

Evaluation of the Links Worker Programme in 'Deep End' general practices in Glasgow

Interim report
May 2016

We are happy to consider requests for other languages or formats. Please contact 0131 314 5300 or email nhs.healthscotland-alternativeformats@nhs.net

Published by NHS Health Scotland

1 South Gyle Crescent
Edinburgh EH12 9EB

© NHS Health Scotland 2016

All rights reserved. Material contained in this publication may not be reproduced in whole or part without prior permission of NHS Health Scotland (or other copyright owners). While every effort is made to ensure that the information given here is accurate, no legal responsibility is accepted for any errors, omissions or misleading statements.

NHS Health Scotland is a WHO Collaborating Centre for Health Promotion and Public Health Development.

Contents

The Links Worker Programme	2
Evaluation of the Programme.....	2
Phase 1: Understanding the Programme theory of change.....	3
Understanding the programme context – practice and community characteristics.....	3
Early theory of change	4
Expanded theory of change	4
Programme resources available to intervention practices.....	7
Theories of change for practice plans and activities	7
Extent to which the Programme will reduce inequalities in health.....	9
Reviewing the expanded theories of change	9
Phase 2	10
Process evaluation	10
Outcome evaluation	11
References	13

This paper describes the evaluation of The Glasgow 'Deep End' Links Worker Programme and provides an interim report of progress.

The Links Worker Programme

The Links Worker Programme (the Programme) is a Scottish Government funded programme which aims 'to support people to live well through strengthening connections between community resources and primary care in deprived areas in Scotland'. The Programme is being delivered as a partnership between the Health and Social Care Alliance Scotland (The Alliance) and Glasgow General Practitioners (GPs) at the Deep End. Delivery partners also include the Scottish Association for Mental Health (SAMH) and the Royal College of General Practitioners Scotland (RCGP).

GPs at the Deep End is a collaboration of general practices serving the 100 most deprived practice populations in Scotland, and 86 of these 100 practices are in NHS Greater Glasgow and Clyde. Further information is available at www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend/

The Links Worker Programme operates within the context of the wide health inequalities that exist between the most and least deprived areas in Scotland. In an attempt to help tackle some of the social determinants of health, such as poor access to services and low use of community-based non-clinical support, Deep End GPs proposed the use of a social prescribing model. The term social prescribing refers to general practices working with local community organisations and other providers and recommending ('prescribing') their services to patients with complex health and social care problems.^{1, 2, 3}

In the Links Worker Programme, social prescribing is being organised through a dedicated member of staff in each practice called the Community Links Practitioner (CLP). These individuals have been tasked with building links between local community organisations, general practices and patients identified by practice staff as having complex social and health needs.

The Links Worker Programme is currently being implemented in seven Deep End practices (intervention practices). There are eight comparison practices that are also based in areas of deprivation but do not have a CLP or associated support in place.

Evaluation of the Programme

NHS Health Scotland has commissioned the University of Glasgow, Institute of Health and Wellbeing to carry out an evaluation of the Programme. It is expected that the evaluation will contribute to the evidence base on the effectiveness of Link Workers models in primary care. The evaluation will be completed in April 2017.

The aims of the evaluation of the Programme are:

1. to define the Programme's theory of change, including the core activities and implied mechanisms of change, and to determine similarities and differences

between intervention and comparison practices in terms of contexts, activities and patient level outcomes

2. to describe and assess the process of implementing the Programme
3. to assess the effectiveness of the Programme in intervention practices in achieving the intended outcomes at patient, practice and community levels compared with non-intervention comparison practices
4. to draw conclusions about the extent to which the Programme has worked as intended, and to identify lessons about the sustainability and transferability of the Programme.

The evaluation began in September 2014 and includes two phases.

Phase 1:

- describes GP practice and community characteristics in which the Programme is operating
- explains the Programme 'theories of change' (a comprehensive description and illustration of how and why a desired change is expected to happen in a particular context)

Phase 2:

- is an outcome and process evaluation of the Programme using mixed qualitative and quantitative methods to assess the impact of the Programme on a range of short, medium and longer term outcomes at patient and practice levels.

Phase 1: Understanding the Programme theory of change

A theory of change explains how and why an intervention works and shows the plausible links between aspects of an intervention, such as its activities and outcomes. Theories of change also take into account the context in which initiatives work. To do that at the simplest level of the context of the Programme is described in terms of practice and community characteristics.

Understanding the programme context – practice and community characteristics

Data about practice size and demographics were accessed from the Information Services Division (ISD). And data on the availability of local community support services in areas served by intervention and comparison areas were accessed through two sources: firstly the Glasgow Council for the Voluntary Sector's (GCVS) list of community and voluntary organisations within each postcode district area of the intervention and comparison practices, and secondly the ALISS (A Local Information System for Scotland) website that provided a list of organisations within a one mile radius from the postcode district (e.g. G51) of each GP practice.

The analysis found very few differences between intervention and comparison practices and they operate in comparable, deprived, environments. Their patients have similar age distributions and although intervention practice populations include slightly more patients living in areas with the highest levels of deprivation they also have more GPs per 1000 patients than comparison practices. Availability of

community support organisations is also similar in terms of the mean number of services provided by the third sector available in a local area.

Early theory of change

The Programme team had already developed an early theory of change for the Programme. The Programme takes the form of a 'Links Approach' whose key features include a general practice team development component as well as a links worker with a community focused role.

The Programme is expected to generate seven primary care team capacities (improvement in team wellbeing; shared learning, probably within and between practices; increased awareness of opportunities, and of patients' needs; improved 'intelligence' or understanding of local opportunities; signposting of patients to local resources; problem solving by the practice team; and network building by the practice team).

The Programme expected that the ways through which practices should generate the seven capacities should be determined locally to suit practice characteristics and ways of working. These capacities are expected to lead collectively to the patients being better off in relation to:

1. adapting to a diagnosis (information, understanding, practical support)
2. living well day to day (financial needs, social life, healthier lifestyle)
3. facing challenges (preparing for crises, managing crises, extending options)
4. navigating systems (effective communication, support during transitions)
5. dying well (planning for death, end-of-life support, bereavement information and support).

Achieving these results with patients is then seen as leading to improvements in the ultimate patient-level outcomes of the Programme: health competence, dignity and autonomy, and relatedness. The results (1 to 5) are seen as a valuable end in themselves and specific outcomes of improved patient health are not explicitly stated.

Expanded theory of change

The early theory of change was used as the starting point for the evaluation and was further developed through research work undertaken as the programme was becoming embedded in practices. In order to do this, and to capture potential variation between intervention practices and between intervention and comparison practices, focus group discussions were conducted with Programme and practice staff in the seven intervention and the eight comparison practices, and four interviews were conducted with members of the Programme's Executive and Management Group between November 2014 and January 2015. Data was also extracted from Programme documents.

These data were used to develop an overarching 'programme theory' describing Programme implementation and how activities would achieve outcomes at the level of the patient, the practice and the community. Table 1 below outlines the expanded theory of change.

Table 1. Theories of change at for activities at patient, practice, and community levels of intervention synthesised across practices

Level of intervention	Resources	Activities*	Short-term outcomes	Medium-term outcomes	Long-term outcomes
Patient	Practice Development Fund (much of it spent on more time and staff) Community Links Practitioner	1) non-clinicians 2) clinicians 3) community links practitioners engagement and working one to one with patients 4) patient participation in practice organised and related activities	More able to acquire, access, and use available skills, information and support when needed; navigate health and other systems	Self-management of health conditions, and navigating and averting crisis and adapting to challenges Improved relationships with professionals and a sense of being seen and valued as a 'whole person'	More people supported to live well
Practice	Management support	1) improving primary care team wellbeing 2) shared learning and awareness 3) intelligence 4) signposting 5) problem solving	Improved team wellbeing Adequate protected time and resources for shared learning; provision of appropriate, timely information; and improved understanding of social/personal context of illness	Improved skills in identifying and supporting those experiencing barriers to accessing resources, and enabling more effective patient self-management Sufficient time to listen and advise people, and service delivery that actively reflects the lived experience of patients and practitioners	Addressing health inequality

Level of intervention	Resources	Activities*	Short-term outcomes	Medium-term outcomes	Long-term outcomes
Community	<p>Practice Development Fund (much of it spent on more time and staff)</p> <p>Community Links Practitioner</p> <p>Management support</p>	<p>Cultivating relationships with local community organisations through:</p> <ol style="list-style-type: none"> 1) primary care teams 2) community links practitioners 3) meetings and discussions to develop referral pathways and multi-agency resolution of problems 4) training and shared learning to consolidate new and existing community linkages 5) Patient and community involvement with practice activities 6) community capacity development for local organisations 	<p>Stronger practice-community relationship</p> <p>Established cross-sectoral referral pathways</p> <p>Joint resolution of shared problems</p> <p>Improved practice knowledge and intelligence about local community organisations and services provided</p> <p>Improved capacity of local community organisations to support people</p>	<p>Impact on primary care team, NHS services, local authority services, and community resources to support people to live well</p> <p>Creation and sustaining of a more community-oriented practice identity</p> <p>Establishment of practice in the community as 'citizens' that 'give back' to the community; practice as community hub</p>	<p>More people supported to live well</p> <p>Addressing health inequality</p>

Programme resources available to intervention practices

The table summarises the new resources made available to deliver the Programme:

- a practice development fund
- a practice-attached Community Links Practitioner (CLP) who is employed by The Alliance
- management support from Programme staff based in The Alliance
- resource to enable one GP and one Practice Manager to attend a shared-learning event organised by Programme staff, three times per year.

Like many other interventions to change systems in primary care, the financial resources provided by the practice development fund are used by practices to provide existing staff the time to do different things and increased staffing so that clinical and non-clinical practice staff can be freed up from the everyday work to initiate and embed new ways of working. The CLPs are employed by The Alliance but their work is embedded in the practices while The Alliance provides management support for all CLP and staff in practices and convenes the shared learning events three times a year. Practices are given sufficient further resources to allow at least one GP and one Practice Manager to attend these.

Theories of change for practice plans and activities

The Programme is a general practice level intervention that is expected to operate on outcomes at patient, practice and community levels; outcomes at practice and community levels are expected to operate also on patient outcomes.

Right from the beginning, the Programme was designed to allow practices' flexibility in what they did to suit local circumstances. Table 1 above provides a summary of the range of activities that were undertaken, and illustrates the theories of change linking the activities of intervention practices at the level of patients, practices and community links.

Activities at patient level

Intervention practices are undertaking four main kinds of activities to support patients individually:

- all practice staff are working to signpost, to recommend, to refer and to support individual patients to make use of community services
- non-clinical practice staff are talking to patients about local resources and their usefulness
- clinical staff are working one to one with patients
- CLPs are working one to one with patients
- patients are participating in practice organised and related activities.

All of the activities are expected, in the medium term, to lead to patients being more able or likely to access information and resources in their local communities. This in turn is expected to lead to more patients being able to manage their health conditions and being supported to 'live well' in the longer term.

Comparison practices were well aware of the usefulness of 'signposting' and many had heard of useful resources for finding support such as ALISS. However, the lack of dedicated support in the form of funds or CLP meant that none discussed any kind of one-to-one support for patients or signposting of services to patients.

Activities at practice level

Intervention practices are undertaking five kinds of activities to develop their practices in the Links Worker Programme. They are trying different approaches to:

- promoting primary care team wellbeing (e.g. walking groups or relaxation classes)
- enhancing shared learning between staff and increasing awareness of community resources among practice staff
- improving 'intelligence' in the practice about what resources are available in local communities
- increasing the amount of 'signposting' they do
- improving the extent to which they can problem solve for themselves and for patients.

All of the activities described are expected to result in the short term in improvements in team wellbeing and protected time. In the medium term they are expected to result in staff having sufficient time to listen to patients' needs and to support them in addressing some of their non-medical problems. Also to be able to offer support for all problems that reflect the lived experience of patients, and in practice teams that are better able to support or enable patient self-management. These activities, in turn, are expected to lead to more patients supported to live well.

Comparison practices: Although most recognised the usefulness of practice development activities, none of the comparison practices, without additional resource, had been able to undertake any.

Activities at community level

Intervention practices: Original Programme documentation makes it clear that community activity is core to the Programme.

From the very beginning, building community links in order to improve community support for patients has been at the heart of the Programme.

All practices saw the cultivation of relationships with local community organisations as one of the most important activities they undertake. They do this by using the practice development fund to free up time for meetings, visits and secondments between practice and community organisation staff. In addition, CLPs themselves expect to take a proactive role in finding and making ties with local organisations and make themselves available as a liaison between community organisations and the general practice.

There are six types of activities undertaken by practices:

- cultivating relationships with local community organisations by **primary care team members** and by **CLPs** to make community links
- meetings to develop referral pathways and multi-agency resolution of problems with community organisations

- training and shared learning to consolidate new and existing links – patient and community involvement with practice activities
- and community capacity development for local organisations by general practices.

The cultivation of relationships in this way is expected to lead to increased trust between practice and community organisations, which in turn is expected to be apparent to patients. The relationships and trust that are developed are expected to lead to more practice staff feeling confident on where and how to refer to community organisation which, in turn, is expected to lead to more patients being supported to live well.

Comparison practices: Although many recognised the importance and value of community links and trusting relationships with community based service providers, none of the comparison practices had been able, without dedicated resource, to make links with community organisations in any systematic or organised way.

Extent to which the Programme will reduce inequalities in health

In the Links Worker Programme, the explicit aim was ‘to address health inequalities in some of the most deprived areas of Scotland by providing improved access to support for people living in complex social circumstances’.⁴ While a programme delivered at the individual level could not be expected to reduce health inequalities it does have the potential to make an important contribution by taking action to reduce the effect of health inequalities on individuals.⁵

‘Action is required to tackle the unfair differences in people’s experiences of environmental factors such as work, education and health. These differences are largely beyond an individual’s control but can limit their chances of living longer, healthier lives. Action should, therefore, be taken to ensure equal access to public services, targeting high risk individuals with intensive, tailored individual support with a focus on young children and the early years’.⁵

There were differences in the extent to which respondents (see page 3) expected the Programme to result in fewer health inequalities. With this in mind, the evaluation team recommended a re-articulation of the Programme’s aims to reflect this and it was accepted by programme management. The aim of the Programme is now ‘to mitigate [reduce] the impact of the social determinants of health in people that live in areas of high socioeconomic deprivation’.⁶

Later stages of the evaluation will consider more closely the extent to which the Programme can reduce the effects of health inequalities, and the views of those involved about how this might be achieved.

Reviewing the expanded theories of change

A Programme theory of change should be plausible (is the Programme theory achievable within the organisational and political context?), do-able (should be resourced in a way that its planned implementation is realistic and matches the aspirations of the programme), and testable (open to evaluation).

There is some evidence, both experiential and formal, that the theories of change that emerged from Practice and Programme staff are internally plausible, that is, they make sense if there are no other challenges. But moving from building relationships between practice and community organisation staff to making those relationships work for patients will be essential if outcomes are to be achieved. This will be more difficult in the context of austerity, changes to benefits and cuts to funding for community organisations. These present challenges for service users, for general practices attempting to meet resultant increased demand, and for third sector organisations seeking sustainable funding, threaten the external plausibility of the theory of change.

The variation in practice activities and in ability to make change happen quickly, as well as between the CLPs themselves, presents some challenge to the do-ability of the theories of change in some practices. It is clear, however, that activities are being undertaken at all levels, even in the early months of the Programme.

The testability of the Programme will be enhanced by the evaluation measuring patient level outcomes in relation to wellbeing and quality of life, which could be used to establish the likelihood that the Programme will result in 'more people supported to live well'. Related research into community organisational perspectives explores the ability of the Programme to forge long-term links between general practices and community organisations.⁷

Phase 2

Process evaluation

Phase 2 will enable us to describe the process of implementing the Programme, and to assess the effectiveness of the Programme in intervention practices in achieving the intended outcomes at patient, practice and community levels compared with non-intervention comparison practices. This will be done by completing:

- an email survey of open-ended questions to a practice level panel of stakeholders in intervention and comparison practices
- in-depth interviews with lead GPs and CLPs in intervention practices
- analysis of relevant documents (mainly Practice Development Fund application forms and Practice's six-monthly reports).

It is important to note that only interim analysis of this data has been completed. Conclusions may change as more data are collected and analysed in later stages of the evaluation.

On the whole, respondents from practices and the Programme were optimistic about the results the Programme will achieve, despite external constraints and some difficulties in making things happen in some practices because of staff shortages.

Activities to promote team wellbeing were reported most satisfying with palpable benefits to team morale and cohesion. Making links with community organisations was also highly satisfying. Because of the continued difficulty to integrate IT systems, activities to grow 'intelligence' were reported as least satisfying.

The greatest barriers encountered were those associated with gaps in provision of local resources for some patients groups (such as older people), insecurity of funding for third sector organisations and resultant high staff turnover, and high demand for some services in the face of increasing problems caused by austerity and changes in welfare support.

The responses from comparison practices provide insight into practices keen to operate in a community-focused way by undertaking some activities to support their patients and investing in team wellbeing. However, without the investment from the Programme there is no concerted, coordinated, approach to make and use community links across the board.

Outcome evaluation

Quantitative methods have been used to assess the effectiveness of the Programme in intervention practices in achieving the intended outcomes at patient, practice and community levels compared with non-intervention comparison practices.

The five data sources being used for the quantitative outcome evaluation are:

- pre-existing case histories of patients referred to a CLP during the first four months of the Programme
- an audit of short-term outcomes for patients referred to a CLP during the 11-month period prior to the start the evaluation
- postal, self-completed questionnaires to capture long-term outcomes from patients referred to the CLP and study team in intervention practices followed up nine months later
- postal, self-completed questionnaires to capture long-term outcomes from patients in comparison to practices at baseline and nine months later
- self-completed questionnaires from staff in both intervention and comparison practices at the start of the evaluation (March 2015) and nine months later.

It is important to note that data for the evaluation period is currently being validated and consequently the progress reported here may be amended in the next phase of the study. The quantitative analysis of case histories of patients referred to CLPs during the first four months found that almost three quarters of referrals were made by GPs. Recorded reasons for referral were a complex mix of social, mental and physical health problems. More than one-third of referred patients did not engage with a CLP. Reasons for non-engagement were varied, although in almost half the cases no reason was recorded. The average age of patients referred was 49 years and 60% were female. The CLPs had an average of four contacts per patient, lasting 45–60 minutes per face-to face contact. They found 88 different community organisations that might help patients with problems that they had identified.

The stage of reporting from phase 2 of the evaluation will include findings from:

- views from staff questionnaires
- patient outcomes data collected with patient questionnaires (baseline and nine-month follow-up)

The recruitment targets for patients have been achieved. Baseline questionnaire data have been obtained from 300 patients from intervention practices and 612 patients from the comparator practices. The nine-month follow-up questionnaire data collection is ongoing (due for completion by October 2016) and early response rates have been 77% from patients in the intervention practices and 90% from patients in the comparator practices.

Baseline staff outcome data were obtained from 123 Practice staff (62 from the intervention practices and 61 from the Comparator Practices). The nine-month follow-up questionnaire data collection commenced in May 2016.

For more information about the evaluation please contact NHS Health Scotland at healthscotland-evaluationteam@nhs.net

For more information about the Links Worker Programme visit: <http://links.alliance-scotland.org.uk/>

For information about the evaluation visit: www.gla.ac.uk/researchinstitutes/healthwellbeing/research/socialscientistsinhealth/research/changingpublicpolicyandpublicpolicyforchange/lwpevaluation/

References

1. Mossabir R, Morris R, Rogers A, Kennedy A, Blickem C. 2015. A scoping review to understand the effectiveness of linking schemes from healthcare providers to community resources to improve the health and wellbeing of people with long-term conditions. *Health and Social care in the Community* 23; 5: 467–84.
2. South J, Higgins TJ, Woodall J, White SM. 2008. Can social prescribing provide the missing link? *Prim Health Care Res Dev* 9: 310–318.
3. Teuton J. 2013. *Social Prescribing: Background Paper: Summary of published research prepared for Scottish Government Advisory Group on Self-management and Social Prescribing for mental health*. Edinburgh, NHS Health Scotland.
4. Health and Social Care Alliance Scotland. 2013. *An exploration of how link workers can support people to live well and strengthen connections between community resources and primary care in deprived areas in Scotland: Project Initiation Document*.
5. NHS Health Scotland. 2015. *Health inequalities: What are they? How do we reduce them?* Edinburgh, NHS Health Scotland.
6. Links Worker Programme website available at <http://links.alliance-scotland.org.uk/>
7. Smith M, Skivington K. 2016. *Community Links: Perspectives of community organisations on the Links Worker Programme pilot and on collaborative working with primary health care. A sub-project of the Evaluation of the Links Worker Programme in 'Deep End' general practices in Glasgow Edinburgh*. Edinburgh, NHS Health Scotland.

