Public Health Scotland

Learning from the community link worker early adopters

July 2020

Contents

Acknowledgements

We would like to thank the participants who took the time to contribute to this fieldwork and shared an honest account of their experiences to help others.

We would also like to thank the early adopter sites and NHS Health Scotland (now part of Public Health Scotland) colleagues who provided practical support to set up and facilitate the fieldwork.

Glossary

ALISS — A Local Information System for Scotland – service directory

DOCMAN — A document management system used in general practice

EMIS — Clinical IT system used in some general practices in Scotland

EMIS Web — Version of EMIS that provides remote access to patient records

GP Cluster — A professional grouping of typically between five and eight general practices which enables peer-led quality improvement activity within and across practices and supports their contribution to the oversight and development of their local healthcare system

OneNote — A digital notebook

Read codes — Coded thesaurus of clinical terms that practices use to manage the data in patients' records

SPIRE — The Scottish Primary Care Information Resource is a service which allows information to be requested from GP practice records and collected centrally to produce statistics for Scotland as a whole

SWIFT — A social work management information system

Vision — Clinical IT system used in some general practices in Scotland

Vision Anywhere — Version of Vision that provides remote access to patient records

WhatsApp — A mobile messaging application which can support group conversations

Executive summary

Introduction

In 2016, the Scottish Government made a manifesto commitment to recruit up to 250 community link workers (CLWs) to work in GP surgeries in Scotland's most deprived communities. Following this commitment the Scottish Government funded five early adopter (EA) sites in 2017. These EAs in Dundee, Glasgow, Inverclyde, Edinburgh and North Ayrshire were funded to sustain and develop their existing CLW programmes. The overarching aims of the EA CLW Programmes at the outset included supporting people to live well through strengthening connections between community resources and primary care, and for CLWs to become members of the wider general practice multi-disciplinary team where appropriate.

CLWs became one of six priority areas within the 2018 General Medical Services (GMS) contract, where they are described as:

> 'A non-clinical practitioner based in or aligned to a GP practice or cluster who works directly with patients to help them navigate and engage with wider services. They often serve a socio-economically deprived community or assist patients who need support because of, for example, the complexity of their conditions.'

What is the study about?

The primary aim of this study is to contribute to an understanding of the implementation and delivery of link working in the EA sites and to capture this learning to help inform ongoing delivery and potential wider roll-out of this and other similar models of care and support.

What we did

Qualitative interviews and focus groups were carried out with 51 participants in total between February and July 2019. They were from a range of roles including CLWs, CLW service managers, GPs and general practice staff, Health and Social Care Partnership (HSCP) managers, and support staff from across the five EA areas.

These discussions were audio-recorded, transcribed and analysed thematically using NVivo qualitative data management software.

The qualitative approach enabled in-depth discussions with participants to understand their perspectives of working within the EA programmes. Participants were asked about their experiences in implementing and delivering CLW programmes, perspectives on different models of delivery, and any barriers and facilitators to delivering a CLW programme.

What we found

The EA areas had developed a core programme of work in general practice settings that they had been delivering for a number of years, and CLWs were allocated to one or more practices. Shifts in funding and governance arrangements following the introduction of the new GMS contract had created challenging circumstances for the EAs with some describing substantial pieces of work for both HSCPs and CLW services around new commissioning requirements. Those affected felt there had been a lack of communication about the changes from Scottish Government and local commissioners, creating uncertainty for staff about job security and continuity of service for practices. When funding for the CLW programmes shifted to being distributed on an NHS Scotland Resource Allocation Committee (NRAC) basis, this also created challenges and uncertainties locally about how funding would be prioritised for primary care services.

A variety of service models have developed across the EAs to reflect local needs and service arrangements. Participants in some areas expressed concerns that pressures to deliver CLW services in additional practices as a requirement of Primary Care Improvement Plans would put pressure on the capacity of the existing CLW teams and may lead to a reduction in service quality without additional CLW resources being funded. There were also mixed views on how resources should be allocated to support local population needs, in particular in relation to deprivation.

Participants described the importance of the CLWs non-clinical role, supporting patients with complex social and health needs. The CLWs in the EAs provide support to patients across a range of needs from early intervention to crisis

situations. These CLWs' work ranges from signposting patients to additional support to supporting complex case management.

CLWs within the EAs came from a wide range of backgrounds and sectors, something that participants described as being beneficial to the team. Having a community development background was seen as a particularly useful attribute for CLWs and participants felt that CLWs have a good understanding of and connection with community and third sector organisations. Participants highlighted the need to agree boundaries of the CLW role to ensure they have dedicated time to focus on social issues. They felt that the length of time that CLWs had to spend with an individual helped create space for them to open up about what was important to them and ensured that they could be linked appropriately to the services they needed. It was also clear from participants that it is important for CLWs to be seen as full members of the multi-disciplinary team in each practice. This ensures their role is seen as being on a par with others and means that patients are more likely to be treated in a holistic fashion.

Participants felt that GP practice development activities had led to more appropriate referrals to CLWs. GP and practice team buy-in to the CLW programme relies on practices understanding the role of the CLW and the difference it could make to patients. Facilitators to delivering a CLW programme included:

- having a lead GP with responsibility for the service

- good relationships with practice managers and reception staff

- CLWs shadowing members of the practice team to understand their roles

- a CLW being attached to a practice full-time, something that is not always possible due to CLW resource in an area, or indeed appropriate for local need.

Further enablers of practice buy-in included the practice readiness for change, a supportive practice manager and the practice team having confidence in the sustainability of the service. Participants agreed the importance of all stakeholders investing time upfront to agree how the service will be implemented and delivered at a practice level, thereby managing expectations and having a shared understanding of the programme.

Participants identified a number of challenges to delivering a CLW programme. The availability of community and statutory services is a key issue for the implementation and sustainability of CLW programmes and highlights the importance of ensuring local services are available and resourced, particularly within the context of austerity. Where services were not immediately available for CLWs to link people to, either because they had waiting lists or did not exist within that area, CLWs often found themselves filling a gap in service provision to ensure individuals got the support they needed. The CLW role cannot be seen in isolation and the sustainability and potential for a CLW programme to succeed will be dependent on the availability of sufficiently resourced services and support to refer patients to in the local area.

There was some indication from participants that CLWs are helping to release GP time. However, it was not within the scope of this study to evaluate any related evidence from GP data sources. It is also important to note that there are other important measures for understanding the value of a CLW programme and it will be crucial to ensure this type of data is interpreted within the local context and to understand how patients and the whole multi-disciplinary team (MDT) is impacted. Challenges relating to how CLW programmes can demonstrate impact included extracting data from GP systems, and being able to complement this with qualitative stories that describe patients' experiences of the CLW services. A minimum core dataset being collected by the EAs will provide some quantitative data about those individuals who have engaged with the EA programmes, the reasons for referral into the programmes and the types of support they receive.

What are the key learning points?

There were a number of core components that participants believed were necessary for a successful CLW programme. These were:

Delivery of the CLW service

- A team of social practitioners with mixed backgrounds and experience of working in different sectors
- CLWs being physically based in a general practice for most of the week

- Dedicated time for patient-facing, practice-based and community-based activities

Supporting the CLW role in a general practice setting

- A shared understanding of the programme by HSCPs, GP practice teams, CLW teams and community organisations

- General practice buy-in to the CLW programme

- CLWs being integrated members of a primary care team

- Good relationships between CLWs, primary care teams and community-based organisations

- Clear arrangements for line management of the CLW team and 1:1 support

- Regular peer support opportunities for CLWs

- Clear lines of clinical supervision

Practical resources for the CLW

- Up-to-date knowledge of community services

- Regular CLW team time for peer support and to share knowledge and resources

- Minimum training requirements, in particular in mental health

- Access to Practice IT systems

Sustainability of a CLW service

- Clarity of CLW role with defined boundaries

- CLWs have sufficient capacity to meet the needs of their practice population

- Availability of community and statutory services to link patients to

Supporting CLW programmes across Scotland

- Availability of networking and learning opportunities for CLW (and similar) programmes

- Clarity on funding lines and timely commissioning processes

- National agreement over the key components of community link working

Conclusion

This study aimed to contribute to an understanding of the implementation and delivery of link working in five EA sites in Scotland. The views and experiences of participants have provided learning about the design and implementation of CLW programmes in the context of the new GMS contract. The study highlights a number of findings which can be used by other CLW programmes, and may be transferable to the implementation of other priority areas within local Primary Care Improvement Plans. This includes the need for clarity of roles, the enablers of multi-disciplinary team working, and some of the practical challenges relating to available space, IT, and monitoring and evaluation.

1. Introduction

In 2016, the Scottish Government made a manifesto commitment to 'recruit up to 250 community link workers to work in GP surgeries in Scotland's most deprived communities'.[1,2]

Following this, in 2017, the Scottish Government funded five early adopter (EA) sites as part of a National Scottish Government Community Link Worker Programme to sustain and develop their existing CLW programmes: Dundee, Glasgow, Inverclyde, Edinburgh and North Ayrshire.[i]

The overarching aims of the EA community link worker (CLW) programmes at the outset included supporting people to live well through strengthening connections between community resources and primary care, and for CLWs to become members of the wider general practice multi-disciplinary team where appropriate. At that time there was also a focus on supporting GP practice teams working with individuals and communities who experience socio-economic deprivation. However, national shifts in how the programme was funded and delivered resulted in some local changes to these initial aims.

Community link working was later formalised as a key priority area in the Memorandum of Understanding (MoU)[3] of the General Medical Services (GMS) contract in 2018, and the responsibility for funding and delivery shifted away from a national programme. The CLW programmes are now a local responsibility within Health and Social Care Partnerships (HSCPs) to be delivered as part of their Primary Care Improvement Plans:

> 'The roles of the CLWs will be consistent with assessed local need and priorities and function as part of the local models of care and support.'

Some of the EA models of service delivery were developed and implemented to be based within general practices. Others have evolved over time from a more

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[i] The EAs had been running a CLW-type service for between 1.5 and 8 years (average 4.5 years) at the time of this fieldwork

community-based service to the current model which is embedded within primary care.

This study was undertaken to capture learning about the implementation and delivery of community link working in five EA sites within this changing policy landscape. This is intended to develop an understanding of the impact of shifts in policy and funding as well as identifying key lessons which can inform existing and future development of the EAs and other similar models of service delivery.

All of the EA sites have also been involved in the development of a minimum core dataset (MCD) [4] which is currently being piloted to help provide standardised data across the CLW EA sites.

This study is one of a portfolio of studies which will contribute to the delivery of the Scottish Government's ten-year National Monitoring and Evaluation Strategy for Primary Care Reform.[5]

2.   What is a community link worker?

Community link workers (CLWs) are described in the 2018 GMS Contract in Scotland[6] as:

> 'A non-clinical practitioner based in or aligned to a GP practice or cluster[ii] who works directly with patients to help them navigate and engage with wider services. They often serve a socio-economically deprived community or assist patients who need support because of, for example, the complexity of their conditions.'

[ii] GP clusters were introduced in Scotland with the 2016/17 GMS agreement. Each GP practice will have a practice quality lead who will engage in a local GP cluster. Each GP cluster will have a GP designated as a cluster quality lead with a coordinating role. GP clusters are expected to have direct involvement and influence in improving the quality of all health and social care services provided to patients registered within their locality. (Available at: www.sehd.scot.nhs.uk/pca/PCA2016(M)07.pdf)

The CLWs in some areas are known, or have previously been known, by other names such as community connectors, link workers, community links practitioners and health and wellbeing practitioners. In this paper, all are referred to as CLWs.

In order to understand how to evaluate the EAs, a theory of change (ToC) was developed.[7] A theory of change explains how and why an intervention works and shows the plausible links between its activities and outcomes. It also takes into account the context in which initiatives work. The ToC informed the development of relevant evaluation questions that were prioritised in discussion with the EA teams and Scottish Government. Some of the evaluation questions identified as priorities will be answered through the MCD data analysis. The current study was designed to provide important qualitative and contextual data to add to the understanding of developing and delivering CLW programmes.

3. Aims and objectives

The primary aim of this study is to contribute to an understanding of the implementation and delivery of link working in the EA sites and to capture this learning to help inform ongoing delivery and potential wider roll-out of this and other similar models of care and support.

The main objectives of the study are to understand:

- the experiences of CLW programme teams in implementing and delivering the programmes within a shifting political and service landscape

- CLW team perspectives on the potential impact of different models of delivery on reach, referrals and how well integrated the community link worker becomes within a GP practice

- the extent to which wider service capacity might be a barrier to a programme's success and sustainability

- the barriers and facilitators to delivering a CLW programme

- what other areas can learn from current experience.

4. Methods

Qualitative fieldwork was undertaken by the evaluation team at NHS Health Scotland (now part of Public Health Scotland) between February and July 2019. Eleven interviews (face-to-face or phone) and seven focus groups (of between 4 and 12 participants) took place with a total of 51 participants representing a range of roles and length of experience from across all five EA areas.

Key contacts (usually CLW managers) in each EA area helped to set up focus groups with CLWs and sought permission to share the contact details of additional potential participants so that researchers could send them an information sheet and consent form and organise interviews directly. Key contacts were asked to recommend participants from a range of roles, including team and service management, support staff, and GPs, who had been involved in the EA programme.

In order to avoid identifying individuals, participants have been grouped by their roles. Table 1 shows the number of participants that took part in the study across the five EA areas.

Table 1: Participant numbers and roles

Role type	Total number of participants	Number of EA areas represented
Community link workers, CLW team leaders or CLW managers	38	5
General practitioners or practice managers	4	3
Wider management roles, e.g. primary care, health improvement, inequalities, third sector interface	5	5
Support staff, e.g. locally based data and/or evaluation support, national programme facilitator	4	5

The fieldwork was carried out using a semi-structured topic guide (see Appendix 1), which allowed flexibility to explore emergent areas with participants and tailor questions towards specific roles, while maintaining an overall consistency in questions between sites. Each interview and focus group was audio recorded. Data were transcribed verbatim by a private transcription service who had signed a confidentiality agreement with NHS Health Scotland. The returned transcript was quality checked for accuracy and anonymised, and entered into NVivo qualitative data management software. The data were analysed thematically by two researchers and codes were cross-checked for accuracy. The research objectives and topic guide were used to draw out themes from the data and additional themes that emerged during discussions were also included.

In line with Neale and West's recommendation for presenting qualitative data,[8] the research team have avoided quantifying the findings except in a small number of cases where it was important to do so.

Where appropriate, the report highlights whether a topic came up spontaneously or as a result of direct questioning. In order to encourage honest responses, participants' anonymity was guaranteed. For this reason, none of the views presented will be attributed to individuals, EA areas or professional roles if this makes them identifiable.

The study protocol received a favourable opinion from the NHS Health Scotland Research Development Group (RDG).[iii]

To maintain confidentiality of the participants, all quotes presented in the following sections are labelled by interview number or focus group number. For example, focus group 1 is noted as [FG1].

[iii] The RDG provides research ethics guidance and approval for studies that do not require approval from an external research ethics committee.

5. Findings

The following sections present the findings from the analysis of the focus group and interview data:

- An evolving programme of work

- Who CLWs are, what they do and how they do it

- Building an understanding of the CLW role and awareness of the CLW service

- Setting up a CLW service

- Reach of the service

- Benefits of the CLW programmes

- Additional challenges for community link working programmes

A number of the findings are relevant to multiple sections, and are cross-referenced in the text where appropriate.

While most EAs had developed a core programme of work in general practice settings, some were also implementing tests of change to explore the potential contribution of a CLW in other settings, e.g. emergency departments, or for specific conditions, e.g. dementia, or cancer through the Transforming Cancer After Treatment service.

In all EA areas, CLWs were allocated to practices. In addition, some EAs were exploring thematic posts covering a whole HSCP area, e.g. youth health, asylum seekers and community justice.

The findings presented in the following sections focus on the core services being delivered in general practices only.

5.1 An evolving programme of work

During discussions, participants were asked about changes in policy, service delivery and funding shifts and whether they perceived that this had influenced the delivery of their CLW programme in any way. The EAs have already been delivering

CLW-type services locally for a number of a years and had been impacted by the introduction of the new GMS contract.

Participants were asked if and how they felt the new GMS contract had impacted on CLW programmes. When the new GMS contract was agreed it meant that local funding and governance arrangements for CLW programmes shifted from Scottish Government to HSCPs. Some existing service providers had to reapply to deliver CLW services in order to meet the legal commissioning requirements for the HSCPs. This was described as a substantial piece of work for both the commissioners and those who had to apply or reapply for their contracts due to the short-timeframe and scale of the work involved.

Existing providers of CLWs who were affected by the tendering process felt that there had been a lack of communication about the changes from Scottish Government and local commissioners, which created uncertainty for staff about job security and continuity of service for practices. As the timescales were challenging and the process was new to HSCPs and Clusters, participants reflected that one of the main pieces of learning was to start the commissioning process earlier in future if this is feasible due to funding timeframes and governance requirements.

The Community Link Worker Programme is funded as one of six priority services set out in the GMS Contract MoU. Funding for these services comes from the Primary Care Improvement Fund (PCIF), which is distributed on an NHS Scotland Resource Allocation Committee (NRAC) basis. Community Links Workers are allocated in accordance with the MoU, which states that CLWs are allocated based on local need and priorities. However, it is expected that the first priority for allocation will be more deprived areas. Some participants felt that this created a complicated landscape for managers to work in within the broader local primary care structures where decisions relating to funding and service priorities are being made at a strategic level:

> 'No, well it's determined at [area] level […] And this is a tiny part of a massive agenda. And just the whole juggling of priorities. So people obviously, they want to get the most out of their money, they want to do the best they can with the money, they want the biggest impact. […] So, working out how you juggle, and therefore, the resource that goes

alongside each of these things, is challenging, and the phasing of it. So it's just a very messy, cluttered, complicated landscape, but it's not because anybody is being obstructive or difficult, it's just, it's complicated.' [I3]

There had been an understanding among CLW managers that there was going to be dedicated CLW funding for the EA programmes until 2020, although shifts in governance and funding arrangements had led to some uncertainty. However, some services had already employed staff on permanent contracts to deliver the service prior to its inclusion in the GMS contract. Participants described how this created tensions with Local Medical Committees and GP Sub-Committees who were reluctant to use the PCIF to fund pre-existing projects and meant that existing CLW team resources were being stretched to meet additional demand within limited budgets.

Some participants also raised concerns that other priority areas of the Memorandum of Understanding (e.g. pharmacotherapy and advanced practitioners such as musculoskeletal physiotherapists) were seen as 'quick wins' for GPs and so funding would be prioritised for them and diverted away from CLW programmes.

How early adopter areas are implementing community link workers

As the EA programmes were locally determined, they had all developed slightly different models of service delivery, some of which had evolved over time. This included varying employment and contractual arrangements:

- NHS, council or third sector employment contracts

- Differences in terms and conditions between sites, e.g. pay

- Mixture of permanent and temporary contracts

- Honorary contracts and service level agreements between CLW and practices

In two of the EA areas, multiple organisations held CLW contracts. Where there were different service providers in an area, the commissioning organisation (whether that was a third sector interface or HSCP) aimed to have an overarching consistent approach to CLW recruitment and service delivery. This was felt to be challenging as

differences in organisational philosophies and culture meant that there were 'nuanced' differences in how each organisation worked.

In general, broad job descriptions were set by the commissioning organisation which had sufficient flexibility to be operationalised at a practice level to meet local population needs.

In one EA, the CLW contract was awarded at GP Cluster level rather than at a HSCP level, as it was decided that it could disadvantage smaller providers who may not have had the capacity and infrastructure to provide the service at scale.

Participants in some areas expressed concerns that pressures to deliver CLW services in additional practices as a requirement of Primary Care Improvement Plans would put pressure on the capacity of the existing CLW teams and may lead to a reduction in service quality without additional CLW resources being funded.

As there is currently no standard method or tool for estimating the number of CLWs required to meet population need, HSCPs reported allocating CLW resource using a range of different measures, including practice population size.

Participants in management roles reflected that it has been challenging to decide how to allocate CLWs when there was so much need for support within their practice populations and insufficient resource. Some felt that the decision should be made on the basis of Scottish Index of Multiple Deprivation (SIMD), whereas others felt that there needed to be a more sensitive measure to identify pockets of deprivation, or that every practice should have access to a CLW.

An additional challenge identified by participants was whether to restrict CLWs to a target group within a very mixed practice population and the practical difficulties of identifying eligible patients and targeting specific groups of patients within a universal service:

> '…I'm anticipating that, in some areas, there may be a bit of reticence to do it, because people think it's intrusive and we can't ask these things. There might be the bit of, well it's an open service, therefore anybody can use it. And so, there is this tension about, it's a, you know, because general practice, it's an open service for anybody, therefore this

programme should follow that. Which I don't disagree with, but I still think you need to stop and have a think about, well who might…be missing, who might benefit.' [I3]

5.2 Who CLWs are, what they do, and how they do it

This section describes the characteristics of CLWs, the activities they undertake with patients, general practices and partner organisations, and the way they work across these different domains.

Who CLWs are

CLWs within the EAs came from a wide range of backgrounds and sectors (including mental health, justice, older people, children and young people, and the health, social care, third, and education sectors). Participants described the benefits of having team members with experience of working in different settings, in particular, primary care and community settings. Having a community development background was seen as a particularly useful attribute for both patient facing and community-based activities.

The person specification used in recruitment was acknowledged by participants as a contributory factor in creating diverse CLW teams:

‘So they're a very mixed team that, you know, [we] deliberately made sure that, you know, we cast the net wide in terms of the type of person who would qualify to apply for this post, so that's been beneficial.' [I4]

Participants felt that this broad range of experience within CLW teams was beneficial as it reflected the cross-cutting nature of the CLW role. They reported how it has meant that within the CLW teams they were able to draw on each other's areas of expertise and networks and it helped them to navigate different sectors and access the most appropriate support for the person they were working with. The following quote illustrates the importance of regular team meetings in facilitating this knowledge exchange (see also Section 5.2):

'So, we have that coming together every week to be able to talk, and I genuinely do believe, I mean, if I didn't have this opportunity to sit with everybody, and have everybody's knowledge base to be able to go to, I'd feel as though I'd lost my right arm. Because I wouldn't know what to do.' [FG2]

What CLWs do

There were three common domains of CLW activities across the EA areas:

- patient facing activities – direct activities with and support for patients

- general practice development activities – raising awareness of the role and community services

- community-based activities - developing an understanding of, and relationships with community and third sector services.

However, the activities CLWs did in each of these domains varied at a number of levels: by HSCP, general practice, individual CLWs, and even from week to week. The following sections describe the similarities and differences in the roles CLWs perform in each of the domains and the factors influencing the different models of delivery.

There was agreement at a HSCP and management level that while the programme needed to have some consistent elements within EA areas, it was important that the CLW role was sufficiently flexible to respond to local population and practice needs (see also Section 5.1).

The CLWs that took part in the study supported this view by explaining that there was no such thing as a 'typical week' as it depended so much on their caseload and the urgency of new referrals. In general, CLWs worked autonomously and managed their own diaries. While some had regular clinic times and tried to keep some time aside every week to maintain their 'links' with referral organisations in the community and third sector, and to do administration, they emphasised the need to keep their diaries flexible to accommodate patient-facing activities. Some CLWs described how

the differences in how and what they did could depend on their background, skills and preferred working style.

Patient facing activities

The type of patient facing support CLWs provided ranged from signposting to complex case management, with CLWs commonly having an initial person-centred conversation to identify an individual's non-medical and social needs and priorities, and agreeing a plan of action to meet those needs.

CLWs in all EA areas described helping people to navigate services across a continuum of need from early intervention to crisis. The overall length of time CLWs worked with someone varied by EA area. In some instances this was limited to a set number of appointments (e.g. four). In others, it depended on how much support an individual needed. Each EA area delivered their service in a way that aimed to support and enable people to find their own solutions rather than create a dependency on the CLW service.

There was agreement across participants in different roles that the length of time that CLWs had to spend with an individual helped create space for them to open up about what was important to them and ensured that they could be linked appropriately to the services they needed, which was more challenging to achieve in a 7-10 minute GP appointment.

> 'From simple things to organising a food parcel, to getting someone's central heating set, to sorting out all the benefits. So the patients, you see a huge change in them, by being able to take all these worries off their plates and that's something, as a doctor, you just don't have the opportunity to do that because we see so many patients. But the link worker has got 50-minute appointments, they can really get to the bottom of some of these issues and we see huge benefits to their physical health.' [I9]

Where services were not immediately available for CLWs to link people to, either because they had waiting lists or did not exist within that area, CLWs often found themselves filling a gap in service provision to ensure individuals got the support

they needed. This highlighted an issue of how sustainable this was for some CLW teams (see also Section 5.7).

Participants across the EAs expressed different opinions about the boundaries of the CLW role, with some believing that CLWs should only be working with people to identify their priorities and goals and then linking them into appropriate services, rather than providing services directly.

'And I suppose as a GP it's more signposting, but where the link worker comes in this is not a signposting role, this is a kind of a close relationship with a patient who struggles to navigate the system. And their responsibility is to help people gain access to community and third sector resources that would support them with their health and wellbeing.' [I10]

This participant went on to emphasise the importance of clarity around the role of the CLW within their local programme:

'If you're designing your link worker project you need to almost make sure that they're not a support worker and not a counsellor, that they [CLWs] are professionals that have patient-centred conversations and help to support people to access resources to help with their … non-medical resources for their health and wellbeing. So being clear what they're not is important.' [I10]

However, participants in other areas described that it was more widely accepted that CLWs would provide some practical help to patients as well as linking them in to more specialist support where required. Where specialist services were under strain and in particular, where demand was more immediate and individuals presented in crisis, for example in welfare-related situations, some participants believed there was a risk that CLWs were getting pulled into areas outside their expertise and without the necessary legal protections.

In some areas, CLWs supported people to fill in forms for Personal Independence Payments and Universal Credit applications and contacted a welfare rights adviser for information or advice if required. In other areas, CLWs wrote supporting letters and accompanied people to assessments to act as an advocate, for example, if they

had learning disabilities or mental health issues. Some people expressed concerns related to the lack of indemnity CLWs had if something went wrong. Others were worried about the potential damage to a CLW's relationship with their patients if their application was unsuccessful.

There was also a difference of opinion between and within EA areas about the appropriateness of CLWs conducting home visits, and not all EA areas offered them to patients. Some CLWs expressed that they felt this was a barrier to engaging with more vulnerable people who were less able to attend their practice for any reason. CLWs who had experience of home visits reported that doing a joint visit with a worker from another organisation such as the Fire Service, had benefits for both organisations (in relation to addressing safety concerns of lone-working), and the patient as they received more holistic support.

General practice development activities

General practice development activities were commonly reported to serve two main purposes: to raise awareness of the CLW role and increase practice staff awareness of community resources available in the practice area (see also Section 5.3). These activities varied at a practice level in a number of aspects including the formality, type and frequency of activity, and which practice staff were involved.

Participants described a mixture of formal and informal opportunities for practice development that were led by, or involved, CLWs. These included protected learning sessions, update meetings to share what the CLW had been working on, newsletters, a local information folder for practice staff, whole practice team visits to community organisations, and regular information stalls run by different community organisations within the practice for staff as well as patients.

It was felt that these activities contributed to increasing the appropriateness of referrals to CLWs and kept practice staff up to date with local service availability. Participants also felt that raising awareness and understanding of the service led to increased referrals from practice staff and, over time, self-referrals from patients. Additionally, increased awareness of community services reportedly gave GPs and practice staff more confidence to do simple signposting or social prescribing, which freed up CLW to support people with more complex social issues.

Community-based activities

Community-based activities were identified as a core component of link working in the EA sites and included: service mapping, building relationships with, and developing service directories of, statutory and Third Sector organisations. These activities were perceived to be important in developing an understanding of, and relationships with the community and third sector services available for patients within the local area (see also Section 5.3).

Participants conveyed the importance of CLWs regularly getting out and meeting community services so that they know they are recommending appropriate, quality services and support to their patients, and also to help these services understand the role of the CLW.

It was considered essential that CLWs have a good understanding of the services they linked to, regardless of whether they signposted or accompanied patients to them. Participants felt this improved the appropriateness of the onward referral and built trust and credibility with patients and local services.

CLWs described instances where they had given feedback to community organisations on how their service could be adapted to better meet the local populations' needs, for example by increasing the number of sessions they offered.

All EA areas highlighted the importance of service mapping activity as a key ingredient to delivering a CLW programme. This helped CLWs understand what services were available locally and build relationships with the organisations they were referring ('linking') to. The information was used on a daily basis by CLWs themselves when deciding who to link an individual to, as well as in the practice development and community-based activities outlined above.

Service mapping required regular updating to ensure the information was accurate. CLWs protected time to keep existing links 'alive' and build new links in a number of ways including:

- attending community events or network meetings

- following community groups on Facebook

- inviting guest speakers to their team meetings.

As CLW teams experience staff turnover and locally available services can change over time, it was considered essential to have links between agencies and not individual workers to ensure greater sustainability of the CLW programmes. All CLW teams collated information in some form of resource folder and/or service directory. Examples of these included a physical folder and/or an electronic shared folder or resource such as OneNote, A Local Information System for Scotland (ALISS) or a local equivalent. They also shared their service mapping activity with other CLWs in team meetings, for instance through a 'who did you meet this week' standing agenda item. Information was also commonly shared via a CLW team 'WhatsApp' group.

Every EA area gave examples of similar initiatives to CLWs operating in their local area. These also ranged from simple signposting services to intensive case management, and targeted different population groups based on their demographics (e.g. age, ethnicity), condition (e.g. cancer), or addressed specific needs (e.g. housing, physical activity, welfare). Some EAs had attempted to map CLW-type services with a similar remit in their area to identify where they could collaborate and add value to each other's work rather than duplicating effort. From the perspective of the CLW teams there was sufficient need and demand for non-medical and social support for individuals to require the capacity of these different services within areas. However, from a general practice perspective, the cluttered and often changing landscape of CLWs and other similar services meant it was hard for them to keep up with the role and boundaries of these different providers. This underlined the importance of having clear boundaries around the CLW role and supporting practice staff to understand what it can offer. This view from EA teams further highlights the issues relating to capacity and clear boundaries raised earlier in the report.

How CLWs work

CLWs mostly worked at a practice level but some also gave examples of sharing information and resources with clusters. In general, CLWs covered between one and five practices each. Local factors that affected whether it was possible for a CLW to cover more than one practice included:

- the size and demographics of the practice population

- how engaged the practice were in the CLW programme (as this increased referrals)

- geographical proximity and potential travel time between practices.

Covering multiple practices was felt by participants to limit the flexibility to support patients at short notice and impact on the quality of the service they could provide. For instance, one participant discussed this was the case even working within a small geographical area:

> 'When I used to work with four [practices], I just felt the quality of my work just wasn't as good. I was much more having to kind of just … to be a signposting service and just kind of give people leaflets and stuff, because I just couldn't fit in anything else.' [FG5b]

Other CLWs also reported that covering multiple practices reduced the likelihood of CLWs becoming embedded members of a practice team, a factor that was highlighted as an essential ingredient to the success of a CLW programme (see Section 5.3):

> 'I've found that two [CLWs] in practices that were busy was actually ideal, because as has been said, it's about building up the relationships in the practice, just physically being there, having short conversations in the corridor, and that informal contact is the key ingredient in terms of being part of the practice, but two, you could cover two, and that was an ideal thing for me as a worker.' [FG5a]

CLWs provided cross-cover for practices if colleagues were on leave or if there was a vacancy. In one area, if CLWs were responsible for more than one practice they tried to ensure that these practices were in different GP clusters so that, in the event of a staff absence or vacancy, one cluster area would not be too adversely affected. In another EA area, they had been able to use a buddy system to cover a practice if a CLW was absent or on leave.

5.3 Building an understanding of the CLW role and awareness of the CLW service

Although community link working was well-established in most EA areas, it was relatively new to some practices within an EA area, or the programme had changed focus since its original inception due to changes in staff numbers. This section describes participants' experiences and learning around setting up and embedding the CLW programme.

Achieving practice buy-in

Practice buy-in was described by participants as being fundamental to the success of the CLW programme and was closely related to CLWs feeling embedded within practice teams. Participants felt that important enablers to securing practice buy-in included:

- practice teams understanding the CLW role and what difference it could make for their patients

- a practice's readiness for change

- a supportive practice manager

- confidence that the service was going to be in place for a long period of time.

The importance of this final point around the perceived longevity of the CLW service was that it provided time for practices to understand the role of the CLW and embed the service within the practice and develop relationships. Securing longer-term funding for the CLW programmes was perceived by some participants as having contributed to practices' engagement with CLWs:

'I think as well for some of the practices, especially if they're getting a [CLW] for the first time, they've been so used to services coming and going, especially in the third sector, that for them to invest that energy and time into the relationship there's kind of that attitude, well what's the point, 'cause you're only going to be here for six months, or you're only going to be here a year. So I think that's what's been really good about our programme, is they've seen that it's been invested and it's been longer

term and so the [CLWs] have got great relationships within their practices. Like, they're involved in practice nights out, the Christmas nights, all of these things, that they're seen as being part of the practice team.' [I1]

Becoming an embedded member of a primary care team

While participants estimated that it could take between six months and a year for a CLW to feel embedded as part of a primary care team, they explained that this was dependent on practice culture, team personalities, and practice dynamics rather than time alone. However, there was agreement across all EA areas that it does takes time to establish a CLW service in a practice, to develop trust between practice members and embed the CLW service into the practice work so that, for instance, referrals increase:

'… you have to have an expectation that it's not going to happen overnight. And you're not going to be chock-a-block with appointments, because it'll take a wee while to filter in, and then all of a sudden, you'll be inundated, and you'll be like, oh my goodness, you know. So you have to have that feeling that, okay, it's taken a few months to embed in, but that's normal […]' [I8]

One participant described their aspiration for CLWs in their EA area becoming a recognisable member of the practice team:

'It would be good just to be … you know that you can go to your GP and you can see the practice nurse, you can see the pharmacist, you can see the doctor and you can see the link worker. So those are … it would be good that we're just actually part of that. That we're just there. That everybody just knows that you can do that.' [FG1]

Participants described some facilitators they believed had helped in developing more integrated working between practice teams and CLWs:

- Having a lead GP with responsibility for the CLW service
- CLWs building a good relationship with practice reception staff

- CLWs shadowing members of the practice team to understand their roles

- CLWs being based in a practice full-time was perceived to be an advantage over working across multiple locations or not having a fixed base

- Practice team awareness and understanding of the CLW service

There was widespread agreement that being physically based in the practice was a key enabler to integrated multi-disciplinary team (MDT) working as it increased visibility of the CLW and helped build relationships with practice staff (see also Section 5.4). The benefits experienced by CLWs who were based in a practice were highlighted by this participant:

> '… they're hosted by the practice that they are based in, so that gives them that opportunity to become fully embedded in the practice and to be seen as being part of the practice team which really enhances then communication, referrals, that baton of trust, if you like, as well. Because the GPs and the practice staff have an opportunity then to get to know the worker and get to build a relationship with them, because they're based there 95 per cent of the time.' [I1]

Where participants had direct experience of CLWs being embedded in practice teams they were able to articulate the benefits of the CLW to patients, primary care teams and the wider system:

> 'I just think it's just … to me a very joyful time to be in general practice. And the reason for that is because I think that these new team members allow us to take the focus off the individual doctor and that other people can have good patient-centred relationships and offer help to our patients, so that to me is the link worker as part of that changing pattern of general practice and primary care. And I think the other thing that's been amazing is how much we understand now what's happening on our doorstep that we didn't know before. That's really good, that's been healthy, not working in a silo.' [I10]

While the majority of practice teams were now highly supportive of their local CLW programmes and the added value of the CLW role, there was a perception from some EAs that some professionals described as 'old-school medical' were more likely to be initially resistance or sceptical about the non-clinical nature of the CLW service:

> 'I think GPs failed to see, initially, the value added-ness that this role could bring to them. They couldn't understand why somebody who was a non-medically based person could take away any of their work, and things like that. However, it took a while, but we got there.' [FG2]

In these cases CLWs recognised the role they had in helping to build that understanding and trust within practice teams:

> 'And I think to get their head round a very different concept, a social model, which is so different from the medical models that people within health use. So I think that … and we've had to do that really gently and by proving what, kind of, good work and how jointly we can work. If we work with somebody on a social issue, then that might improve their health and lessen how many times they come to the GP. So I think it's helping doctors and other health professionals see the links between social issues and people's health.' [FG1]

The lack of a formal professional status and non-medical role of CLWs were perceived by participants to be barriers to GPs understanding what the service could offer their patients, which contrasted with other new members of the MDT, for example, physiotherapists. Some CLWs reported having to repeatedly justify their role and credentials particularly within health circles. In practical terms, there were some examples where CLWs expressed that they felt that other professions were being treated preferentially with regard to clinic time or desk space.

Building positive relationships within multi-disciplinary teams

Good relationships between CLWs and the practices were described by participants as being crucial to the successful delivery of a CLW programme. Front-line

participants (CLWs, GPs and practice managers) identified the need for CLWs to adapt and build effective relationships with different members of the practice team, especially practice managers and reception staff. Practice managers helped to facilitate a CLW's integration into the practice and reception staff were able to signpost and endorse the service to patients.

As the MDT expands, some practices were taking steps to bring together new and established members of staff to understand each other's roles and support their integration into the practice and existing 'tight knit' MDTs:

> 'We've found it quite effective to actually use one of our staff training sessions over a lunchtime to have each of the new … like the link worker, the mental health practitioner, the physiotherapist, sort of speak to the whole team, saying this is what I'm here to do … just a quick question and answer session, and I think that was really effective for everyone, the new members of the team and the existing team as well, to get to know what it was all about and be able to share that then with the patient. So, I think that face to face, there's something to be said for that, developing a relationship that way with the team. That's probably the most positive way to do it, I would say.' [I11]

At the time of fieldwork the GMS contract changes were still relatively recent, and the new roles and patient pathways that had been introduced in some EA practices were still being refined. However, despite the early stages of this work participants reflected that there were already some examples of CLWs working well with colleagues in the wider MDT, in particular mental health practitioners, to provide a holistic package of care for patients.

As new members of the MDT came on board, participants described how some primary care teams refined their referral pathways and triage options for patients so that they saw the right person, first time. In one example, where both CLW and mental health practitioners were in a practice, CLWs would continue to support people with low level mental health issues from a non-clinical perspective to allow mental health practitioners to support people with more moderate to extreme conditions. Some participants reflected on how team members were adapting and

learning about new ways of working and boundaries between different roles (see also Section 5.2), and understanding how to provide the best possible support to patients within the new MDT arrangements that had been developed in some EA practices:

'Everybody's having to learn, how do I best use this person, what is their role, what's gone well, what do they not need to see? So it's just a constant process. And although I get what a pharmacist does, what a pharmacist does in my practice is very different to other things. And what we do is, you have to kind of uniquely shape that role to work with your practice, the way your practice is set up, the attitudes of how people work. So it is quite a personalised thing. But it's proactive. It's not a passive process.' [I10]

This participant went on to highlight the importance of developing these working relationships within practices, embedding new ways of working together, as highlighted earlier in this section. The importance of communication within the team and learning from each other to deliver a better service for patients was described:

'The other day I was walking past a room and in that room was our midwife, our CPN and our link worker talking about the support and care for a very vulnerable pregnant woman and there was no GP there. And these three health professionals are managing and supporting this woman in very difficult times, and it doesn't need to be a GP. And her needs are being met in a way far better than the pure medical model. So that's exciting for me, that's exciting.' [I10]

Raising awareness of the CLW service

The main facilitators to building awareness and understanding of the CLW role were considered to be the CLW actively promoting the service within the practice and local community, and for stakeholders (patients, practice staff and organisations) to experience the service first-hand and see the benefits for themselves and then tell others (see also Section 5.2).

Internal and external promotion of the CLW's was viewed as key to increasing awareness of CLW services. CLWs made use of, and encouraged a range of channels for promoting the service including:

- newsletters, fliers/leaflets, posters, community noticeboards, pop-up banners, events, presentations to practices and in the community, case studies of CLW patient experiences

- GP 'champions' telling other GPs about their experience of their practice's CLW service

- word of mouth, e.g. the friends and family of people who have used a CLW service.

One focus group participant explained how the expansion of their CLW team had given them more time to get out and actively promote the service and become a well-known face in their local community:

'I think word of mouth is very important, I think it is something that we all still have within communities, and I think it is important for us to not lose sight of the community element of it. And it's very easy to do that, because you do get involved in strategic elements of things, you get involved in the practice side of things. And you can find your time really starting to build up, and you can find your time starting to be filled, and all your time is in a practice. And I think it's important for us, as link workers, to be out and about, because we're not practice link workers. We're community link workers, and I think being out there is important.' [FG2]

5.4 Setting up a CLW service

The following section sets out the key practical arrangements that participants described as being important in the successful delivery of a CLW programme.

Participants agreed the importance of all parties investing time at the planning and development stage to agree how the service would be implemented at a practice level. This was considered by participants to be important in terms of securing practice buy-in and also in managing expectations about the time it can take to

develop the service (see also Section 5.3). Participants noted a range of service elements that were important at this stage including clarity of service role, boundaries, practical systems and relationships, as illustrated by one interview participant:

> 'I think even to get buy-in from the practice team … you need to be clear about what you're offering, what the benefits can be, how it's going to function, you need to have a clear system for how the referrals are going to work, who they're going to be able to go to if there are issues, but the key to it is getting the person in about the practice, getting to know people, getting to know the community and building those relationships, and I think recognising that that takes time and it's not going to be an overnight, here's your link worker, they're going to be up and running straightaway. It's not the sort of service that will work well like that. It has to be built over time.' [I11]

Practical resources

CLWs across all EA areas identified some practical requirements they needed to be able to carry out their role effectively:

- A desk or somewhere to sit in the practice

- Space to see patients or speak to them over the phone

- A computer or laptop with access to practice IT systems

- A mobile phone

- Access to a car or good public transport, especially if working across multiple practices

As described in Section 5.3, being physically based in the practice was a key enabler to integrated multi-disciplinary team working. However, physical space in practices was at a premium in some of the EA areas and was expected to be under increasing pressure as the MDT expanded.

Participants described the adaptations practices, and in particular practice managers, had made to accommodate new staff:

- Rearranging existing practice accommodation and purchasing additional desks

- Hot-desking arrangements

- Using a shared room for administration work to free up clinic space

- Larger practices hosting staff from nearby practices with limited space

- Reviewing timetabling to maximise free rooms on different days of the week

- CLW sometimes meeting patients in alternative settings in the community after their first appointment in a practice

Access to practice IT systems

Most CLWs described having had access to at least some practice IT systems but this very much depended on a general practice's own policies. CLWs who had access to practice software such as DOCMAN, Vision and EMIS described how this helped them work autonomously as part of the primary care team. These programmes allowed them to receive electronic referrals, book appointments, and crucially (in some practices) view and update patient records to inform and record the support they provided.

Additionally, some practices had EMIS Web or Vision Anywhere which supported remote working on laptops and avoided the need for CLWs to be in a practice to input data. CLWs who had this capability reported that this helped them to use their time more efficiently. Some EA areas had also invested in developing external web-based data recording systems (e.g. Salesforce) that enabled CLWs to record information and also linked to practice systems such as Vision. This created a secure, accessible system from which data could be more easily extracted for reporting.

Where CLWs did not have access to SWIFT (social work recording database) it was important that any safety concerns were included on the referral so CLWs did not put themselves at risk when doing home visits. Some EA sites also had lone worker

policies, processes or technologies, e.g. 'safe shores monitoring' which allowed colleagues to know each other's whereabouts if they were doing home visits.

Practice meetings

CLWs gave examples of attending practice meetings for a number of different reasons. These were valued by CLWs as an opportunity to promote the CLW role and community resources, provide feedback on referrals, discuss patient needs and risks and the support currently being provided to individual patients. Participants felt that their involvement in these meetings helped them to provide a more coordinated approach to patient care.

There was a wide variety of meeting types that CLWs may be engaged in, for example, MDT, practice meetings, partner meetings, practice development sessions, business meetings, and speaking to GPs on a 1:1 basis. Participants reported considerable variation in relation to CLW involvement in practice meetings. The extent to which CLWs were involved in practice meetings varied by practice and in the following ways:

- Invited to meetings or had to ask join a meeting

- Frequency of attendance – weekly, monthly, only when something relevant, never

- CLW might attend for some or all of the meeting

Where participants were part-time, worked condensed hours or across different practices they reported that they might never meet the whole MDT if they did not share the same working patterns or workspace. The CLWs who reported this felt that it impacted on their ability to build relationships with these groups.

Inductions for CLWs

Induction varied between EA areas, employing organisations and from practice to practice. The induction content and level of intensity ranged from getting an access code for the building and facilities and being left to get on with things in a practice, to five weeks of more extensive induction offered by the employing organisation. Participants reflected that less intense general practice inductions may be more

likely for CLWs who were replacing a previous CLW in a practice and more intense where the service was completely new to a practice.

Induction activities included: training, meetings with community organisations, being paired with a buddy and familiarising themselves with the service directory. Shadowing other CLWs and practice staff was reported as a good way of getting to know people and understand practice processes.

Training

CLW training was commonly done at induction (if applicable), and as a refresher or on an ad hoc basis when a training need was identified. It was offered by a range of different sources including: the employing organisation, HSCP, GP practice, or partner organisations.

CLWs reported having different types of training which helped them develop the knowledge and tools to work in a general practice environment, and the necessary skills to provide support to patients:

Knowledge and tools for working in a practice:

- IT training on general practice systems, e.g. EMIS and Vision

- Understanding general practice and how it works by shadowing members of the practice team

Supporting patients:

- Applied Suicide Intervention Skills training (ASIST), safeTALK, trauma, mental health first aid for children and young people, psychologically-informed environments

- Topic-specific: alcohol, drugs, dementia, child protection, harm training, stigma, welfare rights and welfare reform

- Motivational interviewing, time management, managing conflict, dealing with difficult situations, case management

The training needs of a CLW depended on an individual's background but there was strong agreement about the value of 'ASIST' and learning about how a practice worked for all CLWs.

Supervision and support to do the CLW role

CLWs were asked about the types of supervision and support they received to do their role. The type, availability, and frequency of supervision varied between employers and general practices.

Most CLWs were directly line-managed by their employer who had responsibility for a team of CLWs within an EA area. On a day-to-day basis, CLWs would often seek support from practice managers, who would in turn contact a CLW's manager if there were human resources issues such as professionalism, behaviour, and time-keeping.

There were some examples of tensions between practices and CLW or HSCP managers which arose because of a lack of understanding of each other's contexts and pressures, and in particular because each general practice had its own way of working.

There was overall agreement that GPs should hold the clinical risk for the patients that CLWs saw. CLWs gave examples of how they would go to GPs or mental health practitioners within the practice if they had concerns about a patient or to seek advice. One EA area had a named GP lead in every practice. However, in general, GPs were often under pressure and did not always have capacity to provide supervision and some did not see it as their role.

The unique nature of the CLW role meant that some participants felt isolated professionally and valued regular peer support opportunities (either face to face or by email or phone) to connect and debrief with other CLWs even if they were an integrated member of a practice team.

CLWs discussed the fact that they are exposed to some distressing stories and patient disclosures which can place emotional strain on the CLWs themselves:

> '…there's no amount of training out there can prepare you for everything that you're going to see. Child protection was my background. And I've

had adults come to me with things, and I have gone home, and I have sat there in utter silence for the full night. And it's not been, it's just, no amount of training could have done, and changed how I would have dealt with that, just because of what the subject matter was, and things like that.' [FG2]

Even where formal supervision was in place, some CLWs felt like they would benefit from a named person they could chat to at short notice to speak with for advice, guidance, and also to debrief after they have listened to a patient talking about a distressing situation. Some practices had open door policies where this informal support was more readily available (usually from GPs). Other CLWs related this to the challenges of lone working and the need for contact with other colleagues, for instance:

'It's important to have a base, I like to know that I've got a base that I can come back to. And like everyone has said, there'll be times when you think, well there's maybe only one person in, but if you're having a really, like, oh I don't know what I'm doing with this individual, or this has happened, or whatever, it's having somebody you know that's likely to be around, and just say, even if it's just a duty worker, that might be for that couple of hours, you know, you're going to come back, and you've got somebody else to speak to. And I think it's really important, because we're lone working, autonomous working, I think it's important that you have a support network, and a base you can come back to. To protect your own mental health and wellbeing, I think it's very important.' [FG4]

While CLWs were generally based in their practices for most of the week, some teams had a dedicated team base that they could use for administration.

Some EA sites had dedicated team time to meet every week, others met less frequently (4-6 weekly). CLWs raised concerns that this time needed to be protected as demand increased on their role and capacity.

CLWs valued the opportunity to get together as a team for the reasons outlined above. There was a preference for 1:1 support over group supervision as it gave

everybody the chance to talk about the issues that are most important to them. A participant in one EA also felt this avoided meetings becoming a 'group moaning' session.

In addition to practice and employer supervision some CLWs also reported receiving external supervision with a focus on emotional support from a local counselling organisation, clinical psychologist, or through online psychotherapy. This type of supervision was less commonly reported and was often less frequent than other types of supervision or only received for a limited time. CLWs who had received this type of support expressed the importance of being able to offload in helping to build the personal and professional resilience they needed to do their role without getting overwhelmed.

5.5 Reach of the service

Participants were asked who they felt the CLW service reached and if there were any groups who were less likely to engage. The findings presented here are based on the participants' perceptions of who the service is or is not reaching. The minimum core dataset will provide quantitative evidence on the demographics of those who have engaged and reasons for referral.

Eligibility for CLW services

The majority of EA areas had minimal exclusion criteria for their CLW service other than age (most services only worked with adults). One EA area highlighted during fieldwork that they specified that people with drug and alcohol issues which required specialist support needed to be involved with the relevant services before they would work with them.

Broadly, participants reported their patients as 'anyone who is struggling to deal with something on their own'. While CLWs reported that the vast majority of patients referred to them were appropriate for the service, the reason given on the referral was not always the priority area for the patient, or was masking an underlying issue that emerged during initial person-centred discussions with the CLW. For example, mental health issues such as anxiety and depression were often related to a wide

range of social issues such as housing, welfare rights, employment, debts, and social isolation.

One participant highlighted how the referrals to the CLW in one practice have evolved over time from those with a more health improvement focus (e.g. exercise referral schemes, smoking cessation support) to being focused on more complex issues that individuals are facing that require an in-depth, person-centred approach to meeting their needs.

> '… it is a person-centred service, because it is about the needs of the person that's sat there […] right back at the beginning we would get, needs to stop smoking, and lose weight, and the person's sitting there with no heating in their house, and damp, you know. So it's about, actually, what that person wants and needs at that time, and looking to make sure that that's respected, and they [CLW] work ethically, and in a good, caring manner.' [I4]

Some of the interviews and focus groups exposed tensions between strategic or management roles and CLWs around introducing health improvement activities such as alcohol brief interventions into their appointments as standard. The CLWs that raised this issue felt that this had potential to undermine the person-centred nature of their interactions with the patient and reduce their conversation to a checklist rather than having the flexibility to focus on what was important to them. This further highlights the need for clarity of roles and agreed boundaries for the CLW services (see also Section 5.2).

Referrals and demand for the service

Participants described a range of referrers to CLW support. In most cases this was primarily GPs and, to a lesser extent, members of the wider practice team for example, receptionists, nurses, community psychiatric nurses, etc. External referrals, for instance from statutory services and third sector organisations were only accepted in a minority of practices. Participants from practices which had been offering CLW services for longer, also reported small numbers of self-referrals from patients.

Referral methods were unique to practices and in some cases individual members of staff within the same practice had different preferences for how they referred into the service. These included using practice systems such as EMIS and DOCMAN, Microsoft applications such as 'Tasks' or Outlook calendar, by email, on paper, or face to face.

Some CLWs managed their own diary while others had open diaries that could be populated by practice staff.

CLWs discussed how they felt the appropriateness of referrals from practice staff had improved over time as the service had become more embedded in the practice and understanding of the role had increased (see also Section 5.2). Most CLWs had opportunities to provide feedback on referrals either through informal conversations in the practice, during practice meetings, or by updating the patient notes which added to the continuous service learning within practices.

In general CLWs found it hard to predict their workload which often came in peaks and troughs. When they were at, or nearing capacity, CLWs in one area described how they requested that practice staff only referred patients considered to be in crisis until their capacity freed up, to ensure they could still give a quality service and to avoid creating waiting lists.

5.6 Benefits of the CLW programmes

Participants were asked if they thought that the CLW programme had resulted in any benefits for patients and practices. They were also asked to reflect on whether they felt that CLWs were reducing the pressure on GP workload which is one of the main aims of the GMS contract.

Overall, participants in equivalent roles across all EAs described a broadly similar range of interrelated benefits of the CLW services that they had observed or experienced first-hand. There was agreement that CLWs had the time, skills and resources to support people with non-medical issues, which they believed had an impact on addressing social issues, reducing the frequency of GP attendance, how GPs spent their time and job satisfaction.

GPs described CLWs as an 'extra tool in their toolkit' to offer patients. For example, patients that they have struggled to fully support for a number of years were perceived to have benefited from the CLWs' different way of thinking and from access to community and third sector resources that neither patients nor GPs were previously aware of.

> 'I think it's just having another route of support for people. I think you just feel that you're being a wee bit more productive with what you're doing when you're passing it on to the link workers and you know that they're going to get the support that they need, you don't feel as at a loss sometimes for patients in terms of where you go next with their issues, and I think in that sense we're maybe not seeing them back so much with those recurring social issues that we can't really fix, and it's taking away that element of frustration a little bit, because you know that there is somewhere that they can access that support. So, in that sense, we've probably seen a reduction in that workload. That's probably the biggest benefit, yes.' [I11]

Other participants gave examples of patients who had been frequent attenders with their GP but who have made fewer GP appointments since engaging with the CLW. GPs also reported seeing fewer patients with unmet non-medical needs, meaning they were able to use their skills and time more effectively as expert medical generalists. This time could be spent either with different patients or to have consultations that could focus on health/medical issues with patients whose social issues were now being supported through the CLW service:

> 'I think our link worker is great, she does a lot of good things but we've seen huge benefits to the patients that she has helped, people who were coming to see us on a weekly basis, we now don't see for months at a time, because she's managed to sort out some of the other issues and that's huge for us, to free up some time as well.' [I9]

Another participant reflected this benefit of the CLW service and the way that medical information systems could also support this understanding:

'… they [GP] can just deal with their diabetes, they can just support them with their [chronic obstructive pulmonary disease] COPD, because they know they can look on the medical record and they can see the [CLW] is engaging with them or linking them into services or doing other things with them. So it definitely relieves the pressure that's on primary care by having that worker in the practice.' [I1]

Some participants also gave examples of how a CLW's early involvement with patients with social needs meant that they could be linked into lower-level interventions in the community which was felt to have avoided the need for more specialist input.

'Things like, we're seeing less COPD exacerbations in one patient, just simply because our link worker has been in touch with that part of the council and she's got a grant and she's got gas central heating and her damp has gone and her chest is so much better. So she's got a lot better, so we're seeing the follow-up of these patients, is changing because they're getting an intervention at an earlier stage, which is significantly helping their health conditions, some physical, some mental health type things.' [I9]

5.7 Additional challenges for community link working programmes

Participants were asked to consider some of the challenges that they had experienced that they perceived might impact on the success of the CLW programmes locally. This section covers the issues they raised in relation to the availability of services to link to, demonstrating the impact of the service, and sharing best practice and learning.

Community and statutory service availability

Participants in all EA areas described how CLWs rely on good quality services to link people to. There were implications for CLWs' workloads when the services they linked to had long waiting lists, or if they closed or changed their referral criteria to

protect their limited resources. In the following example, a participant describes how the CLW workload and waiting list increased as a result of one of the mental health services they linked to closing:

'… we've had times here where the waiting … our referral rates have gone right up when something else has happened, so there used to be a really good voluntary sector mental health project just back here, and that closed, and we knew that was going to happen, and at the time, because we worked really well with them and we used to refer to each other all the time, and so since they've closed, our referral rates went right up, and that was really difficult.' [FG5a]

Service gaps varied between EA areas. However, CLWs commonly reported the impact of austerity on patient lives and services due to budget cuts. Participants across all areas highlighted that the capacity of mental health services and welfare rights or money advice services were stretched, which meant delays in people receiving support for those issues.

Participants described the impact of community and statutory service availability on the CLW role, and in particular the 'brutal' waiting lists for mental health services; and that social workers were 'heaving under referrals'. Other service gaps reported by participants included intensive support worker services, befriending services, social support for men, and weight management services.

The participants in every EA area described how the CLW programme created additional referrals to and also demand on community-based services. The resulting long waiting times and, in some areas, lack of service availability, meant that CLWs reported regularly stepping in to provide support to patients until a service became available to accept a referral from the CLWs. As well as creating additional strain on CLW resources, one respondent highlighted that this also risked masking unmet needs:

'People should refer to the agency that somebody, the most appropriate that fits the circumstance, or the need, regardless of the wait. Because when people don't do that, what happens is, you create a falsehood,

yeah. It's not rocket science to know that […] the need outstrips the resource, yeah. But the only way you'll ever hope to gain appropriate resource, is by identifying the need in the first place.' [FG4]

Demonstrating the impact of CLWs

Participants were asked to describe their experiences of demonstrating potential impact of the CLW services. The EA areas had participated in local evaluation or research to learn from programme implementation and to try to understand the impact of their CLW service at some point prior to shifting onto the EA funding stream in 2018. However, participants also reflected that more recent local monitoring and evaluation activities were limited by insufficient capacity and resources to support the work, and ongoing challenges relating to quality of data and the ability to extract data from GP systems for analysis and learning.

Participants across the EA areas expressed their frustration at not being able to readily evidence the impact of the CLW service and were keen to be able to improve how they reported on the quality and outcomes of their service. Few EAs reported having access to dedicated support for evaluation and monitoring of their CLW service but all had sought advice and support from a variety of academic researchers, local evaluators, quality improvement teams, and Local Intelligence Support Team (LIST) analysts at some stage since the service began.

Some participants expressed concern that the success of their service would be judged on more readily available statistics such as the number of referrals and appointments with the CLW, rather than outcomes for patients and services which were harder to measure. In particular, participants discussed the challenge of capturing the emotional impact of their service on patients:

'Like, when I had that man came in to see me, and he was about an hour and 40 minutes, and he just talked nonstop, and I was kind of like, and there was no one after him, so he just went on, and on, and on. And then eventually at the end of it all, he went, oh my god, I feel so much better, he said, I feel so much lighter, I'm just gonna float up the road now. Now, I was like that, by the time it was done, because there was some pretty

heavy stuff. But he felt fantastic, and away he went, you know what I mean. And then he popped back another time for a couple of wee bits and pieces, kind of benefits related. But how do you capture that, you know what I mean, how do you capture, "I floated up the road".' [FG3]

The quote above further illustrates the potential emotional impact of the role on the wellbeing of the CLW as highlighted previously in Section 5.4.

At the time of the fieldwork, there was variation in the type and frequency of requests for information on CLW programmes from HSCPs. Participants gave examples of capturing outcomes data for a range of different reasons including: internal monitoring, evaluation, and service improvement.

EAs shared some examples of how they had, or planned to, capture what difference the CLW service had made for patients, using qualitative and quantitative methods:

- Case studies and patient stories were commonly used to describe the patient journey, illustrate the emotional impact of services on patients (as described above), and help understand limited available quantitative data.

- Follow-up telephone calls with patients and/or organisations to hear what had happened after they had been linked.

- Focus groups with patients who had used the CLW service.

- One EA used Warwick-Edinburgh Mental Wellbeing (WEMWBS) Scales to assess change in patient mental wellbeing over time.

- Comparison of patient GP attendance pre- and post-CLW involvement (number of appointments and reasons for attendance).

- A week of care audit, which captures the member of the practice team who saw each patient and whether they felt they were the most appropriate professional to see that individual. This was reported to be insightful but labour intensive as this information was manually collected then typed up for every practice appointment in one week.

While the methods used varied by EA, there were common reflections about the challenges of attributing the outcomes to CLW input, and in particular, measuring the long-term impact of the service on patients' lives.

Some participants also reported how it was challenging to illustrate a patient journey using data extracts from practice systems as they could only extract basic information based on Read codes.[iv] As these information systems (e.g. EMIS and Vision) had been designed with a clinical focus, EAs reported that they often had to use alternative labels to capture the types of social support that CLWs provided. For example, in one EA area a Read code for 'refer to Citizen's Advice' was assigned to another service as they didn't have Citizen Advice services locally. This had resulted in some data that was extracted from GP systems requiring a lot of cleaning before it could be analysed.

As the EAs have evolved from pre-existing services that were all established at different times, they each had their own data collection systems, specifications for data, and locally agreed definitions for categories of data (e.g. reasons for referral). For this reason it has been challenging to achieve consistency of reporting across EA areas.

One of the main challenges reported by participants was the difficulty in extracting individual patient-level data from practice information systems. Participants described their frustrations in being able to extract meaningful data from practice systems, and some CLWs had continued to keep their own records on Microsoft Excel or Access which, in some cases, had meant entering the same data on two separate systems creating additional workload for CLWs. Some areas have adapted their data collection systems for all data to be collected on GP systems such as EMIS. One area had developed a data collection system using a web-based tool for recording data. The advantage of this had been that it was linked to the practice's own system, and it was possible to readily access programme data for analysis.

Participants expressed hope that SPIRE would enable the service to access patient data on practice systems in the short to medium term and that the GP IT

[iv] Read codes are a standardised set of clinical terms that are used in patient records.

re-provisioning process would result in improved functionality to support access to this kind of data for programme planning and learning for services such as CLWs in the future.

A national minimum core dataset currently being piloted with EAs attempts to standardise the collection of some data across the EA areas. While there was agreement from participants that this will be helpful, they reflected that it has been an extremely slow process and information governance processes have taken over a year to resolve. Some participants reflected that if this dataset had been available earlier it may have saved EAs the time and effort of developing their own interim measures. However, as the EAs already had pre-existing data collection systems in place other participants acknowledged that this would not have been a simple process.

Sharing best practice and learning

Sharing of informal learning at a national level and across localities has been sporadic and this was highlighted as a gap by the EAs. Some participants discussed a few examples of EA areas visiting more established programmes for advice and support when they were starting out with their own programme.

> 'So there's not really been that ability to actually learn from others … in terms of, you know, the early adopters, and what they're going through, and what systems they're putting in place, and what their, the barriers they're coming up against, and being able to share that. So that's been a lost opportunity.' [I4]

One EA had previously created records of learning[v] for their programme. However, this had stopped as they no longer had sufficient capacity and funding to continue collating the information at scale.

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[v] www.alliance-scotland.org.uk/blog/resources/links-worker-programme-record-of-learning-series-2/

There appeared to be limited awareness among participants of the Scottish Public Health Network website resources,[vi] but there was some indication that this type of information was or could be helpful.

Participants expressed that they would be keen to have more regular opportunities to find out what is happening around the country through a national network of CLW and similar services, to learn from the experiences of others and enable others to learn from the experience of the EA sites.

6.   Summary of key findings and discussion

This study aimed to contribute to an understanding of the implementation and delivery of link working in five EA sites in Scotland, by capturing learning to help inform delivery and developments of this and other similar service models. This report has described the experiences of five EA areas implementing CLW programmes within a general practice setting.

While each area had a locally-defined model of service delivery, there was strong agreement from the participants in this study about a number of core components that were necessary for a successful CLW programme. These were:

Delivery of the CLW service

- A team of social practitioners with mixed backgrounds and experience of working in different sectors

- CLWs being physically based in a general practice for most of the week

- Dedicated time for patient-facing, practice-based and community-based activities

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[vi] https://www.scotphn.net/resources/community-link-workers-support-information-guidance/clw-support-information-guidance-2/

Supporting the CLW role in a general practice setting

- A shared understanding of the programme by HSCPs, GP practice teams, CLW teams and community organisations

- General practice buy-in to the CLW programme

- CLWs being integrated members of a primary care team

- Good relationships between CLWs, primary care teams and community-based organisations

- Clear arrangements for line management of the CLW team and 1:1 support

- Regular peer support opportunities for CLWs

- Clear lines of clinical supervision

Practical resources for the CLW

- Up-to-date knowledge of community services

- Regular CLW team time for peer support and to share knowledge and resources

- Minimum training requirements (e.g. mental health)

- Access to practice IT systems

Sustainability of a CLW service

- Clarity of CLW role with defined boundaries

- CLWs have sufficient capacity to meet the needs of their practice population

- Availability of community and statutory services to link patients to

Supporting CLW programmes across Scotland

- Availability of networking and learning opportunities for CLW (and similar) programmes

- Clarity on funding arrangements and timely commissioning processes

- National agreement over the key components of community link working

The CLW programmes across the EA areas varied in different aspects of how the service models were developed, local arrangements for delivery, and employment arrangements for CLWs. Although participants felt that national agreement of the key components of community link working would be helpful, this was not in place following the shift from a nationally funded programme to local delivery through the HSCPs. A set of agreed core components of a CLW programme may, however, help to build understanding of the role among key stakeholders.

The experience of implementing and delivering the programmes within a shifting policy and service landscape has presented opportunities and challenges for CLW programme teams. In particular, when the funding stream moved to being the responsibility of HSCPs as part of the new GMS contract this resulted in challenges for some of the programmes due to uncertainty around commissioning of services, levels of funding, and security of employment contracts for CLW teams.

There is no overarching national method for assessing need to inform how best to allocate CLW resource and this is determined locally. This has led to a wide variety of groups benefitting from input but participants reflected that there may also be some groups of people missing out on accessing a CLW in some areas. There were concerns within some EA sites that the increased pressure to cover more practices through the Primary Care Improvement Plans without additional resource could impact on the quality of service that CLWs were able to provide.

CLWs perform a wide variety of roles and functions across and within EA areas. This means they can be very responsive to the needs expressed by patients but can also lead to blurring of boundaries and lack of clarity as to who should be doing what. This has implications for governance and CLW capacity.

It was clear from participants that it is important for CLWs to be seen as full members of the multi-disciplinary team in each practice. This ensures their role is seen as being on a par with others and means that patients are more likely to be treated in a holistic fashion. Where feasible, studies that focus on the extent to which

effective MDTs (where the CLW is accepted as a fully functioning member) contribute to improved patient outcomes would add to the understanding of the potential impact of roles like the CLW in primary care.

Some CLWs have clear lines of accountability and support but for others this seemed more problematic. It was clear from the discussions that CLWs needed a combination of professional support, emotional and wellbeing support and adequate supervision. Without this, CLWs can feel lonely and unsupported. This needs further consideration as existing CLW programmes continue to develop and new ones are implemented.

There was some indication from participants that CLWs are helping to release GP time, however, it was not within the scope of this study to evaluate any related evidence from GP data sources. The longer appointments with a CLW, their ability to deal with non-medical issues more directly, and the linking of physical health with social and mental health were all suggested as contributing to perceived changes in how GPs spent their time, as this means that GPs are able to use their time to focus on patients with clinical issues. This needs further investigation through quantitative data collection, but is a promising indication of workload shift. It is, however, important to note that this is not the only important measure for a CLW programme and it will be crucial to ensure this type of data is interpreted to understand it within the local context and to understand how patients and the whole MDT are impacted.

While CLWs connect patients to services they require in the community, it was clear from participants that the help patients receive was dependent on the type of services available in the local area and their capacity to provide support. Where there was limited capacity within community services or none currently available, this had meant that some CLWs were providing a version of the support themselves, trying to 'hold' the patient while waiting for a service to become available. In some cases the lack of capacity in the community and the CLW service meant that it was not possible to meet the needs of the patient at that time. The CLW role cannot be seen in isolation and the sustainability and potential for a CLW programme to succeed will be dependent on the availability of sufficient services and support to refer patients to in the local area. This has been affected by the impact that austerity has had on some communities and the lack of resources in some areas where

statutory services have been cut or funding is no longer available for community and third sector services and support.

Strengths and limitations of the study

This paper is intended to inform learning rather than provide a definitive set of recommendations about community link working. The main strength of the work is in the qualitative approach taken as the interviews and focus group discussions with participants enabled us to gain an in-depth understanding of their perceptions and gather rich data about their experiences and learning.

The focus of the study was to collect learning about implementing and delivering a CLW service. As these services are primarily locally determined (particularly following the policy and funding shifts from a national programme to the responsibility of HSCPs), it meant that there were variations in ways of delivering services even, for instance, between different practices within an EA area. This paper has, where possible, drawn on common themes and key lessons raised by participants during the interviews and focus groups. The study is limited, however, to describing the range of different ways that services were delivered as it would not be appropriate to include any judgement on which is the 'best' model, particularly due to the locally evolving nature of the services designed to meet the needs of practice populations.

As local EA teams were asked to recommend GPs or Practice Managers to take part in the fieldwork and act as an initial liaison with CLW teams, it is possible that there may be have been a bias towards general practice staff with a positive experience of the CLW programmes. However, the participants gave open and honest reflections of their own experiences that included the learning that could be taken from more challenging situations. The findings also highlight a range of challenges in setting up and continuing to deliver the service. The study only included a small number of GPs and practice managers due to the time and resource available to the research team. It is therefore possible that other practice staff from services that were perhaps less engaged would have offered a different perspective about the CLW services and this should be considered by readers when reading this paper.

Conclusion

This study aimed to contribute to an understanding of the implementation and delivery of link working in five early adopter (EA) sites in Scotland.

The views and experiences of participants have provided learning about the design and implementation of CLW programmes in the context of the new GMS contract. The study highlights a number of findings which can be used by other CLW programmes, and may be transferable to the implementation of other priority areas within local Primary Care Improvement Plans. This includes the need for clarity of roles, the enablers of multi-disciplinary team working, and some of the practical challenges relating to available space, IT, and monitoring and evaluation.

The minimum core dataset will provide some quantitative data about those individuals who have engaged with the EA programmes, the reasons for referral into the programmes and the types of support they are receiving. Further work would be required with stakeholders to help capture CLW's contribution to improving outcomes for patients, staff and services in a more systematic way, and to understand the availability and capacity of the support and services to which CLWs refer patients.

Appendix 1 – Topic guide

Topic guide – Community Link Worker Programme: Learning from the early adopters

Version 2 – 21 February 2019

Introduction

The primary aim of this study is to contribute to an understanding of the implementation and delivery of link working in the EA sites and to capture this learning to help inform ongoing delivery and potential wider roll-out of this and other similar models of care and support. The main objectives of the study are to understand:

- the experiences of community link worker (CLW) programme teams in implementing and delivering the programme within a shifting political and service landscape

- CLW team perspectives on the potential impact of different models of delivery on reach, referrals and how well integrated the CLW becomes within a GP practice

- to what extent wider service capacity might be a barrier to the programme's success and sustainability

- the barriers and facilitators to delivering a CLW programme and what other areas can learn from current experience.

Definition

This should be shown in square brackets – e.g. [CLW]. Adapt this for each site due to different names of programmes and job titles.

During the interview

Individual participants will not be identifiable from any report or publication placed in the public domain. Every effort will be made by the research team to ensure that

data is not presented in a way that will identify areas and individual organisations. This will be checked by the research team to ensure anonymity is maintained.

[Questions will be adapted dependent on participant and role – e.g. strategic and delivery roles]

A. General questions

Can you start by telling me about your role with the [name of programme]?

Role, length of time involved, where based (practice, community)

How the practice got involved, who led this, etc.

Can you tell me a little about the model of delivery in your area/practice?

Single practice or cluster models

Is this the right balance? Any pros or cons to this approach? What are the benefits and challenges?

B. Reaching patients

How are patients referred into the [CLW] service, and in your experience does this have any influence on if or how patients engage with the service?

Any changes over time – different routes, awareness of service, appropriate referrals, nature of referrals?

In your experience do you feel the right people are being referred to the [CLW] service?

Who are they? Are there any gaps in provision? Does the focus of the service need to change – any groups you feel the service is not reaching but needs to?

C. The programme

How has the programme been received by other members of the primary care team(s) in [this area or your practice]?

Was there agreement that a [CLW] was needed? What's the understanding of the programme?

Has the [CLW] programme or individual worker become an integrated part or member of the primary care team(s)?

How has this happened; what supported it; any challenges faced?

What has influenced this, e.g. leadership, facilities and resources, shift to HSCPs, Primary Care Improvement Plans, etc?

What are the perceived benefits of having [CLWs] in this area or practice?

What have been some of the facilitators and barriers to setting up and delivering the programme in this area or practice?

D. The system

In your experience, do you feel the programme reduces pressure on the GP practice team?

How, which parts of the practice, understanding referral processes and teams engagement with the [CLW/service]?

What resources (systems and structures) are required to support implementation and continued service delivery?

Strategic and management support, financial resources (e.g. practice development fund), access to practice space and equipment

Since your programme started there have been a number of changes in service delivery, funding and shifts to the HSCP. How do you think this has influenced delivery of the programme?

> Pros and cons, challenges this has raised, any facilitators for the change, perceptions of support from Scottish Government, Health and Social Care Partnerships (HSCPs), etc.

Does the programme enable stronger practice-community relationships?

Do you feel that the relationships between GP practices and community organisations are sustained or sustainable?

> Reasons for this, are connections via individuals or organisations

E. Measuring success

In your view, what does or would success of the programme look like?

> For patients, practices, community organisations, etc.

In your experience, is programme information and learning used by HSCPs and Community Planning Partnerships to inform service planning?

> How? Barriers, facilitators, etc.

Following on from this, do you feel that the programme contributes to an understanding of local partners to determine how best to address the needs of their population?

> e.g. type of services people need and where available or not – does this shift provision or funding?

Do you feel there is sufficient support for monitoring and evaluating the programme?

> Local, national

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