Developing a Culture of Health

The role of signposting and social prescribing in improving health and wellbeing
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Foreword

The Health and Social Care Alliance Scotland (the ALLIANCE)\(^1\) has an ambition of ensuring that Scotland is a place where we can all enjoy our basic right to health and that policies such as the Scottish Government’s “Route Map to the 2020 Vision for Health and Social Care’, are translated into real and positive change in people’s lives”.

We’ve heard loud and clear from the National Conversation\(^2\), about the need for improved connectedness at all levels – between individuals, teams, services and systems. The need for a more democratic approach to health, where knowledge is shared and the wisdom of people living with long term conditions and disability is utilised, has been reflected in conversations across the land. Conversations have indicated that, despite living in an increasingly networked world, the benefits of collaborative infrastructures and being connected at personal, local and national levels are still to be properly realised. A fitting response means linking the promise of unconditional care, offered by our health and social cares services, with the excellent sources of support, which lie in most communities.

There is growing interest in the concept of health outside the usual health buildings, and the need to strengthen a community response to issues such as inequalities in health, the increasing numbers of people living with multiple conditions or who are lonely, an ageing population, rising social need and mounting financial pressures. Developing this concept will require a change in relationships between people, professionals and society.

In Scotland, the enthusiasm for changing these relationships has been seen in recent Scottish Government policies, which indicate a shift away from the traditional professionalisation of health. There is greater awareness of the potential of a more reciprocal approach, one which means “we’re all in this together.” Mutual signposting is emblematic of this approach as it is part of the collaborative process needed to facilitate access to much needed support and a more efficient sharing of community resources. Improving the health of people living and working in our communities, will take commitment, time, reliable resources and a planned approach. This report lays out why this is important and includes encouraging examples of how a culture of health is already being developed across Scotland.

Ian Welsh
Chief Executive

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new roles and support for navigators, health trainers and advisors who help patients and service users understand, access and navigate community-based services that will improve their health

The terms social prescribing and signposting both mean linking people with non-medical sources of support. The terms are often used inter-changeably, however the term “social prescribing” usually relates to clinical settings and is thought by many to be less appropriate to describe a more social, co-created model of health.

Nesta’s More Than Medicine3 describes social prescribing as a “clear, coherent and collaborative process in which healthcare practitioners including GPs, practice nurses and community matrons work with patients and service users to select and make referrals to community-based services”. Signposting is described as being “new roles and support for navigators, health trainers and advisors who help patients and service users understand, access and navigate community-based services that will improve their health”.

Although often associated with exercise and art prescriptions in primary care, both terms can represent connecting people to whatever keeps them well. This may be formal or informal and can mean anything from talking to someone, making contact with statutory health and social care, welfare and housing agencies, linking with others by phone or online, accessing financial support and being linked to clubs and formal groups and organisations.

There are many terms for the systems to support social prescribing and signposting, such as link working, community referral, community connecting and many more. Whatever term is used, it is just one part of a much wider approach, which represents a more distributed responsibility for health and which links people with the right support at the right time, in the right place.

All of us can signpost – friends, police, social care workers, health care professionals, pharmacists, community development workers, volunteers, third sector staff, members of the community.

Developing a culture of health

Approaches to developing a culture of health in our communities are changing, as more is understood about what we can do to protect and improve the wellbeing of the nation. The Scottish Government’s commitment to increase healthy life expectancy and deliver care in a homely setting, can only be met through developing a culture of health; a culture which encourages an ethos of co-ownership of public services and sharing responsibility for transforming our health system. This commitment supports a shift to a more reciprocal, community facing model of care. This shift will only happen if the power of people in communities - volunteers and non-clinical staff, is harnessed through open approaches and social innovation. Working in new ways means tapping into the knowledge and creativity of others outside the health and social care services, such as community development workers, service designers and anthropologists.

The Scottish Government is prioritising investment in transforming healthcare services to meet the needs of the future and ensure delivery of the 2020 vision. Frameworks to support this transformation include legislation to integrate health and social care, community and workforce planning and recommendations made in numerous reports, reviews and academic research.

A vital agent of the radical change described in The Healthcare Quality Strategy for NHSScotland (2010) and the Commission on the Future Delivery of Public Services (2011), is to ensure that all resources are utilised so that people and staff living and working in communities can access the most appropriate support. The Christie Commission made recommendations about managing demand and enabling people to do more for themselves and each other. An important theme was that effective services must be designed with and for people and communities - “working closely with individuals and communities to understand their needs, maximise talents and resources, support self-reliance and build resilience” and “prioritising preventative measures to reduce demand and lessen inequalities.” Distributing responsibility for care and support, will, by its nature, ensure a more equal distribution of the duty to promote individual and community wellbeing. This has particular importance in collaborative efforts to address inequalities in health.

A more integrated model has been strongly endorsed by feedback from the National Conversation on a Healthier Scotland (supported by the ALLIANCE’s community engagement and partnership programme). Conversations across the nation have referred to problems caused by a lack of integrated services and systems, with many reporting that they have been unable to access the right care, in the right place, at the right time.

“ There was a widespread acknowledgement that there are a lot of good activities and initiatives happening across the country but a lack of awareness by professionals and individuals was a barrier to people being made aware of them or referred to them.”

National Conversation blog (January 2016) 4

Transforming relationships between providers of care in communities is fundamental to this approach. Signposting will contribute to the Chief Medical Officer’s (CMO) recommended shift away from “doctor knows best” to a model which makes the best of individual and community assets.

The Chief Medical Officer’s Annual Report, “Realistic Medicine” (2016) describes a shift towards improving population health through de-medicalising health and wellbeing and introducing a greater focus on prevention, self management and health literacy. Signposting has a vital role in this more democratic approach - the IMPACT Fund, administered by the ALLIANCE, is championing self management and encouraging innovative approaches to supporting people and carers.

There is a growing insight into the significance of issues, which are hard to define - such as the nature of complexity, the art of collaboration and importance of connectedness. Being less open to definition also means that these issues are less amenable to counting, gathering data and intelligence – it is hard to provide evidence for the impact of some of the most important aspects of our lives. Future advancements may be made with more diverse forms of data which takes account of the multiple impacts on people’s lives.

In Scotland, collaborative infrastructures are being developed through plans to integrate health and social care, community planning partnerships and to establish multi-disciplinary and multi-sector teams. Making these connections draws professional and lay people together in a way which can support community health. However, it is vital that this integration is more than just an operational process. The Health and Social Care Alliance Scotland (the ALLIANCE) has a human centred view of integration - as being part of our lives, not a form of organisation. Strong local relationships and being connected to help has a high value for people living, working and being cared for in communities, and is especially true for people who are lonely.

Loneliness

“Once loneliness enters your world it can bring with it, depression, anxiety, lack of self-esteem and so much more. It is as if loneliness builds a wall around you, you cannot break out and no outside contact can get in.”

This quote is included in a blog post on the National Links Worker Programme (NLWP) website. Community Links Practitioners identified loneliness as being a significant problem. Dr Peter Cawston, Clinical Lead of the NLWP and a participating GP, described in a blogpost how local people are getting together to do something about it. The following is an edited extract from the blog:

“Towards the end of 2015, with the support of the National Links Worker Programme, my practice started a community led health group to identify a local health issue and help find possible solutions. The problem they latched onto right away? Loneliness!

The group met about two hours a week to share stories and ideas, members feel the meetings have been of enormous benefit in their lives “I felt so low and so alone... but when I walked through the door (which was hard) I was surprised how lovely the people were, I felt comfort and it gave me a sense of peace in my mind”.

This is more than a just a self-help group however, the group is influencing training and development in the practice. An entire afternoon of protected learning time was devoted to the topic of loneliness, supported by training from Befriending Scotland and attended by a local Church of Scotland minister who shared his experience.

The NHS has no magic answer to loneliness, despite the evidence of its impact on health and the group do not think that their hard pressed GP practice team could or should take on the burden of trying to solve this problem.

What this small group of people is becoming passionate about is that they might be able to reach out even to a few other people who may be feeling as they do. One of them took action early on. At Christmas she went down her street and invited people who she knew had lost a partner and would be alone at Christmas. Was this a crazy idea? Would anyone come? Not only did seven people arrive, but they spent all afternoon chatting about the past and playing games, not leaving until 10pm!

7. Links Worker Programme blogpost, Dr Peter Cawston; http://links.alliance-scotland.org.uk/2016/03/promising-links/
Our community led health group now has a name: Promising Links, and they have a purpose - to support one another and to provide a safe welcoming time in the week when others can join them. As well as coffee and cake, they are looking at trying out some light group physical activity and new things, like yoga or head massage. Such small and simple steps, requiring no great top down plan, but how transformative! Proof, if proof was needed, that with a little encouragement and support people themselves can begin to find the answers to even the most overwhelming of problems”.

Loneliness has been described as an urgent public health issue, by the Campaign to End Loneliness, a coalition of organisations working to address the problem. Changing circumstances such as moving to a new area, loss of employment, retirement, losing family and friends can often lead to loneliness, and, although there are positive aspects of growing older, ageing is too often associated with poor physical and mental health and loneliness. The Coming of Age report cites relationship status, especially being divorced or widowed, the amount of time spent alone, poverty, a history of loneliness and poor health as circumstances which may result in loneliness.

There is growing academic interest, in the relationship between loneliness and health and wellbeing. The Campaign to End Loneliness states:

- The effect of loneliness and isolation on mortality exceeds the impact of well-known risk factors such as obesity, and has a similar influence as cigarette smoking
- Loneliness increases the risk of people experiencing high blood pressure
- People who live with long term conditions and disabled people are more likely to experience loneliness
- People who are lonely are more likely to experience depression and other mental health problems.
- People who are lonely are more likely to:
  - Visit their GP, have higher use of medication, higher incidence of falls and increased risk factors for long term care
  - Require residential or nursing care at an earlier age
  - Use accident and emergency services.

8. Campaign to End Loneliness http://www.campaigntoendloneliness.org/
Policies to support signposting

The health environment is not the sole supporter of good health – health outside “health buildings” is supported by all of us. Support for de-mystifying health, and more joint working between disciplines and sectors have been set out clearly in a number of Scottish Government strategies, and NHS Boards are reviewing their strategic plans, particularly in the context of development of Integration Joint Boards. The basis of these strategies are in Scottish Government’s 2020 vision proposal that people should be treated as close to home as possible by multi-disciplinary teams in communities with strong links with local services. This has particular relevance for mitigating the effect of inequalities in health.

Developing a culture of health in Scotland will require all government portfolios to include a reference to health and wellbeing. Phrases such as “building community capacity” are scattered through a wide range of government policies, such as education, arts and culture, lifelong learning, employment, housing, and public services. Threading a reference to health through all policies will develop a sense of common purpose.

The European Portal for Health Inequalities describes a strategy policy - Health in All Policies (HIAP). The rational for HIAP is that health is influenced by social, environmental and economic factors, which lie beyond the realm of the health sector. Such factors and processes act as determinants of health by influencing the underlying conditions of an individual’s life situation.

The importance of health literacy has being recognised in Scotland; an action plan – Making it Easy, has been developed to highlight the hidden problem of low health literacy and the impact that this has on our ability to access, understand, engage and participate in our health and social care. Health Literacy means more than being able to read leaflets and be able to make appointments. By improving people’s access to health information and their capacity to use it effectively, health literacy is critical to living well. This includes what is sometimes referred to as community health literacy – the ability to access, understand and use community support. Making it Easy calls for all of us involved in health and social care to systematically address health literacy as a priority in our efforts to improve health and reduce health inequalities and describes actions the Scottish Government and partners are taking to help all of us in health and social care collaborate and help realise this ambition.

An organised approach to engaging people to improve public health, has been articulated in the Royal Society for Public Health’s “Rethinking the Public Health Workforce.” A wider workforce in local communities can include anyone who has contact with people in need of support and who are in a position to point them in direction of helpful resources. This refers to the role that nursery and school teachers, police, firemen, librarians, hairdressers, postal workers,

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12. Health In All Policies http://www.health-inequalities.eu/HEALTHEQUITY/EN/policies/health_in_all_policies/
cleaners and tradesmen could have as being part of the wider health workforce.

“Pulling Together”, the Report of the Independent Review of Out of Hours Primary Care Services\(^\text{15}\) refers to the importance of people being able to access the right support at the right time and the need for systems to facilitate collaborative working.

An important strategic development is around strengthening the link between public health, primary care and local providers of support. This is reflected in the new general practitioner contract, which will be introduced in Scotland in 2017. The focus of the contract is to encourage continuous quality improvement in the wider health and social care system and will encourage flexibility, so that general practices are better able to develop services according to local need. The new contract indicates a move away from the burden of meeting numerical targets, such as the Quality Outcomes Framework used in primary care, and signals support for a more community facing primary care approach.

The contract makes reference to the Transitional Quality Agreement, an element of which is an expectation that general practice clinicians will “provide appropriate lifestyle advice.” Providing lifestyle advice will often involve signposting people to support in the community.

These approaches are echoed in Scottish Government’s National Clinical Strategy\(^\text{16}\), which provides a blueprint for health and social care for the next ten to fifteen years.

The strategy states that the aim of primary care “must be to support people to maintain the maximum level of health they can achieve, but in a way that encourages independence and self-management and reduces dependence on the healthcare system.” Knowledge of local resources and signposting will be vital in realising a recommendation to “provide more community-based services to replace some that have previously been provided in hospital.”

The 2015 Review of Public Health in Scotland\(^\text{17}\) also signals strong support for partnership working and more collaborative action:

“Responsibility for public health action also rests with the wider NHS, with national and local governments, the pivotal role of Community Planning Partnerships and Integrated Joint Boards. The third sector, other public services, communities and the private sector make a major contribution as does the wider public workforce across the public sector and voluntary and community sectors. These are considerable organisational and people resources, but not all the potential is being realised.”

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Part of the solution will be in attaching a value to connecting people and identifying practical ways to do it. Strengthening the pathways between providers of support, through mutual signposting, is at the heart of this networked approach, and has significant spin offs, such as improved local relationships, sharing skills, raising awareness of prevention, self-management and health literacy.

Living Well in Communities, a portfolio in Health Improvement Scotland, aims to support people to spend more time living at home or in a homely setting, which would otherwise be spent in hospital. This work will involve a range of stakeholders across the health and social care landscape, including health and social care partnerships, housing associations, third sector organisations and private sector social care providers. Improvement activity will focus on particular areas but share a common theme of improving links across partnerships and sectors.

This approach is supported by Nesta and the Health Foundation in a publication “At the heart of health: Realising the value of people and communities.” The key findings are that person and community-centred approaches for health and wellbeing have significant potential to improve outcomes for individuals, support the development of strong and resilient communities and, over time, help reduce demand on formal health and social care services. There is evidence from both research and practice to demonstrate the benefits of person- and community centred approaches, across three dimensions of value:

- Mental and physical health and wellbeing - person and community centred approaches have been shown to increase people’s self-efficacy and confidence to manage their health and care, improve health outcomes and experience, to reduce social isolation and loneliness, and build community capacity and resilience, among other outcomes.

- NHS sustainability - these approaches can impact how people use health and care services and can lead to reduced demand on services, such as emergency admissions and A&E visits.

- Wider social outcomes - person and community centred approaches can lead to a wide range of social outcomes, from improving employment prospects and school attendance to increasing volunteering. They also can potentially contribute to reducing health inequalities for individuals and communities.


Over 90 per cent of interactions about healthcare start and finish in primary care, and so staff in general practice are in an ideal position to provide advice on healthy behaviours and signpost people to support. There is widespread agreement that general practice is often not the most appropriate environment to address non-medical, social problems as there is not enough time to explore complicated issues and staff do not usually have adequate knowledge of available sources of support.

In 2013, the Scottish Government announced a fund of £1 million towards a Primary Care Modernisation programme, to trial and test at scale a range of new models of care. The learning from this work will inform future planning and spread of developed and tested new ways of working across Scotland before 2020. Many of the new models have a focus on strengthening local connections, signposting and greater integration of services in communities.

The approaches being developed draw on a wide variety of influences such as reports of GPs at the Deep End and South Central Foundation Alaska’s Nuka model and the House of Care.

Below are just a examples of initiatives which are emerging across Scotland.

Headroom is exploring a new model in primary care in deprived areas of Scotland. The focus is on learning more about improving quality of care and more efficient ways to support people with complex needs, such as those living with multiple conditions, mental health and social problems. This is being approached through testing new ways of working – for example, encouraging stronger community connections.
through social prescribing, collaboration between health, social care and local authority sectors.

Lothian Headroom is establishing new ways of working with a diverse range of partners and agencies, to deliver improvements which are aimed at the critical ‘life-wrecking’ dimensions of inequality; mental health, alcohol, drugs, severe parenting problems, environment, employability, long term conditions and social isolation.

Govan Headroom, in NHS Greater Glasgow and Clyde, are developing innovative approaches to collaborative working across four practices, community health services, social services and the third sector. This is informed by reports of GPs at the Deep End, including reference to provision of additional children and family and adult social worker staff, enhanced GP time and improved support to community health services to enable better outcomes for patients with complex health and social care needs.

Two general practices in Forfar have merged and are involved in a Headroom project in NHS Tayside. The practices already worked collaboratively with their patients, and their model aims to build on this relationship to develop and redesign services. Learning from the South Central Foundation in Alaska (NUKA model) is a key reference in this model.

Community Renewal have pioneered a holistic way of working with people who have complex life issues, which is based on continuous holistic assessment and a case management approach and which takes a longer view of meeting a person’s needs. One of Community Renewal sites is in NHS Grampian, where the organisation is collaborating with local general practices and organisations to transform quality of care. The approach has been influenced by the NUKA model and has a focus on “deep community engagement”, adopting a personal, holistic approach and building lasting relationships with people and their families which preserve continuity of care.

Community Compass, a Carr Gomm project, established in 2013, is an example of the benefits of signposting and partnership working. During the planning phase of the project, community assets were mapped out, gaps identified and local organisations, both in statutory and non-statutory sectors, were contacted to discuss a joint approach to address local health issues. Community Compass collaborates with the Craigmillar Medical Group and other organisations such as the Thistle Foundation, to support residents in the Craigmillar area of Edinburgh. The project is designed to connect people with local services and help them overcome issues, which are not clinical. People are referred to the service with a range of issues such anxiety, depression, social isolation, debt, unemployment, housing and financial worries.

Staff offer time to listen and discuss possible opportunities which may include support to join community activities, referral to food banks, finding work, advocacy, company to attend appointments and be linked to welfare, housing and financial advice. Community Compass has established a number of local groups where gaps have been noted, such as a cookery, gardening and cycling groups and a Men’s Shed.

22. Carr Gomm, Community Compass; http://www.carrgomm.org/our-services/communities/communitycompass
23. Thistle Foundation, Charity supporting people with disabilities and health conditions; http://www.thistle.org.uk/
Many general practices across Scotland are partnering with local organisations, for instance representatives from Citizens Advice providing information to older people about Power of Attorney, finance, fuel poverty and the like. Carnoustie Medical Group, at Parkview Primary Care Centre, is a good example of local collaboration. A vacant room in the practice is being put to good use after Business Manager, Lynn McGowan, noted a need for patients to have a point of contact for advice and signposting for non-medical matters such as loneliness, finances and relationship counselling. A local volunteering group, Voluntary Action Angus helped to set up the service, which was originally provided once a week, but due to demand is now two days a week. Patients may drop in or be signposted by any members of the practice team.

The practice also works in partnership with Angus Carers who provide support, advice and assistance to people, their family and carers in both Carnoustie and nearby Monifeith health centres. Carers may drop in to the practice, or email Angus Carers for advice. Angus Carers have a multi-faceted role and attend practice multidisciplinary meetings where their input is invaluable and the arrangement provides an important opportunity to strengthen local relationships.

Community Health Connections in NHS Fife has been funded by the Community Planning Partnership to encourage signposting. The programme enables GPs to signpost people to a health coach, who provides a service at three practices at Lochgelly Medical Centre. The health coach helps to access information and connect people to sources of support in their community, which can include opportunities for volunteering, employment, physical activity and support for issues such as bereavement, welfare and finance.

24. Voluntary Action Angus; http://www.voluntaryactionangus.org.uk/
25. Angus Carers Association; http://www.anguscarers.co.uk/
Signposting, primary care and inequalities in health

Many initiatives have emerged in Scotland to mitigate the effects of inequalities in health. On average, people living in deprived areas of Scotland die more than 10 years earlier than people in affluent areas and become ill in their 50s rather than their 70s. The problem of persisting inequalities in health is well described in reports by GPs at the Deep End, Health Scotland, the Health and Sport Committee and the Glasgow Centre for Population Health and many research projects.

A GPs at the Deep End report (2010), which focused on the experience of social prescribing among GP practices in deprived areas, provided useful insight. This report described a high proportion of GP consultations being driven primarily by the experience of social adversity, especially poverty and financial problems, as well as experiences of violence, addictions, housing and other difficulties. GPs felt that they were often unable to respond effectively because of a lack of time, but also because of difficulties in accessing community-led services, which they knew could benefit their patients. The report includes the observation that “often the patients who could benefit most from these services are the least empowered to seek them out. They may find it difficult to phone up new people/go to new places to seek help.”

The Links Project (2010) enabled ten General Practice teams to explore the nature of their connections with local communities. The 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. An emerging vision for improving links in communities is personalised, relationship based and supported by robust technology.”

Key observations from the Links Project include:

- 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

30. Glasgow Centre for Population Health, http://www.gcpch.co.uk/
• 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.

The Links Project included the following recommendations:

• Consider sustainable model for maintaining connections to community, for example a link worker, with librarianship and connecting role, to develop and facilitate links

• Encourage events in protected learning time, such as visits to local resources

• Implement ALISS project in primary care to improve access to online local information

The chart below illustrated the need for mental health or addiction services in a participating practice in Glasgow:

![Chart illustrating types of services needed](chart.png)

The Links Project 2010
The Royal College of General Practitioners Scotland (RCGP Scotland) are supportive of signposting approaches to link people to non-medical sources of support, to compliment any medical treatment.\textsuperscript{33} A RCGP Scotland report, Living Better (2011), supported development of a more community-facing general practice. The report advises that “improvements are needed in partnership working between primary healthcare, local authorities and the voluntary sector to improve and develop links with community resources” and recommended “expansion and awareness raising regarding these new initiatives (such as ALISS\textsuperscript{34} and other local resource toolkits) among GP practices.”\textsuperscript{35}

Evidence to support signposting came from Sources of Support (SOS), a pilot social prescribing scheme which formed part of the Dundee Equally Well test site.\textsuperscript{36} The (SOS)\textsuperscript{37} was established to address the socio-economic and personal circumstances that affect health and well-being. Link Workers with backgrounds in mental health and community development were appointed to work across practices in deprived areas. Link Workers used structured conversations to establish a rapport and tease out the issues people wished to address, create a plan of action and provide support to access local services. Analysis of SOS cases highlighted the range and complexity of people’s lives, and it was noted that Link Workers gained a very detailed knowledge of mainstream and community based services through the programme.

The BRIDGE project (Building Relationships In Deprived General practice Environments)\textsuperscript{38} (2012), focussed on older people and also referred to the benefits of signposting and strong local links. The project recommended a system which included: a) A practice based link worker which made all other activities happen b) Active identification of people in need; c) Building relationships with community service providers; d) Providing older people with up to date information about services; e) Supporting older people to engage with services; f) Feedback and follow up to know how people got on.

Improving Links in Primary Care (2014), a partnership between Health and Social Care Alliance Scotland and (RCGP Scotland), developed these themes. The project identified three interconnected enablers of improving links in primary care: mapping assets as a way to strengthen local relationships and share knowledge of local resources, using ALISS and adopting a links worker approach.

The types of support needs identified at the beginning and the end the Improving Links in Primary Care project, are shown below. These had changed substantially over the course of the project, with a large increase in the need for support for mental health and addiction, and also for social isolation and carers support. Improving Links in Primary Care found that at the start of project, only 20 per cent of staff thought they had adequate links with community resources.

\begin{itemize}
  \item A Local Information System for Scotland http://aliss.org/
  \item http://www.gov.scot/Publications/2015/11/4703
  \item Enabling Health and Wellbeing in Older People (the BRIDGE) accessed 02 04 14 http://www.gla.ac.uk/media/media_282275_en.pdf
\end{itemize}
Figure 9. The type of support need identified changed by the end of the project.
Practitioners recommended a local community resource in 78 per cent of cases identified with a support need (an increase on the percentage recommended at the start of the project). By the end of the project over 50 per cent of practice staff (69 per cent of GPs) felt that the project had increased their knowledge of local resources and this increase was generally maintained six months after the end of the project.

Staff confidence in being able to inform patients about local resources more than doubled from only 23 per cent feeling confident at the start to 49 per cent by the end, which was sustained six months after the end of the project.

The project supported findings from similar initiatives, that simply providing an opportunity for primary care teams to strengthen local relationships had benefits for all, but is not easy to achieve, it takes commitment, time, reliable resources and a will to do it.

RCGP Scotland project, Engaging Community Assets (2014)39, also added evidence about the benefits of signposting. The project noted the problem of social isolation and echoed findings that building relationships and professional connections were extremely important to facilitate signposting from the health sector to social enterprises. Recommendations included that a follow on project should be developed for a longer duration with a possible focus on social isolation, and that practices would require a dedicated Engaging Community Assets Facilitator to build links with their communities and related organisations.

These projects and many other initiatives across the UK, laid the foundation for a Randomised Control Trial to explore the value of a links worker in general practice.

The National Links Worker programme40, which aims is to help mitigate the impact of health inequalities in Scotland, was established in January 2014 and is funded by Scottish Government until March 2019. The programme is a partnership between Health and Social Care Alliance Scotland (The ALLIANCE) and GPs at the Deep End, and delivery partners include Scottish Association for Mental Health (SAMH) and the RCGP Scotland. The programme is a Randomised Control Trial and is being evaluated by a team from the University of Glasgow.

The rationale for the programme is that if individuals feel supported in their lives, then they are more likely to respond to information on ways to improve their health and to live well. The programme has been developed with reference to the Links Approach, the theoretical conceptual framework which underpins the programme and which includes reference to seven essential capacities:

- Team wellbeing
- Awareness
- Shared learning
- Intelligence and information management
- Signposting
- Problem solving
- Community networking


Community Links Practitioners (CLPs) are based in seven general practices, which deliver services in the most deprived areas of Glasgow (practices were recruited through the GPs at the Deep End initiative). **CLPs have three main aspects to their role:**

- To provide one-to-one support to individuals from the practice list, helping to identify issues which can improve their health and wellbeing.
- Support people to access local resources and contribute to building the capacity of local networks and community assets.
- Collaborate with practice staff to support development and implementation of the seven capacities identified in the “links approach”.

An important aspect of the programme is to gather and share learning about signposting, the links worker role and to support others who are interested in working in this way. This is being achieved through producing a series of Records of Learning.

Numerous examples are emerging from the Links Worker Programme, of how simply strengthening local relationships benefits all. For instance a participating practice contracted a community group to provide practice staff with lunchtime yoga sessions as part of the ‘team wellbeing’ capacity of the links approach. As well as contributing to a closed loop local economy, the practice and the yoga group are building a deeper relationship and improving understanding of what each other offers. Staff now have more confidence in signposting others to the yoga class and a GP commented “I’ve noticed how my clinical practice has benefitted from being much calmer immediately after the yoga session.”

One of the CLPs, Gerry Mitchell, describes how signposting people to community resources, is a vital aspect of his link working role.

“People, referred to me by their GP, came with a variety of social issues that were affecting their general health and wellbeing; social isolation, bereavement, addiction; and physical and mental health conditions such as obesity, depression and anxiety. One of the ways I am supporting people, has been through weekly Links Health Walks. Through the health walks I have been able to have regular contact with a group of patients, hear updates on their progress and I can signpost them to resources. Participants like Peter and Walter are seeing the benefits:

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41. General Practitioners at the Deep End, University of Glasgow; http://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend/reports/

42. The National Links Worker Programme, Records of Learning; http://links.alliance-scotland.org.uk/resources/
Peter has been walking with the group for six months now and although he has a long term reliance on alcohol, he has made positive steps towards reducing his consumption and no longer drinks during the day. As well as attending the walks he now also attends a local charity who offer daily activities and free lunches. Peter was living on £15 per week after bills and I have helped him access welfare and financial support from his Housing Association and a Welfare Officer. Signposting Peter to these resources has resulted in him engaging positively with most resources, whereas in the past he had a strong record of non-attendance and disengagement with services.

Walter has been on a health improvement journey since joining our walking group and this progress has been aided by signposting to community resources. Walter joined the walk to overcome isolation and to try to reduce his weight. He has been clean of alcohol and drugs for seven years and says that he needs to be busy and involved in activities to maintain this. As he made progress he also joined the Wheelbeing Cycle Programme, delivered by Glasgow Bike Station, and now cycles regularly. He regularly talks about the impact that the walking group has had on his ability to access the right resources.”

**Links Health Walks, Pollok Park Glasgow**

The Links Health Walks have helped participants access social groups, computer literacy classes, cooking classes, benefits advice, employment and training opportunities, housing support, addiction support and advice, counselling, smoking cessation and physical and mental health support and advice. Signposting to local resources also provides important support to community groups.

These initiatives are providing insight into the benefits of social connectedness, local social networks, social innovation and the challenges and benefits of shifting from a top down performance measured health system to one which is more horizontal, and co-produced.
Signposting and mental health

A significant number of people who contact health services have problems related to mental health, and yet the Scottish Action for Mental Health’s (SAMH) report Know Where to Go\(^43\), reported that 800,000 adults did not know how to access help. When GPs were asked what kind of information on mental health would be useful, 87.3 per cent suggested guides on local resources, including opportunities such as walking groups, stress management groups, voluntary sector support services. Know Where to Go recommended using ALISS.

Well Scotland, the national mental health improvement website for Scotland\(^44\), has developed a useful website for professionals who work in, or have an interest in improving mental health. One of Well Scotland’s priorities is about self management and social prescribing.

A Self Management and Social Prescribing Advisory Group, established following publication of the Scottish Government’s Mental Health Strategy 2012-2015\(^45\), explored how self management and social prescribing could improve mental health and wellbeing. A number of subgroups were established, including Knowledge into Action, Building Capacity, Inequalities and Data, Monitoring and Evaluation. The Knowledge into Action group focused on examining the evidence to support social prescribing in relation to mental health, the effectiveness of these approaches as well as factors that facilitate or hinder service implementation. An implementation guidance paper\(^46\) was developed which draws on published research, local practice and evaluations, and learning from champions who are leading approaches to social prescribing in Scotland. Accompanying these papers are tools and useful case studies of initiatives in Scotland, to help staff develop self management and social prescribing approaches.

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\(^{43}\) Scottish Action for Mental Health, Know Where To Go: Your Guide; http://www.samh.org.uk/media/241903/samh_know_where_to_go_-_your_guide.pdf

\(^{44}\) Well Scotland  http://www.wellscotland.info/priorities/Social-Prescribing-and-Self-Help


Using signposting data for local health improvement

Integrated Joint Boards (IJBs) have been set up to oversee integration of health and social care services as required by the Public Bodies (Joint Working Scotland) Act 2014. It should be assumed that most communities have assets and it is up to the various local agencies, such as IJBs, to identify them and be sure that local people and professionals know about them.

IJBs and GP clusters present an important opportunity to develop a coherent policy for encourage signposting between local providers of care, as they are in a position to corral local knowledge, improve efficiency and collect data. IJBs will require a robust data infrastructure to gather information about the spread and use of community assets, which will include statutory services, the third sector and volunteering. Collecting data about local activity will inform ideas for local health improvement.

Indicators which could reflect a healthy community could include local air quality, number of cycle pathways, rate of employment, levels of income, quality of housing and education, number of local assets and access to support, number of people living with long term conditions, admission rates to hospital, number of people who are lonely and how many are living well in a homely setting. Good local collaboration will be vital to nurture healthy communities, and will be signalled by strong local relationships and high rates of signposting.

The “big data” (aggregated sets of data) resulting from pooling information could be used to share intelligence about wellbeing with the community, perhaps in simple terms such as posters in libraries, shops, schools etc to encourage interest and co-ownership of health and wellbeing services. Linking data will help indicate the impact of services, spot trends and gaps in provision, make funding and workforce decisions and plan health and social care services.
Signposting and digital technology

Barriers to collaboration and sharing data include cultural differences, disparate IT systems and the competition, which exists between organisations and sectors, especially in strained financial climates.

Digital technology systems are fundamental to support signposting in fast paced health and social care services. Digital (internet-based) technology is playing a much bigger role in our lives. The Scottish Household survey (2014) notes that 64 per cent of Scottish adults with long term conditions use the internet, however 34 per cent do not have access and this is amplified in more deprived areas. UK-wide figures suggest that 75 per cent of people search the web for health related information and many are using the internet to find out about both local and national sources of support47.

The Scottish Government’s eHealth strategy aims for a change in eHealth person-facing services in the future. This will include a ‘patient portal’ (a web site or app) where Scottish citizens will be able to access a range of eHealth services including a summary of their medical record and the ability to book appointments online. The portal could also include tailored health information and has potential to link to tools, such as ALISS to signpost people and staff to relevant local resources.

A Local Information System for Scotland (ALISS)

Accessing the right support can be as important and life changing as a medication, but you need to know what’s available. Most communities have a network of hubs offering useful support, such as libraries, faith communities, schools, general practices, voluntary groups and community clubs. However they may not be well known and directories of resources are duplicated and hard to maintain. A Local Information System for Scotland (ALISS) has been developed to address this issue by improving access and visibility of local resources.

ALISS is funded by the Scottish Government and administered by the Health and Social Care Alliance Scotland. ALISS has been developed collaboratively, with people with long term conditions, disabilities and poor literacy. An open approach has been used for all aspects of development, developing the code in open source means the system can be used and re-purposed by others worldwide. The system provides a means for people and communities to contribute and share their knowledge of local resources (assets) and directory of resources.

ALISS currently (2016) indexes information on approximately 71,000 assets which have been added by around 1,200 ALISS account holders. These include third sector, public sector and members of the public. **ALISS is supporting signposting in various environments such as:**

- General practices and the National Links Worker Programme
- Practitioners involved in Project InS:PIRE (Intensive Care Syndrome: Promoting Independence and Return to Employment) at Glasgow Royal Infirmary
- Community pharmacists and pharmacy staff who can access information about community resources through the ALISS powered search box on the Community Pharmacy Scotland website
- Scottish Fire and Rescue Service (SFRS), local authority liaison officers and home fire safety officers. An ALISS search box is embedded in the SFRS intra-net with work progressing to include this feature in the main SFRS website
- The Living It Up Programme.

The ALISS programme is collaborating with a number of health boards, local authorities, health and social care partnerships and third sector interfaces to support the development of information portals. ALISS is partnering with NHS 24 in a project which aims to create a national support services directory which will include information about community assets. The programme is also collaborating with NHS National Support Services to explore ways in which information derived from the ALISS system can be used to support responsive service planning and commissioning. The system is attracting the support of professionals and service planners who see the potential for mapping local resources, spotting gaps in provision and signposting.
Living it Up

Living it Up is Scotland’s health, wellbeing and self management website for people over 50. The website is funded by the Scottish Government, Innovate UK, Highlands and Islands Enterprise and Scottish Enterprise and is managed in partnership with a consortium of key stakeholders. Although originally designed for people living with long term conditions, the site is useful for all, as it provides information at both a local and national level and includes inspiring stories about people managing their own health and wellbeing regardless of age or situation, tools and technology to help improve health and facilitate signposting.

A significant body of evidence is being developed in Scotland, as more is understood about the link between accessing support after discharge from hospital and the nature of recovery. This has become a focus of study in the Intensive Care Unit (ICU) environment.

People who have a stay in an ICU often find the experience alarming and confusing, and significant phase of the recovery process takes place after discharge home. However, recovery may be hindered by a lack of collaborative infrastructures to support communication to ensure support after discharge.

Because of the specialised nature of ICU, people are admitted from a wide geographical area, and staff are very unlikely to know what support is available in each person’s community. Support may be available, but the key issue is knowing what’s there and how to link people with useful resources. Projects in Scotland which are exploring the impact of a stay in ICU, include Project InS:PIRE in Glasgow and the RELINQUISH and PROFILE studies in Lothian.

Project InS:PIRE (Intensive Care Syndrome: Promoting Independence and Return to Employment) project, is funded by the Health Foundation and is based in the ICU of Glasgow Royal Infirmary. The project is led by a team from NHS Greater Glasgow and Clyde, in partnership with the University of Glasgow.

The aim of InS:PIRE is to explore how the health and wellbeing of people who have been admitted to an ICU can be improved after discharge, and includes specific emphasis on recovery of family members. The team piloted a five week rehabilitation programme for ICU survivors and their family and carers, which focused on patient education, peer support and self-management. Each week participants received one hour of physiotherapy as a group, as well as individual sessions with health professionals, to help facilitate quicker recovery and return to work. Participants collaborate with clinical staff to identify and agree a number of personal outcomes to aid recovery.

The project team established a signposting system, which gives participants an opportunity to meet third sector organisations, such as a carer’s group, Glasgow Council for Voluntary Services and Citizens Advice who provide advice on local support, housing, benefits and employment.

51. UK Clinical Research Network Study Portfolio; Preventing early unplanned hospital readmission after critical illness; http://public.ukcrn.org.uk/search/StudyDetail.aspx?StudyID=18023
52. A Personal Outcomes Approach, People Powered Health and Wellbeing; the Health and Social Care Alliance Scotland http://pphw.alliance-scotland.org.uk/co-production/personal-outcomes/
Participants were encouraged to look for their community resources, using ALISS to find formal and informal support in their local area. Examples includes signposting a participant to an Open University Access Course, a participant with a physical disability to advice about driving, and another to volunteering opportunities, as a first step towards regaining employment).

InS:PIRE is already making a difference to ICU survivors and their carers, interviews with participants have demonstrated positive benefits to both their psychological and physical health. The benefits to project staff can be seen in a short film produced by the People Powered Health and Wellbeing Programme ‘Inspiring Better Outcomes’ which explains how the team were supported to adopt a personal outcomes approach. Project InS:PIRE has awarded further funding from the Health Foundation to scale the project across Scotland.

RELINQUISH (Recovery following critical illness, a Longitudinal Qualitative exploration of perceived healthcare and Support needs among ICU survivors: developing timely interventions following Hospital discharge), aimed to find out more about people’s healthcare and social support needs during the year after discharge home from an ICU in Lothian.

The project found that people required a broad range of physical health, emotional and wellbeing support such as housing, financial support and employment, and that the need for support developed and changed over time. Family and carers often didn’t know where to turn to get the right help at the right time. A lack of signposting made the recovery process much more prolonged and difficult. One of the outcomes of the RELINQUISH study has been development of a website, RECOVER plus, to signpost people and staff to community-based resources including third sector organisations and charities. The website provides information on common physical problems which may arise after a stay in an ICU and includes patients’ stories, videos and a chat room to share experiences.

The RELINQUISH study supports preliminary findings of PROFILE (Preventing Early Unplanned Acute Hospital Readmission Following Critical Illness), which is ongoing at time of writing (2016). Research by the University of Edinburgh’s critical care research group has shown that 23 per cent of people admitted to intensive care units in Scotland have an early (90 days or fewer) unplanned readmission to an acute medical ward, which has an obvious impact on people’s lives and may represent an inefficient use of resources. The PROFILE study aims to understand the experience of ICU patients and their family members and carers from hospital discharge to recovery in the community and to identify risk factors which may influence an early unplanned readmission to hospital.

One of the preliminary findings in the PROFILE study, suggests that preventing and reducing the risk of readmission requires awareness of the value of signposting and improved communication across critical, acute and primary care services and between community social and third sector services.

55. Project InS:PIRE; Inspiring Better Outcomes, People Powered Health and Wellbeing, Health and Social Care Alliance Scotland; http://pphw.alliance-scotland.org.uk/resource/project-inspire-inspiring-better-outcomes/
56. Recover Plus; http://www.criticalcarerecovery.com
Signposting and the third sector

The Improving Links in Primary Care project found that mapping local assets improved local relationships and knowledge and understanding of local community resources. This was seen as being an important way to learn about resources to support self-management. As one GP noted, “I think from our perspective, the important thing was we’ve known lots has been going on out there locally, but we’ve never had the opportunity to systematically map it, or collate before; and the project, to me, has been an absolutely fantastic opportunity for us as a practice to see exactly what’s out there. I see it as a stepping stone onto a much, much bigger self-help agenda.”

A number of resources are available to support asset mapping, such as the ALISS Asset Mapping pack, which describes the process and tools. The process of asset mapping is described by the People Powered Health and Wellbeing programme in a blogpost.

The third sector is a major provider of health and social care services in Scotland, 55 per cent of the sector is employed in social care or health, with a further 17 per cent employed in housing, which has vital link with health. The third sector in Scotland is made up of around 45,000 organisations, large and small – charities, community groups, social enterprises and voluntary organisations. They have a collective annual income of £4.9 billion and deliver a range of good causes with support of 1.3 million volunteers, 180,000 trustees and 138,000 paid staff.

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58. ALISS Asset Mapping pack, the Health and Social Care Alliance Scotland, http://www.alliance-scotland.org.uk/aliss-resources/
Many third sector organisations are community-based, and so have a detailed “bottom-up” understanding of the issues affecting people’s lives and an ability to reach people in need. Examples of third sector activity:

- Prevention, supporting self-care and self-management
- Supporting people with learning difficulties, long term conditions
- Counselling, mental health and recovery support
- Addiction services - alcohol and drugs
- Children and older people’s services
- Palliative care
- Provision of health and social care services
- Supporting people who are lonely, befriending
- Cognitive and physical impairment
- Provision of aids and adaptations, care and repair schemes
- Supporting carers
- Shopping services
- Community food and health initiatives, patient transport, volunteer driver schemes
- Accommodation, housing and tenancy support
- Advocacy, advice and information
- Human rights, social enterprise, volunteering

A good example of the connecting role of the third sector is Community Health Exchange (CHEX), which supports and promotes community development approaches to health improvement. CHEX provides support to networks of community led initiatives with a focus on addressing health inequalities. CHEX play an important role in linking community initiatives with statutory sector and voluntary organisations and their publication - More Communities at the Centre\(^{60}\) includes case studies of people in communities being involved in considering the health priorities that matter to them.

Organisations such as the Scottish Consortium for Learning Disability\(^{61}\) and Enable\(^{62}\), have also been championing person centred approaches and linking people to support through the role of Local Area Co-ordination for many years.

Voluntary Action Scotland, have produced evidence of the contribution of the third sector\(^{63}\) and the impact of Scotland’s third sector interfaces (TSIs). TSI’s have a valuable connecting role across third, public and private sector partners, and have a focus on local activity and community priorities.

Like all other services, it is hard to measure the preventative effect of the third sector’s contribution, but the following examples show how multi-sector partnerships are very likely to be improving health and wellbeing and preventing and managing crisis.

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60. More Communities at the Centre; Evidencing community-led health; CHEX, http://www.chex.org.uk/
61. Scottish Centre for Learning Disabilities, accessed 03 05 14 www.scld.org.uk/local-area-co-ordination
62. Enable http://www.enable.org.uk/Pages/Enable_Home.aspx
Penumbra The Edinburgh Crisis Centre

The Edinburgh Crisis Centre is run by Penumbra and is a partnership with NHS Lothian, City of Edinburgh Council, Edinburgh Carers Council and Edinburgh Crisis Centre Users Group. This unique service provides a 24 hour helpline for people aged 18 or over who live in Edinburgh and are experiencing social or emotional distress. Support can also be provided to people who are carers or supporters of someone experiencing distress.

Service users receive sensitive, one to one support and information and the centre provides a safe private space for people in distress to receive support along with the possibility of staying at the centre for up to seven nights.

Table shows reasons for contact (providers by users at first contact) with Penumbra, over a 12 month period. ‘Other’ refers to when no reason for contact provided or the contact was incomplete.

The British Red Cross (BRC) provides a Home from Hospital Service across the UK. In
The British Red Cross

Scotland, the service operates in Glasgow, North Lanarkshire and Ayrshire, supporting the work of the Emergency Departments in eight acute hospitals. Each service has its own access criteria and although support is targeted at older people, it is available to vulnerable people over eighteen years of age.

The service varies to suit local priorities but may include the following:

- Transport from hospital to home in a BRC ambulance, with trained staff
- Ensuring the person is safe and settled at home, which may involve checks on home safety and security, utilities, availability of food, contacting family, friends or agencies, helping with practical tasks (for example, dealing with pets, making a snack, clearing rubbish)
- A follow-up telephone call within 24 hours of discharge to check on the person’s wellbeing and contact statutory services if any concerns
- In selected cases, a worker will arrange a follow-up visit and, if required, provide short-term support
- Other support includes arranging transport to hospital appointments and supplying mobility aids such as wheelchairs.
Samaritans, who have 20 branches across Scotland, offer confidential services to support people who are feeling distressed, in a state of despair, suicidal or need emotional support. In the period 2010 - 2014 Samaritans in Scotland had 1.152m contacts through branches across the country via telephone, SMS, email and in person.

The table below shows telephone, email and SMS contacts received by Samaritans by hour of day for the month of March 2015, which is consistent with other months of the year.

**March 2015: % of total contacts received by hour of day**

![Graph showing contacts by hour of day for March 2015.](image-url)

- **Telephone**
- **Email**
- **SMS**
Developing a signposting approach

Signposting should be regarded as a component of a long term, whole system approach rather than a one off project, initiatives can only be sustained if co-produced with local people and groups and integrated with hubs such as local public services, general practices, libraries, voluntary and third sector groups.

However, the very simplicity of mutual signposting belies its challenges - it doesn’t just happen, it requires an awareness of the value of every single contact with other human beings, empathy, skills in finding, understanding and using information (information and health literacy), a knowledge of local and national sources of support and organisational, digital and technical skills.

The London Borough of Bromley Primary Care Trust hosted a workshop in 2002 to explore social prescribing, which identified six prescribing factors:

- Information with advertising and directory access but no face-to-face contact
- Information and telephone line with advertising and patient self-initiated telephone discussion with a health worker
- Primary care referral to social prescribing appointment
- Primary care referral or self-referral to clinic in general practice acting as a “one-stop-shop”
- Primary care referral or self-referral to clinic in general practice also offering advice, referral or signposting onwards
- Non-primary care referral from practice-based staff sent to referral centre offering one-to-one facilitation

Developing a Culture of Health

Therapeutic conversations

The first step in signposting is talking and listening, linking people to support often needs patience, and an ability to judge how and when to introduce new ideas. It may involve having difficult conversations, as people may feel emotional, embarrassed and find it hard to articulate their feelings.

Conversations in health can have a huge impact in people’s lives, with words lingering in the mind for a long time, they may necessarily have a narrow clinical focus or be broader in range, sharing knowledge and decisions and exchanging information about available support. This is usually dependent on the time available and practitioner’s interest and knowledge of sources of support.

Consideration may need to be given to details such as what words to use, what approach to take in someone’s home, how to have conversations with an interpreter or carer present, how to explore options, share information, prioritize issues, how to take account of complex needs. This requires consideration of social, emotional and practical support and individual belief systems.

Where these conversations take place is also important - places outside the usual health buildings can be more fitting as they are less intimidating than a consultation room. This approach is taken by many third sector organisations, the Links Health Walks are a good example of how walking and talking can be therapeutic for all. This aspect of connecting is explored in Conversation that Change Lives - a leaflet produced by the PPHW programme.

Therapeutic conversations are a focus of numerous initiatives, such as the Thistle Foundation’s Lifestyle Management course, Community Renewal and TheWEL initiatives. The essential core underpinning TheWEL is the process of change. People are guided into a self-enquiry where they develop an awareness of health and wellbeing, and critically, an approach based on self-compassion.

66. Community Renewal; http://www.communityrenewal.org.uk/
67. TheWEL; http://www.thewel.org/theWEL/Home.html
Mapping local assets

“ My mother’s name was Joan Whitelaw. She had been: a daughter, a sister, a wife, a mother, a friend. Six years ago, I walked out of a hospital with my mum after her diagnosis of dementia and we walked out alone, with no support. For this reason I am committed to raising awareness of the impact of dementia on families so that nobody else should have to go through the loneliness and isolation that I did. People don’t know that there’s support out there, helping them get it really makes a difference.”

Mapping assets can help to:
- meet others in local area, form relationships, swap notes
- prompt conversations about keeping well and making connections
- reveal ‘hidden’ services, activities and places
- prompt people to think about who and what’s in their local network
- how they might link with local people, group and services
- generate ideas on how to share this information
- develop ideas about how to use local information

Mapping local assets is a useful way to find out about available support and to meet others in the community with a common purpose. Assets can be mapped simply by getting together and can start by inviting participants to think about “what helps you to keep well?”

Participants are encouraged to share personal experiences and recommendations of activities, places, organisations and examples of what they do to be healthy and happy.

68. Tommy Whitelaw; Dementia Carers’ Voices Health and Social Care Alliance Scotland; http://www.alliance-scotland.org.uk/what-we-do/our-work/voice-of-lived-experience/dementia-carer-voices/

69. ALISS resources; http://www.alliance-scotland.org.uk/what-we-do/our-work/digital-and-technology/
House of Care

The House of Care\(^70\) is a model which helps to make sense of the various contributors to living well in communities. Each of the structures, the roof, foundation and the two walls of the house, represent the essential elements needed to enable people to be in the driving seat of their care. The House of Care is useful as it illustrates the components required to ensure that care and planning conversations link people to sources of support – which is whatever they consider keeps them well. Mutual signposting and referrals, represent the criss-crossing pathways which connect the structures of the house.

ALISS is a valuable element of the foundation of the House of Care, because of its role in gathering and sharing information about sources of support, and in gathering data which can be used to guide allocation of resources.

The House of Care Adopter Programme, directed by the Health and Social Care Alliance Scotland (the ALLIANCE), works with five sites – Ayrshire & Arran, Greater Glasgow and Clyde, Lanarkshire, Lothian and Tayside. The focus of the programme is on ensuring people living with long-term conditions:

- are empowered by the model of care and the care planning process
- are enabled to articulate their own needs, deciding on their own priorities, supported by health and social care professionals through a collaborative conversation
- are supported to develop the knowledge, skills and confidence to manage their condition(s) effectively in the context of their everyday life; and
- have an improvement in their experience of care, which should become more coordinated, with a measurably improved ‘patient experience’.

The Royal College of General Practitioners, both at a Scotland and UK level, are strongly committed to supporting developments in collaborative care and support planning, viewing it as fundamental to the change required to address the crisis in general practitioner recruitment. Their Blueprint for Scottish General Practice\(^71\) and 2016 Manifesto make explicit mentions of their support for the House of Care programme in Scotland.

\(^70\) Scotland’s House of Care [online] Available at https://houseofcare.wordpress.com/ [Accessed: 12 February 2016]

\(^71\) Royal College of General Practitioners (Scotland) Blueprint for General Practice; 2015; http://www.rcgp.org.uk/rcgp-nations/~/media/Files/RCGP-Faculties-and-Devolved-Nations/Scotland/RCGP-Scotland/Blueprint-2015/RCGP-Scotland-Scottish-Blueprint-for-general-practice.ashx
Considerations when setting up signposting approach

A number of issues should be addressed when setting up signposting systems:

- National context, how will systems contribute to national policies for future models of care such as integration and care in homely setting.
- Local context, how do systems fit with local civic conversations (for example local development plans for environment, transport, local authorities, housing, community groups, health and social care).
- Cost of infrastructure to set up and sustain signposting process.
- Signposting may initially create additional demand as previously hidden unmet needs are addressed, however may save cost in longer term, particularly if people are linked to employment opportunities.
- If appropriate, choose models of community connectors / link workers.
- Consider capacity of statutory, voluntary and third sector groups to cope with an increase in signposting to their resource. Note should be taken of the number of times people have been turned away, due to lack of resource and these audits shared with IJBs. This will help indicate unmet need and track improvement in communities.
- Governance and accountability, for instance, assessing risk and the process to follow if party to confidential information. (This key issue has been addressed in the National Links Worker Programme who have produced a Record of Learning series, one of which references governance and information sharing protocols).
- Collecting data to indicate strength of local integration. Collecting this data would contribute to knowledge about whether people who most need support get it.
- Seek people in communities who are in position to signpost and who may have contact with people in their homes (for example voluntary sector, community nurses, social care workers, postmen, police, pharmacists, community development workers, mental health teams). There are also usually some local “town criers”, well-known, skilled communicators, who are part of large networks, such as volunteers in lunch or sports clubs, health visitors, librarians.
- Consider targeting signposting initiatives in areas of high demand, such as deprived areas, Accident and Emergency departments.
- Consider how to share information and keep directories of local information up to date.
- Consider training in aspects of community connecting, for example:
  - developing a links approach and forming local relationships.
  - individual and community health literacy.
  - having therapeutic conversations with people with diverse health beliefs and cultures (talking about debt, relationships, bereavement).
  - how to access local resources (on and off line).
  - mapping local assets.
  - the role of advocacy, signposting is an important factor in helping people to access a range of sensitive information (eg financial benefits, employing help in the home, support with mental health).
Conclusion

This report has highlighted just a few of the many initiatives across Scotland and the UK, which are influencing ideas about how connectedness can improve outcomes and both individual and system level. The benefits of friendly local relationships, collaborative infrastructures and refining knowledge in a more systematic way seems like common sense, however these benefits are not yet fully realised across the nation. Infrastructures such as integrated joint boards, general practice clusters and the inter-sector working recommended in numerous policy documents, have potential to address this by providing the frameworks needed to support improvement - provided adequate funding is available to sustain development.

Scotland is in a very good position to encourage a culture of health through connected communities. Recent government policy indicates a move to de-mystify medicine and foster a shared approach to making decisions about our health. This encompasses a more democratic approach to health - one which recognises that medicines and clinical interventions will always be necessary but that support from outside health buildings and the links between them have equal value. Signposting is one small part of a much wider connected system, one which connects us to whatever keeps us well and happy. Being linked to the right support, in the right place at the right time can change lives and contributes to developing a culture of health.
Resources

Health and Social Care Alliance Scotland  
www.alliance-scotland.org.uk/

The National Links Worker Programme – Records of Learning  
http://links.alliance-scotland.org.uk/resources

ALISS A Local Information System for Scotland  
www.DALISS.org

The ALISS asset mapping pack  
https://www.aliss.org/about/

Scotland’s House of Care  
https://houseofcare.wordpress.com/

Health Improvement Scotland, Living Well in Communities  

Self-management and social prescribing for improved mental health  
Website provides links to information, case studies, information and tools  
http://www.wellscotland.info/priorities/Social-Prescribing-and-Self-Help

Health Literacy Place – Scotland’s Action Plan for Health Literacy  
Website provides links to information, case studies, information and tools  
http://www.knowledge.scot.nhs.uk/healthliteracy.aspx

Alzheimer Scotland - Dementia Advisors support individuals, families. The role involves signposting,  
community connecting and capacity building.  
http://www.alzscot.org/services_and_support/dementia_advisers_and_other_local_advice

Values into Practice, A Framework for Local Area Coordination in Scotland  
Social Prescribing for mental health – a guide to commissioning and delivery

Campaign to End Loneliness – a toolkit for health and wellbeing boards
http://campaigntoendloneliness.org/toolkit/why/

Thanks for the Petunias, Guide to developing and commissioning non-traditional providers to support the self-management of people with long-term conditions
http://personcentredcare.health.org.uk/sites/default/files/resources/thanks_for_the_petunias_-_a_guide_to_developing_and_commissioning_non-traditional_providers_to_ssm_for_people_with_ltcs.pdf

Evidence to inform the commissioning of social prescribing, February 2015
University of York, Centre for Reviews and Dissemination
https://www.york.ac.uk/media/crd/Ev%20briefing_social_prescribing.pdf

Social Prescribing – A Review of Community Referral Schemes, University College London;
https://www.ucl.ac.uk/museums/research/museumsonprescription/Social-Prescribing-Review.pdf

Asset-Based Community Development (ABCD) North Western University, USA.
Asset mapping tools:
http://www.abcdinstitute.org/toolkit/

Ways to Wellness - Link Workers provide support to people with certain long-term health conditions in Newcastle West.
http://waystowellness.org.uk/

The social and economic impact of the Rotherham Social Prescribing Project
http://www.varotherham.org.uk/social-prescribing-service/
Further Reading


ALISS Health Literacy Report
http://www.alliance-scotland.org.uk/aliss-resources/

ALISS Report 1 and Report 2
http://www.alliance-scotland.org.uk/aliss-resources/

General Practitioners at the Deep End Reports
http://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend/reports/

The Links Project; Developing the Connections between general practices and communities
http://www.scotland.gov.uk/Publications/2012/05/1043/0

The Improving Links in Primary Care

Enabling Health and Wellbeing among older people, capitalizing on resources in deprived areas through general practice
http://www.gla.ac.uk/media/media_282275_en.pdf

Dundee Healthy Living Initiative
http://www.dundehealth.co.uk/

Scottish Consortium for Learning Disabilities LAC National Development Project
http://www.scld.org.uk/local-area-co-ordination

Fair Society, Healthy Lives; The Marmot Review. Strategic Review of Health Inequalities in England post 2010
http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

Why Social Prescriptions are just what the doctor ordered. Guardian, 3 November, 2013
http://www.theguardian.com/society/2013/nov/05/social-prescribing-fishing-group-doctor-ordered

The Living Better Report
Time to Care Report, Royal College of General Practitioners (Scotland)

The Enabling State, Carnegie Trust
http://www.carnegieuktrust.org.uk/publications/2012/the-enabling-state---a-discussion-paper

Developing Social Prescribing and Community Referrals for Mental Health in Scotland; 2007,

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http://www.scotland.gov.uk/Publications/2010/05/10102307/0

Report on the Future Delivery of Public Services by the Commission (The Christie Report) Scottish
Government, June 2011
http://scotland.gov.uk/Publications/2011/06/27154527/0

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http://www.nesta.org.uk/events/assets/features/mass_localism

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demos.co.uk/files/Unlocking%20innovation-web.pdf

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why it matters and how it can be accelerated:
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can save money and save lives, NESTA, 2009
http://www.nesta.org.uk/publications/reports/assets/features/the_human_factor

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The NHS in 2030; A Vision of People-Powered, Knowledge-Powered Health System. NESTA, 2015