11.2 Aberdeen Links Service

Improvement Project Title: Aberdeen Links Service
Executive Sponsor (Chair of Outcome Improvement Group): Sandra Ross
Project Lead: Jenny McCann
Aim statement (What are we trying to accomplish? Over what time? Numerical target for improvement?) Extend the link working approach across primary care to support 3,000 people to attain their own identified outcomes by 2021
Link to Local Outcome Improvement Plan: This is a project within the LOIOP under Stretch Outcome 11. Healthy life expectancy (time lived in good health) is five years longer by 2026 and Key Driver 11.2 Building community resilience through a peer supported approach to health literacy distributed amongst social networks.
Why is this important: The concept of Link Working (including embedding Link Practitioners into GP Practices) has been successfully tested across the Deep End Practices in Glasgow[1]. https://www.alliance-scotland.org.uk/blog/resources/links-worker-programme-record-of-learning-series-2/. This project seeks to test local application and quickly to scale up and spread the model within an Aberdeen context. Reduced resources and growing demand across Health and Social Care means that there is a need to shift the focus from managing symptoms to prevention and resolving underlying causes. The development of the Aberdeen Links Service takes a step towards holistic management of individuals by introducing a complimentary non-medical skill set into the practice as well as supporting the existing staff to adopt the links approach. It is anticipated that this resource will help address socioeconomic inequalities and social determinants of health, as well as building capacity in General Practice. The programme is envisaged to reduce pressures on mainstream primary and community care services by meeting a need for joined up support across the Health and Social Care Partnership. This will be achieved by embedding Link Practitioners into GP practices, the local communities and wider ACHSCP and Community Planning Aberdeen locality teams. The partnership recognises the current (and future) challenges posed by an ageing population with long-term health conditions and the prevalence of health inequalities combined with fiscal challenges. Given these significant challenges across the health and social care systems in Scotland there is a need to shift to alternative and more preventative types of planned care. The ACHSCP is committed to carefully considering approaches to reduce health and social inequalities and in particular, to balance provision of universal or more targeted service delivery with identified needs in and across localities. The Aberdeen Links Service reflects this commitment and will be an important development to achieve this. This project seeks to use the community link working approach (tested in the Deep End practices in Glasgow) as a framework to facilitate transformational change within primary and community care. The programme will provide an opportunity to add intelligence about ways to prevent and reduce health inequalities and support an improved focus on person

[1]

centre care planning and self-management. The underpinning goal of the Aberdeen Links Service is to assist general practice teams (and the wider health and social care system) to develop new capacities to become more effective in enabling patient self-management and supporting people to live more interconnected lives, which support their general wellbeing and sense of belonging.

The overall expected impact is that the Aberdeen Links service will strengthen connections between community resources, third sector organisations and primary care, therefore enhancing social prescribing activities with the practice population.

Secondary impact will also include improved wellbeing, increased social connectedness for people and satisfaction with the Aberdeen Links Service. Staff benefits will include increase confidence, understanding and confidence.

People Benefits

- Improved wellbeing:
- Increased social connectedness:
- Satisfaction with Aberdeen Links Service:

Measures: (How will we know if a change is an improvement?)

The LOIP states that this project will "support people to attain their own identified outcomes". The Aberdeen Links Service is about providing PC support to enable an individual to access the appropriate services to help them overcome their identified challenges. These are identified with the person at point of engagement and are highlighted as the persons "priorities". These are worked through in the order of priority as set by the individual and are achieved at the point they are "linked" with an appropriate resource or service. In this context the identified project measures are:

Outcome measures

- Number of referrals to Aberdeen Links Service
- % of people with identified outcomes achieved

Process measures

- Number of Link Practitioners assessed against skills and experience matrix
- Number of training sessions delivered to Link Practitioners
- Number of peer support sessions held
- Number of people attending peer support sessions.
- Number of people taking up a social prescription (number of onward referrals to partners by category, to identify if quality and range of social prescriptions has improved)
- Number of Aberdeen Links information sessions delivered to referrers

Balancing Measures

- Number of onward referrals to Third Sector Referrals (could potentially destabilise the system)
- Identified gaps for onward referrals to inform future service development and improvement
- Number of people that disengage with the Aberdeen Links Service

Change ideas (What can we do that will result in improvement?)

Develop a skills / experience matrix as a mechanism to ensure range of expertise, experience and abilities exist within the team and to inform recruitment activity.

Develop a mechanism for Link Practitioners to share experience, knowledge, best practice and information to continue to improve quality and range of social prescriptions.

- Testing peer support sessions on a monthly basis
- Link Practitioners to attend value based reflective practice training

Information sessions to develop the knowledge and understanding about the Links Approach and its benefits among of referrers.

Potential Barriers

1. There is a risk that cultural resistance may lead to a lack of "buy in" to the new service/ different ways of working from stakeholders: primary care, practice population, third sector and community organisations.
2. Working across different sectors means there could be risks associated with governance e.g. ensuring appropriate data sharing processes and protocols are I place
3. Development of a digital platform is dependent on the development of a national project, which could hinder Link Practitioners abilities to support signposting
4. There is a risk that the demands for the service outweigh the capacity to provide a service
5. Risk of flooding community with new and additional referrals

Project Team:

Sponsor – Sandra Ross (ACHSCP)
Project Manager – Jenny McCann (NHSG - ACHSCP)
Subject Matter Expert – Dr Raj Gupta (Independent contractor - GP at Scotstown Medical Practice)
Subject Matter Expert – Shona Alexander (Independent contractor - Practice Manager at Carden Medical Practice)
Improvement Advisor/Coach – Stephen McNamee (ACC - ACHSCP)
Data Manager – Dr Calum Leask (NHSG - ACHSCP)
Senior Link Practitioner – Jenny Wooley (Third sector – Scottish Association Mental Health, SAMH)
SAMH Service Manager – Cat Anderson (Third sector – SAMH)
ACVO/ Third Sector– Jane Russell (Third Sector)
Sport Aberdeen – Keith Gerrard) (Third Sector)
Police Scotland – Shona Stewart
Service Participant – To be identified

Outline Project Plan		
Project Stage	**Actions**	**Timescale**
Getting Started (Project Score 1-3)	• Project team established • Initial baseline established • Draft charter developed • Charter submitted to CPA Board	Complete Complete Complete Sep 2019
Designing and Testing Changes (Project Score 4-7)	• Design changes for initial testing • Test Peer Support sessions with Link Practitioner Team on a monthly basis using PDSA over a 3-month period • Using PDSA test impact of having value based reflective practice trained Link Practitioners • Using PDSA test applicability of skills/ experience matrix • Evaluate overall achievement to date and plan further PDSAs or move to implementation	Aug 2019 Aug -Sept 2019 Sept – Dec 2019 Sept – Nov 2019 Dec 2019
Implementing and sustaining changes that demonstrate improvement (Project Score 7-10)	• Agree which change ideas tested are proven to work that we will seek to embed permanently • Continue to gather data • Assess whether improvement levels are sustained	Jan 2020 Jan – Mar 2020 April 2020