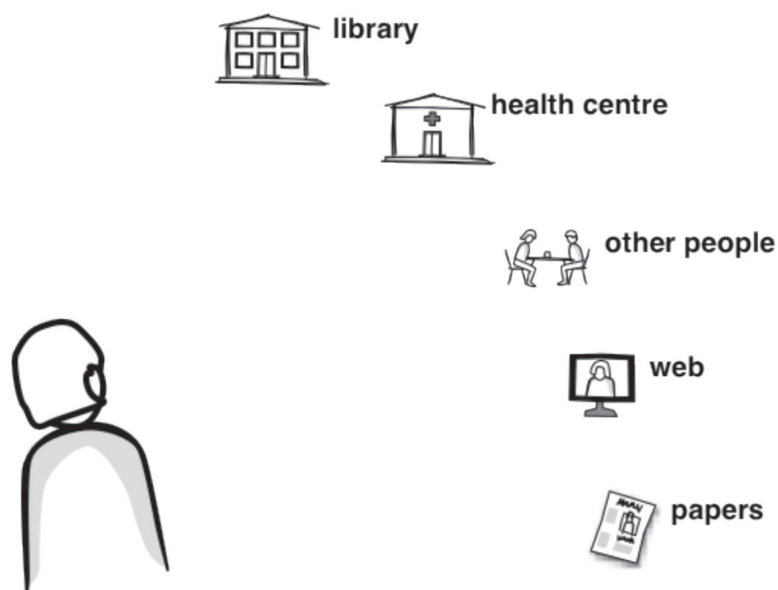


Links Project Report



**Developing the connections between
General Practices and their communities**

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General Practices and their communities**

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1. Acknowledgements

This report is based on feedback and information contributed by ten General Practices, six who deliver care in the most deprived areas of Glasgow and in four different areas of Fife. The project was developed during a particularly busy period in general practice when there is higher demand from winter viruses. In addition, 2010 - 11 was a particularly bad winter with snow and ice over Scotland which affected project meetings.

The Links project provided an example of what it is possible to do with engaged practices and strong leadership in a short timescale. The valuable information collected is testament to impressive teamwork, the skills of Clinical Leads, interest and enthusiasm of many individuals and project management and service improvement support from Long Term Conditions Collaborative (LTCC). The Links Project Steering Group is very grateful to the following General Practices for their considerable effort and contribution:

Glasgow

Drs Boyle, Treadgold, Duffy & Morley, Pollock Health Centre
Dr Alison McBeth & Partners, Gilbertfield Medical Centre
Dr Roger Black and Partners, Whitevale Medical Group
Drs Wilson, McGinley & Sheppard, Easterhouse Health Centre
Dr Robert Jamieson & Dr Elizabeth Day, Bridgeton Health Centre
Dr Nugent and Partners, Drumchapel Medical Centre

Fife

Inverkeithing Medical Group Practice
Dr Ross and Partners, Leven
Feddinch Practice, St. Andrews
Newburgh and Abernethy Practice

Special thanks to Clinical Leads, Dr Peter Cawston (Glasgow) and Dr Sonia Devereux (Fife), for their thoughtful advice and detailed feedback. We are also very grateful to Professor Graham Watt and Professor Stewart Mercer of Department of General Practice, Glasgow University, for their valuable input and for establishing collaborative working relationships with the General Practices.

2. Summary

The Links Project was a six month project, sponsored by Scottish Government's Self Management Programme, Long Term Conditions Unit and Long Term Conditions Collaborative (LTCC). The project was established in October 2010 to allow General Practice teams, time and practical support to explore the nature of their connections with the communities they serve. Service improvement methodology was used to explore the potential for primary care to be a vital connector by ensuring that sources of local support are identified and utilised.

The project provided a chance to develop themes emerging from numerous recent reports and projects and to learn more about social prescribing and reciprocal approaches required to encourage self care and self management of long term conditions. (Social prescribing is also known as community referral and signposting and is a mechanism for linking patients with non-medical sources of support within the community).

Recognising individual and local assets and taking advantage of all possible sources of support is particularly important in areas of high deprivation, where people are likely to be less empowered, have complex needs, poorer understanding, lower levels of literacy and are less willing to access support unless it is close by.

People's needs often span several service silos and just as care needs coordination, so does local support. However local directories may not be useful as information produced by libraries, Community Health Partnerships, general practice, voluntary and community groups is often siloed, scattered, transient, not updated and hard to access.¹ Most communities have a network of hubs which connect people and offer useful support, such as libraries, churches, schools, voluntary groups and community associations. However many are not well known, may be unconnected, under used, poorly understood and may struggle to maintain their resource because of short term funding. During the course of the project, teams gathered data, case studies and met to explore aspects of linking with communities which influence signposting to non medical resources.

Summary of results (Glasgow and Fife are reported separately)

Glasgow

- The total number of patients with potential to participate was 23,906 (this is combined list size of the 6 practices)
- Information was gathered from 3,704 consultations
- an average of 18% of patients seen were identified by practitioners as having a need for support
- 50% of the identified need was for mental health or addiction services
- of those patients with an identified need, 75% were signposted to a resource
- 57% of patients signposted expressed an intention to accept the opportunity
- of patients referred during January and February who were followed up by practices in February and March, 60% had contacted the community resource
- 70% of those who made initial contact were still using the resource 4 – 6 weeks after signposting
- Some patients were asked to rate the usefulness of the services on scale of 1 – 5 (1 = not useful, 5 = very useful). Of 35 who answered, 18 (51%) rated the service as useful (4 or 5) and 7 (20%) did not find it useful (1).

Between December and March:

- staff who knew enough about community resources to inform patients increased from 24.5% - 65%
- staff confidence to inform patients and recommend community resources increased from 43% to 81%
- staff who considered their practice had good links with community increased from 22% to 48%
- practices identified community resources and created or improved directories of community services.

¹ Making local information easy to find is aim of the ALISS (Access to Local Information to Support Self Management) a Scottish Government Project, see www.aliss.org

Fife

- Potential pool of 34,421 patients from 4 practices was used to gather information
- Percentage of consultations identified by practitioners as having a need for support varied (23%, 23%, 21%, and 5%)

Between January and July 2011:

- staff who knew enough about community resources to inform patients increased from 27% - 65%
- staff confidence to inform patients and recommend community resources increased from 39% to 74%
- staff who considered their practice had good links with community increased from 30% to 61%
- practices identified community resources and created or improved directories of community services.

Key observations about linking with community resources:

- a significant number of people living in deprived areas in Glasgow were willing to accept a recommendation from a GP to attend a community resource
- a significant number of patients in Glasgow who accepted the recommendation were still attending 4 – 6 weeks later
- personalised, relationship based approaches are important in connecting services
- it is essential to form good relationships so that trust and common purpose is strengthened, to encourage sharing of care and to disperse responsibility
- access to up to date local information to support community connections is essential
- online access to local information is important
- links which are specific to local context appear to have high value
- experiential learning and making connections is a more powerful tool for understanding and generating action than reading pamphlets
- consultation time is a vital consideration in making effective use of the relationships practices have with patients
- social prescribing was an unfamiliar concept to some members of staff, but there were accounts of significant change in perspective
- staff were interested in signposting to local resources if they had opportunity to become familiar with them.

Key factors in meeting project objectives:

- the project was set up quickly with little bureaucracy, local and national relationships and networks were key to successful organisation
- securing a GP with strong leadership skills who engaged with local practices
- engagement of practice staff who were willing to invest their time and ideas
- Scottish Government budget to allow staff time out of practice to use service improvement tools, make connections in community, reflect on findings
- provision of project management, data analysis and report writing

“Network citizens: power and responsibility at work” describes how new communication networks are “facilitating new relationships and connections between people that circumnavigate old hierarchies” and how “structured organisations must now negotiate new relationships with increasingly empowered individuals.”²

The Links Project found that working with people you know is important. Cultivating local connections and community networks presents an important way to increase opportunities for improving quality of health and wellbeing; however a cultural shift may be needed to encourage joint working. Adopting an organised approach to linking resources may have significant mutual benefits for citizens, primary care teams and providers of support. An emerging vision for improving links in communities is personalised, relationship based supported by robust technology.

3. Background

Health care planners worldwide are seeking effective ways to promote health and wellbeing, prevent poor health and improve management of long term conditions. Existing models of supporting people to live well are not sustainable and bold approaches are required to ensure the NHS in Scotland continues to meet the needs of the future, particularly for those who are poorest. There may be potential for general practice to enhance integration of health and social care and traditional and non medical support by making stronger connections with the communities they serve. Primary and secondary prevention of poor health and supported self management will be key to improving life expectancy in deprived areas.

Scotland is in an internationally important position to demonstrate improvement in quality of healthcare and has set out an ambitious vision for achieving this in the Health Quality Strategy for NHSScotland (2010).

An important factor in realising the vision of the Quality Strategy lies in our system of universal coverage and expertise of providing care in deprived areas. The GPs at the Deep End report³ makes reference to primary care’s unique position in the NHS:

“Routine contacts with patients, accessing general practices with a wide range of problems, provides over 90% coverage of the population. Serial contacts provide continuity, flexibility, coordination, sustainability, long term relationships and trust. No

2 P 37 and p 63; Bradwell, P., Reeves, R.; Demos (October 2008); Networked Citizens; www.demos.co.uk/files/Network%20citizens%20-%20web.pdf

³General Practitioners at the Deep End: Glasgow University, September 2009
http://www.rcgp.org.uk/college_locations/rcgp_scotland/initiatives/health_inequalities/deep_end_reports.aspx

other part of the NHS has these essential intrinsic features. Such features make general practice the natural hub for NHS activity, especially in very deprived areas. The challenge is to link this hub with other professions and services so that patients receive co-ordinated, integrated care, according to their needs."

The role of social prescribing was explored in one of a series of 12 articles produced by the GPs at the Deep End.⁴ The GPs who took part in the Social Prescribing Project thought that it was important to help patients take control of their health and wellbeing and saw this as a core primary care role, centred on their personal relationships with individual patients. The GPs "*valued other organisations that can further this goal, and regularly point patients in their direction*".

Primary care teams are central to developments designed to increase social capital and members of the team, such as receptionists who often live locally and community nurses already have valuable local knowledge. This is particularly important as the rising number of people with long term conditions are higher users of the health and social care services and account for a majority of GP appointments.⁵

Support to live well may be accessed through signposting to local opportunities for arts and creativity, physical activity, learning new skills, volunteering, mutual aid, befriending and self-help, as well as support with issues related to employment, benefits, housing, debt, legal advice, or parenting.

This community aspect of supporting self management was explored in the Scottish Government ALISS project⁶ (Access to Local Information to Support Self Management). Adult learners, who were attending an adult literacy group, tracked their journey of seeking support to live well with their long term condition(s) in their local community. The findings were that although support was there, people usually missed it; it was hard to access information about local resources. The ALISS project echoed numerous reports which refer to the negative impact of poor health literacy and need for robust advocacy systems.

The Links Project was an opportunity to examine accessing local support from another angle, the perspective of primary care staff, to find out what they knew about community resources and how prepared they were, both culturally and in practical terms, to signpost people to local groups and organisations.

The project used service improvement methodology to diagnose problems, identify opportunities for change, plan and test changes and measure improvement. One of these methods was the Plan Do Study Act, a cycle of change which encourages growth of knowledge through making changes and then reflecting on the consequences on those changes.

⁴ Social prescribing in very deprived areas, p 350. British Journal of General Practice, May 2011

⁵ Managing Long Term Conditions, Auditor General for Scotland, p4, Audit Scotland
www.audit-scotland.gov.uk/.../nr_070816_managing_long_term.pdf

⁶ ALISS Access to Local Information to Support Self Management, ALISS Health Literacy Report:
<http://www.aliss.scot.nhs.uk/wp-content/uploads/ALISS-Health-Literacy-Report-2010-01.pdf>

4. Aims

The aim of the project was to develop and test a sustainable local model to improve links between general practice and community support by signposting patients to local services.

The approach was to focus on rapid service improvement rather than produce a piece of research. The project was a discrete piece of work, designed to identify potential areas for further development and describe lessons which could be shared nationally.

The following issues are important but were beyond the scope of the project:

- patient's views of being signposted
- governance issues for proposed "link worker" (with a function of eg brokerage, advocacy and liaison between practices and communities)
- community group's views of being on receiving end of signposting
- benefit to patients
- economic benefit to NHS
- effect of signposting on sustaining / supporting community resources

5. Method

A Steering Group with membership from relevant organisations was formed, chaired by Frank Strang, Deputy Director of Primary Care, Scottish Government. (See Appendix 1) It was agreed to fund six primary care teams £7,500 each for six months and £4,000 for a Clinical Lead role. The purpose of the fund was to protect time for teams to make links with community resources and to examine their attitude to using community resources. The original group of practices were working in areas of deprivation in Glasgow and were recruited through the GPs at the Deep End initiative.⁷

Eleven practices were interested in participating, and six were picked from the hat. A Clinical Lead was chosen, a General Practitioner with responsibility for organising local practices, ensuring data was gathered and reporting to the Steering Group. This role was critical in connecting practices and providing a link to Scottish Government.

Participating General Practices (Glasgow)

General Practice	List
Pollock Health Centre, Drs Boyle, Treadgold, Duffy & Morley	2,966
Gilbertfield Medical Centre, Dr Alison McBeth & Partners	4,988
Whitevale Medical Group, Dr Roger Black and Partners	5,563
Easterhouse Health Centre, Dr Wilson, McGinley & Sheppard	2430
Bridgeton Health Centre, Dr Robert Jamieson & Dr Elizabeth Day	2,646
Drumchapel Medical Centre, Dr Nugent and Partners	5,313

⁷ General Practitioners at the Deep End: Glasgow University, September 2009
http://www.gla.ac.uk/media/media_146570_en.pdf

Such was the interest that at a later date four primary care teams from Fife joined the project, their inclusion offered an opportunity to run the project in different areas of Fife, with contrasting practice profiles. (Findings for Glasgow and Fife are reported separately).

Participating General Practices (Fife)

General Practice	List
Inverkeithing Medical Group Practice	18,500
Dr Ross and Partners, Leven	3,165
Feddinch Practice, St. Andrews	8,891
Newburgh and Abernethy Practice	3,865

Practice teams were assisted by the LTCC to use improvement methodology to identify and test their improvements and share learning. The following data gathering tools were selected:

- 1. Practice team questionnaire** – to capture:
 - knowledge and understanding of current processes to signpost to community resources
 - individual staff knowledge of services and confidence to signpost
- 2. Baseline Survey** - used in 50 consecutive consultations for each practitioner on 3 single days in December, January and February to identify:
 - patients identified as being suitable for signposting to community resources
 - types of resource
 - if staff signpost / recommend a resource
 - community resources in highest demand
- 3. Longitudinal Survey** - to capture:
 - individuals signposted to a community resource during a 5 day and 3 day period
- 4. Patient Follow Up** – there were follow up surveys to ask some patients of those on the longitudinal list:
 - if patients had accessed the community resource and their experience of the service
 - were still in contact with resource 4 – 6 weeks after signposting

Practices developed different methods for compiling a **Practice Directory of Community Resources**.

They used **PDSA (Plan Do Study Act)** - a cycle of quality improvement designed to encourage incremental change. Practices agreed to complete three PDSAs on a monthly basis. (Appendix 2)

They also produced **Case Studies** using video and meeting notes to collect and share feedback from staff.

6. Findings - Glasgow

6.1.1 Practice Team Questionnaire

Participating staff completed questionnaires. In the short period from December 2010 to March 2011, staff felt more informed (24% - 65%), more confident (43% - 81%) and their views on whether they had good links had also improved (22% - 48%).

Glasgow			
<i>Do you know enough about community resources to inform patients?</i>			
	Yes	No	Not Sure
Dec 2010	16 (24%)	33 (49%)	18 (27%)
Mar 2011	31 (65%)	9 (19%)	8 (17%)
<i>Do you have the confidence to inform patients and recommend they use community resources?</i>			
	Yes	No	Not Sure
Dec 2010	29 (43%)	22 (33%)	16 (24%)
Mar 2011	39 (81%)	1 (2%)	8 (17%)
<i>Do you think the practice has good links with community resources?</i>			
	Yes	No	Not Sure
Dec 2010	15 (22%)	17 (25%)	35 (52%)
Mar 2011	39 (48%)	1 (10%)	8 (42%)

Below is selection of staff answers to 3 questions:

1. What makes it hard to signpost?

- could be seen as intrusive
- feel I might offend
- lack of knowledge about contact details and whether service still operating
- some services have long waiting times or are not available locally
- not sure patients would want discuss local resources at the front desk
- people's poor physical and social health prevents them attending

2. What needs to happen within the practice to make it easier for you as an individual?

- more contact with local services to increase awareness of what they offer
- regular updates from resource providers to inform of changes
- having referral forms on docman
- feedback from services on patient progress
- more time in appointment
- nothing, as I feel as practice we have done all we can
- folder with resources available and up to date contact numbers

3. What needs to happen within the practice to make it easier?

- contact telephone numbers on A4 sheet which can be given to patient
- all information in one booklet to give out
- longer appointment times would give opportunity to explain community services to patients
- faster internet connection

6.2 Baseline survey

Data was collected for a baseline survey in 3,704 consultations in 6 practices. The survey was conducted 3 times: December 2010, January and February 2011. The table shows totals for 3 months.

Practices identified services required for their population:

Mental Health, Addiction, Employment, Benefits, Cardiovascular System Risk, Carers and "Others". "Others" included exercise classes, weight management, smoking cessation, housing, homeless shelter, child care, victim support, panic, loneliness, domestic abuse, back pain, parenting advice, epilepsy support. It should be noted that in a small number of cases, there was inconsistency in how staff classified services – for example smoking cessation was sometimes recorded as "other" and sometimes as "addiction."

Practice	No of consultations	No of patients identified for support	Percent of all consultations identified for support	No of patients recommended a resource	Percent of patients identified who were recommended a resource	No of patients who expressed intention to use resource	Percent of patients who expressed intention to use resource
A	579	124	21%	113	91%	71	63%
B	584	75	13%	57	76%	46	81%
C	493	49	10%	40	82%	28	70%
D	565	155	27%	86	55%	47	55%
E	450	134	30%	115	86%	28	24%
F	1,033	139	13%	96	69%	67	70%
TOTAL	3,704	676	18%	507	75%	287	57%

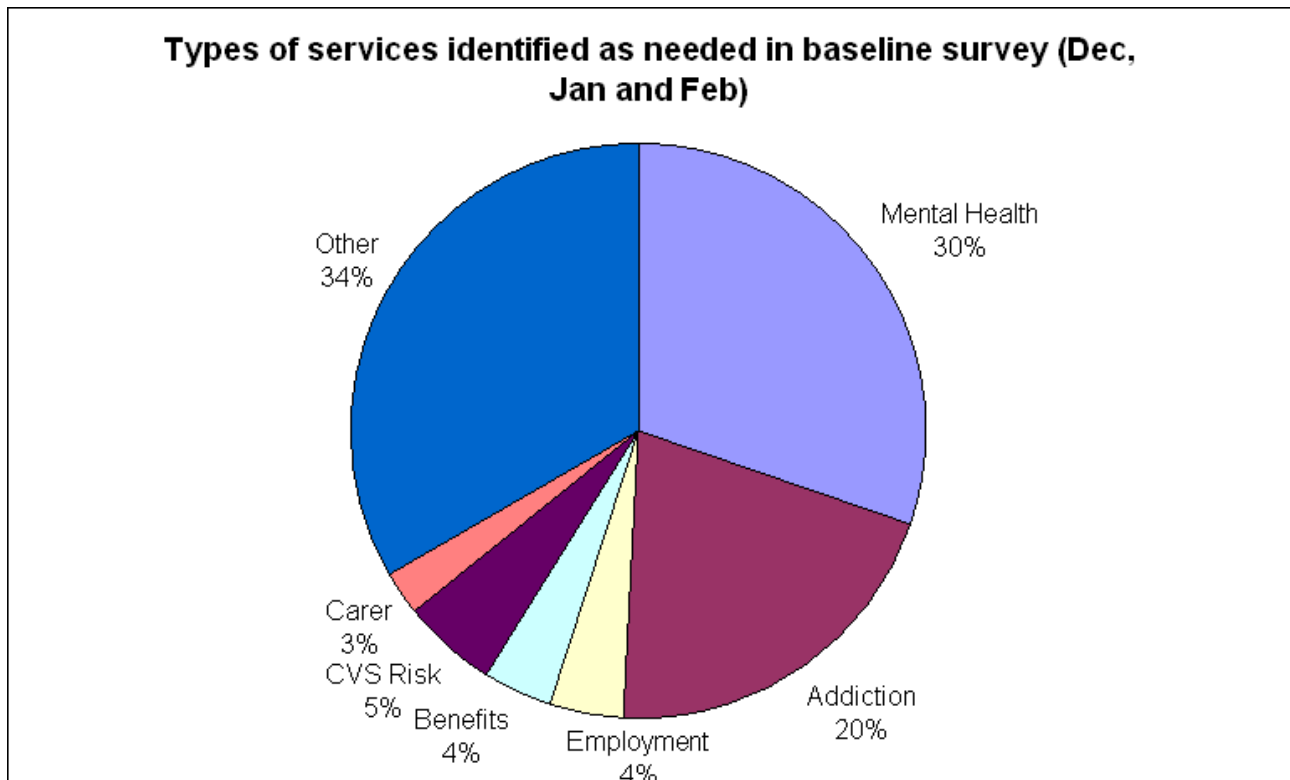
The percentage of patients identified for support hardly varied in 3 reporting periods (19%, 18%, 18%), nor did the number recommended to a service (73%, 77%, 75%). In the first two months staff occasionally did not know a suitable resource, however this improved in February.

The reasons for not recommending a service included:

- patient already in contact with a service
- not enough time
- too many issues
- already discussed and not interested

The number of patients who expressed an intention to accept the recommendation varied between the different months, (57%, 62% and 49%). The February figure was lower because one practice had a particularly low acceptance rate. There was considerable variation between practices, with between 10% and 30% of patients being identified for support. Generally those practices with high rates of identifying patients have lower rates of patients accepting the recommendations. This may be due to differing practice populations or to differing assumptions about level of need by practice staff. Overall 8% of consultations led to a patient expressing an intention to use support (ranging from 6% - 12% between the 6 practices).

The chart below shows that 50% of patients were identified as in need of mental health or addiction services.



6.3 Longitudinal Survey

During 5 days of recording in January and 3 days in February, 81 and 50 individuals respectively were signposted to community resources. A total of 83 (62%) of these patients were followed up by staff in February and March. Of those, 50 (60%) had made contact with the service. **Of the 50 who made contact, 35 (70%) were still using the resource 4 – 6 weeks later.**

6.4 Patient Follow Up After Signposting

Practices identified patients to follow-up four weeks after initial consultation. Questionnaires were carried out by practice administration or health practitioners.

February and March 2011				
Patient follow up (ie visited practice in January, contacted in February)				
	Patients Identified	No. followed up	No. followed up who made contact with service	No. who made contact who are still using service
Total	131	83	50	35
Percentage		63%	60%	70%

Examples of reasons given for **not making contact**:

- planning to get in touch
- chose to use church first
- previous experience – so don't think it would help
- time
- working in mental health and didn't want to contact services in this area
- feeling better with tabs
- GP contacted on patient's behalf
- patient had to go to hospital with tumour
- feeling unwell (flu) / still thinking about it

Examples of reasons for **not attending**:

- feel unsure about contacting them as feel uncomfortable with strangers
- ill health prevents attendance
- nerves, anxiety about making the phone call. Aiming to do this at some point
- no phone – homeless
- “didn't feel COPE would be beneficial. Has contacted another service instead”
- “planning to do so”
- “does intend to go but working and caring for mum”

Some patients who were followed up were asked to rate the usefulness of the services on scale of 1 – 5 (1 = not useful, 5 = very useful). Of the 35 who answered, 18 (51%) rated the service as useful (4 or 5) and 7 (20%) did not find it useful (1). In some cases patients were waiting to be seen as some services had long waiting lists.

6.5 Directory of Community Resources

Each practice developed directories of community resources, some available online. These usually contained name of resource, telephone number, contact name, address.

6.6 Case Studies and Practice Developments

The following case study is provided by Dr Nugent and Partners, a practice in a deprived area with a practice population of 5,313. Fifteen members of staff formed five groups to visit community based initiatives to find out what was provided:

Group 1 visited the local women's refuge and identified key resources and were impressed by the quality, ethos and perspective of the women's refuge team.

Group 2 visited the West CAT team for drug or alcohol problems where self referrals are accepted. Staff can be refer to a wide range of agencies, prescribe medicines and arrange home visits.

Group 3 visited a children's rights team in Yoker which visits Drumchapel High School. The team provides a wide range of support to young people such as advice on bullying, drugs and children's panels.

Group 4 visited Momentum which through a link worker system helps people with multiple difficulties by providing range of support. There is a wait of no more than a week for a 1-1 appointment.

Group 5 visited the Donald Dewar Centre and were impressed by the quality of the facilities and the informed, enthusiastic and friendly nature of staff.

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The visits were later discussed by staff, the early part of the session was attended by five representatives from local services; COPE (Caring Over People's Emotions), the Library Service, Carr-GOMM, Glasgow West Regeneration Agency and Drumchapel Arts Project. The following is a snapshot of their narrative:

Transitions from school: Those who visited the children's rights project asked whether there might be a gap in assisting young adults to make the transition from school to adulthood and wondered what role the practice could play.

Extending knowledge about communities: There was discussion about the time and capacity required to make necessary connections for the benefit of patients. A GP was to have sufficient knowledge of community resources for a GP to say "*I can't help with this, but the library can.*"

Role of Administration Staff: It was suggested that a training resource was needed to ensure that administration staff had sufficient knowledge to match services to patients.

Discussion between practice and community members: It was noted that there was a great deal of support and that those providing support had, like the surgery, a strong ethic of care. Participants from practice and community organisations agreed it was essential to form strong relationships to build trust and common purpose. Staff from community organisations felt there was an under referral of people from general practice.

Discussion with practice staff only: The team felt there was an opportunity for receptionists to signpost, which was considered different from an information management role. Receptionists spoke of wishing to be able to help patients beyond simply saying "the doctor will call you back". It was suggested that a link worker/librarianship role be developed to provide a point of liaison.

Another suggestion was to establish a volunteer programme for signposting. The visits highlighted the number of patients working in local organisations, also seeking to provide good community care.

One organisation, COPE (Caring Over Peoples' Emotions), which promotes resilience and coping strategies, offered a weekly presence at Dr Nugent and Partners.

Some edited comment from staff:

- I didn't know how agencies received referrals ... I will start using their services now
- the Links Project was valuable for us and for patients who are registered with us
- Visits worked incredibly well - good to get out of the practice, meet people and see clients using the services. Otherwise just a picture portrait from leaflets and visits from project staff, which is not as powerful as actually seeing services in action
- I will spend a half-day with medical students going around community centres picking up leaflets and speaking to staff
- Would be helpful to have an annual showcase of local resources
- we need a web based directory of services with a snapshot of what's available
- makes you realise that we're all working towards the same goal
- filling out questionnaires was useful, made you realise how many people are presenting with mental health needs or financial worries and we're not the experts

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- There's been a clear improvement in my awareness as a GP of the various community resources. For so many years you're aware that new projects start and you're not too sure who they're suitable for and what's available
- there are some great enthusiasts, people who love their area of work and to see not only what the service is but who the patient would meet.. face to face contact has been a great thing
- we've found out about resources even here in the health centre that we didn't know about
- ... discovered a lot of team knowledge we haven't tapped into

7. Findings - Fife

Four Fife practices joined the project at a later stage, in December 2010. Practices used the same tools, with some additions, to ensure comparable information. Three or four PDSA's per month were completed which reviewed service improvement aspects of the project.

7.1 Practice Team Questionnaire

Staff who knew enough about community resources to inform patients increased from 27% - 65% and staff confidence to inform patients and recommend community resources increased from 39% to 74%.

7.2 Baseline Survey

The range of social issues identified in Fife was broader than identified in Glasgow and included social isolation, alcohol problems (both patient and family members), abuse, obesity, inactivity, mental health problems, addictions, employment issues and financial problems. Participating clinicians reviewed 50 consecutive consultations and recorded additional support needs in January 2011. The percentage of consultations reporting a need for a community resource varied (individual practice results: 23%, 23%, 21% and 5%). Example of needs identified **in one practice**:

55 people had a total of 91 support needs (some people had more than one issue): 22% social isolation, 22% CVS Risk, 20% mental health, 20% obesity, 16% benefits/employment problems, 14% addictions and 9% relationship problems.

7.3 Longitudinal Survey

Five clinicians from each practice completed this survey at the beginning of the project and three months later (January and April 2011.) Clinicians were asked to record (for one week) details from consultations in which they "signposted" a patient to a community resource or a non-clinical support service, clinicians also asked patients for consent to follow-up.

Numbers of recorded consultations in which patients were sign-posted, was much lower than in the baseline survey, only 3-9 per practice. The following reasons were given:

- the "issue" may be identified but may not be appropriate to sign-post to resources on that occasion
- clinician may not have enough knowledge of local services to sign-post
- too many other issues needing to be considered during consultations
- need to obtain patient consent for follow-up which increased the complexity of the consultation
- lack of time during the consultation hindered sign-posting

7.4 Patient Follow-up after Sign-posting

This process was time consuming. The original plan was for non-clinical staff to follow up patients after sign-posting, however it was often more appropriate for clinicians to do this. Of those patients contacted some had “not yet” accessed the website or community resource. Patients appreciated the information and a few patients went on to access a service as a result of the follow up contact.

7.5 Directory of Community Resources

During the early part of the project the majority of staff reported that they were unable to advise patients about community resources due to lack of information. In order to support staff practices developed a directory of local community resources. Two practices recorded details for 60 different community resources. It was hoped that the information collected could be utilised either by using ALISS or the “Living with my Condition in Fife” website.

7.6 Case Studies and Practice Developments

- one practice connected to a local exercise referral pathway
- arrangements were made for individual staff to visit organisations listed in their directory, to improve practice knowledge and links
- Two practices organised “road-shows” for practice and community staff. This provided the opportunity for organisations such as local library; Cool-to-talk; Circle-of-Comfort; Scottish Slimmer’s to present their services, an event which evaluated very highly
- discussions with Citizen’s Advice and Rights Fife service resulted in one practice making arrangements for a weekly session to be held in the practice
- a focus group was formed to discuss improving voluntary help

Some edited comment from staff:

Advantages:

- database of community resources will benefit me as it’s time consuming finding information
- know much more now about the available community resources, I have referred patients to a variety of things e.g. "cool 2 talk", Zumba, mood café
- Protected Learning Road-show was exceptionally helpful in highlighting available resources
- Now have the CAB coming in regularly, very helpful x 4 comments
- I know considerably more than I did in January
- We are able to inform people that there are 82 community projects available ranging from "Bums off Seats" to Alcoholics Anonymous

Disadvantages of the project:

- frustrations around getting the whole practice team involved
- it was time-consuming and difficult to fit in with everything else
- there was some repetition
- time needed to fill in forms
- Need an easy access point for resources? Touch screen facility in for patients
- need feedback from users about resource before I feel comfortable signposting

Reflections from Fife

- patients appreciated the holistic approach, however there was concern about extended consultation times
- development of practice directories was a useful product of the project
- members of staff were enthusiastic about finding out about local resources
- Contacting local resources, establishing an accurate database and organising the project was very time consuming. Ways of sharing knowledge with staff not involved in data collection would need to be established
- road-shows held by two practices improved the teams' knowledge of local services and strengthened links between practices and services
- staff felt hopeful that patient care would improve as they were better able to offer or suggest local community resources

8. Conclusions

It was particularly significant that four weeks after an initial consultation, 35 out of 131 patients living in deprived areas in Glasgow were still using a service which had been recommended by a GP. A shared view was that improved relationships between community resources and General Practice could have a positive impact on patients and practice teams.

There was real enthusiasm from most practice staff to learn about new resources and a willingness to utilise them more fully. Practitioners could see the benefit of local collaboration if this was properly supported by an organised approach and technology. Facilitating protected time for staff to make connections was key. Provision of central support and coordinating leads provided a good method of improving links with communities.

Making a case for General Practice developing links with community resources

Scotland's public health record, changing demography and economic climate demands that all opportunities for joint working are considered. Radically different, unsiloed approaches are required to capitalise on individual and local assets, tailored to personal need. An important aspect of personalising care in very diverse populations is an ability to be flexible and to ensure staff are aware of the range of available options.

Tapping into opportunities to connect agencies will have economic benefits as a proactive, organised approach to pooling resources will enhance each contribution and save precious resources. Understanding the nature of local contributions and complimenting, not duplicating, services will nurture sustainable healthy communities.

A recommendation from a practitioner may have extra value. The significance of having local knowledge was highlighted during a meeting, when Clinical Leads described the therapeutic value of discussing non clinical aspects of care. A clinician who knows about local walking clubs may be regarded by patients as showing a special interest.

Developing reciprocal approaches may not only enhance relationships with patients but provide much needed support to local groups and organisations.

How to make links

The nature and practicalities of making links was explored. Forming face to face relationships was key in making decisions on whether or not to signpost. Staff who visited local resources were usually impressed after meeting service providers and learning how services were delivered, which increased confidence to signpost.

Time was a factor highlighted throughout the project; time to form trusting relationships, meet others in the community, consultation time, time to update information and share local knowledge.

Engaging particularly interested individual members of staff had a high value. For instance, in Glasgow practices, one GP in training was a very enthusiastic participant, one employed a PhD student and another was assisted by an attached GP trainee. The role of reception and administrative staff in making links was seen to be very important.

Maintaining links

There were many references to how best to maintain links once they were made. The vital enablers were opportunity to meet face to face complimented by appropriate technology to allow access, storage, printing and distribution of information. There were many ideas on how this could be achieved, for example local (urban) practices could pool resources and distribute responsibility for curation of information. There were suggestions of regular updates from community groups and annual "fairs" to maintain links.

Primary care is in a unique position through the system of patient registration to form trusting relationships with local citizens over long periods of time. There is an opportunity to mirror these trusting relationships between GP practices and communities. There are numerous pioneers in Scotland ready to champion strengthening connections and community networks, but just as care needs coordination, so does available expertise and innovation. We will all reap the benefits if support is pooled to address the needs of the increasing numbers of Scots living longer with long term conditions. However, there was insufficient time within the project period to find a sustainable model.

9. Recommendations

1. Share lessons from the Links Project with other practices and appropriate local and national organisations through meetings, conferences and wide dissemination of final report
2. Implement ALISS project in primary care to improve access to online local information
3. General Practitioner to be seconded to Self Management Programme to help develop themes and recommendations of Links Report
4. Consider sustainable model for maintaining connections to community, eg a linkworker, with librarianship and connecting role, to develop and facilitate links
5. Extend approach to examining links between primary and secondary care and community care
6. Relevant professional organisations to consider incorporating knowledge partnership in primary care professional training and development
7. NHS Education Scotland to give consideration to developing “community resources work” as part of “working with others” for GP registrars / other NHS staff
8. Identify existing and emerging levers to encourage connecting function of General Practice (such as “community orientation” competency in Registrar training and QPA)
9. Data gathering tools developed in Links Project to be adapted for re-use as evidence for GP appraisal and revalidation: under sections ‘Working with Colleagues’ and ‘Relationships with Patients’
10. Encourage events in protected learning time, such as visits to local resources (this could be relatively low cost and shared between practices)
11. Consider use of service improvement techniques to release time for signposting

Suggestions for further research:

1. Does signposting to local resources by GP practices lead to improved self management
2. Establish steps involved in signposting and level of attrition between each step
3. Governance guide to signposting for levels of staff
4. Does signposting to local resources increase the demand on practices (e.g. for sick lines, housing letters, letters of support and advocacy)
5. Patient’s view of being signposted
6. Mechanisms for feedback to practices on patient progress from community services
7. Consideration of extra resource required (time, administrative costs, consumables, hardware) if staff extend their social marketing role
8. Referral rate from various groups to local resources (some organisations felt there was an under referral from general practice)
9. Produce guidance for organisations on presenting information for general practice.
10. Service improvement initiatives should consider collaboration with innovation and design units in Scottish Art Colleges.

Funding has been agreed for Phase 2 of the Links Project in 2012 - 2013, which will be taken forward in a partnership between RCGP and LTCAS. Some of the above suggestions may be addressed in this new Phase.

10. References and Further Reading

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<http://www.diabetes.org.uk/upload/Professionals/Year%20of%20Care/Thanks%20for%20the%20Petunias%20a%20guide%20to%20developing%20and%20commissioning%20nontraditional%20providers%20to%20support%20the%20self%20management%20of%20people%20with%20long%20term%20conditions.pdf>

Appendix 1 Links Project Steering Group

Chair:

Frank Strang, Deputy Director, Primary Care Directorate

Members:

Dr Peter Cawston, NHS GG&C, Clinical Lead for Glasgow

Dr Sonia Devereux, NHS Fife Clinical Lead for Fife

Professor Graham Watt, Deep-End Coordinator, Glasgow University

Professor Stewart Mercer, Professor of Primary Care Research, Glasgow University

Christine Hoy, Programme Manager Self Management, Scottish Government

Susan Bishop, LTCC Programme Manager, Scottish Government

Nigel Pacitti, LTCC Regional Manager, Scottish Government

Fraser McJannett, LTCC Project Manager, Scottish Government

Iona Phelp, LTCC Regional Manager, Scottish Government

Marie Curran, LTCC Information Manager

Kevin Geddes, Director of Self Management, Long Term Conditions Alliance Scotland

Kay Barton, Head of Health Improvement Strategy and Support, Scottish Government

Tim Warren, Policy Lead, Health Improvement Strategy and Support, Scottish Government

Karen Ross, Long Term Conditions Programme Manager, NHS GG&C

Ingrid Hale, LTC Programme Manager, NHS Fife

Marion McLeod, National Co-ordinator for Scottish Practice Management

Susan Kennedy, National Co-ordinator Practice Nursing



Report of Links Project Closing Event

14 December, 2011

**Long Term Conditions Alliance Scotland Hub
Bath Street, Glasgow**

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Introduction to Links Project closing event

Frank Strang, Deputy Director Primary Care, Scottish Government and Chair of the Links Project Steering Group, welcomed 34 delegates to the final process of Links Project. The purpose of the event was hear feedback from participants, identify key learning points and contribute ideas on what should happen next. Mr Strang announced that the Scottish Government had awarded a fund to a partnership between RCGP (Royal College of General Practitioners in Scotland) and LTCAS (Long Term Conditions Alliance Scotland) to develop the Links Project and so it was important that delegates helped shape next steps.

Presentations

Professor Graham Watt

Professor Watt set the scene by reflecting on the successful process of setting up and developing the Links Project, which he considered was as worthy of comment as the actual outcome, as it provided a good example of how general practice and central government can work very well together when conditions are favourable. The project was set up quickly, through local and national relationships and was facilitated locally by strong leadership from two Clinical Leads. The project was comparatively "light" on bureaucracy and was reminiscent of the Scottish Primary Care Collaborative. The project allowed groups of practice staff protected time to meet each other and establish vital connections between and within teams and with others in the community.

The six Glasgow practices were recruited through the GPs at the Deep End, which was formed out of a meeting of the 100 GPs working in the most deprived areas of Scotland. Professor Watt referred to the work of Dr Tudor Hart who has influenced approaches to improving care for people living in deprived areas and described the intrinsic features which capture the essence of general practice:

Contact, Coverage, Continuity, Coordination, Flexibility, Relationships, Trust

Professor Watt reflected on the importance of "connectedness" with a quote from Don Berwick, Head of US Medicare and Medicaid who suggested health practitioners needed to ask, not only "What do I do?" but also "What am I part of?" This was at the heart of the Links Project as practice staff were given a rare opportunity to reflect on their connections with the community. Professor Watt thought local health systems could be less fragmented if general practices made better links not only in community, but with other NHS primary care services, health improvement, out of hours, elective referrals and hospital services. Integrated care depends on multiple relationships, which he described in terms of a wheel with a hub, the hub being NHS general practice, because of its intrinsic features, while the rims are other services, such as Keep Well, services for child health, elderly, mental health, addictions, community care, secondary care, voluntary sector and local communities. Connecting hubs and rims are the spokes, or links - channels of communication needed to make contact. A consistent message from Deep End practices was that these spokes needed to be short, in terms of local, familiar, timely and trusted connections.

Professor Watt described the Social Prescribing workstreams of GPs at the Deep End initiative. Key learning points were that:

- Practices are keen to make use of non-medical community resources, but don't know what is available
- Providing relevant, up to date, local information is a huge challenge
- Practices can't extend their activities, when core activities are under pressure

Professor Watt concluded by acknowledging participants' valuable input into a project which should be further developed.

Dr Peter Cawston – Clinical Lead in Glasgow

Dr Cawston reflected that having health meant having the resources to live and die well which included helping people to find and use resources in the community themselves. Dr Cawston was interested in participating in the Links Project as it represented why he chose to work in general practice in the first place and was reminiscent of his positive experiences of working in communities about ten years ago. At this time, community development work was supported by LHCC's (Local Health and Community Care) and local action groups, many of which were manned by volunteers so that costs were minimal.

Valuable relationships and connections formed during these days had been lost as other pressures were introduced by primary care contracts, which had produced benefits, such as improved management and organisation of long term conditions, but had sacrificed relationships with communities. There is now less time for making connections and developing approaches such as those which were explored in the Links Project.

It was interesting though not surprising that the biggest area for onward referrals in deprived areas was for addictions and mental health. This is another reminder that the problem with living with a long term condition is not just the disease, but the lack of personal, family, community and financial resources to be able to make the best of things. The Links Project provided time for relationship building and the numbers of patients accessing local organisations after signposting was impressive.

However many staff working in primary care feel like hamsters on a wheel because of pressures introduced by the Quality Outcomes Framework. Even if there is a great belief in the value of new work, there is no spare capacity to do anything about it. If people and communities are to be properly supported using person centred approaches, then horizons will have to be simplified.

Dr Sonia Devereux – Clinical Lead in Fife

Dr Devereux described how the 4 Fife practices, with a combined patient population of 34,421, worked with this project to increase links with community resources. Although the Links project had differed from the project proposal originally described, all practices fully engaged with the work, attended all meetings and completed all questionnaires and surveys. The Fife practices acknowledged that they did not have the background experience of the Deep End initiative, which possibly provided the Glasgow practices with a better understanding of the context of the project.

As this was a short term initiative, usually only the lead GP and administrative lead in each practice was involved in data collection and meetings therefore practices experienced some difficulties informing and involving all members of the primary health care team, as it was not appropriate to expect everyone to be familiar with the complex project protocol. Some data gathering tools were thought to be too complex, of limited benefit and represented a lot of effort (in particular the PDSAs); however all practices valued the directory of community resources and reported this as one of the most important outcomes of the work.

Participating practices thought the main aim was to assist clinicians to use sign-posting to link patients and relevant non-medical resources within the community. The use of sign-posting rather than referring patients to these resources was important in order to facilitate patient choice regarding when and whether they wished use the resource recommended. At the start

of the project only 24% of staff were confident enough to sign-post patients this increased to 65% at the end of the project. The main factors that influenced the increased staff confidence and knowledge were the awareness and discussions regarding social prescribing, direct contact with staff from community resources and the availability of an up-to-date community resource directory. The initial data collection in Fife identified a broader range of social issues compared to Glasgow, including all the issues identified in the city plus social isolation, obesity, relationship problems etc. Due to this and also the greater geographical area the community resource directories were larger than expected with two practices having over 60 listings.

Each practice worked differently with community groups two practices had “road-show” type events, one practice extended the idea of “speed dating” into “speed knowledge” whereby community groups had 5 minutes to present to the practice team, this meeting evaluated very highly by the practice staff and also the community groups involved.

Dr Devereux concluded by reflecting “sign-posting is not a single step and needs more consultation time” and “you don’t know yet what you’ll need to know later”. An important finding, reported by all practices, was that patients appreciated the “extra” care offered when clinicians shared information about community and web-based resources.

Hilda Davis of COPE (Caring Over People’s Emotions)

Hilda introduced her talk by reflecting on Maslow’s Hierarchy of Needs and holistic approaches, based on seeing the “whole person” in context of their whole lives. Hilda described challenges to engagement, which included stigma and fear, pride and denial, learning style, awareness and expectation and setting priorities.

Existing healthcare models are still designed around acute, reactive care which does not lend itself to encouraging self care. There is a need to improve the way services are designed and offered. Working in partnership in communities will pay great dividends, especially when local people are involved in the creation of services. Primary care had much to gain by knowing the quality of voluntary sector services and how to refer.

One key challenge for developing local groups are separate funding streams; chasing funds demands time and energy. Another challenge was having to change priorities to match trends, for instance, just as a service is developed and the need established, resources may be directed at new priorities. This means more effort may be directed at applying for funds than for developing local responses. Hilda described a pragmatic approach like a fajita - bend and fold the funding to ensure you respond to local need but still fit with funders’ priorities.

Hilda also highlighted the benefit of supporting social enterprise. Third sector partnering statutory services can generate income which can be re-invested in service development. Joint working makes sense as general practice and local groups share common objectives.

Peter Ashe – the ALISS project

Peter’s presentation addressed the need for practices and community organisations to be able to find information about local support easily, which is the aim of the ALISS project. (Access to Local Information to Support Self Management).⁸ Peter outlined the process of loading directories of resources gathered by the Links practices’ into the ALISS Engine. The data was presented by practices in different formats and was edited before being uploaded. Peter demonstrated the easy process of uploading a local asset into the Engine, and showed the value of a shared ‘national local index’ vis-à-vis individual Practice databases. Peter

⁸ See www.aliss.org

described an example of community asset-mapping which will inform future data-gathering by general practices. Peter concluded by addressing the 'quality assurance' concern associated with collecting the informal support which people often find useful. He described the user designed 'distributed collaborative curation' for contributions from individuals and a variety of groups who provide support for self-management of long term conditions.

Open Discussion

Project specific comment

It was generally agreed that the Links Project had been worthwhile, but there was still much to learn. This included finding out what it is that encourages people to take up support and follow up arrangements for people who had been signposted. Many participants felt the burden of collecting data had been too time consuming.

Role of General Practice

There was discussion about the prospect of a "one stop" general practice and whether signposting was a role for primary care, some GPs were known not to be keen on signposting. However others thought it was appropriate that GPs had community links. Receptionists' and practice nurses' had an important role, however more time was needed, both for consultations and to be part of the community. It was suggested that a way to create time would be to change the Quality Outcomes Framework.

Directories of local resources – leaflets in the bin

Delegates were familiar with the sight of leaflets in the bin, thrown out because they were not appropriate or out of date. There was agreement that online and paper directories of community resources were very useful, but difficult to keep current.

The value of signposting people to local resources

There was discussion about the nature of consultations and the therapeutic value of discussing local support. Being able to inform patients about community groups was viewed as "being a good thing" and could be interpreted as "going the extra mile".

How to get people together

Various ideas emerged about how to make community connections. It was agreed that just one person in the team could make links, and it was noted that Keep Well had been a catalyst for meeting local groups. An annual marketplace type event, which had been successful in Fife, would be easy to arrange.

Third Sector relationship with General Practices

A number of issues were discussed about the interface between local organisations and general practice. It was acknowledged that developing this relationship would represent a change in culture for many practices and would require time to evolve. Governance arrangements would have to be considered, to ensure people signposting were not party to confidential information. It was important to ensure feedback after signposting to know if people attended, stayed the course and benefited from support. It was thought useful for local organisations to learn how best to present their resource to primary care. Also keeping track of services required but not available would be useful.

It was pointed out that signposting is not only a role for primary care. For instance, the role of Community Navigators is being considered by some local planning partnerships as part of Scottish Government's Reshaping Care for Older People. Community Navigators are similar to local area coordinators and are ideally placed to signpost to local resources through, for example, Self Directed Support (where people are awarded an individual budget to ensure

they have tailor made support). Community Navigators can help access both statutory (eg district nurses) and third sector support (eg church, Citizens Advice). This role will be ideal in connecting services with other support available to individuals through their own, family and community resources, thereby maximising their independence.

Feedback from groups – key points

Groups were formed to explore 3 themes:

- Implications for practice teams
- Levers and Motivators
- Developing Links Project – next steps

Implications for practice teams

- Relationships– careful thought needed about practice roles and responsibilities
- Value of being aware of local resources needs to be in team consciousness
- Need for a champion to maintain and update information
- The whole team must be involved
- Need for a link worker
- Not necessary for GP to lead this work
- Receptionists and practice nurses have important role in signposting
- The Links Project should be on practice agendas
- Find ways to share knowledge, use local knowledge of staff

Levers and Motivators

- Collect evidence on benefits for patients
- Comparative data - collect data about rates of signposting between practices
- Incentivise – use the GP contract to introduce ideas about practices connecting in communities and drop other aspects of QOF (use the LES?)
- Collect evidence on practical benefits for practices and communities groups
- Reshaping Care for Older People and the Change Fund

Developing Links Project – next steps?

- Yes, the project should be further developed, there was a lot to learn
- Idea of a links worker should be further explored. This role might be particularly pertinent for deprived areas, though may have less value in more affluent areas
- Primary care will be useful place to extend the Links Project
- Developments in Reshaping Care / Change Fund are consistent and complimentary, important to make connection with this work
- Service design element to future work will be useful
- Any further work should be robustly evaluated
- Any new work should pay attention to the agile processes used in the Links Project and the value of having strong local leadership

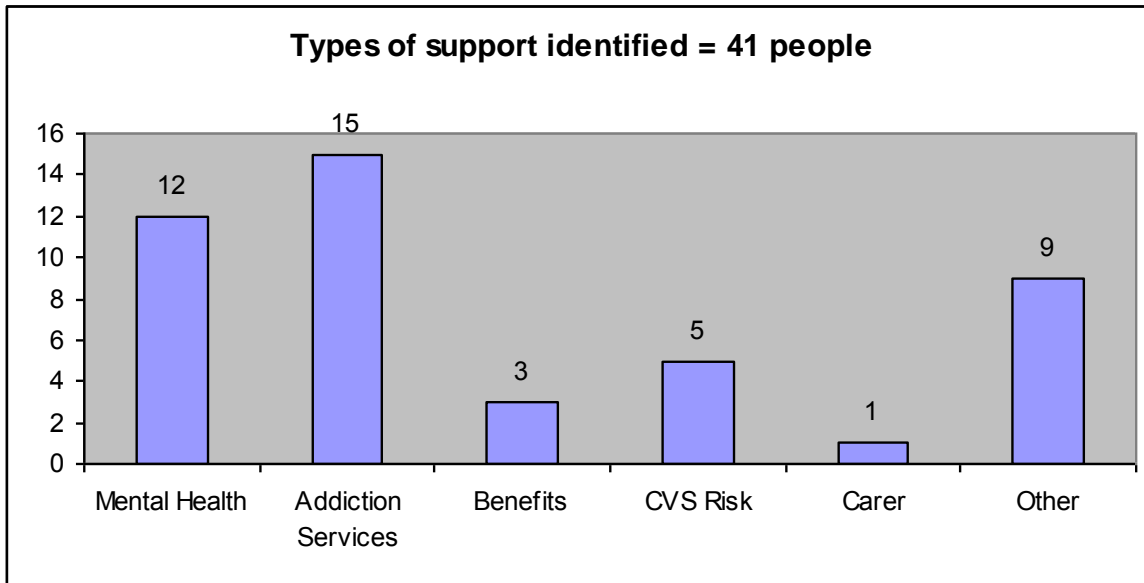
Close

Mr Strang brought the meeting to a close by summarising key learning points. The Links Project had been useful and had generated a lot of interest. The process of establishing the project quickly was a key learning point. Mr Strang concluded by reflecting on the multiple positive benefits if people and communities are properly connected but support, technology and time is needed. On behalf of the Steering Group, Mr Strang thanked participants for their hard work and enthusiasm and wished them all well.

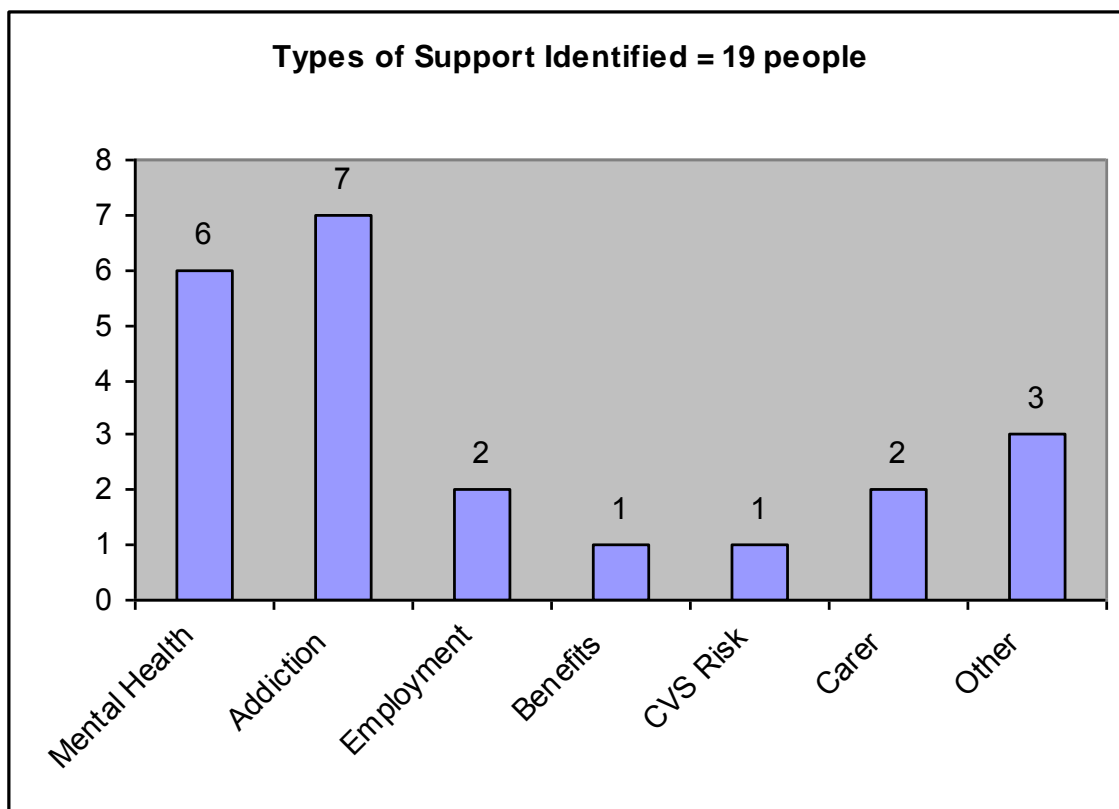
Appendix 3 Glasgow Practice Data

Types of services by practice (may be signposted to more than one service)

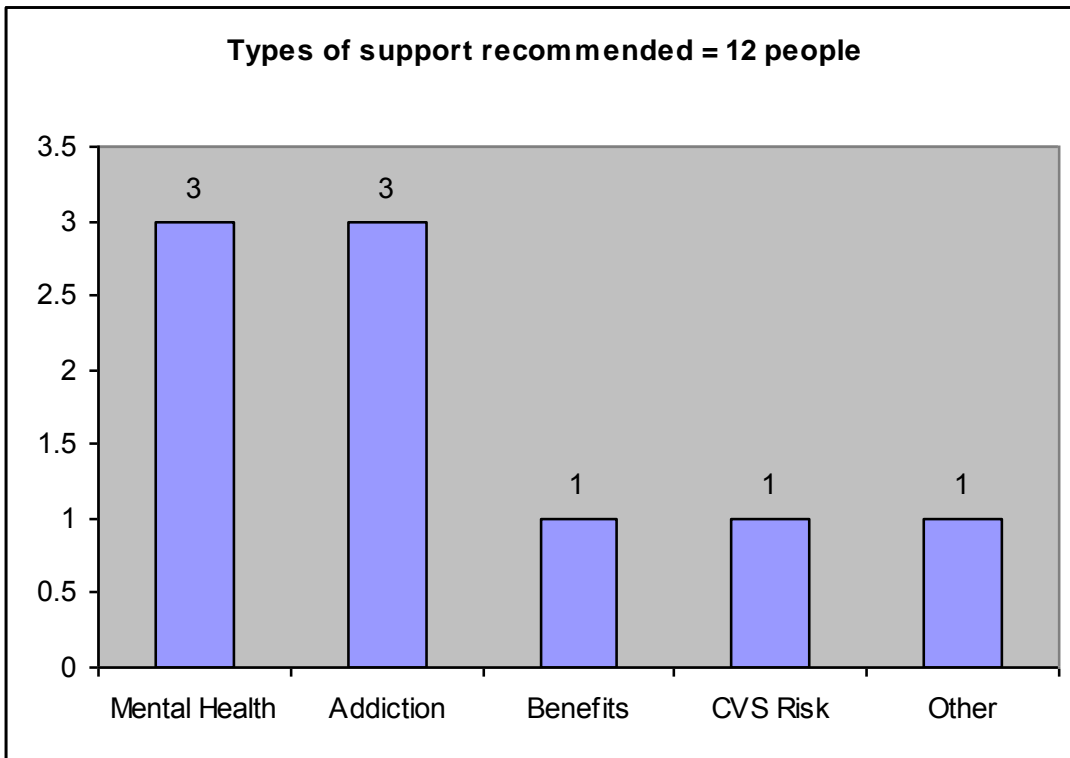
Practice A



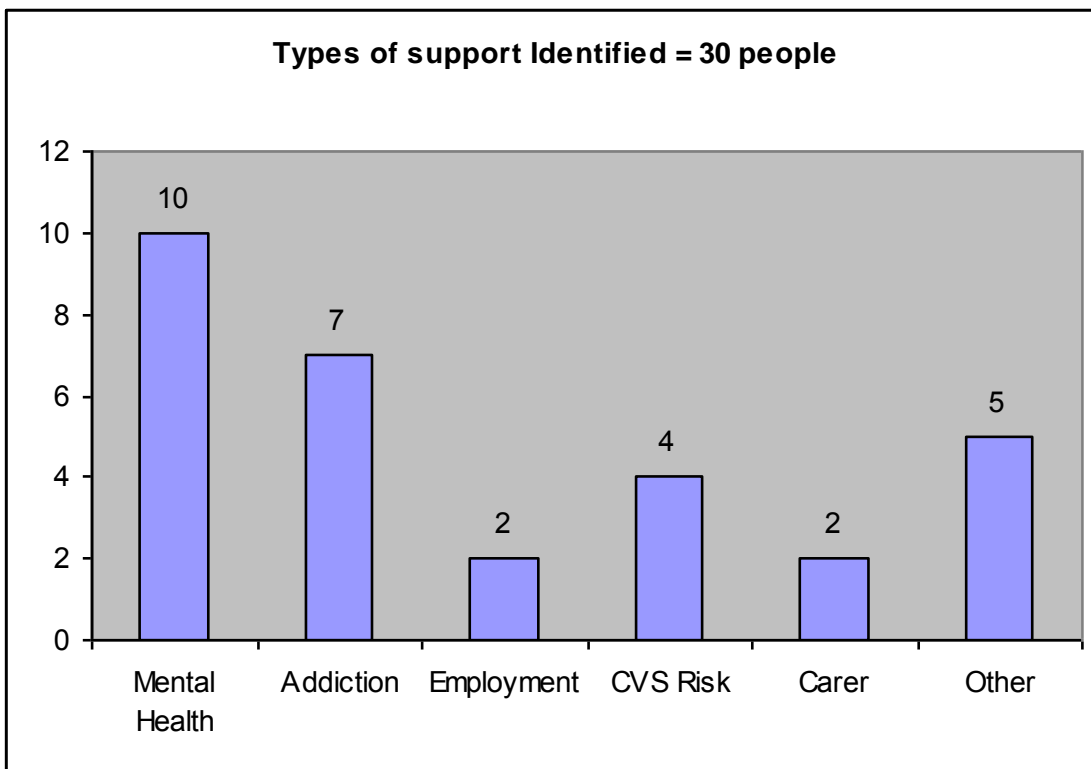
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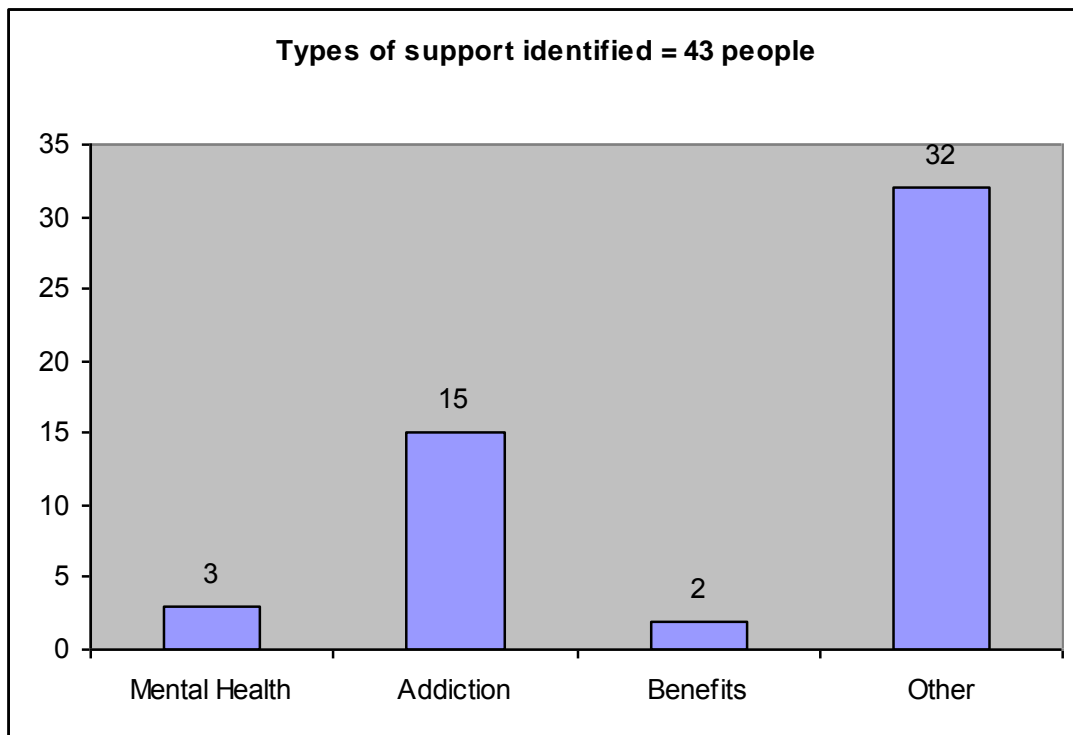
Practice C



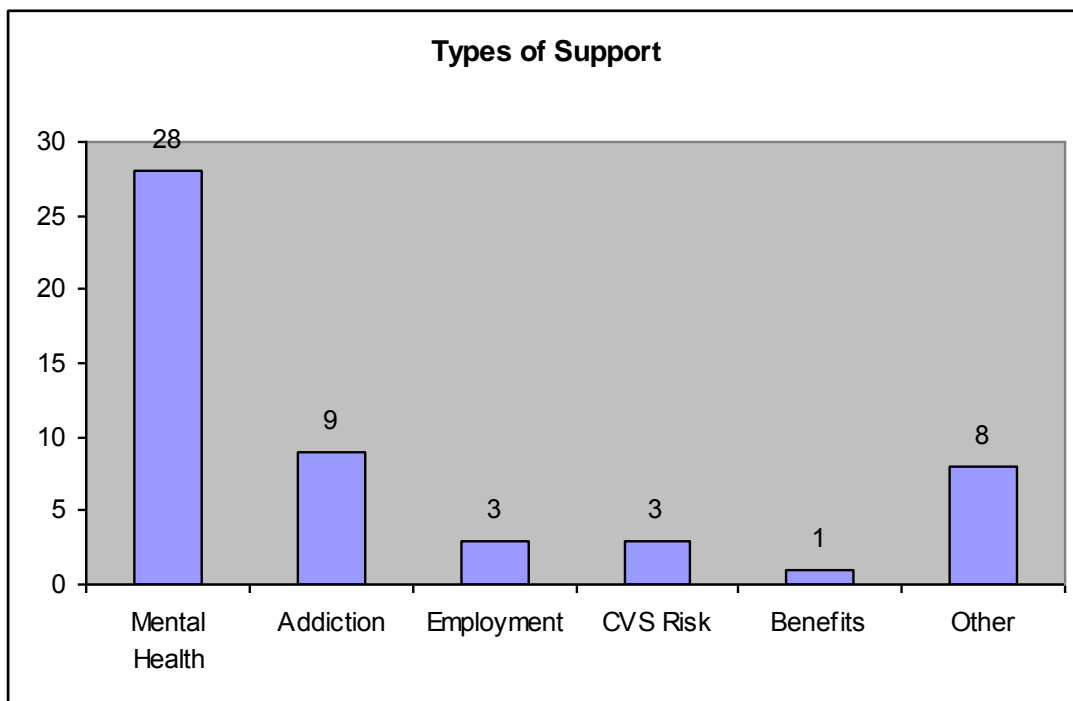
Practice D



Practice E



Practice F



Glasgow Baseline Survey Results

Results of baseline survey for December 2010, January 2011 and February 2011.

The percentage of patients identified for support hardly varied in 3 reporting periods (19%, 18%, 18%), nor did the recommended to a service (72%, 78%, 76%). Number of patients who expressed an intention to accept the recommendation varied (56%, 60% and 37%) which may be due to one practice with a particularly low acceptance rate.

December 2010							
Practice	Number of consultations	Number where patient was identified for support	Percent of all consultations where support need identified	Number who were recommended resource	Percent of those identified that were recommended	Number who expressed intention to use resource	Percent of those recommended who accepted
A	179	33	18%	31	94%	20	65%
B	184	30	16%	19	63%	17	89%
C	200	23	12%	18	78%	15	83%
D	50	20	40%	12	60%	4	33%
E	150	39	26%	35	90%	10	29%
F	400	75	19%	46	61%	26	57%
	1163	220	19%	161	73%	92	57%

Scottish Government Links Project Report December 2011

January 2011							
Practice	Number of consultations	Number where patient was identified for support	Percent of all consultations where support need identified	Number who were recommended resource	Percent of those identified that were recommended	Number who expressed intention to use resource	Percent of those recommended who accepted
A	200	41	21%	39	95%	25	64%
B	200	22	11%	19	86%	16	84%
C	193	13	7%	12	92%	7	58%
D	292	85	29%	46	54%	30	65%
E	150	49	33%	43	88%	15	35%
F	400	48	12%	39	81%	30	77%
	1435	258	18%	198	77%	123	62%

February 2011							
Practice	Number of consultations	Number where patient was identified for support	Percent of all consultations where support need identified	Number who were recommended resource	Percent of those identified that were recommended	Number who expressed intention to use resource	Percent of those recommended who accepted
A	200	50	25%	43	86%	26	60%
B	200	23	12%	19	83%	13	68%
C	100	13	13%	10	77%	6	60%
D	223	50	22%	28	56%	13	46%
E	150	46	31%	37	80%	3	8%
F	233	16	7%	11	69%	11	100%
	1106	198	18%	148	75%	72	49%

**Number of people identified as requiring each type of service in each practice
From baseline surveys Dec, Jan, Feb 2011**

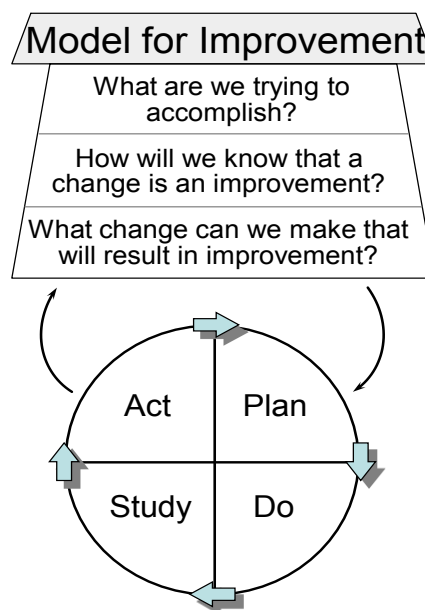
Services identified	Mental Health	Addiction	Employment	Benefits	CVS Risk	Carer	Other	
Practice A	42	33	2	5	7	3	47	139
Practice B	27	18	9	8	5	5	18	90
Practice C	17	11	2	8	2	1	11	52
Practice D	61	35	11	4	12	7	38	168
Practice E	8	37	0	3	3	0	98	149
Practice F	73	23	9	1	12	3	34	155
Total	230	154	33	28	41	19	252	757
Percentage	30%	20%	4%	4%	5%	3%	33%	100%

Appendix 4: PDSA Cycle of Change

PDSA Cycle

A structured trial of a process change. Drawn from the Shewhart cycle, this effort includes:

- Plan - a specific planning phase;
- Do - a time to try the change and observe what happens;
- Study - an analysis of the results of the trial; and
- Act - devising next steps based on the analysis.



This PDSA cycle will naturally lead to the Plan component of a subsequent cycle.

Creating an Improvement Culture provides essential knowledge on change management approaches and continuous improvement.

These tools and techniques allowed the practice staff to fully understand their existing processes, identify where duplications and delays occurred and areas where improvement work could be focussed in a way that met the needs of the local service.

The resulting improvements were reported as PDSAs on the Community of Practice and were accessible to colleagues across Scotland in order to provide them with examples to draw on that helped them in the planning and execution of further change projects.

“Views of the Practice Team”

This questionnaire is about local ‘community’ resources (help lines, charities, support groups, websites etc) rather than NHS and ‘health’ services.

Your job title

GP Practice

1. Do you know enough about community resources to inform patients?

NO YES NOT SURE

2. Do you have the confidence to inform patients and recommend they use community resources?

NO YES NOT SURE

3. What makes it harder for you to recommend these resources to patients?

4. Who are patients likely to ask within the practice for information about local community resources?

Doctor Receptionist
Nurse Other Please Name:
Healthcare Assistant No-one

5. Do you think the practice has good links with all local community resources?

NO YES NOT SURE

6. What needs to happen within the practice to make it easier for patients to use local community resources?

For you as an individual:

At a practice level:

(Similar questionnaire to one below, used for phone and web based services)

FACE TO FACE

**Follow up Questionnaire for patients
having been signposted to Community Resources.**

- *This questionnaire will be used 4 weeks after practitioners have identified patients to be signposted to community resources. Using the initial longitudinal survey sheet each patient will be contacted and the following 10 short questions asked to gain an understanding of the patient experience of the signposting.*

Hello, this is fromthe local surgery, we are trying to gain some feedback on the resources that we, as a practice, offer to you. Do you mind if I ask you 10 short questions about your recent experience? Y / N

1. About 4 weeks ago, (practitioners name) suggested that you use theto give you some help. Do you remember (practitioners name) suggesting this? Y / N
2. Did you make contact with by either phoning or face to face? Y / N
3. If you did not make contact, what was the main reason or reasons that prevented you?
4. Did you attend any sessions face to face? Y / N
5. Are you still attending this resource that (practitioner's name) suggested to you? Y / N
6. If you are not attending, are you on a waiting list? Y / N
7. If you are on a waiting, how long have you been asked to wait?
8. If you stopped attending, what was the reason or reasons that made you stop?
9. How easy was it to "find and get to" the resource? Easy 13.....5 Difficult
10. Overall, how helpful has this resource been in helping you since (practitioner's name) suggested that you attend? Not Useful 13.....5 Really Useful

That's the questionnaire over, many thanks for your time.



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