Implementing the Links Approach

‘Links Worker’ Roles

Social Determinants in Primary Care

In Our Words: stories from the National Links Worker Programme

Team Wellbeing in General Practice

Record of Learning
Series 2

Defining the Links Approach
building the primary care links approach conceptual framework

Other available series 2 modules:
# Record of Learning
## Series 2

## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td><strong>PART ONE: Relevant context of the Links Approach</strong></td>
<td>1</td>
</tr>
<tr>
<td>The impact of socioeconomic inequalities and social determinants of health</td>
<td>1</td>
</tr>
<tr>
<td>Mitigating the impacts of social determinants of health</td>
<td>2</td>
</tr>
<tr>
<td>Capacity in general practice</td>
<td>3</td>
</tr>
<tr>
<td>The limits of target driven care</td>
<td>3</td>
</tr>
<tr>
<td>The failure of the case management approach</td>
<td>4</td>
</tr>
<tr>
<td>The weakening of the generalist function</td>
<td>4</td>
</tr>
<tr>
<td>Unmet need and the inverse distribution of care</td>
<td>5</td>
</tr>
<tr>
<td>The Links Worker Programme: building capacity in general practice</td>
<td>6</td>
</tr>
<tr>
<td>The general practice team embedded links worker</td>
<td>7</td>
</tr>
<tr>
<td>Integration, transformation and evolution</td>
<td>9</td>
</tr>
<tr>
<td><strong>PART TWO: Components and features of the Links Approach</strong></td>
<td>10</td>
</tr>
<tr>
<td>Seven Primary Care Team Capacities</td>
<td>10</td>
</tr>
<tr>
<td>Capacity one: team wellbeing</td>
<td>10</td>
</tr>
<tr>
<td>Capacity two: shared learning</td>
<td>11</td>
</tr>
<tr>
<td>Capacity three: awareness</td>
<td>12</td>
</tr>
<tr>
<td>Capacity four: intelligence</td>
<td>13</td>
</tr>
<tr>
<td>Capacity five: signposting</td>
<td>13</td>
</tr>
<tr>
<td>Capacity six: problem solving</td>
<td>13</td>
</tr>
<tr>
<td>Capacity seven: network building</td>
<td>14</td>
</tr>
<tr>
<td>Self management and living well</td>
<td>15</td>
</tr>
<tr>
<td>Self determination theory</td>
<td>16</td>
</tr>
<tr>
<td>Personal outcomes</td>
<td>17</td>
</tr>
<tr>
<td>Health Competence</td>
<td>17</td>
</tr>
<tr>
<td>Dignity and autonomy</td>
<td>17</td>
</tr>
<tr>
<td>Relatedness</td>
<td>17</td>
</tr>
<tr>
<td>Conclusion</td>
<td>18</td>
</tr>
<tr>
<td>Bibliography/Further Reading</td>
<td>19</td>
</tr>
<tr>
<td>About the ALLIANCE</td>
<td>20</td>
</tr>
<tr>
<td>About GP’s at the Deep End</td>
<td>21</td>
</tr>
</tbody>
</table>
Introduction

Building on the Primary Care Links Approach Conceptual Framework Paper, authored by the Links Worker Programme’s Clinical Lead, which originally set out the rationale and theoretical framework which underpins the National Links Worker Programme (NLWP), this module draws on learning from the experience of the programme and wider developments to date. It aims to provide an understanding of the components of the links approach, including the seven identified primary care team capacities that comprise this, as well as the theory of self-determination that is key to the personal outcomes the programme seeks to help participants realise. It sets these within relevant contexts such as social and health inequalities and the current pressures on general practice, particularly those serving socioeconomically deprived communities.

PART ONE: Relevant context of the Links Approach

The impact of socioeconomic inequalities and social determinants of health

As the charts below show, inequity in life expectancy between the most deprived and least deprived 20% of Scotland’s population stubbornly persists.

Figure 1. Average Life Expectancy at Birth, Scotland 1999-2000 to 2009-10

The difference in healthy life expectancy (HLE) for the most and least deprived 20% of the population is even more marked. In 2011-12, HLE at birth for the least deprived 20% (69.1 years) was 20.8 years longer than for the most deprived 20% (48.3 years).

Healthy life expectancy: key points. Life expectancy (LE) is an estimate of how many years a person might be expected to live, whereas healthy life expectancy (HLE) is an estimate of how many years they might live in a ‘healthy’ state

This means people living in our most socioeconomically deprived communities can expect to become affected by chronic long term health conditions in their 50s as opposed to their 70s for those living in the least deprived. GP practices in socioeconomically deprived areas therefore support a much greater number of people with multiple conditions from a younger age.
Multiple Conditions refers to the presence in an individual of a combination of more than one physical condition and/or physical condition(s) alongside mental health conditions, these are often exacerbated by complex social issues. Sometimes referred to as multi-morbidity in medical parlance.

Other recent research suggests that the compound health impacts of socioeconomic deprivation are the key factor behind these figures. Life expectancy across Scottish cities is not systematically lower once deprivation is accounted for (BMC Public Health 2015 15:1057). This only strengthens the case for both tackling structural causes of deprivation at source and targeting interventions in socioeconomically deprived areas if there is to be any likelihood of reducing health inequity in Scotland.

While the National Links Worker Programme is heavily influenced by the agenda around tackling health inequalities, these are a deep rooted, long standing and widespread phenomena in Scottish society. At the scale of the originally funded programme (working in seven GP practices for two years), it would therefore have been unrealistic to have explicitly claimed that making an impact on health inequalities was likely to be a demonstrable outcome for the programme in terms of being measurable by the external evaluation being applied to it. During the development phase which preceded live delivery, the articulated aims of the programme therefore became:

1/ Mitigating the negative impacts of social determinants of health through enabling people to live well and supporting them to access local resources.

2/ Contributing to the evidence base around this way of working.

The programme can therefore be viewed as a response to health inequity that will help inform future direction without needing to be understood as something that will necessarily on its own, certainly at its original scale of delivery, possibly be able to lead to a marked reduction in such.

Mitigating the impacts of social determinants of health

Social Determinants of Health (SDH) are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems.

Specific examples include:

- Availability of resources to meet daily needs (e.g., safe housing and local food markets)
- Access to educational, economic, and job opportunities.
- Access to health care services.
- Quality of education and job training.

The World Health Organisation’s Declaration of Alma Ata in 1978 affirmed that “the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector” and condemned “the gross inequality in the health status of the people”. These words continue to resonate. The recent Commission on the Future of Public Services in Scotland (The Christie Report) identified that the greatest challenge facing public services in Scotland is to combat the negative outcomes for individuals and communities arising from deep seated inequalities.

The gap between the top and the bottom income distribution for key outcomes is wider in Scotland than other European countries,
and the experience of social adversity is highly geographically localised in Scotland, leading to a clustering of poor outcomes which include employment, learning and safety as well as health. Quite apart from the social justice implications of this reality, one consequence of this is that a high proportion of demand for public services in Scotland is driven by problems that are potentially preventable and arise from adverse social circumstances.

The experience of the programme to date fits with the understanding that there are two levels on which these problems are preventable. At the strategic level policies which facilitate a more even distribution of wealth and stimulate appropriate investment in those localities of highly clustered multiple deprivation are needed. At an individual level greater autonomy and control over health can be attained by individuals through accessing, and being supported to access, relevant sources of support that can help in beginning to address issues which they have identified as inhibiting their ability to live well.

In addition to the operational effectiveness of the programme it is therefore also important that the learning being gained is used to influence strategic developments in order to help reduce inequity in the manifestation of these social determinants across the population in the first place, as well as to mitigate their negative impacts in those communities where they are currently most keenly felt.

Capacity in general practice

Priorities identified in the Christie Report included the need to maximise scarce resources by utilising all available resources from the public, private and third sectors, individuals, groups and communities and to work closely with individuals and communities. The efforts of all services should focus on delivering integrated services and prioritising preventative measures to reduce demand and lessen inequalities. The report identified the need for both culture change within public services and reconfiguration in order to meet these priorities.

The traditional model of health care espoused by many GPs, as expressed for example in the Royal College of General Practitioner’s Vision for the Future of General Practice in Scotland is that of a bio-psychosocial model of health with the long term doctor-patient or nurse-patient relationship as the key. However over the past decade this model has been subsumed by two competing models of health care: target driven care, and case management models. The dominance of these models, coupled with the unequal distribution of health resources relative to need has engendered an endemic state of crisis management, which means that primary care teams in deprived communities are now heavily compromised in their ability to deliver personalised health care and to “understand needs, maximise talents and resources, support self reliance, and build resilience.” (Christie Report).

The limits of target driven care

One of the great advances in medical practice over the past two decades has been in the establishment of a rigorous research and evidence base for cost-effective interventions in many long term conditions. The National GP Contract, introduced in 2004, used a system of target based payments to incentivise the widespread adoption of evidence based management of long term conditions across Primary Care. This resulted in GP practices being better organised and delivering effective interventions more systematically across their populations.

Ten years later however, GP practices across Scotland find themselves facing a very difficult future, imbued with a sense of crisis. The target driven approach has been unable to cope with the emerging health care needs of the 21st Century.
Emerging health care needs of the 21st century

- greater prevalence of people with multiple conditions
- polypharmacy (the use of four or more medications by one individual)
- environment-driven lifestyle changes
- increasing mental health problems & addictions
- evolving methods for patient information provision
- an increasing focus on self-care & self-management
- increasingly complex health and social care needs

Attempts to annually update targets to try and adapt to these demands placed enormous resource burdens on practices, with the need to produce data to sustain funding becoming an increasing drain on resources rather than an incentive to quality improvement. The phrase “running faster to stand still” is apt in encapsulating this state of affairs. Targets had become a barrier to quality improvement, not a facilitator.

The focus of targets on disease specific approaches with outcomes narrowly defined as clinically measurable indices (such as blood pressure, smoking status or clinical outcomes) has failed to address the reality of an increasing number of individuals affected by multiple conditions arising in socially complex environments.

The dominance of this reactive disease based model has contributed to the fragmentation of services, the creation of a wide culture of dependence on prescribing and medical interventions and the widening of health inequalities. This has now been recognised by the Scottish Government, who have announced the dismantling of the Quality & Outcome Framework in the national GP contract from April 2016.

The failure of the case management approach

Alongside target driven care, case management has been the favoured approach developed for the delivery of services in the community. This has been widely adopted by Community Health Partnership services and specialist community outreach teams. The past decade has seen a proliferation of case management teams characterised by names derived from acronyms, referral pathways, inclusion and exclusion criteria, allocation meetings, waiting lists, case loads, and other managerial tools. The strength of this approach is in the ability to record activity and throughput and to create efficient structures around systems of accountability. In many ways such services do what they do well, for those patients who ‘fit’ the predefined ‘caseness’ on which the service is predicated.

However, many people do not neatly fit with entry criteria, are not good at accessing services, still need help after discharge and are unable to negotiate the complex and sometimes baffling structures put in place to protect the ‘caseness’ of the service. There has also been a high cost in duplication of systems, protection of team boundaries, and a growing collusion of anonymity through overly bureaucratical avoidant structures failing to take responsibility for the numbers of complex and multi-faceted cases which are left for GPs to manage unsupported.

A consistent finding from the Deep End Project is that patients in socioeconomically deprived areas need referral services which are quick, local, flexible and familiar. Too many referral services lack these qualities and are accessed less successfully as a result. The treatment burden which falls on patients is particularly hard for those with multiple conditions.

The weakening of the generalist function

The Royal College of General Practitioners and the British Medical Association have both warned that General Practice is currently facing a recruitment crisis and that the profession is facing a series of threats to its ability to deliver a safe and sustainable service. One factor which has led to this difficulty has been the relative disinvestment in Primary Care as compared to investment in more expensive ‘downstream’ specialist care services: a fall of
20% over the past ten years compared to the overall NHS budget. Despite providing over 90% of all patient contacts with the NHS, funding for General Practice is currently at a historic low level of 7.8% of the Scottish NHS budget. This represents a cumulative loss of £1.1 billion pounds of investment in the past ten years compared to a scenario in which funding had stayed at the level (9.8%) it was in 2005/2006 (RCGP Scotland, A Blueprint for Scottish General Practice, July 2015).

Alongside this weakening of general practice, services which used to be closely allied with general practice, such as district nursing, health visiting and sometimes social work, have been withdrawn to area-based work. The consequent weakness of the generalist function, which is able to deal with patients’ problems close at hand, and which is so necessary for the “gatekeeper” function to work (when patients are confident in primary care, they are less likely to present at hospital) has resulted in the fragmented and dysfunctional nature of community based care. Primary Care as a whole is less able to deliver on the vision for integrated person centred care than it was in 2004.

A person-centred approach means focusing on the elements of care, support and treatment that matter most to the patient, their family and carers.

Unmet need and the inverse distribution of care

In addition to this general pressure being faced by all GPs, a recent study funded by the Chief Scientist’s Office has found that those practices who serve the poorest Communities in Scotland are facing particular further pressures. The study has shown that the allocation of funding tends to favour practices in more affluent areas. This is true even in absolute terms (the average funding provided per patient per year) but is particularly marked if the level of complex multiple health problems is taken into account. More specifically, the poorest 40% of the Scottish population suffer from 47% more complicated multimorbidity (either 5+ conditions or the combination of mental and physical health problems) yet receive 8% less GP funding per patient per year (Br J Gen Pract 2015 Dec; 65 (641): e799 -e805). This is a key public health issue if the 2020 vision is to be realised and the problem of health inequalities in life expectancy across Scotland’s people is to be lessened.

The inverse care law describes a perverse relationship between the need for health care and its actual utilisation. In other words, those who most need medical care are least likely to receive it. Conversely, those with least need of health care tend to use health services more (and more effectively).

Figure 2. GP Funding Exacerbates the Inverse Care Law in General Practice

Beyond the statistics, the daily experience of Deep End practice teams is of being faced with a very high demand for GP availability, complex consultations with multiple physical and mental health needs to address, being expected to respond to the health impact of pressing social and economic problems and trying to support people whose resources for self-management – finances, life skills, health literacy, social support or adequate housing arrangements – are often compromised.

Additionally, a feature of the inverse care law holds that, in general, people living in socioeconomically deprived areas are not expressive in their demands and can have very low expectations, even though they have the lowest life expectancy and most unfavourable health outcomes. This has resulted in those with the greatest health needs falling behind and being ignored by a system struggling to cope.
The Links Worker Programme: building capacity in General Practice

The Links Worker Programme should be understood as an intervention that is being targeted not simply at the individuals who access the services of a Community Links Practitioner, but as a systems intervention which aims to act as a catalyst to wider changes in the primary care team. The provision of a CLP is only one of these changes. The underpinning goal is to assist general practice teams to develop new capacities to become more effective in enabling patient self management and supporting people to live better. This involves finding ways to strengthen the general practice team within the realities of the constraints which they face, to build on the biopsychosocial orientation and to foster a wellbeing centred culture of care.

**Self management** is about people living with long term conditions being in ‘the driving seat’. It supports people to live their lives better, on their terms. Self management supports and encourages people living with long term conditions to access information and to develop skills to find out what’s right for their condition and, most importantly, right for them.

The term **living well** or **living better** is used in the wider context of supporting people in the same manner even if they would not necessarily identify themselves as having a long term condition.

While there is clearly an urgent need for funding inequalities to be rectified through a new GP contract funding formula, this will always be a blunt tool, subject to many competing interests, and limited as a mechanism for resource distribution in Primary Care. If serious attempts to devise approaches that might successfully tackle health inequalities are to be made, new models to target resources effectively are needed, models that will both reach those with the greatest health needs and create a transformation in practice capacities and culture. The investment in Deep End practices through the Links Worker Programme creates a model for investment in Primary Care that is targeted at mitigating the impact of health inequalities through strengthening the capacity of general practice teams in the following ways:

1. Planning care more effectively around the needs of those that have the most complex health and social care needs, and who are the most vulnerable and least equipped for managing their own health independently.

2. Creating an ethos of awareness of social factors and a proactive response by clinicians and Community Links Practitioners to support resilience in individuals facing crisis or experiencing acute social need.

3. Enabling practices to develop the capacities to become more outward looking and connected within their communities, to strengthen their understanding of community assets, thus enabling them to help patients to access the health, social and third sector support that they need at that time.

4. Helping to build capacity, among both statutory and third sector community resources, in identifying and developing responses to unmet need as well as in sharing the learning being gained in terms of opportunities for optimising systems so that they may become more accessible and responsive to individuals for whom they are intended to benefit.
There is an increasing interest in the development of links worker models to improve collaboration and communication within public services and to enable people with complex personal circumstances to access resources to support them. The rationale for links workers is that if individuals feel supported in their lives they are more likely to respond to information on ways to improve their health. If these people were to be successfully supported sooner rather than later then there is a potential that their risk of developing long term conditions would be reduced or further complications delayed/prevented if they have already contracted long term illness(es).

The evidence base for links worker interventions is currently limited although there is some, mainly qualitative, evidence which suggests that links workers have a positive impact in helping individuals to make positive behavioural changes. That evidence base however is growing as a result of a number of recent initiatives to develop the role. Within Scotland these include for example the Dundee Sources of Support Links Worker Programme and Keep Well outreach workers as well as links workers being developed by a number of third sector organisations.

A recent publication by University College London which presented a review of evaluations of projects that have included a focus on social prescribing, and taken place within the UK over the past 20 years, does also mention a range of positive findings, including reduced A&E visits and outpatient hospital appointments, significant improvement in depression, fewer GP visits, reductions in anxiety, and increased physical activity amongst other benefits. An overarching objective of the National Links Worker Programme is to make a unique contribution to this evidence base.

There are several concerns however regarding the links worker role in relation to primary care teams. The first of these is their limited capacity to meet the scale of need on their own. A need for social signposting or additional support resources was identified in approximately one in five consultations in a study carried out by the Links Project in 2011 among six Deep End GP practices. Given that more than 90% of all NHS contacts occur within the primary care team, this represents a huge number of people who would potentially benefit. Although the most vulnerable of people undoubtedly would benefit from the support of a links worker, the Links Project found that more than a quarter of people who received simple signposting by their GP or practice nurse had in fact accessed the resource on follow up one month later. This would suggest that while a links worker/Community Links Practitioner is a necessary resource that can focus on those with the greatest need, without developing the capacity of the primary care team to signpost other members of the practice populations directly, only a minority will benefit.

A second related concern is that links worker type roles develop at the periphery of primary care rather than as an integral part of the team. This has probably been the case, for example, in the experience of Keep Well outreach workers. An external link, connected to the team by a formal referral system and with minimal day to day contact, risks losing the benefit of the existing relationships, social capital, local knowledge and expertise already existing within general practice teams, especially given that a key feature of the particular environment of general practice is the volume of informal, incidental, yet extremely valuable collaboration that takes place between staff on a daily basis.

It is much of the rationale being outlined here that is behind the model adopted by the NLWP, that
of the Community Links Practitioners becoming an integral member of existing practice teams. This fundamental feature of the programme is covered in greater depth in several of the Record of Learning Series 1 modules produced by the programme.

The public at large place a high degree of trust in General Practice, so, as an integral part of the practice team, the Community Links Practitioner, as well as other staff, can therefore pass on a ‘baton of trust’ to third party resources within the community, increasing the likelihood that individuals will positively engage with these resources.

Finally, the greatest concern regarding the CLP role is whether it will develop into a long term feature that people in socioeconomically deprived areas come to expect as part of the suite of services offered by general practice, or will come to be seen as a passing fashion. One of the strengths of General Practice has proven to be its durability, with many practices being able to trace their origins to the beginning of the NHS or even earlier. Integration into a community oriented primary care team seems to provide a promising means by which the Community Links Practitioner role can become a sustainable support service in these communities, one that helps repurpose general practice back towards a preventative outlook, such as that envisaged at the creation of the NHS itself.

It is for these reasons that the Links Worker Programme aims to combine the introduction of the CLP role with a practice wide adoption of a ‘links approach’ that works to support the whole team to develop their capacity to enable their patients to access the resources they need to live well and to provide a level of support, ranging from simple signposting, to intensive and ongoing one-to-one meetings and supported visits (provided by the CLP) that is tailored to the needs of each individual.

Rich learning has thus far been gained by the programme around what such practice development activity looks like in reality across the seven practices in the early stages of the programme. This learning is explored further in Record of Learning Module: activities undertaken by General Practices in adopting a links approach.
Integration, transformation and evolution

The National Links Worker Programme (NLWP) is being implemented at a time of flux within the wider health and social care sector. The Public Bodies (Joint Working) (Scotland) act 2014 sets out the legislative framework for integrating health and social care, which is aimed at improving the quality and consistency of health and social care services in Scotland.

In December 2015 Audit Scotland published a report detailing progress that has been made during the transitional year towards setting up the new Integration Authorities and highlighting challenges that were identified through the fieldwork undertaken to inform this report. Many of the challenges highlighted resonate with those which the NLWP has experience of overcoming, such as staff from different sectors, who are expected to work together, having different terms and conditions, workforce development needs and setting up new governance arrangements across different organisations.

Programme learning of relevance is shared in modules published as part of our Record of Learning Series 1, particularly Developing Governance and Management & Recruiting for the Links Worker Programme. The Audit Scotland report also identifies current challenges around recruiting and retaining GP and care staff as issues which are central to successful practical implementation of the new integrated models.

While the mechanics of the integration agenda have a focus on statutory services it is vitally important, as per the Christie recommendations, that the role of all other sectors, including the third sector, is optimised in successfully bringing delivery of services closer to communities and ensuring that they are co-designed with people in order to achieve the Scottish Government’s goal of developing truly person centred care. The NLWP, operates in a new partnership between the third sector and primary care and works to reorientate GP practices to become more connected with what is often a vast array of community resources in their locality. It does so whilst working one-to-one with individuals through holding person centred ‘good conversations’ and is, therefore, extremely well placed for sharing learning with Integration Authorities and others involved with the transformation of Health and Social Care.

Organisations like the ALLIANCE and the Health and Social Care Academy are of the view that the integration agenda presents a valuable opportunity for catalysing truly transformational change across the sector and are, through a number of initiatives, working proactively to help ensure this opportunity is taken. Again, it is with this in mind that the seven capacities of the links approach should be viewed.
PART TWO: Components and features of the Links Approach

Seven primary care team capacities

Each contextual aspect outlined thus far has influenced the shaping of the seven primary care team capacities that have been articulated as areas for primary care teams to work to strengthen in adopting a ‘links approach’. More importantly, they have been shaped from the experience of GPs working at the front line in Deep End (socioeconomically deprived) environments, as shared through the series of meetings of the GPs at the Deep End group, and originally outlined in the Links Approach Conceptual Framework paper, on which this module draws heavily.

A further influence has come from other previous learning, most particularly that arising from three previous projects which have been important precursors to the National Links Worker Programme (NLWP). These programmes investigated similar approaches. They are the Links, Bridge and Improving Links projects. There is a strong overlap with the five “activities” identified by the Bridge project. The term capacities is used in this case however to emphasise that this is a practice wide development process which requires resources and systems as well as the activities of individuals.

Also important are the practice level internal preconditions conducive to the implementation of these activities, which are vital for them to become sustainable, as is the wider community context necessary for them to be effective. These two areas are important aspects around which much valuable learning is being gained by this programme but which space herein does not allow in depth exploration of. Each of these will be examined further using the platform of future Record of Learning modules.

The seven capacities provide the framework within which there is intended to be space for creativity and innovation to flourish and staff to feel motivated and in control of developments. Practices use a development grant of £15,000 per annum, which is administered by the ALLIANCE, to whom six-monthly reports on usage are provided, to develop activities and acquire resources that they see as most fitting for their own environments and development needs. This bottom-up approach, relying on practice’s insight from their own experience at the front line is central to the programme.

The Links Approach is an evolutionary model that aims to create a process of continuous practice development that places the support of people with, and at risk of developing, long term conditions at the centre of systems. The rationale behind the seven capacities that are central to the approach is provided below.

Details of the type of activities that participating practices have been developing through their journey in building these capacities are provided in Record of Learning Module: practice development activities in adopting the links approach.

**Capacity One: Team wellbeing**

In order to effectively mitigate the negative impacts of social determinants of health practices themselves need to have a safe
environment, team members need to have their personal wellbeing supported, and the primary care team needs to have sufficient time to listen and advise people.

A primary care team that is in survival mode, or feels under threat or overwhelmed by demands and needs cannot effectively offer patients support. In recent years there has been no shortage of evidence that this is indeed the case, most strikingly within Deep End practices. High stress levels caused by a lack of capacity for dealing with social issues that individuals present with during GP consultations has been shown to lead to increased stress and reduced self efficacy amongst GPs themselves. We therefore have an unsustainable situation wherein those whom we expect to nurture health and wellbeing in our communities are themselves, in the course of their work, often damaging their own health and wellbeing. An increasing number of GPs are adopting a part-time working pattern as one method of coping, of course this has the effect of reducing capacity still further.

The team wellbeing capacity then is envisaged to provide opportunity for practices to have time and resource to engage in activities that are beneficial to their own mental, physical and social wellbeing. Practices work to identify what to them is likely to be the most relevant mix of activities such as physical activity opportunities, team building and self awareness activities and mental wellbeing activities such as mindfulness and yoga. Often these different elements cross over with one another. An important feature of these activities is providing space to socialise together as a whole practice team.

A primary care team who are, collectively and individually, more sufficiently able to look after their own wellbeing are likely to be more resilient to stress factors and enabled to provide a higher standard of care for the individuals on their practice list population.

Capacity two: Shared learning

In order to develop and maintain a culture of continuous development and improvement it is important that GP practices have protected time for sharing learning (within the practice and between practices), access to educational resources to develop knowledge and skills and the opportunity to share stories about experiences, such as those related to NLWP activities and others concerning activity within their communities.

The 2022 GP report recommends that a model of small clusters of practices who are able to come together to reflect on common challenges and share ideas for development is vital to the future development of general practice.

The NLWP management team facilitates mediums for sharing learning through hosting three joint practice meetings per year as well as others, including blogs and weekly team meetings of all CLPs. The joint practice meetings are attended by the ‘lead links’ GP and Practice Manager from each practice.

An open collaborative environment is nurtured
and enriched over time as practices build familiarity with each other and with the programme management team, allowing practices to feel confident in sharing details of each of their various activities with each other, including their insight into the benefits and challenges encapsulated with each of these. In this way practices learn from each other’s successes and can approach common challenges in a collaborative manner, as well as simply empathising with each other. Through the programme Practice Managers from participating practices also developed their own forum where they could meet without clinical staff to share learning around the particular implications of the developing project for their own roles.

Within each practice it is also important to have space provided for learning and working together to develop new approaches. This allows for all members of the practice team to be involved and to play a part in furthering these.

**Capacity three: Awareness**

In order to be able to identify people who might benefit from information or support, clinicians and their administrative team need to have a wider understanding of the social and personal context of illness, and a commitment to the outcome of a person centred approach and models of self management.

Although the self management model sits comfortably with the core values of General Practice, in reality most professional development and learning resources emphasise chronic disease management and case management models of care. Awareness of the social context of illness, of personal belief systems or anxieties, and of how support might enable better self management is an important capacity for primary care teams.

This capacity in particular complements that of Shared Learning. By providing spaces for sharing learning, practices can feed off one another in collectively building their awareness in this vein.
Capacity four: Intelligence

In order to provide relevant and useful information to those in their practice list, practice teams need to be able to actively gather information, to be able to curate and quality assure that information, and to have efficient and accessible processes for patients to receive this information at the point when it is needed and likely to be responded to.

The support for patients described in this module has as its foundation the ability of the practice team to be able to find and offer accurate information on local resources rapidly, accessibly and at appropriate times for the needs of the patient. This is a huge challenge and requires re-organisation of practice systems for storing and managing information, utilising support from other programmes, such as A Local Information System for Scotland (ALISS) for this to occur.

By developing relationships between practices and community resource staff both via the Community Links Practitioner and through other activities that involve the wider practice team, confidence can be built on the reliability of information on what is available in local communities and how this can benefit practice populations.

Capacity five: Signposting

To make best use of the intelligence that practices gather and manage, practice teams need to be able to confidently and routinely provide information about local sources of support to patients. This needs to be in accessible formats and delivered in a manner and timing when it is acceptable and meaningful. All practice staff, including non clinical staff, need to feel empowered and confident in their ability to identify when signposting is likely to benefit an individual, in their ability to convey information sensitively and appropriately and in the reliability of the information itself.

Current systems for providing information to patients in primary care are often disorganised and highly variable between practices. The links approach seeks to systematically develop this capacity so that patients can be as assured of receiving high quality information as they are of receiving a drug if it is indicated for their condition.

The NLWP has developed a training session for practice staff that combines a guide to use of the ALISS index, which contains details of local resources, with exercises that aim to upskill participants in identifying instances when an individual is likely to be receptive to signposting, as well as in communication techniques that are conducive to delivering such messages. Through this training as well as through the impact of the CLP being based in practice and through other practice development activities, it is intended that practice staff will become well versed in carrying out signposting to the degree that it becomes a habitual and instinctive part of their day to day work.

Capacity six: Problem solving

In order to meet the challenges faced by general practice as well as in managing a process of change such as that set in motion by participation in the NLWP, practice teams need to be able to devise new solutions and overcome barriers that impinge on their operational capacity, as opposed to being in a constant reactive state of crisis management. A culture of proactive problem solving can arise within practices given the support being outlined throughout and across these capacities.

With increased capacity practices would be more able to identify those people who are experiencing barriers to accessing resources, develop expertise in supporting people practically to find solutions to these barriers, and be able to offer motivational and relationship support in taking steps towards self management.

On its own signposting is not sufficient to enable the people who most need support to obtain this. Without additional input signposting is
likely to widen inequalities as it will only benefit those who already have sufficient capacity, or are already in a receptive zone given the particular point in their own journey at which they find themselves, to make use of the information and to surmount any barriers they might encounter.

The level at which the Community Links Practitioner role comes into its own then is through identifying those people with the most complex needs or greatest barriers to accessing support and enabling them to overcome these. The whole practice approach that the programme adopts therefore works, broadly speaking, on three levels, as follow:

For individuals whom practice staff identify as needing only to be provided with information, staff in participating practices should have readily to hand the intelligence in terms of information and systems to provide this directly.

For those individuals who practice staff identify as having some barriers to accessing resources if simply provided with the relevant information, it is intended that practice staff will, over time, become skilled in providing appropriate support for overcoming these barriers.

Finally, for those individuals most in need of support in order to identify which issues they would like to prioritise tackling and identifying which resources they would prefer to access for help in doing so, referrals to the CLP can be made.

The problem solving capacity is intended to permeate all aspects of practice life, wherever practices themselves identify areas that can improve their overall capacity. The underpinning common aim of all activity to this end is improving the experience of and outcomes for the practice population.

Capacity seven: Network building

In order to fully maximise benefits of the range of resources within their neighbourhoods, primary care teams need to develop an extensive network of personal and word of mouth relationships in their local community. They need to work together to facilitate or co-create innovative ways to match local assets and resources to identified unmet needs of their patients and to provide practical and moral support to attempts within the community to protect and build local capacity.

Under pressure GP practices tend to be quite isolated from the communities in which they find themselves. Local resources and services may often not fit the aspirations and needs of people with long term conditions, as they present these to their health care provider. Communities may be quite poor in terms of the resources available, or those which are present may lack capacity to meet demand. However, typically, communities may also have many unused or untapped resources and assets, or there may be considerable duplication due to poor communication and awareness of what is there.

Community Links Practitioners can lead on developing relationships with community resources and facilitate relationships between their staff and the wider practice team. Through these relationships trust and confidence in each other can be engendered and this can then be instilled in individuals via interactions with practice staff. This is a further level at which the skills of a CLP can instigate the strengthening of the ability of the wider team to support people in living well.

Through the awareness and intelligence capacities outlined above CLPs can help practices build a comprehensive picture of what is available in the local area and how this meets the needs of individuals, identifying any gaps or lack of capacity that exists. Through the relationships developed with resource staff it will then be possible to explore ways of working together with these organisations in order to develop responses to these gaps or under capacity.
The links approach is based on a self management model, or more broadly a living well model, of health. This model is set out in the Scottish Government’s Vision for Health and Social Care, that by 2020 everyone will be able to live longer, healthier lives at home or in a homely setting. It identifies supported self management as a key to achieving this vision. As used in this context, self management does not imply the wholesale transfer of responsibility from the state to the individual for their health care needs nor a consumerist emphasis on the autonomy of the individual with respect to their health. Instead self management is defined as the outcome of a process that places the person at the centre, supported by all appropriate individuals and services, working together to achieve the best possible life in the presence of one or more long term conditions.

The term self management is used in the context of people living with long term conditions i.e. any medically identified characteristic that potentially or actually impairs the health of that person. The term living well is used in the wider context of supporting people in the same manner even if they would not necessarily identify themselves as having a long term condition.

In contrast to the chronic disease and case management approaches, this model is infused by three key principles. It is:

- unconditional, in that it has a starting assumption that individuals are multi-faceted and not defined by any given condition or case-ness.
- narrative, in that it emphasises the creation of a coherent story by which the individual seeks to make sense of disparate, disjointed and often contradictory experiences of which long term conditions are only a part.
- relational, in that the individual does not exist in an autonomous vacuum but forms their identity and sense of self from an inter-dependent web of relationships.

The aim is therefore for a person to have the resilience to adapt to a multiplicity of health conditions and other challenges, while having a sense of coherence on which to base their decisions, actions and lifestyle, and making the most effective use of their private and social networks as well as professional services. In order to move towards this outcome however, individuals need to be helped to acquire knowledge and information at key points in their experience, they need to develop the skills with which to use information effectively, for example in navigating a bureaucratic system, in making complex decisions or in changing harmful patterns of behaviour, and they need to be able to access resources such as finances, employment, social relationships, advocacy and professional or peer support.
Self Determination Theory (SDT)

A key feature of the Route Map to the 2020 Vision is to increase the role of primary care to support self management and person centred health services. Primary care can be defined as essential health care made universally accessible to individuals and families in the community through their full participation, at a cost that the country can afford to maintain and in the spirit of self-reliance and self-determination (adapted from Declaration of Alma Ata 1978).

**Self-Determination Theory (SDT)** is a theory of motivation. It is concerned with supporting our natural or intrinsic tendencies to behave in effective and healthy ways. An important proposition of SDT focuses on how social and cultural factors facilitate or undermine people’s sense of volition and initiative, in addition to their wellbeing and the quality of their performance. Conditions supporting the individual’s experience of **autonomy**, **competence**, and **relatedness** are argued to foster the most volitional and high quality forms of motivation and engagement for activities, including enhanced performance, persistence, and creativity. In addition SDT proposes that the degree to which any of these three psychological needs is unsupported or impeded within a social context will have a robust detrimental impact on wellness in that setting.
Personal Outcomes

The broad outcomes towards which the links approach in primary care is directed build on this foundation of self determination. From this base the three components of wellbeing can be constructed: health competence, autonomy and relatedness.

Health competence

The first broad outcome towards which the links approach is directed is to help the individual develop, along with their family, carers, friends and wider community to be the most important assets in developing and maintaining their own health. Enabling people to develop competencies in order to achieve this is a key task of the primary care team. These competencies might include, for example, health literacy skills or the ability to manage time or personal resources. Many of these competencies are taken for granted by health services currently, such as the ability to read, to process information, comply with medication or to attend appointments. However those who would have the most to gain from healthy life choices or from health interventions are often the least able to take advantage of them because they may lack the basic capability to do so.

Dignity and autonomy

The Deep End Austerity Report collected stories from practitioners about the day to day loss of dignity and autonomy suffered by people affected by the widening social and economic inequalities in Scottish society today. Many of these stories demonstrated the barriers to “longer, healthier lives” posed by poverty and endemic social crisis. These external structures of marginalisation are mirrored internally as low self esteem, loss of self efficacy and hopelessness. A second broad outcome of the links approach is to support people to access resources that might enable greater prosperity and security (through safe, well paid and fulfilling employment for example) or to enable individuals to develop a greater sense of self worth or dignity, with the CLP role being available to offer fuller more comprehensive support and protection when necessary.

Relatedness

The third broad outcome towards which the links approach is aimed is in bringing about a transformation in relationships. One of the hidden inequalities in society is the extensive support and informational networks accessed by more privileged sectors and which are not available to many people with the greatest health needs. To give an example, informal peer advice is often sought from friends or relatives who are health, social care or advocacy professionals before contacting health services, yet this network is socially patterned as very few professionals live in socioeconomically deprived communities. The links approach aims towards developing the peer support networks available to everyone, for example through the third sector and voluntary organisations, and at the same time changing the relationship with professionals from one of client and provider towards one of reciprocity and mutual interdependence.
Conclusion

A formative evolutionary approach set within a relevant context is thus outlined in this module. The action learning approach adopted by the programme lends itself to this. The components of the links approach, how these knit together and the rationale behind these is established. The flexibility within a framework and co-produced nature of the practice development aspect of the programme is also articulated. This represents the basis on which the programme can develop a viable ‘whole system’ approach to support the emergence of a new model of community connected general practice in those communities where need is greatest and where targeted interventions are most likely to help reduce health inequalities.
Bibliography/Further Reading

A Blueprint for Scottish General Practice. Royal College of General Practitioners (July 2015).


Health Inequalities in Scotland. Audit Scotland (December 2012).

Health and social care integration. Audit Scotland (December 2015).


Improving Links in Primary Care – Project Report. Health and Social Care Alliance Scotland & Royal College of General Practitioners (September 2014).


Links Worker Programme Record of Learning Module: activities undertaken by general practice teams I adopting a links approach. Links Worker Programme (May 2016)


The 2022 GP: A Vision for General Practice in the future NHS. Royal College of General Practitioners (May 2013).

The Commission on the Future Delivery of Public Services. Dr Campbell Christie (June 2011).


The Links Worker Programme: The Primary Care Links Approach Conceptual Framework. Peter Cawston, Links Worker Programme Clinical Lead (October 2013).
The ALLIANCE vision is for a Scotland where people of all ages who are disabled or living with long term conditions, and unpaid carers, have a strong voice and enjoy their right to live well, as equal and active citizens, free from discrimination, with support and services that put them at the centre.

The Health and Social Care Alliance Scotland (the ALLIANCE) is the national third sector intermediary for a range of health and social care organisations. It brings together over 1500 members, including a large network of national and local third sector organisations, associates in the statutory and private sectors and individuals.

The ALLIANCE has three core aims; we seek to:

- Ensure people are at the centre, that their voices, expertise and rights drive policy and sit at the heart of design, delivery and improvement of support and services.
- Support transformational change, towards approaches that work with individual and community assets, helping people to stay well, supporting human rights, self management, co-production and independent living.
- Champion and support the third sector as a vital strategic and delivery partner and foster better cross-sector understanding and partnership.
"General Practitioners at the Deep End" work in the 100 general practices serving the most socio-economically deprived populations in Scotland. The activities of the group are supported by: the Royal College of General Practitioners (Scotland); the Scottish Government Health Department; and General Practice and Primary Care at the University of Glasgow.

The definition of the general practices serving the 100 most deprived populations in Scotland is based on the proportion of patients on the practice list with postcodes in the most deprived 15% of Scottish datazones. This ranking is based on the Scottish Index of Multiple Deprivation (SIMD).

Deep End practices are at the front line of the NHS in addressing the health and healthcare problems of severely deprived communities. Although they have substantial knowledge, experience and authority, they have largely been neglected in discussions, reports and policies about inequalities in health. GPs at the Deep End argue that by increasing the volume, quality and consistency of care provided for individual patients, and harnessing the intrinsic strengths of general practice – including coverage, continuity, coordination, flexibility, long-term relationships and trust – general practices in very deprived areas can improve population health and narrow inequalities.

Since 2009 General Practitioners at the Deep End practices have sought to challenge two important barriers. The first is the inverse care law, best understood as the result of NHS policies that restrict access to care based on need, and which is manifest every day as the shortage of time within consultations to address patients’ needs. Second, there are dysfunctional links with the wide range of other professions and services, whose contributions and partnership are needed to deliver needs-based care.

The Deep End GPs have argued for a sustained and integrated package of measures to address these barriers, combining at least six key elements:

1. Deep End practices need more time and capacity to address unmet need.
2. Best use needs to be made of serial encounters over long periods.
3. Practices need to be better connected with other professions and services as hubs of local health systems.
4. There need to be better connections between practices across the front line, following the example of the Deep End Project.
5. The front line needs to be better informed and supported by NHS organisations.
6. Leadership needs to be developed and supported at practice and area level for all of these activities.

Full details of the research, advocacy and lobbying work of General Practitioners at the Deep End can be found at http://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend/
Published May 2016. Please contact the ALLIANCE to request this publication in a different format.

The ALLIANCE is supported by a grant from the Scottish Government. The ALLIANCE is a company registered by guarantee. Registered in Scotland No.307731. Charity number SC037475

http://www.alliance-scotland.org.uk/what-we-do/projects/linksworkerprogramme  
@  #makeslinks