KEY MESSAGES

SCOTTISH COMMUNITY LINK WORKER NETWORK

GIVING A VOICE TO SCOTLAND'S COMMUNITY LINK WORKERS

The Scottish Community Link Worker Network (SCLWN) hosted an online event on the 22nd of February 2024. Link workers from across Scotland attended. Roisin Hurst, Project Manager of the SCLWN presented an in depth look at the Essential Connections report published by Voluntary Health Scotland in November 2023. The event was chaired by Claire Stevens, Chief Executive of Voluntary Health Scotland. We have captured the key messages from that event and the concluding discussion.

Research Aims

- The Essential Connections research wasn't a mapping exercise of where CLWs are located across the country as information would be out of date quickly.
- This research focused on looking at the current landscape of CLW programmes in Scotland, how the programmes are designed, delivered and evaluated.
- What learning can we take from this research to support discussions on future service design and delivery?

Research Methods

- Our former colleague Findlay Smith, Network Policy and Research Officer, set out to review what we already knew.
- He conducted a desk-based analysis looking at existing documentary evidence on community link worker programmes in Scotland.
- His main sources of information were Scottish Government PCIP implementation monitoring, HSCP partnership data and annual reports from CLW programmes themselves as well as publicly available documents and academic publications.
- He conducted an online MS Forms survey which was sent to CLWs between January and March 2023 and which received 60 responses.
- He also conducted online interviews with 18 programme leads/managers between March – June 2023.

Programme Design

Responsibility for programme delivery:

- Direct delivery by NHS Boards or HSCPs; delivery by one or more 3rd sector organisation.
- Most CLWs are embedded within TSOs with the associated benefits of fostering links in the community.
- Some HSCPs commission one or several TSOs to deliver a programme; there may be a national TSO operating in several areas, e.g. We are With You
- Others may have multiple TSOs employing CLWs within local communities (e.g. Edinburgh).

CLW distribution:

- Different approaches: some adopt a universal approach, where every practice within that HSCP has access to a CLW.
- Others have based distribution on practice size and level of deprivation, prioritising CLW provision to those communities most in need.
- An estimated 20% of practices in Scotland don't have access to a CLW (based on SG PCIP tracker).
- Challenge of rural areas, particularly capturing hidden rural poverty

CLW allocation:
- Real variations in number of practices a CLW supports; the majority of survey respondents supported 1 to 2 practices; however, others were supporting up to 7.
- Fewer than 2.5 days in a practice affected a CLW's integration into a GP practice.
- A Programme Lead with CLWs each supporting 3 practices described them as being 'spread thin.'

Accessibility:
- In general there are a lack of formal restrictions placed on who could access programmes.
- The Programme is usually for people 16+, not children, although they might be supported indirectly via families/parents.
- Type/severity of issue a consideration, e.g. would not usually support someone with severe alcohol/drug issues or chronic mental health.

Referral pathways:
- Mainly via GPs, but also practice nurses, mental health practitioners, receptionists (sometimes called care navigators)
- Some programmes, although not all, allow self-referral.
- Those that don't said this was due to safeguarding concerns or concerns about overwhelming the service.
- A commonsense approach was used, e.g. someone already in the system and returning to the service, could often contact CLW directly.

Programme Delivery

Terminology:
- Considerable variation in the names and titles associated with CLWs across Scotland doesn't help understanding amongst wider public. We identified 10 different job titles from the 60 survey respondents!
- Variation when discussing terminology relating to CLW programmes themselves, particularly the use of term 'social prescribing'.
- Some more comfortable with this than others…one commented that there were 'pros and cons with describing it as being social prescribing'.
- Concern that the term brings it back to a medical model.

Support provided by CLWs:
- Role is flexible and diverse, but generally a person-centred approach to help with non-medical issues and support the patient to engage with services in their local community. This is demonstrated in different ways:
    - At one end it involves basic signposting, at the other end it involves much more intensive work.
    - Signposting and referring are key components of the support.
    - Quite complex patients – can help to identify their challenges, work with them to improve their health and wellbeing.

    - Personal empowerment and self-management, removing barriers to accessing services – some CLWs will accompany patients to services, other programmes now have a model with dedicated support workers to do this (e.g. Dundee)
- CLWs work collaboratively with others in the multidisciplinary team.

Issues:
- Main issues that a CLW deals with are mental health, social isolation and loneliness, housing, welfare and social security, trauma and financial issues. However, the work is multi-faceted.

Approaches to interventions:
- Complex and multi-faceted, no consensus on how best to structure or deliver a specific model, flexibility is important.
- 3 aspects – number of appointments, model to guide interactions and process for leaving service.
- Number of appointments: from 4 to unlimited. Want to avoid fostering dependence and manage expectations and define what constitutes an intervention.
- Intervention framework: some very structured e.g. MAP model, 'good conversations.'

Leaving the service:
- No formal discharge process, made on an individual basis via user-led discussion.
- Someone may remain within a CLW's caseload for a while. A lack of available services may mean patients are stuck in limbo.
- Lack of robust follow-up mechanisms to monitor patients' uptake of services after exiting. Some CLW programmes do follow-up calls.

Monitoring and Evaluation

- 16 different data collection and management systems identified.
- These ranged from dedicated SP systems, e.g. Elementa,l to bespoke data management systems developed for a single organisation.
- Some are operating without a data management system, relying on Excel and Google Suite.
- Elemental (dedicated social prescribing system) divided opinion. Its ability to integrate with primary care systems and being on GP's desktop (so every time they see a patient, there is a tab that says social prescribing) "that's a huge buy." However, it can restrict the data it allows programmes to collate.
- At practice level, majority reported access to EMIS and Vision, gaining access to practice data systems was challenging due to data protection etc.
- Extracting data from EMIS was difficult due to limited breadth of data produced.
- Scottish Government no longer asks for minimum core data set as was not consistently adopted beyond the early adopter sites.
- Relatively little guidance on how to monitor the implementation of programmes.
- 87% of survey respondents consistently monitored, age, gender and referral source, 85% reason for referral, date of first meeting and onward referral. 78% recorded repeated contact and follow up appts. with a patient.
- Suggestion of some consistency from respondents re data collected e.g. referrals, reason for referrals, demographics; however participants critical of a lack of consistent data across programmes.
- Evaluation – 35/60 survey respondents use an evaluation tool and across survey and interviews a total of 14 different evaluation tools used including SWMWBS (Short Warwick Edinburgh Mental Wellbeing Scale) which was most used due to ease of use and alignment with existing programmes.

- Some felt SWMWBS was too focused on mental health, not allowing other health determinants to be evaluated.
- CLW programmes made a reasonable attempt to evaluate, could be better if more coordination and standardisation at national level but would this be detrimental and impact diversity, flexibility and exploratory nature of work?

Outcomes and Potential Impact

Impact on health inequalities:
- Tackling health inequalities was identified as a primary strategic objective by participants from several programmes; mixed views on degree to which this could realistically be achieved. Tackling health inequalities/social determinants of health -overarching themes across the programme but doubts raised about how CLWs can be the solution to a systemic issue. 'I feel like we are patching up the wider political stuff.' 'There's a limited amount we can do.'
- However, they can address the impacts of health inequalities on individual patients – precise mechanisms to do this subject to debate. Many individuals may not meet criteria for accessing a CLW (e.g. those not attending/registered with GP practice).
- Data they collect is not aligned to measuring impact on health inequalities in any meaningful way, not given the tools to measure the contribution they are making. Little focus on collection of data on health inequalities. Only 13% of survey respondents regularly recording SIMD status of patients. For those collecting and using SIMD data it is not being implemented in a consistent way.

Impact on primary care:
- Difficult to capture impact of CLWs on GP workload.
- Recognised the nuanced roles that CLWs play within practices including reducing pressure in GP practices and supporting people's mental health.
- Almost all raised reduction of pressure on primary care as an overarching strategic objective, 'pulling away the non-clinical work that does evidently end up at primary care's door.'
- Some practices tried to collect attendance rates before and after introduction of CLW programme, some referencing a drop of 30%. Difficult to attribute this to the CLW service itself.
- Qualitative impact on GP's workload, allowing GP to focus on medical issues.

Impact on communities:
- CLW as a connector, also contribution they make to empowerment and strengthening of local communities.
- Identify where there are gaps in services, support development of services, sometimes doing it themselves e.g. health walk training.
- Can't always address systemic issues affecting services, e.g. lack of befriending
- Sometimes prevent services closing due to CLW referrals
- CLWs provide a vital feedback mechanism e.g. to HSCP, for the wider healthcare system on issues facing patients and the community. Some CLWs are linked to locality planning groups and can be used to target funding appropriately.

Impact on patients:
- Improved wellbeing and also changes of support in housing, social security, and navigating complicated systems. Enabling access to financial support.
- Ability of CLWs to introduce patients to previously unknown community resources.
- Increased connection to their community – patient's increased social capital
- Softer outcomes – benefit of having someone listen to their issues.

- Person-centred approach and the time allowed to spend with patient, i.e. someone listening to their issues and offering different solutions.
- Not a panacea 'for some patients, 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 issues and where patients are at the time'.

Future Service Design and Delivery

These 4 areas were identified by CLWs and managers as important to the future of link working in Scotland.

Community Link Working as a profession:
- Diversity in professional knowledge and experience seen as a strengths across the programme, however there are concerns about a lack of structure and support for community link working as a profession.
- A lot of people don't know what a CLW is – HSCS committee into alternative pathways in primary care highlighted lack of awareness of CLWs.
- CLWs aren't registered as professionals/professional accreditation.
- NHS England has a workforce development framework for social prescribing link workers.
- Wales has just launched its framework for social prescribing which has a competencies framework within it and structuring a skills development programme.

Primary care modernisation:
- Some feel CLW programme is low on list of priorities of HSCPs compared to other workstreams. CLW programme a small percentage of PCIF funding within HSCPs.
- Issue of short-term funding, particularly with many CLWs employed in third sector organisations.
- Revision of MOU in 2021 and apparent diminution of community link working within primary care improvement agenda has raised concerns.
- Long term commitment needs to be written into some of the key policy drivers.

Embedding CLWs into GP practices:
- Would like to see every GP practice have a CLW which was one of the recommendations from the Government's report into health inequalities.
- High number of referrals indicates the difference CLWs are making.
- However, some identify the need for a culture change in certain GP practices to fully embed CLWs.
- Operational issues prove more of a barrier i.e. a lack of space within a practice which is one of the main barriers for GP practices. This isn't restricted to CLW services according to the PHS feedback survey into experiences of MDTs in primary care.

Community Link Working at a national level:
- Has commitment to local discretion come at the expense of adequate support and cohesion across the programme?
- Tricky balance between local and national, would programmes be willing to alter their structures to align with abstract national frameworks?
- A form of shared or common agenda for link working at a national level could provide benefits and make it easier when talking to funders.
- Steps to improve the consistency and comparability of evidence across programmes to better demonstrate the collective impact of CLW programmes.
- Modest set of shared measurements indicators or evaluation would be well-received.
- Specific ring-fenced funding for CLW programmes. 'At the moment we are a Cinderella service.'

Next Steps

- The Network has played a key part in moving this agenda forward, based on feedback from members and support from Scottish Government's Primary Care Directorate.
- Other nations in UK and Ireland are ahead in terms of co-ordination e.g. Wales recently launched their Framework for Social Prescribing.
- National CLW Advisory Group being established in March to review CLW programme, will be action-focused and has to report by end of November.

Follow up discussion and Zoom Chat

The University of Manchester-led study into a multi-region evaluation-of-social-prescribing-link-workers in primary care involves a number of universities including Glasgow and Edinburgh and VHS is the third sector partner on the research reference group. The Network has also done some work with NHS Education Scotland to create a social prescribing learning platform on the TURAS website. There may be some learning from the Health and Social Care Staff National Workforce strategy in terms of looking at CLW progression and professionalisation.

This report by Richard Simpson on the RSE website looks at the power dynamics in relation to statutory bodies and the third sector partnerships. Richard also shared information on CERT (Clackmannanshire Economic Regeneration Trust) and Positive Moves a UK-funded programme to help people overcome barriers to employment.

CVS Inverclyde highlighted some of the work they have done to raise awareness across Inverclyde of what support is available via general practice. They have done focus groups, produced literature, made a video about their CLW programme information and use practice TV screens so patients realise the GP doesn't always have to be the first port of call.