Community Link Worker

Evaluation Report

October 2024

Contents

Introduction ... 3
Aims ... 3
Evaluation Approach and Tools ... 4
Data Collection ... 4
Results ... 5
- Referrals ... 5
- Patient Experience of Community Link Worker Service ... 7
- Patient Signposting ... 8
- GP Development Activities ... 9
- Community Based Activities ... 9
- Focus Groups ... 10
  - Community Link Worker – Working Group ... 10
  - Community Organisations ... 11
  - Summary of Discussions ... 11

Recommendations ... 13
Conclusions ... 14

Introduction

In 2016 the Scottish Government committed to recruiting up to 250 Community Link Workers (CLWs) to work in GP surgeries in Scotland's most deprived areas with the overall aim to support people to live well through strengthening connections between community resources and primary care, and for CLWs to become members of the wider general practice multidisciplinary team where appropriate. CLWs were also included as one of six priority areas in the 2018 General Medical Services (GMS) contract. In this they are described as *"A non-clinical 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. They often serve a socio-economically deprived community or assist patients who need support because of, for example, the complexity of their conditions"*.

There are 3 main areas of the Community Link Worker role including patient facing activities; General Practice development activities; and, community based activities.

In Shetland, Health Improvement Practitioners (HIPs) have been providing a therapeutic link worker role as part of a holistic approach, as outlined in a case study from 2018 (page 4). This role has evolved through the ongoing development of the Health Improvement service delivered by the Health Improvement team.

Following a pause in service delivery due to the Covid19 pandemic, the NHS Shetland Health Improvement team began a process of service development to strengthen the provision of health improvement activity within communities and to support patients to access and engage with wider support that is available through statutory and third sector organisations across Shetland. This service development included initiation of discussions with colleagues in primary care to scope how the CLW function could be enhanced.

In December 2021 it was agreed that a working group with representation from Health Improvement, Primary Care, Adult Social Work, Community Learning and Development and the third sector would be established to review activity and consider potential developments. This work sat within a Primary Care Transformation programme being led by the Director of Health and Social Care for Shetland.

Aims

The aim of this project was to contribute to the delivery of the 2018 GMS contract through the NHS Shetland Primary Care Improvement Plan and the underpinning NHS Shetland Clinical and Care Strategy by scoping the delivery of the CLW function which would mean working more closely within communities, placing more emphasis on preventative approaches and continuing to prioritise joined up working and reducing duplication.

Following early discussions is was agreed to pilot a CLW post in two health centres and for this to be delivered in parallel to the HIP therapeutic role. Funding was secured for one full time equivalent CLW post and it was agreed that the CLW Working Group would provide oversight for the project.

The CLW Working Group agreed on the following intended outcomes:

1. Connections between community resources and primary care are strengthened.
2. Pressure on General Practice is reduced.
3. Improved health & wellbeing outcomes for individuals.

4. Gaps in local provision which can address local need and tackle health inequalities are demonstrated with evidence.
5. There is clarity on how the CLW role compliments and aligns with the existing HIP role.
6. Opportunities for enhanced community-based support through future development of CLW activities are identified.

Evaluation Approach and Tools

Due to the development of a pilot project to create a CLW role working alongside the HIP role already established in the Health Improvement team, it was agreed that in order to evaluate the CLW project both process and impact measures would need to be considered.

A suite of monitoring and evaluation tools were established in the planning phases of the project. It is important to note that the tools developed built on risk mitigation identified as part of the risk assessment carried out in 2022, a national minimum core dataset for CLWs and mapping of indicators against each of the intended outcomes.

The following tools have been developed as part of project delivery and monitoring:

1. Referral form,
2. Conversation record,
3. Reflective log,
4. Appointment diary
5. Postcard feedback,
6. Emails to GPs to escalate (as required and in line with support and supervision protocol).

The monitoring tools were developed and tested by the CLW with input from HIPs.

In addition, further bespoke tools were developed as part of evaluation planning to gather feedback, demonstrate impact and capture learning:

A. Primary Care survey
B. Community organisations who have received 3+ referrals from CLW
C. Community organisations with <3 referrals
D. Patient feedback survey
E. Working group feedback session

The evaluation tools were tested by the CLW Working Group members to ensure completeness and appropriateness.

In order to collate and analyse this data, a CLW Dashboard was created. This aspect of the project has been led by a Senior Public Health Intelligence Adviser.

Data Collection

Following an options appraisal for which health centres the CLW post would be based within and a period of recruitment, the CLW post holder commenced in the new role in December 2022. Following a three month induction period, the post holder started to take referrals from

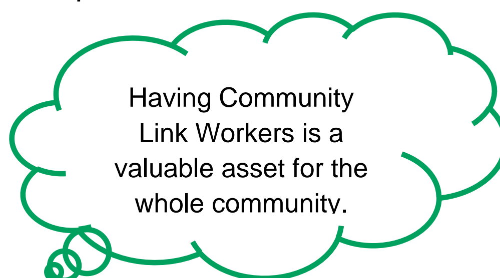
Whalsay Health Centre at the end of March and the Brae Health Centre at the beginning of April.

Since the launch of the CLW service the CLW Dashbaord has been under constant development and continues to be refined in order to ensure transparent and effective collation and analysis of data.

In order to ensure data collection that can demonstrate impact and learning from the process of establishing this project, funding for the project was extended to the end of March 2024 in order to have data from a full financial year. Substantive funding for 0.87WTE of the CLW role has subsequently be granted following the interim evaluation report in August 2023. In order to enable data to collated, there was a short break in patient referrals in March with referrals resuming in April 2024. Further funding was secured from Health Improvement core budget with voluntary changes to hours, bringing the substantive funding for the CLW role to 0.9WTE (30 hours).

Results

Below is a summary of results based on the three core components of the CLW role. The data presented in this evaluation report was collected from March 2023-Febraury 2024.



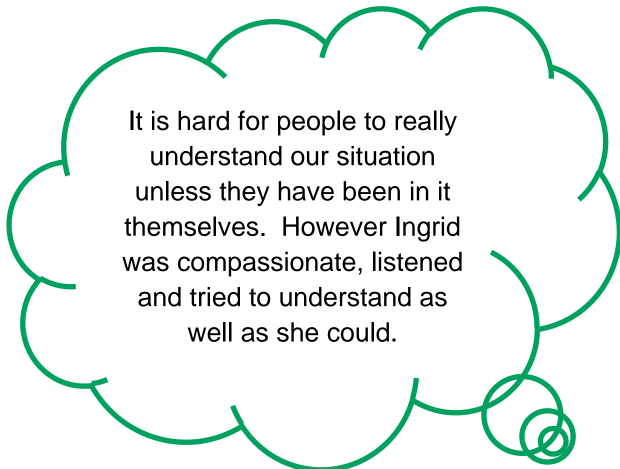
Referrals

As at February 2024, data from the CLW project is presented on the CLW Dashboard.

Figure 1: CLW Dashboard, February 2024

This dashboard reflects the number of referrals for each health centre, who is making the referrals, the primary reason for referrals and the SIMD data for patients.

It is important to note that due to the geography, cost of living, cultural roots and island/remote communities our understanding of inequalities in Shetland should not be limited to the use of SIMD measures.



Referrals consistently came from both Brae and Whalsay health centres, with referrals peaking in the summer months and dropping during winter months, however there was a steady increase from January through to the end of data collection in February.

GPs are creating the majority of referrals, although it is important to note that GPs from both health centres are on the CLW Working Group and therefore very familiar with the project. Wider professionals working within the health centres are likely to have taken longer to establish an understanding of what the service can offer, however nurses were the second most likely to make a referral to the CLW. Interestingly, the third most likely referral type was self-referral from the patient themselves, suggesting that information about the CLW was spreading via word-of-mouth.

Emotional wellbeing, lifestyle advice and financial concerns are significant reasons for referrals with these three categories accounting for just over half of all referrals. Figure 2 illustrates in more detail the issues identified following referral to the CLW.

For most patients, they were signposted for multiple issues and the support required for the individual themselves rather than a family member.

Figure 2: Issues identified following referral to the Community Link Worker

Patient Experience of Community Link Worker Service

When asked about their experience of engaging with the CLW, patients overall had a good or excellent experience across all measures (Figure 3).

Figure 3: Patient experience of engaging with the Community Link Worker

When asked about what they felt they gained from their referral to the CLW, the feedback was overall very positive, with key themes such as help, support and service coming across strongly in Figure 4.

Figure 4: What patients feel they gained from the support provided by the Community Link Worker

Patient Signposting

The CLW referred patients on to services and organisations from across the Third Sector, Local Authority and the NHS with referrals to Third Sector and Other organisations accounting for over double the number of referrals to Local Authority and NHS Services (Figure 5).

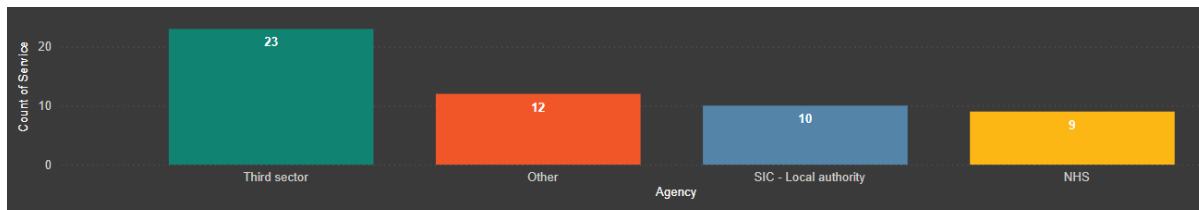


Figure 5: Services where patients were referred

Patient Case Studies

To demonstrate the impact of the CLW role and to provide examples of where the CLW is supporting patients, two case studies have been created and are detailed below.

Case Study 1

An elderly couple were referred by the GP. Patient A had Parkinson's for many years and she mobilises using a zimmer frame. Patient be is in his 80's and mobilises with a walking stick. They have recently had to give up the car. They have both have regular falls.

After a conversation with them it became apparent that grab rails were needed in the bathroom. Photos were taken and the CLW contacted the one stop shop attaching photos of where to install grabs. The carpet at the entrance to the bathroom was frayed and was a trip Hazard. CLW took strong tape and taped it down.

CLW contacted Occupational Therapy and ordered a zimmer frame bag so it was easier for Patient A to transport items around the house. CLW had the bag posted to the house and went along the following week to fit it on the zimmer frame.

The household was frequently bothered with scam calls which was proving to be worrying. CLW contacted trading standards and got a true call fitted on their phone to reduce scam calls.

CLW registered Patient B with the Library as he is very interested in Shetland History – he now gets books that interest him delivered every few weeks. He also attends the men's group weekly.

Patient B thought he would like to improve his balance and is now on the waiting list for OTAGO classes.

CLW had a discussion with the District Nurse (DN) re Patient A using the kettle as it was felt it was very unsafe due to her involuntary movements due to her Parkinson's. DN passed this onto the family with a recommendation of purchasing a tipping kettle to reduce risk of accidents.

Case Study 2

I got a referral from the GP for a family who had moved from England to Shetland. Neither parent had ever lived in Scotland previously so they were very unsure about where to go for support or what could be available for them. They had more than 4 children and the house they had bought was damp throughout.

On my first visit it became clear that they were struggling financially as neither parent had managed to secure a full time job, the financial strain was negative effect on their mental health.

I put through to CAB for a benefits review, and passed on the contact details for home energy Scotland.

The children were unable to take part in sport as they didn't have the right clothing. I got sizes and contacted Lesley Spence from kit for all to see if she could look our sports clothing and shoes. I delivered this as well as a food parcel from the food bank.

I passed on details of where to best look for employment opportunities. One parent is now in full time employment and the other has secured part time work.

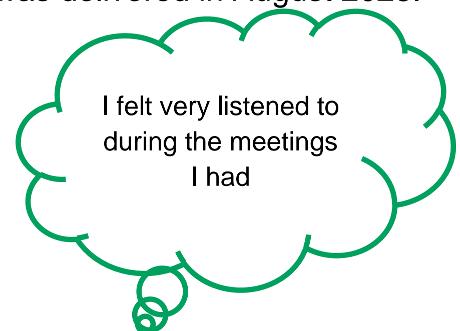
The family is now in receipt of the Scottish child payment which has made a significant difference to them. Home Energy Scotland is reviewing their heating system which will be a lot cheaper to run and will hopefully get rid of the damp.

Their mental health has now improved significantly and they are all now settling in and enjoying life in Shetland.

GP Development Activities

As a result of the project, colleagues within primary care were involved in the planning and delivery of health behaviour change training. Training was delivered in partnership with NES with online training taking place in July 2023 and face to face was delivered in August 2023.

Anecdotal evidence suggests that colleagues working in primary care are more aware of the scope of community based activities which may be of benefit to patients. Whilst they do not have the knowledge of the detail of these services, they have confidence that the CLW can make connections as required.



Community Based Activities

Partnership working with colleagues delivering the Living Well Hubs in Shetland and the Community Development team has been core to ensuring services are connected. Patients accessing any of these services are supported to engage with community based support as appropriate and partnership working ensures duplication is minimal. In order to capture this partnership working, two of the three focus groups conducted involved representatives from community based organisations to ensure their feedback was captured.

Community Link Worker Reflection

The CLW started in her role in December 2023 and spent the first 4 months training and building her local knowledge of the Communities she was going to be working in. In April she saw her first patients in both Brae and Whalsay:

I see myself as a non-clinical practitioner based in the GP practices who supports people with non-medical needs. I am very pleased with how the pilot project has gone and have eally enjoyed hearing peoples stories and being able to offer help and support.

One of the more surprising aspects of the community link workers job has been that some services didn't know about other services!

For example Alzheimers Scotland was looking for someone to come to demonstrate and practice manual handling to their carers group. They didn't know about the manual handling trainer for the NHS. I was able contact him and he went along to one of their sessions.

I was able to pass on information about Cancer card to Clan as they were unaware of this new online information portal.

It has been brilliant to link in with the Living Well Hub. We have done a lot of joint working with patients and we hope to continue to do so.

Ideally moving forward it would be great to have access to the CLW in all health centres.

Focus Groups

Three focus groups were conducted to gather further feedback and capture learning from those involved in the pilot, such as the CLW Working Group and representatives and community organisations and services. Due to the same structure and questions being used and consistent themes from across all focus groups, this section will summarise and present the feedback from all three discussions collectively.

The focus groups were semi-structured with open questions focused on key areas including: what has gone well and why, what could have been done better, what would they like to see the CLW role look like in Shetland in the future.

Community Link Worker – Working Group

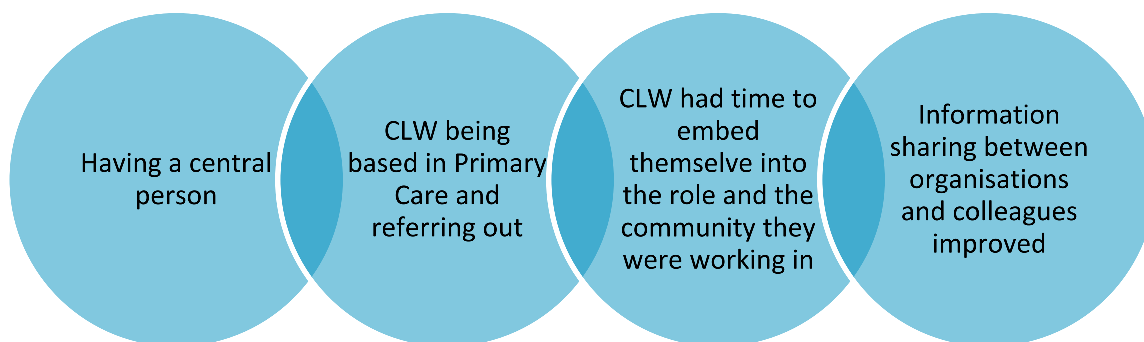
This focus group was attended by most members of the CLW Working Group that has overseen the development and delivery of the pilot of the CLW role in Shetland, this included: two GPs (one from Whalsay and one from Brae), a GP Nurse, Health Improvement Team Lead, Community Learning & Development, Living Well Hub (Brae).

Community Organisations

Two focus groups took place were where representatives from community organisations and services that the CLW may have been referring patients to, or in some cases receiving referrals from, attended. In total 15 people participated across the two focus group and included representatives from the following: Community Learning and Development, Clan Cancer, Dietetics, Public Health, Physiotherapy, Anchor for Families, Ability Shetland, RSPB and the Community Wellbeing Hubs.

Summary of Discussions

What went well?



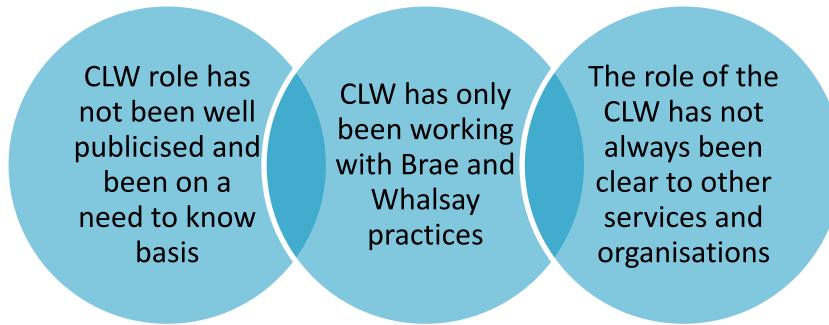
With regards to what went well, there was a consensus amongst members that the CLW has been a very valuable and complimentary addition to GP services. Having a central, accessible, person placed within the NHS has been really successful and improved connections between the community resources available and the GP service. It was felt that this was a clear gap in the services provided prior to the CLW role being developed. Having a central person to refer to has reduced the likelihood of a patient who requires help and support being passed from service to service and getting lost in the system as the CLW was able to navigate the system with them from within the NHS.

It was felt that one of the main reasons for the pilot being so successful was that the CLW was given a few months to embed themselves and learn about the communities they were working in and what services were available and to build relationships with the various organisations and staff they may be referring patients to. It meant that they were the expert in their locality and built trust among the GP staff that they could confidently refer patients to the CLW.

Those from external organisations told how links between, and referrals to, services have taken place that would not have happened had the CLW role not been there and that the CLW being based within the NHS was a significant enabler.

The CLW also enabled better information sharing between services and sectors, something that has been really difficult to do in the past and community organisations in particular felt that this led to a reduction in the amount of duplication of work. GP staff felt that having someone they could confidently refer a patient to, to offer some social support, relieved some pressure on them and provided capacity within their role to support those who needed to see a GP.

What could have been done better?

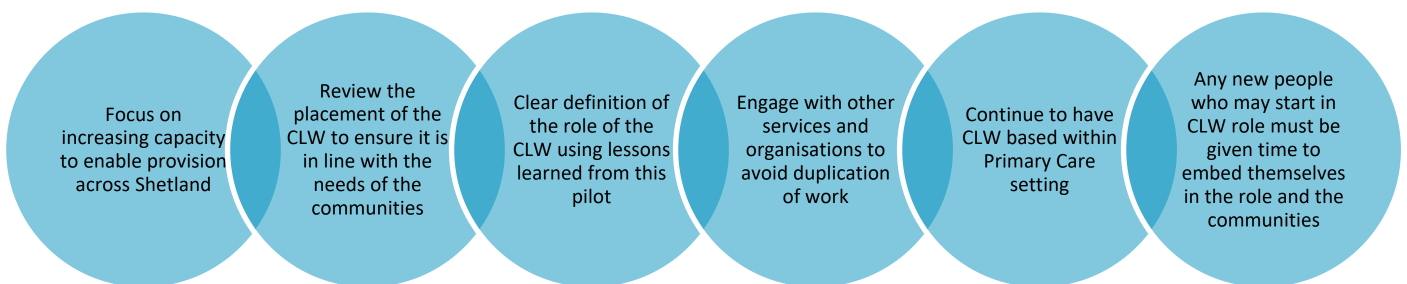


Although the majority of feedback from professionals and patients alike has been mostly positive, there are some areas of improvement that have been identified. The CLW role was not well publicised with organisations and services often only becoming aware of the service when the CLW contacted them for information or to refer someone to them making. It was felt that this meant that the service was only available on a “need to know basis”. This could have unintentionally meant some people who would have benefited from a referral to the CLW did not. It was recognised by the CLW Working Group that this “soft launch” of the CLW was very intentional to avoid overwhelming the service before it could be embedded and the plan would be to advertise the service more widely in future.

Similarly, there was some concern that the CLW was only available to those living in Whalsay and Brae and that this was unfair on people living elsewhere in Shetland and although it was acknowledged that there was only one CLW for this pilot, the inequity should be addressed as soon as it can be.

Due to the lack of publicity and communications around the role, there was some confusion around the role of the CLW and it was felt, particularly by third sector organisations, that this could be clarified and developed further following the pilot.

What does the future look like?



The strongest theme that came across when asked what should happen with the CLW in the future was that it should continue and efforts should be made to provide access to a CLW across Shetland as quickly as possible. While acknowledging that this will take time and require additional funding, it was consistently suggested that the current CLW provision could be reduce in Brae and Whalsay to enable some CLW time to be provided to another locality in Shetland – possibly one outside of Lerwick that does not have a Community Wellbeing Hub currently. It was felt that even just 1 day per week of the CLW would have a significant impact on a community.

It was suggested a number of times that a mapping exercise take place to understand what services are currently available in localities as a way of planning how the CLW service could grow over the next 3-5years.

There was a strong feeling that the CLW should continue to be based within Primary Care receiving referrals directly from GPs and other staff working within General Practice. There was a strong feeling that the positioning of the CLW within Primary Care has been a huge influence in the success of this pilot. As the service grows, it is very important to have champions within the health centres to ensure engagement and communication between GP staff and the CLW is good.

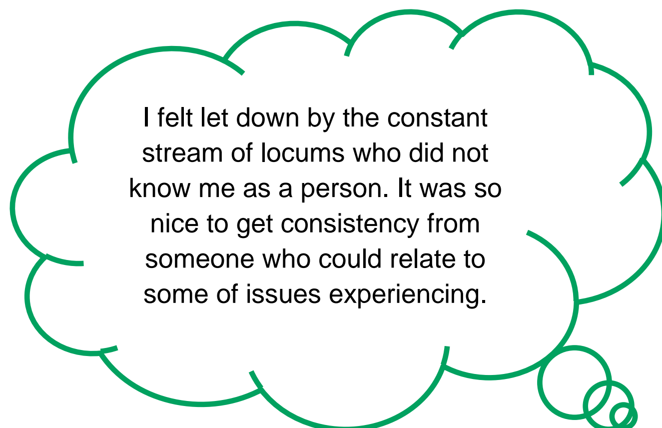
As discussed previously, organisations would like to see the CLW role and remit clarified and advertised much more widely that it has been thus far. Additionally, organisations outside of General Practice would like to be able to refer people to the CLW too.

Recommendations

There are several recommendations from

1. Continued active promotion of the CLW service to ensure uptake and effective use of resources;
2. Promotion of the self-referral route into the CLW service to maximise engagement with patients who are seeking advice and support in relation to non-clinical needs (i.e. not just when their GP considers it a good idea);
3. Continued development of CLW Dashboard to represent as much data on impact and learning as possible;
4. Extended funding to enable demonstration of impact and learning;
5. Develop an options appraisal for further roll out of the CLW service in NHS Shetland;
6. Continued engagement with partners to cascade learning and identifying future opportunities for partnership working within local communities.
7. Develop process of sharing learning with Primary Care workforce and embedding good practice from CLW engagement beyond link worker

Conclusions



The introduction of the CLW role through this pilot has had a positive impact on patients, colleagues in primary care and the delivery of wider health improvement services. It is important to build on this success and aim towards providing this service to communities across Shetland.

There are clear actions that we can take forward with the CLW Working group from the recommendations above. Particularly in ensuring the CLW role is expanded to other health centres. With limited funding availability it is important that health inequalities are not increased by the work undertaken and that any changes to the delivery of the CLW will use local best evidence. There have been key good practice detailed in this evaluation which will be maintained for any staffing expansion undertaken in the future.

It is important that the CLW also remains to have capacity to attend and engage with National teams on Community Link Working and is able to take innovations and good practice to and from the national platform.

There will be continued quality improvement methodology utilised in the ongoing development of the CLW. This will include the data that is being held in the dashboard to how and where the service is delivered. An annual reporting structure will be agreed by the CLW Working group to ensure service updates are recorded and shared.