NHS North Highland Community Link Worker Project

Year 1 Report

1st May 2022 – 30th April 2023

Introductions

I am delighted to be able to share the report of the first year of the delivery of the Community Link Worker service in Highland. There has been a significant amount of work involved in establishing and delivering the services and I would like to thank all involved.

The CLW service has been welcomed by individual GP practices as a valuable addition to their multi-disciplinary teams and I hope the report gives an insight to how the service has been operating in the first year.

Dr Tim Allison
Director of Public Health, NHS Highland

This report gives an oversight of the first full year of service delivery to Highland GP practices that have been allocated Community Link Worker hours. It makes recommendations for future development of the service. The data presented has been extracted from Elemental; the social prescribing platform used for referring and reporting.

I hope you will find this report informative and useful in demonstrating the impact of Community Link Workers in primary care.

Cathy Steer
Head of Health Improvement and Community Link Worker Service Lead.

Contributors

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Introduction

Welcome to the first-year report on the delivery of the Community Link Worker Project in North Highland.

Change Mental Health have been commissioned by NHS Highland to provide the service and the report focusses on the work carried out to set up the service through to the delivery of the Community Link Worker service.

Background/Context

A memorandum of understanding between the Scottish Government, the British Medical Association, Integration Authorities and NHS Board of the new Scottish General Medical Services (GMS) Contract was agreed in April 2018. Embedding Community Link Workers (CLW) into general practices in Scotland is one of the six key priorities that GP practices will have to provide to patients under the 2018 General Medical Contract. The service aims to reduce the workload on general practitioners (GPs) and enhance GP and third sector relationships.

Each of the key workstreams were allocated a percentage of board funding. The Primary Care Improvement Funding (PCIF) totalled £7,113,437 in Highland with 7% of that allocated to the Community Link Worker Workstream which Public Health/Health improvement, NHS Highland agreed to lead on. £1,485,000 was allocated to the CLW workstream for a 3-year period.

Between September 2018 and January 2019 NHS Highland, UHI and 9 third sector partners held a series of stakeholder events to explore what was happening locally around social prescribing in Highlands. The benefits of sharing best practice and approaches were evident.

The CLW Working Group was established with members meeting for the first time in January 2019. The working group was set up to develop CLW service in Highland. The group reported to the Primary Care Implementation Plan project team and programme board and met monthly to develop a delivery model for the CLW service across North Highland.

In March 2019, the first issue of the CLW Newsletter was published as part of a series of planned updates to give interested parties more information on how the Highland Community Link Worker Programme was progressing.

CLW Anniversary Party in Golspie

NHS Highland Health Intelligence team (Public Health, NHS Highland) prepared a briefing paper “Community Link Working – targeting resource to need in March 2019. The paper looked at how Community Link Working (CLW) might be targeted at the needs and demands of the practice and practice populations of the Highland HSCP using data from the Scottish Index of Multiple Deprivation (SIMD) and Community Health Index General Practice lists. The Health Intelligence team produce a further paper in July 2019 “Community Link Working – targeting resource to need - an update”.

The funding allocated to the CLW service was not sufficient to provide all 65 GP practices with a proportion of resources. The resource was therefore allocated based on patient numbers and targeted at the most socio-economic deprived communities. The analysis reviewed patient numbers in SIMD 1 & 2 and proportionally allocated each practice hours based on a WTE post. This resulted in 29 GP practices across North Highland being identified and being offered CLW input.

Model of Delivery

Programme Budgeting and Marginal Analysis (PBMA) completed along with developing a gap analysis in relation to provision of Community Link Worker services in North Highland.

An options appraisal was carried out in June 2019 based on the Programme Budgeting Marginal Analysis (PBMA) approach and 5 options were identified:

1. Service delivered by NHS Highland
2. Commission one third sector organisation to deliver the service across Highland
3. Commission multiple third sector organisations to deliver the service across Highland
4. A mixed model of commissioned and NHS Highland delivery
5. Service delivered by GP practices

The outcome of the options appraisal suggested that commissioning one third sector organisation to deliver the Community Link Worker services in Highland would be the best option.

Cost of Living Advice and Awareness at Merkinch Community Centre

Tendering Process

A specification to commission one third sector organisation to deliver service was developed which was submitted to the National Procurement Portal in December 2020. The tendering process was highly competitive with a much higher level of tenderers submissions received than anticipated. In February 2021, six members of the CLW Working Group completed the review of tenders. The contract was awarded to Support in Mind Scotland (now Change Mental Health) with the contract starting on 5th July 2021.

Elemental Social Prescribing Platform

A review was undertaken to find an appropriate software package to support the integration of CLW's with GP practices ensuring the ease of referral into the service and effective monitoring and evaluation. Elemental is an online social prescribing platform designed to integrate digital technology into proving and designing social prescribing. Following a review of a range of IT Products, Elemental/Elemental Core was assessed as best meeting the needs of the CLW service in Highland.

Information Sharing

Both a Data Protection Impact Assessment (DPIA) and Information Sharing Agreement (ISA) were completed and implemented.

After some initial delays due to recruitment, Elemental social prescribing platform developments and the Information Sharing Agreement (ISA), the CLW Service commencing in April 2022.

What is Social Prescribing?

The following definition was agreed in June 2023 by 48 experts from 26 different countries, which included Scotland and has now been accepted by the British Medical Journal.

Social prescribing is:

> "A means for trusted individuals in clinical and community settings to identify that a person has non-medical, health-related social needs and to subsequently connect them to non-clinical supports and services within the community by co-producing a social prescription – a non-medical prescription, to improve health and wellbeing and to strengthen community connections."

(Establishing Internationally Accepted Conceptual and Operational Definitions of Social Prescribing Through Expert Consensus: A Delphi Study by Caitlin Mulhl, University of Toronto)

What is a Community Link Worker?

Community Link Workers follow a social prescribing model and are embedded in GP practices. They aim to address socio-economic and personal circumstances that affect health and wellbeing to improve the outcomes for patients and reduce pressure on GP's time.

1st Year of Service Delivery

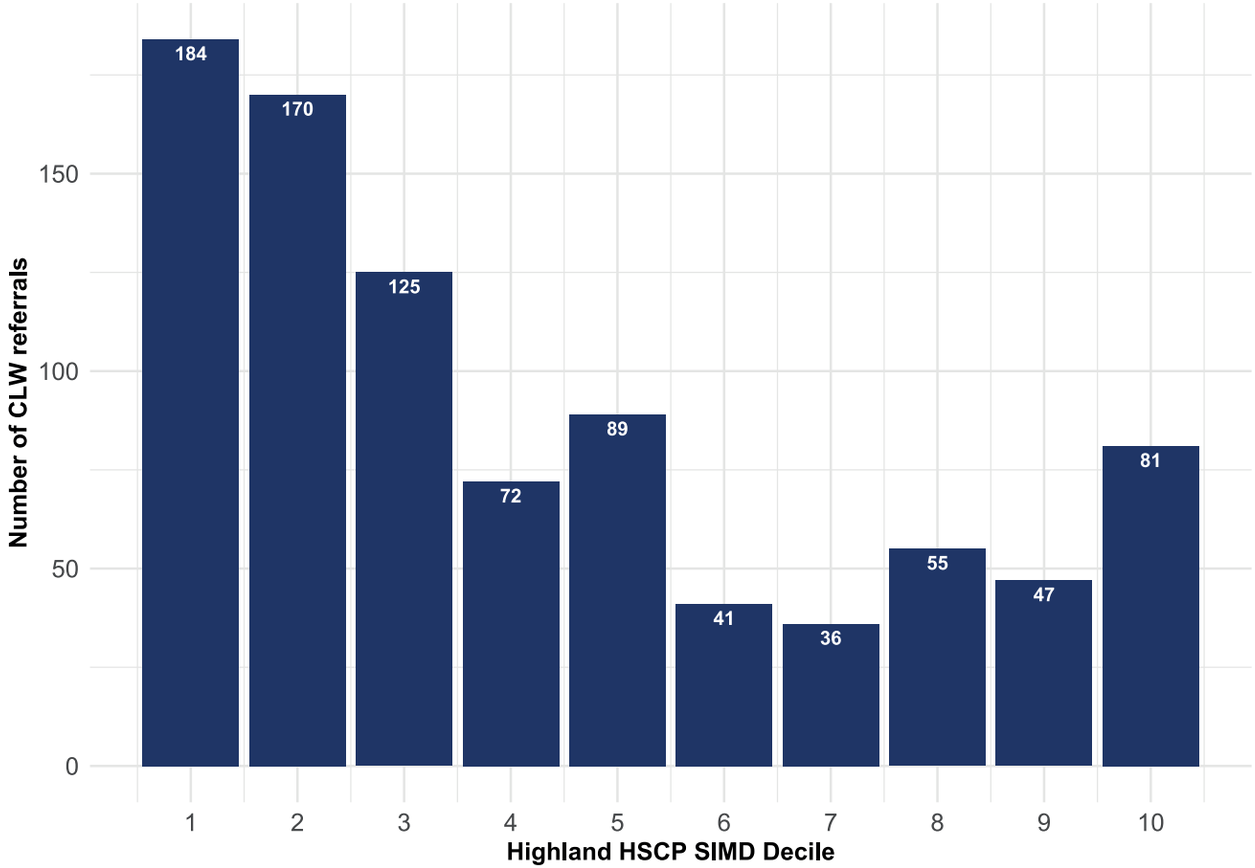
The following section of the report will look at CLW service delivery from 1st May 2022 to 30th April 2023. Data for this report is taken from Elemental (extracted as at 31/05/2023), the software used by the service to manage referrals and case activity.

Mandy and Sharyn presenting at an NHS Social Prescribing event in Inverness

Referrals and outputs

In total, 920 referrals were made to the Community Link Worker (CLW) service in Elemental during the year, of which 38.5% (n = 354) were for clients living within the Highland HSCP Scottish Index of Multiple Deprivation 2020 (SIMD 2020v2) deciles 1 and 2 (target population). Figure 1 below shows the annual number of referrals for all SIMD 2020v2 deciles.

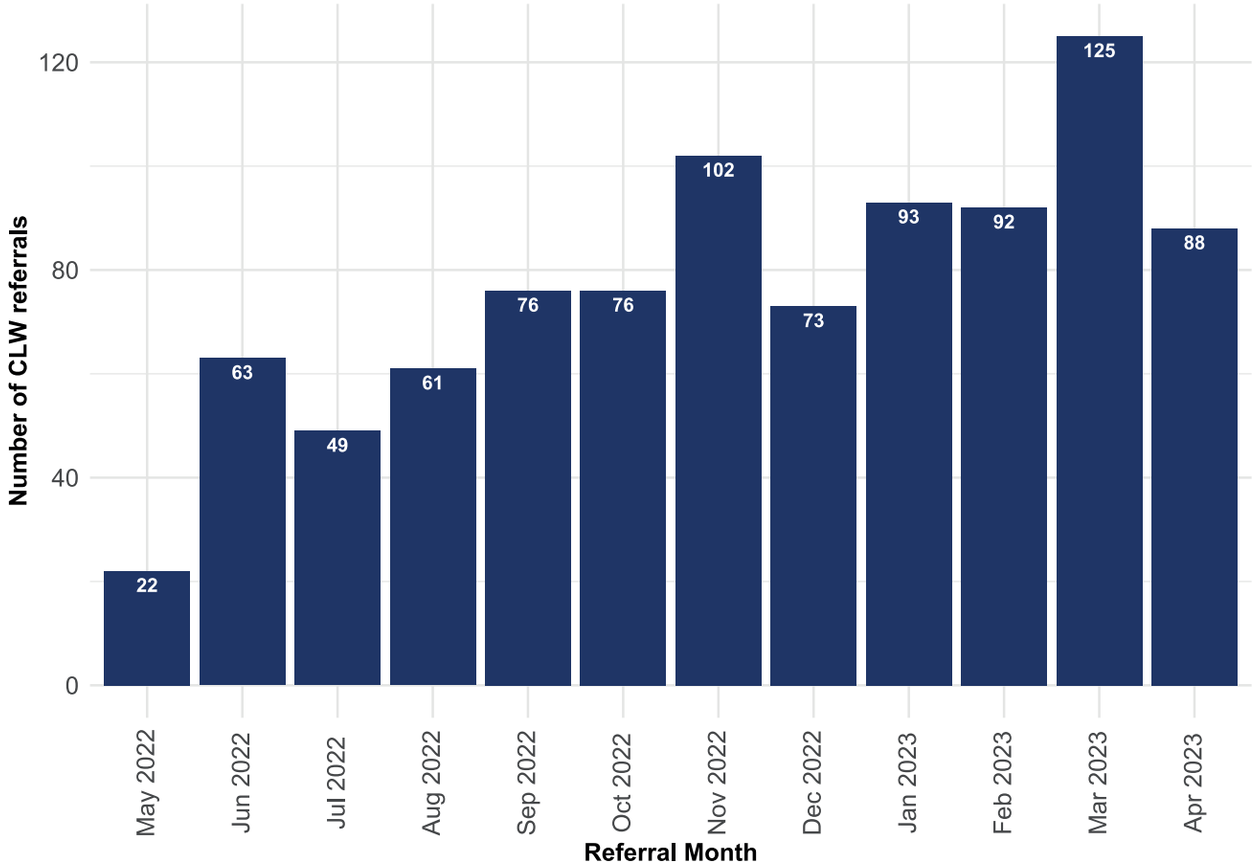
Figure 1: Number of Community Link Worker (CLW) referrals by SIMD decile (1st May 2022 to 30th April 2023)



Note: 20 referrals are excluded from the above data as postcodes were not available in the Elemental records for mapping to SIMD decile. SIMD 2020v2 is used.

Figure 2 below shows the number of referrals made to the service in each month during the year.

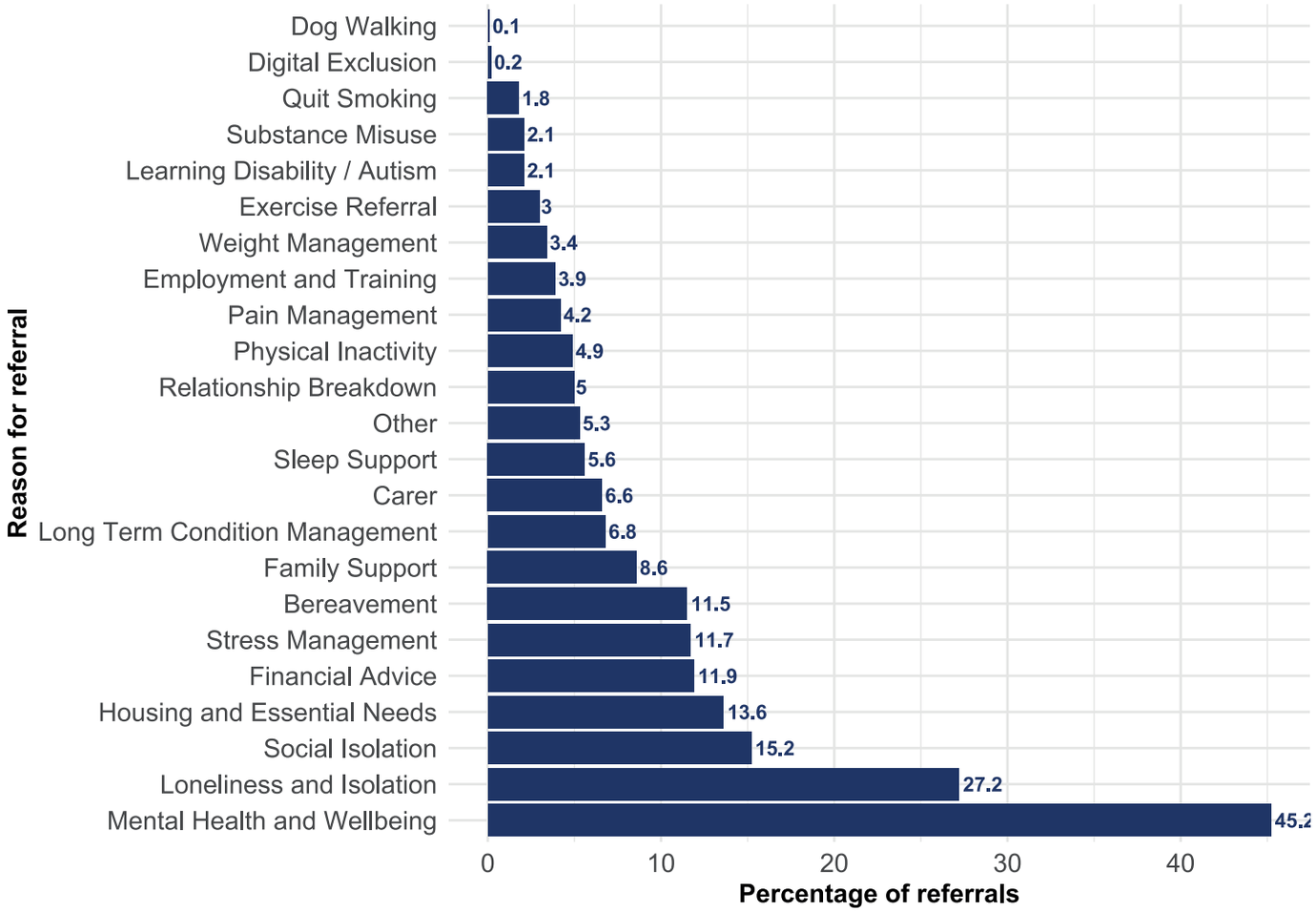
Figure 2: Number of Community Link Worker (CLW) referrals by month (1st May 2022 to 30th April 2023)



Reason for referral

Referrals are made via Elemental to the CLW service giving one or more reasons as appropriate for the referral. Figure 3 shows the percentage of annual referrals (n = 920) for each given reason for referral.

Figure 3: Percentage of referrals with given reason for referral (1st May 2022 to 30th April 2023)



Engagement status

The engagement status of clients referred to the CLW service has been categorised in Table 1 below for those where the referral was either 'Complete' or 'Discharged/Closed' at the time of data extract (31/05/2023), hence final case status was known and could be used to derive the final engagement outcome.

Table 1: Client engagement status (complete, discharged or closed referrals) as at 31/05/2023

Engagement Status	Number of Clients	% of Clients
Completed and discharged	324	50.4
Partial engagement	179	27.8
Did not engage	95	14.8
Referral error	45	7.0

Note: Engagement status is not recorded within Elemental so has been derived using the case status group and case status of referrals from records as detailed below:

Partial engagement: case status group = "Discharged/Closed" AND case status = "No longer requires service" OR "Disengaged" OR "Did Not Attend Appointment" OR "Unhappy with service" OR "Client Deceased"

Referral error: case status group = "Discharged/Closed" AND case status = "Inappropriate referral" OR "Duplicate or Error" OR "Re-referral" OR "Out of area"

Client demographics – age and gender

The average age of clients was 53 for those who fully engaged, 50 for those who partially engaged and 50 for those who did not engage with the CLW service.

Of the 920 referrals to the service during the year, 68.8% (n = 633) were females and 31.2% (n = 287) were males.

Appointments

In Tables 2 and 3 below the types and outcomes of appointments recorded on Elemental by Community Link Workers, where the date of the appointment was within the reported year, are shown by number and percentage.

Table 2: Number and percentage of appointments by type

Appointment Type	Number of Appointments	% of Appointments
Telephone	2062	63.9
GP practice (ward visit)	729	22.6
Community (1 to 1 (face to face))	250	7.8
Text	77	2.4
Email	41	1.3
Other	26	0.8
Video call	21	0.7
Not selected	19	0.6

Table 3: Number and percentage of appointments by outcome

Appointment Outcome	Number of Appointments	% of Appointments
Attended	2000	62.0
DNA (Did Not Attend)	648	20.1
Rescheduled	323	10.0
Not Selected	153	4.7
Cancelled	101	3.1

For the 503 annual referrals that were finalised (complete, discharged or closed) at the date of data extract (31/05/2023), and where the client engaged with the CLW service (fully or partially), a total of 2196 appointments were recorded as having been arranged by the service. On average each client engaging with the service had 4.4 appointments recorded in their case activity. The average was higher for those fully engaged with the service (4.9 appointments per client) compared with those only partially engaged with the service (3.5 appointments per client). The actual number of appointments recorded for each client ranged from 0 to 17 in the finalised case activities.

Social Prescriptions

In total, **1756** social prescriptions were recorded on Elemental during the year.

Table 4 below presents the percentage of interventions prescribed for each quarter in the reported year by the primary category of the intervention.

Table 4: Percentage of interventions prescribed for each quarter by primary category of the intervention

Primary Category	Qtr 1 (May 22 - Jul 22)	Qtr 2 (Aug 22 - Oct 22)	Qtr 3 (Nov 22 - Jan 23)	Qtr4 (Feb 23 - Apr 23)
Mental health	61.2	60.5	61.1	57.6
Social support	70.9	58.4	49.2	51.0
Physical exercise	17.0	14.1	9.1	13.1
Unknown	1.9	5.5	8.6	5.1
Diet and nutrition	5.8	5.7	3.3	4.6
Advice and support	1.9	4.1	3.1	4.0
Clinical support	3.4	3.6	1.9	4.6
Other (< 1% each)	1.9	4.8	4.5	5.6

As the main categories of interventions prescribed are mental health, social support and physical activity, the top services referred to were:

NB: Let's Get On With It Together (LGOWIT) is now known as MySelf Management

SWEMWBS Outcomes

As a measurement of outcomes the short version of the Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS[1]) is used with clients at the start (pre) and end (post) of their case management with the service, when it is relevant and appropriate to do so.

SWEMWBS[1] scores range from 7 to 35 and higher scores indicate higher positive mental wellbeing. A score of >18-20 is indicative of possible depression or anxiety and a score of 18 or less is indicative of probable depression or anxiety. The mean score is 23.5 in UK general population samples[2].

Table 5 below summarises the number of times SWEMWBS was completed for clients pre and post case management with those referred to the service during the year reported, along with the average score for these. Mean scores were obtained by analysis of scores recorded in Elemental (un-paired) and were observed to be higher post compared to pre case management. Some caution should be used in interpretating this as no statistical testing was undertaken. SWEMWBS has also been shown to vary by age and gender, which could be represented differently in those pre and post case management.

Table 5: SWEMWBS measurements at start (Pre) and end (Post) of case management for referrals made during the reported year (as at 31/05/2023)

Number completed (SWEMWBS Pre)	Mean score (SWEMWBS Pre)	Number completed (SWEMWBS Post)	Mean score (SWEMWBS Post)
516	18.5	151	21.7

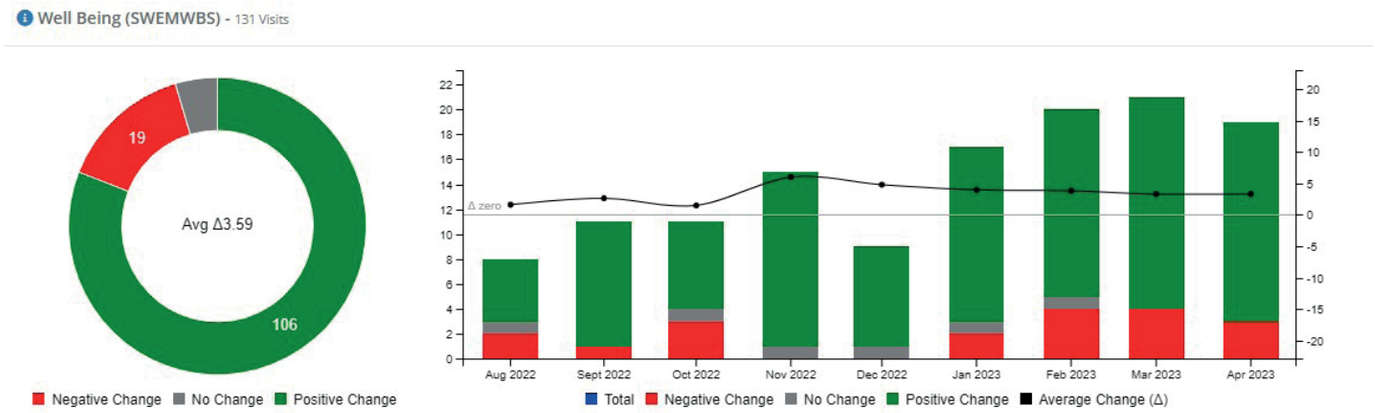
Note: Further SWEMWBS measurements may be taken with clients who were still being actively managed by the service as at the date of data extract for this report (31/05/2023) so these numbers may be subject to change.

Not all clients had SWEMWBS measurements taken at both pre and post case management. Where these were available scores were paired and compared to look at any change over the time the CLW service was working with the client. Figure 4, on the following page, summarises the changes in paired scores for cases closed during the reporting period. There were a total of 131 clients with paired scores within this time period;

106 clients had an increase in score, 19 a decrease and 6 had no change. The average score for these clients increased by 3.6 points between pre and post measurement. Academic evaluation of the SWEMWBS suggests that, minimally, a 1 point change in SWEMWBS can be statistically meaningful at the individual level[2]. This data was taken directly from reports available in Elemental and does not present any statistical significance testing for the change in scores observed. Note that changes in SWEMWBS could occur due to natural improvement in mental health or come about through regression to the mean, as well as due to the impact of the intervention.

1 Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS) © NHS Health Scotland, University of Warwick and University of Edinburgh, 2008, all rights reserved.
2 Warwick Medical School, University of Warwick. Warwick-Edinburgh Mental Wellbeing Scale, How to use WEMWBS, Collect, score, analyse and interpret WEMWBS. Available from: https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/using/howto/ [Accessed 05/07/2023]

Figure 4: Change in SWEMWBS measurements paired scores by month in which case was closed



Note: the figure presented above is taken directly from a report available in the Elemental system.

UHI Evaluation

The UHI lead the evaluation of the community link worker (CLW) scheme within Highland in a way that will capture the relevance of findings for other remote and rural areas of Scotland.

The aim is to capture impact on

- patients,
- the third sector
- the wider health care system.

Data collection tools have been developed to capture impact in each of these areas.

The original questionnaires was designed to be handed out by community link workers themselves as before and after questionnaires. The questionnaires include the following validated measures EQ-5D-5L, WEMWEBS and Lubben social isolation scale. They had been designed in LymeSurvey and appropriate permissions were in place for use of the validated measures.

However, this encountered several challenges including a low response rate. Different several strategies were tried with the community link workers to increase questionnaire response rate. The CLWs have reported that they are seeing many more complex and acute cases than anticipated and they are hesitant to give out the questionnaires. To avoid them having to do this, the questionnaire has changed to use the ICECAP format, which will allow the questionnaires to be sent directly by an administrator within the service delivery organisation.

In addition, Caldicott approval for a transfer of Elemental data from NHS Highland to UHI for analysis was approved. This will provide a more detailed data than would have originally received through the patient completed questionnaire and will compensate for the low response rate.

Regular meetings with the Community Link Workers and UHI have taken place which has helped to record ongoing contextual challenges and influences. A focus group with the CLWs is planned to capture this data as new trends are emerging.

An interview schedule has been designed to capture the experience of a sample of rural primary care staff and third sector workers. Qualitative work started in 2022 with the researcher also spending time within the practices with CLWs. At this early stage, some themes emerging relate to primary care practice capacity, physical space and perceptions of the utility of social prescribing.The University of the Highlands and Islands (UHI) has been awarded funding from the Chief Scientist Office to evaluate the CLW service in Highland. Data currently being collected through a mixed-methods case study design that utilises questionnaires, analysis or primary care usage and interviews with stakeholders. The study commenced September 2021 and will run until December 2025.

The focus on the evaluation will be on remote and rural GP practices and will seek to monitor and measure the impact of the introduction of community link workers in three main areas:

- Impact on patients, their carers and their families
- Impact on the third sector as part of the social prescribing system
- Impact on the wider health and care system

The aim of the research is as follows:

- To investigate the impact of the introduction of community link workers on rural, remote and regional centre dwelling individuals, their families and carers, the third sector, and primary care providers
- To identify the barriers and facilitators to the implementation of a community link worker social prescribing programme outside the large metropolitan contact
- To identify indicators of change for monitoring and measuring the impact of community link worker social prescribing outside urban areas

Case studies

Feedback from Patients

"Talking always helps and gives an initial boost which proves to yourself that you are capable of feeling normal."
"I am delighted with the service, I have gone swimming, been on my Wii Fit doing dances and I have been keeping an eye on my calorie intake which I am managing to stay in my calorie count."
“With the help of your service and antidepressants from my doctor, the future is looking a lot brighter."
"The service has done so much for me, and I am going to keep going to these resources. "
"You have helped me so much. You have helped me understand the grieving process and better still I am now starting the healing process because of our chats. I will be forever grateful for your help."

extracted from November 2022 – January 2023 monitoring report

Case Study 1

Since losing his job, my client has really struggled with his confidence and struggled to lift his mood. Described himself as feeling lost. Through the consultations with my client, I used our resource directory to identify appropriate support networks to refer my client to. I initially referred him to the local Voluntary Group and Men's shed. I have also involved the work of connecting carers.

My client was also referred to Befrienders, which he attended and although the age group was older than he was, he stated that it was good, gave him space and was good company. He is going to keep attending this. Overall, he feels better and more motivated since he was initially referred.

extracted from August 2022 – January 2023 monitoring report Case Study 3

Case Study 2

I have been working with a lady since the beginning of July, this lady was referred for 'Housing and essential needs. At our first meeting she was very clear on what support and advice she required. A housing transfer within the same village, small amount of help at home with housework and a handyperson service who could assist her with some small jobs around her home. I referred her onto services who could support her with this. She now has a supporting letter from her GP for her housing transfer. As a result of my support, she is in touch with a local service that can provide help at home, and in discussion with a handyperson service that covers her area. This lady has expressed she is very happy with this and expressed she feels she has got a lot done in the last month that will improve her quality of life.

extracted from August 2022 – January 2023 monitoring report Case Study 4

Case Study 3

Since an incident of bullying forced him to move, my client has been suffering from loneliness and Isolation, Social Anxiety, physical inactivity, and lack of sleep. Through time and getting to know my client discussing what he would be willing to try and what would be too much for him, I used our recourses to direct him to Mindshift CBT to help him understand his anxiety and to help manage it, which he has done and has stated that he feels a benefit from. I also asked him to make contact with Active Health to help him find a way to become more physically active in a way comfortable to him, with a view that this will help increase his confidence and help improve his ability to get better quality sleep., He has stated that our sessions have helped and feels more willing to try things for himself.

extracted from August 2022 – January 2023 monitoring report Case Study 5

Case Study 4

My client was referred to our service for mental health and wellbeing support. When first contacted, they were closed off and stated that they did not feel comfortable talking about their feelings, nor did they know what support they wanted. However, after reassuring them that our conversations were confidential and that I was there to support them, they began to open up and discuss their issues. It was then when they were comfortable enough that they told me they had experienced several bereavements in the past that they had not properly grieved for. It was apparent that the unresolved trauma stemming from these bereavements played a significant role in the client's low mood and substance use.

My client agreed that bereavement counselling would be beneficial and consented to a referral for the Highland Hospice. Whilst on the waiting list, my client and I remained in contact where I was able to provide them with support and advice on situational issues that had arisen. They are now in contact with Highland Hospice for bereavement support and are still in contact with our service for mental wellbeing support until they feel comfortable., my client stated that our support has really helped them move forward, they feel more positive than they have for a long time, and that they now have the confidence to open up to their family members about their mental wellbeing.

extracted from November 2022 – January 2023 monitoring report Case Study 2

Case Study 5

Patient was referred for support in accessing help to deal with damp/mould in their house, and difficulty accessing funds to help combat this problem. The patient was very open to support from the CLW and attended every appointment made. During discussion the patient disclosed that they would also like help with their IT skills, as they felt more of the world was online and they were being left behind, and a prescription was made to the Adult Learning Service and the patient has attended and is making progress with their IT skills.

Numerous enquiries were made to the Housing Association to try to assess and fix the patients mould problem and, although this service took a long time to reply, the CLW's referral was accepted, and the patient had Energy Advice Service in their house to assess where the mould was beginning and how to fix the problem.

The patient was not interested at this time in attending the CAB prescription for a benefits check but has their details if they would like to proceed with this at a later date.

extracted from November 2022 – January 2023 monitoring report

Case Study 6

An elderly client was referred for Housing and Essential Needs. A carer for their parent, who had recently been diagnosed with Cancer, the client was worried about tenancy if their mother passed away as the tenancy is in her name. The client had issues with alcohol and had been homeless previously and did not want to be in that situation again. The client also disclosed that they were very lonely and finding it difficult to care for their mother, with little contact with others.

The Community Link Worker contacted some community groups to help the client, such as My Self-Management (formerly LGOWIT), as well as contacting Carers Support and MacMillan. They also helped with contact with the Housing Department to help with form filling, and the CAB for help that might be needed in the future. Addictions counselling was also offered to this client to help with their alcohol use.

extracted from February 2022 – May 2023 monitoring report

Scan QR Code for video about Community Link Workers or click 'Watch video' button.

Challenges

Elemental software package

The identification of Elemental as most suitable social prescribing platform for the work was done after the contract was awarded. This resulted in a delay to the service becoming live while Elemental developments took place. Subsequently work with the Access Group who own Elemental proved challenging and incurred costs which were unexpected. This situation has improved over the last 6 months.

Vacant Posts/ Recruitment

At no time over the last year have all CLW posts been recruited to and as of May 2023, there were 1.8 WTE posts vacant. This has been the case for most of the service delivery over the first year but referrals from practices with no allocated CLW have been picked up by other staff so service delivery has not been impacted.

Accommodation within GP practices

All Primary Care Modernisation workstreams have had challenges with space at GP practices. Some GP practices have no available accommodation for CLW's. In some locations there is little or no affordable alternative accommodation.

UHI Evaluation engagement by patients and GP practices.

The process for CLW's to issue questionnaires to patients did not result in the level of return anticipated. There were a range of reasons why patients did not want to take and complete a questionnaire, and this was mainly related to their current state of emotion and stress. Work was undertaken to review how the process could be simplified and the length of the questionnaire reduced. This was completed in collaboration between Change Mental Health and UHI and the process has resulted in Change Mental Health agreeing to send all patients who have been discharged from the service a questionnaire and follow-up several weeks later. As this is a new process, there are limited returned questionnaires to date.

Wifi access at GP practices

CLW's allocated to several practices have been unable to access wifi which is required to use Elemental. Work with e-health has resulted in purchasing dongles which have been allocated to those who need them, but this has come at an additional cost.

Practices referring above and below allocation.

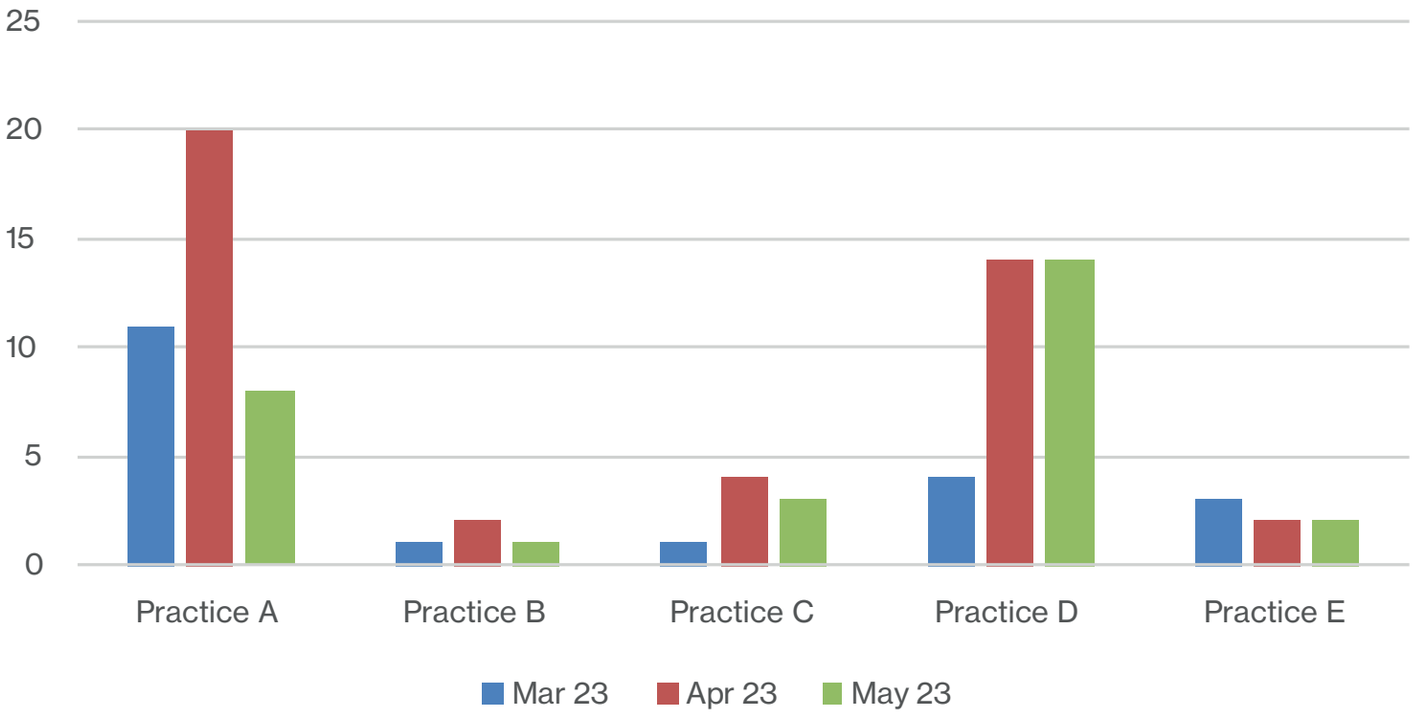
Work has been undertaken to identify referral rates at all practices. Overall 13 practices were below their original allocation and 15 practices above their original allocation. The 6 GP practice with the highest allocation of hours and accordingly therefore with the highest levels of deprivation, have all referred well below their allocation. For 10 practices with the lowest allocation, 8 have referred above their allocation.

Embedding CLW's into GP practices

There is evidence that where a CLW is more embedded with the work of the practice and included in practice meetings, there is a higher level of referrals.

- Practice A – CLW on site & attends practice meetings
- Practice B – CLW on site does not attend practice meetings.
- Practice C – CLW on site end of April
- Practice D – CLW not on site, practice meeting attended at the start of the year.
- Practice E – CLW on site but no regular GP so no practice meetings are held.

Figure 5: Practice referrals March to May 2023



Looking forward

Embedding service within GP practices

There has been substantial work by CMH to ensure staff are embedded within GP practices. In most instance this has been successful but work should continue to ensure that CLW's are valued as part of the wider multi-disciplinary teams who support GP practices.

Directory of Service (DOS) Development

A fixed term project has been agreed that will develop a Directory of Services and activities for social prescribing in North Highland including development of an online resource which will be updated on an ongoing basis by existing resource in NHS Highland. This Directory will be available to all GP practices in North Highland to support social prescribing not just those that have a Community Link Worker.

The posts for have been recruited to and the project will commence in June 2023 with the aim of the directory being available on the Highland Third Sector website early summer next year.

Data collection

Elemental has provided valuable information for data collection and monitoring, but aspect of the reporting does not give the level of detail which might help inform robust data collection. Onward referrals to support services recorded within the platform may appear more than once if exactly the same title is not included. This results in what looks like multiple referrals to different organisations, when in fact they are all the same organisations. It is hoped that the development of the DOS will help to mitigate this and provide a more accurate reflection of where patients are being referred to.

SWEMWBS has not been consistently used with every patient accessing the service and there is more work to do to understand why this is.

Social prescribing network.

Public health has led on organising two social prescribing events. The first was aimed at individuals and organisations who are already social prescribing or have an interest in social prescribing approaches and research. Over 60 delegates attended and rate the event 4.4 out of 5 stars. The second event was aimed at individuals who have an interest in realistic medicine and the development of social prescribing in Highland, in particular Practice Managers/ Nurses, Allied Health Professionals, GPs, and Secondary Care staff. The aim is now to bring those interested from both events together to start to develop a Highland Social Prescribing Network. The learning from the CLW will help inform this work.

Improve communication.

There is recognition that communication between all those involved with the CLW can always been improved and work will be undertaken to make sure a more robust communication strategy is developed.

Elemental process

Monthly meetings have been scheduled with Elemental to address any issues that arise. There is a recognition of the part e-health can play in supporting this work and moving forward they will be included in these meetings.


Highland
Community Link
Project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