments of the CEPN to ensure the facilitators are well informed; reflections of the previous MCLG groups; what the challenges are of managing the group that they facilitate and how to overcome them; understanding the content and process of the next session to ensure smooth functioning of the MCLG groups and learning new skills for managing small groups.

The second session focussed on Collaboration with Centre for Behaviour Change to deliver training which focussed on "What is patient empowerment and how to teach it" run by Prof John Cape. It was attended by all 17 of the CEPN's faculty of facilitators (PNs, pharmacist, GPs and PH). It was designed to leave a legacy of local knowledge and skills in designing and delivering empowerment projects. The training was well received. Newly learnt skills were disseminated at the following round of MCLGs which was on motivating pre and newly diagnosed diabetics to undertake lifestyle changes.

The next session has been scheduled to be held in May.

The cost of each session is £4,210, or about £248 per faculty member.

Cases for the MCLG groups are written either by 2 lead case writers from the faculty or they work with other agencies who are involved in leading the educational sessions, ensuring that they have multi-professional engagement. The cases are usually based on real cases amended for anonymity.

The most important aspect of the case is that they involve the professional groups who attend the MCLGs. This invites the various professionals' perspective to be heard, helping others to understand and appreciate their roles in managing the patient better and breaking down barriers. Once the cases are written, they are circulated to other professionals within and out with the faculty group, inviting comment.

When there are a series of meetings on a subject e.g. heart failure, there is progression of the medical and care needs of the patient. The cases are written so as to provide a challenge if the group needs it and there are explicit areas within the case where there is an invitation to role play part of a scenario, if the group so chooses.

The case writers collate the various resources from the different local agencies who are supporting the educational events. The packs are circulated to the facilitators in advance of each session, setting out the learning scenario and learning objectives. Facilitators were also given a copy of an end of session feedback form designed with the help of the evidence centre to ensure continued evaluation of the meetings. The forms help gain participants' views about the extent to which the session had met the learning outcomes and what they might do differently as a result. Some of the questions in the feedback form varied each session, to account for the specific topic discussed in the session, but most focused on the pre-set learning outcomes specified by case writers.

After each of the MCLG sessions, one of the facilitators writes up the learning for the group and any reflections on the running of the session and sends it to all the other facilitators so that the learning can be shared. At the end of the session, the learning and resources are collated and shared with all the members of the group and also added to the website.

The skills development within the faculty development day has included introductions, ice breaking exercises, creating a safe group and rules of confidentiality, uncertainty in dealing with specific group member and groups behaviour issues, setting up role play, how to involve the patients who attend the groups, how to manage the plenary and endings etc.

Barnet and Enfield CEPN have been working together to recruit qualified nurses new to general practice and giving them an opportunity to study a postgraduate diploma at the University of Hertfordshire. They will spend half time studying at Hertfordshire University and the other half time in General Practice supported by nurse mentors. This scheme has been funded by HEE. As the original plan was that the GPN nurse mentors would run the local educational sessions, it was decided that they would benefit from attending and learning skills to manage small group work.

The other group that has been invited is the Practice Managers. They have regular PM meetings in Barnet to which up to 40 PMs attend which can be difficult to manage. It was decided that they too would benefit from attending and learning skills to manage small group work which they could use to run their sessions better. Both the PMs and the GPN mentors are attending the latter part of the next facilitator development session as the first part is devoted to the MCLG groups.

Impacts

The faculty of facilitator provides skilled facilitators for the MCLGs groups. The faculty development days are popular and the feedback from the facilitators who attend them has also been positive. Some of the feedback about the value of the facilitator development days has been captured from some of the facilitators.

> *'A greater awareness of challenges faced by different HCP , It's made me think about how we include & value the voices of all our professional colleagues(not just the GP's) , improved my skills primarily in running a successful multiprofessional learning group'*
>
> *'These skills include being able to encourage contributions from quieter members while at the same time reducing the disruptive effects of noisier or more negative members*
>
> *'The CEPN has given me the opportunity to develop my small group work skills. I have attended development days, run by the CEPN . These have included practical role play in facilitating a group which was designed to challenge eg including a disruptive member, a quiet member and a talkative member. As a result, I am more mindful of being inclusive in the groups and have greater confidence in trying to navigate away from the more loquacious members. I also now change the format of the session to suit the group and have found that encouraging discussions amongst 2-3 people is more effective in allowing all members to contribute than keeping the discussions to a larger number.'*
>
> *'These skills include being able to encourage contributions from quieter members while at the same time reducing the disruptive effects of noisier or more negative members.'*

With the MCLGs the facilitators play a really important role in helping create a community and ensuring that the group functions well and there is sharing of the resources & information with the participants who are not able to attend.

Having facilitators who represent different professions has resulted in breaking down barriers and in some groups encouraging more pharmacists and nurses to attend the groups that they facilitate.

Other educational events run by the CEPN e.g. evening Pharmacy, GP & PN events; HCSW events, medical student project have also benefitted from having trained facilitators.

The faculty of facilitators training in managing small groups is now being extended to GPN mentors and also Practice Managers helping educational and networking events to be run more successfully in Barnet and further breaking down barriers by creating a multi professional environment of learning.

One of the CEPN facilitators attended UCLP "Dementia Awareness Train the Trainer 2015" in October. This demonstrates added value of network i.e. synergy of developing faculty, being offered opportunities by educational bodies, managing projects enabling implementation of training following facilitator training.

Lessons learnt

An interesting observation by the facilitators is that the better the mix of the professionals within the MCLG groups the better the functioning of the group.

Cases which involved all the multi-professional teams who have been invited leads to better learning about the various professional roles, breaking down barriers and building relationships.

The need to support the facilitators who are managing the less engaged groups. To use more of the experienced facilitators to help co- facilitate to improve engagement within these groups.

If a group is functioning well, to reflect on what makes the group function well and try and apply some of the learning to less well functioning groups.

We are aware that groups run by facilitators who work in the area seem to function well and one of the learning points from this is to try and encourage local practitioners to become involved by becoming a facilitator. We have managed this in one of the less well functioning group.

Increase the mix of different professionals facilitating together. It is interesting to note that in the groups which has a pharmacist and GP facilitating, there is greater attendance of pharmacists hence further breaking down of barriers.

Ensuring that the MCLG group dates are set a year in advance so that there is no clash of educational events ensuring a good turnout.

Need for IT skills for the facilitators as many struggle with creating group lists, adding new people to their circulation list, scanning documents etc. If they were more able, it would help smooth running of the groups.