NHS Highland Community Link Worker Service

Year 3 Report
1st July 2024 - 30th June 2025

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Foreword

I am delighted to share the third year report on delivery of the Community Link Worker service in Highland. The service has been expanded to all 62 GP practices, giving all GP practices in Highland access to the Community Link Worker service as part of a wider multi-disciplinary team. The service has supported 1845 patients over the last year, a 20% increase from 2023/2024.

The information presented in this report has been extracted from Elemental; the social prescribing platform used for referring patients and reporting outcomes. Learning from previous years has helped inform service improvements and the report outlines these and highlight areas for further development that have been informed by feedback from patients, Community Link Workers and GP practice staff.

I hope this report will help to demonstrate the positive impact that the Community Link Worker Service has had on patients and practices across Highland.

Cathy Steer

Head of Health Improvement and Community Link Worker Service Lead

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Introduction

Welcome to the third-year report on the delivery of the Community Link Worker (CLW) Service in Highland.

NHS Highland commissions Change Mental Health to provide the CLW service to all 62 GP practices in Highland. This report describes the progress and development of the service during its third year of delivery and covers the period 1ˢᵗ July 2024 to 30ᵗʰ June 2025. Key highlights from this period include:

A total of **1845** referrals were made to the Community Link Worker service.

A **20% increase** from referrals received in 2023/2024.

The Community Link Worker service expanded across Highland from **29 to 62 GP practices**.

1,909 social prescriptions and **1,354** signpostings were delivered over the year.

For patients that completed SWEMWBS*, the average score increased by **3.14** points between the initial and final measurement, before and after engagement with the Ccommunity Link Worker service.

35.6% of all referrals are from **Scottish Index of Multiple Deprivation (SIMD) 1 and 2.** This highlights a focus on health inequalities.

The **Highland Directory of Services (DoS)** was launched and is being integrated with Elemental to improve onward referral data and recording.
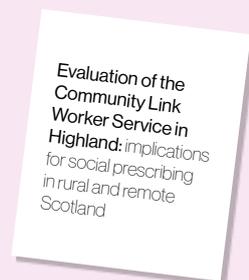
The '**Evaluation of the Community Link Worker Service in Highland: implications for social prescribing in rural and remote Scotland**' was published.

* SWEMWBS is a short version of the Warwick–Edinburgh Mental Wellbeing Scale (WEMWBS). The WEMWBS was developed to enable the monitoring of mental wellbeing.

3rd Year of Service Delivery

Data for this report is taken from Elemental, the referral and case management software package and covers the period 1st July 2024 to 30th June 2025.

Referrals and Outputs

In total, 1845 referrals were made to the CLW service throughout the year, of which 35.6% (n = 656) were for patients living within the most deprived areas of Highland according to the Scottish Index of Multiple Deprivation (SIMD). The following table outlines the number of referrals to the service in each of the 3 years of delivery.

Table 1: Number of CLW referrals each year and percentage of patients living in the two most deprived SIMD areas.

Year of Delivery	Total Number of Referrals	% of patients living within the two most deprived areas according to SIMD
1	920	38.5%
2	1535	43.3%
3	1845	35.6%

The reduction in the percentage of patients referred from the two most deprived areas in Highland according to SIMD may be due to the fact that the service was expanded to more remote and rural areas where SIMD can be less effective at identifying small pockets of deprivation. Figure 1 outlines the number of referrals for all SIMD deciles.

Figure 1: Number of CLW referrals by SIMD decile (1st July 2024 to 30th June 2025)
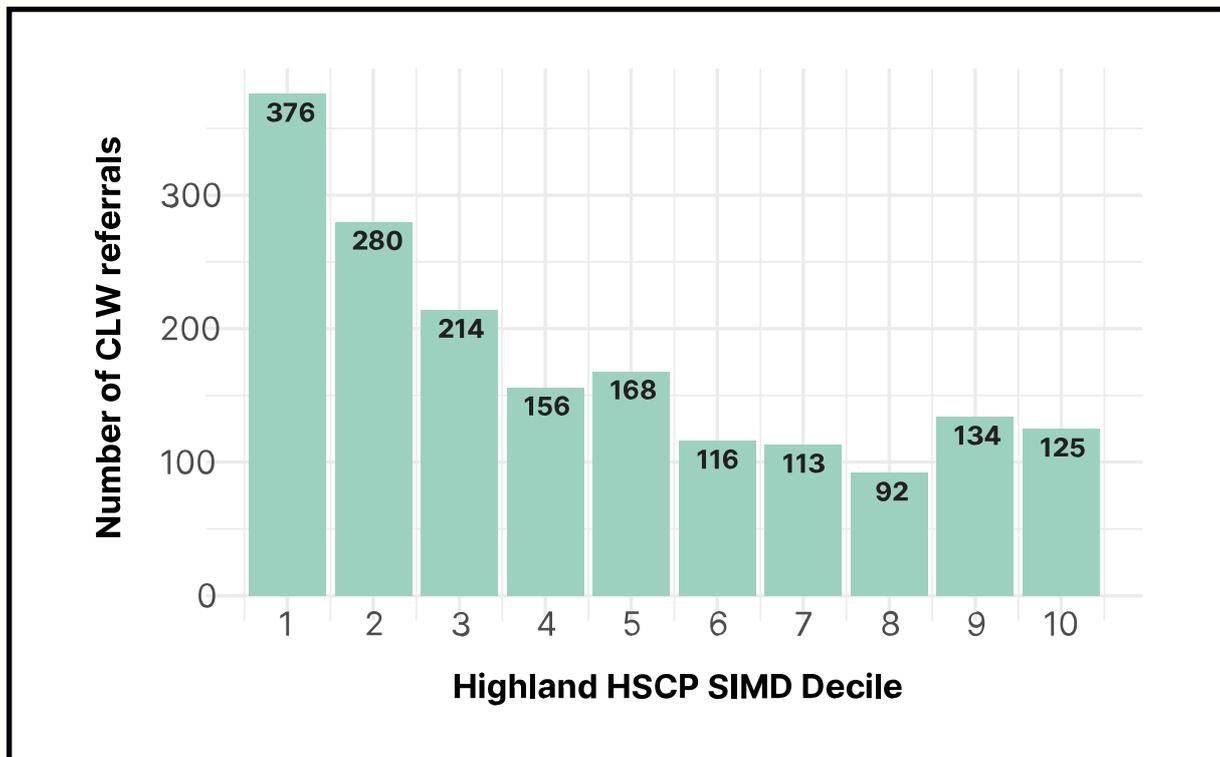
Figure 2: Number of CLW referrals by month (1st July 2024 to 30th June 2025)
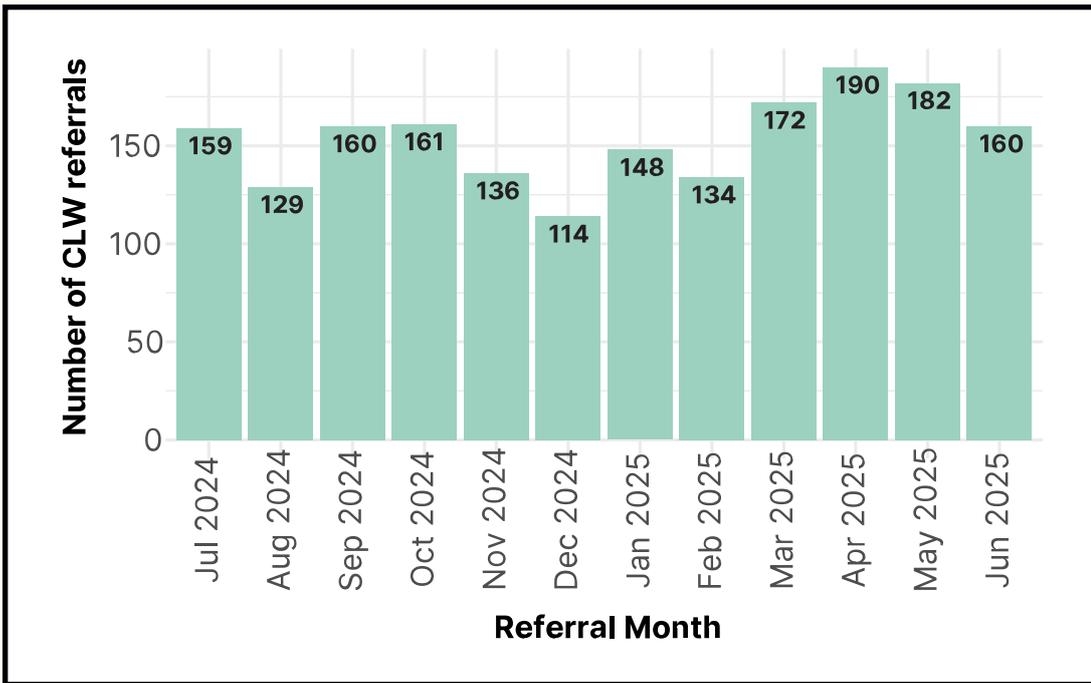
Reasons for referral

Referrals are made by GP practice staff via the Elemental system which records reason for referral.

Figure 3 shows the breakdown of referrals (n = 1845) by reason for referral. Mental health and wellbeing was the most common reason for referral (50.6%) followed by loneliness and isolation (28.2%).

Figure 3: Percentage of referrals with given reason for referral (1st July 2024 to 30th June 2025)

Figure 4: Top 5 reasons for referral to the CLW service by percentage of referrals in Year 3 (with comparison to Year 2 and Year 1)
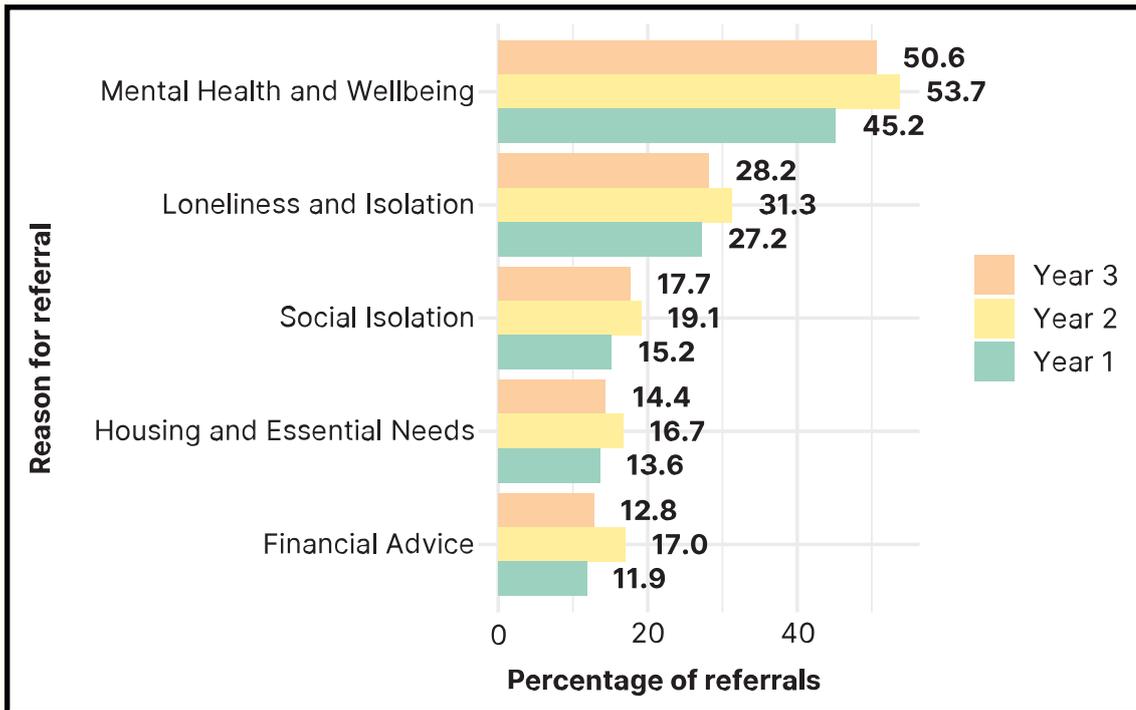
Engagement Status

The following table describes how well clients are engaging with the service. Engagement status is categorised in Table 2 for those where the engagement outcome was either 'Complete' or 'Discharged/Closed'.

Table 2: Patient engagement status (complete, discharged or closed referrals) as at 01/09/2025
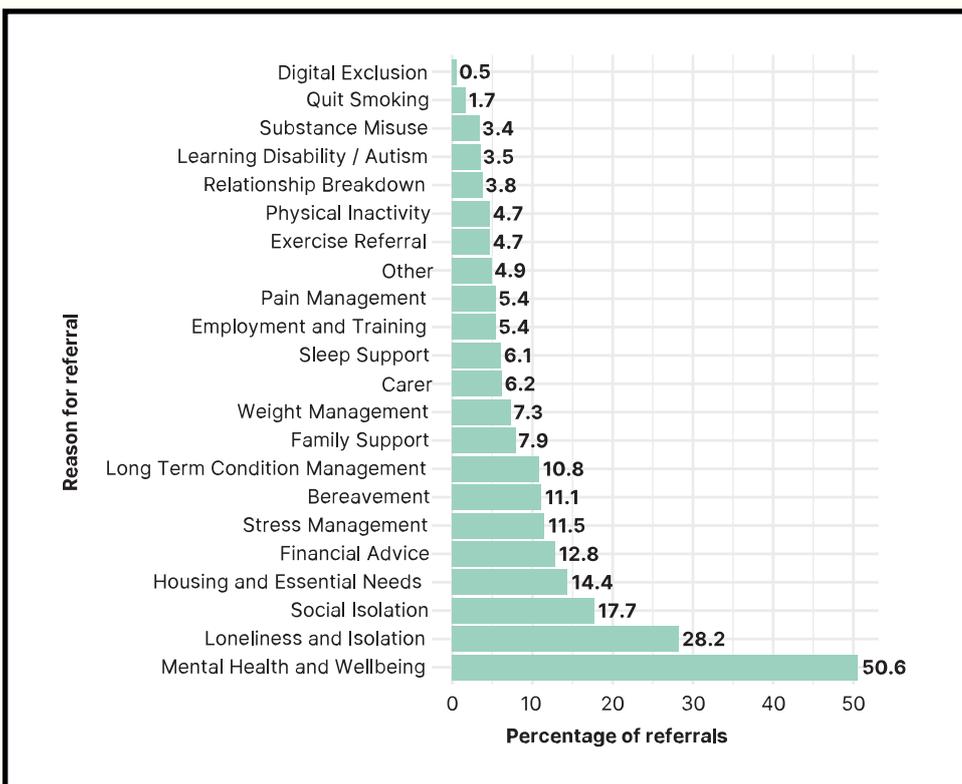
Engagement status	Number of patients	% of patients
Full engagement	891	49.2
Partial engagement	490	27.1
No enagagement	318	17.6
Referral error	111	6.1

Full engagement: case status group = "Complete"

Partial engagement: case status group = "Discharged/Closed" AND case status = "No longer requires service" OR "Disengaged" OR "Did Not Attend Appointment" OR "Unhappy with service" OR "Client Deceased"

No engagement: case status group = "Discharged/Closed" AND case status = "Unable to contact" OR "Referral declined" OR "Not specified"

Referral error: case status group = "Discharged/Closed" AND case status = "Inappropriate referral" OR "Duplicate or Error" OR "Re-referral" OR "Out of area"

Demographics

Gender

Of the 1845 referrals to the service during the year 65.7% (n = 1212) were females, 34.1% (n = 630) were males, 0.1% (n = 1) were non-binary and 0.1% (n = 2) were unknown (includes prefer not to say, not yet disclosed or missing data). The split of clients by gender for each engagement status is set out in Table 3.

Table 3: Percentage of patients by gender for engagement status

Engagement status	All clients	Male (%)	Female (%)	Non-binary (%)	Not yet disclosed (%)
Full engagement	891	31.1	68.9	0.0	0.0
Partial engagement	490	34.7	64.9	0.2	0.2
No enagagement	318	41.2	58.8	0.0	0.0

Figure 5: CLW service referrals by gender (total n=1845)

Gender of those referred

- Female: 65.7% (1212)
- Male: 34.1% (630)
- Not specified: 0.15% (2)
- Non-binary: 0.05% (1)
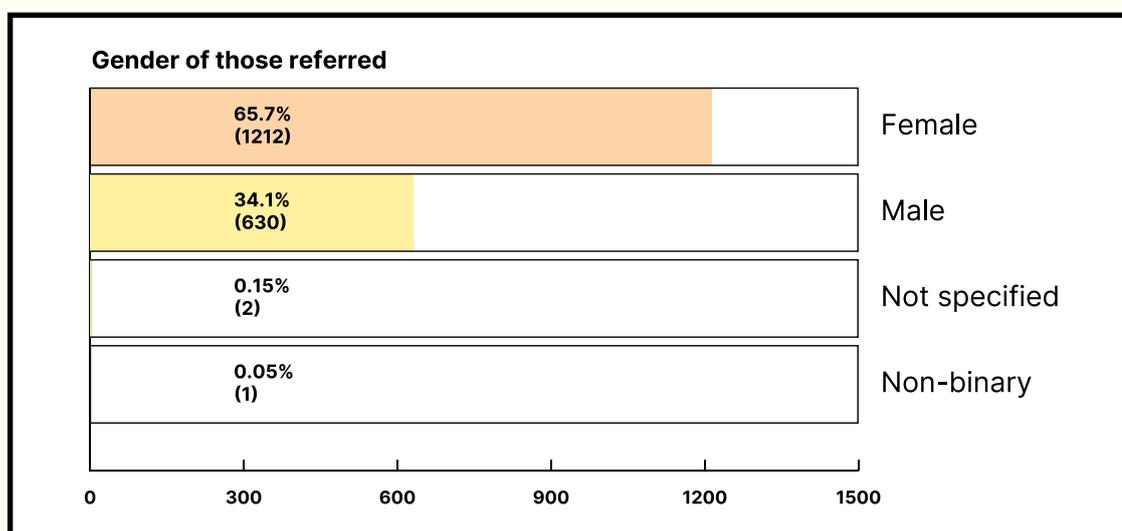
Age

The average age of clients was 55 for those who fully engaged, 47 for those who partially engaged and 52 for those who did not engage with the CLW service.

Figure 6: Average age by CLW service engagement level

Average age	Engagement levels
55 years	Fully engaged
47 years	Partially engaged
52 years	Did not engage
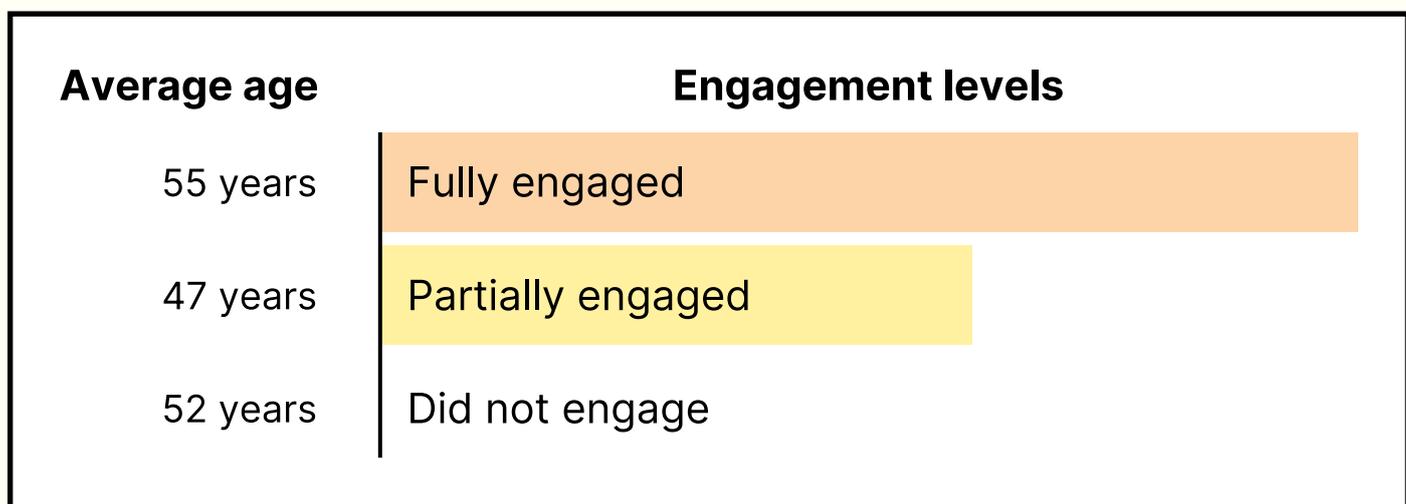
Appointments

In total, 6483 appointments were recorded on Elemental during the year. Appointments on Elemental refer to CLW engagements or sessions with patients. This compares to a year 1 total of 3225 appointments, and a year 2 total of 5533 appointments.

Figure 7: Recorded appointments within Elemental for 22/23, 23/24 and 24/25

Number of appointments

Year	Appointments
Year 1	3225
Year 2	5533
Year 3	6483
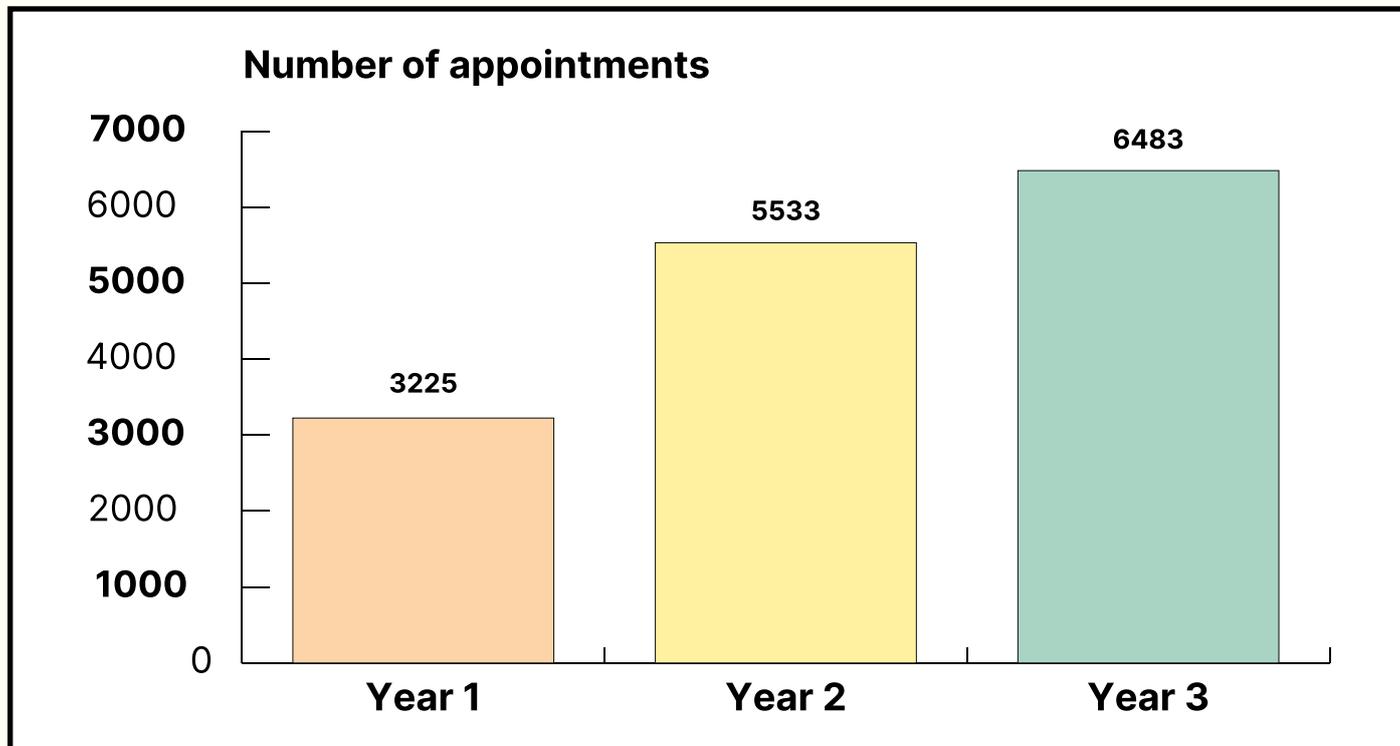
Tables 4 and 5 describe the types and outcomes of appointments recorded on Elemental by CLWs, where the date of the appointment was within the reported year.

Table 4: Number and percentage of appointments by type

Appointment type	Number of appointments	% of appointments
Telephone	4149	64.0
GP practice (ward visit)	1828	28.2
1 to 1 (face to face)	177	2.7
Scheduled appointment	134	2.1
Video call	72	1.1
Text	44	0.7
Not selected	31	0.5
Other	25	0.4
Email	16	0.2
Office visit	5	0.1
Obtaining and reviewing information	2	0.0

Of the 6483 appointments recorded, 64% were telephone appointments, 30.9% were face to face appointments and a further 2% were text, video call and email engagements.

Table 5: Number and percentage of appointments by outcome

Appointment outcome	Number of appointments	% of appointments
Attended	4031	62.2
DNA (Did Not Attend)	1378	21.3
Rescheduled	552	8.5
Cancelled	365	5.6
Not selected	157	2.4

For the 1381 annual referrals that were finalised (complete, discharged or closed) and where the patient engaged with the CLW service (fully or partially), a total of 5639 appointments were recorded.

On average each patient engaging with the service had 4.1 appointments recorded in their case file. The average was higher for those fully engaged with the service (4.5 appointments per patient) compared with those only partially engaged with the service (3.4 appointments per patient).

The actual number of appointments recorded for each patient ranged from 0 to 15 in cases where patients fully or partially engaged with the CLW service and where the referrals were complete, discharged or closed following the completion of the support provided.

Social Prescriptions

In total 1909 social prescriptions were recorded on Elemental during the year. This compares to a year 1 total of 1756 social prescriptions, and a year 2 total of 2097 social prescriptions.

The interventions prescribed by CLWs on Elemental are allocated a primary category(ies) according to the type of support they aim to provide.

Table 6 describes interventions prescribed for each quarter in the reported year by the primary category of the intervention.

Table 6: Percentage of interventions prescribed for each quarter by primary category of the intervention

Primary Category	Qtr 1 (Jul24-Sep24)	Qtr 2 (Oct24-Dec24)	Qtr 3 (Jan25-Mar25)	Qtr 4 (Apr25-Jun25)
Mental Health and Wellbeing	57.6	59.0	53.8	47.8
Social Support	36.5	33.8	16.9	19.2
Unknown	21.4	19.2	15.0	13.4
Loneliness and Isolation	9.9	13.1	19.0	15.5
Physical Exercise/Activity	15.2	11.2	8.3	9.6
Others (each < 1% of year total)	9.6	9.8	9.9	8.0
Disability	3.5	9.5	6.4	9.6
Financial Advice and Practical Support	5.1	7.2	5.1	8.3
Housing	4.0	5.6	5.4	7.5
Emergency Support/Crisis	4.6	7.7	4.8	3.5
Long Term Conditions	1.4	4.6	5.9	7.1
Food Support	3.0	4.1	4.0	4.2
Family and Relationships	2.1	3.3	4.6	3.3
Bereavement	1.4	1.3	4.8	5.0
Employment and Training	2.7	1.8	4.0	3.5
Carers	1.4	2.6	3.2	3.3
Clinical Support	3.2	3.1	1.3	1.5
Learning Disabilities	1.8	2.8	0.8	1.9
Diet & Nutrition	3.2	1.5	0.3	1.0
Problematic Substance Use	0.2	1.8	2.9	2.7
Adult Learning and Digital Inclusion	0.3	1.5	1.3	1.7

Some interventions within Elemental have not been assigned a primary category and are recorded as 'unknown'. The integration of the Directory of Services into Elemental, alongside a review of how interventions are recorded, is expected to help reduce the number of interventions being tagged as 'unknown' in future.

The following tables outline some of the most common social prescribing destinations:

Mental Health and Wellbeing

Intervention/service	Number of social prescriptions
Mikeysline	61
Decider Skills/ Desider Skills App	59
Highland Mindfulness Group	44
Listening Ear	23
Living Life (NHS 24)	22
Listen Well	21

Poverty and Income/Housing

Intervention/service	Number of social prescriptions
Citizen's Advice Bureau (CAB)	82
The Highland Council Welfare Support Team	63
Highland Council Housing	21

Long-term Conditions/Disability/Learning Disability

Intervention/service	Number of social prescriptions
Myself-Management	47
Highland One Stop Shop	20
Maggie's Highland	16

Family/Carers Support/Bereavement

Intervention/service	Number of social prescriptions
Connecting Carers	40
Change Mental Health Carer's Support Service	34
Highland Hospice Bereavement Services	31
Thriving Families	16

Social Support/Physical Activity

| Intervention/service	Number of social prescriptions
High Life Highland Leisure Activities*	42
Men's Shed	29
Nature for Health (N4H)	27
Active Health	29
Partnerships for Wellbeing	20

*High Life Leisure activities have been grouped under 'social support/ physical activity' interventions and do not include the number of social prescriptions made to other High Life activities/ interventions such as library and archive centres, adult learning and countryside rangers.

Signpostings

In total 1354 signpostings were recorded on Elemental during the year. This compares to a year 1 total of 365 signpostings, and a year 2 total of 420 signpostings.

The number of signpostings by month in which it was provided are shown in Figure 8.

Figure 8: Number of signpostings recorded on Elemental by month (1st July 2024 to 30th June 2025).
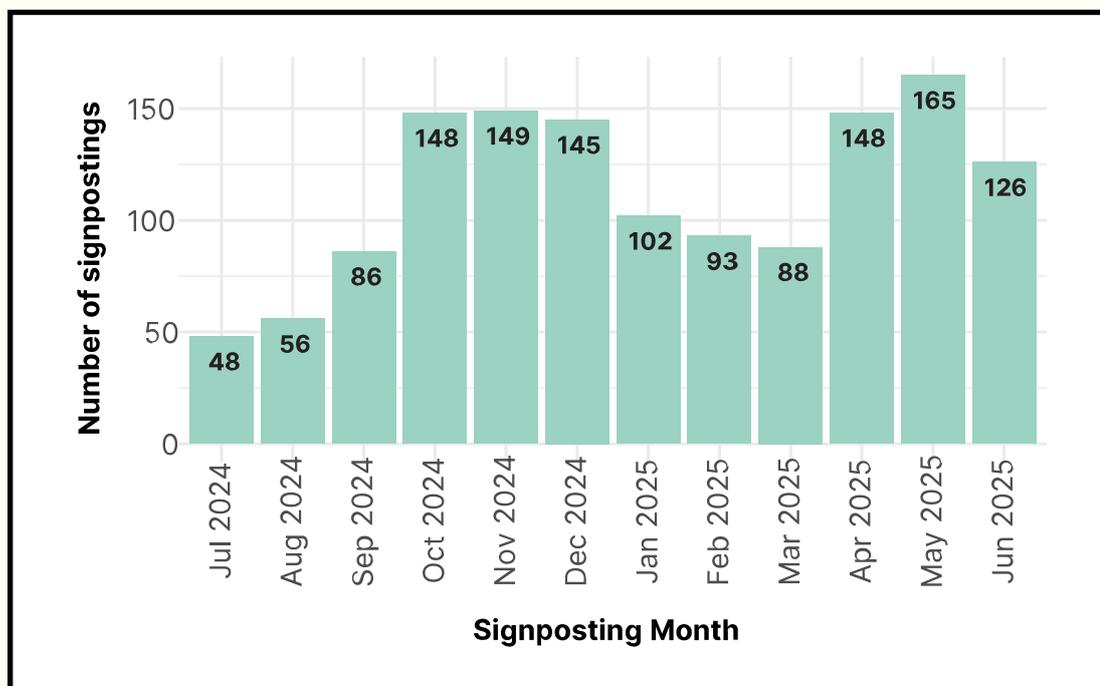
SWEMWBS Outcomes

The short version of the Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS[1]) is a validated tool which is used to assess positive aspects of mental wellbeing and is a measure of outcomes achieved with patients engaging with the CLW service. The CLW completes the SWEMWBS questionnaire with the patient at the start (pre) and end (post) of their contact with the service. This is administered, when it is relevant, appropriate to do so and with patient consent.

SWEMWBS[1] scores range from 7 to 35 and higher scores indicate higher positive mental wellbeing. A score of >18-20 is indicative of possible depression or anxiety and a score of 18 or less is indicative of probable depression or anxiety. The mean score is 23.5 in general UK population samples[2].

Table 7 summarises the number of times SWEMWBS was completed with patients pre and post case management with those referred to the service in year 3, along with the average score. Mean scores were obtained by analysis of scores recorded in Elemental (un-paired) and were observed to be higher following input from the CLW compared to pre case management. SWEMWBS has been shown to vary by age and gender, therefore caution should be applied when interpreting this data and no statistical testing was undertaken. Overall, data from SWMWEBS suggests improved mental wellbeing in patients who engage with the service.

Table 7: SWEMWBS measurements at start (Pre) and end (Post) of case management for referrals made during the reported year (as at 01/09/2025)

Number completed (SWEMWBS Pre)	Mean score (SWEMWBS Pre)	Number completed (SWEMWBS Post)	Mean score (SWEMWBS Post)
1039	18.6	345	21.7

Note: Further SWEMWBS measurements may be taken with clients who were still being actively managed by the service as at the date of data extract for this report (01/09/2025) so these numbers may be subject to change.

Not all patients had SWEMWBS measurements taken at both pre and post case management. Reasons for this include:

- the patient declined the offer to complete the SWEMWBS questionnaire.
- the patient disengaged from the service before the post engagement survey was administered.

Where available, scores were paired to identify any change over the period the patient was being supported by the CLW service.

Figure 9 summarises the changes in paired scores for cases closed during year 3. There were a total of 316 patients with paired scores within this time period.

Figure 9: Change in SWEMWBS measurement paired scores by month in which case was closed.

Of the 316 patients that completed the before and after questionnaire, 249 had an increased score, 47 had a decreased score and 20 had no change. The average score for these clients increased by 3.1 points post measurement. Academic evaluation of the SWEMWBS suggests that, minimally, a 1-point change in SWEMWBS can be statistically meaningful at the individual level 2.
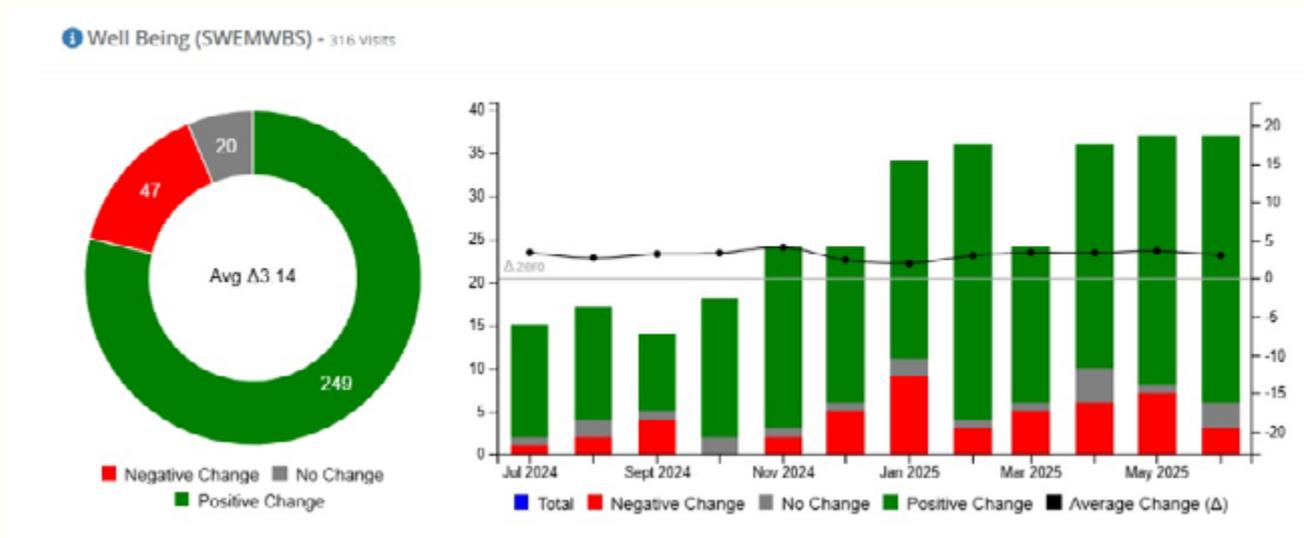
Note: The figure presented above is taken directly from a report available in the Elemental system.

Changes in SWEMWBS scores for individuals can occur due to several factors and changes cannot be accurately attributable to any one intervention.

Case Studies

The case studies in this report illustrate the real-life impact of Community Link Worker support to individuals across Highland. Each case study demonstrates how CLWs combine a person-centred approach, empathy, practical problem-solving and strong communication skills to address complex needs.

The names used in each of the case studies have been changed to ensure anonymity. Patient consent has also been given.

Case Study - Jenny

Background

Jenny is a woman in her late 60's. She was referred to the CLW service by her GP for support with loneliness and isolation, bereavement and mental health and wellbeing.

Issues

- Bereavement following the suicide of a close family member.
- Feelings of anxiety and depression.
- Reluctance to speak about her emotions due to feeling like "a burden".
- Lack of enjoyment in life.
- Intensified emotional distress due to the upcoming festive season.

Support

Using a person-centred approach, the CLW:

- provided empathetic listening and emotional validation, helping Jenny feel heard and supported.
- explored the root cause of Jenny's distress, identifying bereavement as central.
- with Jenny's consent, contacted the suicide bereavement support service to re-establish support.
- successfully arranged renewed support calls with Jenny's previous support worker.
- discussed additional support options for times when she felt emotionally overwhelmed including:

  - Breathing Space.
  - Samaritans.
  - Survivors of Bereavement by Suicide.

The CLW responded to Jenny's increased motivation by:

- Signposting her to Highlife Highland and The Clarity Walks.
- Referring her to a programme of activities at the local leisure centre which offered 7 free taster sessions at either the gym or exercise classes.

Outcome/Impact

- Jenny resumed support calls with the bereavement service and reported feeling "clearer" and more motivated.
- She began sorting through belongings of her deceased family members, something she had previously been unable to face.
- Jenny expressed a desire to improve her physical wellbeing and took steps to engage in light exercise.
- Her mental clarity and motivation led to further positive actions, including clearing out her home.

Feedback

Jenny expressed heartfelt appreciation for the CLW's support:

> "I can't believe the difference in my mental health from when I was first referred 'til time of discharge. I am even cracking on with clearing out my house now that I have the clarity and support I needed, and this is further helping me through the process."

Case Study - Logan

Background

Logan is in their thirties and was referred to the CLW service by the GP as they had anxiety relating to returning to paid employment. This followed several years of living with a debilitating health condition, which was now better managed. Logan was also a parent and a carer for a family member with advanced dementia.

Issues

- Anxiety and low confidence
- Challenges in seeking employment
- Emotional distress related to disability entitlements
- Caring responsibilities
- Long term health condition

Support

Using a person-centred approach, and 6 tailored sessions, the CLW:

- created a safe, non-judgemental space for Logan to share concerns.
- explored Logan's personal and professional challenges with them.
- completed the Short Warwick Edinburgh Mental Well Being Scale (SWEMWBS) with Logan.
- supported Logan emotionally around their disability benefits and upcoming assessment.

Identified and socially prescribed relevant supports, which included:

- Anxiety apps to help manage symptoms.
- Triage Employability Services for training and employment support.
- Thriving Families referral for support with their neurodivergent child.
- Referral to the Disability Employment Advisor (DEA) at the Job Centre for benefits-related support.
- Mindfulness sessions via Zoom to reduce stress and improve relaxation.

Outcomes/Impact

- Logan felt relieved and validated, having shared their concerns.
- Regular video meetings with Triage helped build confidence and motivation, and Logan began updating their CV and practicing interview skills.
- The DEA provided reassurance and practical support, helping Logan feel confident opening mail and navigating the benefits system.
- Logan was still awaiting contact from Thriving Families but felt reassured.
- By the fifth appointment, Logan felt ready to close the referral.
- At the sixth appointment, Logan had secured a job interview for a part-time role suited to their circumstances.
- Logan expressed hope that they would no longer need to reapply for disability benefits.
- Logan was engaging in activities such as swimming, practising yoga and crafting which helping manage their anxiety.
- The final SWEMWBS score showed a positive improvement in mental wellbeing.

Feedback

- Logan found the sessions beneficial, especially the social prescribing and signposting.
- They reported a more positive outlook, having faced challenges and achieved goals.
- They credited the CLW's non-judgmental and encouraging support for helping them overcome barriers to employment.
- Logan described the CLW service as perfect for someone with low confidence and expressed deep gratitude for the support that they had received.

Case Study - Sam

Background

Sam has a history of trauma and previously used alcohol to cope. With support from a Community Psychiatric Nurse (CPN) and six years of Cognitive Behavioural Therapy (CBT), they achieved significant recovery and have been sober for 10 years. They are married with two children and were thriving professionally until a car accident left them wheelchair-bound and registered as disabled.

Issues

- Money worries due to reliance on benefits and their partner's carer income.
- Chronic pain and side effects from medication affecting energy, mood, and motivation.
- Social isolation and loneliness, spending most time alone at home.
- Limited independence, with nearby parents sometimes perceived as overbearing.
- Emotional burden, feeling unable to contribute meaningfully to family life.

Support

Over two months, the Link Worker held six scheduled appointments, with four attended. Through empathetic and consistent engagement, the Link Worker built rapport and trust, enabling Sam to speak openly about their past and current challenges.

Social Prescriptions Offered:

- Highland Disabled Ramblers – to reconnect with a love of hiking.
- Local arts and crafts group – to support mental wellbeing through creativity.
- Befrienders Highland – to address isolation and build peer connections.
- Red Chair Highland – to improve digital literacy and reduce homebound limitations.
- Myself Management – for chronic pain support.
- Road Peace – counselling for road traffic accident victims.

Outcome/Impact

- The regular conversations with the Link Worker were the most impactful, offering emotional relief, validation, and hope.
- Sam self-referred to Befrienders Highland and Myself Management, identifying these as most beneficial.
- Inspired by the support, Sam independently sought out a gym membership to improve wellbeing.
- A positive mental attitude was sustained for two weeks, a significant improvement.
- Sam felt more resourced and motivated to participate in family life and outings.

Feedback

Sam expressed deep gratitude for the Link Worker's time, empathy, and persistence in offering options. Even though not all suggestions were acted upon immediately, Sam appreciated having them available for future consideration. They reported feeling heard, supported, and hopeful, with a renewed sense of agency.

Together, these case studies highlight the breadth of skills that CLWs being to their role and their ability to deliver person-centred, holistic support to improve health and wellbeing outcomes.

The following summarises the key skills demonstrated across all three case studies.

Skills Demonstrated by CLWs

Active Listening and Empathy

- Building trust through empathetic listening and emotional validation.
- Offering reassurance and emotional support during challenging times.

Person-centred and Holistic Approach

- Assessing needs and preferences in a holistic way, considering emotional, practical and family needs.
- Co-producing tailored support plans that reflect individual goals.

Social Prescribing including Signposting

- Connecting individuals to community resources and services aligned with their interests and challenges.
- Providing clear, effecting signposting to promote wellbeing and independence.

Advocacy and Communication

- Acting as an advocate for patients when engaging with external services.
- Liaising with agencies to ensure a co-ordinated and timely support.

Empowerment and Motivation

- Encouraging proactive steps and self-referral to build confidence.
- Offering motivational support to sustain engagement and progress.

Consistency and Follow-Up

- Maintaining continuity of support through regular check-ins.
- Ensuring ongoing support and monitoring progress over time.

Measurement and Evaluation

- Use of wellbeing measurement tools (SWEMWBS).

Feedback

Patient Feedback

"You are the kindest person I have spoken to about my issues. This has made me feel excited about healing."

"I've taken a lot from my 2 sessions with you. Your reflective questioning has really helped me to start re-framing some of my thought processes, to be less harsh on myself and to feel more ready to embrace this new phase of my life."

"The service has been brilliant. It helped just to talk about things, and I felt like you really listened and spent a lot of time to come up with things that were personalised to my needs and interests."

"I honestly am so grateful for your help; I thank you from the bottom of my heart. If it wasn't for you, I wouldn't have those timetables on my fridge ready to take the next step."

"I feel more positive about my thinking. My insecurities are less. Less worrying in my head and less " what if's". I feel reassured and guided to think positively."

"I am starting a new life, I have stopped smoking, I have my finances under control and am starting exercise to become more healthy. Thank you very much for the help"

"My Community Link Worker is a warm and empathic listener and has encouraged me to face reality without feeling belittled."

"I feel happier and more content. I enjoyed the interaction with the CLW and learning about what's available locally in term of services and activities. I really appreciated the referral."

"If I hadn't been referred to my Community Link Worker I would still be lost in the system waiting for help after my stroke. They helped me get referred to a stroke nurse and physiotherapist so I could start getting back to my old life again. They are a saint."

GP Practice Staff Feedback

"We are so lucky to have you in the practice, you are making a real difference to patients."

"The patient says they really appreciate the time our CLW has spent with them, they have found all the advice the CLW has provided really useful and said that they feel better knowing someone is helping them. They appreciated having someone to talk to in their own environment as they said they felt comfortable and how at ease they were made to feel."

"Thank you, it was great to see a positive change in the patient's attitude and overall outlook."

"Just to say, I had another patient give positive feedback about her sessions with you today. She has been seeing you for low mood and isolation. She was very happy with the support you gave her."

"The link workers we have worked with have been nothing short of outstanding, you go the extra mile with your work with the clients you support."

2024 – 2025 Highlights

Service Expansion

Additional funding was received from the Primary Care Modernisation Project Board at the beginning of 2024 to expand the CLW service to all GP practices in Highland. Resource was allocated on a cluster basis to ensure a focus remained on tackling health inequalities.

The service was expanded from 29 GP practices to all 62 GP practices in Highland during 2024.

Community Benefits – Local clean up activities

NHS Highland is committed to maximising the positive impact of its procurement activities through Community Benefit Clauses (CBCs). These clauses require suppliers to contribute to social, economic, or environmental improvements as part of their contract delivery.

This year, staff across Change Mental Health took part in local clean-up activities:

- In Fort William, three staff members walked along the River Nevis and Glen Nevis, collecting litter and helping to preserve the natural beauty of the area.
- In Golspie, two staff members joined a beach clean, collecting rubbish and engaging with members of the public to raise awareness of the charity involved.
- In Invergordon, two staff members collected plastic waste and discarded bottles along a popular dog-walking route. The clean-up not only improved the local environment but also provided a chance to reconnect and plan future team activities.

Community Link Worker Third Sector Remote and Rural Fund

This fund was established to support social prescribing by helping to increase or create capacity to accept referrals from CLWs in remote and rural areas.

The fund aims were to enable third sector organisations to:

- Continue existing services
- Expand current provision
- Establish new methods of service delivery

The fund was managed by the Highland Third Sector Interface (HTSI) on behalf of NHS Highland. A funding panel was convened at the end of June 2025, where eight organisations were successful in securing funding to deliver services aligned with the fund's aims. A reporting schedule is in place and will run until the funding period is complete in April 2027 to provide information on progress and impact.

Highland Directory of Services

The Highland Directory of Services (DOS) was developed by the Health Improvement team in Public Health with support from the Highland Third Sector Interface. The DOS aims to provide the CLW service with easily accessible information on opportunities to refer or signpost patients to and to integrate this into the Elemental system which manages referrals and case records. Existing groups, services and initiatives were mapped against the reasons for referral and included a wide range of in-person, online and self-help support.

The DOS was launched in April 2025. It is a user-friendly online tool designed to help individuals and families in Highland find information about local and national organisations and activities that support health and wellbeing. This includes information on support to tackle loneliness, bereavement and financial hardship and how to access social clubs and sporting activities. The directory brings together a wealth of resources in one accessible place.

The integration of the DOS within the case management system will improve social prescribing and signposting information and help improve recording of referral destinations.

- The Highland Directory of Support Services (YouTube)
- Highland Directory of Services website

CLW Service Patient Survey

A new patient survey was launched in June 2025 to capture the experiences of individuals supported by the CLW service.

While an embedded monitoring and evaluation tool already exists within Elemental, it is limited in how it can provide information on patient experience. To address this, a survey was developed to provide an additional opportunity for patients to feedback on their experiences of the service. The survey is ongoing, with no fixed end date, allowing data to be drawn at any point in time and across any chosen timeframe.

Survey Methodology:

- The survey was developed using Smart Survey.

- Patients access the survey through QR-coded business cards which are given to patients by CLWs. Direct links to the survey are also shared via email or text message.

- The survey includes a mix of quantitative (e.g. rating scales) and qualitative (open-ended) questions to help provide a comprehensive understanding of patient experiences.

- Responses are collected anonymously to protect patient confidentiality and encourage open and honest feedback.

Data from the survey will be extracted on a quarterly basis and reviewed alongside monitoring of survey uptake and response rates. Only one patient survey response was received in June 2025; therefore, results have not been included in this report which covers the period 1 July 2024 to 30 June 2025.
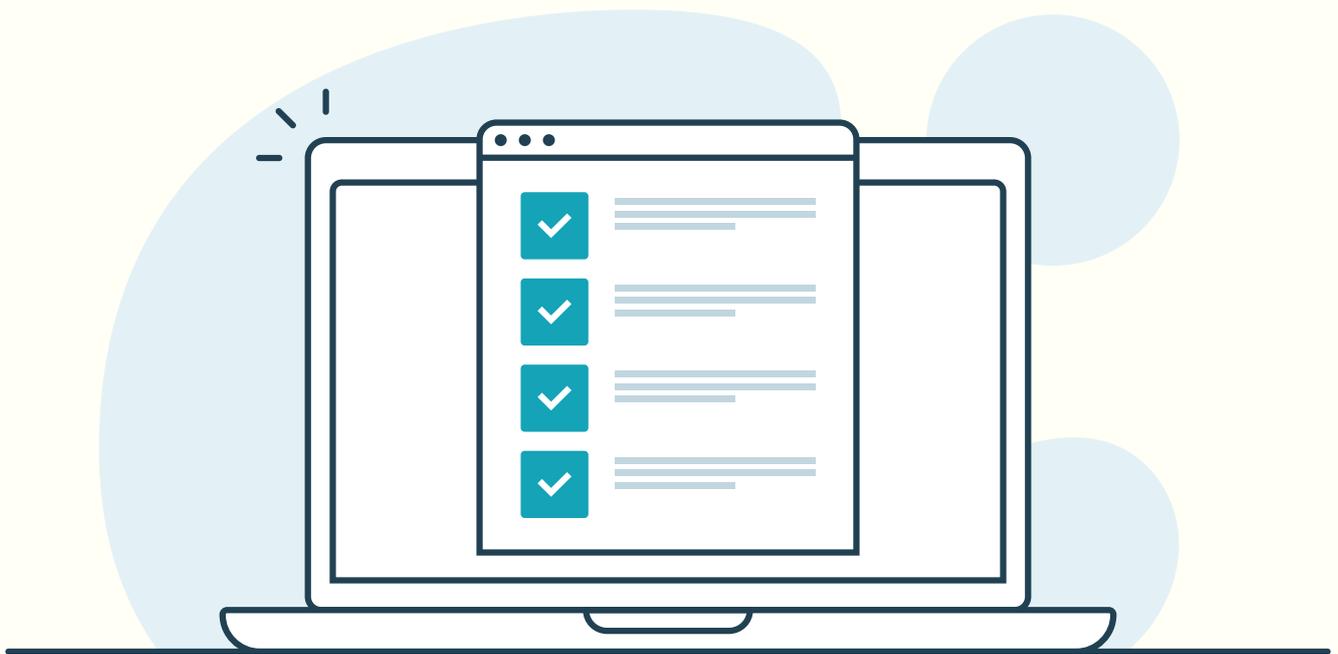
UHI Evaluation

The University of the Highlands and Islands (UHI) undertook an evaluation of the CLW service in remote and rural areas within Highland. The evaluation was funded by the Chief Scientist Office (CSO) and combined elements of quantitative and qualitative research methodology to assess the impact of the service. The study explored outcomes for service users, implementation challenges, and indicators of change, using questionnaires, interviews, focus groups, and service data.

Aims

1. To investigate the impact of the Community Link Worker (CLW) service on rural and remote dwelling individuals, their families and carers, the third sector and primary care providers.

2. To identify barriers and facilitators to the implementation of CLW Social prescribing outside the large metropolitan context.

3. To identify indicators of change for measuring and monitoring impact of the CLW service

Key Findings

- **Positive impact on service users:** 68% of respondents reported improvements in mood, confidence, and ability to self-manage health conditions. The ICECAP-A wellbeing capability tool showed statistically significant improvements across all domains.

- **Barriers to implementation** included limited third sector provision, long waiting times, transport challenges, and stigma in close-knit communities.

- **Facilitators of success** included person-centred approaches, good communication between CLWs and referrers, and access to a variety of support services.

- **Third sector organisations** noted increased referrals and highlighted the potential of CLW data to support funding applications.

- **Primary care providers** reported reduced inappropriate consultations and improved job satisfaction due to the CLW service.

Recommendations

- Strengthen communication and feedback loops between CLWs, referrers, and third sector organisations.

- Refine referral criteria and promote awareness of the CLW service.

- Support CLWs with ongoing training, peer support, and integration into primary care teams.

- Further explore the use of ICECAP-A as a tool for health economic evaluation in rural areas.

Conclusion

The CLW service in NHS Highland has demonstrated steady growth and meaningful impact in rural communities. Continued investment in communication, training, and evaluation will be key to sustaining and scaling the service.

You can access the briefing report on the CSO website.

Challenges

Developments For Elemental

Elemental is the social prescribing software that is used by the CLW service. There have been delays to scheduled developments of the Elemental system throughout the year. A key challenge this year has been the Read Code pilot designed to enable data flow from Elemental back into Vison. The integration would allow social prescribing activity to be automatically recorded in the patient's clinical record, reducing duplication, improving data accuracy and supporting patient outcomes. The pilot at one GP practice encountered some technical difficulties; however, work is ongoing with Elemental to resolve these issues.

Capacity Management

Following discussion with the Primary Care Improvement Plan project team which oversees delivery of the service, each of the 62 GP practices were assigned an estimated annual referral allocation which was set at the beginning of the new contract on 1st July 2024. This approach was introduced to support effective management of the CLW capacity and to ensure that the service is directed towards patients with the greatest need.

Referral activity has been monitored throughout the year, with practices receiving quarterly updates comparing their actual referral numbers against their allocation. These updates have facilitated constructive discussions between GP practices, the CLW service, and individual CLWs, helping to manage capacity and assess the need for alternative ways to manage caseloads where necessary. There will be ongoing review of referral rates across all practices to inform future decisions about referral allocations, capacity and caseload management.

Looking Forward

Elemental Developments

access Elemental

It is anticipated that the following requested developments will be completed and integrated in the near future.

1. Risk Assessment Enhancement

Following feedback from Change Mental Health, it had been identified that several safeguarding concerns and significant risks were not being highlighted point of referral. To address this, the risk assessment section within Elemental was reviewed and revised to improve clarity and usability. This update will ensure appropriate support and risk management can be put in place from the outset. The risk assessment enhancement within Elemental is expected to go live in January 2026.

2. Referral Allocation management

To support effective referral management across practices and clusters, a quota alert system has been requested as a development within the Elemental Platform. This new feature will provide automated alerts to referrers when they are approaching their practice's allocation of referrals. If the practice allocation is reached, a review will be initiated to assess the current capacity of the CLW service. This may include discussions around alternative ways to manage capacity and caseloads if appropriate.

This approach aims to support practices to monitor their referral rates, ensuring access to CLW support across practices and clusters is targeted at those most in need.

Surveys

Building on the insights gathered from the recent patient survey, work is being progressed to develop two additional surveys to gather feedback to inform service development and improvements.

- CLW Survey

  - This will gather feedback directly from CLWs to better understand their experiences and challenges and gather suggestions for improving the service.

- GP Practice Survey

  - This will seek to gather feedback from GP practice staff on how they have integrated the CLW service into the work of the practice, capture perceived impact on patients and highlight opportunities for developing and improving the service.

These surveys aim to provide a more rounded view of the CLW service from multiple perspectives, helping to shape future developments and ensure the service continues to deliver on its aims and meet the needs of patients.

Improvements In Data Gathering and Analysis

Over the last 12 months opportunities to enhance the quality of the data captured through the Elemental social prescribing platform have been identified.

To support continuous learning and improvement, work is underway to:

- Improve the quality of data capture by improving consistency and accuracy of recording.

- Explore the full reporting capabilities of Elemental, enabling deeper insights into patient outcomes and helping to identify areas for further improvement and development.

- Continued review and integration of the Directory of Service (DoS) to ensure it remains accessible and works effectively to support delivery of the service.

These improvements will help strengthen the evidence base, enhance service delivery and help support third sector and community partners across Highland to develop opportunities for CLW's to socially prescribe.

Improvement Plan

In the coming year, work to implement the recommendations from the University of the Highlands and Islands (UHI) evaluation of the CLW service will be undertaken. These recommendations, combined with the insights from the patient survey, CLW survey and GP practice survey, will form the foundations of a comprehensive improvement plan focusing on strengthening service delivery. By using the evidence from feedback and evaluation, we aim to ensure the service continues to evolve to the meet the needs of patients and GP practice staff.