

Enabling health and wellbeing among older people;

Capitalising on resources in deprived areas through general practice

- BRIDGE – project

Building Relationships In Deprived General Practice Environments

Funded by the Scottish Collaboration for Public Health Research and Policy



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bridge

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The staff in three 'Deep End' general practices were wholly committed to this project. The practices are not named here but this is their project. Staff in these practices and the community workers they worked with deserve great thanks for their commitment to enabling health and wellbeing amongst the people they work with and for.

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Summary

Aim:

The Bridge Project aimed to develop a system (BRIDGE – Building Relationships In Deprived General practice Environments) through which general practices in deprived areas can identify older people in need and help them access resources and/or participate in activities known to help prevent or delay disablement and enhance wellbeing.

Methodology:

We used participative methods with staff in general practices, community organisations and older people to understand, co-design and ‘road-test’ the system in 3 stages, including a knowledge exchange event.

Key Results:

The likely ‘active ingredients’ of a general practice based system included: a) Identification of a practice based link worker; 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. Practices, older people and community organisations easily made sense of BRIDGE, knew what they needed to do and maintained their enthusiasm and commitment throughout the project. However, they were hampered by the time available and the relatively low availability, accessibility and suitability of community resources in deprived areas. Practices had time to find and contact only a few local organisations, with variable success, in terms of their attraction to older patients. With more time, all practices felt that these links could be developed.

Conclusions:

Improved linkage of practices to community assets is not a system that can be “switched on”, with large numbers of patients being processed from the outset; rather, it is a complex system, comprising many relationships which need building up over time, based on experiment and shared learning. Many of these links are horizontal, working across organisations. Allowing these links to develop organically through building relationships is likely to be more successful than a vertical “top-down” approach. If implemented in this way, BRIDGE has considerable promise.

Where to next?

Over the course of our project we recognised that our vertical approach to designing and road-testing was evolving into a horizontal system requiring the active experience of practices, older people and community organisations in context. We suggest future studies take a slower, action-research orientated, approach, underpinned by theory, which recognises and responds to the messiness of everyday general practice and community organisations working with real people with all their variety.

The Bridge Project Bridge project was funded by the Scottish Collaboration for Public Health Research and Policy as a research and development project to enable health and wellbeing in later life.

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1. Introducing Bridge

Older people in deprived areas experience poor health and associated disability at earlier ages.

We know the kind of interventions that will promote healthy ageing and prevent or delay disablement in later life [1]. They are:

- a) Support to increase physical activity, including interventions to reduce falls;
- b) Comprehensive case review, tailored to need with long term follow-up;
- c) Increased access to assistive devices and home modifications; and
- d) Increased access to opportunities for social (group) interaction.

The problem is that we do not know how to ensure that older people have access to, and are supported to use, these interventions. The problem is exacerbated in areas of socioeconomic deprivation, where older people often have lower expectations for their health and healthcare, and service providers can fail to acknowledge their eligibility for services[2]. Lower levels of literacy and of health literacy in deprived areas contribute to the problems [3].

Social capital, the value of connections within and between social networks, are important for health and can play a part in preventing hospital admission[4]. But access to social capital is different depending on your socioeconomic status, gender and age[5] particularly in deprived areas[6] where many problems loom larger. In addition, lack of good quality infrastructure (such as transport links) in deprived areas means that social resources are often fragmented; resources are THERE, but can be difficult to access[7], are not known to local people, or they may not see themselves as eligible to use them[2].

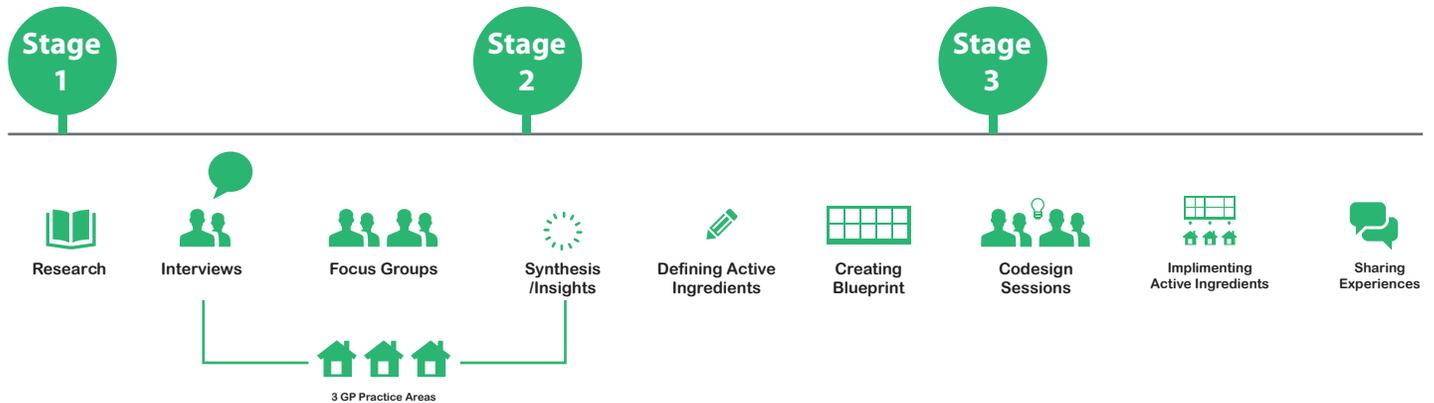
Primary care practitioners have an important role in building social capital in local areas. Because general practice in the UK is universally accessible, older people usually have on-going relationships with practice staff, and will use resources recommended by their practice, including referrals onto social care and other community-based services. At the same time, primary care practitioners are trusted by voluntary and community sector providers. These things mean that primary care practitioners can act as successful service brokers, ‘bonding’ social capital in a local area[8]. In addition, by co-ordinating access to complex social care systems on behalf of users and their families, primary care practitioners can act as a ‘bridge’ to resources which promote social capital.

The Scottish Collaboration for Public Health Research and Policy funded the Bridge Project as a research and development project.

Bridge's key idea is that general practices can act as the bridge between older people and the resources in their local communities. For older people, being linked to, taking part in and contributing to activities run in their local communities is expected to help reduce social isolation, increase physical activity and enable improvements to health and wellbeing.

This report is an overview and findings from the BRIDGE project undertaken from January 2012 to February 2013. Here you will find details of the project process, findings from the research undertaken in three GP practices in Glasgow and the results from implementing a Service Design in these practices.

2. Aims and Methods



Aims

The project aimed to develop a system (BRIDGE – Building Relationships In Deprived General practice Environments) through which general practices in deprived areas can identify older people in need and help them access resources and/ or participate in activities known to help prevent or delay disablement and enhance wellbeing.

Our research questions were:

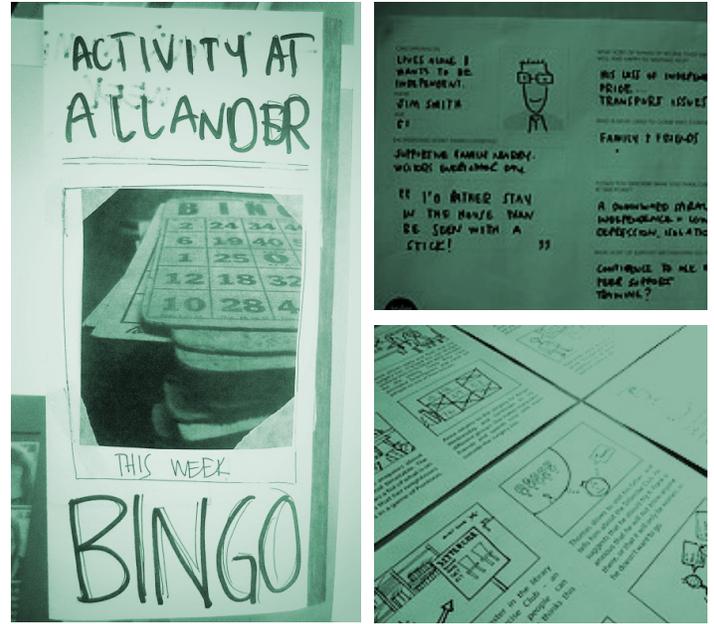
1. What are stakeholders' and experts' views on what works to increase access to and participation in activities to promote older peoples' health in primary care?
2. What are the likely components (the 'active ingredients') of a primary care based system designed to increase access to and participation in these activities in deprived areas of Scotland?
3. How are these 'active ingredients' expected to operate on these outcomes?
4. How feasible is the approach in Scottish general practice operating in deprived areas?

5. What are the potential barriers and facilitators to implementation of the approach, its embedding into routine practice and its further evaluation?

6. What are the potential benefits to older people?

We used participative, qualitative, methods including co-design to develop the BRIDGE system.

The process included both academic research and design methods detailed in our overview of the process. The design methods were a new addition which added a creative dimension to the project and turned research findings into a blueprint of active ingredients which were implemented into three GP practices. The research was done in three stages.



Stage 1: Gathering evidence on the likely 'active ingredients' of the system

We reviewed evidence gathered as part of two previous studies [1, 9] and conducted a scoping search of Medline from 1998-2011 for evidence of interventions promoting physical activity or reducing social isolation in older people, delivered through general practice.

We conducted 5 focus group discussions and 13 individual interviews with a range of informants including practice staff, local community workers, leaders of centrally organised exercise and activity programmes, older people and 'experts' in the field who had developed similar projects elsewhere in the UK (see table 1). We asked what participants thought about general practices getting involved in helping older people make use of local resources, what they already did to support this, what they would like to happen, and what would help and hinder general practices doing this. The design methods meant they were not just the usual question and answer sessions. We developed bespoke tools that included pictures, sketching ideas, and playing back ideas in picture forms. We think the visual methods helped make the imagined possibilities more real for participants. We asked the experts to tell us about other programmes that had also involved general practices and to recommend relevant published and unpublished literature to supplement our own searches.

Our approach to identifying participants is detailed in Appendix 1. Table 1 shows who we interviewed.

Stage 2: Participative re-design of the system (the complex intervention)

We used data generated in stage 1 to identify the potential 'active ingredients' of a system and gather views on its potential feasibility. Through detailed reading of transcripts, literature and visual documentation and through iterative, creative, discussions in the team, illustrating ideas on the wall we identified patterns of views on: a) what is currently happening; b) what respondents think should happen; c) barriers and facilitators; d) solutions. By doing this we identified key 'touchpoints' (every contact between an individual, general practices and community organisations) which might be incorporated into the BRIDGE system and used them to develop and refine the first draft of the blueprint.

Two co-design events were held to develop the blueprint, attended by around 20 stakeholders: 3 older people, 3 people working in community organisations, representatives from each practice (including GPs, practice nurses and practice managers) and invited guests with insight from similar projects elsewhere in Scotland. This session gathered final ideas, problems, opportunities and insights on the proposed system resulting in a second draft and list of what would need to happen in stage 3 (Appendix 2). A final meeting in each practice then planned the 'road-test' of the system.

Data collection method	People attending
General practice staff	
Practice 1 focus group	1 GP, 1 practice manager, 1 receptionist, 2 representatives from 2 local community groups and 2 older people from a community group.
Practice 2 focus group	2 GP trainees, 1 GP, 1 practice manager, 1 practice nurse, 1 receptionist
Practice 3 focus group	2 GPs, 1 practice manager, 1 practice nurse, 1 community group representative
Older people	
Mapping interview 1 Practice area 2	1 female age 74
Mapping interview 2 Practice area 2	1 male age 63
Mapping interview 3 Practice area 2	1 male age 70
Older people focus group 1 Practice area 1	1 man (age 68) 7 women (ages 60, 63, 63, 67, 69, 78, 80)
Older people focus group 2 Practice area 3	4 women (ages 71, 77, 79, 91)
Local community workers	
Community Interview 1	Community Centre Manager Practice Area 2
Community Interview 2	Coordinator of Central Older People Exercise Programme
Community Interview 3	Coordinator Central Older People Exercise and Social Activity Programme
Community Interview 4	Manager Lunch club/day centre Practice Area 2
Community Interview 5	Coordinator Central Walks Programme
Community Interview 6	Manager Lunch club/day centre Practice Area 3
Expert Interview 1	Lead on a large programme of preventative health care in England.
Expert Interview 2	Lead on the evaluation of a large programme of preventative health care in England. Has particular expertise in social isolation
Expert Interview 3	Academic general practitioner with expertise in the promotion of physical activity in later life through primary care.
Expert Interview 4	Led a programme of work to connect older people with activities based in their community to improve health and wellbeing.



Stage 3. Assessment of the system's potential for widespread implementation with good rates of reach and engagement and potential for benefit

Each practice tested the key ingredients of the blueprint by attempting to contact and connect up to 20 older people with community services. Practices were asked to complete a pro-forma for each individual engaging with the service at outset and at 2 weeks and 4-6 weeks on: physical and social activity, type of activity required and engagement and basic satisfaction with the recommended activity. At the end of the project a group interview with practices explored how the road test had worked in practice, the potential benefits to the practice and to older people and future improvements. We also aimed to conduct 9 interviews with older people to explore the impact on them and perceptions of what was good and not good about the service. In the event, in the time available, only 3 people wanted to take part.

Finally, practices were invited to share their experiences of the BRIDGE system at a Knowledge Exchange Event held on 16 March 2013, attended by 44 participants from government and local health, social and third sector organisations.

3. Results

3.1 What is the context for Bridge? Views of its potential, what would work and what not work

Our scoping review showed that, while there were interventions targeting physical activity or social isolation, few directly involved general practice staff either identifying or supporting patients. There was no evidence that the interventions had considered the work that had to be done to reach and sustain involvement with community-based activities or with the individuals themselves. This became a key focus for our qualitative work.

Respondents in phase 2 made 5 important points.



How to identify the ‘right’ people



An individual approach to overcome barriers to participation is important



Individuals with local knowledge are best to identify local resources



Activities need to be in close proximity or practice based



Enthusiasm for working with practices to find new ways of operating



How to identify the 'right' people

Many respondents had an intuitive feeling about the type of older people who would benefit from the BRIDGE system. They were people who had become socially isolated, often confined to their homes by physical immobility but also by apprehension towards social contact. A common perception was that some older people used practice consultations for social contact. Sometimes isolation was seen to develop insidiously; sometimes there were clear 'triggers' such as illness, loss of a spouse or retirement. No-one working in practices thought a 'screening' approach, in which the target population would be identified by practice records and followed up, would work. Contact had to be more personalized.

“GPs having a good relationship with the individual. ..., the average [number of visits to the GP] for older people, is seven a year. Obviously you’ve got huge standard deviation in that, but the average is seven visits to the GP practice. If some have come in more than that, why? And if there’s nothing that’s wrong with them, they may just be coming for company.”

- (Expert interview 2)



An individual approach to overcome barriers to participation is important

Respondents identified lots of barriers to getting people involved in local activities. They thought:

- Some older people are resistant to offers of help. They are stoical, don't want to bother the doctor and have a strong desire to remain independent.
- Money might well be a problem. Getting involved in new things might be seen to threaten benefits and people might be worried that new activities will cost them money which they cannot afford.
- Some people might be trapped with their bad habits (for example smoking, drinking, poor diet) It is known to be very hard to change. People who have a history of alcohol and drug abuse were also seen as difficult to reach because of associated antisocial behavior.

There was consensus that overcoming these barriers needed personal contact and trusting relationships based on individuals' situations. Personal contact would help people feel valued and build confidence.

“It’s maybe if they do live alone it’s that whole walking in somewhere on your own for that first time isn’t it? Or even having the confidence to ask if there’s anything going on. Sometimes you know we forget that some people don’t actually have that in them. They’ll go to the doctors to go and get what they’re going for and just let the doctor tell them what they need and then go home. They don’t, some people don’t have the confidence to ask.”

[Community Centre lead, practice 3]



Individuals with local knowledge are best to identify local resources

Some practice staff said they lacked confidence in the services that were available in their local areas. Apocryphal stories of bad experiences of recommending a service that was no longer available led to a general distrust of community based services. The work required to maintain up to date knowledge of what was available was seen as too onerous within the bounds of normal practice time.

Both stakeholders and experts identified the importance of individuals with local knowledge as facilitators to help engage people with community services. Practice staff (often receptionists) were identified as having local knowledge with one in particular already acting informally as a source of information. Older respondents said they liked it if a member of practice staff “knew the right person to phone” or took time to talk to them although there was also caution that people may resent health issues being discussed by receptionists. Older people themselves were seen as important mines of local knowledge.

“The patients themselves do, you know, quite often do, do things. And [...] it would be quite useful to actually speak to them and find out what they do[and ask] ‘ would it be possible for other people to become involved in the things they’re doing’.

(Practice focus group 3)



Activities need to be in close proximity or practice based

There was a strong feeling that activities had to be very local. This was for very practical reasons (ease of travel) but also because of perceived boundaries between which areas were acceptable for local people to operate within, based on historical expectations and patterns of use.

The physical surroundings of socially deprived areas were seen as a potential constraint to getting people to use community resources. Poor facilities, poor surroundings, safety at night and poor transport infrastructure were all listed as potential barriers. Where facilities were available there was an indication that they did not always fit with an older generation. The use of practice premises for activities was suggested as a solution by both experts and stakeholders. People were expected to feel comfortable in the practice environment and it was also easy to get to.

“Transport. Not able to get out. If they’re disabled how do they get here? We don’t have a bus. [other] Community Centre has a bus and they pick the elderly up from their homes and bring them to the Centre. We don’t have that. So that could be one of the downfalls that we have, that we’ve not got any... Because we have been asked “will we be getting picked up” you know “do you, do you, will you arrange for this or that”. But we can’t because we don’t, we’d have to arrange for mini buses and again the funding’s very tight.”

(Interview community centre manager, practice 2)



Enthusiasm for working with practices to find new ways of operating

General practice has not traditionally been formally involved in connecting older people with community services but throughout our stage 1 research we found great enthusiasm for the idea.

Older people felt that on the whole their general practices were not providing them with information or support in relation to increased social contact and physical activities. There was a perception that consultations were mainly medical with a focus on prescribing rather than more preventative activities. But they were enthusiastic about the idea of more information and support from their practice.

Staff in community organizations and general practices also expressed a high degree of enthusiasm for creating a better system for identifying and engaging older people with community based services. They felt that this was an underused link which could benefit all parties. There was however a concern that there would be a lot of work required of practices in setting this up and that an individual or group would need to be employed to take on the roles and responsibilities.

“There... there should be something, that’s what I can’t understand. In the community centre now they have all these things there, from bingo to dancing and woodwork, you name it. You would think they would have something there for an hour or half an hour for old people once a week, you know what I mean? There must... there must be more people that would like... would like to, you know?”

(Mapping Interview)

3.2 Active Ingredients

What are they likely to be?

Following data analysis and co-design events we identified six key components that were likely to be the active ingredients of any BRIDGE system in general practices.



a) Identification of a practice based link worker



b) Identification of a link worker



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

Whilst these components were all likely to be necessary, exactly how they were put together and delivered locally was to be determined by each practice. The components were expressed in a 'Bridge in Practice' note to practices (Appendix 2) and further discussed at meetings in each practice. Practices did not ask for any amendments to be made.



>> Identification of a practice based link worker

There was a clear need for a dedicated link role in the BRIDGE system – someone whose job it was to 'make things happen'.

Practices made a strong case that this person should be an inpractice worker and not 'parachuted in from outside'. Benefits were: local knowledge; understanding the history and needs of the patients; ability to respond to ad hoc requests; and a central point for communication within the practice. The role could be performed by a receptionist, secretary, health worker or practice manager at relatively low cost and by more than one person, as long as there was active communication.

“I think you would need somebody employed just to do that job (identify local resources) because that would take up a lot of time and it would just get bigger and bigger.”

(Practice focus group 1)



>> Active identification of people in need

There were said to be clear indicators (illness, the death of relative or close friend, change in family circumstances, retirement, loss of mobility, stopping driving) which might help identify the type of people who might benefit from the BRIDGE system. However, it was clear that the actual identification is likely to require an individual approach which balances the subtle “gut feeling” that someone needs support with careful questioning to identify any changes to social situation which might trigger problems with physical or social inactivity. In areas of social deprivation it was thought that the age can range from 50+, however this needs to be considered on a case by case basis.

“What sort of things tip people over the threshold? The illness of her friend who no longer gets out now because of a stroke. So she’s lost her twice-weekly contact with someone. [...] She gets steadily more isolated, less motivated.”

(GP, Practice focus group 3)



>> Building relationships with community service providers

A key step for practices was to become more aware of the work done in local community organizations, and to know and trust the providers of local community providers. Thus recommendations could be personal and based on experience.

Solutions included:

- Drawing on the knowledge of practice staff that live locally i.e. reception staff; patients who already use local community services; and practice staff who work on the fringes of the community i.e. practice nurses, district nurse, occupational therapists.
- Inviting community providers into the practice to talk about their services.
- Practice visits to the community providers.
- ‘Tea-parties’ or ‘market-places’ in the practice in which community organizations, patients and practice staff could learn what was on offer and get to know one another.

“We could possibly call a meeting of all the agencies.”

(Practice focus group 1)

“Taster sessions for general practice staff and patients would be good”

(Co-Design event sticky note)

“We could set up an event for service providers to tell practices about their activities”

(Co-Design event sticky note)



>> Providing older people with up to date information about services

Some, but not all, older people may be responsive to being provided with up to date information about local community services in the form of an information leaflet given out by a member of practice staff, or sent out by the practice or by improved information in the waiting room. Information endorsed by the practice and information which had a personal experience element was thought to be beneficial.

“Well, I mean, that’s what I was saying, if maybe all the pensioners were saying they’ve got a wee thing (leaflet) once a month or once a year or twice a year, saying, these activities are on in your area. I mean, I don’t expect it to be next door to me, I know it could be in schools or libraries or whatever, know.”

(Mapping interview 3)



>> Feedback and follow up

Following up on older people who have used the BRIDGE system was thought to be important in monitoring the individual’s wellbeing and in developing the links between the practice and the community organization. Monitoring would help to identify what has worked and what hasn’t, allowing changes to be made to the system.

“... the idea of you know using us a hub where patients who are, folk who are involved in particular groups or whatever, using it as a sort of feedback to let us know this is what works and this is what could be helpful to other folk, and maybe them being a resource for taking some of our patients along. So that you know it comes more of a to-ing and fro-ing, centre-view...”

(Practice focus group 3)



>> Supporting older people to engage with services

There was a clear need to find more proactive ways of engaging people who were felt to be difficult to reach. A personal approach was seen to be important and several different approaches were suggested for attracting people to activities, some of which overlapped with approaches to general practice staff getting to know community providers, including:

- Holding a tea party event in the practice where older people can meet community service providers.
- Regular manned stalls at the practice where community service providers attend the practice at times when older people are likely to be attending i.e. during flu clinics.
- Taster session, such as walks starting at the practice.
- Using practice premises to hold groups or exercise classes.
- Directories of local information sent out through the practice.
- Link worker facilitating the contact between patients and community organizations.

“Maybe through the health, the doctors’ surgeries might be a good thing. It could be that we could have you know, if we could arrange with a surgery that we have an information stall there maybe once a month, advertising things that’s going on, talking to people as they come in the door. They’d maybe have to see that’s a benefit for them you know than having us in their building.”

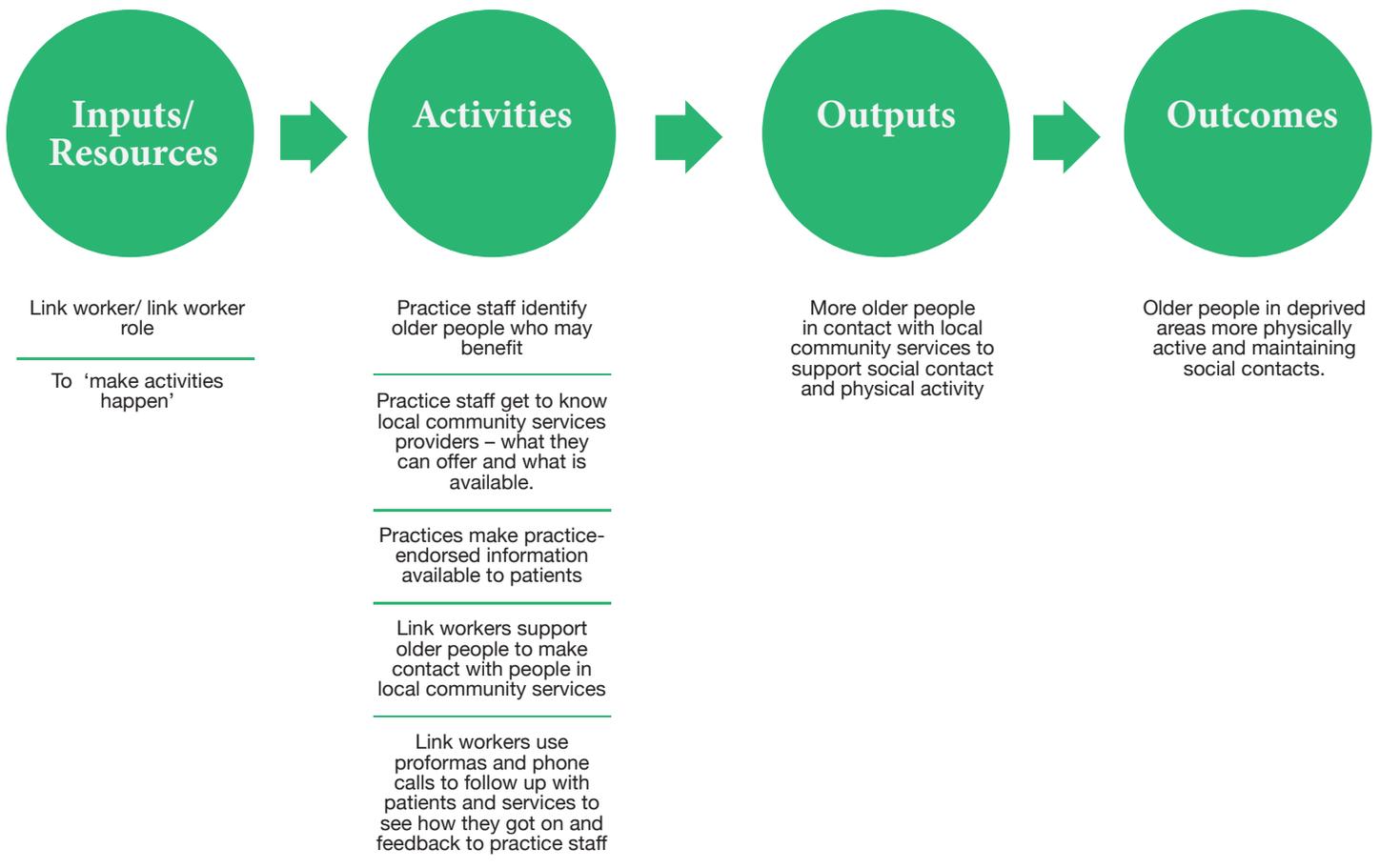
(Community Centre manager Practice 2)

How are these ‘active ingredients’ expected to operate on these outcomes

How the components of the system were expected to operate together can be seen in figure 1. The link worker role, performed by one or more practice staff working together, was essential to ‘make things happen’. Activities were inter-related. Building relationships with local community organizations and experiencing the services they had on offer were important so that the recommendations could be based on personal experience and embodied knowledge. Increased access to practice-endorsed information, strongly endorsed by older

people in stage 1 interviews, was expected to alert some to potential opportunities locally and reinforce the practice’s commitment to local organizations. Practice staffs’ active identification of older people and then supporting them to make initial contact was expected to work by first motivating contact and then helping to overcome initial reluctance. Follow up of older people and of local organizations was expected to work by providing feedback of what works well and less well to engender commitment to the system and reinforce its sustainability.

Figure 1. Logic model of expected relationships between components of the BRIDGE system



3.3 What happened when we road-tested Bridge?

3.3.1 – What the practices did

Practices were free to implement the core components of the system in whatever way suited them but the need for the research to finish at the end of March 2013 greatly curtailed the time they had to try things.

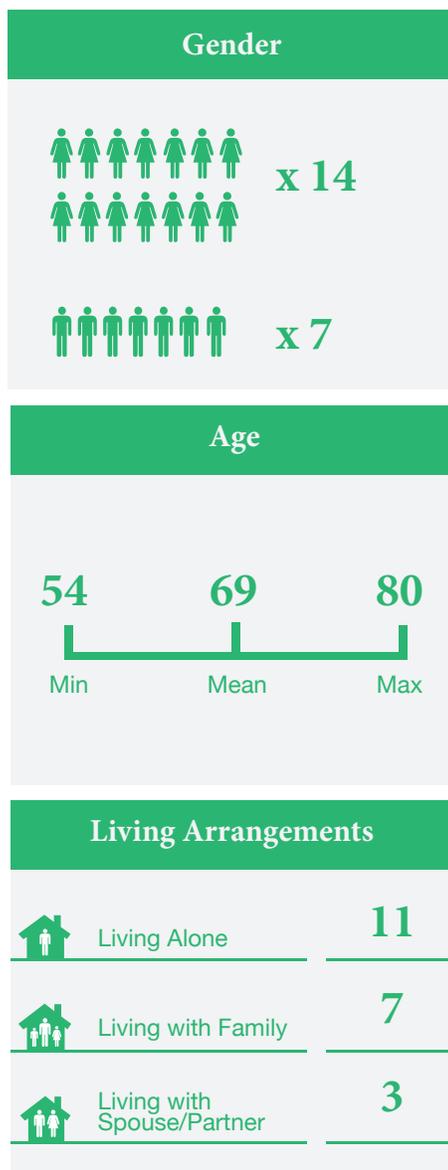
 Practice One	Method of recruitment of older	Methods for engaging with community groups	Extent of involvement of the whole practice	Activities
List size: 4835	A variety of methods including posters in the waiting room, flyers with repeat prescriptions and during consultations.	Community groups were approached via telephone and invited to attend the coffee morning.	The BRIDGE project was discussed at weekly practice meetings.	Coffee morning information event for older people. All people attending were given information packs containing leaflets for local community groups.
Practice staff	Older people were invited to attend coffee morning information event and a taster walk.	Groups attending the event included a health and fitness project, one local church and a centrally delivered programme which included health walks and exercise programmes.	Of three GPs in the practice one lead GP was actively involved. The other two identified a few patients for the coffee morning but were not as engaged with the project as the lead GP.	People who agreed to sign up to road-test completed pro forma with the link worker and were matched up to specific groups.
GPs: 3	People were signed up at the coffee morning event.	In addition a community centre/ lunch club and a mental health support service were contacted. The former was unable to attend but the practice already had a relationship with the organisation and later visited the practice on an alternative date.		Follow up was carried out for the purpose of the pro forma
Practice manager: 1	Number Contacted:			
Practice nurse: 1	Approx 100			
Reception staff:3	Number Attending Event: approximately 30			
District nurses: 2	Number signed up to road test: 13			Taster walks coordinated by Glasgow Walks programme held for three consecutive weeks. Leaving from the practice with coffee after in the waiting room.
Link Worker Role				
Secretary and practice manager				

 Practice Two	Method of recruitment of older	Methods for engaging with community groups	Extent of involvement of the whole practice	Activities
List size: 2922	The link worker generated a list of people over 60 who were suitable for the project (screened to remove those not suitable).	Link worker phoned the community organisations and arranged to visit them or for them to come into the practice.	This was a small practice and all practice staff were engaged with the project including helping to identify people for the service.	Older people attended a 30-40 minute meeting with the link worker to identify needs.
Practice staff	Letter sent to all those appropriate. Followed up with phone call.	Groups contacted included local community learning centre, community gardening Project and a local church.		Link worker made first contact with the community organisation and with the patient's permission passed on their details.
GPs: 2	Invited to attend for BRIDGE meeting with link worker	Groups identified but not suitable included ethnic minority groups, a community centre/ lunch club (which was found to be due for closure) and local pubs which have pensioners days (not seen as appropriate for the GP to recommend these).		Link worker followed up on these contacts if they were not made.
Practice manager: 1	Number contacted: 55			
Practice nurse: 1	Number expressing an interest: 12			
Reception staff/clerical staff: 2	Number who attended for initial meeting: 7			
Attached Health Visitor: 1	Number still engaged: 4			
Plus Assitant: 1				
District Nursing Team: 3				
Link Worker Role				
Practice manager				

 Practice Three	Method of recruitment of older	Methods for engaging with community groups	Extent of involvement of the whole practice	Activities
List size: 4207	All 8 practice staff identified potential names of older people for the service.	The link worker had contacted the local community service by telephone but had not had time to go out and visit them.	All members of the practice staff had been engaged with and enthusiastic about the project and had been active in identifying people for the service.	Interested individuals were invited into the practice for a meeting with the link worker.
Practice staff	Link worker phoned each person then followed up with letter Also used electronic notice board in the waiting room to advertise the project.	Community organisations contacted included a lunch club/day centre and centrally delivered walks and exercise programme.		The link worker facilitated contact with the community services by phoning on behalf of the older person.
GPs: 4	Number contacted: 44	A community development initiative offering craft, health walk and a community garden was visited by the practice nurse.		Two taster health Walks were arranged from the practice.
Practice manager: 1	Number showing initial interest: 29			
Practice nurse: 1	Number who attended for initial meeting: 10			
Link Worker Role	Number signed up: 6			
Receptionist/ health assistant				

3.3.2 – The older people who took part

Table 3. Demographic characteristics of participants in BRIDGE system from 3 practices (N=21)



In the time available only 21 participants agreed to complete proformas. Tables 3 and 4 shows that practices were engaging the right kind of people; although most were female they were of the right age, most lived alone and were interested in a wide range of social or physical activities (Table 5).

The people who responded definitely felt that they would like more social activity and more physical activity (table 4). They were the kind of people we were targeting and they were interested in a very wide range of activities (table 5).

Table 4. Social and physical activity reported by participants in BRIDGE system from 3 practices (N=21)

	Frequency of social activity (prior to involvement with BRIDGE)		Frequency of physical activity – self-reported days per week active for 30 minutes or more (prior to involvement with BRIDGE)	
Every Day	4	1 days	5	
More than three times a week	3	2 days	7	
Less than twice a week	8	3 days	1	
A few times a month	3	4 days	1	
Never	3	5 days or more	7	
Interest in more social activity		Interest in more Physical Activity		
Yes	19	Yes	16	
No	1	No	5	
No Response	1			

We tried to follow up these 21 people after 2 weeks and after 6 weeks, to see how they got on. We found that attendance at two weeks was low, but on the whole for 'good reasons' (table 6). However, follow up to 6 weeks was patchy, largely because the project ran out of time.

Table 6. Reported attendance at activities after 2 and 6 weeks(N=21)

2 week follow up Attendance at activities after 2 weeks		6 week follow up Attendance at activities	
Attended Activities	2	Attended Activities	0
Not attended activities	17	Not attended activities	12
No Data	2	No Data	9
Intention to attend activities in future		Intention to attend activities in future	
Planning to attend	10	Planning to attend	9
Not planning to attend	5	Not planning to attend	2
No Data	6	No Data	10
Intention to attend activities in future		Intention to attend activities in future	
Health Problems (including hospital appointments)	4	Health Problems (including hospital appointments)	2
Timing (clash with other activities, weather, etc.)	4	No local walks available	3
Decided not to attend	2	Decided not to attend	2
Activity/class not started yet	2	Activity/class not started yet	2
Activity/class didn't meet needs	2	Waiting for info	2
Activity not available	1	Enough to do already	1

Table 5. Activities participants were interested in*

Activities		
	Walking	8
	Exercise Clubs/classes	7
	Lunch Clubs	5
	Arts and Crafts	4
	Games	3
	Book Clubs	2
	Meeting Clubs	2
	Computer Classes	1
	Social Clubs	1

3.3.3 – Experiences of Bridge in practice

Discussions in practices showed that some things worked well and some less well. The **link worker role** was seen as particularly valuable because they: knew patients, local travel, organisations, were enthusiastic, able to work opportunistically and feed back to the practice.

Yeah definitely, with [link worker] as well, I think she was quite, she knew what she had to do so she was very, when she was signing up you could hear that she was really encouraging the patients and saying, you know, about walking and stuff because NAME does alot of walking herself so she could sort of encourage them that way you know and once you get started you could hear her saying, “once you get started you will really enjoy it” and stuff. So I think when somebody’s actually doing something then they can talk to someone else about it, if you are not, then it’s just it’s not the same.”

(Practice 1 Roadtest Feedback)

Practices found they had to try lots of different ways of **identifying people** who might take part. It was trial and error, suited to local circumstances and individual practices. There was certainly no ‘one size fits all’ or right or wrong way to do it. Practices may have set out with one idea on how to contact and encourage people to take part but ended up with another. For example, one practice had a poor response to letters inviting people into the practice to discuss potential activities but a good response to putting the opportunity on the electronic notice board in the surgery:

“(F) I know because my thinking at the beginning of the project was that we had loads of names and it would be you know pretty much people that would be interested so I didn’t go all out advertising until we started picking up on the fact that we were getting a lot of people that were saying “no”.

So we decided to put it on the JX board and put a poster up and explaining a bit about it, and more patients that were sitting in the waiting room were coming forward to the desk and volunteering so we had a different kind of patient then, not one that we had thought of, there’s someone else that was coming in thinking, “do you know I’d quite like to do that”

(Practice 3 Roadtest Feedback)

However, a lot of practices said they needed to change how they worded information and made contact with people. Some older people did not like being called 'older' and did not respond positively. All agreed that a personal touch was necessary.

Getting to know local community providers was time-consuming and again, different approaches were successful in different practices. A 'coffee morning' approach, held in the practice, worked well to help practice staff get to know providers but was also really good at identifying older people who were interested in more activities, and felt welcomed and comfortable in practice.

"(B) Well the patients, we did, we advertised it in posters, put it on prescriptions, we did like a wee leaflet and put it in all the elderly, well over 60, I think we went for patients... but I mean a couple of days into that patients were coming in and saying "why haven't

I got a leaflet?" because if something's happening here the word just spreads within a couple of days which is good, so there was a lot, there seemed to be in the lead up to it there was a lot of people phoning, "what time is the coffee morning?"....."

(Practice 1 Roadtest Feedback)

Organising coffee mornings took time and finding a time that was good for lots of providers was very difficult in the time available. A particular constraint was felt to be a lack of community organisations with which to link and a lack of good quality facilities. Even if they were available, respondents felt they were not always nice to attend, or suitable for the particular target group. With more time more organisations with which to link and develop relationships may have emerged.

"Finding places was a nightmare in the east end of Glasgow, serious nightmare, there is only one club I've managed to find that is actually in the heart of this area. They are very limited as to what they can take, they cannot offer a lunch club, they do have a lunch club but they are again limited to the number that they have, they have closed down the other one that was down at [area name] that's gone now, they have not reopened it, to my knowledge they are not going to.."

(Practice 2 Roadtest Feedback)

Practice staff's experience with community organisations was inevitably influenced by the enthusiasm of who they interacted with. One organisation, Glasgow Walks, was fantastically helpful, keen and enthusiastic, and offered 'taster walks' from local practices.

"I think it's the enthusiasm of them I mean it was great that Glasgow Walks came out and spent so much time and then she came back here and did the first walk and the woman from the [lunch club/community centre] is just so enthusiastic, I think it's the enthusiasm, I must admit..."

(Practice 1 Roadtest Feedback)

However, an experience with someone less enthusiastic could be off-putting.

There was yeah there was a gardening project up the back which didn't go down too well, it did, I contacted them and spoke to a girl who initially set it up and she was very welcoming you know, it would be great bring them up, terrific, went up and saw it it's absolutely fantastic, went again to refer a patient up and the girl went off on maternity leave and I got this [...] girl that was like "no no we don't need anybody" and basically put the phone down on me so yeah so that was the end of that project"

(Practice 2 Roadtest Feedback)

Although literacy could be a problem in some areas, the increasing **availability of information in the practice was valued**. Practices staff were sometimes surprised by how helpful the noticeboards were and certainly, the practice-based coffee morning and walks were seen as very successful.

"I think we will maybe start using one of the notice boards just for you know the different organisations so that it's quite clear for the patients and if they maybe put at the bottom if they need any information to speak to reception they can sort of guide them on, keep encouraging, I know NAME will but the other 2 doctors as well and our practice nurse to keep encouraging the patients and always have a stack of leaflets on their desk so that they don't have to say anything they just have to hand something over."

(Practice 1 Roadtest Feedback)

Practice staff found some things very useful to enable older people to **engage in local activities**. The practice coffee morning and practice-based walks were both mentioned but also the reputation of local facilities, and how pleasant they were to attend and also the link workers local knowledge of how to get there, although transport could still be a problem.

“Yeah transport definitely is an issue, just around here with our patients from [place name] trying to even get there’s no buses come down this way, [link worker] that day as well had copied the timetables and stuff that was the other reason NAME is really, [link worker] uses public transport so she knows where every bus goes to so the patient would maybe say I don’t know what bus to get to that and [link worker] would know exactly so that was good when they were sitting having their chat as well it was helpful.”

(Practice 1 Roadtest Feedback)

Practices continued to be enthusiastic about Bridge and were keen for something similar to continue. As one doctor said, it was ‘great to have an alternative to pills:

“(A) Yeah and so it’s great in a consultation to be able to have, to say, to have something to say look there’s this available, there’s this available, so it actually makes life a lot easier because rather than throwing tablets at them, as you know it’s not going to work, you’ve got something concrete that you can offer them so that’s been great.”

(Practice 1 Roadtest Feedback)

Some thought it could be sustainable without too much extra resource, although some were worried that enthusiasm would dry up over time if results were clear.

“I: Yeah so you think, you feel it’s something that’s kind of sustainable without too much funding? (A) Yeah well really all we need is the leaflets from the organisations and you know if we could just yeah do a coffee morning even twice a year that would be...”

(Practice 1 Roadtest Feedback)

The main problem all practices experienced was time – everything took longer than they, or the research team, expected and much more could have been done if we had not had the constraints of working to a research funding deadline.

4. Discussion

The Bridge project was a systematic attempt to co-design and ‘road test’ a system through which general practices in deprived areas can identify older people in need and help them participate in social and/or physical activities. Its novel features were:

First, we started from the knowledge, contact and relationships which general practices already have of older patients;

Second, we based the project in general practices serving very deprived populations; and

Third, we engaged practices, local organisations and the target population in co-design of the system.

Of course, embedding new ways of doing things in routine practice life involves a lot of work. We found that practices, older people and community organisations easily made sense of BRIDGE, knew what they needed to do and maintained their commitment throughout the project despite the many pressures competing for their time and attention. However, they were hampered by the projects’ relatively brief time horizon and by the relatively low availability, accessibility and suitability of community resources in deprived areas. Practices were able to contact only a few local organisations, with variable success, in terms of their attraction to older patients. With more time, all practices felt that these links could be developed.

Practices would welcome additional information concerning community resources in their areas, such as information collated by the ALISS project [13] provided it is accurate, local and up to date. Housing Association representatives who attended the knowledge exchange event were enthusiastic about linking with practices and exchanged details. People are keen on the idea of Bridge and want to make it happen.

The prior knowledge of patients by practice staff was helpful in excluding patients for whom referral to community resources would be inappropriate. Some did not respond because they did not consider themselves as either old or vulnerable. Practices quickly learned to avoid such language. Other patients, who were thought suitable for the project, proved set in their ways and resistant to suggestions. Some were disappointed in what was offered.

The apparently simple aim of the project proved complex and multi-faceted; in particular the matching of knowledge of individual circumstances and preferences with suitable community resources, which were not always available. With more time, there was confidence that such problems could be ironed out, improving the match of needs and resources, building knowledge and confidence in the various links and allowing better definition of “what works for which type of patient”.

A major strength of the project was the use of existing practice staff to make contact with patients, building on previous relationships in a link worker role, sometimes undertaken by 2-3 colleagues. The role has potential in future projects linking people with local assets in BRIDGE-type work.

Improved linkage to community assets is not a system that can be “switched on”, with large numbers of patients being processed from the outset; rather, it is a complex system, comprising many relationships which need building up over time, based on experiment and shared learning. In this sense, our approach mirrors the tensions between ‘vertical’ and ‘horizontal’ approaches to public health systems apparent for 40 years [10]. We began with a “vertical” approach, by which our stage 1 learning would inform and feed into a blueprint, which could then be implemented and ‘road-tested’. We did conceive

a blueprint, in terms of an intellectual idea of what we were trying to do, and we communicated and discussed this with the practices. But the actual delivery wasn't vertical, rolling down from above, it was horizontal, as practices tried to integrate the various elements in a complex environment. The actual system, emerged slowly, and is still emerging, by trial and error, as experience is gained.

In the time available, the project could collect only limited information on the use and outcome of increased links to community resources. There was widespread support for the system and enthusiasm for continuing the project. However, more time and an action orientated approach may be needed that takes account the motivations and interests of patients in taking part in physical and social activity. Improvements in longevity, independent living and decreased use of hospital services may arise in consequence, but are unlikely to be the main motivating factors for patients, practices or community organisations.

Conclusions

1. Linking older people with community resources for physical and social activity via general practices is a complex process, involving many different relationships, each of which takes time to develop.
2. The availability, accessibility and acceptability of community resources in some deprived areas were less than expected.
3. Initiation of the process is best carried out by practice staff, who are known to patients.
4. A key step is matching knowledge of individual circumstances and preferences with knowledge of suitable community resources.
5. There is no substitute for local trial and error in developing this approach.
6. Practices could be helped with additional information about local resources.
7. Each link takes time to develop, however, limiting the number of such links that a practice can focus on in the short term.

What does this project add?

BRIDGE demonstrates that it is possible to develop and implement systems to support support the health and wellbeing of older patients within general practice, rather than outside it. This requires shared work and commitment from practices, patients and community organisations to develop and sustain such approaches.

Implications for Practice or Policy:

There is considerable enthusiasm for the BRIDGE approach. Our close working relationship with the Scottish Government's Joint Improvement Team, the ALISS project and the Deep End Group means that learning will be fed into subsequent approaches to enabling health and wellbeing in later life. The lessons from this project will enable policy makers, practitioners and community groups to consider the key facets of an implementable and sustainable system, easily accessed by older people.

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Enabling health and wellbeing among older people;

Appendix

Appendix 1

Details of methods used to identify participants

General practice staff:

We invited general practices in the DEEP End Group [23] to a BRIDGE information event. Representatives from 10 general practices attended; six expressed interest in further participation and 3 were randomly selected to participate. General practice staff attended a focus group briefing on BRIDGE.

Older people:

We sent out invitations to 150 people, aged between 55 and 80, identified through general practice registers. As required by NHS ethics committee, potential respondents were invited to contact the research team by telephone, email or post if they were interested in taking part. Of 150 letters sent, only 8 replied (three were not suitable and one withdrew). We conducted 3 interviews. We also asked community group leaders in all three practice areas to identify older people to take part in focus group or mapping interviews, from this we were able to convene focus groups in practice areas 1 (8 participants) and 3 (3 participants plus 1 recruited through the practice).

People working in local community groups:

These respondents were identified by asking the practice managers to identify local community groups and through internet searches of local and Glasgow wide community services. In the event, of 9 approached, 6 agreed to be interviewed and 3 took part in practice focus groups.

‘Experts’:

We conducted telephone interviews with four experts in the field of preventative healthcare in older people. Expert interviews 1, 2 and 4 were identified by searching of the literature and internet for relevant programmes. Expert interview 3 was identified through professional networks and literature searching.

Appendix 2

Second draft of blueprint: Instructions for practices.

BRIDGE in practice. Making it happen

The overall objective is to develop and pilot a way of linking general practices and community organisations to help older patients overcome problems of social isolation and/or physical inactivity. There are three essential set of tasks.

1. The practice - community organisations bridge

- Each practice will choose 4-6 community organisations which you want to establish better links with, probably including some Glasgow-wide organisations (Glasgow Life, Glasgow Walks) and other organisations based locally. We will give you some suggestions.
- An initial task will be to establish connections, clarify contact points and best methods, times and routes of communication. The idea is for you to get to know the people in the community organisations and the opportunities they offer your patients so you can develop trusted relationships with them.
- You may wish to invite some people from the community organisations to a short lunch or tea in your practice and ask them to tell you what they do. Many have expressed willingness to do this. Through this we think you will identify one person – the ‘champion’ in the organisation – that you know you can link with and will get back to you.
- You might want to offer publicity materials for these organisations in your practice and consider “endorsing” the information. We discussed this with your colleague(s) who were able to come to the co-design meeting on 22nd August. Patients

who need no help in making connections could then make contact with the organisations on their own.

2. The older person – community organisation bridge

Identifying patients

- Over a period of 6-8 weeks, practices will be asked to identify patients who might benefit from contact with one or more community organisations.
- There will be no “entry criteria”, except “age”. Rather, at the end of the project, we shall review what types of patient have been identified – this may help to provide entry criteria for future work. But we would like you to think in advance of the type of patients you will invite and how you will identify them.
- Given that the project provides a small amount of additional resource to facilitate patient’s use of community organisations, the focus should be on patients who may require additional support in making first contact and use.

Making the link between patients and organisations

- All identified patients should be notified to one person in the practice (the “bridge person”), who will make arrangements with the patient (as needed), contacting the community organisation as required, possibly reminding the patient beforehand and making contact to ask how the first visit went.
- We know that the practice having on-going interest might stimulate people to stick at it so a phone call two weeks and six weeks later will be good. This can be used for follow up as well.

- For some patients, it may be useful to recruit them, not only as potential users of community organisations, but also as “partners” in the project, road testing the links that have been set up, and emphasising the usefulness of their feedback, positive or negative.

3. Getting feedback

- You will want to know whether your effort is worth it and so will we, so the bridge worker should follow up the patients 2 weeks and 6 weeks after they were given the initial contacts with the proforma. We will explain this when we visit. At this point up to 5 patients will be recruited for a longer interview.
- Interviews will also be held with practice staff (GPs, PNs, practice manager, receptionist, link worker, as appropriate).

4. Essentials for delivering these tasks

Timing

- Time (i.e. funding) constraints mean that evaluation of the pilot can only be completed for patients entered into the system by 31st December 2012
- Beginning perhaps on 1st November 2012, each practice will be asked to enter 20-30 patients into the system. Allowing for patients who drop out before making contact with the community organisation, this should provide about 20 patients per practice for follow up.
- It is planned to complete the follow up and interviews by mid-late February, in time to produce a report and hold a knowledge transfer meeting in late March 2013.

Resources and how to deliver the project

- £600 per practice is available to provide protected time for a practice meeting in October 2012 to plan delivery of the project in each practice
- £3000 per practice is available to deliver the project, meeting the core objectives however the practice decides (protected time to establish links, facilitation of links, keeping the practice informed, maintain links with each organisation, follow up)
- It is possible that the link role will involve additional hours for an existing member of the practice team, rather than a new member.
- We shall convene joint meetings of the persons carrying out the bridge role in each practice at the outset of the project and again after 4 weeks.

5. The tasks involved

Practices may decide that they want to put all their resource into one person to be the bridge worker or they may want different people to do the tasks. Whichever you decide these things need to happen:

- Establish initial links and routes of contact with community organisations (CO)
- Keep practice staff informed about the study
- Have a single point of contact for patient notification within the practice

- Maintain a record of all notifications, including reasons for the notification
- Make arrangements with each patient for an initial visit to the community organisation
- Ensure with the CO that the patient is expected
- Remind patient by phone on the day prior to the visit
- Contact by phone on the day after the visit to collect feedback
- Contact for follow-up information at 2 and 6 weeks (phone interview)
- Help arrange follow up interviews with practice and CO staff
- Liaise with Clare Dow (researcher)
- Liaise with persons carrying out the link tasks in the other practices.

6. Questions for final design meetings

1. Will you have one bridge worker or divide tasks between people? Who will do what?
2. We have some potential community organisations – do you want to add to the list? Who will contact them? How will you get to know them?
3. How will you indentify older people?
4. Who will talk over the possibilities with them and help them make contact?
5. Who will follow them up?
6. How will you know whether you think this is working for you?

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