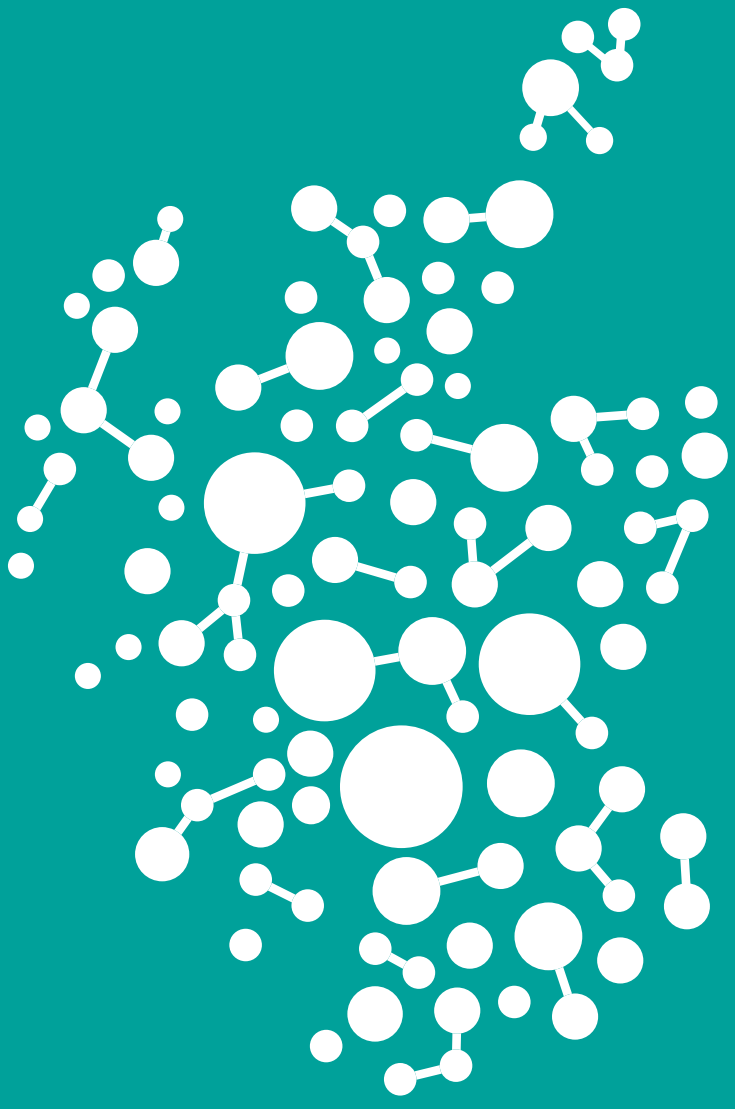
SCOTTISH COMMUNITY LINK WORKER NETWORK

GIVING A VOICE TO SCOTLAND'S COMMUNITY LINK WORKERS

ESSENTIAL CONNECTIONS:
Exploring the range and scope of community link worker programmes across Scotland

Findlay Smith

November 2023



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ESSENTIAL CONNECTIONS: Exploring the range and scope of community link worker programmes across Scotland

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Executive summary

Context

Voluntary Health Scotland (VHS) is the national intermediary and network for voluntary health organisations across Scotland. Our purpose is to create a healthier, fairer Scotland, served by a thriving voluntary sector. Since 2021, the Scottish Government Primary Care Directorate has provided project funding to VHS to establish and develop the Scottish Community Link Worker Network (SCLWN). The Network aims to create a shared space for community link workers (CLWs) in primary care settings across Scotland to share learning, and to develop, network, and support each other to improve outcomes for their patients and communities.

In 2016, the Scottish Government committed to recruiting at least 250 CLWs to work in GP practices. Community link working was then included as one of six key priority service areas within the Memorandum of Understanding (MoU) for the 2018 General Medical Services contract. Subsequently, CLW programmes have emerged incrementally across Scotland, with over 300 CLWs currently working in GP practices across Scotland in 2023.

This research aimed to capture and understand more about the range of community CLW programmes working in GP practices across Scotland since these developments. Whilst the SCLWN hears, anecdotally, from members about the positive impact that their respective programmes have across the country, relatively little was known about how these programmes were designed and implemented, or the perspectives of practitioners working within programmes.

Evidence was gathered between January and June 2023 from an online survey completed by 60 CLWs working in GP practices and interviews with 18 CLW programmes leads and managers across Scotland. We also analysed publicly available documents and reports on community link working in Scotland and across the UK.

Key Findings

Programme Design and Structure

A range of approaches has been applied to the design and structure of CLW programmes, with each reflecting local needs, priorities, and capacity. Whilst overall responsibility for programme implementation lies with Health Boards/Health and Social Care Partnerships (HSCPs), as part of their wider responsibility for implementation of MoU services, service delivery varies between direct delivery by HSCPs and/or NHS, or delivery by one or more Third Sector Organisation, with the latter constituting the majority of services. Similar differences were apparent in the distribution of CLWs across Scotland. In some programmes, allocation of link workers was based on factors such as GP practice size and level of deprivation, others opted for a universal approach and attempted to provide every practice within their area access to a CLW. This was accompanied by variation in the number of GP practices supported by each individual CLW, the accessibility of the various programmes, and referral pathways.

Programme Delivery

A range of terminology was used to describe the CLW role, for example Community Link Worker, Social Prescriber, and Community Links Practitioner. Whilst there was broad agreement that CLWs took a person-centred approach to support patients who were dealing with complex non-medical issues within their local community, this was demonstrated in different ways between link workers and was often responsive to local and patient needs. Examples include the number of appointments a CLW had with a patient, the use of a framework or model to guide interventions, and the appropriate point at which a patient ends their involvement with the service. However, the diversity of the role was recognised as beneficial, along with the importance of working collaboratively within multidisciplinary teams.

Monitoring and evaluation

A lack of guidance on how best to monitor and evaluate the implementation of CLW programmes has resulted in a fragmented approach. Variation was found in data collected and management systems used to monitor CLW programmes; some presenting as more challenging than others. The same variation was found in the measures used, if used at all, to determine the impact of CLW programmes.

Outcomes and potential impact

The strength of CLWs in helping to tackle the impact of health inequalities at an individual level was widely recognised. There was less certainty regarding the contribution CLW programmes made towards tackling wider systemic health inequalities. Despite one of the intended outcomes of the introduction of CLWs being to reduce pressures on primary care, especially GPs, this is currently difficult to identify beyond anecdotal evidence.

CLWs occupy an intermediary role between primary care, patients, and local communities. This offers a unique position of strength, trust, and networking potential from which to support and connect patients within their local community. Again, the potential for wider systemic change was questioned, with CLW programmes holding untapped potential for increased contribution to strategic decision-making processes.

Equally difficult to conceptualise and capture was the impact on patients. Some CLWs cited use of wellbeing tools, whilst others referred to changes demonstrated in access to appropriate individualised support, recognising that for some patients the change may be small but nevertheless significant. This highlighted both the challenge of identifying tangible outcomes and impact across CLW programmes, and in capturing the 'softer' impact that CLWs can have on patients.

Future service design and delivery

Research participants discussed several areas of consideration for the future design and delivery of CLW programmes in Scotland, including the recognition of link working as a profession with core competencies and a clear progression pathway and career structure.

Whilst the ability to develop programmes in-line with local needs was welcomed by participants, a consistent view was expressed that a more coherent approach across Scotland would enable the collective and national impact of CLW programmes to be demonstrated more effectively.

The perceived low priority afforded to CLW programmes relative to other MoU services, and uncertainty over long-term funding at a national level raised questions and fears among participants about the sustainability of programmes.

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Introduction

Voluntary Health Scotland (VHS) is the national intermediary and network for voluntary health organisations across Scotland. Our purpose is to create a healthier, fairer Scotland served by a thriving voluntary sector.

Since 2021, the Scottish Government Primary Care Directorate has provided project funding to VHS to establish and develop the Scottish Community Link Worker Network (SCLWN). The Network aims to create a shared space for community link workers (CLWs) in primary care settings across Scotland to share learning, and to develop, network, and support each other to improve outcomes for their patients and communities. This report presents the findings of research conducted by Findlay Smith, Policy and Research Officer at VHS, into the range of community link worker programmes commissioned specifically to work with and within GP practices across Scotland. The research did not attempt to investigate other forms of link working or social prescribing prevalent in Scotland.

Context and background

Whilst similar programmes and activities have been implemented for a number of years, community link working in its current form across Scotland can be traced back as early as 2010. In October 2010, the Scottish Government funded a six-month Links Project exploring options to improve links between general practice and community support by signposting patients to local services (Scottish Government, 2012). This involved ten GP practices, six in Glasgow (recruited through the 'GPs at the Deep End'[1] project) and four in Fife. One of the main recommendations from this project was to look at the implementation of a "link worker with a librarianship and connecting role, to develop and facilitate links" between primary care and the community (Scottish Government, 2012: 20).

Several similar projects were introduced in the following years, exploring various elements of the link worker approach. Examples included 'Improving Links in Primary Care Project' in Nairn, Edinburgh, Dundee and Kinross jointly delivered by the Health and Social Care Alliance ("the ALLIANCE") and the Royal College of General Practitioners (Health and Social Care Alliance Scotland and Royal College of General Practitioners, 2014); the BRIDGE (Building Relationships in Deprived General Practice Environments) project in Glasgow (Wyke et al., 2013), and the Community Activity Mentor role introduced in Edinburgh as part of the Headroom Project (EVOC, 2017).

Two projects stand out as pioneering within this context: Sources of Support in Dundee, and the Deep End Links Worker Programme in Glasgow. Both were sponsored by the Scottish Government and considered as comprising a national pilot. These paved the way for the government's eventual commitment to develop the current Scotland-wide programme. Sources of Support was part of the Equally Well test site in Dundee (NHS Tayside, 2011). It sought to address the socio-economic and personal (i.e. non-medical) issues that affected the health and wellbeing of people in Dundee. Following an initial pilot phase, beginning in March 2011, during which one GP practice had access to a link worker, three link workers were employed across four GP practices in the city. An evaluation of the programme was published in November 2015 (Scottish Government, 2015).

The Glasgow Deep End Links Worker Programme was delivered in partnership between the ALLIANCE Scotland and GPs at the Deep End. Launched in April 2014, seven Deep End GP practices in Glasgow were provided with a practice development fund, a full-time Community Links Practitioner, and management support. An additional eight practices were included as comparators. An evaluation of the programme was commissioned by NHS Health Scotland (now Public Health Scotland). The findings of this evaluation, carried out by the University of Glasgow Institute of Health and Wellbeing, were published in May 2017 (Mercer et al., 2017).

1 Deep End GP practices are those with the highest levels of socioeconomic deprivation. The Deep End GP network originated in Scotland in 2009 with the aim of providing grassroots interventions to improve patient care in areas with the highest patient need.

In 2016, the Scottish Government committed to recruiting at least 250 CLWs to work in GP practices and direct people to local services and support within Scotland's most deprived communities by 2021. This commitment was restated in the 2020 Programme for Government. Whilst the Scottish Government did not meet this commitment by 2021, it was met in 2022, despite continued disruption from the COVID-19 pandemic.

In 2017, five early adopter sites were established in Dundee, Glasgow, Inverclyde, Edinburgh, and North Ayrshire (Public Health Scotland, 2020). These sites, funded by the Scottish Government, were selected to maintain and develop existing CLW programmes within their areas.

Community link working was then included as one of six key priority service areas within the MoU for the 2018 General Medical Services contract. The MoU describes a community link worker as:

> "a generalist practitioner based in or aligned to a GP practice or Cluster who works directly with patients to help them navigate and engage with wider services, often serving a socio-economically deprived community or assisting patients who need support because of (for example) the complexity of their conditions or rurality"[2].

Implementation of the MoU, and responsibility for the recruitment and delivery of community link worker services, was passed to Health and Social Care Partnerships (HSCPs). Through locally agreed Primary Care Improvement Plans (PCIPs), funded via the Primary Care Improvement Fund (PCIF), HSCPs were required to implement community link worker services, as part of primary care multidisciplinary teams, in a way that responded to local need and worked as part of available systems of care and support.

The MoU was revised in 2021[3], and whilst all six MoU areas remained areas of focus, HSCPs were encouraged to prioritise action on Pharmacotherapy, the Vaccine Transformation Programme (VTP), and Community Treatment and Care (CTAC). Plans for CLWs (along with Urgent Care and 'Additional Professional Roles') were to be maintained, however it was anticipated that they may progress at a slower rate to enable commitments to VTP, CTAC and Pharmacotherapy to be implemented. Following the introduction of amended regulations, there is now a statutory responsibility for boards to deliver the three priority services, with no such requirements in place for CLWs, Urgent Care, and 'Additional Professional Roles'.

2 MoU is available at: https://www.gov.scot/binaries/content/documents/govscot/publications/correspondence/2017/11/delivering-the-new-gms-contract-in-scotland-memorandum-of-understanding/documents/delivering-gms-contract-in-scotland---memorandum-of-understanding/delivering-gms-contract-in-scotland---memorandum-of-understanding/govscot%3Adocument/Delivering%2BGMS%2Bcontract%2Bin%2BScotland%2B-%2BMemorandum%2Bof%2Bunderstanding.pdf

3 The revised MoU is available at https://www.sehd.scot.nhs.uk/publications/Memorandum_of_Understanding%202-GMS_Contract_Implementation_for_PC_Improvement%2030_July_2021.pdf

Subsequently, link worker programmes have continued to emerge incrementally across Scotland. Recently published data from the Scottish Government identified, at March 2023, 27 CLW programmes[4], each with their own unique approach to service design and delivery, with over 300 CLWs employed across these programmes. Of the 903 GP practices in Scotland at this time, approximately 722 had access to a CLW to some degree (Scottish Government, 2023).

The SCLWN has consistently heard from members about the positive impact that CLWs have. However, we know relatively little about how the various programmes have been implemented, and the experiences of those working within them. The most recent large-scale mapping of community link worker (and social prescribing) programmes in Scotland was published in June 2017, when the Scottish Government commissioned VHS to map voluntary sector approaches to link working as part of a scoping exercise to inform the development of a national link worker programme (Voluntary Health Scotland, 2017). The "Gold Star Exemplars: Third Sector Approaches to Community Link Working Across Scotland", identified 43 'CLW' programmes in 31 of the 32 Scottish local authorities.

A review of the five early adopter programmes was published in July 2020 (Public Health Scotland, 2020), plus there have been several studies looking at either individual or small groups of programmes in Scotland. However, we lack an up-to-date picture of the total range of programmes across Scotland.

This research was conducted to document and learn from the current range of CLW programmes across Scotland. It is not intended to provide a purely descriptive mapping of all programmes due to the constantly changing landscape. Rather, our aim is to provide a snapshot of CLW programmes across Scotland, and to understand more about why they are being delivered in the manner they are.

4 Ayrshire and Arran, Forth Valley, and Lanarkshire are each presented as a single programme within this data.

Methods

Desk-based analysis

The first method of data collection was desk-based documentary analysis. This involved the collection of secondary data during December 2022 – May 2023.

The main sources of documentary evidence were:

- Scottish Government Primary Care Improvement Plan implementation monitoring
- Health and Social Care Partnership data (e.g., Annual Performance Reports, Strategic Plans, and Annual Accounts)
- Annual reports published by CLW programmes across Scotland

Case studies from individual programmes were reviewed along with publicly available documents (grey literature) discussing CLW programmes, and academic publications covering CLW programmes in Scotland.

Whilst such documentary evidence provided a broad outline of many programmes in Scotland, it did not allow for a comprehensive overview due to significant variation in the availability of documentary evidence across programmes.

Online survey

An online survey was conducted between January to March 2023. This was targeted at CLWs working within primary care and was distributed through the Scottish Community Link Worker Network. At the time of conducting the survey, 200 CLWs were members of the SCLWN.

The survey aim was to source both descriptive information about a range of individual programmes and to garner individual CLW perspectives on the delivery of their respective programmes. As such, it contained a mixture of both closed and open-ended questions (see Appendix A for survey questions).

A total of 61 responses were received. This was reduced to 60 as one was excluded for duplication, giving a response rate of 30%. To ensure the anonymity of survey participants, all quotes have been assigned a number, and are indicated by the letter S before respondent number (i.e., S1, S2).

Interviews

Interviews with a total of 18 CLW programme leads or managers were conducted between March – June 2023. Twelve interviews were conducted one-to-one while three group interviews were conducted, each with two participants (see Appendix B for interview guide).

Interviews were conducted using Microsoft Teams and lasted between 40 and 70 minutes. All were audio recorded with the participants' consent, transcribed, and analysed using thematic analysis. In this report, interview responses are indicated by the prefix Int before respondent number, (i.e., Int.1, Int.2). Reference is only made to a specific CLW programme if the pertinent information is available publicly and cannot be linked to any participants.

Findings

A synthesis of the findings gathered from the documentary analysis, survey results, and semi-structured interviews is presented covering five key areas:

1. **Programme design and structure,**
2. **Programme delivery,**
3. **Monitoring and evaluation,**
4. **Outcomes,**
5. **Participant views on the current policy landscape surrounding link working in Scotland.**

Programme design and structure

A range of approaches was identified in the structure and design of community link worker programmes, with each reflecting local needs, priorities, and capacity. Five main themes emerged in relation to design and structure:

- responsibility for programme delivery,
- link worker distribution,
- link worker allocation,
- accessibility of CLW programmes across Scotland; and
- referral process.

Responsibility for programme delivery

Whilst strategic responsibility for the link worker programmes is assigned to Health and Social Care Partnerships, programmes are split (albeit unevenly) between:

- direct delivery by HSCPs and/or NHS Boards; or
- delivery by one or more Third Sector Organisation (TSO).

As can be seen in Appendix C, of the twenty-six programmes included in this research, nineteen are delivered by at least one TSO[5].

5 This information is recognised as incomplete and was gathered through collection of publicly available data.

Regarding the decision to embed CLWs within TSOs, it was felt that this model contained several inherent benefits, primarily the ability of CLWs embedded within TSOs to develop new and foster existing links with their wider community. Whilst this view was not shared unanimously, it was suggested by several participants working within TSOs that embedding link workers within smaller organisations was particularly beneficial in building relationships between primary care and the wider community. It enabled them to build upon the links that TSOs had established within their communities:

> "Something I think has worked really well is our [community] link workers' connection with the community. So, although they're sitting within the GP practice, they visit a lot of community groups, that helps them to identify gaps and build up those relationships and know what's happening in the area … I think that the service would look quite different if it was an NHS employee rather than being able to be within the community" (Int.14)

Individual HSCPs have taken different decisions on whether to commission a single or several TSOs to deliver a programme. Several programmes are delivered by a national TSO operating within a specific area. For example, 'We Are With You', delivers community link worker services in Argyll and Bute, East Lothian, Renfrewshire, and Glasgow. However, in other cases an explicit attempt was made to deliver the service in partnership with multiple TSOs based within local communities.

Community link worker distribution

Different approaches are being taken to the distribution of CLWs across GP practices. For example, most programmes have opted for a universal approach and attempted to provide every practice with access to a CLW, although the exact method for allocation varies. In others, this is based on factors such as the level of deprivation or practice size, with CLW provision prioritised to communities most in need.

Recently published Scottish Government PCIP tracker data provides approximate percentages of practices without access to a CLW; suggesting that an estimated 20% of practices across Scotland do not have access to a CLW (Scottish Government, 2023). Looking across the 27 areas with a CLW programme, 21 have universal access, meaning that every GP practice, in principle, has access to a link worker, while 6 have partial access with only a selection of GP practices having access to a CLW.

In most HSCPs, every GP practice has access to a CLW. However, the degree of access varies significantly between programmes as distribution is shaped by several factors such as the number of link workers relative to the number of practices, practice size, and the number of localities in each area.

For programmes where not all practices have access to a link worker, the decision, for many, was due to limitations in funding and capacity, with programmes having to determine how best to identify practices in order to deliver the most effective service. In the majority of cases, this was done through a combination of deprivation levels, identified through the Scottish Index of Multiple Deprivation (SIMD) and practice size:

> "We looked at the funding we had available, we then looked at the GP practices which sat within the areas of most deprivation … and then we tried to devise a service provision which would cover the majority of patients within the areas of deprivation" (Int.14)

> "The budget we were allocated was not sufficient to cover [all of our practices], so the Health Intelligence Team did a bit of scoping to identify the practices with the highest deprivation in terms of SIMD 1 and 2 and practice numbers" (Int.1)

There are some exceptions to this, for example the Edinburgh Community Link Worker Programme. Currently, there are 24 CLWs covering 45 of the 70 GP practices across Edinburgh. The initial cohort, part of the commitment to recruit 250 link workers in Scotland's most deprived areas, was targeted towards areas of high deprivation (Edinburgh Health and Social Care Partnership, 2021). Following the change to PCIF, several 'non-deprived' practices subsequently chose to spend a portion of their allocation on link workers.

Such inequitable access to link worker programmes presented a particular challenge to areas with large rural populations. This is reflected in the fact that several of the practices without access to a CLW are remote and rural areas. Whilst services, in most cases, are designed to map with areas of urban deprivation via the SIMD, there was concern amongst interviewees that current models do not sufficiently capture hidden rural poverty. The dilemma posed by the need for an optimally effective service whilst operating with finite resources means that several smaller practices within these areas lack access to a link worker:

> "If we had provided the service starting with those more rural areas first, we wouldn't have been able to meet the needs of the proportion of the population that we reach at the moment … it's not ideal, but it is the best compromise we have at the moment" (Int.11)

Community link worker allocation

A further point, present across both deprivation-focused and universally provided services, is the number of GP practices supported by each link worker.

Figure 1 Number of GP practices supported

As demonstrated in Figure 1, the majority of CLWs surveyed (36) provided support to 1 or 2 GP practices. However, others (9) were supporting over 7, including one CLW covering 13[6].

There are multiple possible explanations for such variation in the number of practices that respondents supported. For example, some were employed by programmes where service provision was structured via locality, therefore CLWs were responsible for supporting each practice within this locality, inherently requiring them to cover multiple GP practices. Other CLWs were employed by programmes with limited capacity relative to the number of practices they were required to support, therefore were required to divide their time between several practices, irrespective of whether they were structured by locality.

Participants were broadly in agreement with the principle that the fewer practices a CLW was assigned to, the more effectively they could integrate themselves within primary care in order to deliver their service. This was made explicit in some programmes, where there was an expectation that a CLW should not support a practice for less than a specified amount of time per week:

> "I think certainly no less that the 2½ days [per week in a single practice] is helpful … it's very difficult to manage your caseload when you've got lots of different practices and you're not in them for very long" (Int.8)

Another interviewee, whose CLWs were supporting an average of three practices each, felt that they were "spread thin … whereas if they had fewer practices to cover it would probably be better" (Int.13).

Accessibility of community link worker programmes

There was a general agreement among interviewees that CLW programmes should be as accessible as possible to people seeking support within their community. This was reflected in the relative lack of formal restrictions placed on who could access the programme.

To access a CLW, in all cases, a patient must be registered with the corresponding GP practice.

The most common variation in accessibility concerns age. Whilst no programmes involved in this research placed an upper age limit on patients accessing the CLW service, there was a distinction between those who worked with patients aged 16 or 18 and over. Participants did suggest that there was some flexibility in these restrictions, as although they did not work directly with patients under the age they could, for example, work with a family:

> "Occasionally, when a link worker is working with a family there will be some chat about children in the family as well, but we don't deal directly with children" (Int.6)

> "Age-wise it is 16 plus, but what we've said is if there's somebody under that age, we can give support through a parent or guardian. It needs to be the adult that we work through, but we can certainly help families in that situation, and we have done" (Int.8)

6 Respondents within the N/A category (n=6) provided information on the total number of practices supported by their CLW programme, not the number of practices they support individually.

One survey respondent stated that, "we only take adults (18+) but if there is a child with any issues the GP can refer their parent" (S10). Another, whose programme worked with people aged 16 and over, explained that "we also support parents therefore many under 16s receive the benefit of support although not always directly" (S45).

The type and severity of issue that a patient was dealing with is also a consideration. Where patients are seen as requiring more specialist support, for example with substance misuse issues, they would be referred to a more appropriate service:

> "We try not to say no to anybody, but if somebody is currently using drugs in an unstable way, or substances in an unstable way, then I don't think we would look to reach out to them, basically because they're probably not in the right place" (Int.12)

> "If anyone's main issues are about drug and alcohol use, then we won't work with them, initially they would go [to specialist support]. But if we're working with somebody and we discovered through our work with them, that there are issues about drinking alcohol, then we'll get them the help that we need. We wouldn't just say we're not working with you anymore" (Int.13)

Whilst mental health was identified as one of the most frequent reasons for referral by 95% (n=57) of respondents, and several programmes were explicitly focused on people dealing with mental health issues, most link workers will only deal with mild to moderate cases. This was a point repeatedly emphasised by interviewees, as CLWs were not seen as an appropriate service for those dealing with severe mental health issues or crises:

> "We are not a crisis service … obviously nobody can ever surmise when they are going to have a crisis, so if somebody does go into crisis then we'll support them and refer them back to their GP to access more appropriate support" (Int.4)

> "The only things we don't see is if anybody has severe mental health issues because we're not mental health trained" (Int.15)

Another interviewee explained that, whilst their programme would not accept people experiencing a mental health crisis or psychosis, "we do work with people who've got a mental health diagnosis" (Int.13).

Referral pathways

All survey respondents identified GPs as being within the three most common sources of referral to their service. As an example, in Edinburgh, GPs were responsible for 61% of all referrals from 2019-2020, and 79% from 2020-2021. In Glasgow, GPs were responsible for 71% of all referrals to the ALLIANCE CLW programme, and 85% to the We Are With You CLW Programme between 2020-2021.

Other than GPs, referrals came from a variety of sources both internal and external to a GP practice. Survey respondents identified nurses (n=27), mental health practitioners (n=18), practice receptionists (n=23), and self-referral (n=18) as being among the most common sources of referral to their programme.

In several programmes, however, referral was restricted solely to either a GP or clinical staff within a practice, although programme leads described a gradual broadening of referral sources:

> "We didn't know how it was going to go when we started. Like all the link worker programmes, we're going in blind. We didn't know who they were going to refer or how many referrals we were going to get. We started for the first year just being the GPs but now we've opened up to Advanced Nurse Practitioners, practice nurses, any kind of clinical support within that practice" (Int.15)

> "We are expanding to the other primary care workstreams. We have mental health nurses who would be able to refer. We are just starting to work with the First Contact Physiotherapists who would be able to refer. So, we are not restricting it just to GPs" (Int.1)

Staff attached to practices, for example District Nurses and Health Visitors, can refer in some instances. Whilst some restricted referral to clinical staff only, multiple programmes extended this to include reception staff. In one instance, this was an attempt to increase referral rates (S24). However, the overriding rationale for including receptionists in the referral process was the recognition of their position as care navigators, and their pivotal role in facilitating access to services. One practice had introduced a dedicated referral team that were located at reception for this reason:

> "Receptionists are really well placed to identify people who are lonely. So, you get, and this has always happened, you get older people who maybe have a [long] repeat prescription list, but they only order one and two things at a time, and they come in two or three times a week to order those one or two things because it's their social interaction and they've nothing else. So, we've encouraged reception staff to identify these people and suggest, maybe you'd like to see a link worker" (Int.6)

The question of self-referral also led to a wide range of responses. Participants representing seven programmes stated that their respective CLW programmes did not allow self-referral, with variation in rationale. In one case, this was due to safety concerns for CLWs. Among programmes that did accept self-referral, it was felt that effective risk assessment could mitigate these concerns. There was also a suggestion that allowing self-referral may potentially overwhelm the CLW service. For example, one participant suggested that self-referral may complicate the process of differentiating between medical and social issues, thereby failing to help reduce the burden on GPs:

> "The link worker could generate a caseload on their own. Whereas the funding is supposed to help reduce the workload for, primarily, GPs. The idea is that the GP or practice nurse will refer to the link worker so that you start to separate out the medical issues from the social issue" (Int.6)

Other participants, including those within programmes that allow self-referral, discussed their dilemma regarding its inclusion and potential to inundate the service. In one programme, which has incorporated self-referral from its inception, "there was a bit of discussion about that, because it was really important that we didn't overwhelm the service" (Int.11). However, in this instance, these concerns were alleviated over time with self-referrals estimated as making up less than 2% of referrals in some localities (Int.11).

Respondents from one programme trialled self-referral within a single locality but found limited success. In this case, it was primarily attributed to limited engagement from patients who had self-referred into the service. This programme was also preparing to trial allowing reception staff to refer.

Several programmes implemented and actively encouraged self-referral although reported mixed experiences. In contrast to the concern regarding GP burden, self-referral was seen as an effective method of streamlining referral processes, eliminating the need for intermediary consultations with GPs:

> "It takes a layer out of the process for people if they don't need to go and speak to somebody when they know [the CLW] is the person that can help them" (Int.9)

Whilst there may be some disagreement about the impact of self-referral on GP time, and on the wider capacity of primary care, this was largely focused on new referrals entering the system. Participants were broadly in agreement that self-referral was particularly effective for patients returning to the service. For example:

> "Self-referral I think works. We seem to see more self-referral when it's someone returning, and rather than contacting the GP … they are coming straight to the link worker" (Int.8)

Furthermore, even in programmes where self-referral was not conducted, several participants described an 'informal' self-referral process whereby returning patients could have direct access to a link worker without passing through the practice beforehand:

> "A lot of people who have been with the programme before will refer back in themselves without having to go through the GP and get appointments" (Int.9)

> "We don't have any follow up in place at the moment, but we do try and make sure that patients know how to come back in. And they can self-refer back in. It doesn't have to go through the clinical systems. If somebody who has been in touch with us before wants to ring up and come back in, then we don't have a problem" (Int.12)

Programme delivery

As a result of the discretion afforded to HSCPs in the delivery of MoU services within their PCIPs, there is a variety of delivery models in place for the delivery of CLW services across Scotland, each with their own associated benefits and challenges. Whilst a comprehensive breakdown of these differences is not provided in this report, two key distinctions were identified:

- the community link worker role; and
- approaches to interventions.

Community link worker role

Terminology

There is considerable variation in the names and titles associated with 'Community Link Workers' across Scotland. As shown in Figure 2, respondents to the survey held multiple job titles, and there was debate regarding the most appropriate, and accurate, way to describe link working across Scotland.

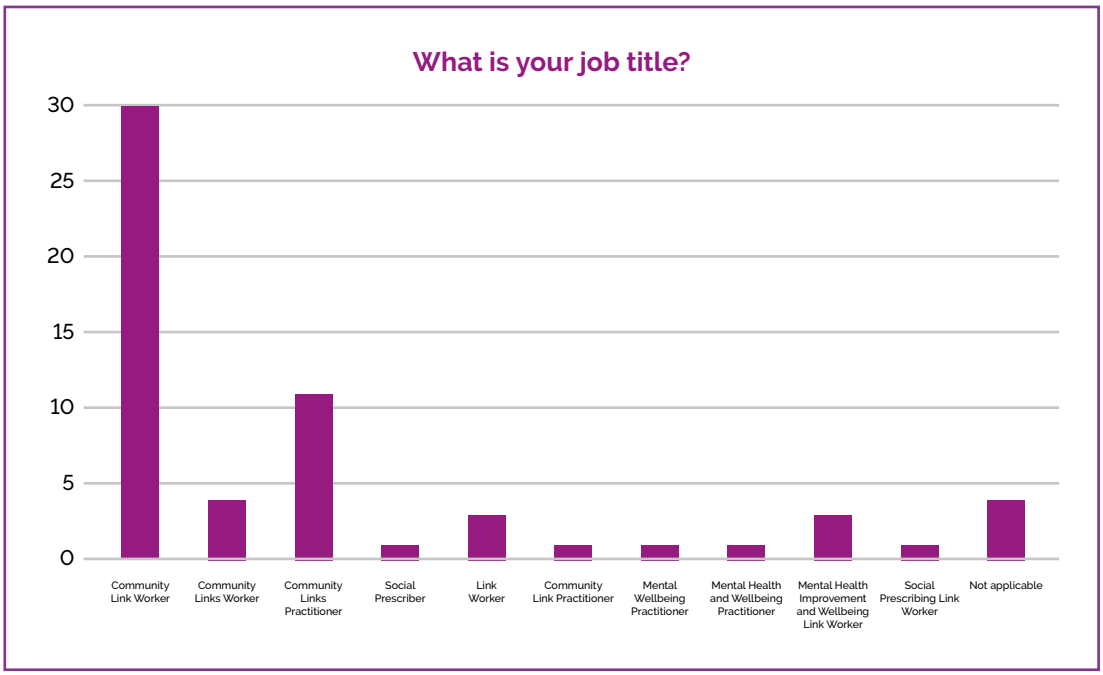

Figure 2 Link Worker job titles

Although the most frequently adopted nomenclature is 'Community Link Worker', several other terms are used including Social Prescriber, Community Link Practitioner, and Mental Wellbeing Link Worker. However, programmes seem to be moving to adopt the term 'Community Link Worker' to align with other areas. For example, one interviewee explained changing from 'Community Connectors' to 'Community Link Workers' "to tie in with [other programmes], because everywhere else is link workers" (Int.4).

There were varying opinions among interviewees regarding the most appropriate terminology when discussing CLW programmes, particularly around the use of the term social prescribing. Whilst some were comfortable describing their programmes as social prescribing, others felt that it did not provide a wholly accurate picture of their work:

> "There are pros and cons with describing it as being social prescribing, but it's definitely not signposting, it's much more than that" (Int.1)

> "I think there are values attached when people start talking about social prescribing. I know there is a big buzz around that at the moment, but it brings it back to a medical model. Whereas we are trying to soften it by saying we are community link workers, and the two get conflated" (Int.12)

Support provided by community link workers

Terminology notwithstanding, findings show that the role of CLWs is flexible and diverse. There was a general agreement that CLWs take a person-centred approach to supporting patients with non-medical issues to engage with services in their local community, however this manifested in different ways between participants. As one interviewee explained:

> "I have been describing this kind of continuum. At one end of the continuum, you have got your basic signposting, somebody that does simply require the information and can then take that and do their own thing. At the opposite end of that scale, you've got what is more of a support worker, so somebody who is doing a lot more intensive type work, visiting people's homes, doing the day-to-day smaller stuff" (Int.5)

When describing the CLW role, participants occupied various points along this continuum in both principle and practice. Unsurprisingly, signposting and referring patients to community and statutory services was highlighted by survey respondents as a core component of the link worker role.

> "Supporting the GP practices with patients who may need signposting to non-medical agencies, groups or organisations" (S15)

> "Signposting and linking individuals to local and statutory services which will, in turn, alleviate issues such as social anxiety, depression, financial concerns and isolation" (S6)

> "Linking people into community groups, services and activities that will help them through a difficult time in their life" (S44)

Whilst signposting and linking patients to community and statutory services was a core part of the work of all CLWs, the role, as described by participants, is significantly more wide ranging. In some cases, a patient may only require basic signposting, however several interviewees described how the CLWs often take a more comprehensive approach to supporting patients:

> "For most people, it's not just a simple case of you just need to go and see organisation X. It's not just a simple signpost. It is actually support and advocacy in dealing with some of the more complicated stuff that's going on for people" (Int.9)

> "It's definitely more than signposting. We can have quite complex patients. So, we would describe it as a holistic person-centred approach, and really working with the individual to identify what their challenges are and then working with them to improve their health and wellbeing" (Int.14)

Participants were near-unanimous in stating the necessity of a person-centred approach to supporting patients, within which signposting was considered a constituent part. As one CLW explained:

> "I work collaboratively with patients to identify areas in their life where they are currently experiencing challenges and may have unmet needs. I then make suggestions of resources, organisations or activities which may benefit them, and when relevant can refer on to partner organisations" (S22)

Several CLWs described their role without making an explicit reference to signposting, emphasising other aspects such as personal empowerment or assisting patients in self-management:

> "[My role involves] empowering people to make changes in their mental health and wellbeing, supporting those isolated to find the confidence to get back into their communities" (S33)

> "Supporting people to develop self-management strategies for long-term health conditions, mental health, and personal stressors" (S19)

The role that CLWs play in actively working to support and remove barriers to patients accessing services was also emphasised:

> "There is a lot of link working in there, as in connecting people to services. We try to elevate that to really breaking down the barriers to attending services" (Int.11)

> "We are very clear that this isn't about passing people on to other services, it is about reducing the barriers to people accessing services. That handholding, that removal of barriers, that really intensive support that means somebody might have the opportunities to take up something that is going to help them" (Int.1)

There was, however, some variation across programmes in the degree to which this formed a significant element of CLWs' roles, with several practical differences in the support they provide. For example, in certain programmes, link workers could provide support by accompanying and supporting patients to engage with services in their community:

> "[Patients] may not have the self-esteem to promote themselves or advocate for themselves. That's where I think the value is with the link workers … They will support someone; they will go with them if need be" (Int.3)

By comparison, in several programmes CLWs either did not, or could not, perform such a role. This may be an organisational issue, as was the case in one programme where this was performed by a dedicated support worker and the CLW had a case management role. It may also be a capacity or workload issue, whereby if people are anxious or concerned about going to a service in person, the CLWs "can't physically [go] out at the moment because we don't have the capacity to do it" (Int.15).

Findings identified aspects of the CLW role that did not directly relate to the individual support they provided to patients, but were of vital importance to the effective implementation of CLW programmes. Survey respondents highlighted working collaboratively with their associated multidisciplinary teams as a key component of their work, and central to ensuring that patients receive effective support. For example, "working in partnership with the GP practices to provide community support" (S10), "maintaining relationships with practices and external organisations" (S4), and "bridging the gap between GPs, practice staff, patients and communities" (S1).

What issues do community link workers help with?

Among the 60 survey respondents, mental health was identified as the main reason for referral, with 95% of respondents identifying it as a primary issue. Social isolation and loneliness were also a significant concern, with 82% reporting this as one of the most frequent reasons for referral. Other common reasons for referral included housing (60%), welfare and social security (55%), trauma (52%), and financial issues (47%). Interviewees reinforced the survey findings, that mental health and social isolation were the primary reasons for referral.

Participants' responses were consistent with available data detailing reasons for referral. In Edinburgh, for example, annual report data from the previous three years showed mental health to be the leading reason for referral. In the 2019-2020 period, mental health constituted 37% of all referrals. The following year this rose to 50%. In the most recent period of 2021-2022 mental health referrals were at 48%. Social isolation and loneliness[7] was the second most common reason for referral throughout, at 26% in 2019-2020 (EVOC, 2020), 23% in 2020-2021 (EVOC, 2021), and 29% in 2021-2022 (EVOC, 2022).

Whilst these issues may be the primary reasons for which a patient is referred to a CLW, the challenges faced, and the nature of the support received appear multifaceted. Throughout the course of working with a patient, CLWs frequently discuss additional issues that were not originally captured within the initial referral.

7 'Social isolation and loneliness' was recorded as a single category.

A patient's needs will often extend beyond a single issue, and they may present with multiple referral issues that require support. For example:

> "We have an hour or so with the person, so we can sit and talk. We have often found that people are referred for one thing from the GP, but when they sit down with a CLW there is a whole host of other things that are contributing to the one thing that the GP has sent them for" (Int.2)

Within this context, multiple interviewees noted a pronounced change, pre and post-COVID-19 in the underlying issues that patients presented with. Whereas previously, CLWs may have spent the majority of their time working on relatively straightforward issues and linking patients with the appropriate services, throughout the COVID-19 pandemic and cost-of-living crisis, several programmes have noticed a marked shift in the severity of issues patients are requiring support for:

> "It's about focusing on what we can do to help, which activities we can link you in with, or it used to be. Since the pandemic and now the cost-of-living and fuel poverty, there is much more helping people to go to warm banks, food banks, applying for hardship funds" (Int.6)

> "The financial burden, the cost-of-living crisis, the need for food and quality housing has been around for the past 18 months and it doesn't seem to be going anywhere. If anything, it's getting worse for people" (Int.7)

Approaches to interventions

The specific intervention provided by link workers is complex and multifaceted with no consensus among participants regarding how best to structure, or deliver a specific model. There is a general aversion to overly prescriptive approaches, with participants highlighting the flexibility in support offered to patients as one of the key strengths of CLW programmes across Scotland. Within such variety, three main aspects to CLW interventions emerged as particularly noteworthy:

- the number of appointments a patient can have with a CLW
- the use of a model or framework to guide interactions with patients; and
- the process by which patients 'leave' a CLW programme.

Number of appointments

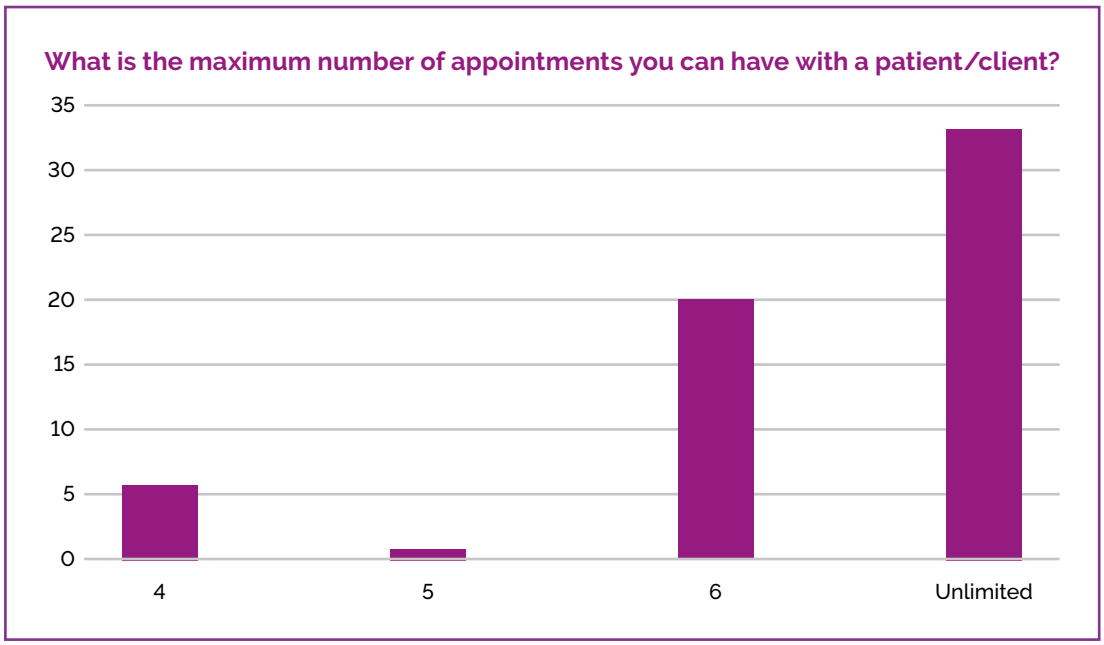

Figure 3 Maximum number of appointments available with CLW

As shown in Figure 3, responses range from four sessions to no upper limit in the majority of cases. Interviews showed a similar variety of responses, ranging from, three appointments to no upper limit.

Although the exact numbers vary, there are common considerations that were present across programmes. In many, although not all, cases, upper limits on appointments were interpreted as guidelines as opposed to concrete rules:

> "We say up to eight, but if something is not finished by eight appointments then we won't get rid of somebody" (Int.2)

> "It is supposed to be time limited; we are a short-term service. I think our model is 4-6 or 6-8 appointments, I'd say 6-8 appointments … but there is some flexibility in that" (Int.5)

> "Although we say 4-6 sessions, [a CLW] can work with somebody longer than that, but we just ask that they let their team leads know" (Int.10)

One interviewee explained that although 4-6 was the preferred number of appointments within their programme, they have worked with people "who have done 12-16, or unlimited, sessions" (Int.7).

Interviewees expressed differences of opinion regarding the benefit of setting expectations about the number of appointments a patient may have with a CLW prior to working with them. Some suggested that stating a specific number of sessions may have a detrimental effect on patient outcomes:

> "If at that initial visit you are saying to someone, "you will have four appointments with me", you are already setting that person up, no matter what their issues are, to get through it in 4-6 sessions … We just felt that this would be setting people up to fail" (Int.3)

Others were more receptive to the idea, suggesting that it may help in managing expectations regarding the service:

> "It is something we encourage link workers to be really cautious of at the beginning. Having those boundaries to make sure they explicitly tell patients during the first appointment that they are a short-term service" (Int.5)

Across both time-limited and unlimited programmes, the most frequently cited concern around the number of appointments was not wanting to foster dependence. Careful management of caseloads and the number of appointments was also seen as vital to preventing bottlenecks within primary care, as patients remaining in the system for a prolonged period may reduce the opportunity for others to access. Participants repeatedly stressed that CLWs were not intended to act as a long-term holding service, however in practice this was often difficult to navigate as some patients required longer-term support due to the complexity of their cases, or whilst they were on waiting lists for other services.

Findings also suggest differences in opinion regarding what constituted an appointment. For example, one participant explained that:

> "We count appointments as a significant interaction where anything has changed. Because [CLWs and patients] do touch base every so often and to class that as an appointment would be taking something away from the person as well" (Int.7)

In other programmes, appointments are limited to a set number of 'interactions', including, for example, telephone calls. This was a question posed by several interviewees:

> "I think there are nuances in terms of what we do. We might have an initial conversation with somebody. It might take two minutes, but that person goes off the phone happy, connected. Is that a specific piece of work or is it an inquiry? Is it an intervention with a beginning, middle and an end?" (Int.12)

Intervention framework

Different programmes have adopted a variety of frameworks and tools to guide the delivery of their service.

Some opted for a relatively structured framework, whilst simultaneously allowing for the degree of discretion required to support patients on an individual basis. For example, one participant, whose programme did not limit the number of appointments, described using a Red-Amber-Green framework, linked to a Motivation-Action-Prompt (MAP) behaviours change model, to guide interactions with patients. In this model, a patient entering the service would automatically be assumed to be in the red phase.

Support in this phase would consist of approximately three to four sessions of one hour each within the first month. Following this, a patient moved into the amber phase, focusing on self-actualisation and working towards personal goals. It is expected that during this phase the number and duration of sessions would reduce. In the green phase patients would prepare to exit the service. Whilst acknowledging that this approach may not work in every situation, they described the CLWs as being "really clear about the MAP approach in terms of the motivation, action, and prompts" (Int.12).

In another example, one interviewee explained:

> "We've designed a model which is about trying to be very task focused. So, first appointment it's really about assessment of needs. And the last appointment is really about making sure that people have come to a natural end… people are very people-y and they don't always fit into it" (Int.11)

Some have adopted frameworks to guide individual interactions without an overarching model of the process of CLW-patient interactions. For example, one programme had introduced the '[8]Good conversations' model.

In other cases, the approach was more implicit, with participants acknowledging that a more consistent approach or theory underpinning their service may be beneficial:

> "We've done loads of work in the past about mission statements, we never quite got there. But there is a sense within the team in terms of what we're working towards … I think that it's really important to actually look at that again and review that" (Int.13)

Other interviewees described an emergent process where the service would develop organically, and good practice regarding CLW interventions would be identified through trial and error:

> "When we started it was; let's go with it, see how it works, what's working, what's not working. We have, about six months ago, started to look at our process map of what's happening" (Int.15)

Leaving the service

Given the flexibility inherent in the delivery of CLW programmes, the process by which patients leave the service varies both within and between programmes and patients. There was limited evidence from participants of any formal discharge process for patients, and decisions about when a patient is ready to leave the service were primarily made on an individual basis. Reticence was expressed about the potential introduction of formal processes, suggesting that they would be largely inappropriate for the type of service CLWs provided, and that their use would risk depersonalising the service. This sentiment has led to tension in some areas, as one interviewee described:

> "We are enshrined in clinical systems at the moment and we're desperately trying to hold on to our identity. It's really, really difficult when you're working with district nurses and allied health professionals who have a whole discharge pathway, and they tell us, "You need a discharge letter". We're like "no, we don't, we want to do it person-centred". So, we've resisted the templates and everything so far" (Int. 12)

8 Good conversations are part of the House of Care model, an approach that supports a shared agenda for conversation focusing on what matters to the person, rather than 'what is the matter'. https://www.gov.scot/publications/person-centred-care-non-executive-directors/pages/7/

Even in cases where programmes had identified an ideal number of appointments that a patient is to have with a CLW, a degree of flexibility remains whereby patients can remain within the service for longer than initially stated:

> "We have a model that we're working towards, and staff are trained to use that model as the basis for their support. But there's so many variations, it's not the case that people will have four appointments and be forced to leave" (Int.11)

In principle, participants were in agreement that the service comes to an end when patients have received their required support and have been directed to an appropriate service. However, it is expected that this decision is negotiated to some degree between the patient and CLW:

> "Everything is a user-led discussion. It's not a case that the link worker goes "right, that's me done my job and you're out, it's not like that at all" (Int.8)

This does mean, however, than in some cases patients can remain within a CLW's caseload for an extended period. One survey respondent stated that:

> "Before the pandemic, I met with people up to six appointments, however, since then, this number varies as I am still working alongside people who were referred to my service three years ago" (S7)

Similarly, a lack of available services often means that patients may be stuck in limbo waiting to access their required support:

> "It can be quite challenging to close a case because what the CLWs are seeing is that a lot of the services they are referring to can have quite lengthy waiting lists. I know a lot of them put cases in a kind of holding place, waiting to do one final follow up to make sure that the service that patient is waiting for has actually come into place" (Int.5)

There was some degree of concern expressed regarding the lack of robust follow up mechanisms to monitor patients' uptake of services after they had exited the service. Currently, the majority of services had no systematic way of knowing whether or not an onward referral was effective. For example, one participant acknowledged:

> "That's something we have to work on at the moment. We are not really sure if people are following it up. Sometimes people can just prescribe something to somebody and we go off and we don't see them again. They can be discharged because they received the information they want to receive, and we don't follow up to know whether they have been to something or not" (Int.2)

Several programmes introduced small mechanisms through which this could be achieved, however the information they gathered was limited. For example:

> "We have a follow up call. We'll text to ask you how you are doing. We have that built in to the follow up at some level, but in terms of how people are doing after six months to a year, there is no collection of that" (Int.11)

Monitoring and evaluation

Data management systems

This research identified a total of 16 different data collection and management systems being used to monitor the implementation of CLW programmes across Scotland. At organisational level (i.e., within the specific CLW programme), 11 different systems were being implemented ranging from dedicated social prescribing systems such as Elemental, to bespoke data management systems developed for a single organisation, to some programmes operating without a data management system and instead relying on Excel and Google Suite. A list is provided below of those named:

- Elemental
- Milo
- Nebula
- Lamplight
- CASTLE (Internal Citizens Advice Bureau data management system)
- Bespoke data management system (anonymised by author)
- Access Spreadsheets
- Excel
- Google Suite
- Power BI

At the practice level, participants had access to one of six different data management systems:

- EMIS
- EMIS Web
- Vision
- Vision 360
- Vision Anywhere
- Docman

Regarding the use of data management systems at organisational level, Elemental, a dedicated social prescribing system, divided opinion. Its primary benefit, according to some interviewees, was its ability to integrate with primary care systems. One programme, trialling Elemental at that point in some of its practices, had experienced mixed results, however:

> "The big thing that keeps us tied to trying with Elemental is that there is a tab on the GPs' clinical system, so Elemental is integrated into the GPs' Vision system. It is there on their desktop – every time they see a patient there is a tab that says social prescribing. That's a huge buy" (Int.6)

There were several practical challenges associated with the Elemental platform. For example, multiple participants felt that Elemental was restrictive in the data it allowed programmes to collate, particularly when compared to more comprehensive, albeit non-link worker specific, systems such as Salesforce. By comparison, another interviewee whose programme had used Elemental from the beginning was less critical, and felt that it was relatively straightforward to use, allowing them to extract sufficient data on their programme. Other systems developed outside of the context of link working were seen as difficult to use. One participant using Nebula, originally developed for recovery and addiction services, found it challenging to produce the required bi-annual reports. Several other programmes did not use a data management system as such, instead relying on manual spreadsheets.

At the practice level, the majority of participants reported having access to EMIS and Vision for case management. Whilst beneficial in allowing programmes to become better integrated with GP practices, drawbacks were reported. For example, gaining access to practice data systems in the first instance was particularly challenging:

> "We decided to use Vision, which is the GP platform, Vision and EMIS. For us to be able to add patient notes and things like that. And again, I would say that was fairly difficult because it's the GPs' platform, and trying to get the data protection and stuff surrounding us using that was quite a big one" (Int.15)

Another interviewee experienced similar issues:

> "There are system issues in terms of data and data recording. Our link workers will record on the practice system, so EMIS or Vision. We have no idea what they record in those systems because they are not ours" (Int.9)

Several participants found that extracting data from EMIS was difficult due to the limited breadth of data produced. For example, EMIS does not record the number of sessions a CLW has with patients, only the first session.

Data collection

A Minimum Core Dataset for Community Link Workers was developed by NHS Health Scotland (now part of Public Health Scotland) in 2018 to monitor and learn from the implementation of the five early adopter sites established in 2017. Designed to align with data already being collected locally, it collected baseline information on patient demographics and referral data. Beyond this data set, which was not consistently adopted beyond early adopter sites and is no longer a requirement for collection, there has been relatively little guidance on how to best monitor the implementation of link worker programmes.

Findings suggest two concurrent trends in the monitoring of CLW programmes across Scotland. First, 87% of survey respondents consistently monitored age, gender and referral source as part of their work. 85% recorded the reason for referral, the date of their first meeting with a patient, and the onward referral. 78% recorded repeat contact and follow up appointments with a patient. When analysed in conjunction with interview data, there is a suggestion of some consistency in baseline descriptive indicators:

> "Elemental allows us to have a really good snapshot of referrals, reason for referral, demographics" (Int.11)

> "We have a manual spreadsheet. We've just brought in a regional approach to that which I'm very pleased about. Just in terms of source of referral, some basic ID, and what the reason for referral was etc. We have a regional spreadsheet for that" (Int.12)

> "We've got quite a massive data measurement plan, which calculates just about everything you can imagine. Date of birth, sex, SIMD areas, reason for referral, and again, the secondary reason once we get that through, how long the appointments take, where are we referring on to" (Int.15)

However, beyond a small group of shared descriptive measures, participants were critical of a lack of consistent data across programmes.

> "What is a frustration is that there is no standardised reporting from the link worker programmes" (Int.10)

Evaluation

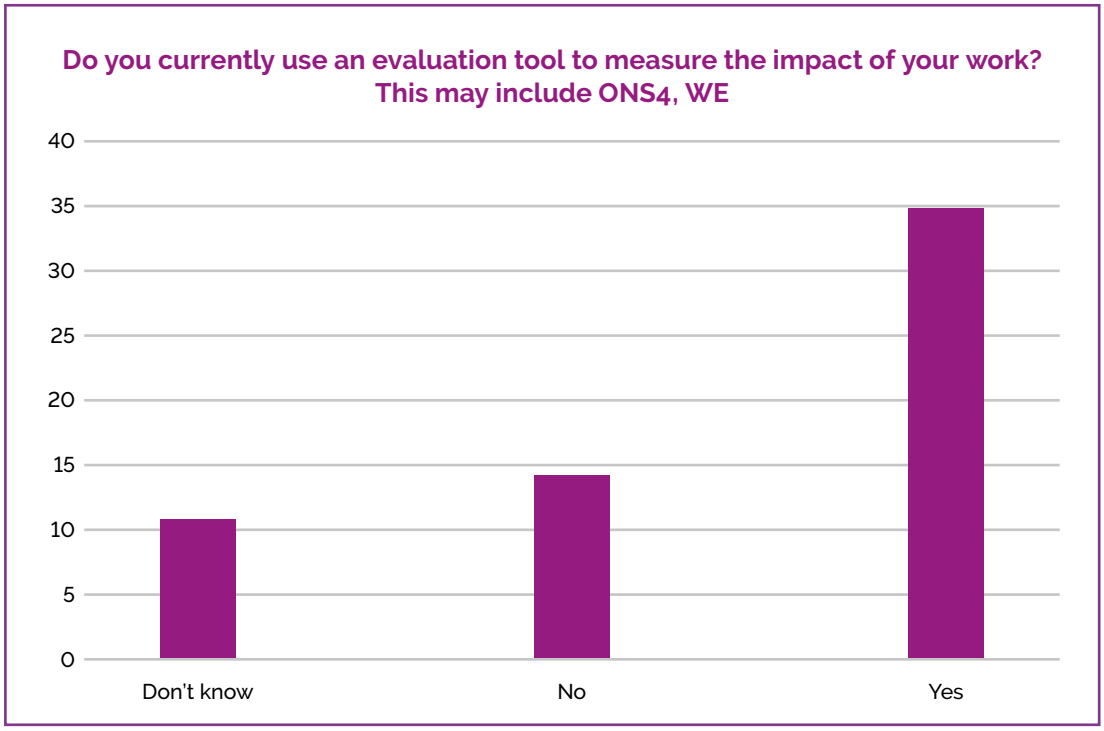

Figure 4 Evaluation tools used by CLW programmes.

35 survey respondents stated that they currently used an evaluation tool as part of their work. Among these 35 respondents, 12 different evaluation tools were identified. Drawing on both interview data and documentary analysis, a total of 14 evaluation tools were identified as being currently used in CLW programmes across Scotland:

- Short Warwick Edinburgh Mental Wellbeing Scale (SWMWBS)
- Outcomes Star
- Lamplight
- ONS4
- Nebula
- OutNav
- Milo
- Access People Planner
- Five Ways to Wellbeing
- Recovery Outcomes Web
- 4 x Bespoke evaluation tools

The most frequently used evaluation tool among respondents was the Short Warwick Edinburgh Mental Wellbeing Scale (SWMWBS). Most participants cited its ease of use, or alignment with existing programmes as the primary motivation.

> "For working through getting the answers and getting results, we thought it was the quickest, easiest, and because there's people using it already" (Int.9)

Ensuring completion rates had proved challenging for several programmes, with multiple participants highlighting inconsistency in its use, and the difficulty identifying an appropriate 'end point' at which to determine a second score.

> "Initially we used to do it at someone's first appointment and then their final appointment, but the thing is you weren't always sure when individuals' final appointment might be or people might fall off and not engage. We have started doing it on the first appointment and the fourth appointment" (Int.3)

Another programme, initially with exit completion rates of 13%, increased this to approximately 55% by switching to paper copies and asking patients to complete the form in the GP practice. Two programmes had previously used SWMWBS and stopped, with one switching to ONS4 as they felt that SWMWBS, with its focus on mental health, did not allow for other health determinants to be evaluated.

Some commentators might argue that relative to other similar initiatives brought in at the same time, most CLW projects have actually made a reasonable attempt at evaluation in shortish timescales. Likewise, one might argue that whilst better co-ordination and standardisation of the work nationally would probably have made this more impactful, it could also have been detrimental, given the diversity within CLW provision across Scotland and the exploratory nature of the work.

Outcomes and potential impact

Participants discussed a variety of outcomes that link worker programmes may contribute towards including; tackling health inequalities, reducing pressure on primary care, the potential to strengthen communities, and the impact of CLWs on patients.

Impact on health inequalities

Whilst tackling health inequalities was identified as a primary strategic objective by participants across several programmes, mixed views were expressed on the degree to which this could realistically be achieved.

There is a recognition that CLWs have a role to play in this regard, with tackling health inequalities cited as an overarching theme that runs through the majority of link worker programmes.

However, participants were apprehensive about the positioning of CLWs as a potential remedy to wider systemic issues:

> "I think that's a really difficult one. And it's something I personally struggle with sometimes because it feels like we're patching up the wider political stuff" (Int.12)

> "Originally the programme was brought in to tackle the social determinants of health and to support people who are living in the most deprived areas with those social determinants of health. In reality, there's a limited amount we can do" (Int.14)

> "If we are going to tackle health inequalities, that's a systemic, multifaceted change, there's no way a link worker can do anything about health inequalities. So, it's a bit of a smoke and mirrors thing" (Int.11)

Whilst tackling health inequalities at a systemic level is beyond the reach of a single programme, there was a consensus among interviewees around the role that link workers can play in helping to address the impact of health inequalities on individual patients. The precise mechanisms through which this could be achieved, however, were subject to debate. Whilst often targeted towards those living in areas of high deprivation, some suggested that many individuals may not meet the criteria for accessing a CLW, for example those not attending or registered with the corresponding GP practice.

The ability of CLW programmes to effectively measure the contribution they make to addressing health inequalities within their local community was discussed:

> "Although some of the programmes may be to tackle health inequalities, we were not given any measurement tools. We were only asked for the Minimum Core Dataset. So, postcodes, gender, ethnicity, and reason for referral. We weren't really given the mechanisms to measure that" (Int.10)

The little focus afforded to collection of data on health inequalities can be seen to some degree in survey findings, with only 13% of respondents regularly recording the SIMD status of patients. Multiple interviewees suggested that the data they collected

on their programmes was not aligned to measuring impact on health inequalities in any meaningful way. For others who made use of SIMD data, this was not being implemented in a consistent way at the time of the research:

> "The only thing I think would be relevant is that we can map the number of patients and areas of social deprivation on patient lists versus number of referrals. So, we know we're getting a higher number of referrals in the most deprived areas" (Int.14)

Impact on primary care

Findings suggest similar ambiguities in participant perspectives on the impact of CLWs on primary care. There was recognition that whilst CLWs can play an important role in reducing pressures on primary care, this could not be achieved through a single programme. Whilst this makes the exact influence of CLWs on GP workloads relatively difficult to capture, participants did identify nuanced roles that CLWs play within practices.

When asked about the overarching strategic objectives that their programme was contributing towards, almost all participants raised the reduction of pressure on primary care:

> "Essentially, it's to reduce the pressures in GP practices" (Int.8)

> "Supporting people's mental health but also taking away the pressures on GPs, those are the high-level objectives we have" (Int.3)

> "I do always talk about one of our main outcomes being reducing the GP workload as well. Tackling health inequalities, but also pulling away the non-clinical work that does evidently end up at primary care's door" (Int.5)

However, quantifying this impact has presented a significant challenge to date, and no participant had been able to achieve this effectively. One participant recalled their programme conducting studies on attendance rates in the years before and after the introduction of a CLW to the practice, with a drop of 30%, however attributing this to the link worker role was extremely difficult. Across programmes, despite anecdotal evidence suggesting that GP workloads were being reduced, the quantitative evidence remains elusive:

> "We don't have data on the impact on GP time, that's going to be something that's really tricky to isolate" (Int.14)

Whilst the prevailing sense was that the impact of CLWs on primary care was near impossible to measure quantitatively, there is the possibility the CLWs can have a positive qualitative impact on GP workloads. For example, it was suggested that, whilst not necessarily causing an absolute reduction in the number of appointments a patient has with their GP (e.g. if a patient had accompanying medical issues outside the remit of a CLW), it may allow GPs to focus on immediate medical issues, as "it would make the GP's time more efficient so that they wouldn't have to go through the social issues" (Int.10).

Impact on communities

Findings also illustrate the multifaceted impact the CLWs have within their local communities. Fundamentally, this revolved around the role that CLWs can play in facilitating connection between primary care, patients, their local communities, and the wider healthcare system. Occupying this intermediary position between various community stakeholders allows them to function as a "missing link" between often siloed services, develop and in-depth knowledge of their local area, contribute towards strengthening and empowering existing community assets, and to function as a feedback mechanism with the wider healthcare system.

By acting as a conduit between primary care and the community, CLWs complement the role of GPs and other primary care staff who may not have the capacity to fully engage in the wider community, or to monitor services outside of a medical setting:

> "That's where we see ourselves sitting. We're not clinical, we're not that side, but we are the missing link. Because the GPs don't have the time to do the community mapping and know everything out there in the community" (Int.15)

Mapping the resources and services within their community is a key component of the CLW role. Having a comprehensive understanding of available resources and support systems within communities enables them to establish trust, and make meaningful connections with the wider community and enables them to more effectively support patients to access services:

> "They have very good links within the community. They are able to go along to community events. People know their faces. They can make links, and they have the time and capacity to make links with third sector organisations, people trust their reasoning and decision making around referral and signposting" (Int.14)

This, in turn, assists patients in accessing timely and appropriate support within their area:

> "Part of the job, the link worker role, is that they map out their area. They gain knowledge and resources. We have access to a lot of amenities and people have quicker access than if you wait for a few weeks or months" (Int.4)

In addition to their role in connecting patients with the community, participants also described the contribution that CLWs can make towards the empowerment and strengthening of local communities. This is especially important as the effectiveness of CLW programmes is, to a large extent, dependent on the services available to patients:

> "It's about developing our relationships with our third sector partners and the community groups and understanding what the issues are for them. Because without that network of what's going on out in the community, we've got nothing to link in to" (Int.12)

Whilst it is important to emphasise that addressing wider systemic issues regarding the availability and provision of community services sits beyond the scope of a single programme, by focusing on building relationships with community assets it was suggested that CLW programmes can contribute towards enhancing community wellbeing:

> "Part of the outcome might be that community link workers could support the development of services in communities. That might not mean that they do it themselves, but that they support other people to do it" (Int.1)

This can manifest itself in several forms including CLWs identifying gaps in service provision, even establishing support groups for people with specific conditions. For example, one participant described how their link worker had helped establish support groups for people suffering from chronic pain, an art club for wellbeing; and also helped to connect previously isolated community organisations to deliver an integrated service (Int.5). A further participant cited specific examples of CLWs having supported people to access previously underutilised community services. For example:

> "There was a service, [name removed], run by Voluntary Action, which was on the verge of closing down because they weren't getting any referrals for it. Our link worker started referring people to them so now their system is up and running. There was another one in [name removed] that didn't have many referrals. They were running an anxiety group, but they never had the numbers to run it until our link worker came along" (Int.2)

Whilst participants did present some evidence to suggest that CLWs can have a positive impact on services and service availability within their wider community, the extent to which CLWs can address systemic issues affecting community services remains limited. As one participant stated, "if we have 100 people on our books who need befriending and there isn't any, what systemic change needs to happen to address that?" (Int.11).

Findings do however suggest that the CLW programmes function as a feedback mechanism within the wider healthcare system. They gather real time data on issues faced by patients and the community and provide valuable insights that can be used to improve services and address gaps in provision.

> "If there are issues that are being raised by a number of link workers around a particular problem or service, it allowed us to go back to the HSCP … It's been really helpful because it is current, live data showing the issues that people are facing" (Int.9)

Participants explained that this feedback loop enabled strategic decision makers to identify and address the needs of their community more effectively. In some instances, this was a relatively informal process whereby individual programmes would raise issues on an ad-hoc basis. For example, one programme maintained "a list of services that are missing in the community" (Int.2), which could be used to advocate for increased support or draw decision maker attention to unmet need. Others described a more structured approach with CLWs embedded within strategic decision-making processes:

> "Our link workers are linked into the locality planning groups, the consortiums, and other avenues within the community. Our data actually gets used by health improvement and third sector organisations to target funding, to look at the gaps" (Int.15)

> "We ask for feedback as Commissioners about what the gaps are, so that we can try and target with grant funding or any other sort of funding towards those gaps and try and meet the needs and build capacity within the community" (Int.10)

Impact on patients

The voices of patients were not included in this research; however, a range of views were expressed on the impact of CLW programmes on patients. Such contributions provide valuable insights into the perspectives of programme practitioners on the effects of their work.

When discussing the impact of their programme, several participants focused primarily on the outcome of their work. Within this context, improvement in subjective wellbeing was consistently identified as the primary long-term positive outcome for patients who had successfully engaged with CLWs. Interviewees cited both improved wellbeing scores and positive patient feedback as indicators of effectiveness in this context.

Whilst acknowledging that such mechanisms alone will not reflect the entirety of impact, a general trend was described towards improved wellbeing among the majority of patients who had engaged with CLWs. For example, based on data that their programme had collected, it was suggested that there was "almost universally, an improvement in wellbeing scores" (Int.11). Another responded that "93% of people who completed [a wellbeing scale on entry and exit] recorded an improvement in their scores" (Int.14). Varying data collection and evaluation practices across programmes make this difficult to substantiate, and, where collected, much of this information is not publicly available.

However, improvements in patient wellbeing are apparent across a number of programmes. For example, in Glasgow between April 2020 – March 2021, 73% of patients working with CLWs employed by We Are With You recorded a statistically significant increase in wellbeing scores upon exiting the programme (Glasgow City HSCP, 2021). Similarly, in Edinburgh, there was an average increase of 28.02% in subjective wellbeing scores among patients who completed SWMWBS upon entering and exiting the CLW programme (EVOC, 2020).

Others focused on tangible impacts that could be directly attributed to working with a CLW, ranging from changes in support with social security, resolution of housing and financial difficulties. CLWs were seen as being well positioned to assist patients in navigating complicated systems and enabling access to financial and other benefits that they were entitled to. In Dundee, for example, between 2017-2018, "84% [of patients] had some positive outcome including decreased social isolation, improved or new housing, financial and benefits issues being addressed, and increased confidence, awareness and self-esteem" (Dundee HSCP, 2018: 51).

Unsurprisingly, enhanced access to services was also seen as one of the primary outcomes of working with a CLW. Particular emphasis was placed on the ability of CLWs to introduce patients to previously unknown community resources and organisations, to connect patients with services tailored to their individual needs and circumstances, thus reducing barriers to accessing services. As explained by interviewees:

> "The CLWs are finding things that people had no idea existed, or didn't know that there were organisations out there that could help them" (Int.2)

> "I think the links worker programme opens up so many opportunities for individuals that they otherwise wouldn't know where or how to access" (Int.3)

The potential for increases in a patient's social capital after working with a CLW were also highlighted. It was understood among participants that through working with a CLW, patients could become more integrated in their community, form new connections and strengthen existing relationships. For example, as one interviewee suggested:

> "[Patients are] connected into their area. There's obviously increased health and wellbeing, reduced isolation and loneliness, but we help them build better relationships at home and in the community" (Int.7)

This view was also shared by CLWs themselves, as evidenced by the following survey responses:

> "Increased support in areas that people feel are important to them. Increased connection to the community for ongoing support" (S10)

> "People volunteering within their local community. People accessing social services support or from third sector organisations. People making new friendships or reconnecting with old friends" (S28)

> "People become more engaged in their own community" (S29)

CLWs were not seen as a panacea for patient issues, and the potential for varying impact was acknowledged. Patients presented with complex problems and interdependencies that were unlikely to be fully addressed by a single programme. Therefore, the precise nature of individual issues and circumstances of each patient was seen as influencing the impact of CLW programmes. As one interviewee noted:

> "For some patients that come to us, by the end of their time working with us their lives won't be dramatically changed. And for others there is dramatic change. It just depends on the issues and where patients are at the time" (Int.13)

Another survey respondent expressed a similar sentiment when discussing their direct experiences of working with patients:

> "Results and cases vary. But generally, people find it incredibly positive to have someone to listen to their issues and offer different solutions" (S27)

This quote does, however, draw attention to another aspect of the impact of CLW programmes on patients, as in addition to the tangible outcomes that patients experience, participants also discussed the potential for their programmes to have a 'softer' impact on patients.

In this regard, the person-centred support received was understood as having an inherently positive impact, allowing them to identify and focus on issues that were of importance to them and aligned with their needs and goals:

> "We deal with the whole person, not just the specific thing they have been sent for" (Int.2)

> "Having someone that is listening to them, taking on board what they have to say and helping them address the issues that are important in their life. I think that is the main thing" (Int.3)

> "Link workers are not going in with a set prescribed agenda. People can bring their issues and the link worker will work to support them" (Int.9)

> "[CLWs] build trust. They ask what matters to you, not what is the matter with you" (Int.10)

Associated with this was the time afforded to patients when working with a CLW:

> "[Patients] get time to talk. They're not limited to a five-minute consultation. They can talk about all their issues and get it all out there. We'll give them the choice. It's not, "this is what you're going to go do". It's "what do you want to do?". So, I think it relaxes people" (Int.15)

The time and space that patients had to work through the issues they faced were seen as one of the primary benefits of CLW programmes, particularly when compared to other services within primary care:

> [A GP practice is] a highly pressurised environment where the staff are very, very good at assessing need in a short space of time. But it's not a place where you can sit, talk, and think. So [the CLW programme] is a really great asset to bring into that setting" (Int.11)

Future service design and delivery

Findings identified several issues that, whilst not fitting succinctly into the previous sections of this report, were prominent within the data and deemed worthy of further discussion. These are:

- the professionalisation of the CLW role,
- the position of link working relative to other elements of primary care modernisation,
- the embedding of CLWs within GP practices; and
- the potential introduction of a framework to structure link working across Scotland.

These issues cut across several, and in some cases all, of the findings presented in this report and were identified by participants as particularly important to the future of link working in Scotland. It is not the intention of this report to provide concrete recommendations at this point in time, but it is hoped their inclusion may prompt future action.

Community link working as a profession

The general practice CLW role attracts people from a variety of backgrounds and experiences. The diversity in professional knowledge and expertise associated with this was seen as one of the major strengths of CLW programmes across the country:

> "There has been a broad spectrum of people that can apply for the post, and they bring a wealth of experience with them which is great … you will have somebody that has specialised in adult protection working with people with social work backgrounds. It just really helps and adds to the fabric of the team" (Int.13)

> "We have social workers alongside community development workers. We have mental health workers alongside support workers. People from Women's Aid. All sorts of people from the health and social care sector have come in to link working over the last few years and that cross pollination is massive" (Int.11)

Whilst the breadth of experience that CLWs bring to the role was widely seen as positive, there were concerns regarding an absence of structure and support for community link working as a profession. Participants felt that this presented a significant challenge to the future of link working across Scotland. As one participant, who had worked as a CLW in multiple areas in Scotland, explained:

> "A lot of people don't know what the link worker role is. In [one area of Scotland] you could ask, "do you know what a link worker is?", and people wouldn't have a clue. I think it is important to get us on the radar, have some continuity across Scotland, and ensure that it is a recognised profession" (Int.4)

Comparisons were made between link working and other professions within Scotland. One participant drew parallels between their experience as a link worker and their previous occupation:

> "I came from the SSSC (Scottish Social Services Council) where you were registered as a professional. Health colleagues are registered as professionals. Link workers aren't" (Int.8)

Another commented on the position of link workers relative to nurses:

> "It's very difficult. Where you have very clear clinical structures, for example with nursing, of your banding, your staff nurse and charge nurse, and who is taking responsibility at which level. They have professional accountability. We don't have that same anchor" (Int.12)

The comparison was also drawn between link working in Scotland and other nations within the UK. In January 2023, for example, NHS England published a "workforce development framework" for social prescribing link workers (SPLWs) (NHS England, 2023). This aimed to:

- Provide clear and consistent standards for practice.
- Provide guidance on the support, supervision and learning and development of SPLWs.

- Promote the development of a strong and capable workforce of SPLWs.
- Support improved quality and consistency of social prescribing and reduced variation in outcome and access standards.
- Demonstrate the benefits of SPLWs as part of a multidisciplinary team.

It includes 'core competencies' for the link worker role and identifies resources to support employers in the recruitment and embedding of SPLWs within services.

Whilst the infrastructure to support link working is well-established in England, for example, The National Association of Link Workers, the two Scottish networks, (SCLWN and SSPN) are at an earlier developmental stage. They are nevertheless aware of the need for frameworks and agreed standards.

Participants did discuss the potential for a form of professional accreditation, although these discussions prompted varied responses. Some suggested that some degree of continuity across Scotland would be beneficial when seeking to establish community link working as a profession.

> "There is no consistent approach to it, which then makes it very difficult to have it valued as part of that multi-disciplinary team. There are no professional qualifications. Not that there has to be clear qualifications, but even just a basic foundation for the role would eradicate some of those issues" (Int.9)

> "In terms of us being a new profession, I think there's more work that needs to be done around that and I would be quite favourable to some kind of accreditation. I think it would help set the bar in terms of us being professional like everybody else" (Int.13)

Community link working and primary care modernisation

Participants highlighted the position of link working compared to other elements of primary care modernisation, expressing concern that CLW programmes were afforded little priority in comparison to other services. This was apparent at both the HSCP and national levels.

Whilst not representative of all cases, participants felt that their CLW programmes were low on the list of priorities for their respective HSCPs. In one case, it was suggested that this may be attributed to the lack of professionalisation, exacerbated by the fact that many programmes are not delivered through the NHS or HSCPs. For example, one participant described a 'gut feeling' that, as their service was delivered by a third sector organisation, they were not afforded the same treatment as other primary care workstreams. Others were more explicit in their statements, including participants representing programmes delivered through HSCPs. In such cases, the primary contributing factor was the limited funding for CLW programmes compared to other services. For example:

> "Because of the temporary funding it is very hard to be taken seriously. We are very, very low down on the list of priorities for the Partnership, or it feels like it at times" (Int.4)

> "It's definitely not the top [priority for the HSCP]. It is not the most invested, and we have a small percentage of the total PCIF investment. We don't have a dedicated staffing resource other than the link workers, and there is no management resource. It probably sits at the lower end in terms of investment. Now the primary care modernisation boards have been told to focus on getting some of the other workstreams fully implemented, so it is likely that that will continue" (Int.14)

Such examples serve as a microcosm of the wider concern regarding the position of link working at a national level, particularly following the shift in focus associated with revision of the Memorandum of Understanding in 2021. This apparent diminution of community link working within the primary care improvement agenda was a significant worry among participants:

> "My main concern is that at some stage [Scottish Government] will say, "okay, primary care modernisation is done, no more money". What do we do then? In terms of the smaller programmes, you might be able find the money from elsewhere. But some of the bigger programmes, there is no way that the Health Boards are going to be able to absorb that. No way" (Int.1)

It was suggested that any commitment to link working would benefit from a more explicit statement regarding the position of link working within this context.

> "If we want long term commitment, it needs to be written into some of the key policy drivers. But there is also something about where it sits in relation to the other parts of the MoU" (Int.9)

Embedding community link workers within GP practices

The process of embedding CLWs into GP practices, and the degree to which this has been achieved across Scotland, was a recurring theme. This was particularly salient given the recent calls for community link workers to be embedded across all GP surgeries in Scotland. This was first included in the Scottish Parliament Health and Social Care Committee's inquiry into alternative pathways into primary care, and restated in its "Tackling health inequalities in Scotland" report (Scottish Parliament, 2022a: 2022b). The degree to which link workers are successfully embedded, or integrated, within practices has also been identified as a key contributing factor towards successful implementation of CLW programmes (Chng et al., 2021). Findings in this context suggest that whilst the process of embedding CLWs into GP practices has been largely positive, there are pervasive issues that will continue to present challenges if not given adequate consideration.

Despite early challenges, participants were largely positive regarding their experiences in embedding their respective CLW programmes within primary care. This was routinely evidenced through two examples. Firstly, several participants described positive experience and feedback from GPs and the wider practice team:

> "I think, where the CLW is in the surgery, it has been amazing. We have had really good feedback from the GPs, and their patients have given them really positive feedback saying that the CLWs have made a huge difference to their life" (Int.2)

> "Initially we had maybe a bit of scepticism from the GP. I'd like to think they have overcome that, and the challenge now is that more practices want a link worker but there isn't the funding available" (Int.10)

> "On the ground, being in the practice, I think you can just feel a reassurance from staff that they've got an extra string to their bow. Making the link worker part of the multi-disciplinary team has been very successful in the practices that we are in" (Int.5)

Secondly, the high number of referrals that many programmes receive was cited as evidence of the degree to which their CLWs were embedded within their respective practices. As one participant explained:

> "Our community link working service is going very well and is getting good feedback from the GPs. That is echoed in the number of referrals. They wouldn't refer into a service that they weren't happy with, and that has taken about a year of building up those relationships" (Int.14)

Although they did point out that whilst the process of CLW embedding within practices had gradually strengthened: "there are still some GP practices where there are challenges" (Int.14).

This sentiment was shared by others. In a small minority of practices this was attributed to a lack of "buy-in" from GPs and occasionally the wider practice team. This may, in part, be reflective of unwillingness to deviate from an established medical model of care, with the suggestion that "there is still, within some areas, a culture change needed within primary care" (Int.3).

One interviewee described how ideological differences in the approach to working with patients between CLWs and GPs had created tension within their programme:

> "I think there's a real struggle between GPs and what they understand the programme to be about, how they want to use it and how we view it. I think they can sit together, but I don't think it's easy all the time. We struggle with relationships with some GPs because they can go off on a tangent that doesn't really sit well with what we're trying to do" (Int.7)

This issue was only highlighted within a limited number of those included within this research, with practices appearing broadly receptive to the principle of link workers. Findings suggests that the primary factors preventing the effective embedding of CLWs into primary care are operational, not ideological. The most prominent of these was space within practices to accommodate link workers. As shown in Figure 5, only 55% of respondents had regular access to office space in their allocated practices.

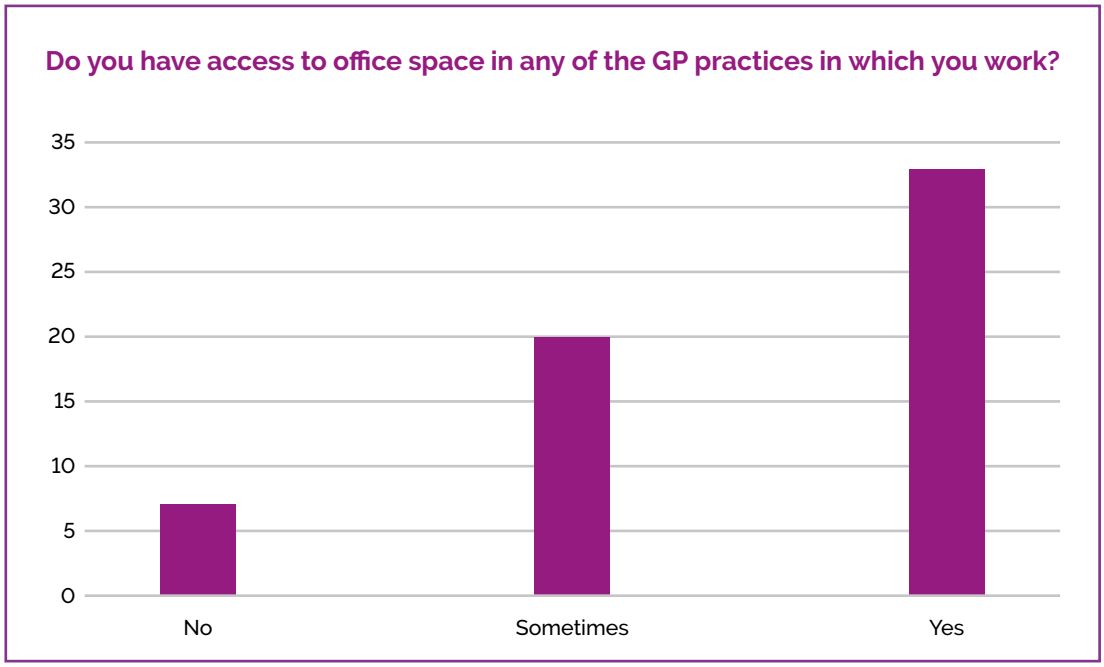

Figure 5 Availability of office space in GP practice

This was reflected in interviews:

> "I think the room space is a challenge, but it always has been because there is such a demand now in terms of the [GP] contract with other partners needing room space and GP practices" (Int.13)

One programme, first implemented during the COVID-19 pandemic, had not been able to embed their CLWs within practices:

> "The project started in COVID, so we were not able to get into practices at all. There was always the thought that the link workers would sit there occasionally anyway, but with the pressures on GP practice to find space, that's not happened" (Int.4)

Multiple programmes have resorted to sourcing additional space elsewhere in the community. For example, one participant, whose programme contained "about five or six surgeries where there is no room for the link workers" (Int.2), explained they were often "working in a community corridor in part of the NHS building" (Int.2). Another explained that, although most of the CLWs had office space at least part of the time, "for some of them we've rented external space, or they might have a space within a nearby Health Board building" (Int.14).

Space within practices was also acknowledged as a significant factor preventing the further expansion of CLW programmes to new practices. For example:

> "I think one of our biggest issues has actually been space within our GP practices. In most of the GP practices that haven't taken a link worker it's purely from a space point of view. They want one, but don't have anywhere to put us on a weekly basis" (Int.15)

Community link working at national level

The lack of a coherent national structure for community link working was a particularly salient topic among respondents. As discussed, the Scottish Government have given HSCPs leeway to design and deliver MoU services within their respective PCIPs in line with local needs and capacity. Although this was welcomed by participants, there was some concern that this commitment to local discretion may have come at the expense of adequate support and coherence across programmes. For example, one participant, whilst welcoming the discretion afforded to them, stated that:

> "What I have found enormously sad is that the government set this up, and there was meant to be all of this support around it, and it has fallen by the wayside" (Int.1)

Another felt that this lack of structure would present a major barrier to further expansion of their programme:

> "There has got to be a better structure in place if this is what we want in every GP practice … Give us something, some structure, because just now we are flying by the seat of our pants" (Int.14)

Parallels were drawn between Scotland and other nations and it was suggested that, at a local level, community link working across Scotland was relatively well developed. However, this was not reflected in the overarching structures supporting this activity:

> "Scotland should be good. Scotland should be ahead of the game. We are in terms of the grass roots, but we are absolutely failing the structural aspect" (Int.10)

Whilst not an exact comparison, the Welsh Government's approach to social prescribing was highlighted by several participants as an example of a positive development. In July 2022, the Welsh Government launched a consultation on a "National framework for social prescribing". This sought to develop an agreed model of social prescribing for Wales, a common understanding of the language used to describe social prescribing with actions to embed this model through a national framework. This framework "will consist of a set of standards, guidance and actions developed at a national level to ensure a consistency of delivery at a local level" (Welsh Government, 2022: 10).

Whilst the desire for a more structured approach within Scotland is apparent, participant responses illustrated the challenges presented by the inherent trade-off between the introduction of national frameworks or guidelines, and delivery at a local level:

> "Thinking of other programmes that have national drivers that sit behind them. You either get to the lowest common denominator, which means it's minimalist and almost pointless, or it's quite specific and then you go "this makes no sense, because the context in Glasgow is this and the context in Highland is that" (Int.9)

A further complicating factor is the extent to which existing programmes may be willing to adjust their established practices, developed alongside their local communities, to align with abstract national frameworks:

> "There was no steer or guidance from the government [when establishing our programme], and I would be very upset if they now come and give us a three-line whip as to how it has to be done" (Int.1)

As noted, participants discussed the contribution of community link working to a number of different outcomes at individual, system, community, and strategic levels. However, there was a perceived lack of clarity regarding the overarching aim of CLW programmes, and how this was to be implemented across programmes. For example, the use of a "theory of change"[9] approach was discussed, however only a small number of individual examples were identified with limited effect noted. Two interviewees discussed having worked on developing a theory of change within their respective programmes, but in both instances, this had not played a significant role in informing implementation of the programme. Another suggested that, although there was an implicit understanding of how the programme strived to achieve its intended outcomes, this had not been formalised into a clear framework for action:

> "I think it's something that we should actually be doing so that we can share that with any of the individuals who maybe don't understand as much about what the link workers, and the programme, should be doing. We certainly know from our point of view what we think the outcomes should be and what it's designed to target. But we have not done the logic modelling for it" (Int.14)

Participants suggested that a form of shared or common agenda for link working at a national level would provide benefits:

> "It is hard when you're going to people who have the power to provide funding and they're like, "well what is a community link worker? What do they do?". So, I suppose that would be my wish … just something that we can say we're all working towards" (Int.9)

> "If we just have Scottish Government saying "this is what we want you to do, have that flexibility, and here is the evidence base behind it", then that would make it a lot easier for us to operationalise" (Int.14)

Reflecting the wide variety of methods employed across programmes, participants also identified data collection and evaluation as an area where more support, structure and consistency was needed. Although a national evaluation was seen as impractical, and largely inappropriate in this specific context, several steps to help improve the consistency and comparability of evidence across programmes and better demonstrate the collective impact of CLW programmes were suggested.

Whilst previous experience with the Minimum Core Dataset yielded limited results, and its use has since been discontinued, the potential introduction of a modest set of shared measurements, indicators, or evaluation approaches for use across programmes was broadly well received:

> "If we are going to prove that link working support works, we need to have standardised reporting as much as possible" (Int.4)

9 Process by which a desired change is expected to happen in a given context. A theory of change involves mapping out goals and interventions for desired change, and identifying measurement to assess outcomes.

> "It would be great if there was a really succinct database that was user friendly, didn't take up a lot of time, and we recorded all the same or similar information" (Int.13)

> "I know nobody likes targets, but I wish there was more of a government influence saying "this is what we want to get from the link worker programmes" (Int.15)

However, there were several challenges associated with this. For example, the varying data collection requirements placed upon programmes from numerous stakeholders and partner organisations significantly complicates the process of identifying appropriate shared data points. One participant described this process taking place within their own programme:

> "We are having a bit of a debate around that at the moment, about what we need to provide to whom. Because we don't think it is the same universally" (Int.1)

Another, whilst supporting the idea in principle, was unsure about how this could be achieved in practice:

> "It's a big job though, the programmes are so different, and the funding streams are asking for different things. You don't want link worker programmes to have to report one way for one thing, and then have others that have to report in a different way" (Int.4)

Adequately accounting for this variation whilst simultaneously ensuring a degree of consistency again presented the problem that "it's either so complex that nobody can use it, or if it's not, it's not really worth it" (Int.9).

> "I think it would be welcome because anything that increases the evidence base would be useful. But it would need to be something that was fairly generic, and that wasn't used as a performance management measure for boards. I think that's really important" (Int.14)

Irrespective of the precise form or focus that any future policy on community link working may take, the necessity of continued support and commitment from the Scottish Government was made explicitly clear.

> "I would like to see an ask from Scottish Government for link workers to be implemented in health boards, and that direction to be accompanied by funding. Specific ringfenced funding if possible" (Int.14)

This was particularly salient given the precarious position of many programmes across Scotland. One notable example being the anticipated reduction to the CLW programme in Glasgow first brought to public attention in August 2023[10]. Several participants, whose programmes were also either on temporary funding, or nearing the end of a funding period, were extremely concerned about the sustainability of their programme:

10 https://www.bbc.co.uk/news/uk-scotland-glasgow-west-66553592

"Not knowing what's happening come the end of March causes so much stress on staff that are working with really vulnerable people. We are making them vulnerable by not being able to tell them what's happening with their jobs. I think that's an absolute tragedy" (Int.3)

"That's where the temporary funding aspect is difficult because there is nothing to keep people apart from a passion for the job. That is the big issue, we need to have confirmed recurring or permanent funding" (Int.4)

"At the moment we are a Cinderella service. But the difference we make, it's not just nice to have, it's part of everyday general practice" (Int.6)

Conclusion and final comments

This report has presented the findings of research which aimed to document and learn about a range of CLW services working in primary care settings across Scotland. Whilst not presenting a comprehensive, descriptive account of every programme, it has demonstrated the diversity of work being undertaken by CLW programmes within the communities they serve.

Monitoring and evaluation is one topic that attracted calls from study participants for greater consistency and joining up across the country, as a pre-requisite for developing robust data and a clear national picture.

The position of community link working within the Scottish Government's primary care policy agenda, and the future of national policy on community link working, were prominent themes throughout this research. Whilst the Early Adopter sites were established as part of a national programme and funded directly by Scottish Government, post-2018 community link working has occupied a more ambiguous space at a strategic national level in the view of many study participants. Ministers have consistently championed community link working as part of their vision for Scotland's health, and indeed there appears to be strong cross-party political support for link working. However, Ministers have opted largely to devolve most decision making about service development and delivery to the local level. This includes both Health Boards and HSCPs within the context of MoU implementation, and the various TSOs working across Scotland to deliver CLW services. There isn't currently a national strategy on community link working to which people can refer.

We see the lead responsibility for community link working at a national level resting with the Scottish Government's Primary Care Directorate. However, we observe that the wider issue of non-medical preventative support – including social prescribers, community navigators and condition-focused link workers – is attracting increasing and welcome attention and support from several other Directorates. This includes the Population Health Directorate which, during the course of 2023, agreed to provide a resource to support the development of the Scottish Social Prescribing Network.

While the Scottish Government's focus on community link working is welcome, it isn't enough to convince all CLWs and programme managers that the longer-term development and sustainability of their programmes is secure. This report has highlighted their continued frustration regarding the short-term funding of their programmes and the detrimental impact this has on them and the communities they serve. It is hoped that the intelligence gathered in this report is used to support strategic discussions at a national level regarding the long-term future of community link working in Scotland.

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Appendices

Appendix A – Survey questions

General Information:

- What is your job title?
- What is the name of your employing organisation?
- Which area of Scotland do you work in (Listed by HSCP)?
- Do you work full or part-time?
- How long have you been in your current post?
- How many GP practices do you support?

Community Link Worker Role:

- Please complete the following sentence. "As a Community Link Worker, my role involves…"
- What do you see as the main positive outcomes of your work for patients?
- Have you completed any training since you started your role?
  - Please explain the focus of this training and, if possible, who it was delivered by.
  - Please state any training that you would find useful.

Service Delivery:

- What are the most common methods by which people are referred to you? (Please select the three most frequent methods)
- Are there any restrictions on who can access your service? (e.g., you do not accept self-referral, 16/18+)
  - If yes, please list them.
- Please select the main reasons for referral to your service.
- How do you conduct appointments? Please tick all that apply and/or add to the 'other' box.
- Do you have access to office space in any of the GP practices in which you work?
- What is the maximum number of appointments you can have with a patient?
- What is the average number of appointments you have with each patient?
  - What is the average length of appointment with each patient?
- What type or services do you most frequently refer people to?

Monitoring and evaluation:

- Do you use a data recording or management system as part of your work?

  – Please state the data recording or management system(s) used.

- Do you monitor any of the following as part of your work? Please tick all that apply and/or add in the 'other' box. [note – Respondents were given a choice of data points from the Community Link Working Minimum Core Data Set]

- Do you use a specific tool to keep track of the organisations and resources in your community? (e.g., ALISS)

  – Please state the tools(s) used.

  – If you do not use a specific tool, what methods do you use to keep track of the organisations and resources in your community?

- Do you currently use an evaluation tool to measure the impact of your work? (e.g., ONS4 or WEMWBS)

  – If yes, please state the tool(s) used.

- Have you previously used an evaluation tool to measure the impact of your work?

  – If yes, please state the tool(s) used.

- If you answered no to the two previous questions, please state how you measure or record impact of your work.

- What data or evidence do you think should be collected in the future to best demonstrate the impact you have as a Community Link worker?

Appendix B – Interview guide

Programme Description and Delivery:

- When and how was the programme established?

- How many link workers are part of the programme?

  – How was this decided on? (population need, funding availability etc.)

  – What training is provided to CLWs? (mandatory, optional, induction etc)

- How many GP services does the programme cover?

  – How were they chosen? ('Deep End', SIMD Status, they approached you etc.)

- How many partner organisations are involved in the management and implementation of the programme?

  – Can you please name them.

- Can you please describe the typical process by which somebody will interact with the CLW programme.
  - How can they be referred? (Are there any restrictions on who can access the service?)
  - What type of support is provided? ('signposting' to 'holistic')
  - Is it time-limited? (e.g., limited to 4-6 sessions)

Programme Theory:

- Do you have a logic model (programme theory/theory of change) for the programme?
- What do you consider to be the primary issue(s) that the Link Worker programme is trying to address? (e.g., health inequalities, inverse care law).
  - How were these identified as priority issues?
    - Has this changed over time? If so, why?
- What do you consider to be the main positive outcomes of the programme for patients?
  - Have they changed over time? If so, why?
  - How do you think the programme contributed to achieving these outcomes? [Why does it work?]
  - Do you think these outcomes are similar for all groups or patients?
- What have been the main challenges you have faced in implementing the programme?
    - From an operational level?
    - At the delivery level?
    - Other?
- Are there elements of your programme that you think different programmes could learn from?
  - If yes, can you please explain?

Programme Monitoring and Evaluation:

Monitoring

- Do you have a data collection system/process in place to monitor the implementation of the programme?
  - If yes, can you please explain how this works/what is measured?
    - In 2018, Public Health Scotland and the Scottish Government developed a Minimum Core Dataset. Have you used this to inform the way you collect data?
  - If no, how do you monitor the implementation of the programme?
- How does the data you collect help track progress towards addressing the issues we discussed earlier?
  - Priority issues?
  - Patient outcomes?
- Have you experienced any challenges in collecting data on the implementation of the programme?
- What data do you think should be collected/indicators should be used to best monitor the implementation of community link worker programmes?

Evaluation

- How do you evaluate the programme?
  - Do you use a specific evaluation tool? (ONS4, WEMWEBS)
- What are your thoughts on evaluation of CLW programmes more broadly?
  - How do you think it could/should be used to capture the impact of your programme more clearly?
  - Is there something you would like to see included in evaluations that is not currently?

Learning

- How do you use this monitoring and evaluation to inform practice?
- Do you interact with or share learning with other programmes?
  - If yes, how do you do this?
  - If no, is this something you feel as though your programme could benefit from?

Appendix C – Responsibility for programme delivery

(Please note that this information is recognised as incomplete and was gathered through a combination of publicly available sources and data held by Voluntary Health Scotland)

CLW Programme	Delivery Organisation(s)
Aberdeen City	Third Sector Organisation
Aberdeenshire	Aberdeenshire Health and Social Care Partnership
Angus	Third Sector Organisation
Argyll and Bute	Third Sector Organisation
Ayrshire (combined)	Hybrid (Community link workers employed by both TSO and HSCP)
Clackmannanshire and Stirling	Third Sector Organisation
Dumfries and Galloway	NHS Dumfries and Galloway
Dundee	Dundee Health and Social Care Partnership
East Dunbartonshire	Third Sector Organisation
East Lothian	Third Sector Organisation
East Renfrewshire	Third Sector Organisation
Edinburgh	Third Sector Organisation
Falkirk	Third Sector Organisation
Fife	Health and Social Care Partnership
Glasgow	Third Sector Organisation
Highland	Third Sector Organisation
Inverclyde	Third Sector Organisation
Lanarkshire (combined)	NHS Lanarkshire
Midlothian	Third Sector Organisation
Moray	Third Sector Organisation
Orkney	Third Sector Organisation
Perth and Kinross	Perth and Kinross Health and Social Care Partnership
Renfrewshire	Third Sector Organisation
Shetland	NHS Shetland
West Dunbartonshire	Third Sector Organisation
West Lothian	Third Sector Organisation

Voluntary Health Scotland (VHS) is the national intermediary and network for voluntary health organisations across Scotland. Our purpose is to create a healthier, fairer Scotland served by a thriving voluntary sector.

Since 2021, the Scottish Government Primary Care Directorate has provided funding to VHS to establish and develop the Scottish Community Link Worker Network (SCLWN). The Network aims to create a shared space for community link workers in primary care settings across Scotland to share learning and develop, network and support each other to improve outcomes for their patients and communities.

This research aimed to explore and understand more about the range and scope of Community Link Worker programmes working in GP practices across Scotland.

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