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
Final Report, March 2016

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Acknowledgements

Abbreviations

CLP: Community Links Practitioner

GP: General Practitioner

NHS: National Health Service

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The Links Worker Programme

The Links Worker Programme is a Scottish Government funded programme, being piloted in very deprived areas of Glasgow, which aims to support primary care patients with complex needs to mitigate the impact of the social determinants of health. The Programme is being delivered as a partnership between the Health and Social Care Alliance Scotland and General Practitioners (GPs) at the Deep End (1). It provides resources to general practices to allow them to develop a 'links approach', which aims to strengthen connections between community resources and primary care. In order to evaluate the Programme, volunteer GP practices were randomly allocated either to be given the intervention or to be in the comparison group (service as usual). The main resource relevant to this report is a Community Links Practitioner (CLP) employed in each of the seven intervention practices. The CLP works with patients, referred from GPs, other health professionals, and self-referrals, to help them determine how best their goals can be achieved, particularly by linking them into the most appropriate community-based support available.

The University of Glasgow is conducting a three-year, mixed method, independent evaluation of the Links Worker Programme, commissioned by NHS Health Scotland. As a sub-project to the main evaluation, NHS Health Scotland commissioned further research to explore the Links Worker Programme from the perspective of community organisations that receive referrals from CLPs. The sub-project is the focus of this report.

The sub-project evaluation

This project aims to uncover issues relevant to developing intersectoral working between primary care and local community resources to achieve public health goals, and to gain a better understanding of the view of those working in community organisations about the 'Links Worker' model of social prescribing.

Each of the six CLPs working at the time of this sub-project evaluation took part in a semi-structured qualitative interview, which uncovered the challenges that they face in generating and maintaining links with organisations that could support the practices' patients. These challenges and views on the Links Worker Programme more generally were then explored with 30 representatives from community organisations via in-depth qualitative interviews. These participants were recruited from a range of different organisation types and sizes to reflect the variation in community services with which the Links Worker Programme aims to link. Data were analysed to identify themes anticipated from reading other relevant research and themes emerging from the data.

Findings

Participants from community organisations talked mainly about the role of CLPs themselves rather than more generally about the GP practices. This means that any benefits they identified related to the advantages of the relationships they had developed with the CLPs.

Main advantages of collaborative working between CLP and community organisations

Community organisation representatives identified numerous benefits to working collaboratively with CLPs:

▪ CLPs were the extra resource that enabled 'case management' for the most vulnerable patients. This was seen as a valuable asset that was otherwise missing for these people. CLPs were felt to be well-placed for this case management role; they were at the centre of a potential network of resources, with a broad knowledge of the patient, available support, and close links with primary care practitioners.

▪ Referrals they had received had changed since CLPs were in post and the people referred were more appropriate for their services. This was seen to be because CLPs had developed a breadth and depth of knowledge about the local area and the resources available. They had done this through the extensive collaboration efforts.

▪ CLPs were seen as being able to facilitate a community organisation presence within GP practices even if there was no direct engagement with GPs. Prior to the implementation of the Links Worker Programme it was said to be difficult to engage with practices. Various reasons were given for this, for example, lack of GP time, reception staff or other gatekeepers preventing access, attitudes within practices against engagement and organisational processes. They appreciated that CLPs understood their services and had the potential to educate practice staff on available community resources.

Main challenges to collaborative working between CLP and community organisations

CLPs identified two main challenges in attempting to build relationships with community organisations: capacity and funding; and organisational processes and attitudes. These issues were also raised in interviews with community organisation representatives alongside other challenges that these participants brought up, which were related to the sustainability of the Links Worker Programme.

The funding environment was frequently raised. It was seen as strained by austerity measures, leaving many community organisations unsure about their future. Community organisation representatives talked about capacity-related issues but remained largely positive about being able to take on more referrals from CLPs,

stressing their organisations were flexible enough to develop coping mechanisms for large increases in capacity (e.g. by hiring extra workers, developing new funding bids). Some also felt that they may be in a better position to apply for funding if they had increased referrals. CLPs were concerned about this issue, as they did not believe it fair to send patients to services that were unable to cope with them.

Process and organisational attitudes were also raised by CLPs as challenges to creating and maintaining links with, particularly larger, community organisations. They found that the referral processes in place were often bureaucratic and inhibitive both for patient engagement and for locating appropriate individuals with whom they could develop and sustain collaborative relationships. In addition, CLPs reported a lack of enthusiasm and low morale of some staff in larger organisations compared to those in small community organisations. They also viewed this as a challenge to developing collaborative working with these organisations. Participants in some larger community organisations did acknowledge that organisational processes could be challenging, but tended to view this as necessary to protect confidentiality and to ensure that work was being carried out within organisational guidelines. A minority of these participants also noted that they had tried to connect with the Links Worker Programme at management rather than CLP level in order to discuss how the organisations could work together, but had not been able to engage in this way.

As seen, the case management role of CLPs was valued by community organisations; however there was concern over whether this role was sustainable. Each patient requires a lot of the CLP's time, limiting the number of patients that they can have on their case load at any one time. With increasing demand on this type of service, discussed in relation to austerity, there was some concern that the CLPs would be able to support only a minority of the patients most in need.

The tendency for participants, both CLPs and those from community organisations, to view the collaborations as being built upon individual rather than organisational relationships is a potential challenge for the Programme. For example, community organisation representatives felt that their relationship was with the CLP as an individual rather than the GP practice as a whole; and likewise, CLPs felt that their relationship was with particular individuals within community organisations rather than the organisations as a whole. Without any formal collaborative process between organisations, any change in personnel on either side is likely to lead to these efforts being undone and any relationships having to be rebuilt from scratch, as opposed to inter-organisational relationships that might be sustained regardless of individuals involved.

Finally, community organisation representatives highlighted the need for CLPs to possess particular individual qualities and skills for the Programme to be successful. For example, CLPs' attitude and approach to the patients and to the role were seen

as very important. These are difficult qualities to assess, but are a consideration for making appointments to these roles.

Findings in relation to the defined Programme Theory of Change

From the community organisation point of view, there is some evidence of progress towards certain outcomes identified in the Programme Theory of Change. For example, there was some progress towards the short-term outcomes of practice-community relationships and exchange, albeit largely between individuals rather than the organisations as a whole, and improved appropriateness of referrals, in that many community organisation representatives felt that the patients they were being referred from the CLPs were more appropriate for their service than the referrals they had received pre-implementation. There was also some optimism around the medium-term outcomes. However, the challenges already mentioned raise questions about whether these outcomes will be fully realised in practice.

Discussion and conclusions

Overall, the majority of participants in the study viewed the Links Worker Programme positively. They appreciated the collaborative working that had developed with the CLPs, particularly the joint effort in ongoing support offered to patients most in need. Having CLPs situated within GP practices was viewed positively, as it allowed access to primary care health professionals but also because of the standing that GP practices have within communities owing to their longevity and to the feeling that patients hold a certain level of trust in their GP practices; where community organisations come and go, GP practices tend to remain a stable first point of contact for patients requiring services.

There was some evidence that the Programme theory of change outcomes were being progressed towards, however, not without potential barriers being highlighted. On the one hand, the Programme is being implemented at an important time, to help mitigate some of the impacts of the social determinants of health, which have increased as a result of austerity measures (2). On the other hand, the Programme encounters a challenge because these austerity measures have also had a negative impact on opportunities for sustained funding for community organisations. Although some community organisation representatives considered that they might be in a better position to apply for funding because of increased referrals from CLPs, this is questionable when taken alongside the context and the cuts that they also discussed. This raises questions about the sustainability of the Programme, as without the availability of adequately resourced community organisations the CLPs do not have anywhere appropriate to refer patients.

There were some differences in views of the Links Worker Programme from organisations of different sizes; those from larger organisations did not appear to have developed such collaborative relationships with CLPs or always see the wider

benefits of engaging with the Programme. Also, CLPs felt that it was more difficult to engage with larger organisations because of processes and organisational attitude. Such processes were recognised by community organisation representatives as potentially causing difficulty, but it was highlighted that they were necessary for the function of the organisations. It is possible that engagement between the Programme and these larger organisations at management level may encourage the wider benefits of the Programme to be recognised and allow for collaborative efforts to move forward, within existing structures and processes.

1 Introduction

1.1 Background

The Scottish Government funded Links Worker Programme is being piloted in some of the most socially deprived areas of Scotland. The programme follows a social prescribing model; a method of linking people to non-medical support or resources available in their communities, which may help to address the health and social problems that they experience. Community Links Practitioners (CLPs), with a "community-orientated role", have been employed in seven Glasgow GP practices to support patients to access community resources with the aim of improving their health and wellbeing. A further aim is for CLPs to support the practices they work within to become more 'community orientated'. CLPs work within a third-sector management structure alongside a team of other CLPs. Community resources include various organisations e.g. from very small volunteer-based organisations to city-wide arms length external organisations (those that are separate from Local Authorities, but work in partnership with them and are to some extent subject to their influence), and statutory groups. To support long-term patient outcomes, the Programme aims to improve links between primary care teams and these community resources. The Programme is being delivered in partnership between the Health and Social Care Alliance Scotland and General Practitioners at the "Deep End", a group of GPs who work in GP Practices serving the 100 most socioeconomically deprived populations in Scotland (by area-based deprivation level). The University of Glasgow has been commissioned by NHS Health Scotland to conduct an evaluation of the Links Worker Programme. This is a mixed-methods evaluation that is expected to contribute to the evidence base on the effectiveness of Link Worker models of social prescribing in primary care. It is a three-year project and started in August 2014. As a sub-project to this main evaluation, a further piece of work was commissioned by NHS Health Scotland, in November 2015, to explore the perspective of the community organisations with which the CLPs are 'linking' and referring patients. This report focuses on the progress of this sub-project: 'Community Links: the perspective of community organisations on the Links Worker Programme pilot and collaborative working with primary health care'.

Despite the key role that local community organisations are expected to play in social prescription, little is known about the degree to which they are willing and able to play such a role. Community resources, as well as GP practices, in these areas are also 'in the deep end' and arguably are a less powerful or resourced group of workers who may experience similar kinds of pressures that pertain to GPs. To fully assess the intricacies of the processes of referral and support between GP practices and community organisations it is necessary to consider the perspective of key actors in each sector; the views of people working in community organisations require further investigation. The research of the sub-project allows these aspects to be explored.

1.2 Aims and objective

This research will explore the perspective of those who represent community organisations who receive referrals from CLPs. It aims to uncover issues relevant to developing intersectoral working between primary care and local community resources to achieve public health goals, and to gain a better understanding of the view of those working in community organisations about the 'Links Worker' model of social prescribing. In doing so, from the perspective of those representing community organisations, the objectives are to:

- investigate whether there is an appetite for such collaborative work with primary care;

- explore the barriers and facilitators to the implementation of the Links Worker Programme;

- review whether the Programme theory of change is realistic in context.

Lessons that are important for the future development of the Glasgow Links Worker Programme and others will be provided.

It should be noted that this study investigated the challenges that CLPs faced in directly building collaborative links with community organisations, and did not seek to explore further work that they were doing within their GP practices to build relationships there and influence practice culture. Further reports from the main evaluation of the Programme will, however, provide findings related to this other work of the CLPs.

2 Methodology

2.1 Study design and sampling

This is a qualitative study involving individual in-depth interviews with representatives from community organisations. Five initial pilot interviews with representatives of community organisations in Links Worker Programme areas were conducted. These participants were identified via CLP referrals and through organisations within one mile of the intervention practices in A Local Information System for Scotland (ALISS), an online database. Referral data only gave the organisation type and area, therefore it was not always clear what the exact organisation was, and there was no information about which member of staff within the organisation was collaborating with the CLP. These interviews highlighted that more could be gained from recruiting participants from organisations that had some contact with the Programme. Organisation representatives that did not know about the Programme were positive about the theory but could only talk hypothetically about whether it would work in practice, whereas those who had some involvement with the Programme were more able to discuss their views of the barriers and facilitators its success. Additionally, hundreds of community organisations exist in each of the localities of the Links Worker Programme practices; therefore it is not reasonable to assume that CLPs will have 'made links' with all. In order to target those that have had some dealing with the Links Worker Programme, organisations were identified via the CLP. 'Community organisation' covers a variety of different organisation types; here, it includes statutory services such as social work, Department for Work and Pensions etc. as well as smaller local voluntary organisations such as local foodbanks. Interactions with General Practices are likely to vary between organisations with different funding, operations, and management structures; therefore both statutory as well as charitable organisations were sampled for this study. Ethical approval for the study has been obtained from the College of Social Science Research Ethics Committee at Glasgow University (ref: 400150043).

To reflect the various different issues and priorities that patients identified in their first consultation with the CLP, a broad range of organisations were recruited in terms of their focus e.g. mental health, bereavement, employment support; organisations of different size and structure were also recruited. To explore the range of issues relevant to creating links between primary care and community organisations, participants from both frontline staff (those who see clients on a day-to-day basis), and managerial staff (those who are more involved in the strategic operation of their organisation), were recruited to the study.

2.2 Research methods and data generation

Following five pilot interviews with community organisation representatives, the initial phase of the research involved carrying out in-depth interviews with the CLPs, in order to elicit the types of challenges that they face in generating and sustaining links

with community organisations. Following the pilot interviews, the research team expected that the interviews with community organisation representatives could be better shaped by having the CLPs provide some context around the issues that they were facing in terms of building relationships. It was intended that as well as probe on the issues that the CLPs identified, further issues identified by the community organisations would be explored. One of the researchers (KS) requested to attend one of the CLP weekly meetings, at which point the CLPs were informed about the research being undertaken and asked to make contact if they would be willing to take part. A follow-up email was sent to CLPs via their manager. All six CLPs volunteered to take part in a face-to-face interview (all of the CLPs that were working at the time of the research). They were provided with information about the study, given the opportunity to ask questions, and signed a consent form before the interview took place. Interviews were conducted in the CLPs' office or in a public place—whichever was most suitable to the individual CLP. All interviews were digitally recorded, transcribed verbatim, and de-identified. The interviews aimed to uncover more detail about the challenges e.g. whether there are any patterns in organisational type and the nature of how challenges are experienced and dealt with (see Appendix 1 for topic guide). These interviews were used to inform subsequent interviews with participants of community organisations and also to allow comparison of different perspectives (CLPs and community organisation representatives) on the same issues.

The organisations suggested by CLPs were recorded in a database, which detailed organisation focus e.g. mental health, bereavement etc.; organisation type e.g. small charity, charity; and geographic area. It was intended to recruit enough organisations to provide variation across these factors, but also bearing in mind that there was a time restriction (four months of funding with recruitment throughout the Christmas period). It was expected that around 30 interviews would be sufficient. Given that CLPs were interviewed first, some information on the involvement of the organisations in the Links Worker Programme was available prior to the interviews with community organisation representatives.

Thirty-eight potential participants from the community organisations were contacted by phone and/or email, with details provided by the CLPs, and invited to take part in an interview. Only one refused to take part in the study, stating that the research was too time consuming. A further seven did not respond to the email/phone call or agreed to participate but an interview could not be arranged in the data collection period. Each was provided with a Participant Information Sheet and, at time of interview, informed written consent was obtained. Interviews took place at the participants' workplace or the research unit. A topic guide was developed for community organisation representatives based on the aims of the study and altered following the interviews with CLPs to reflect relevant issues that CLPs identified (see Appendix 2: Topic Guide: Community organisation representatives for topic guide). Interviews covered the following topics: participants' views on what the Links Worker

Programme can achieve and its sustainability; relationships between primary care and community services; relationship with the CLP; the referral process and appropriateness of referrals; organisational capacity; and working with other organisations. Interviews were flexible to allow any topics arising to be freely explored. They were digitally recorded, transcribed verbatim, and de-identified.

In-depth interviews with CLPs were conducted in late November/early December 2015 and with community organisation representatives in December 2015 and January 2016.

2.3 Data analysis

Analysis explored themes that were anticipated from previous studies of social prescribing interventions, which had helped to shape the topic guides e.g. (3-6), as well as those that emerged and were developed and explored throughout the interviews. The principles of Framework Analysis were employed to facilitate the interpretation (7). Emerging themes were recorded by the researchers; three of the research team (MS, KS, and NRC) independently developed initial coding frameworks based on two CLP transcripts and two community organisation transcripts each. After discussion, one coding framework was agreed and all interview data were coded in Nvivo v10 (qualitative coding software) according to the framework by one researcher (MS). This framework was flexible to allow new codes to be added where they arose from further community organisation interview data. The finalised coding framework was discussed and agreed upon once all data were collected. To explore cases and themes, code summaries were written and patterns within each code were explored, as well as patterns across participant groups.

Collecting more data in qualitative research does not necessarily lead to more information, because as themes arise they are entered into the analysis framework and there reaches a point where more data does not lead to new themes, but repeated coding of the same themes. There were two considerations to determine when to stop recruiting participants to this study: no new themes being added to the analysis framework (data saturation); and, practically, the time available. Data saturation was reached from the perspective of the main fieldworker (MS); towards the end of the interview run, around the mid 20s, no new major issues or themes were arising, and novel data was a facet of the individual nature of the organisations rather than an aspect of overall themes that had not been broached.

3 Results

3.1 Participants

The results are based on the analysis of the data from individual interviews with all six CLPs and 30 representatives of community organisations. Table 1 provides details of Community organisation representatives. The achieved interviews represent a range of organisations in terms of type and focus, and participants in terms of job role.

Table 1: Details of Community organisation representatives

CO	Organisation type*	Organisation focus	Participant job role
1	Charity (local)	Community integration	Frontline/management
2	Statutory	Spiritual Service	Frontline
3	Charity (local)	Community engagement, education	Management
4	Charity (national)	Cancer	Management
5	Charity (city wide)	Alcohol abuse	Frontline
6	Statutory	Advice	Frontline
7	Statutory	Social work	Frontline
8	Charity (local)	Women's centre	Frontline/management
9	Charity (city wide)	Arts/wellbeing	Management
10	Charity (city wide)	Bereavement	Frontline/Management
11	Charity (local)	Wellbeing	Frontline
12	Statutory	Psychotherapy	Frontline
13	Statutory	Employment	Frontline
14	Charity (city wide)	Alcohol abuse	Management
15	Statutory	Mental health	Frontline
16	Charity (local)	Financial advice	Frontline
17	Charity (city wide)	Dementia	Frontline
18	Statutory	Advocacy	Frontline
19	Charity (City wide)	Sexual abuse	Frontline
20	Charity (local)	Media and arts/wellbeing	Management
21	Charity (city wide)	Wellbeing	Management
22	Statutory	Health improvement	Frontline
23	Charity (city wide)	Wellbeing, arts	Management
24	Charity (local)	Community development	Frontline
25	Charity (city wide)	Employment	Management
26	Charity (local)	Wellbeing	Frontline
27	Charity (local)	Wellbeing	Management/Frontline
28	Charity (local)	Foodbank	Management/Frontline
29	Charity (city wide)	Mental health and wellbeing	Management/Frontline
30	Statutory	Mental health	Management

* Local branches of nationwide charities had the support of a wider network but were independent as they were responsible for their own branch's funding and had local autonomy; participants at city-wide charities tended to be at the main office and had some responsibility for frontline staff as well as experience of frontline work themselves.

Management and frontline staff did not necessarily have alternate views on any of the issues that were being discussed, but it was useful to have both groups in the sample as they had different levels of experience. Those in management roles were able to elaborate more on certain higher-level issues and provide strategic overview; they were more able to discuss, in a broader sense, the context of health service links with community organisations. This was perhaps because they were more experienced in the sector and had a longer historical perspective of the third sector environment and how it had changed over the years. Whereas frontline staff had more patient contact and were most likely to be the ones developing relationships with CLPs.

There was some patterning within the data, whereby participants from larger community organisations discussed slightly different challenges for the Links Worker Programme than those in smaller organisations. CLPs' views of challenges to collaborating with community organisations also differed by organisation size. Here 'larger organisations' refers to statutory organisations and charities with significant contracts to deliver services across the city e.g. from the council and NHS; and smaller organisations are local charities set up in one area with only a handful of paid employees and the support of local volunteers, with or without the backing of a wider network from being a branch of a national organisation.

3.2   Main Results

This main results section explores the perspectives of the community organisation representatives of the Links Worker Programme. Where appropriate, CLP data are drawn upon i.e. if views differed, or where particular challenges were highlighted by CLPs. Further research exploring the views of CLPs is ongoing in the main evaluation and will be reported separately (8).

In exploring the processes, challenges, and benefits of the Links Worker Programme, the main findings from the analysis were related to the relationships necessary for collaboration. Benefits of the Programme were intrinsically associated with potential collaborative working between community organisations and CLPs, and challenges to realising the Programme aims largely arose from difficulties in establishing these relationships. The following sections therefore explore the advantages of collaborative working between community organisations and CLPs, and the challenges to such collaborative working, before finally presenting analysis of the data in relation to the Programme's stated theory of change.

3.3   Advantages of collaborative working between Community Links Practitioner and community organisations

Here the views of the community organisation representatives on the potential benefits of collaborative working with CLPs are explored. Where other relationships were considered important for collaborative working between stakeholders e.g.

between community organisation representatives and practice staff, they were thought to be facilitated by the relationship held with the CLP. Therefore, as well as the direct benefits of working with CLPs—case management and appropriateness of referrals—this section explores how the collaboration with CLPs has facilitated links between community organisations and both GP practices and other community organisations. Finally, the particular benefits of the Links Worker Programme in the context of austerity, which were highlighted by participants, are discussed. All of the advantages discussed in this section were considered by participants to be beneficial because they are expected to lead to better outcomes for patients; the central and mutual aim of all participants.

3.3.1 Case management

The main benefit of the Links Worker Programme, from the point of view of community organisation representatives, was that it provided patients with a central point of contact, or case manager. They felt that CLPs could act as a bridge between all of the different stakeholders e.g. they have an understanding of the patient, the GP context, and the other available resources across the city. Community organisation representatives noted that patients who were previously 'hard to reach' were now finding routes to appropriate support via the case management role of the CLP, which they viewed as an encouraging development.

> 'So our experiences with clients at that practice that are working with the Link Worker, that they get substantially more support than we would've been able to provide, even if we're aware of other services and other projects, other groups, 'cause we just don't have the HR capacity to be able to spend that substantial amount of time with people, making sure that they're accessing all the support that they can or are entitled to.' (CO1)

The role of the CLP was perceived by the majority of community organisation representatives as about engaging patients with a network of community resources, rather than simply as a referral point. Fulfilment of this role was thought to be contingent on local knowledge, the importance of which was emphasised by most participants. This 'local knowledge' was about being able to provide information regarding what was happening on the ground in local communities, something that could only be garnered by working locally and fostering local connections. This included knowledge about gaps in services in the community, neighbourhood issues, potential development of local resources and future initiatives, and an understanding of local geography, both physical and social, which was then used to develop common ground on which to build relationships with patients.

> 'Her knowledge of all things knocks me over sometimes, you know, she has a vast knowledge of how she can help families. And she does it in a very unthreatening way.' (CO3)

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The benefit of the CLP, from the community organisation perspective, goes beyond supporting patients to access and even engage with appropriate support—they often continue to work collaboratively with each organisation and patient involved to ensure the patient's continued support. The input that the CLPs had with patients varied depending on their needs, but community organisation representatives appreciated a collaborative approach to supporting patients where appropriate. For example, CO12 suggested that the CLP brought something extra to their consultations with patients and even talked about the benefits of ongoing joint consultations:

> '[CLP] seemed to be a fount of knowledge of the local area, which she was quite keen to try and involve the client in. So I think it is about, there is a capacity for someone in that role, I think, to coordinate the different aspects of someone's care, but also to have that kind of broad-based knowledge of what might be most useful for them. So I think, you know, I think that's the benefit of it. And I think also just working jointly. So in that respect, you've got someone who has a social work interest but is working for the health service. So if I see somebody jointly with her then you have got both of those aspects being covered. So I think that's a huge benefit.' (CO12)

It was clear from many of the community organisation representatives that they felt that partnerships were forming with their CLP, with clear two-way dialogue. However, even in cases where participants did not yet have such close collaboration with CLPs, they could still appreciate the role of the Programme in engaging patients with systems of support.

3.3.2   Appropriateness of referrals

Community organisation representatives appreciated that the referrals they received from CLPs tended to be appropriate to the service they could offer. Many of the community organisation representatives highlighted that the CLPs' overarching understanding of the available services are in the local area and their ability to point people to the most suitable services, rather than just any available was one of the central benefits of the Links Worker Programme.

> 'Int: Alongside that do you have any ideas about why it is [CLP] is sending people that are so appropriate or more so than maybe other people?
>
> Well she's very switched on, she's very proactive and she's, she knows what's out there in her area. I don't know how many organisations she knows but it must be a huge amount. And so she really does save a lot of time and for the NHS a lot of time and for the client as well, she's, she can place them in the right places. I don't know, it just seems, obviously there's a cost to her post, but it would be interesting to see how much time

she saves and how effective she is, because for us it's a marked difference between having a role like that and not having one in the GPs surgeries.' (CO10)

An integral part of the CLPs' role is becoming familiar with local organisations and building relationships with staff in them. CLPs gain in-depth knowledge of what each organisation is able to do and the specific services they can provide; they have "a good understanding about what we can offer" (CO8). Particularly if a patient has multiple complex issues, CLPs are able to spend time with that patient, build up relationships of trust, figure out what they need and what their priorities are, and then direct them to the appropriate services.

> 'The difference in the level of referrals coming through [CLP] from that practice is, you know, I can't even quantify it because I certainly wasn't getting those referrals through the GPs, or nurses, or practice nurses or anything, from that practice. So I think… And it's generally people who really are quite vulnerable. If they've been referred through [CLP] they've generally got a lot of social issues going on. I think the group of people she refers is correct. So I can only imagine that that's one practice, so if there was somebody of a similar role attached to each practice that… You know, the referrals to services, and I presume she refers to other services, like housing, and different things like that as well...' (CO6)

While there were two community organisation representatives who had concerns about the reduction in referrals coming from GP practices with CLPs, the large majority were very positive about the change in referrals since the implementation of the Links Worker Programme. The two organisations were larger scale organisations contracted to provide a service and had in the past received a high volume of referrals from the Links Worker practices. There was some concern that patients were being diverted elsewhere, which on the one hand participants thought was a good thing as many of them would not have been suitable anyway, but on the other hand they were also conscious that the patients who would benefit from their support might not be getting it. It was not clear why there had been a drop in referrals and participants had not been able to connect with the Links Worker Programme to explore further. Issues with community organisation representatives contacting the Programme are discussed further in section 3.4.2.

3.3.3 CLPs facilitating community organisation presence in GP practices

Community organisation representatives had mixed assessments of GPs' attitudes to social prescribing and collaborative working outside of the health sector. Where some felt that GPs were hostile to social prescribing, they often recognised that this was changing, and also acknowledged the pressures that GPs faced, mainly related to time and targets, that made it difficult for them to fully engage with a holistic approach to patient care. Even where they did sense a shift away from the medical

model of health, across the board community organisation representatives suggested that, prior to the Links Worker Programme, as a "third sector representative or professional trying to get forum with GPs is very, very difficult" (CO17). This difficulty was related to many aspects beyond attitudes to social prescribing, including administrative staff acting as stringent gatekeepers to GP practices, the limitations on time for GPs, and the high demand for access to clinics by community organisations.

Some community organisation representatives identified practical issues around access to GPs for themselves and their patients ("the way that the appointment systems work can be unhelpful for people" CO26). It was clear that it was not only GPs that community organisations needed to build relationships with to engage with primary care. Reception staff and practice managers were cited as being gatekeepers, and if they were not on side then this could cause an issue for development of any collaborative work.

> 'As I say, we're paid for by the NHS so we will still struggle to get sometimes past a receptionist in the health centre. No matter, almost, what we do. Sometimes it's just the challenge of actually dealing with that practice, the way they're set-up. We also have totally different experiences with practices where it's just fantastic, they get it, they see the benefits, they see the clients progressing, they see what is possible. And they buy into it and they want it, and they, you know, and "You helped wee Mary, I've got another couple of wee Marys, will you see them?" D'you know what I mean? And it's that kinda relationship. So I think… I'm not denying the link workers have a tough job 'cause they absolutely do, but I think the practices themselves sometimes don't make it easy for services in general to link in with them.' (CO25)

One of the goals of the Links Worker Programme is to bring about a change in practice culture (9). Community organisation representatives viewed this as a difficult, but important task for CLPs. This is something that will be explored further, from the practice perspective, in the main evaluation (8).

Where participants felt that they had a "route in" (CO23) to GP practices via the CLP, they were more positive about being able to collaborate with primary care. They felt that for this to work the link had to carry "weight, gravitas, authority and credibility with a GP practice" (CO16). The CLPs' physical location in the GP practice allows personal contact with GPs and facilitates the development of a mutually respectful working relationship, which community organisation representatives felt that they could potentially tap into.

> 'Because they're on site and because they're part of the mechanism of that daily practice, they're probably going to be at meetings that I'm not

going to be at, they're probably going be hearing about patients or families or carers.' (CO17)

Many participants viewed CLPs as being able to facilitate these links with primary care, aiding them to "get a foot in the door" (CO13) of sites that had previously been perceived as being relatively difficult to penetrate. One participant described this opportunity as "gold dust" (CO16). CLPs act as advocates for community organisations with GPs, and facilitate awareness of the organisations' existence as well as the model of social prescribing. They have an understanding of both primary care and community organisation structure and function, and are in a position to help negotiate the communication between these; they are "in a position to champion" (CO27) each others' work. A minority of community organisation participants stated that they had been invited by the CLP to provide an overview of their organisation's work to staff within GP practices e.g. at the practice staff meeting. This was viewed positively, but more often community organisation representatives talked about benefits of the Programme in terms of the CLPs' awareness of their organisation and the CLPs making referrals and working with them rather than the GPs or other primary healthcare staff doing so.

> 'So the warmth is coming from the relationships that the community links practitioner is able to develop because she's there in a position to actually understand the dynamics of a surgery, which are really full-on. I mean, it's high pressure. But the Community Links Practitioner is in there to get an understanding of the inside workings and also the external needs. And bring them together.' (CO27)

This feeling was reflected amongst CLPs, for example, they talked about being more sympathetic to the GP role since becoming a CLP.

> 'I've experienced it myself as a worker, trying to get a liaison; some kind of relationship with GP surgeries is not an easy thing to do. And now working within the organisation, the GPs practice, you can understand some of the constraints and the reasons why. You know, the contract, the, you know, the money and…[...] I might defend GPs a wee bit sometimes, whereas before I would've joined in, you know, the… the, you know, the huffing and puffing. But now, you know, it's a slightly different kind of perspective. So I can see why… why that relationship of, you know, or that link has not really, sort of, grown over the years.' (CLP2)

As well as being able to liaise with someone located in primary care to collaborate on patients' needs and to improve access to health services for people in need, participants felt that having initiatives endorsed by GP practices was also important.

> 'Communities have seen projects come and go. And 'Hiya! I'm here, I'm here for three years, and I'm gonna make everything all better.' So the

community is now really versed on how community development works. So their trust in, in new projects, their trust in initiatives that are on their doorstep is really, really fragile. Whereas the GP is still that person within the community that an individual still trusts.' (CO27)

3.3.4 CLPs facilitating links between community organisations

The most beneficial links that were discussed for community organisations were with CLPs and GP practices, but the opportunity for CLPs to be the linking factor between different community organisations was briefly touched upon by some community organisation representatives. It was suggested that CLPs could "broaden horizons" (CO11) because they were aware of the landscape and of the patients' priorities.

> 'So I see there's a role there for the Links Programme to almost be like human directories, where they know the services, they know the services' capacity, they know the services' waiting lists, and they use the services appropriately.' (CO21)

Development of inter-community organisational links could facilitate closer working and referrals between available resources. Here, the CLP was thought of as a "go-to person to try and ensure that there is this kind of multi-disciplinary team approach" (CO12). Many of the community organisation representatives valued this possibility; however it was more hypothetical rather than something that had happened in practice.

3.3.5 Other potential benefits

Some of the community organisation representatives discussed how the CLP could have a positive impact in their organisation outside of working collaboratively with patients and improving knowledge within their GP practices. For example, it seemed that some of the CLPs had become deeply involved in working with smaller organisations to develop programmes, and in strategic decision making. Additionally, one organisation suggested that the CLP had helped them with funding applications as they lacked experience of doing this. However, when asked, most community organisations had not realised that support with funding applications was an option; they did not feel that it was appropriate to ask for support from the Links Worker Programme for this, or had sufficient expertise in this area within their own organisation.

3.3.6 Advantages of collaborative working in the context of austerity

Community organisation representatives, in particular, emphasised that the Links Worker Programme was particularly vital as a mitigating factor in the context of austerity. These participants talked about political decisions that had created the extra burden on services e.g. changes to welfare benefits and the use of sanctions,

meaning that more people were in situations where their health was affected by underlying social circumstances.

> 'It's great that a programme like the Links Programme is being piloted at a time like this, which is incredibly… it's essential, so in terms of more partnership working, getting people the right resources, [...] especially within the current kind of political climate and framework that we're all working within.' (CO1)

It was noted by several community organisation representatives that such an initiative provided the opportunity for specific patient needs to be identified more quickly (particularly in prioritising patients with multiple needs and complex interwoven issues), referrals to be more appropriate, and therefore time and resources, already in short supply, not to be wasted, which in times of limited funding was more important due to a general lack of services.

> 'I think it becomes even more important, you know, because at the end of the day it's, you're cutting down wasted time if you're signposting to the right organisation right away. And not only that, I mean there are certain charters out there for people who are visiting GPs, you know, there are rights and responsibilities for organisations to look after people in an effective way. And, you know, if we're doing things ineffectively then that's, it could be time delays etc., etc. And I think that's, you know, we know there's austerity out there, but I think that anything to do with helping clients get the help they need quicker or more effectively, I mean I don't think anybody could really argue with that.' (CO10)

There was a perception that the Links Worker Programme had the potential to improve the efficiency of systems. This was not only relevant to referrals, but to creating an established network of health and social care organisations, emphasizing the need for relationships between those involved. Both community organisation and CLP participants highlighted the importance of all parties working together, particularly in the context of austerity.

Although community organisation representatives did note some particular advantages to the implementation of the Links Worker Programme in the context of austerity, there were also challenges to the Programme identified as a result of austerity measures. These are explored, alongside other challenges, in the following section.

3.4 Challenges to collaborative working between Community Links Practitioners and community organisations

Most of the challenges that CLPs discussed in terms of developing links with community organisations were related to how easily they could support their patients to engage with such organisations. Two over-arching barriers, capacity and

organisational attitude, emerged. These issues were explored with community organisation representatives and are reported in this section. Further challenges to the Links Worker Programme were highlighted by community organisation representatives and these are also explored in this section. They were around the themes of the sustainability of the CLPs' case management role, the preponderance of individual over organisational relationships, and the importance of individual characteristics of the CLPs.

3.4.1 Capacity and funding

Despite community organisation representatives highlighting the potential advantages of the Links Worker Programme during austerity; clear challenges to its success were also related to this context. It was felt that austerity measures had brought about an increased demand for services alongside cuts in the same services and reduced opportunities for funding for community organisations. There were many reports that the funding environment is increasingly strained, which manifested as fear and uncertainty about what the next funding cycle would bring, and several community organisations were in turn unsure of the sustainability of their organisations.

> 'I'm seeing more and more of the time, the resources demand, the stretch on organisations in terms of the amount of people that seem to be getting referred to these organisations now. And I think potentially the quality of service of these organisations could suffer. Potentially. I'm worried about that.' (CLP7)

Such challenges were related, by CLPs, to the difficulty in forming the relationships that all participants had identified as essential to the Programme. Where some community organisation representatives viewed the Links Worker Programme as having the potential to support engagement with their services during times of reduced capacity, CLPs felt the need to pull back from services that did not have sufficient capacity to support patients, because they did not feel it was fair to the patients as they were concerned about whether individuals would get the best service available. CLPs stressed that they would not dismiss the potential of such organisations, but would hold off with referrals until they saw evidence of the situation changing. CLPs were, however, careful to note that they had to distinguish between whether it was in fact the organisation being difficult to engage with rather than patients' individual issues around not feeling ready to engage.

As a result of funding cuts in statutory services, but unrelated to the Links Worker Programme, a small number of community organisation representatives reported an increase in the number of people being inappropriately directed to their services, as a "dumping ground" (CO8) and they were not always in the position to support their complex needs. This was particularly the case with patients with complex mental

health issues. In these cases it was not necessarily only GPs that were making inappropriate referrals, but other services as well.

> 'Well, a lot of the mental health places shutting down; we're getting a lot of referrals from different agencies. But unless there's somebody that can be there to support that person, we're not really the place for them 'cause we've not got any training, you know? We've not got the experience or anything like that.' (CO8)

Confirming some of the CLPs' concerns, in terms of capacity, smaller organisations suggested that they would not turn people away but instead would adjust priorities, run a triage type approach, or develop waiting list systems, perhaps prioritising clients in greatest need the higher demands on capacity there were.

> 'I think again it's just about doing that 'can do' thing. I mean I know, you know, you might think, 'Oh my God, listen to her, you know, she's trying to sprout a set of wings.' It's got nothing to do with that, you just need to believe that you're gonna be able to make, you know, you're gonna have to help people. You need to start where they are. So the capacity, it's just about the will.' (CO3)

One issue with this response, however, was that organisations would tend to deal with crisis cases and not really have time to support those that required more long term engagement. Community organisation representatives acknowledged that a fire-fighting approach was not best-suited to support individuals with enduring and complex health and social challenges, and in recognising this they frequently highlighted the important role of the CLP, suggesting that the CLP was well situated because they could take some of the burden of case management and long term client engagement. This comes back to the CLP having an ongoing relationship with patients, rather than being the point of contact for referral.

> 'And we just don't have the resources, both in terms of time and financial resources, to be able to chase up and continue to provide. Like, we need someone to come to our door basically and annoy us until we help them. And, yeah, so there's been many failures on our side and there are always failures on our side because we haven't been able to properly support individuals for the reasons I already mentioned. And the Link Worker is pretty good at making us feel bad by chasing us up and going "Have you done anything with this individual?" and then we go "Oh, no, crap. Like, we haven't even thought about them for the past, like, three weeks." So, yeah, but, yeah, those are our own failures and the Link Worker does well out of delicately highlighting the fact that we haven't maybe done everything that we could've, but…' (CO1)

Where CLPs potentially viewed this as a problem, community organisation representatives plainly saw it as the reality rather than a terminal issue, and tended

to view CLPs as being able to contribute to improving the situation. In a few cases, participants even discussed some benefits of being close to capacity. They suggested that higher demand for services would put them in a position to apply for further funding; an increase in referrals would result in greater capacity as they would be in a stronger position to apply for funding for staff and volunteers. The majority of small organisations aspired to increasing their size, capacity, and reach. Rather than view CLPs as a potential source of too many referrals, they were perceived as a source of more clients when organisational capacity was increased through funding opportunities.

> 'We are trying to build capacity but we're doing it depending on what funding we're able to achieve [...] We could develop a strand of programming, if we got the funding to support it over a period of years, to take on a greater number, and there is an intention to do that.' (CO9)

On the other hand CLPs' view is that reduced capacity makes collaboration difficult.

3.4.2   Organisational process and organisational attitude

A range of issues around processes, including approaches to patient engagement and stringency of bureaucratic systems, were seen as major challenges to creating links between CLPs and larger community organisations. This section draws largely on the CLPs' perspective as it was they who identified this as a major challenge, but incorporates community organisation representative views where appropriate.

Engaging with services on their patients' behalf was not always simply a case of phoning and making an appointment, but often required the CLPs' negotiation of the systems involved. They explained that for patients in complex circumstances this could act as a barrier to engaging with the appropriate support. There was frustration around these issues, which were true of multiple different organisations, because it appeared as though the organisations did not necessarily account for the lack of resources that patients were able to deploy in engaging with them, which created basic barriers at the very initial stage. CLP2 described some of these challenges that each of the CLPs individually identified:

> 'It's the persistence and the frustration that goes along with it. And if you, you know, I know individuals that have said "D'you know what? Forget it, forget it. I'm not gonna bother with that." And I've said "No. We will bother with it. And I'll do the hard work, and don't you worry about it." [...] making umpteen phone calls is not a hard thing to do but it's a pressured thing to do for some people, and if your life is in chaos or you're not feeling well, or back to that thing about repeating yourself, or if you're not very articulate and you don't quite like the phone...' (CLP2)

Such systems of contact that were thought to exist particularly in larger organisations were seen not only as a barrier to making referrals for patients, but also as a barrier to the CLPs' ability to make links.

> 'You know, I had a conversation with them the other day and was passed to eleven different people. And still didn't get the problem resolved. And that's not unusual [...] just really not knowing what's going on within the organisation themselves because it's so big [...]. I think that's it, it's a massive challenge in these big organisations, where the left hand doesn't know what the right hand is doing.' (CLP6)

These issues around making links with community organisations chiefly related to larger organisations and the complex, often inflexible and not always user-friendly, systems in place to facilitate engagement within codes of conduct. CLPs recognised that the issue tended to be systematic rather than concerning individuals within the organisation, but noted that it created a "massive barrier" (CLP6) to actually being able to talk to individuals consistently on a named basis, one of the prerequisites of developing relationships.

It was also recognised that this was partly to do with capacity, and managing workload, but CLPs noted a difference between organisation size in that even when smaller organisations were busy and at capacity, they did not take the same approach as the larger services.

> And that's where I see health and the third sector actually, perhaps change the culture, and that they don't shut the door. They don't have, necessarily, exclusion criteria. You know, they will work above and beyond the call of duty. And it's not to say that social work won't, please don't misunderstand me, I think, but, you know, they're a very – their resources are rather tight, so, they have to very much use their eligibility criteria and so health and the third sector will quite often be frustrated by what they feel is a lack of response. (CLP3)

Large organisations were thought to have less autonomy owing to the need to adhere to strict protocols in the way that they deal with individual cases. In some cases these protocols only serve to exacerbate the very conditions for which the patients are seeking help e.g. anxiety and stress. Where CLPs found it relatively straightforward to engage with individuals in smaller community based organisations, larger organisations tended to have central call centres, making it difficult for CLPs to get through these filters and make headway with developing links with case worker individuals within organisations who could help make decisions to help patients or facilitate patient engagement. They valued personal named contacts as a way of making inroads to an organisation, and where this was not possible they did not find it easy to uncover suitable alternatives for engaging with these organisations.

'It's that loss of connection and that loss of personal relationships that you can build up with people, and they get to know you and trust you, and vice versa.' (CLP2)

Community organisation representatives from smaller organisations also occasionally touched upon the issue of lack of individual contact when discussing the difficulty of establishing a network of support in their local areas. Like CLPs, some were frustrated at the processes that these organisations had to follow.

'I think they are, you know, there's a kind o' managerialist culture. I think that all of those things stifle innovation and creativity.

Int: What's the effect of the organisation being too big then? How does it stifle?

Well, because the bigger the organisation, the more you get into hierarchies, the more you get into rules and regulations.' (CO12)

This example shows that further than organisational process, there was some feeling around the barrier created by cultures within organisations. Some of the CLPs were also concerned about the difficulties of engaging with these organisations even when they managed to gain contact with particular individuals, which they related to organisational attitude and issues around disengagement and low morale of staff. They perceived "a culture and certain attitudes" (CLP7) that they did not feel were necessarily conducive to supporting patients. Partly because of the different scale of the organisations, but also because of the way that they are run, CLPs perceived a difference in the enthusiasm of individuals in smaller organisations.

'Some of the organisations and the people that are running them are completely… there's a real passion there, because I think they gravitate towards these kinds of things. They either set them up themselves… [for example] … I mean everyone that works in [organisation] is passionate about cycling, so there's that thing going on, and there's a real desire to see change going on.' (CLP7)

Evidence of such a lack of enthusiasm or passion was not clear in exploring the data across interviews with participants from larger organisations. However, it emerged that larger organisations displayed a tendency towards not necessarily recognising the wider benefits, or feeling that they were appropriate or being realised, of being involved with the Links Worker Programme in the same way as participants from smaller organisations. Although they often recognised the potential, they were perhaps less sure about the reality.

Some participants of large community organisations felt that, since the Programme is city-wide and the larger community organisations are also city-wide, stronger connections were required at a higher level i.e. with the Links Worker Programme management, in order to obtain a full picture of what was going on across the city

that would be relevant to each organisation, and to discuss how their processes could be aligned. Due to the relatively autonomous role of the CLPs, the Programme was developing slightly differently in each area. A few of the larger organisations brought up that it felt slightly "disjointed" (CO4), and noted that they had difficulty making contact with the Programme as a whole.

> 'I think the theory of it is great but the practicality is not working across all seven, d'you know? And I would like to see that, from our point of view, before it went wider.' (CO25)

The CLPs' frustration around organisational process was discussed as a challenge by community organisation representatives as well. However, these participants did not view the issue with frustration, but as a necessity that would have to be worked around. Larger organisations do have processes and procedures in place that participants felt, for good reason, they could not ignore. For example one talked about being "very constrained within the law and the framework that we work in" (CO7), meaning that they could not immediately agree to sharing information regarding particular cases that they were working on because of confidentiality agreements.

Although voicing the opinion that the Links Worker Programme was a good idea and a positive initiative overall, there was one suggestion from a participant from a large statutory organisation that CLPs should focus on supporting patients with less complex needs, rather than being involved in the kind of crises management that organisations like, for example, social work typically deal with e.g. issues related to family cohesion, abuse etc. This suggestion was made because it was felt that a system is already in place to respond to these cases, and there were concerns about the extent to which CLPs were trained enough to deal with issues of high complexity and risk. However, this was not the feeling from the majority of other participants— they valued that extra resource was being provided in attempt to support the most vulnerable and the most in need, who may otherwise be missed. These participants viewed the CLP as being best placed at the centre of the network of support for the patients, particularly situated within the GP practice, which was often the "first port of call" (CO19) for people who need support. Such a network was essential, given the complexity of patient circumstances. This is relevant to the CLP acting as a case manager for many of the patients referred to them.

> 'So in the past you would have had an employment agency [...] and they'd have been pretty much responsible for getting people and trying to support them into employment. But obviously there are barriers to employment. Some of those barriers are health barriers and therefore the person would need supported to try an' address some of they health barriers. Some of the barriers are financial, some of the barriers are social, some of the barriers are, you know, a combination of these things, they're family issues. So therefore there's a recognition and we need to try

and bring all these different parts of the puzzle together so that we can support this individual.' (CO16)

The dominant view was that where patients live within complex health and social situations the solution is unlikely to be straightforward, but instead needs to be matched with collaborative thinking and working, and aided by someone to manage this response. This was a task perceived to be appropriate for CLPs given their position, knowledge, and skill set.

3.4.3   Case management by CLPs

One criticism of the Links Worker Programme was that there were not enough CLPs, and that community organisations could only collaborate on those patients that were at the specific intervention practices. However, although positive in principle about roll-out, some of the community organisation representatives did voice concern around the sustainability of the Programme, given that the CLPs were involved in a lot of individual case management, which was both time consuming and complex. CLPs took each patient on a case-by-case basis, therefore their role varied greatly. Some of the community organisation representatives pointed out that this meant the CLPs were spread rather thinly and recognised the challenging nature of their role.

> 'The Link Worker's job is… a little bit difficult, shall we say? So in terms of they're working with so many different groups of individuals with different specialist needs and, to some extent, they're – to use a very general term – doing quite a lot of casework support. And I think that's a big ask to have someone who's working with so many different groups to understand those specialist needs and to be able to support everyone as well as they can.' (CO1)

Relevant to this is that the CLPs did not necessarily expect that their role would include such a level of case management or that patients would require quite as much support to engage with services. Although CLPs have relative autonomy and ability to support patients at a very broad level, this is time-consuming and the demand for their services is high. Each of the CLPs talked about being extremely busy with supporting patients, who often have complex circumstances and are in contact in times of crisis. Whilst community organisation representatives recognised that this role may not be sustainable, they did not have particular suggestions for improving engagement without the case management support of the CLP; they felt that the complexity of the cases involved required this type of input. However, as discussed in the previous section, CLPs suggested that there were inherent problems with some referral processes, which could potentially be improved to alleviate the situation to some extent.

3.4.4 Individual rather than organisational relationships

CLPs and the majority of community organisation representatives clearly valued their collaborative relationships, however, both found it difficult to progress these individual relationships on to a more lasting collaboration between organisations i.e. independent of the specific individuals involved. CLPs frequently mentioned that links tended to be developed between themselves and one member of an organisation rather than necessarily the organisation as a whole.

> 'Sometimes you can have a really good relationship with an organisation, and then a worker leaves and it completely changes the dynamic. You know, you've built up a relationship with one person, you feel like you've a good sense of each other, each other's roles, and then somebody moves on and that's lost. And the nature of the third sector is that that's continuous often.' (CLP3)

Similarly, community organisation representatives felt that their relationship was not with the GP practice, but with the CLP situated in the practice. Although they did occasionally talk about better awareness of their service among GP practice staff, facilitated by the CLPs, community organisation representatives did not state, or allude to, having a collaborative relationship with the GP practice as a result of the Links Worker Programme that would continue if the CLP was no longer in post. This is not to say that the Programme did not facilitate contact between the two organisations, of which the potential benefits have already been covered, but raises questions for the sustainability of the Programme. The CLP was described as being the 'link', the 'connector', without which access routes would be closed.

> 'Our relationship didn't really exist before and now there is a relationship. I would still say that it is mostly going through the Link Worker, so there's still the need for the third party, but I don't think that's ever gonna change, just with the way that GP practices are structured. I think there would always need to be a Link Worker to be able to facilitate that relationship.' (CO1)

The necessity of the CLP to facilitate links between community organisations and GP practices was not necessarily viewed as a problem by participants (both groups); as long as the CLP was in place that two-way connection could exist.

3.4.5 Individual characteristics

Community organisation representatives talked a lot about how the effectiveness of CLPs, and by extension the Programme, was very much dependent on the individuals involved. Participants identified a number of traits that they thought CLPs needed to succeed in their role. Of particular importance was "attitude" towards the work and the sector in general e.g. having the appropriate motivation. One participant identified further qualifications as being a "third sector" mindset, and

suggested that if CLPs were employed within the NHS rather than third sector, that they might lose the mentality that made them so effective in engaging with organisations and patients.

> 'Because she's a third sector person working within a statutory environment with third sector values and she's building a bridge there. [...] The health board isn't her employer. I would think if the health board became the Link Worker employer it would be the very thing that you're saying – it would be 'How can we get all these people moved out as fast as possible?' Whereas the Alliance's ethos is about respect, self-management, putting people at the heart o' decision-making. So anyone that works for them, they're hard-wired in that direction so CLP6's hard-wired in that direction.' (CO21)

Organisational engagement was dependent on having a positive and adaptive approach, possibly required because of the wide diversity in the type of organisation that they had to engage with. Community organisation representatives felt that engaging with patients and with community organisations required friendliness, approachability, and the motivation to help people. In addition, skill set was also seen as vital to the CLP role, as suggested by CO12:

> 'I think you really kind of do need people who are kind of change evangelists but who also have got these skills of… high degree of communication skills, very persuasive, very influential, because they're not going to be drawing on a position of particular power so it's going to be all those influencing skills that they need. So I think the extent to which it's going to be realistic, it's probably going to be heavily dependent on recruitment.' (CO12)

This community organisation participant also highlighted the need for leadership abilities in developing new initiatives. "Change evangelist" here relates to the work that CLPs were identified as doing in changing attitudes in practices, but more so in convincing community organisations of the utility of their efforts e.g. that there were wider benefits to be had from building a relationship with the CLP, as sources of information, and as collaborators. As discussed, however, this was still to be realised amongst many of the larger organisations.

3.5   Analysis in relation to Programme Theory of change

In relating the data collected to the Links Worker Programme theory of change that was set out in the initial Programme documentation (**Error! Reference source not found.**), it is possible to gain perspective on whether there was any advancement towards the community-level outcomes. This section largely draws on the findings reported in previous sections as a way of summarising whether progress had been made.

Table 2: Short, medium, and long-term outcomes at the community level, of the Links Worker Programme, from initial Programme documentation (9)

Outcomes		
Short-term	**Medium-term**	**Long-term**
More and stronger practice-community relationships and exchange; referral pathways established between the general practice and community resources; increased patient referrals to community based resources; joint resolution of shared problems.	Impact on NHS services. Impact on local authority services Impact on scope and capacities of community resources to support people to live well Impact of programme ethos on community	Development of social capital

3.5.1 Short-term outcomes

As shown in an earlier section on CLPs facilitating community organisation presence in GP practices, the large majority of community organisations stated that prior to the Links Worker Programme they had no inroads with the GP practice whatsoever. The implementation of the Programme had provided the opportunity, through the CLPs, for two-way dialogue between community organisations and GP practices. It was clear that there was progress on practice-community relationships and exchange; however, as mentioned these were between the community organisation representatives and the individual CLPs rather than necessarily the GP practices as a whole.

Formal referral pathways from CLPs to community organisations were not necessarily established, but there appeared to be some progress of improved appropriateness of referrals via the CLP. However, referral pathways were still not sufficiently developed for them to function without the relationships between CLP and individuals within community organisations, owing to the development of individual rather than organisational relationships. It was not possible from this study to quantify whether there were increased numbers of referrals from GP practices to community-based resources.

Joint resolution of shared problems has been realised mainly in terms of collaboration on individual patients, as discussed in the advantages of collaborative working between CLP and community organisations section.

3.5.2   Medium-term outcomes

The findings suggest that it may be more difficult for the CLPs to develop links and collaborate with larger rather than smaller organisations. Such larger organisations were often providers of NHS or local authority services. Although all participants were generally positive about the potential for the Programme to impact on services, through improved referrals and case collaboration, there appeared to be more challenges to working towards these outcomes with larger organisations. For example, bureaucratic [processes and organisational attitude](#) were seen as particular barriers.

The qualitative evidence suggests that the Links Worker Programme has been able to, though to a limited extent, impact on the scope and capacity of some community resources to support people to live well. For example, there was suggestion from a couple of organisations that they were being supported by the CLP to develop their capacity through funding applications and shared events. However, most were unaware of this possibility.

There was optimism from many of the community organisation representatives that the Programme would impact positively on the community for those who were most in need of support e.g. by being at the centre of a network of support, identifying and connecting all available assets to support vulnerable people. Some community organisation representatives did consider more broadly how the Programme ethos could potentially impact upon the community as a whole, rather than just for the most vulnerable individuals.

> 'It's not just concerned with making connections, it's concerned with…
> with a variety of different issues and questions around, around the patient
> and around the community, I suppose. Around building personal, personal
> resilience, community resilience in different ways. It's… It's a sort of multi-
> faceted, multi-stranded kind of approach at building, building resilience,
> identifying assets, connecting people with their own, their own sources of
> strength with sources of strength from within the community. And working
> in whatever way they can. I think it's quite loose in the sense that they can
> work out what works best in their own setting, to… to build community
> strength and confidence, and so on.' (CO2)

Although positive, these were early thoughts only mentioned by a minority of community organisations about what the Programme could achieve rather than examples of actual change.

3.5.3   Long-term outcome

The long-term outcome of the Links Worker Programme, as stated in the original programme documentation, at the community-level, was an increase in social capital. It is not possible to assess from this research whether patients experienced

an increase in social capital. The main evaluation of the Links Worker Programme will provide some qualitative analysis of this, drawing on interviews with patients. However, it is clear from the findings presented that the CLP can be seen as a 'boundary spanner', which has been described as a strategic brokering role that involves connecting two or more systems with partially conflicting goals or expectations (10, 11). Previous research has hypothesised that in deprived areas this type of 'bridging' social capital is the key to health improvement as it is what allows people to access resources outside of their immediate environment (12). However, the potential for increased social capital for patients associated with the Links Worker Programme may be limited to their association with the CLP, rather than necessarily their own increased social capital. Nonetheless, being part of a "well-connected society" is thought to be beneficial for individuals as they may reap some of the benefits of living in the area, possibly even when they are poorly connected themselves (13). Whether the areas are becoming more 'well-connected' remains to be seen, and given that the findings highlighted that relationships tended to be on an individual rather than organisational level, there are perhaps limitations to the area being better connected overall.

4   Discussion

This report has explored the perspective of those who represent community organisations who receive referrals from CLPs and the CLPs themselves. It has uncovered issues relevant to developing intersectoral working between primary care and local community resources to achieve public health goals.

There were some methodological limitations to the research presented. One of the main reasons given by CLPs for some relationships being more challenging to establish was a lack of an available named contact and general difficulty of being able to approach individuals within community organisations. For the same reasons it was extremely difficult for the research team to recruit participants from these organisations that CLPs were not able to provide named contacts for. However, in the main the CLPs talked about challenging issues rather than challenging organisations overall. Therefore it was possible to recruit participants who, although had some relationship with the CLP also had experienced challenges in building this collaboration. These challenges could therefore be explored. It is possible that because of the way that the community organisations were recruited to the study that the views on collaboration with the CLPs were more positive than they would have been if community organisation representatives were identified without the input of the CLP.

Overall, the general idea behind the Links Worker Programme and the model of social prescribing has been viewed positively by community organisations. However, a minority were unsure about whether it works in practice. Community organisation representatives were enthusiastic where they had experienced a change in the level of contact that they had with GP practices because of the relationship that they had with the CLP. They also appreciated that CLPs were able to put time and effort into supporting individual patients, often feeling that they were best-placed to manage the variety of services with which patients were engaged. There was some indication that the outcomes set out in the Programme Theory of Change were being progressed towards, however as discussed, there remain questions about whether all are realistic in context.

The Initial Links Worker Programme planning did not set out exact details of what the CLP role would entail, but stated the main aspects were "providing one-to-one community oriented support for individuals as well as the primary care team development aspect of engendering a links approach"; it was expected that the CLP "roles were there to be shaped somewhat by each successful candidate" (14). The Programme management team drew upon previous social prescribing projects and found much variation in the links worker roles. It was therefore an informed, but iterative process to the development of the role. It is not clear whether the Programme management expected there to be as in-depth case management as is currently being delivered by CLPs and as community organisation representatives

perceive the CLP role. From this study it appeared that CLPs did not expect to be spending quite as much time case managing, but saw it as necessary, and that community organisation representatives valued this aspect of the role. Other than the issue of time commitment by the CLPs, another concern about the case management role of the CLP is that it could lead to patients becoming reliant on the CLP, rather than the Programme supporting them to better manage independently. This issue will be further explored in the main evaluation, particularly in qualitative interviews with patients.

A dominant theme within the data was the Links Worker Programme in the context of austerity; many of the community organisation and CLP participants highlighted this as an important consideration when thinking about the Programme's success. There were two reasons for this: participants were positive about the timing and need for the Programme because their clients were facing increased strain (for example because of changes in benefit allowances) and required extra support as a result of austerity; and funding pressures brought about by austerity measures led to some anxieties about community organisation capacity to support such need. This can be thought of as a 'perfect storm'; whereby the combination of circumstances exacerbates the situation further.

Although community organisations were not necessarily concerned about the increase in referrals they may receive from the Links Worker Programme, they also did express that they were frequently only able to respond to crisis situations rather than provide the ongoing support that many patients required. Some were positive about the increase in referrals as it could lead to better chances of securing further funding, however this seemed rather at odds with their own discussion of the increasingly restricted funding opportunities. This strategy is potentially risky within the aforementioned context of austerity and funding cuts, and is likely to be a challenge to the Links Worker Programme overall, as CLPs found that reduced community organisation capacity made collaboration difficult. Other examples show that where community organisations receive extra referrals because they provide a good service, it is not necessarily matched with extra funding (15). In the context of austerity, such additional resources are not particularly stable. The danger of community organisations taking on extra referrals in the hope of being able to secure funding is that they will not necessarily be able to appropriately support the patients that they take on, putting patients at risk of being passed from one service to another that does not support them. If community organisations cannot accommodate the increased level of referral from CLPs, bearing in mind that there are currently only seven practices engaged in the Programme, then the CLPs will be left to absorb the workload that GPs pass on. It appears that CLPs are already doing a significant amount of work with each patient, often acting as case manager, but for the Programme to work they need to be able to rely on the support of other organisations as well.

As in other social prescribing studies, the presence of an individual to make links was 'pivotal' to the success of the Programme (5); this study highlighted that with a change in personnel (CLP or within organisations) the links would likely have to be completely rebuilt. Rather than organisational links being developed by the Programme, it was clear that strong individual links were being fostered. Such links were largely appreciated on both sides, and there were clear advantages to the collaborative working that ensued. However, there were particular challenges for CLPs developing links with larger organisations.

As mentioned, as well as linking primary care and community resources, another aim of the CLP role is to support GP practices to become more community oriented. Some of the community organisation representatives discussed that they had been invited into GP practices to introduce themselves to GPs and other primary care staff to raise awareness. However, the community organisation representatives did not go into much detail on the extent to which they felt that GPs were becoming more community orientated, beyond the existence of the CLPs in the practices. However, this should not lead to the conclusion that GP practices are not becoming more community orientated; these participants do not necessarily have contact with the GP practices to know if the practice culture has changed, and this is not an indication that it has not. For example, GPs may be more aware of community resources and more positive about the support that they can provide, but still only refer to the CLP as the best person to decide where to link patients, in which case community organisation representatives would still not have direct contact with GPs. Community organisation representatives were positive about the possibility of the CLPs and the Links Worker Programme integrating, to some extent, primary care and community resources. Additionally, the interviews with CLPs did not ask about what work they were doing to change practice culture; this is part of the main evaluation research and will be reported separately.

There were differences in opinion of the Links Worker Programme between participants from large and small community organisations, which were reflected in how the CLPs viewed their ability to develop relationships with these different organisations. More work is required to get these larger organisations on board, as they are a big part of the support network available. For organisational links to develop it is possible that dialogue is required at the management level in each organisation as well as at the frontline/CLP level. These organisations have necessary processes in place for referral and collaboration that do not appear to be easily bypassed, and it is likely to take time and effort to cultivate lasting working relationships. Further effort from Programme management to engage with management of such organisations, at city-wide level, would perhaps be more fruitful than the time that CLPs would require to engage with frontline staff from these services.

5 Conclusions

The qualitative study set out in this report has shown that the aim for CLPs to have a community orientated role and support links between GP practice and the community is being achieved to some extent; however, some challenges related to the sustainability of the model remain. Collaboration between primary care and community is being facilitated by CLPs, and it is clear that community organisation representatives largely value the case management need that is being somewhat filled by CLPs. Challenges that remain are relevant to the funding climate, especially in the current context of austerity; but also the ability of individuals to develop lasting links between organisations, particularly larger organisations; and the capacity, in terms of time and resource, of the CLPs to continue to intensely manage such complex cases.

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7 Appendix 1: Topic Guide: Community Links Practitioners

1) **Understanding of what is easy and what is "challenging" in the context of organisation**

   What did you understand initially when we asked you to identify organisations that were easy to deal with?

2) **Challenges in more detail**

   What are some of the common challenges you come across working with the various organisations that you do?

   Are there any patterns by organisation type? Size?
   (Prompts: Size of organisations, Type or organisation, culture of organisation, particular individuals (e.g. charismatic leaders or sceptical individuals))

   What are the aspects or processes you consider to be challenging over all the organisations you deal with?
   (Prompts: Organisational aspects as described above? Processes of referral? Cultural issues?)

   What are the outcomes of dealing with a "challenging" organisation?
   (Prompts: For patients? For CLPs? Referral pathway?)

   How does meeting a challenge in an organisation change your approach to that organisation? Would you try to use the organisation again? Is there enough choice to approach alternative organisations with similar remits?

   Are there particular patients issues that have you have experienced creating challenges in engaging with other organisations (Prompts: Mental Health, Physical health?)

3) **Nature of relationships with specifically identified challenging organisations**
   Please describe the organisation in a bit more depth?
   (Prompts: funding, size, remit, inter-connection with other organisations, level of establishment)

   Who is it that you deal with regularly? Are there multiple individuals?

   What is the nature of the challenge that you have with these particular organisations?

   Why do you think that this challenge arises?

   What could be done to make this relationship less challenging?

8   Appendix 2: Topic Guide: Community organisation representatives

1) Awareness of the intervention and views on what can be achieved from it.

How did you find out about the link workers project?

What involvement have you had with the programme so far?

Do you or others in your organisations know any of the LWs and have dialogue with them? E.g. would they call you to talk about issues that they are having or referrals that they are making?

What do you think the Link Worker Programme can achieve for clients? (And, probe on what it doesn't achieve)

What do you think the Link Worker Programme can achieve for your organisation? (And, probe on what it doesn't achieve) (mutual support?)

Discussion of the aims of the Link Worker Programme and whether the participant feels they are realistic in context.

What do you think the Link Worker Programme can achieve for primary care? (And, probe on what it doesn't achieve) -> probe on austerity

Do you think LWP can address health inequalities? Broader determinants of inequality framework?

2) Relationships between primary care and community services.

Do you feel as though you can work together; are you working together to achieve a mutual aim?

Prior to the LW pilot did you feel as though you had any relationship with the GP practice? Has your relationship with the GP practice changed at all since the introduction of the Link Worker?

3) Relationship with Link Worker and referral process

How do link workers make referrals? Is there a process/protocol (for the CO)? Does it work?

When it's working well, smooth referrals etc., why do you think that is?

When it doesn't work, why do you think that is?

(context, participant issues and variability, capacity etc.)

What would be the ideal collaboration? What do you hope to achieve with this collaboration?

4) Appropriateness of referrals & ability to support Link Worker referrals

Do you find that your service is appropriate for the people who are referred by Link Workers?

Do the issues that participants have match the expertise of the organisation? Do you/organisation feel able to support people referred by LWs and make a meaningful contribution

Is this in a way that GPs cannot?

[Is there an issue with getting referrals from LWs for the most difficult cases e.g. the hardest to help (in order to move them round services and essentially get rid of the difficult work?)]

5) Capacity

Do you, within your organisation, have the capacity to support those who are referred?

I.e. do you have the resource/time for extra referrals (or were you already at capacity prior to the LW pilot)?

Has the relationship with the LW helped you to secure any additional funding or move towards this?

6) Working with other health and social care services.

Do community organisations feel able to refer to the health service i.e. local health centre or GP practice, when they recognise a need to do so, and do they have working links with such services?

[Is there a problem with thinking of community organisations as a substitution for health services in supporting these patients? Similar to the integration of health and social care—integrated community support may be necessary, but is there a danger that it will be treated as a substitution for medical care? COs don't necessarily have training in MH issues, although may be able to provide support for some of the issues that are related to MH e.g. unemployment, money etc.?]

8) Sustainability

Sustainability of the relationship with Link Worker

Sustainability of the organisation

Sustainability of the link worker programme.