

# Gold star exemplars

**Third sector approaches to  
Community Link Working  
across Scotland**

April 2017

"It's a gold star exemplar. The big thing is the level of evaluation and the feedback on outcomes. This gives them the evidence to support the method."

Chief Executive of a partner Housing Association describing the work of a local third sector Community Link Working initiative

## Acknowledgements

VHS is very grateful to everyone who played a role in this study and report.

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We thank all members of the Reference Group for providing such helpful feedback and suggestions.

Particular thanks to Naureen Ahmad and Kate Burton for their support and guidance throughout.

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A very big thank you to all those voluntary organisations who so willingly contributed their time, insights and data for our survey work and case studies.

# **Gold Star Exemplars**

## **Third Sector approaches to Community Link Working across Scotland**

**A report to the Scottish Government**

**June 2017**

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# 1 Introduction

## Background

- 1.1 Voluntary Health Scotland (VHS) is the national intermediary and network for voluntary health organisations in Scotland <sup>1</sup>. VHS was commissioned in July 2016 by the Scottish Government to conduct a scoping exercise to help inform the Scottish Government's development of a national Community Link Workers programme.
- 1.2 The aims of the research were to:
1. To identify the number and range of Link Worker initiatives in primary care settings currently being delivered by the third sector across Scotland.
  2. To inform the Scottish Government's development of a national Community Link Workers programme through the provision of this intelligence.
- 1.3 For the purposes of the study, the following definition of Community Link Working (CLW) was agreed with Scottish Government.

'Community link working is

- An approach (or range of approaches) for connecting people to non-medical sources of support or resources in the community which are likely to help with the health problems they are experiencing;
- Used interchangeably with other terms, such as social prescribing, signposting, supported self management, and community referral;
- Used in primary care and enables staff to draw on non-medical options to support their patients;
- Used with a number of different client groups and draws on a wide range of different community based services, including arts and cultural activities, green space, debt advice, physical activity and leisure, bibliotherapy, learning, volunteering, housing advice, benefits, employment and legal advice (Friedli et al, 2007);
- Person-centred and tailored to the individual's needs, irrespective of where it is delivered.'

## Methodology

- 1.4 We adopted the following methodology:
1. Scoping interviews to provide a context for the study, to explore the scope and limitations of the research, and to inform the methodology. These were held with:

Naureen Ahmed, Scottish Government  
Allan Johnstone, Voluntary Action Scotland VAS  
Ella Simpson, Edinburgh Voluntary Organisations Council (EVOC)  
Kate Burton, NHS Lothian

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<sup>1</sup> Registered Scottish Charity SCO35482, Company Limited by Guarantee SC267315.

Karen Sutherland, Scottish Huntington's  
Frances Simpson, Support in Mind Scotland  
Helena Richards, Carr Gomm

2. An online survey for third sector service providers, which received 60 responses
  3. An online survey for Third Sector Interfaces (TSIs), which received 15 responses (Glasgow and East Lothian TSIs submitted responses under the service provider survey, making the number of TSIs represented altogether 17)
  4. Three case studies to explore examples of Community Link Working in greater detail (Community Connectors in Glasgow, Dundee City Council Advice Services / GP surgery co-location in Dundee, Wellbeing Service at Thistle Foundation in Edinburgh)
- 1.5 A Reference Group comprising the following people provided advice and guidance as the study developed:
- Naureen Ahmad - Policy Manager, Creating Health Team, Health Improvement and Equality Division, Population Health Improvement Directorate, Scottish Government
- Kate Burton - Public Health Practitioner (Welfare Reform and Health Literacy), Scottish Public Health Network, NHS Lothian
- Rachael McKechnie - Team Leader, Social Justice and Regeneration Division, Scottish Government
- Jacqueline Campbell – Health and Social Care Integration, Integration Division, Directorate for Health and Social Care Integration, Scottish Government
- Chris Gourley - Links Worker Programme Learning and Evaluation Officer, The Health and Social Care Alliance Scotland
- Jaqui Reid - Programme Director - Third Sector Health and Social Care Support Team, The Health and Social Care Alliance Scotland
- Dr John Anderson - Primary Care Lead, NHS Health Scotland
- Claire Stevens – Chief Officer, Voluntary Health Scotland
- Kiren Zubairi - Policy Engagement Officer, Voluntary Health Scotland

## Other research

- 1.6 We were not required to undertake a literature review for the study. However the following studies are of particular relevance to anyone interested in understanding more about the nature and evidence of CLW and social prescribing in Scotland.
- 1.7 Evaluation of the Links Worker Programme in 'Deep End' General Practices in Glasgow (Glasgow University. Currently being undertaken)  
<http://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/socialscientistsinhealth/research/changingpublicpolicyandpublicpolicyforchange/lwpevaluation/> Interim

report (2016) available at <http://www.healthscotland.scot/media/1201/27362-evaluation-of-the-links-worker-programme-in-deep-end-general-practices-in-glasgow-07-16.pdf>.

- 1.8 Forecast Social Return on Investment Analysis on the Co-location of Advice Workers with Consensual Access to Individual Medical Records in Medical Practices (Improvement Service 2017)  
[http://www.improvementservice.org.uk/documents/money\\_advice/SROI-co-location-advice-workers.pdf](http://www.improvementservice.org.uk/documents/money_advice/SROI-co-location-advice-workers.pdf).
- 1.9 Evaluation of GCVS Community Connectors programme (FMR Research, Glasgow. Currently being undertaken).
- 1.10 Inquiry into community capacity-building which improves health and wellbeing, and supports the process of health and social care integration. The report (November 2016) focuses on a Community Links project in rural Aberdeenshire, and identifies what makes for good practice in community linking, and what supports its development and spread. <http://whatworksscotland.ac.uk/wp-content/uploads/2016/11/LearningAboutCommunityCapacityBuildingCommunityLinksWorkerAberdeenshire.pdf>.



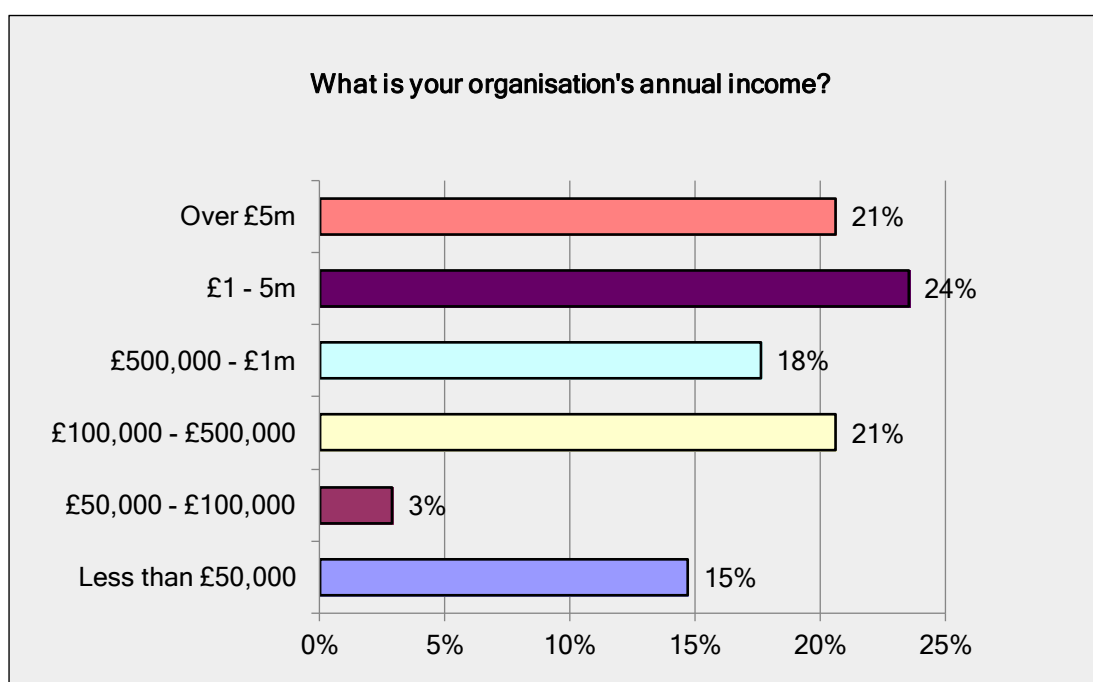
## 2 Findings from service providers

### Profile of respondents

- 2.1 60 third sector service provider organisations responded to the survey, of which 39 submitted complete responses. The remainder varied in completeness.
- 2.2 94% of respondents described themselves as registered charities, with one voluntary organisation and one social enterprise.
- 2.3 The majority of organisations described themselves as working in the health or social care fields, with half engaged in community development.

Which of the following categories best describes the overall work of your organisation. Please select as many as apply.		
Answer Options	Response Percent	
Health	74%	
Social care	68%	
Community development	50%	
Disability services	45%	
Advice and advocacy	45%	
Older people's services	40%	
Befriending	32%	
Children and young people's services	29%	
Financial inclusion	21%	
Housing	8%	
<i>answered question</i>		<b>38</b>
<i>skipped question</i>		<b>22</b>

- 2.4 Organisational income was varied, with 45% half having an annual income of more than £1m.



## Geographical coverage

- 2.5 The CLW programmes described covered 31 of the 32 Scottish local authorities, with only Orkney having no examples.

## Range of programmes

- 2.6 Respondents were asked to describe their CLW programmes. 43 different programmes were described. These are all reproduced below. No 'filtering' was applied.

### **Action on Depression (AOD)**

AOD work in partnership with a consortium of GP's/NHS Lothian. GP's make the referrals to us, we deliver 6 week self-management learning programmes within one of the GP's premises and provide mood score assessment and feedback on participation, improvement and outcomes. In addition AOD receive over 5000 emails per year and 2500 telephone calls from across Scotland asking for advice, information and help in managing depression, we signpost to services, liaise with health agencies and refer individuals to our AOD self-management courses. A less formal support system is facilitated via 10 peer support groups operating 2 weekly in areas across Scotland, each group is supported by AOD with information and advice on services in their area.

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Chief Executive  
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### **Aberdeen Council for Voluntary Organisations (ACVO)**

£700k allocated in Aberdeen for 20 posts to cover the 30 GP outlets. A co-designed approach with 3rd and public sector. Agreement that it will be commissioned from the 3rd sector and TSI on steering group for roll-out of programme. TSI would have preferred CLW manager to be in TSI but it will be a public sector role. TSI currently supporting 1.5 days per week of a CLW to ensure continued delivery of service in one cluster area.

Susan Morrison  
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### **Art in Healthcare**

Following a successful pilot with one GP practice, we are now recruiting staff member to act as CLW with funding from Big Lottery Fund for 3 years. People who are experiencing mental health issues caused by loss, isolation, loneliness and physical illness will be supported by a programme of visual arts activity organised in partnership with the healthcare sector. The project is delivered using an occupational therapy supported pathway model that uses person-centred techniques. Development will include helping people to move from health or care settings to mainstream community settings by building confidence in service users to engage locally.

Margaret O'Connor  
Chief Executive

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### **Arthritis Care Scotland**

Joint Working was set up to address the lack of support to help people diagnosed with inflammatory arthritis to stay in or return to work. Partner initially with GGC and Grampian Rheumatology clinics, though referrals can be made from any NHS and other organisations – Job Centre Plus, third sector, self-referral too. Referrals can be made from any area in Scotland.

Maureen McAllister  
Manager

07825 104972

[maureenm@arthritiscare.org.uk](mailto:maureenm@arthritiscare.org.uk)

### **Carerslink East Dunbartonshire**

I offer Health/Wellbeing Reviews to unpaid carers. They make goals, which I help them to achieve by referring and signposting to other services within my and other organisations and agencies.

Paul Peter  
Operational Manager  
[paul@carerslink.org.uk](mailto:paul@carerslink.org.uk)

### **Carr Gomm**

This is a new service about to start. It is a PSP with NHS Lothian. We are employing a team of specialist link workers to work alongside trauma specialists (adults and children/young people) in a new centre based in the community. The CLWs will meet people who can self-refer and have a first conversation, assess their needs, including their suitability for a service, plus other needs such as benefits & debt, addictions support, community activity support etc. The CLW will make a plan and support the person to fulfil it.

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Project Manager  
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### **Carr Gomm Community Compass**

We support people to access the groups and services they need to improve their health and wellbeing. We get to know them and make a person-centred plan based on what their priorities are, which may be different to what they were referred for. We then help them to fulfil that plan, reviewing their progress regularly. We support people to attend groups and activities, actually taking people if they need it, recognising that they may not have the confidence to go to something on their own.

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**Chest Heart & Stroke Scotland (Cardiac and Respiratory Support Services)**

Cardiac & Respiratory Support Service - resources for people living with long-term heart or chest condition eg heart failure, COPD (chronic obstructive pulmonary disease). We provide; information; opportunities to meet/share experiences; signpost to local support available; support for carers and families. Done through: befriending services, patient/carer meetings, social support groups, newsletters, support for self-management.

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**Community Renewal Trust (1)**

We have a long-running project which is currently active in East Edinburgh where we employ a Health Case Manager who works with around 40 patients per year with "life wrecking circumstances" with long term flexible and intensive one to one support. The Health Case Manager is a professional therapist with counselling qualifications and does much more than just signpost to services and third sector organisations. We have developed an assessment and goal setting process, called the "Holistic Assessment" to support this. We have gathered an evidence base that this is often a transformative experience for people with the most complex needs - leading to increased wellbeing and reduced GP attendance.

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**Community Renewal Trust (2)**

For NHS Grampian Modernising Primary Care we are leading a transformative change management project. 1) Engagement with local residents and local support providers ("community connectors") to better integrate GP Practice into community and enable effective referrals. 2) Training of GP Practice Front of House staff to link them to community connectors. 3) Training GPs, Practice Managers and Practice Nurses in Holistic Assessment to enable them to identify, prioritise and support patients through community connectors. 4) Our staff are supporting a very small number of patients one-to-one as a trial. This is not a typical Link Worker project in that we are increasing the capacity of the GP Practice and community connectors directly rather than providing a staff member to do signposting.

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**Dundee City Council Advice Services**

The Council's Advice Service in partnership with Dundee Citizens Advice Bureau and Brooksbank Centre and Services currently work in 6 GP surgeries providing access to income maximisation, debt advice and other socio-economic supports for patients within each practice. Express client permission to access medical records is a unique feature of the service in 5/6 surgeries. Experienced welfare rights officers staff these practices. Referrals are made mainly by primary care

staff or via self-referral. Practice rooms are available and access to Vision and Docman systems. Appointments are made by practice staff. The model is a co-location one, not an outreach one.

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**Dundee healthy living initiative**

Dundee healthy living initiative is locality based with either a community health nurse or worker based in the area. We use community development approach to identify need in the areas and look at how to engage with local people to meet the needs. We look at physical and mental wellbeing of individuals and families. We work with age 16+ but also do family work. We also recruit and support local people to become volunteers within our organisation and help groups to start them support them to become self-sustained.

(no contact details)

**Equally Well / Sources of Support**

The Sources of Support scheme utilises link workers who adopt a holistic person centred approach, taking referrals mainly from GPs for patients who have poor mental health and wellbeing affected by their social circumstances. The LWs meet with patients for a maximum of 4 consultations to identify root causes and services/ activities that can help. They support patients to access these and use a variety of skills including advocacy, negotiation, facilitation and networking. Outcomes included improved housing, prevention of homelessness, increased social contact, reduced anxiety, access to benefits/ prevention of sanctions, employment and learning etc.

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**Falkirk and District Association for Mental Health (FDAMH) (Falkirk)**

We work directly in 2 GP practices but also accept referrals from all GP practices in Falkirk district to our service. We focus on people referred due to reduced mental wellbeing / mental illness and have skilled, trained practitioners providing the service.

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General Manager  
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**Fife Forum**

Local Area Co-ordination for adults and older people.

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**Glasgow Council for the Voluntary Sector (GCVS)**

The Community Connectors service connects older people and their carers to local services, facilities and activities, providing tailored, informed support. The main focus of the programme is to support older people and their carers to be able to maintain their independence as they get older and to ensure they are able to access appropriate support when they need. Good conversations are at the heart of our approach with our practitioners working to outcome planning processes and adopting an asset based approach to their work. The programme also aims to foster stronger links between third sector organisations and statutory agencies, improving connections and developing pathways at a local level.

Gillian McCamley  
Community Connectors Programme Manager  
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**Headway East Lothian**

Informal as part of our own service of promoting self-management, referring to other agencies & services as required by service users.

Joyce Cattanach  
Development Officer  
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**Heal The Whole of Me Community Interest Company (HTWOM)**

HTWOM is commissioned by NHS Forth Valley, Clacks and Stirling Councils to provide signposting to and information on supports and services for mental health and wellbeing in Forth Valley. With additional funding (and a willingness to see the value in this approach) HTWOM could promote this service far more successfully and serve 54 health centres and not just one as the CLW project does.

Jude Clarke  
Director and manager  
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[judemclarke@gmail.com](mailto:judemclarke@gmail.com)

**Health and Social Care Alliance**

The Programme is a Scottish Government funded programme which aims at researching how the primary care team can mitigate the impact of the social determinants of health. The programme is being delivered as a partnership between the Health and Social Care Alliance (The ALLIANCE) and General Practitioners at the Deep End (The Deep End). The programme is guaranteed funding until March 2019 and is accompanied by a quasi-experimental designed piece of research conducted by the University of Glasgow. CLPs join practice teams and work with the practice population. They have no exclusion criteria or maximum number of contacts.

Mark Kelvin  
Programme Director  
0141 404 0234  
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**Health in Mind**

Borders Navigator: supporting people of working age who are feeling lonely or isolated and/or struggling with their wellbeing to connect with services and groups within the Eyemouth area. Midlothian Access Point: supporting people to either connect with local groups and services or be referred into Psychological Therapies. New referral pathway for those who would have previously been referred directly into PTS. Also available for self referrals.

Wendy Bates  
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**Healthy Valleys**

Community Health Matters is essentially a 3 pronged approach to reducing health inequalities in the Clydesdale locality; 1) social prescribing project - building on a short term pilot project with the Douglasdale GP Practice, 2) the creation of community hubs to better serve the needs of rural communities and 3) the Volunteer Buddy Project integrating previously successful Healthy Valleys' mental health projects (OAA and Time Out) to support vulnerable adults and young people to maximise involvement and build upon community connectedness.

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**Improving the Cancer Journey (ICJ)**

Improving the Cancer Journey is a community based service supporting the holistic needs of people affected by cancer in Glasgow. ICJ invites all people newly diagnosed with cancer to have a holistic needs assessment. If they take up the offer, a dedicated link officer conducts the assessment and coproduces a care plan, helping them address the needs identified and referring to appropriate services.

(no contact details)

**Inspiring Scotland**

Since 2012 Link Up has focused on addressing inequality and improving the lives of people living in Scotland's most vulnerable communities. It's active in 10 neighbourhoods across Scotland. Link Up workers act as a platform to uncover and harness hidden social capital. It creates opportunities for local people to connect, get to know one another, and develop social activities for their own enjoyment and that of the wider community. Link Up participants find positive relationships, support networks, a heightened sense of purpose, skills, and many of the outcomes that are the bedrock of greater wellbeing: self-belief, confidence, friendships, motivation, aspirations.

Marie-Amelie Viatte  
Link Up Performance Advisor  
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**Lochee Parish Church**

The programme is a new initiative based in a local parish church, supporting people in recovery from substance misuse. This involves engaging with people in a variety of ways. The Community Worker regularly attends drop-ins to talk to people and listening to people/encouraging change talk and giving advice/guidance/signposting where appropriate. This builds trusting relationships with service users. Through this engagement or from referrals the worker can also provide more intensive one to one support such as supporting them to appointments, community activities and developing their life skills. The programme is also currently involved in facilitating a recovery music group and relapse prevention group.

Louise Davis  
Community Support Worker  
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**Macmillan Cancer Support**

Several services: improving cancer journey in Glasgow (ICJ) spreading to Dundee and Fife offers holistic needs assessment to everyone diagnosed with cancer and then a care plan which is co-ordinated in Glasgow across 238 organisation with 77% uptake from the most deprived areas. people are seen at home or in library or places of their choice with aim of connecting them and reducing isolation in addition to meeting their support and care needs. 80% report feeling more confident to self manage and about the same report less isolation. independent evaluation -interim results - extremely positive and impactful; transforming care in Glasgow; other services we are spreading is information and support in communities and we are working mainly with libraries and leisure services to do this. Alongside we have a movemore programme. Both support people with cancer and aim to reduce isolation and stress and connect people with each other - the libraries offer drop ins and a cup of tea and movemore offers support and physical activity. Both signpost to other organisations. All of these services work closely with NHS primary and secondary and specialist services. ICJ doesn't rely on referral which makes a huge difference and evaluation tells us the people who need it are accessing it, whilst those choosing not to are more independent or have other support available. Lastly we have a 1:1 support service in Forth Valley housed by NHS which bridges between acute and the community based services offering holistic needs assessment and care planning from health care assistants as well as a phone line promoting self confidence and management whilst meeting immediate needs. Also our national transforming care after treatment programme has 23 pilots across more sites than I have ticked (missed these ones but cover most areas) which many offer holistic needs assessment and all are joined up partnerships with Macmillan and community health and social care partners.

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**Midlothian Council**

The Access Point is all about guiding people to access the support they need to increase their mental wellbeing—reducing low mood and feelings of stress; increasing confidence and self-esteem. It can help through supporting to: understand more about why people may feel unwell; find out what's going on in the local community—groups, activities and services; access the support that will work best for them. People are seen in a private space by either a Nurse Therapist, who is trained in providing talking therapies, or the Access Point worker who specialises in providing community based support.

Martin Bird  
Mental Health Planning Officer  
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**Midlothian Local Area Co-ordination (ENABLE Scotland)**

Local Area Co-ordination works alongside children and adults (up to 64 years) with learning disabilities, physical disabilities and sensory impairments; and their families. We enable people to become more confident and support them to achieve their dreams and live a good life. We work alongside communities, groups and organisations supporting them to become more welcoming and inclusive. We give people information and help them to find out about things. We take time to build up relationships with individuals and their families. We plan with people and communities, to build capacity. We raise awareness that everyone should be included and help improve how public services work. We only work with people who want us in their lives and go at pace that suits people. We focus on what people can do, not what they can't do.

Catherine Acton  
Service Leader  
0131 454 1785  
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**Mood Project**

This is a community links programme specific to our project. An informal community links programme and not initiated by primary care. We developed the service as an additional arm to the services we provide and the way we work to meet unmet need for our service users. We are seeking funding to formalise this service as a pathway for service users from primary care to the community in the West Lothian area.

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**Neighbourhood Networks in Scotland Ltd**

Neighbourhood Networks is a Voluntary Organisation funded by a range of local authorities to develop peer support networks of vulnerable adults. These are facilitated by local Community Living Worker coming from the same network areas. Workers are well connected, know lots of organisation and local resources and share this information with the peer group. The workers facilitate peer support for individuals to get connected and involved in their communities. Support is centred around 8 outcome areas including health and wellbeing, friendships and

relationships, managing money, confidence and self - esteem, volunteering and employment, independent travel, life skills and community connections.

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Acting Director  
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### **Penumbra**

We receive referrals from the local social prescribing scheme. Our service supports adults experiencing mental health difficulties to explore self management tools and techniques and also engage with their local community (leisure, education, employment opportunities).

Emma Wilson (on maternity leave from 30.09.16 so thereafter Ashleigh McLeod)  
Support Manager  
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### **PKAVS**

Providing direct support to individuals to access services. Raise awareness of services through information sessions, 1 to 1 support, etc. Reduce isolation: isolation was identified as a key issue in the research. This is being addressed through new activities such as Men's Walking Group, One to One Support and trips.

(no contact details)

### **Recovery Across Mental Health (RAMH)**

Provides direct person centred access for individuals who are repeat attendees at GP's or for whom some aspect of Community involvement supercedes the need for medical intervention.

Stephen McLellan  
Chief Executive  
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### **RNIB**

Vision Support Officers (VSOs) work in the community to support people who have a learning disability, autism or dementia. There are also Children's VSOs working with and supporting families. VSOs raise awareness of hidden sight loss by delivering specialist training, working with internal and external colleagues to develop referral pathways. Support may be through appropriate signposting, giving information and directly supporting assessment and optometry appointments.

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**Scottish Communities for Health and Wellbeing**

The essence of community-led approaches to improving health and wellbeing relies on effective local partnerships and the building of trust and respect as well as delivering what you say you will do for individuals and for partner organisations. SCHW organisations have extensive expertise and experience in doing this. They are truly effective linking organisations with, in most cases a variety of community link workers. This is not a new ideas for our organisations.

John Cassidy  
Director  
0141 583 5031  
[john.kcassidy@ntlworld.com](mailto:john.kcassidy@ntlworld.com)

**St. Ninian's Stay and Play Family Support Group, Dundee**

We are a non judgemental support service for families. We provide a Stay and Play opportunity and activities for parents to improve interaction with their children, to increase self confidence in dealing with themselves, with others and with external agencies, to develop increased awareness of their child's development, reduce isolation, anxiety and stress and increase their awareness of and opportunities for personal development. We also improve the overall development and resilience of each child. We provide opportunities for training and developing our volunteers especially those with learning difficulties or as a way back into work.

Rhona Armitage  
Trustee/Line Manager/Fundraiser/Volunteer  
01382 350238  
[cooriekiminca@tiscali.co.uk](mailto:cooriekiminca@tiscali.co.uk)

**STRIVE Wellbeing**

Links Practitioners are there to help patients, working alongside the GP, to get people on a positive and individual path to resolving challenges that daily life brings. We assist with health, stress, isolation, depression, anxiety, housing, benefits, alcohol, finances and many other matters.

Gayle Bell  
Head of Wellbeing  
01875 615423  
[gayle@strive.me.uk](mailto:gayle@strive.me.uk)

**Thistle Foundation**

The Wellbeing Team is part of the Lothian House of Care Collaboration, a partnership between the NHS, social care and third sector. Led by Thistle Foundation, the team is comprised of NHS Lothian and Thistle staff embedded in 20 GP practices to support people with or at risk of long term conditions to live well. Practitioners support practices to adopt a house of care approach by: providing one-to-one and group based self management support; targeting inequality via intensive support for people in complex situations. Further learning support is offered on a regular basis by the Collaboration.

Mark Hoolahan  
Deputy CEO  
07552 277423  
[Mark.Hoolahan@thistle.org.uk](mailto:Mark.Hoolahan@thistle.org.uk)

**Thistle Foundation**

The Wellbeing Team supports people (18 years of age and over). Having a conversation with a practitioner gives you an opportunity to talk about what really matters to you in life and explore how to improve your health and wellbeing. This can help you to discover solutions, gain confidence and feel more able to manage life when living with health problems and other difficulties.

Flora Henderson  
House of Care Project Lead  
0131 661 3366  
[flora.henderson@thistle.org.uk](mailto:flora.henderson@thistle.org.uk)

**Waverley Care**

Waverley Care provides assertive outreach support and prevention services for people living with HIV and/or Hepatitis C and to those at risk of contracting these conditions. In doing so we work closely with all referral partners to deliver a responsive service to meet the individual needs of our client base. This involves working closely with primary and secondary care. We are contracted by the NHS Boards in each of the local authority areas indicated above to deliver these services.

David Cameron  
Senior Manager  
0131 558 1425  
[david.cameron@waverleycare.org](mailto:david.cameron@waverleycare.org)

**Your Voice**

The Community Connectors service pilot is intended to be outcomes led and flexible to deliver the aims of the project, and test the model in the 12 month period. The Community Connectors should work with a range of individuals with a wide variety of health and social care support needs, in the broadest sense – including social isolation and social exclusion.

Karen Haldane  
Executive Officer  
01475 728628  
[karen.haldane@yourvoice.org.uk](mailto:karen.haldane@yourvoice.org.uk)

**(Unnamed organisation)**

Helping to minimise unnecessary GP involvement. Building resilience and Social Connectedness Quote from GP: "This now means I don't need to give people tablets for conditions they don't have".

(no contact details)

**(Unnamed organisation)**

We support patients being discharged from the Royal Edinburgh Hospital. We offer support to manage mental health, relationships, being part of the local community and work and learning.

(no contact details)

**(Unnamed organisation)**

We work with the local links worker in the local Deep End practice, so we are one of resources that they link to as opposed to a funded CLW programme we are an asset they link to and we work in an integrated way e.g. Happier in Your Skin an anti obesity and physical activity and wellbeing campaign.

(no contact details)

## Role of the host organisation

- 2.7 More than 80% of organisations saw their main roles as signposting, taking primary care referrals, and supporting people to take up services in other organisations.

What role does your organisation play in the your CLW programme / service? Please tick all that apply.		
Answer Options	Response Percent	
We signpost to other services	89%	
We take referrals from Primary Care	81%	
We support people to take up appropriate services in other organisations	81%	
We manage the service	73%	
We develop a personal plan with the person	73%	
We assess people's needs	71%	
We support people to take up appropriate services in our organisation	67%	
We build capacity in local third sector organisations	48%	
We provide training and shared learning for local third sector organisations	46%	
We are a partner in the service	44%	
We make referrals to Primary Care	40%	
We build capacity in Primary Care	31%	
<b>answered question</b>		<b>52</b>
<b>skipped question</b>		<b>8</b>

- 2.8 Almost three quarters of respondents were the lead partner in the programme.

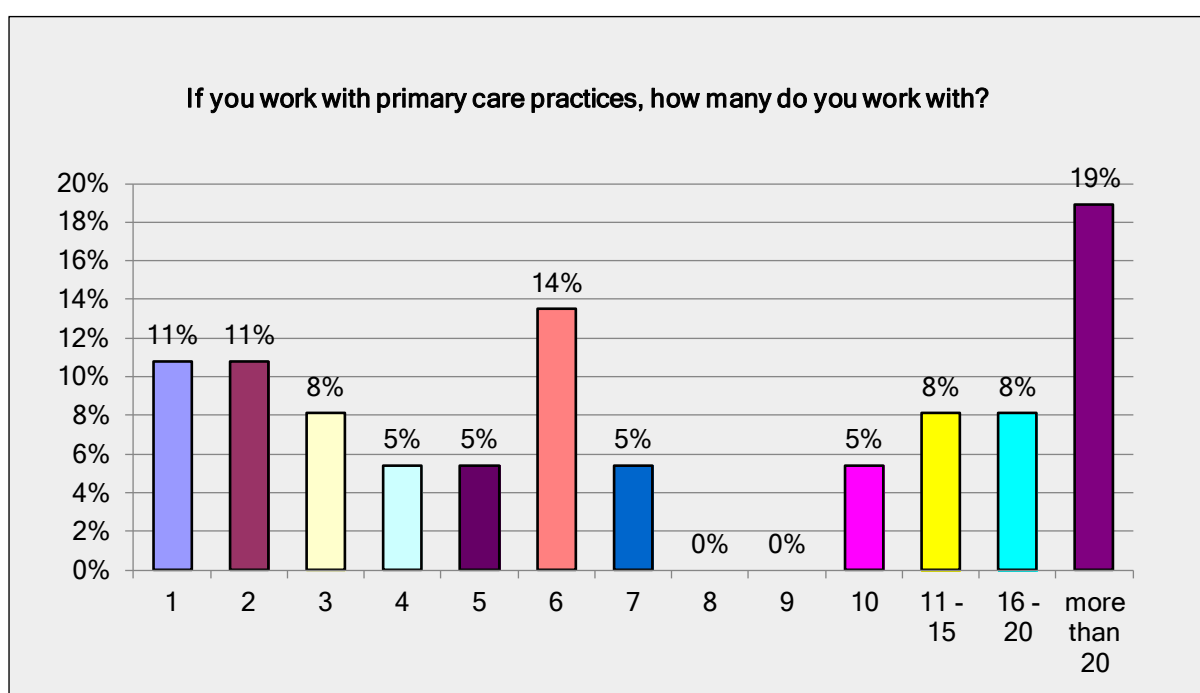
Who is the lead partner in your CLW programme / service? Please select one.		
Answer Options	Response Percent	
Your organisation	72%	
NHS	13%	
Local authority	11%	
Third Sector Interface (TSI)	4%	
<b>answered question</b>		<b>47</b>
<b>skipped question</b>		<b>13</b>

## Referrals

2.9 Word of mouth and self referral were the largest source of referrals, followed by GPs.

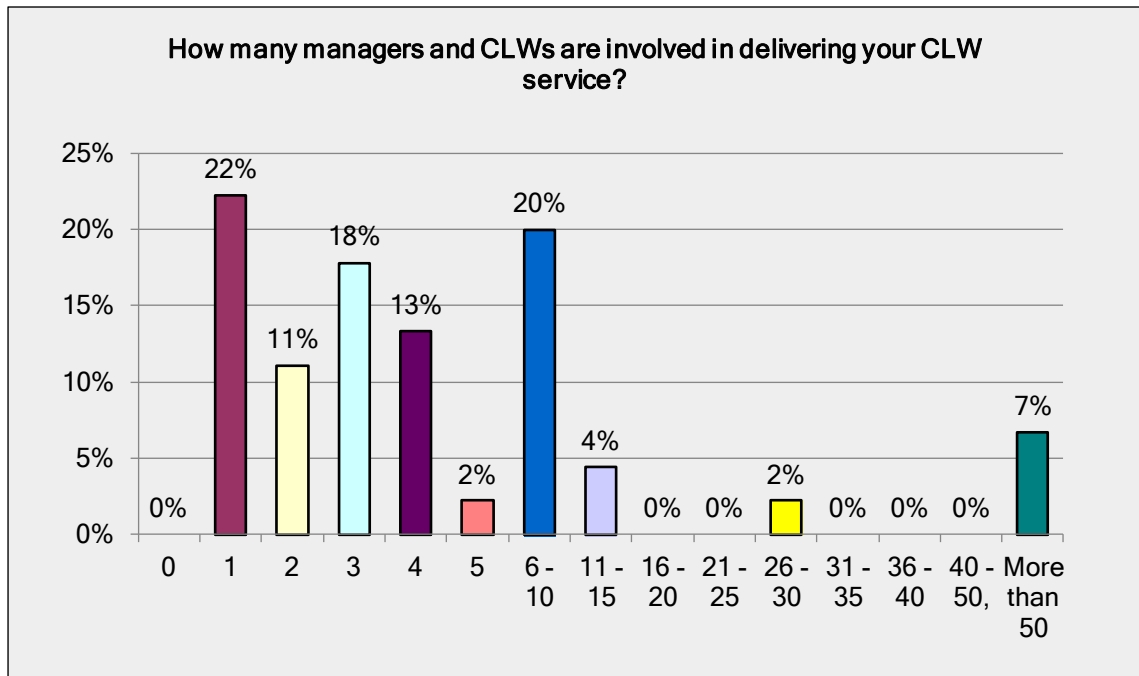
Who makes referrals to your CLW programme / services? Please tick all that apply.		
Answer Options	Response Percent	
Word of mouth / recommendation from previous participant	88%	
Self referral	88%	
GPs	82%	
Third sector organisations	72%	
Practice nurses	70%	
Social workers	68%	
Health Visitors	60%	
Community Psychiatric Nurses	52%	
<i>answered question</i>		50
<i>skipped question</i>		10

2.10 CLW programmes tended to work either with a small number of GP practices (40% worked with five or less) or with rather larger numbers (19% worked with more than 20).

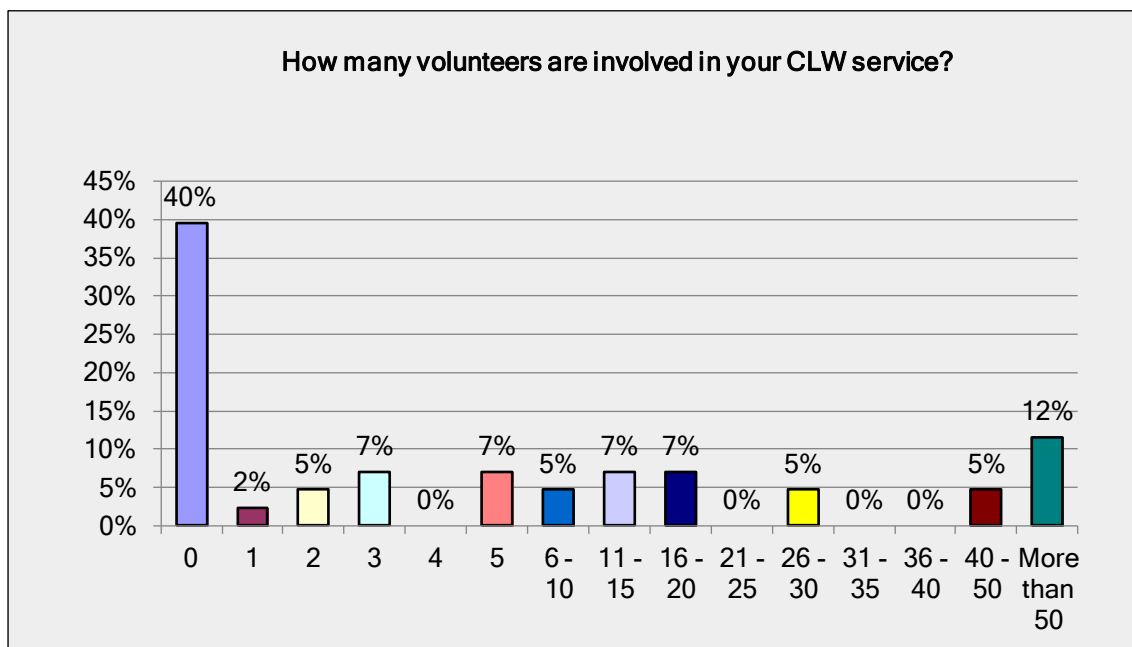


## Staff and volunteers

- 2.11 Respondents were asked about their staffing and volunteer arrangements. Most had ten or fewer managers and CLWs, but two programmes were significantly larger, with one employing more than 50 staff.



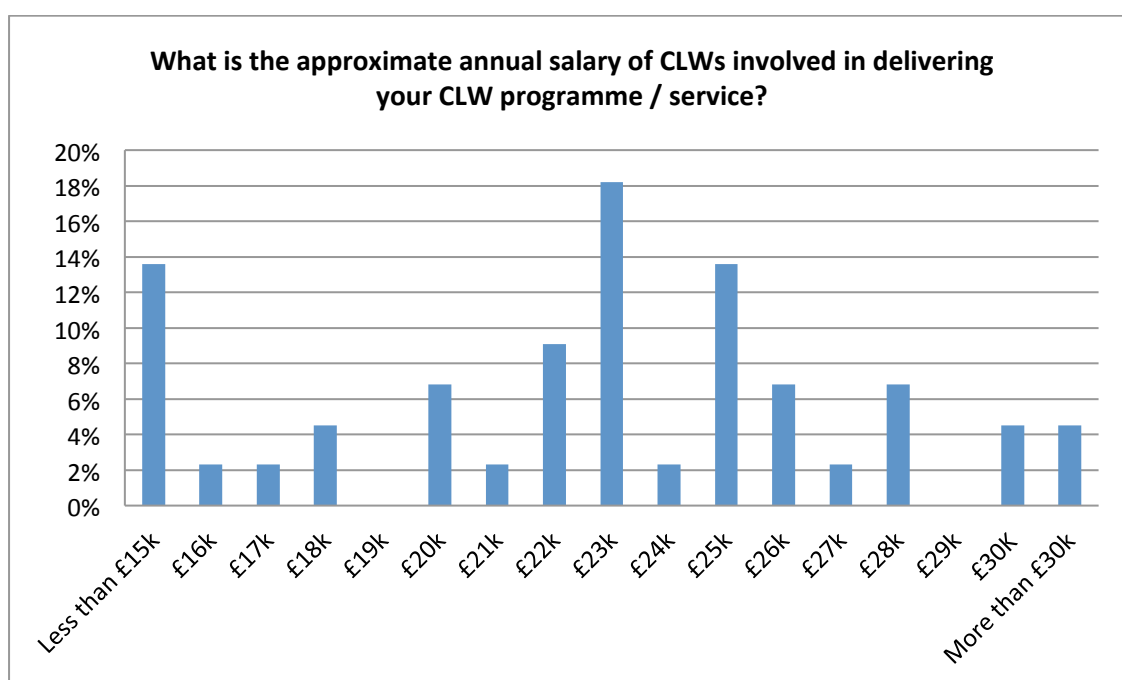
- 2.12 40% of respondents had no volunteers, but the others involved varying numbers - from one to more than 50.



- 2.13 Staff and volunteer roles tended to overlap with regard to: linking to other local organisations; providing local intelligence; and supporting people. Staff however were more involved in assessment, referral, and management of the service.

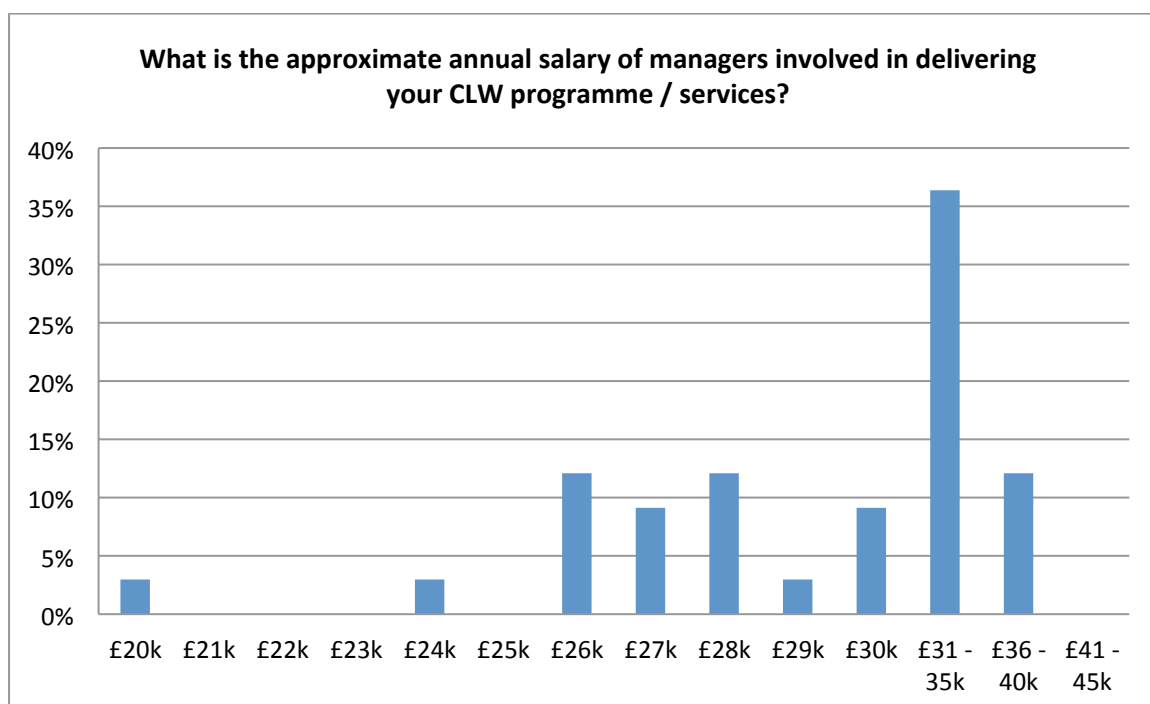
Staff and volunteer roles		
	Staff	Volunteers
They provide links with other community organisations	98%	68%
They provide intelligence about what is available locally	98%	64%
They make referrals to other organisations	92%	18%
They support people on a 1:1 basis	92%	79%
They assess people's needs	88%	11%
They manage the service	82%	21%
They help with admin functions (including IT and website maintenance)	60%	46%
They build capacity in local third sector organisations	58%	32%
They build capacity in primary care teams	42%	7%

- 2.14 Salaries for CLWs varied considerably.





2.15 Salaries for managers also varied but most were between £31K and £35K.



2.16 62% of respondents did not have staff based at primary care practices.

## Funding

2.17 The two most frequently occurring sources of funding were the local authority, followed by the Integration Authority. It is worth noting that significant resources were additionally generated from other sources, including organisations' own fund raising efforts.

Where does the funding come from? Please select all that apply.		
Answer Options	Response Percent	
Local authority	44%	
Integration Authority	38%	
NHS	31%	
Own fund raising	31%	
Scottish Government	29%	
Trust/Foundation	29%	
Self generated (earned) income	13%	
BIG Lottery	8%	
<i>answered question</i>		48
<i>skipped question</i>		12

- 2.18 Grants were the largest source of funding. For most programmes (55%), funding was secure only up until 2017.

What type of funding is it? Please select all that apply.		
Answer Options	Response Percent	
Grant	54%	
Service Level Agreement	35%	
Fund raising	31%	
Contract	25%	
Seed / start-up / development money	23%	
<i>answered question</i>		<b>48</b>
<i>skipped question</i>		<b>12</b>

- 2.19 Overall, most programmes (77%) spent between £10K and £500K on staffing costs annually, with about a quarter of respondents spending £5 - 10,000, a quarter £10 - 50,000, and a quarter £50 - 100,000.

Approximately how much money do you spend annually on staffing costs (manager, CLWs) for your CLW programme / service?		
Answer Options	Response Percent	
Less than £5,000	7%	
£5,000 - £10,000	2%	
£10,000 - £50,000	29%	
£50,000 - £100,000	24%	
£100,000 - £500,000	24%	
£500,000 - £1m	9%	
More than £1m	4%	
<i>answered question</i>		<b>45</b>
<i>skipped question</i>		<b>15</b>

## Outcomes for people

- 2.20 Respondents were asked to rank in order of importance the outcomes for people achieved by their CLW programmes. Respondents tended to prioritise outcomes related to general positive health over access to specific services and facilities.

Please rank in order of importance the following outcomes for people which your CLW programme / service aims to achieve (1= most important).		
Answer Options	Rating Average	
Improved general health, living well, and a self-management strategy	4.74	
Being seen as a 'whole' person	4.92	
Improved confidence and self esteem	5.28	
Reduced anxiety and depression	5.66	
Increased resilience for dealing with crises through support and networks	5.81	
Positive lifestyle change	5.97	
More able to access and use available information and support	6.32	
Improved socio-economic situation (eg housing, benefits & practical support, foodbank, clothing store)	7.65	
Improved access to community facilities	8.14	
Increased knowledge of groups and services available	8.16	
More able to 'navigate' health and other services	8.33	
Able to adapt to a diagnosis	9.77	
Improved relationship with professionals	10.62	
Positive travel on employability pathway (eg having accessed educational or training opportunities)	11.21	
<i>answered question</i>		<b>42</b>
<i>skipped question</i>		<b>18</b>

## Outcomes for communities

- 2.21 Similarly, respondents were asked to rank the outcomes for communities, with the priority being given to more effective use of community resources.

Please rank in order of importance the following outcomes for communities which your CLW programme / service aims to achieve (1 = most important).		
Answer Options	Rating Average	
More appropriate referrals to community based resource through understanding the service they offer	4.09	
Impact on community resources to help people live well	4.33	
Resolve shared problems jointly	4.84	
Increase referrals to community based resources	5.03	
Impact on NHS services	5.24	
Develop stronger community / general practice links	5.29	
Impact on the local community	5.29	
Establish referral pathways	5.52	
Develop ('bridging') social capital	5.94	
Impact on local authority services	7.25	
<i>answered question</i>		<b>37</b>
<i>skipped question</i>		<b>23</b>

## Strengths of third sector CLW programmes

- 2.22 Respondents were asked to identify the main strengths of third sector organisations being involved in delivering CLW programmes. The responses fell into four broad categories: trust; holistic approaches; partnership; flexibility and innovation.

### Trust

- 2.23 Third sector organisations were seen as having the trust of local communities, and thus a measure of credibility with local people and organisations.

*'They are close to their communities and understand how people affected by health inequality need extra input and third sector organisations have this expertise and often draw on highly developed knowledge / skills such as person-centred, strengths based ways of working.'*

*'3rd sector organisations are seen as being neutral and are trusted in the community, whereas often local authority or NHS services are not. This makes it easier to form relationships with the people referred to us and improves the outcomes we achieve. We also already have good relationships with local community organisations and other 3rd sector groups.'*

*'We are a trusted brand and evidence from Easterhouse demonstrated Macmillan and libraries were more trusted than health and social care; we know the impact of isolation with a cancer diagnosis worsening this and want to make sure people access the support they need.'*

*'Local projects and community based Organisations have the trust of local people/patients/service users/beneficiaries and therefore can identify and engage much better than statutory agencies.'*

### Holistic approaches

- 2.24 Third sector organisations were described as offering holistic, person centred services. This 'non-medical' and 'non-clinical' dimension was felt to be an important factor in drawing in service users.

*'They have the time to work with the individual, knowledge of local community, can engage with other organisations and quickly deal with issues - such as lack of training or awareness of issues being experienced by service users. Have flexibility to offer a holistic service.'*

*'Due to the growing person centred asset focused approach of most Third Sector Organisations, they are equipped to create meaningful connections based on the person's best hopes for their future and in supporting individuals to develop strategies that help promote better self-management.'*

### Partnership

- 2.25 Third sector organisations are used to working in partnership with other organisations, and this was seen as a major strength for CLW programmes, working across sectors and organisational boundaries.

*'Positive partnership working, common aims for individuals' outcomes, co-production, flexibility in offer, specialist knowledge and training,'*

*'The ability to work flexibly and in partnership with a wide range of organisations. The trust that develops between service users and third sector is particularly strong (sometimes in contrast to their experience of statutory services).'*

### **Flexibility and innovation**

- 2.26 The ability to respond quickly and flexibly to identified need was an important facet of third sector working. This also facilitated innovation.

*'Third Sector organisations bring more innovation and often are not tied to historical bureaucracies and structure which can be difficult to change. In the example of Neighbourhood Networks a flexible and responsive service can be provided due to a non traditional model of support being on offer. Neighbourhood network workers don't follow a shift pattern instead they can offer a flexible responsive service to networks to maximise the opportunities in people's communities.'*

*'3rd sector organisations often offer more person centred responses to people experiencing inequalities. They can be more flexible, respond more quickly, are more compassionate and often go the extra mile for patients.'*

### **Challenges facing third sector organisations involved in CLW programmes**

- 2.27 Respondents identified two main areas of challenges for third sector organisations delivering CLW programmes - funding, and statutory sector perceptions of the third sector.

#### **Funding**

- 2.28 The most frequently mentioned challenge (by two thirds of respondents) was funding. This was seen as short term, unpredictable, and subject to the whim of statutory services.

*'Funding is usually our biggest challenge - being sustainable and being able to retain staff as a result. Pay scales can also be an issue as they are lower than NHS and local authority so we can lose staff.'*

*'Our main challenge is funding - or lack of it and its insecurity. This is also often misunderstood by statutory agencies and is seen as a lack of commitment / professionalism and not seen as the fact that workers don't know if they will still have a job in a few months' time.'*

*'There is a pressure due to funding - contracts are often on a year to year basis, making planning ahead difficult. There is a sense that Third Sector will be the first to go and on-going work is lost. Projects end with short warning and no-where to pick this up.'*

*'Funding is currently the main issue. AOD receive some NHS funding through a SLA however many services are provided free to the user at point of contact and we have to raise funds via donations to support this. voluntary sector organisations should not be continually expected to support initiatives without funding.'*

*'Securing adequate funding to cover costs to invest in best practice and 'what works' is a continuous challenge.'*

### **Statutory sector perceptions of the third sector**

- 2.29 Many respondents felt that the role and work of the third sector was not widely recognised, and was poorly understood by public sector organisations. As a result it was often undervalued.

*'Having a meaningful dialogue with overstretched primary care (and other statutory service) teams is difficult. Except for a few cases, they don't properly understand how we can usefully complement their work and indeed alleviate the pressures they face.'*

*'The risk of being sidelined or completely ignored by the statutory organisations - who just choose to do their own 'version' of Links Working and reinvent the wheel.'*

*'Credibility from NHS staff, encouraging referrals to service, establishing outcomes - especially if sign posting, following up outcomes where someone has taken considerable time to reach solution.'*

*'Statutory services don't always recognise the contribution made by 3rd sector organisations. We have been referred to as "enthusiastic amateurs".'*

*'Not always taken seriously or professionally enough. Seen as amateurs, inadequate resources, disengaged from service planning.'*

### **Unmet patient need**

- 2.30 Respondents were asked if there were unmet patient needs which they were aware of, which could potentially be met by third sector services. These fell into three broad categories: mental health; social support for non-clinical needs; overwhelmed services.

#### **Mental health**

- 2.31 Several people mentioned the demand for mental health services, and the problems of accessing these services.

*'To provide additional support to people such as those with mental health problems i.e. as well as medication from the doctor, they could be involved in a music therapy group run by a third sector programme. People with mental health/physical health/substance misuse issues also often have other life challenges to face such as money problems, housing issues, relationship issues etc which they could be supported with from third sector programmes.'*

*'Mental health is a real issue for many of our clients, however access to mental health services is poor and difficult to achieve.'*

*'The rising incidence of mental health issues across the board and the isolation and loneliness experienced by older people could use up infinitely more resources and in particular time. It is hard to see how these can be effectively tackled without greater resources being invested in the social model of health and in particular community led approaches to improving health and wellbeing.'*

### **Social support for non-clinical needs**

- 2.32 There was clearly a role to further develop services which met people's para-medical needs. Often these were currently taking up time and resource in primary care.

*'The evidence indicates that public services, inc. health, results in a lot of demand failure. People often go to their GP, not for a medical ailment, but because they don't have anyone else to turn to for a bit of reassurance, guidance, support, or even simply company. This creates repeat visits and undue pressure on a system that's not set up to respond to those issues.'*

*'Through our asset mapping process we have mapped 320 services and identified 2 significant gaps in provision which are community transport and general befriending. The majority of befriending services in Glasgow are provided by condition specific organisations with very few delivering befriending to older people that are isolated or have lost their confidence or who have mobility issues.'*

*'Patients are struggling with the number of reassessments and scrutiny of their current claims and awards. Routine ESA and PIP reassessments for benefit together with inadequate support to negotiate the increasingly complex and changeable benefits system mean that many patients are struggling. Often clients come to their GP for help around such issues or are adversely affected by the levels of stress that the situations generate for them.'*

*'I think the next step is volunteers to meet people at their doors and support people to leave their houses and connect with others.'*

### **Overwhelmed services**

- 2.33 A simple failure of supply to meet demand was highlighted by respondents, with several saying that if they had the resources, there would be significant progress in meeting local needs.

*'The issue is capacity....we have more referrals than we can cope with and that is an unsatisfactory position for practitioners who see the value of early intervention.'*

## Sustainability

- 2.34 Respondents were asked to rank in order of priority a number of factors that challenged sustainability. Unsurprisingly, funding was the biggest challenge.

What are the sustainability challenges for third sector organisations involved in CLW programmes / services? Please rank in order of importance. (1 = most important).		
Answer Options	Rating Average	
Funding is inadequate to cover costs	1.44	
The capacity and willingness of primary care staff to engage with third sector organisations	2.76	
Dependency on individual relationships rather than systems	3.32	
Local community organisations capacity to take on new referrals	3.58	
Third sector organisations capacity and skills to evaluate services	5.06	
Third sector organisations' staff turnover	5.41	
The capacity and willingness of third sector organisations to engage with primary care staff	5.74	
answered question		38
skipped question		22

## Using the third sector to develop CLW programmes

- 2.35 Respondents were asked to comment on how the third sector could contribute to the development of CLW programmes. They identified three main functions: involvement in service design and planning; mainstream service delivery; the provision of specialist expertise.

### Service design and planning

- 2.36 The third sector should play a role in the creation of relevant local services, drawing on its ability to co-produce with service users. Its ability to develop pilot projects was seen as integral to this. It would be important to see the third sector as an equal partner in this process.

*'Invite the third Sector to the table to discuss innovative practice and to also learn from success and failures (just as important). Be open to trying different models and create some pilot projects which are evaluated to determine the success.'*

*'Encouraging input from third sector in the design of such services and also engaging further with people who have lived experience and will be accessing such programmes.'*

*'A willingness on the part of professionals to recognise that there are skills and opportunities within the third sector that can enhance the services provided by the statutory sector. Working more closely and jointly, sharing practice and using the skills mix to the betterment of people. Recognising that 'patients' have skills and abilities too.'*



## Mainstream service delivery

- 2.37 The sector could potentially be involved in many aspects of the core delivery of services. There would be opportunities for organisations that operated Scotland-wide to scale-up their services from one area to another, sharing lessons learnt in the process.

*'Being aware of the skills and talents that reside in third sector organisations and appreciating them as a huge community resource in dealing with individuals with difficulties within the community who fight shy of the "statutory authorities" and live in isolation and poverty.'*

*'Local 3rd sector organisations (of a good size and stability) should be used as the delivery organisation for the CLW programmes. This could be the same organisation in several areas if they have the local links and the expertise - no point re-inventing the wheel if they have a good model which works. The model needs to be one which will engage well with local GPs and again, there should preferably already be a history of local engagement there so that some practices can act as advocates for the programme in new practices.'*

*'Going forward we strongly advocate for additional support to integrate primary care with third sector services available in the community. We favour an approach which is both supportive in meeting the need of those with complex needs which go beyond medical problems and empowers them by involving them in shaping the support they receive.'*

*'Evaluation is critical and where something works and this can be clearly demonstrated it should be backed in favour of "new and/or innovative approaches" that funders often require and are often risks in terms of sustainability or success. Third Sector partnering with successful models and providing services that either complement or further bolster those models' capacity is the preferable way forward.'*

## Specialist expertise

- 2.38 The specialist knowledge and expertise that resided in many third sector organisations was thought to be an important contribution. This fell into two categories - knowledge of the local needs in a particular geographic area, and specialist understanding of specific medical conditions.

*'Context differs across practices and localities. Therefore, it's important we avoid a dominant model of service, building on what works and what exists already. This offers opportunity to learn from a diversity of approaches.'*

*'A CLW programme ought to create a bridge between individual-focused care received in surgeries and opportunities in the community for people to be supported to connect, to help themselves, and to help others. This results in much richer and interconnected support networks through which entire communities can take action together towards more positive outcomes for all, with less reliance on doctors to fix them.'*

*'We use specialist staff to act as link workers for very complex and vulnerable patients. The 3rd sector is an important part of the referral pathway for patients in terms of responding to specific needs and issues and could be doing more in relation to providing befrienders and volunteers.'*

*'Partner with condition specific services for conditions that have a profound impact on health and work. Use their knowledge to engage with service users to create pathway of support to improve capacity to manage condition, understand rights, improve capacity to deal with issues.'*

*'Community Link Working already exists in a number of 3rd sector orgs - invest in them!!!'*

## 3 Findings from the TSIs

### Profile of respondents

- 3.1 The 32 Third Sector Interfaces (TSIs) exist to build empowered, resilient communities with a thriving third sector. There is a TSI in every community planning partnership area. 20 of them are single agencies and 12 of them are formed of partnerships across bodies historically associated with supporting their local voluntary sector, social enterprises and volunteers. They are independent from Government but the Scottish Government invests in four key functions which form a bedrock to their role. TSIs are held to account through a set of common standards, services and outcomes agreed with the Scottish Government and against which they report. From this bedrock they grow a diverse range of services and support that is flexible and focussed on need as they find it. Increasingly TSIs also play a role in brokering social capital, bringing together different agents locally across sectors to address specific issues from reshaping care to early years, community transport and more.
- 3.2 15 TSIs submitted responses (13 of which were complete). These were:
- Aberdeen
  - Aberdeenshire
  - Argyll & Bute
  - Dumfries & Galloway
  - Edinburgh
  - East Ayrshire
  - East Renfrewshire
  - Falkirk
  - Inverclyde
  - Moray
  - Renfrewshire
  - South Ayrshire
  - West Dunbartonshire
- 3.3 Two TSIs (Glasgow and East Lothian) submitted responses to the Service Provider survey, describing specific programmes with which they were involved.

### Range of programmes

- 3.4 All 15 TSIs were aware of CLW programmes in their areas, varying in number from one to ten. In total they were aware of 26 national organisations running CLW programmes, 23 regional organisations, and 30 community organisations.
- 3.5 Respondents were asked to describe CLW programmes with which they were directly involved. 11 different programmes were described. These were:
- Home from hospital in-reach (East Renfrewshire)
  - Community Enablers (Argyll & Bute)
  - East Ayrshire Community Connectors (East Ayrshire)
  - Community Connectors (South Ayrshire)
  - Community Connectors (Inverclyde)
  - FDAMH Social Prescribing (Falkirk)
  - Community Links (Aberdeenshire)

WDCVS Social Prescribing Service (West Dunbartonshire)  
 Link Up (West Dunbartonshire)  
 Community Compass (Carr Gomm) (Edinburgh)  
 Community Activity Mentors (EVOC/NHSL) (Edinburgh)

## Role of the TSIs

- 3.6 The main roles performed by third sector service providers in CLW programmes (as seen by the TSIs) were: managing the service; supporting people to take up services in their own organisation; signposting to services; supporting people to take up services in other organisations.

What is the role of third sector service providers in this programme / service? Please tick all that apply.	
Answer Options	Response Percent
They manage the service	100%
They support people to take up appropriate services in their organisation	100%
They signpost to other services	89%
They support people to take up appropriate services in other organisations	89%
They assess people's needs	78%
They take referrals from Primary Care	56%
They make referrals to Primary Care	56%
They are a partner in the service	44%
They build capacity in local third sector organisations	44%
They develop a personal plan with the person	33%
They provide training and shared learning for local third sector organisations	33%
They build capacity in Primary Care	11%
<b>answered question</b>	
<b>9</b>	
<b>skipped question</b>	
<b>6</b>	

- 3.7 In all cases, the TSI was the lead partner.

## Referrals

- 3.8 Referrals came from the following sources, with two thirds being generated by social work, word of mouth, or self referral. Almost 60% took referrals from the NHS (including GPs, practice nurses, and health visitors).

Who makes referrals to this CLW programme / service? Please tick all that apply.		
Answer Options	Response Percent	
Social workers	67%	
Word of mouth / recommendation from previous participant	67%	
Self referral	67%	
GPs	56%	
Practice nurses	56%	
Health Visitors	56%	
Community Psychiatric Nurses	56%	
Third sector organisations	33%	
<i>answered question</i>		9
<i>skipped question</i>		6

- 3.9 CLW programmes tended to work either with a small number of GP practices (two or three) or with 16 - 20.

## Staff and volunteers

- 3.10 Respondents were asked about their staffing and volunteer arrangements. None of the programmes mentioned had more than ten staff. Three programmes had no volunteers, with the remaining four ranging from six to more than 50.
- 3.11 Staff and volunteer roles tended to overlap, for example with a shared focus on providing local intelligence. Volunteers in particular provided links to other community organisations.

What roles do staff and volunteers perform? Please tick all that apply.		
Answer Options	Staff	Volunteers
They manage the service	89%	
They provide intelligence about what is available locally	89%	75%
They make referrals to other organisations	78%	25%
They provide links with other community organisations	78%	100%
They support people on a 1:1 basis	67%	75%
They build capacity in local third sector organisations	67%	
They assess people's needs	56%	
They help with admin functions (including IT and website maintenance)	56%	25%
They build capacity in primary care teams	22%	

- 3.12 Salaries for CLWs varied considerably, ranging from less than £15K to £24K. Salaries for managers varied less, and were in the range £25K to £29K.

## Funding

- 3.13 The majority of programmes were in receipt of funding from the Integration Authority, and grants were the main type of funding, with over 70% taking this form. A significant amount of funding was generated from other sources, including organisations' own fund raising efforts.

Where does the funding come from? Please select all that apply.		
Answer Options	Response Percent	
Integration Authority	78%	
Own fund raising	33%	
Scottish Government	22%	
Trust/Foundation	22%	
Self generated (earned) income	22%	
BIG Lottery	11%	
NHS	0%	
Local authority	0%	
<i>answered question</i>		9
<i>skipped question</i>		6

## Outcomes for people

- 3.14 Respondents were asked to rank in order of importance the outcomes for people achieved by the CLW programmes. The greatest priority tended to be on accessing support and services.

Please rank in order of importance the following outcomes for people which third sector CLW programmes / services aim to achieve (1= most important).		
Answer Options	Rating Average	
More able to access and use available information and support	4.60	
Positive lifestyle change	4.64	
Increased knowledge of groups and services available	4.73	
Being seen as a 'whole' person	6.10	
Improved general health, living well, and a self-management strategy	6.10	
Increased resilience for dealing with crises through support and networks	6.60	
More able to 'navigate' health and other services	7.10	
Improved confidence and self esteem	7.20	
Reduced anxiety and depression	7.73	
Improved socio-economic situation (eg housing, benefits & practical support, foodbank, clothing store)	8.00	
Improved access to community facilities	8.30	
Improved relationship with professionals	9.10	
Able to adapt to a diagnosis	11.00	
Positive travel on employability pathway (eg having accessed educational or training opportunities)	11.60	
<i>answered question</i>		11
<i>skipped question</i>		4

## Outcomes for communities

- 3.15 Similarly, respondents were asked to rank in order of importance the outcomes for communities achieved by CLW programmes. Here, they laid the emphasis on more effective links between primary care and community resources.

Please rank in order of importance the following outcomes for communities which third sector CLW programmes / services aim to achieve (1 = most important).		
Answer Options	Rating Average	
Increase referrals to community based resources	2.70	
Develop stronger community / general practice links	3.10	
More appropriate referrals to community based resource through understanding the service they offer	4.50	
Establish referral pathways	4.78	
Impact on community resources to help people live well	4.80	
Resolve shared problems jointly	5.30	
Impact on the local community	6.10	
Develop ('bridging') social capital	6.45	
Impact on NHS services	7.44	
Impact on local authority services	7.60	
answered question		11
skipped question		4

## Strengths of third sector CLW programmes

- 3.16 Respondents were asked to identify the main strengths of third sector organisations being involved in delivering CLW programmes. They emphasised the importance of the third sector's ability to deliver services that were flexible and person-centred, based on local knowledge.

*'Being able to be person centred, solution focused and ability to take a holistic view of the situation. Not taking a medical view and treating people as an illness.'*

*'We have co-produced the service highlighting the strength of the TSI to know what is on the ground and to be able to support third sector orgs to continually improve and develop - this has built confidence in the referrers and helped streamline the system.'*

*'Offer choices and flexible approaches which meet local needs. The range of services meant we were able to offer activities and supports locally which were not previously available through statutory services. Local knowledge meant gaps were more easily identifiable - solutions were sought from including views of local people.'*

*'Third Sector is local, knows a community, was probably set up by that community, and any investment stays in organisations in the local area.'*

## Challenges facing third sector organisations involved in CLW programmes

- 3.17 Respondents identified two main areas of challenges for third sector organisations delivering CLW programmes - statutory sector perceptions of the third sector, and funding.

*'They are not yet acknowledged as an equal partner. They do not have voting rights at IJB level, are consistently not given full credit or respect for the contribution they make, and whilst there has been great progress in terms of improved partnership working, cynicism both within the public sector and the third sector presents a risk to the third sector contribution being fully realised.'*

*'Local GP leads, as recently as August 2016, said they were reluctant to use third sector services because they were unregulated, untested, and 'here today gone tomorrow' so it was more effort than it was worth.'*

*'Resource and recognition of their value. Acceptance of their level of quality provision as being equitable to that of statutory services.'*

## Unmet patient need

- 3.18 Respondents were asked if there were unmet patient needs of which they were aware, which could potentially be met by third sector services. Responses tended to emphasise the need for locally available services, especially those which focused on well-being and mental health.

*'Locality based one stop shops would prevent many of the emergency admissions and repeated reliance on GP practices (who do not as yet fully understand that non-medical issues that cause mental health issues are not always solved when another crisis is mopped up. These are cumulative and debilitating, and strip people of the feeling that they can self manage their lives when living within budgetary constraints and/or long term conditions.'*

*'Preventative interventions which support keeping well. They have a role to play in patient discharge pathways and ensuring people have access to all locally based supports. Raise awareness of Third Sector supports with H&SC professionals.'*



## Sustainability

- 3.19 Respondents were asked to rank in order of priority a number of factors that challenged sustainability. The biggest challenge concerned primary care staff's reluctance to engage with the third sector, followed by funding issues..

What are the sustainability challenges for third sector organisations involved in CLW programmes / services? Please rank in order of importance. (1 = most important)		
Answer Options	Rating Average	
The capacity and willingness of primary care staff to engage with third sector organisations	2.67	
Funding is inadequate to cover costs	3.13	
Local community organisations' capacity to take on new referrals	4.00	
Third sector organisations' capacity and skills to evaluate services	4.50	
Dependency on individual relationships rather than agreed systems and processes	4.83	
Third sector organisations' staff turnover	5.33	
Primary care's capacity and skills to evaluate services	6.14	
The lack of agreed competencies and skillsets for staff delivering CLW programmes	6.43	
The capacity and willingness of third sector organisations to engage with primary care staff	7.00	
answered question		11
skipped question		4

## Staff skills and experience

- 3.20 Respondents were asked to identify the key skills and experience required by CLWs working in the third sector. Responses focused on the value of having a range of flexible skills, being able to work with individuals and communities, and 'knowing the patch'.

*'Understanding of local community. Be able to work in a flexible, non judgemental way. Have good interpersonal and communication skills. Be a good listener. Be able to work in a person centred way. Be well organised and resourceful.'*

*'Intelligence of local 3rd sector and communities is key; strong interpersonal skills; able to facilitate engagement and to facilitate groups of people; contacts within HSCP; community development skills; excellent connections and relationships across all third and public sector; sensitive to needs and aspirations; good communication skills; flexible and innovative in problem solving.'*

## Using the third sector to develop CLW programmes

- 3.21 Respondents were asked to comment on how the third sector could contribute to the development of CLW programmes. Responses highlighted the powerful combination of the TSI as a strategic third sector body within the local authority area, with the networks of local community based voluntary organisations, and the resulting potential for partnership between the third and statutory sector.

*'Using the third sector established networks and resources on how to work with and knowledge of communities, volunteering, building capacity, community engagement, partnership, collaboration, facilitation.'*

*'Using the TSI to be the linking organisation in the whole concept, either hosting or employing the programme manager The 3rd sector is well placed to provide a diverse range of areas of expertise to link from GP's to patients and the sector.'*

*'What has worked really well locally is the use of a collaborative approach to the programme - working with multiple third sector organisations; facilitated by the TSI.'*

*'Partnership between NHS and Third Sector organisation to deliver a CLW programme. Ensure a clear MOU and audit lines to overcome temptation of the delivery organisation to 'keep' referrals for themselves and grow, ignoring or worse, taking-over existing community assets.'*

## 4 Case studies

### Purpose of the case studies

- 4.1 The purpose of the case studies was to permit an in-depth exploration of how a small sample of CLW programmes operated in practice.

### Methodology

- 4.2 Originally, four case studies were planned, but for reasons of time (the need to report early in the new year), and timing (the Christmas holidays), it was agreed to undertake only two case study visits. Following discussions with the Reference Group, it was agreed to visit:
- GCVS's' Community Connectors' service (west coast, managed by a TSI, involving the housing sector, and focusing on older people), and
  - Dundee City Council's Advice Services / GP surgery co-location (east coast, managed by the local authority but with an emerging partnership with the third sector, involving financial advice services, and focusing on people of any age)
- 4.3 The researcher spent a day visiting each of these services. This provided an opportunity to hold face-to-face meetings with the Programme Manager, staff involved in programme delivery, volunteers (in Glasgow), service users / patients, and primary care staff.
- 4.4 Thistle Foundation in Edinburgh offered to submit a description of their Wellbeing Service in response to the key areas of inquiry. This has been included.
- 4.5 The areas of inquiry were:

#### *General*

1. How was your CLW programme initiated, and how did it develop? What were your expectations?
2. Please describe your current programme, including partner organisations, staffing, and funding.

#### *Outcomes*

3. What outcomes for people have been achieved? What is the evidence?
4. What outcomes for communities have been achieved? What is the evidence?
5. Has the programme led to any other outcomes (intended or unintended)? What is the evidence?

#### *Capacity building*

6. In what ways has the programme strengthened primary care services?
7. In what ways has the programme strengthened other third sector organisations?
8. In what ways has the programme strengthened your own organisation?

### **Sustainability**

9. How sustainable is the programme (short, medium, long term)? Which factors support this, and which threaten this?
10. What is your relationship with your Integrated Joint Board (Health & Social Care Partnership)?
11. What are the main lessons that have been learnt from the programme?

### **Partnerships**

12. In what ways has the programme helped develop partnerships with other organisation (Primary Care, Local authority, Integration Authority, Third sector organisations, TSIs)? What stage are these at?

### **Other**

13. Do you have any suggestions as to how the third sector can better contribute to CLW programmes?

## **Findings from the case studies**

- 4.6 The case study visits proved to be a valuable addition to the qualitative research dimension of the study. In particular, they provided:
  - A chance to understand the strategic and operational contexts of the programmes, how they had developed, and how they viewed their future;
  - A deeper understanding of the range and diversity of the stakeholders and partners involved with the programmes;
  - An opportunity to meet service users / patients (who clearly articulated the value of the service they were receiving), and to examine how anticipated programme outcomes translated into improvements in people's lives;
  - Further insights into how the respective programmes were being evaluated. The Improvement Service was undertaking a Social Return on Investment (SROI) assessment of the Dundee programme, and FMR Research Consultancy was evaluating the Community Connectors service in Glasgow;
  - Scope for debate about the sustainability of the programmes, and the key determinants of this.

## 5 Case study one

### GCVS 'Community Connectors'

#### Glasgow Council for Voluntary Organisations

- 5.1 Glasgow Council for Voluntary Organisations (GCVS) is a registered Scottish charity and the main development agency and advocate for voluntary and community organisations in Glasgow. It is one of the four partners (GCVS, Volunteer Glasgow, Community Enterprise in Scotland and the Third Sector Forum) that make up Glasgow's Third Sector Interface. Over 600 voluntary organisations in Glasgow are members of GCVS.

#### History and development of the programme

- 5.2 The Community Connectors service in Glasgow was developed following the Reshaping Care for Older People (RCOP) consultation on the Draft Joint Strategic Commissioning Plan 2013 - 16 which was undertaken between April and July 2013. The views of over 500 stakeholders were taken into account. These included written responses, online surveys, and consultation events. Amongst other findings, respondents highlighted the need for relevant information to be made available to older people at a local level and on a face-to-face basis, using person-centred approaches, and highlighted the importance and benefits of having older people better linked into their communities, to reduce social isolation. Driven by third sector pressure to address this long-standing gap, FMR Research, a Glasgow based research consultancy, was then commissioned by GCVS - the Third Sector lead partner in the RCOP partnership - to explore the scope for a Community Connectors service in Glasgow.
- 5.3 The service, which began in June 2015, and took its first clients in September 2015, has been funded initially for two years (with a high likelihood of third year funding) from the Scottish Government Integrated Care Fund monies through Glasgow's Health and Social Care Partnership. The service also reports into the Accommodation Based Strategy Group. The Community Connectors model was designed, building on good practice evidence from the experience of the Deep End Link Worker and Local Area Co-ordination (LAC) programme activity, and from third sector knowledge of 'what works'.
- 5.4 The project is located within, and managed by, Glasgow Council for the Voluntary Sector (GCVS), which is the lead partner within the Glasgow Third Sector Interface (the agreed third sector 'lead' in the city). In this role GCVS provides technical, capacity building and development support to the third sector. It also communicates with, and keeps detailed data on, over 1,600 Third Sector organisations across the city.
- 5.5 The staff team comprises the Programme Manager, Volunteer Coordinator, and Programme Coordinator (Asset Mapping) who are based centrally at GCVS, and three small area based staff teams (Practitioner, and Client Liaison and Admin Officer) located within partner organisations' premises - at Queens Cross Housing Association, Shettleston Housing association, and Southside Housing Association.

5.6 The aims of the Community Connectors service are to:

- Support people to live well day to day through enabling access to community-led resources that will support them to meet their financial needs, participate in social life and adopt healthier habits;
- Improve communication, connectivity and referral pathways, reducing barriers to services and so enabling greater activity and take up of support by older people.

5.7 The service is open to anyone over 60 or anyone caring for someone over 60, and who lives in the areas covered by the three host Housing Associations. Particular target groups include older people in periods of transition (for example those who have recently moved house, or experienced ill health); older people who are frail and vulnerable, at risk of social isolation, not eating well, or facing challenges; men, and; carers.

5.8 People can self-refer, or can be referred by another agency. Referrals are received by email, telephone, post, online or in person. To date, 507 referrals have been received, and there are currently 130 active clients. Referrals tend to be older people who are 'just coping', or who are in a time of transition. The sources of referrals are as follows:

Self referral	26%
NHS	23%
Housing Associations	19%
Social Work	15%
Third sector	10%
Family / friends	6%
Other	1%

5.9 To aid the process of onward referral, Community Connectors have 'asset mapped' 260 city-wide and local organisations.

5.10 Staff meet the person referred, and they encourage the client to identify the issues they wish to address. The priority is to build up a relationship.

*"We try and have 'good conversations, when we look at what matters to them, not at what is the matter.... Older people trust us because we're curious about them. We never let process get in the way of the relationship." (Manager)*

5.11 The client's needs are assessed under the following headings, using a visual 'wheel' tool: physical health and wellbeing; mental health and wellbeing; keeping myself well; safe and comfortable at home; mobility and access to transport; connections (family, friends, unpaid carers); networks (groups, work, volunteering, activities); financial wellbeing; access to information; control and choice; clear about needs and goals. Using their asessed-based, good conversations approach, the Community Connectors Practitioners work to obtain a full picture of the client, seeking to fully understand what matters most to them, what is already working for them and what they want to achieve. Building on existing assets established in this initial stage, the practitioners support clients to engage with services only when it is clear that it will aid them in the achievement of their goals, and ensure that dependency is not fostered. Working in this manner ensures that the process is tailored to the person's own aspirations, and complements their existing and developing assets, thus optimising their chances of success in creating lasting change.

- 5.12 A volunteer buddy service provides additional support for clients to help them build their confidence to take first steps. For example, they may support them to become more confident in using the bus, or accompany them to meet other people and do activities. This is seen as a valued part of the overall service. The premise of the Buddy Service is to support the person to build their skill, resilience and confidence to optimise their chances of continuing independently when the buddy support is no longer available.

*"My buddy gave me my tomorrow back." (Manager, quoting a client)*

## Outcomes

- 5.13 The project has prioritised collecting robust base-line data, updated at regular intervals in the engagement process with each client, to chart progress and distance travelled. Data is logged within a bespoke Customer Relationship Management (CRM) system.
- 5.14 Additionally, the project has been evaluated independently by FMR Research Consultancy. The findings of the mid-way evaluation indicate that the core values and person centred approach of the project produce good outcomes for its client base. Net Promoter Score is an internationally recognised management tool that can be used to gauge the satisfaction and loyalty of beneficiaries to help assess how likely they would be to use the service again or refer others in. The research findings saw Community Connectors being assigned the maximum NPS of +100. While this score is unusually high, the qualitative element of the research clearly demonstrates that the results are a natural outcome of using a person centred, asset based approach, underpinned by practitioners skilled in 'good conversations'.

## Outcomes for people

- 5.15 The service puts considerable emphasis on achieving agreed outcomes for its clients. It is able to demonstrate that 40% of clients have made between 10% and 50% improvements on the 'wheel' scores (the assessment tool). Staff draw a clear distinction between 'outputs', such as the use of a befriending service, and 'outcomes', such as a reduction in social isolation. This is reinforced by one of their partner agencies.

*"It's a gold star exemplar. The big thing is the level of evaluation and the feedback on outcomes. This gives them the evidence to support the method." (Chief Executive, partner Housing Association)*

- 5.16 They have been particularly successful in engaging men.

*"They have an impact on men aged 40 - 65 years - this is a demographic which rarely engages." (Chief Executive, partner Housing Association)*

- 5.17 Staff and clients described how the service had impacted on them:

- A man, referred by the Housing Officer, had not visited the dentist for 25 years. His 'buddy' from the service discovered that the real problem was that he was illiterate, and was able to support him to attend a dental appointment

- A woman with MS was not managing her medication, and experienced incontinence problems. Support from staff led to a review of the medication. Feedback from GPs about the management of long term conditions has been positive.

- A man was having financial problems.

*"I was having trouble with my rent, and they got in touch with someone and within few days it was sorted out. They changed my whole life. I mean I gave up the will to live and everything. They're very compassionate and understanding and sympathetic. They listen to you and help you." (Client)*

- Another man faced housing problems which were impacting on his mental health.

*"I got a letter from the housing association which I read as an eviction. I was on the edge and the housing association put me in touch with Community Connectors. Staff got me to come to the lifestyle management course. I've had anxiety and depression all my life, and this is the best course I've ever been on. I had also lost control of my finances, and they sent someone to work with me for 2 or 3 weeks. The girl who came to visit me made a very simple suggestion - open a savings account. This took away the anxiety. It was a life saver to me." (Client)*

- 5.18 Clients described what they saw as the key qualities of the service. "They listen to you"; "There is unconditional acceptance"; "They treat you as a human being"; "They phone you when they say they will"; "They don't use big fancy words"; "They pick you up and take you places"; "They give you hope".

### **Outcomes for communities**

- 5.19 The Community Connectors service has achieved a number of broader outcomes, beyond its immediate impact on its clients. The service has publicised a wide range of locally available services and there has been a greater uptake of these services. The 'buddies' programme has involved up to 30 people as volunteers, creating better connectivity and networks. The service has been a single point of contact for information within the communities that GCVS serves, and third sector organisations have been assisted to reach their target groups

- 5.20 As result of the asset mapping exercise, the service has had some success in working with communities which were less connected to mainstream services. This included the travelling / fairground community, which has been supported to 'find its voice'.

*"I'm a member of fairground. She {Community Connector} actually looked at me as a person and tret me as a person - not as a Gyppo. At that time my electricity was through the roof. A lovely young man came and checked all my bills and everything like that and the difference is unbelievable - getting me on a different tariff." (Client)*

- 5.21 As a consequence, there is now a higher referral rate from female travellers, facing a variety of health and social problems, including fuel poverty, financial difficulties, literacy, poor health (dampness in their caravans). A partnership has been developed



with 'Care and Repair' to advocate on the issues the community faces. Support from an MSP has also been secured to help tackle the identified issues.

### **Unintended outcomes**

- 5.22 There have been some unintended outcomes which have brought added value to the service. A number of clients have gone on to become volunteer buddies, allowing older people to become active in their communities. The volunteer team contains 30 volunteers across the three areas, ten of whom are active at any one time. The team embraces seven nationalities, and five languages. This demographic mix has helped break down barriers between asylum seekers and refugees and local residents.
- 5.23 The level of information coming back to the service from volunteer buddies who 'walk the walk' in a very real way, has provided a deeper level of feedback on people's strengths, and the barriers and daily struggles they face. This has allowed practitioners to plan their support work with people based on a more effective understanding of the issues.
- 5.24 A lot of older people have connected with each other through the lifestyle management courses. The peer support and independent formation of groups which has sprung from this, has strengthened relationships, provided additional support, and even led to a couple of romances!

### **Capacity building**

#### **Strengthened primary care**

- 5.25 The Community Connectors service has had a positive impact on the primary care practices involved with the service. By providing an early prevention pathway for primary care staff, there has been some measure of reduced strain on the staff teams, and they have been more able to 'stay in role'. They have also built up their knowledge of community assets, particularly through the creation of a single point of contact to access information on services and support.
- 5.26 The service has also been able to provide a feedback loop to primary care staff on the progress referred individuals have made. This has supported case coordination.
- 5.27 The value of Community Connectors, particularly in areas of deprivation, is reinforced by one of the GPs involved in the service.

*"Link workers should be in the most deprived practices, where there is multi-morbidity and the greatest premature mortality. This is where there is the most need for local support." (GP)*

#### **Strengthened other third sector organisations**

- 5.28 Third sector organisations involved in offering support to clients have benefited from the service. They have found that they are more able to boost attendance and get the right people to the right services. Indirectly this helps them to meet their funding criteria.
- 5.29 Providing 'good conversations' training to close referring partners - which GCVS has funded directly - has helped develop common approaches to service delivery.

- 5.30 The service has been able to provide partners with intelligence on community assets, thereby increasing their profile and visibility. Good practice has also been shared between organisations. In particular, the strategic role of the third sector in early intervention and prevention has been highlighted.

*"The impact on the [Glasgow and West of Scotland] Forum is tangible. I can refer to the role of housing in prevention. It keeps us in the game." (Policy Officer)*

- 5.31 Volunteering posts in third sector organisations have been filled, effectively matching clients' interests with the available opportunities.
- 5.32 By providing feedback to third sector organisations on the changes older people have attributed to their work, these organisations have been able to use this evaluation evidence in funding applications.

*"Staff say Community Connectors is an additional string to their bow." (Chief Executive, partner Housing Association)*

### **Strengthened the housing sector**

- 5.33 Key partnerships are with the three 'host' housing associations. They had been trying for some years to address the health agenda (a survey of tenants three years previously identified 37% in poor health). The Community Connectors service has helped people to re-engage with housing associations and the services they provide, as well as supporting people to access social housing. Importantly, the service has increased the sector's knowledge on local assets by feeding in intelligence that helps direct their wider work.
- 5.34 The service has, in a similar way to primary care, allowed housing staff to stay in role and to pass wider issues onto another service. Previously, they would have been struggling to handle many of the issues raised by clients.
- 5.35 Overall, there is some evidence that the service has contributed to tenancy sustainment.

### **Strengthened GCVS**

- 5.36 The Community Connectors service has had a direct, positive impact on GCVS' operational and strategic work, as the host organisation. Connector's work continues to improve and enhance the quality and 'real-time' nature of data GCVS' now holds on Third Sector (TS) community assets in the city, and the contribution the TS makes to the city. In addition the staff teams have alerted GCVS about key gaps in the availability and capacity of services within different localities across the city, which, in its role as strategic development TS lead for the city, GCVS has then sought to highlight and problem solve.
- 5.37 Developmental pathways for volunteers have been created through the buddying scheme, increasing the employability of volunteers, and assisting them to reach 'positive destinations'.
- 5.38 A model of staff team 'self-care' has evolved, based on reflective practice through a variety of mediums. These include team meeting structures, one to one support, and

shadowing. Protected learning has helped to develop a shared language and set of values.

- 5.39 Encouraging the workers to define and shape the values, behaviours, processes and working practices of the service has led to a strong sense of team ownership.

## Sustainability

- 5.40 The central issue underpinning sustainability is the funding model. The service is currently only funded for two years, and there is a degree of uncertainty as to what lies after that. Partner organisations feel that the service demonstrates an effective and efficient funding model, where the housing associations bear the overhead costs (office accommodation, and utilities), while GCVS (the Third Sector Interface) is responsible for staff costs.

- 5.41 The lack of long term funding within the third sector is seen as a problem by partners in the NHS.

*"The worry with third sector services is that the funding runs out. You've built a relationship and then it's gone. It's a huge frustration to GPs." (GP)*

- 5.42 Volunteers are simultaneously an asset and a liability. They add value to the organisation and strengthen its capacity, but it can be a somewhat illusory asset because they may move on with their new found skills and confidence. However, due to Community Connectors having a dedicated staffing resource to support volunteer management and recruitment they are able to manage the turnover in a way that ensure a consistent bank of volunteer buddies is retained.

*"There are challenges retaining volunteers because people use the experience to get jobs!" (Volunteer buddy)*

- 5.43 There have been some key areas of learning which have wider implications for the sustainability of similar schemes:

- The 'good conversation' approach is essential in supporting work within a person centred, asset based approach, and helps protect the staff from 'therapy burn out';
- The importance of preparing partners and clients to work effectively with the service through the use of relevant publicity and information materials;
- The need for flexibility in supporting people to achieve their outcomes;
- Older people are looking for more meaningful and deeper connections on an emotional level with others (and with themselves), rather than simply the uptake of services;
- Small changes in behaviour result in paradigm shifts, and ultimately encourage and support big changes in people's lives;
- Individuals managing one or more long terms condition can struggle to change without lifestyle management support;
- Older people and professionals tend to talk more about 'outputs' than 'outcomes'.

## Third sector contribution to community link working

5.44 The Community Connectors service summarises the critical contribution made by the third sector to community link working:

- Access and connectivity through the TSI to Flexibility and agility in being able to develop service provision in response to identified needs
- Building 'intelligence' on the identified gaps in provision and on 'what works' - and then using this to build further capacity, promote improvement and expand provision
- The use of person centred, asset based approaches
- Working with 'community anchor' organisations - both geographic and thematic.

## 6 Case study two

### Dundee Council Advice Services / GP surgery co-location

#### History and development of the programme

6.1 The Dundee City Council Advice Services / GP surgery co-location initiative began in January 2015. It was informed and shaped by a programme of third sector advisors in GP practices which had been running in Edinburgh since 2001. Staff from Dundee City Council visited Edinburgh in 2014, and subsequently devised the model for Dundee. It was designed to deal with many of the socio-economic issues faced every day by GPs in the surgery, about which they could, in effect, do very little.

6.2 The broader strategic context for the Dundee initiative was current developments in UK welfare reform. The City Council Advice Services were seeing an increasing number of patients who were being affected by the changes to the welfare benefits system. This was in turn having a negative impact on their health and well-being.

*"74% of our clients are in receipt of ESA, DLA, PIP, or Attendance Allowances." (Senior manager, Dundee City Council Advice Services)*

6.3 This often in turn led to increased pressure on NHS services which were unable to meet the socio-economic concerns of patients. Primary care especially found that this was getting in the way of them being able to provide effective clinical care.

6.4 It was acknowledged that in order to improve public health and wellbeing there was a need for a shift in resource distribution and a greater targeting of services and programmes towards early intervention and those most in need.

*"We were trying to do early intervention - to reduce the need for the client to go to an appeal tribunal." (Senior manager, Dundee City Council Advice Services)*

6.5 Following discussions with staff in Edinburgh, the Local Medical Committee (LMC) in Dundee was contacted and potential models discussed. The model was researched throughout 2014, and started Jan 2015.

6.6 There are 22 surgeries in Dundee, and the programme ended up working in five of them: Taybank surgery from January 2015; Lochee Surgery from June 2015; Wallacetown Surgery from April 2016; Douglas Surgery from July 2016; Brooksbank Centre in the Crescent Surgery in Whitfield from November 2016.

6.7 The programme is led by Dundee City Council but has deliberately involved a third sector organisation - the Brooksbank Centre - to increase the capacity of the programme and to draw on its geographic and subject specific expertise. The Brooksbank Centre is a registered charity that provides a wide range of services to alleviate the effects of poverty, particularly in the communities of Mid-Craigie and Linlathen.

- 6.8 The anticipated longer term outcomes of the programme were that:
- More people with health conditions return to or retain employment or meaningful activity
  - Health and Social Care services are accessible, appropriate and inequalities sensitive
  - Health and Social Care services support patients to manage financial insecurity
  - The impact that advice can have on improving patients' overall health and wellbeing is recognised
  - NHS influences other relevant UK, Scottish and local policies that affect health outcomes
- 6.9 The key implementation features of the Dundee model are:
- Earlier intervention before things go wrong for patients
  - Dedicated welfare rights staff in each practice, based on a co-location model, working 2 days per week
  - Confidential interviewing facilities for each session
  - Practice partnership agreements and protocols in place
  - Direct links into Macmillan Service, Fuel Poverty Service (DEEAP), home visiting, budgeting and employability services
  - Access to GP practice bookings systems
  - Access to client medical evidence with express client permission
- 6.10 The programme is funded from within existing Council budgets and through existing resources in the Brooksbank Centre. The cost of office space for the welfare rights staff in the GP practices is absorbed by the practices.
- 6.11 Each of the five Advice Workers has around 50 clients at varying stages of involvement. The confidential interviewing facilities for each session allow for five appointments of between 45 minutes and one hour. Bookings tend to be made one or two weeks in advance, but there is some flexibility in the system to deal with emergencies. Practice partnership agreements and protocols are in place.
- 6.12 It has been important to use staff who bring experience and expertise.
- "I went in as an experienced member of staff. I had done debt, employment support, tribunals. I knew the evidence required." (Welfare Rights Officer, Dundee City Council Advice Services)*
- 6.13 Becoming an integrated feature of the GP practice team has been central to the initiative.
- "We get on well with the [primary care] staff. I go to social things such as the Christmas night out." (Welfare Rights Officer, Dundee City Council Advice Services)*
- 6.14 The success factors of the programme, as described by the Advisors, are:
- Using experienced workers
  - Meeting people on familiar ground (the GP practice)
  - Access to the practice bookings systems

- Access to client medical evidence with express client permission

*"[Welfare Rights Officer] has permission to go into my records without disturbing the doctor. It's not taking up a valuable appointment that somebody else could take up." (Client)*

- Building relationships with the practice

*"The GPs have an understanding that it's not just the medical side. There are other life situations having an impact." (Welfare Rights Officer, Dundee City Council Advice Services)*

- Advertising the service in the surgery (through posters and by word of mouth)
- Not taking on too many appointments, and leaving enough time for the required 'back office' admin tasks

6.15 Currently, the programme is actively looking to expand into more practices.

## Outcomes

### Outcomes for people

6.16 To date, 88% of appointments with Advisers have been kept, and 394 separate enquiries answered. This has translated into some highly successful results for patients, especially for those who otherwise might not have had access to a comparable service.

*"There are some patients who wouldn't engage with anyone else if the Advice Service wasn't there at the GP surgery." (Welfare Rights Officer, Brooksbank Centre)*

*"It's easy to talk to [Welfare Rights Officer]. You're not judged. You feel comfortable. It's in my own surgery, where I've been coming since I was a baby. It's not formal and it's confidential. It's not like 'she's in here because she's got herself into debt'" (Client)*

6.17 There is evidence of improved outcomes for patients' benefit claims and appeals, with £689,294 in client gains being achieved since the service started. There is a faster response times from DWP around ESA and PIP claims.

6.18 One client was referred by her GP. She needed assistance with Employment and Support Allowance mandatory reconsideration. The client attended an appointment at the surgery and the necessary information to form the basis of an appeal was obtained. With the client's agreement and mandate, relevant recent medical records were accessed and sent along with a letter/submission from the Adviser. Within three working days the client had a positive decision, being placed in the Support Group. The outcome was positive in several respects: the service user's anxiety and stress were relieved quickly; there was no further requirement for the practice to supply 'fit notes'; Welfare Rights did not have to proceed to Tribunal; and both her Housing Benefit and Council Tax Reduction were protected. The client then made an application for Personal Independence Payment assisted by Welfare Rights. Incorporating information from the client's medical records a decision was made

without the service user having to attend an ATOS medical examination, and the enhanced daily living rate was awarded within 3 weeks of the application.

## Outcomes for communities

6.19 The initiative supports three of the Health and Social Care Partnership's eight strategic priorities.

- Health inequalities: resources have been shifted to invest in health inequalities
- Early intervention/Prevention: existing resources have been re-directed into early intervention and prevention approaches
- Models of support/Pathways of Care: although a specialist service, this is a remodelling of an existing services designed to improve capacity and access to advice and financial referral paths within primary care

6.20 The programme has become embedded within the five practices in the local communities which they serve, strengthening the overall type and range of support available..

*"The GPs love it. We take cases away from GPs when they come through the doors. There's a reduced need for medical certificates. GPs have a better understanding of what we do and how we help patients. The model encourages officers to become part of the practice team. This bridges the gap between benefits and health knowledge." (Senior manager, Dundee City Council Advice Services)*

6.21 It has demonstrated a way of working with vulnerable people in areas of deprivation without having to 'label' them.

*"It serves an anti-stigma role. It doesn't put people through the mill. We can reach people who are poorly equipped to discuss health issues." (Senior manager, Dundee City Council Advice Services)*

## Unintended outcomes

6.22 The programme has learnt lessons as it has developed. The amount of time required away from the 'coalface', especially for the more complex cases, had not been anticipated.

*"We underestimated the time spent after sessions by Advisors in the 'backroom', having to deal with more material, such as correlating the medical report with benefits." (Senior manager, Dundee City Council Advice Services)*

## Capacity building

### Strengthened primary care

6.23 The programme has had a positive impact on the practices where the service has been operating. There has been increasing use of the service by health professionals (including GPs and practice nurses), and it has taken the burden of socio-economic concerns away from them and helped to alleviate primary care workloads.



*"It allows medical staff to treat patients, not to listen to benefit problems they can't treat." (Welfare Rights Officer, Dundee City Council Advice Services)*

- 6.24 As a result, primary care staff have been better able to make use of their time and focus on medical interventions. Council staff have observed this.

*"One GP said to us - 'where were you all these years?'" (Senior manager, Dundee City Council Advice Services)*

*"A couple of GPs said 'we should have had this years ago.'" (Welfare Rights Officer, Dundee City Council Advice Services)*

- 6.25 Staff in the practices have also commented.

*"It's taken the pressure off the GP. Welfare rights has taken off. The patients are interested. There's no negative issues, not one complaint." (GP Practice Manager)*

### **Strengthened third sector organisations**

- 6.26 The Dundee model is led by the local authority, and entirely reliant on staff from the Advice Services team. One third sector organisation, the Brooksbank Centre, is currently engaged in delivering the service, and this is seen by the Council as one of the programme's strengths. Brooksbank staff echo this.

*"Involving the voluntary sector means there is a greater measure of choice and independence, and access to wider services." (Welfare Rights Officer, Brooksbank Centre)*

- 6.27 Conversely, it has provided key opportunities for the organisation to extend its reach into the local community, and to extend its service 'offer'.

- 6.28 The City Council is planning to involve new partners from the third sector. This includes the CAB and the local Carers Centre.

*"We're open to new third sector organisations coming forward, but they'll need to use the model. We can't do it all ourselves." (Senior manager, Dundee City Council Advice Services)*

### **Strengthened Council Advice Services**

- 6.29 The programme has had a beneficial effect on the Council's Advice Services. At a strategic level, it has enabled the service to reach increased numbers of its key target groups. There is also a better understanding of client needs and how best to respond to these. Significantly, there has also been a reduction in the number of appeals.

- 6.30 At an operational level, Advisors are able to be more productive.

*"We can do a greater volume of work in GP surgeries compared to the past. We get to the nub of the problem and get a result. We do twice the level of work compared to historic advice delivery." (Senior manager, Dundee City Council Advice Services)*

## Sustainability

- 6.31 The Senior Manager in the Council Advice Services was clear from the outset that, if the service was to be sustainable, it would not only need to deliver on its programme outcomes, but it would also need the ability to draw on mainstream funding sources. This meant that the programme was developed with an eye to this. The service was viewed from the start as a way of enhancing their mainstream service delivery, rather than simply as a short term 'project'.

*"I wanted it to be service re-design. It was a conscious attempt to deal with the sustainability issue." (Senior manager, Dundee City Council Advice Services)*

- 6.32 Currently the local CAB is 'waiting in the wings' for the next GP practice to come on board. This will extend the role of the third sector in the programme.

- 6.33 A crucial dimension to ensuring a sustainable programme, is that there is widespread understanding and support for the work among GP practices. This is seen as a 'work in progress', as other practices in the city may not yet understand the model. As part of the further extension to the programme, Advice Services plan to make presentations to them.

- 6.34 Strategic support within the Council is also vital if sustainability is to be guaranteed.

*"As long as we have senior management and Councillors approval we can continue to deliver." (Senior manager, Dundee City Council Advice Services)*

- 6.35 The Improvement Service has recently completed a 'Social Return on Investment' study of both the Edinburgh and Dundee Advice programmes. It found that every £1 invested would generate around £39 of social and economic benefits, and concluded.

*'Funders valued the opportunity that co-locating advisors in medical centres offered to improve their ability to target resources at priority groups. There was recognition that a reduction in health costs will result from the improvements to health and wellbeing and reductions in stress levels reported by clients/patients as a consequence of easier and earlier access to advice services.' (Forecast Social Return on Investment Analysis on the co-location of advice workers with consensual access to individual medical records in medical practices, January 2017)*

## Third sector contribution to community link working

- 6.36 While the programme is led and managed by the Council, the third sector is seen as bringing essential strengths to the service. It increases the overall capacity of the service (and stands to significantly impact on this, if further organisations are recruited to become involved as the programme extends into new GP practices). Because third sector organisations are often located in specific areas (as against city-wide services), they offer important local intelligence about the geographical areas they serve (for example, the Brooksbank Centre is based in Whitfield). Their specialist sectoral knowledge in discrete areas (for example housing, carers) means they can also bring a measure of expertise that enhances the current 'offer'.

- 6.37 In the final analysis, there is an issue of capacity, and partners in the third sector will always be needed.

*"If we were in every surgery, there's no way we would have the expertise. We couldn't do it all ourselves." (Welfare Rights Officer, Dundee City Council Advice Services)*

# 7 Case study three

## Thistle Foundation Wellbeing Service

### Thistle Foundation

7.1 Thistle Foundation is a registered Scottish charity, established over 70 years ago in Craigmillar, Edinburgh. They provide a range of services across Edinburgh and the Lothians, to support people with long term health conditions to live life on their own terms. Services include supported living service, lifestyle management, gym and exercise classes, and specialist support for veterans.

7.2 The following content was provided directly by Thistle Foundation.

### History and development of the programme

7.3 The programme was developed from existing work within the Health and Wellbeing service at Thistle Foundation. Our self-management service has offered an open door to people living with long term conditions for more than ten years. We use a solution focused questioning process to help people explore their best hopes for moving forwards in life, whether this be managing their health specifically or managing life. Support offered by the service has focused on supporting people to self-manage and includes self-management courses, one to one support, and physical activity options with a community gym on site and signposting and support to other services.

7.4 As an early adopter project under the Lothian House of Care initiative the Wellbeing Service is a partnership with NHS Lothian that was developed from 2015 onwards, and aimed to build on Thistle's self-management service by providing more local support to people via GP practices. The pilot aimed to focus its work in GP practices serving people experiencing high levels of health inequalities. To ensure success the pilot focused on practices where GP's and staff had a keen interest in getting involved in this work. The pilot initially provided a service to GP practices in Newbattle and Penicuik in Midlothian, and six practices in Edinburgh's North East locality.

7.5 We feel that Thistle's model adds value to Community Link Work by supporting people to explore self-management and to be more confident at managing their health and life in the future. This is quite distinctive to other types of link working such as those which provide social prescribing or purely sign posting support.

7.6 The Wellbeing Service brings together staff who have experience in supporting people living with long term health conditions via outcome focused, strengths based ways of working. A recent extension to the pilot in Midlothian also brings in additional NHS staff with some occupational therapists joining the team to extend the service across more practices in Midlothian. The Thistle team has a mixed background with some practitioners having a health background, while some have extensive experience working in community based projects working with people in a person centred way, and supporting people with their personal outcomes and self management.

7.7 The project has been funded by a variety of sources over the last year and a half. The Midlothian part of the pilot has been funded by Midlothian's Integrated Care

Fund (ICF) through the Integrated Joint Board (IJB) and the extension of the project is funded by the ICF (2016 - March 2018) and the Primary Care Transformation Fund. The North East Edinburgh pilot has been funded by Scottish Government funding (2015 - 2016), then by the Edinburgh ICF and Long Term Conditions Programme through the Edinburgh IJB from April 2016 - 17. The funding streams described are transitional funds and to date there is no agreement to fund this work through local recurring and sustainable IJB funding streams. There is currently no guaranteed funding for the North East pilot beyond March 2017.

- 7.8 This work receives strategic support via the House of Care (HoC) initiative which is located within the Strategic Plans for the Edinburgh and Midlothian Integrated Joint Boards. As an early adopter project within the HoC initiative the work is by centralised evaluation support and resources. For example, an NHS analyst analyses raw evaluation data which then contributes to evaluation reports.

## Outcomes

### *Outcomes for people*

- 7.9 A range of people related outcome measures have been collected so far in the pilot, including
- Personal outcomes and change on these personal outcomes
  - Change in confidence and coping to manage their situation
  - WEMWBS scores
  - Qualitative story data – demonstrating changes people have achieved
- 7.10 Qualitative data has been collected around what was different about the support the person received, and also from learning cycles run every six to eight weeks within the GP practices to explore the difference the service had made.
- 7.11 The future extension to the pilot in Midlothian will also aim to look for changes the service has made at other levels, such as health care usage, impact on GPs and other services.
- 7.12 Currently the data for people who have been through the service shows statistically significant change on all quantitative measures used.

### *Sophie's story*

- 7.13 Sophie is a 61 year old lady who has suffered with stress and anxiety for over 20 years. She has a social phobia and can only go places she is familiar with (like the GP) or when she has to go to new places, she has to practise repeatedly with her husband who is very supportive. She was referred to the Wellbeing service at the end of last year and has been seen eight times. Since attending she has put some positive changes into place, is managing to reflect on her progress, and is slowly realising her skills and resilience. This has been a difficult year for Sophie with both a family death and family ill health, and also a recent change in her GP she had been seeing for years.
- 7.14 Before attending the service she said she would not sleep well or eat properly for a whole week before any planned event and would have to take diazepam in order to get through it. She wanted to be able to cope better and to manage her stress better and tells me that she is now able to get through the week before an event without stressing or losing sleep over it until closer to the time. She describes strategies she

now uses to manage her anxiety such as focussing on things that distract her and things she enjoys such as going out in the garden.

- 7.15 Sophie tells me she has more confidence and that her husband has noticed she seems calmer and is not as depressed or relying on him so heavily. She says she is now 'more pro-active in dealing with stuff that happens' without relying on other people. She felt she was able to support her sister who has had a stroke by communicating to the hospital concerns about her discharge home.

- 7.16 Working with the practitioner has been really helpful.

*"She doesn't tell me what I should do, but she helps me think about things and helps me notice that I AM doing things. She helps me listen to myself maybe so that I can make my own choices and that is more powerful. The most important thing has been being listened to and not feeling judged. It feels safe. I started feeling a difference on my third or fourth visit."*

- 7.17 Sophie feels she is coping really well now and her mental state is a lot better.

- 7.18 When asked what she hoped for in the future, she said that she didn't think her phobias would ever go away as she had had them for too long. She said she knows she will always have 'limits' but that she now has a way with getting on with them. She would want her confidence to grow even more than it has, and then reflected that that would probably help with the phobias a bit. Things have been getting easier, she is thinking more rationally and is not letting her phobias take over and says she hopes that will continue and things will continue to get easier.

### **Katie's story**

- 7.19 Katie (64) was referred in December 2015 and had her final Wellbeing meeting in June, after eight meetings, approximately once a month. At the time of referral: she was recently retired, is a carer for her elderly mother, her GP was warning about pre-diabetes. She had low mood and did not want to take anti-depressants, if avoidable. Her personal outcomes included wanting to lose weight, increase energy levels, and increase her knowledge about diet/nutrition. As well as the regular one-to-one meetings, the Wellbeing practitioner referred her to the Thistle Foundation Nutrition Lifestyle Management course (10 weeks). Katie really enjoyed the course and fed back very positively about it. She also did a local 'Keep moving' course. She said the combination of both these courses, helped her to feel more motivated.

*"Going to the Nutrition Lifestyle Management course, we inspired each other. One of the men on the course heard me talking about going out on my bike and he said that inspired him to get back on his bike also. We've all given each other something".*

- 7.20 She said that she and her husband are spending a lot of time together, walking and cycling, and she feels this has improved their relationship also.

- 7.21 Katie felt the service was helpful as she was offered an appointment quickly.

*"One hour of your time was very precious to me at the beginning. You had more than a ten minute appointment to offer and I never felt rushed. I was able to talk about my feelings and you just listened."*

7.22 Katie said it helped because the service guided her but she did it herself.

*"Over the time I was having Wellbeing support, I felt like my communication with my husband and family improved. I felt my mood lifted because of this, so I was less irritable & snappy. All these things put together were very important. I'm listening more with friends too. In the past, things would pour out of me sometimes. I'm letting people talk to me again - which is nice because I feel like I'm not being a burden to them. Everything is not about me. In the past I would have went away and worried about what I'd said, and got myself into a bit of a state about it. Have I said things wrong? Now if I have something to say- I say it, but otherwise I just listen."*

*"I have a lot more confidence because I am feeling good in myself. Usually when my sister is up, I can get myself into a bit of a state because she comments on all the things that need done. This time I just ignored her! This meant that I was calmer. We all had a nice day out with mum and my granddaughter reminiscing. It was lovely. I am prioritising my own needs more, for example when I had a bad back. In the past I would have just worked through it, but this time I went to see a chiropractor. My husband was really surprised. It was the best thing I ever done. A big step for me. Another thing for myself. It sort of lifts you and it gave me a good feeling inside. Just being able to say 'I done that for myself. I really enjoyed it'. Feeling a bit better, the pain is disappearing. Also things like getting the house in order, everything down from the attic, getting it sorted and labelled. My husband is doing it with me, which is different because usually I do things like this on my own and he would just leave me to it. That's a big step - doing it together, which is nice."*

*"I just feel calmer in general and better able to cope with things. For example, when my husband was ill and hospitalised, I coped with that well. I just stayed calm and got him into hospital. I even stood back on that. Usually I'd ask lots and lots of questions to the doctors, and my husband would tell me to stop. I've given him his right to listen to the doctor without me interrupting. I'm now learning that he has to ask the questions. This is a big change for me."*

## **Outcomes for communities**

7.23 Although no specific outcomes for communities were collected. The story collection process shows the impact of people managing their health and life differently, and the effect this has including people returning to work, being carers, supporting their family and moving into volunteering.

## **Capacity building**

### **Strengthened primary care**

7.24 The data from the learning cycles has not yet been fully analysed to assess impact on GP practices. However, the GPs have been enthusiastic about the value of the service to the people they see and are keen to have the resource in their practice.



## **Strengthened third sector organisations**

- 7.25 Thistle has other partnerships with third sector organisations and the practitioners have linked with many organisations delivering services in the areas they are working in. The pilot has encouraged cross referral and feedback to GPs has increased awareness of third sector services

## **Strengthened Thistle Foundation**

- 7.26 The programme has increased the profile of Thistle and has given us the opportunity to pilot our centred based work in other settings. We are aware of the value of our core service based at our centre in providing support options (these are not funded by IJB funding).
- 7.27 The project has helped create effective relationships at a strategic level between Thistle's strategic leadership team and strategic leaders within the Health and Social Care Partnership (particularly within Public Health, Primary Care, Senior GPs and new Locality Managers).
- 7.28 It has also created effective relationships at operational level between Thistle's Wellbeing Practitioners and practitioners within other third sector organisations and health workers including Occupational Therapists and Health Coaches.

## **Sustainability**

- 7.29 The North East work is currently unfunded beyond March 2017, so threatening its future. The Midlothian work is funded until March 2018, at which point funding, if available, would potentially come from the IJB.
- 7.30 The main lessons that have been learnt from the programme include:
- Good knowledge of resources in the community to signpost and refer people to is vital, and establishing good relationships with these organisations is important to support referral processes
  - Partnership working between third sector and NHS staff takes time to establish there can be challenges in working process and cultures of the two sectors
  - Managing capacity in the service can be challenging – so ensuring enough resource is allocated for individual practices is difficult. Midlothian is well resourced but the pilot in the North East requires practitioners to work across several practices.

## **Third sector contribution to community link working**

- 7.31 Link working seems to be varied in its methods and length of support. These range from brief signposting support that maybe lasts one or two sessions to longer support over a period of months. Our pilot is not limited to a few sessions we feel it to be truly person centred and works at a person's pace who might need support over a period of time. For some people living in complex situations, initial support sometimes helps to unpick the chaos, while later support helps them to look forward towards self managing and building resilience for the future. A clear definition of link working would be useful so an evidence base can be built to support funding.



## 8 Conclusions

- 8.1 Taking account of the findings of the two surveys, the data gathered through the three case studies, and deliberation with VHS and the Reference Group, we have reached the following conclusions.

### Range of CLW programmes

- 8.2 There is evidence of a wide range of third sector organisations already delivering CLW programmes across all local authorities in Scotland except one (Orkney). These include organisations working locally in single local authority areas, as well as programmes which operate more broadly across several local authorities.
- 8.3 Some programmes focus on specific health conditions. Others concern themselves more with promoting holistic approaches to health. Running through all the programmes is a commitment to person-centred approaches, and an endeavouring to take seriously the need for early intervention and prevention. Mental health figures prominently within many of the programmes.
- 8.4 While a measure of theoretical debate exists about nomenclature (community link working, social prescribing, signposting etc), there is a clear thread that runs through the majority of programmes. Local community services are galvanised for the benefit, health, and well-being of local people, while inappropriate demands on primary care are alleviated, freeing up GPs and practice staff to focus on their 'core' work.
- 8.5 Programmes vary quite dramatically in size. Some are small and localised, working with tens of patients. Others are spread across several local authorities, and may be dealing with hundreds of people. The staffing levels within the organisations reflect this diversity. The third sector bridges this divide, with a long established organisational presence both in local communities, and at a regional and national level.

### Operational issues

- 8.6 The majority of CLW programmes (whether in the public or third sector) have been in operation for a relatively short period of time. Many however, with some justification, trace their roots back to long established third sector practice in local communities. The main functions of CLW programmes are generally: taking referrals from primary care; signposting to services; assessment and personal planning; and, supporting people to take up services in other organisations.
- 8.7 Referrals to programmes tend to be by word of mouth, self referral, and via GPs. Third sector networks at local level are often well developed, and the local intelligence about community resources and opportunities plays an important role here.
- 8.8 Salary levels of CLWs vary considerably, while those of managers are more consistent. This probably reflects the fact that the work is still relatively new and 'finding its feet' with regard to pay scales and terms and conditions.
- 8.9 Volunteers are used in two thirds of programmes. Long seen as one of the defining features of the third sector, volunteers bring the ability to offer local 'intelligence', a connection to local services, a major contribution to organisational capacity, and a

rooted sense of a community's history - important when services are attempting to identify the best source of local support for clients.

- 8.10 Funding tends to come from the public sector (local authority, Integration Authority) but a significant portion is raised through the organisations' own fund raising efforts and from trusts. This reflects a well established feature of third sector organisations - that, because of their independence from government, they are well placed to generate support (financial, human, moral) from a range of different sources. In times of austerity, the value of this 'multiplier effect' is not to be underestimated.

## Outcomes

- 8.11 Third sector organisations delivering CLW programmes are acquainted with the language and practice of outcomes. In many cases they have a highly sophisticated understanding of what this means in practice. The identified 'outcomes for people' described by organisations which responded to the surveys tended to focus on improved general health (including mental health), increased confidence, and reduced anxiety. Specific programmes targeting particular conditions (eg cancer) have also been developed.
- 8.12 Outcomes for communities tended to focus on more effective use of community based resources.
- 8.13 In the context of increasingly stringent demands on third sector organisations to account for the use of money, many have developed robust systems of evaluation and quality assurance. This has informed the way that CLW programmes have developed, with a number of external evaluations being commissioned to validate the work.

## The role and contribution of third sector service providers

- 8.14 Third sector CLW programmes are seen as having many strengths. They are able to gain the trust of people and communities through a generational commitment to local working. Their commitment to a pragmatic and holistic approach to health allows them to engage and involve people, often those who are most vulnerable and distant from services. Skills in partnership working have grown and developed - often out of necessity. Able to operate with a high degree of flexibility and with a predisposition towards innovation, third sector organisations have the capacity to be key partners in CLW programmes.
- 8.15 They have specific skills and areas of expertise - in specialised areas of health, as well as in broader approaches to community development. Their connectedness to, and credibility with, local networks of support places them in a strong position to help evolve local services.
- 8.16 There is a notable emphasis on mental health within many of the organisations involved in this study. Many have articulated the need to further develop mental health and well-being services, and to meet broader 'non-clinical' needs.

## The role and contribution of Third Sector Interfaces

- 8.17 TSIs tend to have adopted a strategic managerial role with regard to CLW programmes - in keeping with their broader advocacy function. There are, however, many examples where TSIs run programmes directly (eg Glasgow). Their third sector

representative role on a range of local authority-wide strategic partnerships and bodies (IJBs, Health & Social Care Partnerships) means they can exert influence with key public sector bodies. With the support of various IT and CRM systems, they are also able to maintain an informed overview of third sector activities and concerns.

- 8.18 The recent Scottish Government review of TSIs and VAS has focused some criticism on certain aspects of their operations such as their current limitations on delivering their core strategic role in relation to community planning, and the variation in quality and range of services delivered locally. At the same time, the review recognises that the third sector is a key partner for government with regard to service delivery, and that the more integrated approach developed by TSIs since 2011 is of value. The review's primary recommendation is that 'the core purpose of the Third Sector Interfaces in future should be on becoming a strategic vehicle for Third Sector involvement in Community Planning and integration'. This has relevance for their strategic role in relation to CLW programmes (see 8.17).

## Current challenges

- 8.19 The key challenges facing third sector organisations as they seek to contribute to the development of CLW programmes across Scotland are twofold. Funding (or rather the limited and short term nature of it) is a major concern. It severely limits the extent to which programmes can be properly trialled, evaluated, and mainstreamed. Few of the organisations taking part in the study were able to say with confidence that their funding would last beyond 2017. There is a need to establish funding regimes which are based on a five year term.
- 8.20 Partly because of this febrile funding picture (with its implications for job security - or lack thereof), and partly because of the historic divide between public sector and third sector services, there are variable perceptions of the third sector among statutory bodies, especially primary care. The disparity in size between the two only tends to exacerbate this. It will be important to address this (for example through joint training, work shadowing, and use of ICT) in any future CLW programmes, building partnerships which are based on mutual respect.

## Current opportunities

- 8.21 The third sector is not a single entity. It is an organically linked family of organisations - large, medium, small, and micro. It has some key defining features (for example independent governance, non-profit funding, the use of volunteers, and a campaigning zeal on behalf of service users), but it is not without its faults and frailties. The most effective way of using the third sector in the CLW programmes would be to:
- Actively involve it in the design and planning of services, recognising and drawing on its areas of expertise;
  - Provide a greater range of mainstream service delivery opportunities through contracts and SLAs;
  - And, further develop its contribution to specialist service delivery, wherever it has a recognised specialism.

## 9 Recommendations

- 9.1 The following recommendations are made in the context of the Scottish Government's Programme for Government Scotland 2016/17 which stated: 'We will recruit up to 250 community link workers to work in GP surgeries.' The recommendations make no assumptions about the level of resources that may be made available for the development and implementation of a national CLW programme.

### The role and contribution of the third sector

#### *Recommendation 1*

- 9.2 The Scottish Government should provide leadership and support for the third sector by communicating a clear message that the third sector should be recognised, valued and embedded as a key partner in the strategic development and delivery of the programme at both national and local levels. This should include the contribution of national third sector intermediary bodies such as Voluntary Health Scotland, Voluntary Action Scotland and The Alliance. In particular, account should be taken of the third sector's ability to:

- Map and provide detailed knowledge of local assets
- Act as a conduit and a bridge between primary care and communities
- Build trust and social capital at a locality level
- Reach and engage effectively with those whom others may have labelled as 'hard to reach'
- Offer holistic, assets based, and person-centred approaches
- Model flexibility and innovation
- Offer specialist and relevant knowledge, experience and expertise.

### Partnership with primary care

#### *Recommendation 2*

- 9.3 Primary care should be supported to identify and involve third sector partners from the outset of developing a CLW service. The planning and development of new CLW roles should involve sustained collaboration between GPs/primary care, Integration Authorities and the third sector (e.g. Third Sector Interfaces) to provide solutions tailored to local needs.

### Workforce development

#### *Recommendation 3*

- 9.4 Cross-sectoral approaches to workforce development and workforce planning should be significantly extended and strengthened, in order to maximise the sharing of knowledge, skills and experience, and the creation of more integrated workforces across the public and third sectors. The inclusion of third sector CLW roles as part of primary care multi-disciplinary teams should be further developed.

### ***Recommendation 4***

- 9.5 The major contribution of volunteers to CLW programmes should be further developed, recognising that they are not a 'cost free' resource. Investment will be needed for the recruitment, training, support, and management of volunteers as a key element to programmes.

## **The focus of investment**

### ***Recommendation 5***

- 9.6 Investment in community link worker approaches should focus on supporting models that build and sustain community capacity and that take a pro-active approach where it is clear that there are gaps in community provision beyond primary care. The introduction of CLWs to a GP surgery needs to avoid simply signposting patients to services, including third sector services, that may already be overstretched and under-resourced.

### ***Recommendation 6***

- 9.7 CLW programmes should aim to commission third sector organisations for a minimum period of three years, in order to ensure the scope for programme quality, partnership development, workforce development, and meaningful evaluation.

## **Sustaining the programme**

### ***Recommendation 7***

- 9.8 The Scottish Government should work with national organisations to scope the financial sustainability of local CLW programmes beyond the term of the current government (2020). That work should begin now to enable sufficient lead-in time for plans to be put in place.



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