NHS Highland Community Link Worker Service

Year 2 Report: 1st May 2023 – 30th April 2024

Highland Community Link Worker Service

change MENTAL HEALTH

NHS Highland na Gàidhealtachd

PUBLIC HEALTH

Introductions

I am delighted to be able to share the report for the second year of delivery of the Community Link Worker service in Highland. The service was introduced in May 2022 and is now fully embedded in many practices. The service has supported more than 1535 patients over the last year and is highly valued by both patients and GPs.

There has been considerable learning from development of this service and the achievement of positive outcomes for patients and general practices has been instrumental in securing additional funding from the Primary Care Improvement Fund to expand the services to all general practices in Highland.

The expansion of the service is a significant undertaking, and I would like to thank all those involved in this work.

Dr Tim Allison
Director of Public Health, NHS Highland

This report gives an overview of service delivery to Highland GP practices that have been allocated Community Link Worker hours. The learning from the first year of service delivery has helped to inform service improvements and expansion of the service to all GP practices in Highland. The data presented has been extracted from Elemental; the social prescribing platform used for referring patients and reporting on outcomes. I hope you will find this report informative and useful in demonstrating the positive impact that the Community Link Worker Service has made to GP practices and their patients.

Cathy Steer
Head of Health Improvement and Community Link Worker Service Lead

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Introduction

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

Change Mental Health has been commissioned by NHS Highland to provide the Community Link Worker service to 29 GP practices. This report details the progress and development of the service during its second year of delivery and covers the period May 2023 to April 2024.

Key Highlights from this period include:

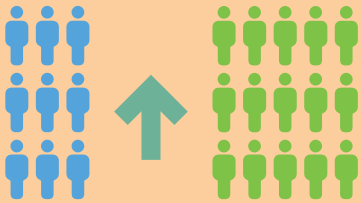
2097 social prescriptions were delivered over the year.

Feedback from GP's has highlighted the CLW service has improved outcomes for their patients and saved them time.

Feedback from GP's has suggested that the CLW service is a valuable addition to their practice.

For patients that completed SWEMWBS, the average score increased by 3.6 points between the initial and final measurement, i.e. pre and post engagement with the CLW service.

Following a competitive re-tendering process Change Mental Health were successful and have been awarded the contract to deliver the CLW Service contract for a further 3 years.



920

Referrals in 2022/2023

1535

Referrals in 2023/2024

An increase of **66%**.

Two additional GP practices, Golspie Medical Practice and Kinlochleven Medical Practice have been added to the list of practices that are benefitting from the CLW service.

CLWs have successfully supported patients to improve their situation through mitigating the impacts of loneliness and isolation, poor mental health, and poverty.

The creation of two new peripatetic CLW posts to support practices, particularly those in remote and rural areas where it may be difficult to find cover for absence or recruit to vacances. This has helped to manage referral rates across practices where it has been needed the most.

Two successful social prescribing network events were held in 2023 in the Highland area, bringing together partners representing primary and secondary care, and 3rd sector organisations, to share information on what is happening around social prescribing and how it can be developed as an approach to support NHS services. The full report from these events is available as a PDF on the NHS Highland website.

The first phase (scoping and planning) of the development of the Directory of Services (DOS) is now complete.

43.3% of all referrals are from SIMD (Scottish Index of Multiple Deprivation) 1 and 2 highlighting a focus on health inequalities.

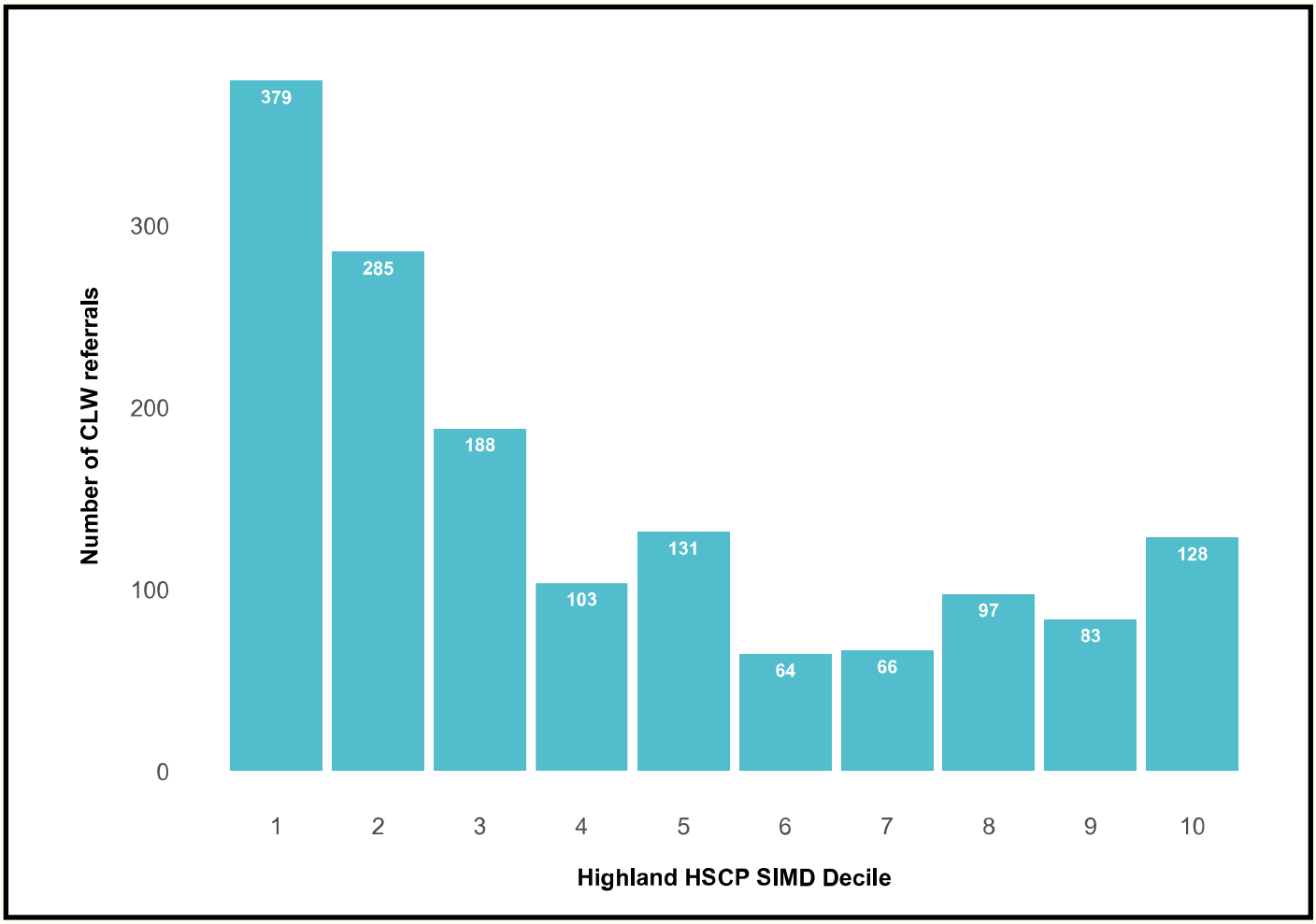
2nd Year of Service Delivery

The following section of the report will look at CLW service delivery from 1st May 2023 to 30th April 2024. Data for this report is taken from Elemental (extracted as at 29/05/2024), the software used by the service to manage referrals and case activity.

Referrals and Outputs

In total, 1535 referrals were made to the Community Link Worker (CLW) service throughout the year, of which 43.3% (n = 664) were for patients living within the Highland HSCP Scottish Index of Multiple Deprivation 2020 (SIMD 2020v2) deciles 1 and 2 (target population). This compares to 920 referrals received in year 1 of the service, with 38.5% of patients living within deciles 1 and 2. Figure 1 shows the annual number of referrals for all SIMD 2020v2 deciles.

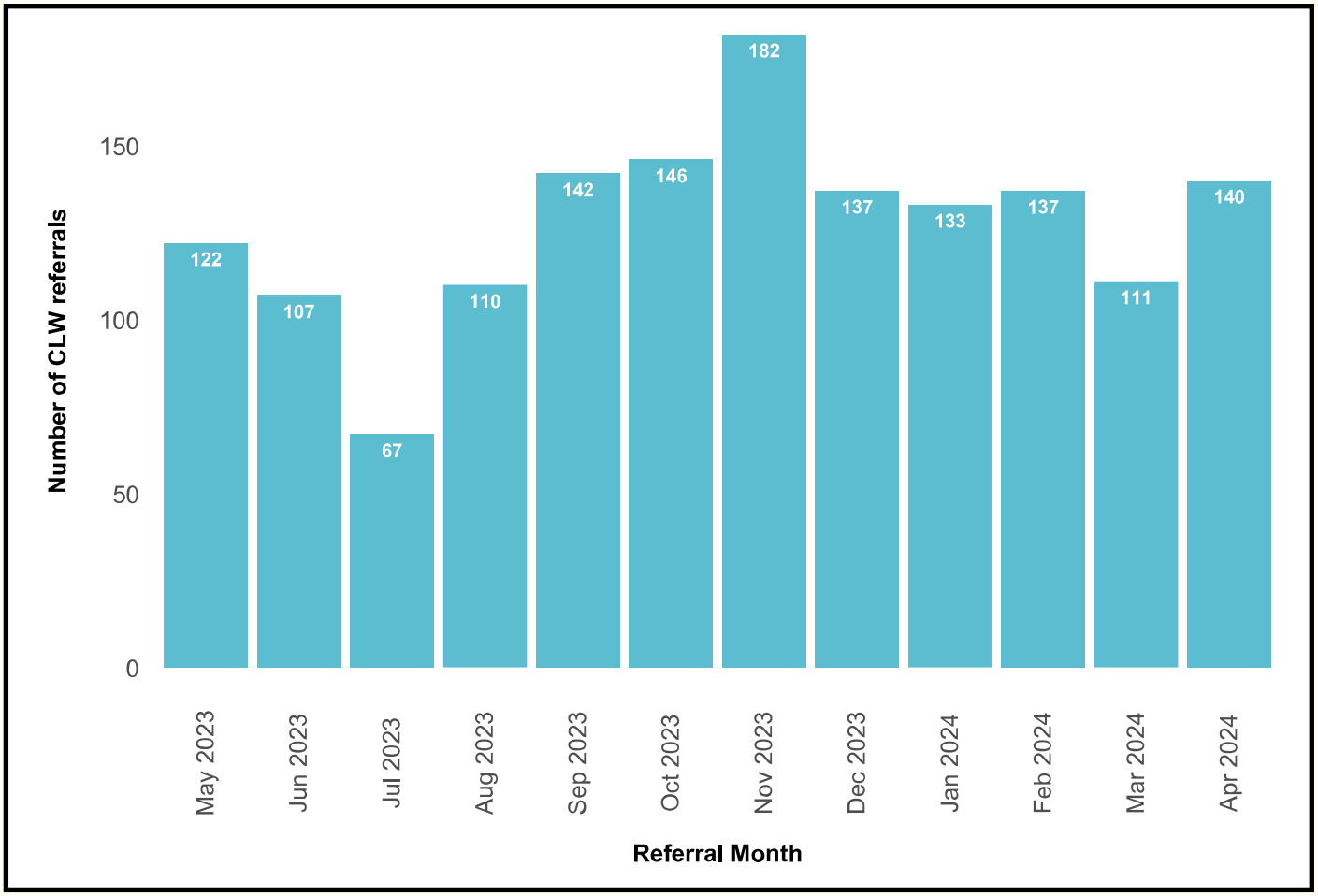
Figure 1: Number of CLW referrals by SIMD decile (1st May 2023 to 30th April 2024)



Note: 11 referrals are excluded from the above data as postcodes in the Elemental records were not available / able to be mapped to SIMD decile. SIMD 2020v2 is used.

Figure 2 shows the number of referrals made to the service in each month throughout the year.

Figure 2: Number of CLW referrals by month (1st May 2023 to 30th April 2024



Reasons for referral

Referrals are made via Elemental to the CLW service giving one or more reasons as appropriate for the referral.

Figure 3 shows the percentage of referrals (n = 1535) for each given reason for referral. Mental health and wellbeing and loneliness and isolation are the most common reasons for referral to the CLW service. Over half of all referrals recorded mental health and wellbeing as a reason (53.7%) and nearly a third recorded loneliness and isolation as a reason (31.3%).

Figure 3: Percentage of referrals with given reason for referral (1st May 2023 to 30th April 2024)

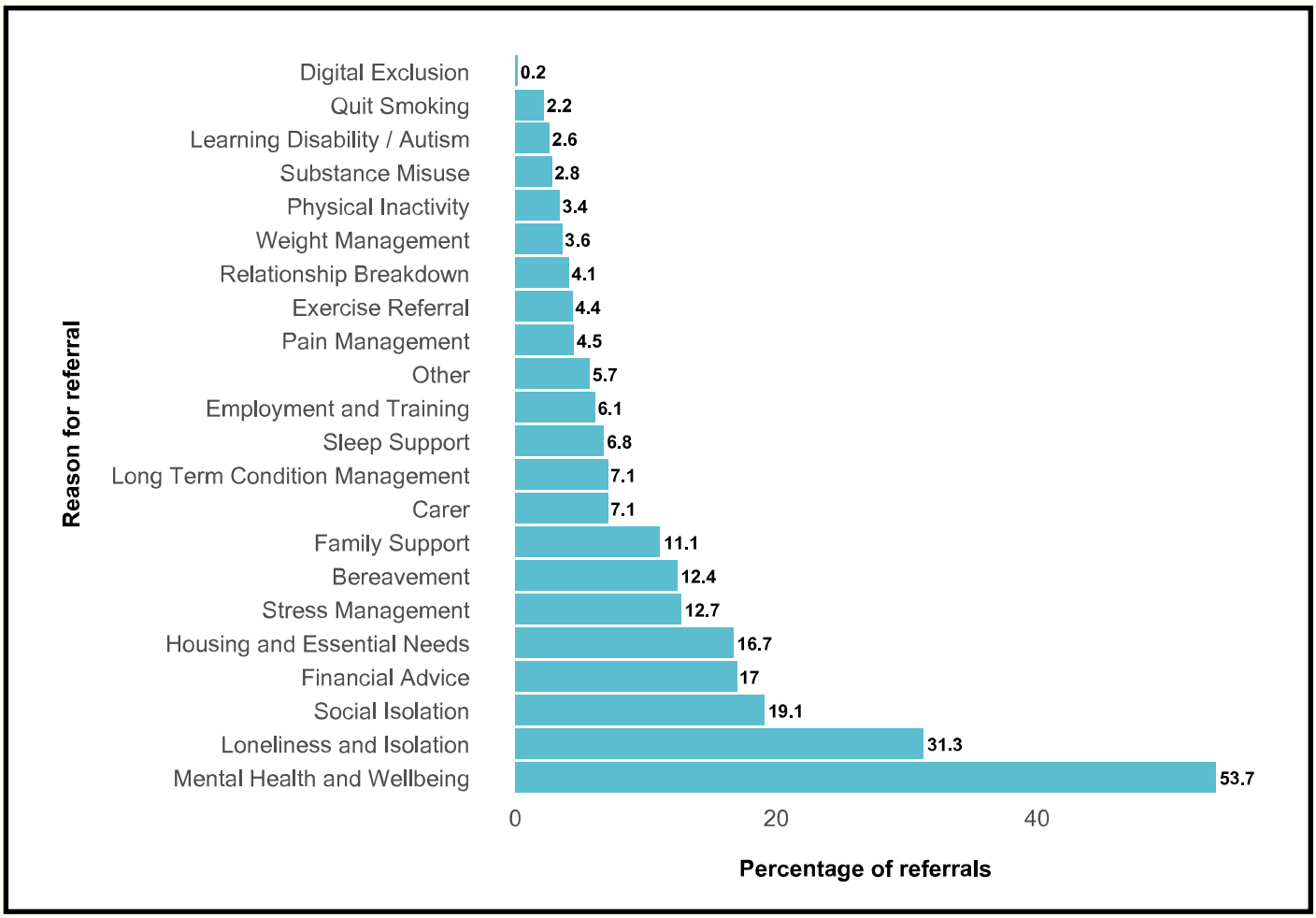
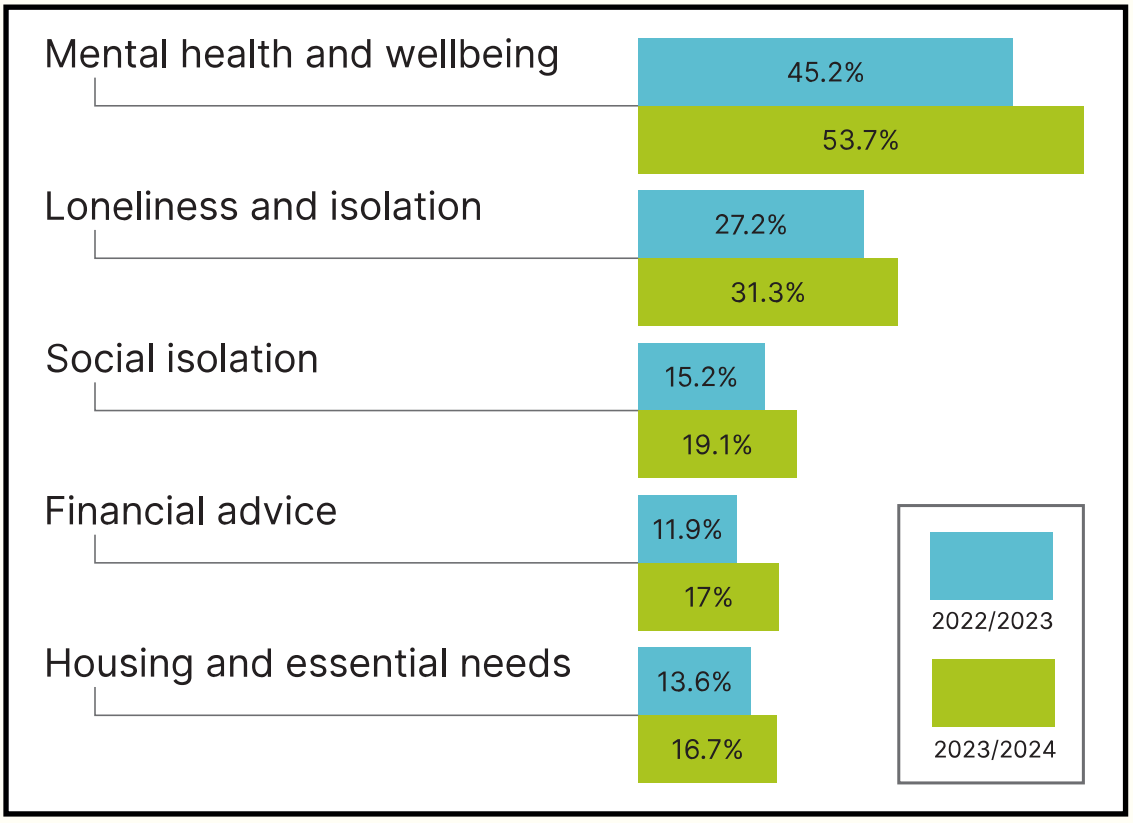


Figure 4: Top five reasons by percentage of referrals in 2023/24 (with comparison to 2022/23)



Engagement Status

The following table describes the engagement status of patients referred to the CLW. Engagement status is categorised in Table 1 for those where the referral was either 'Complete' or 'Discharged/Closed' (data extracted 29/05/2024), hence final case status was known and could be used to derive the final engagement outcome.

Table 1: Patient engagement status (complete, discharged or closed referrals) as at 29/05/2024

Engagement Status	Number of patients	% of patients
Full engagement	634	45.0
Partial engagement	403	28.6
No engagement	279	19.8
Referral error	92	6.5

Note: Engagement status is not recorded within Elemental so has been derived using the case status group and case status of referrals from records as detailed below:

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 – age and gender

Figure 5: Average age by CLW service engagement level

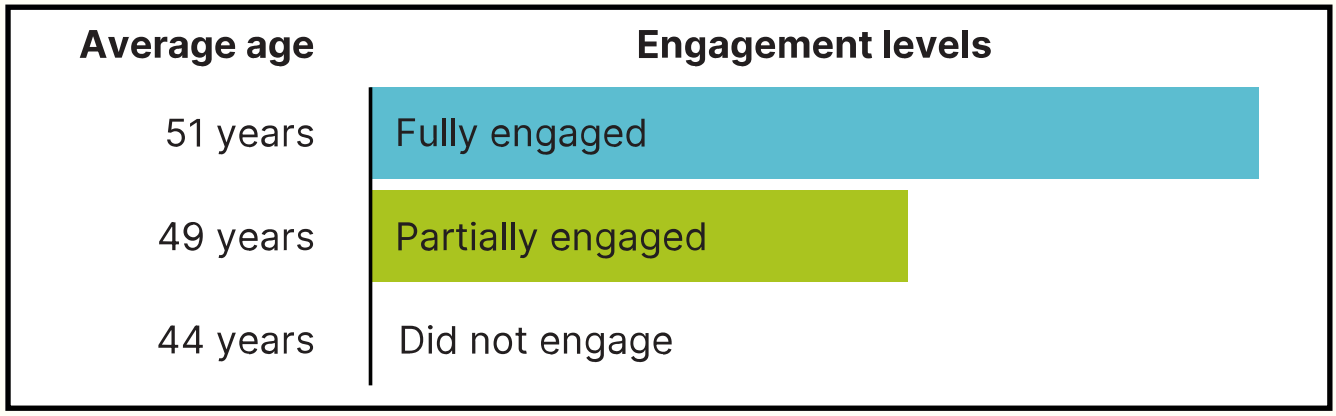
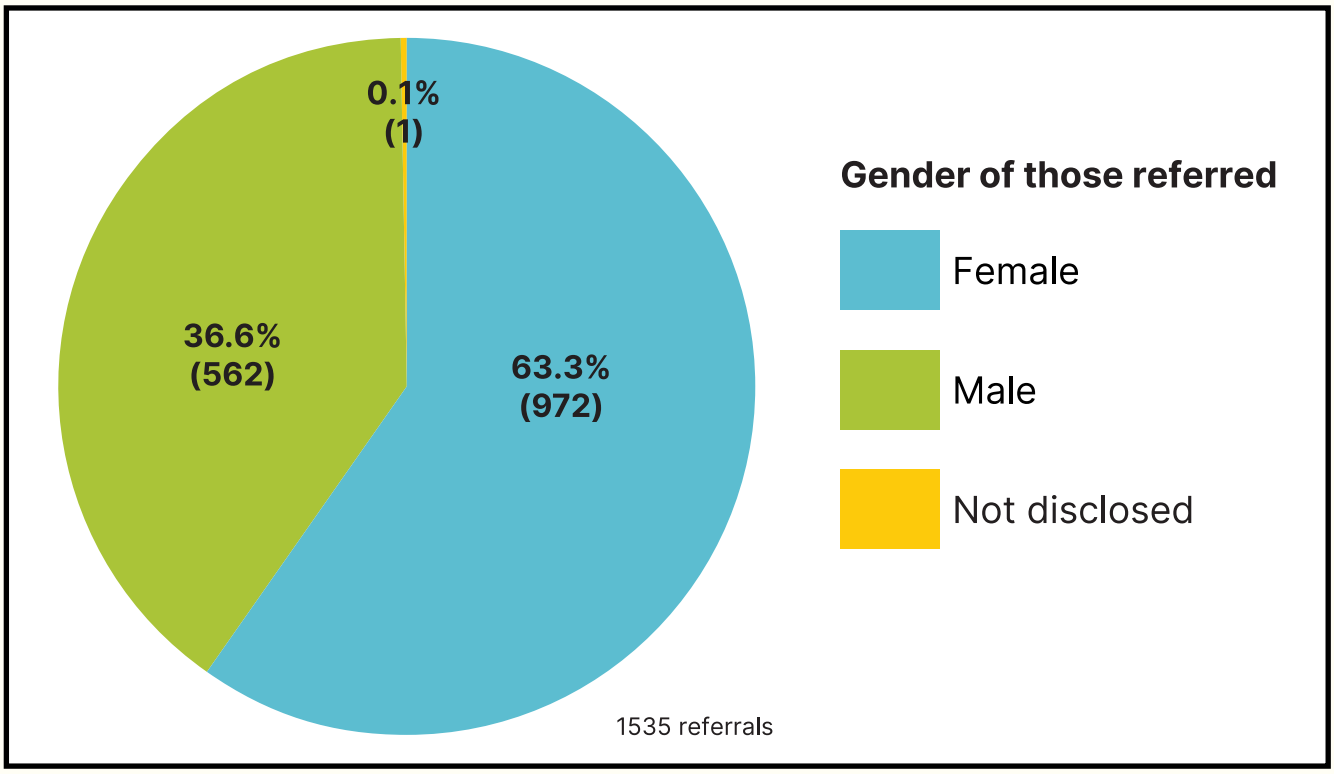


Figure 6: CLW service referrals by gender (total n=1535)

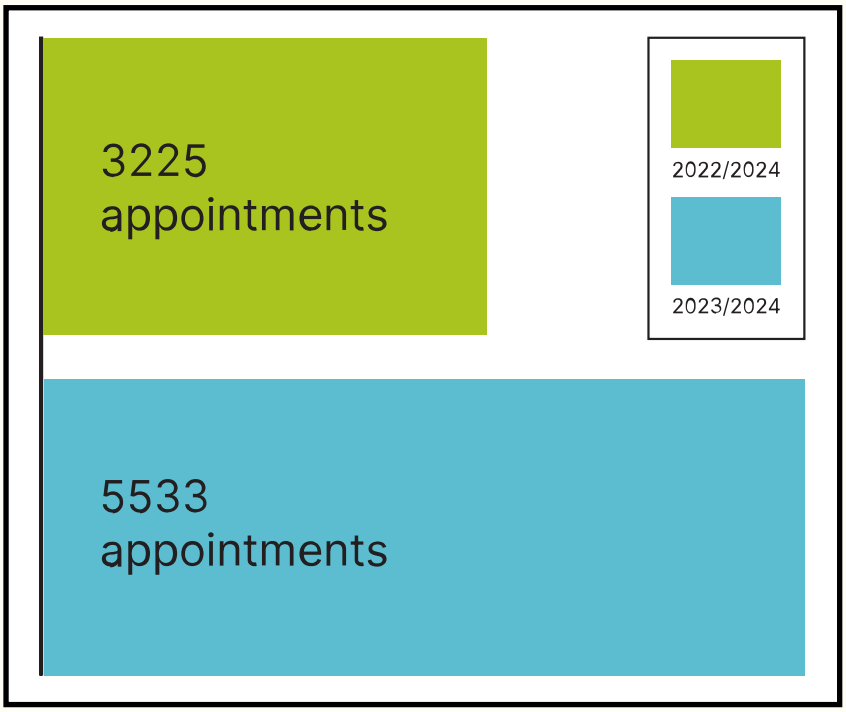


Appointments

In terms of Elemental, appointments mean engagements or sessions with patients.

In total, there was an increase in the number of recorded appointments on Elemental during the year when compared to the previous one.

Figure 7: Recorded appointments within Elemental for 2022/2023 and 2023/2024



In Tables 2 and 3 the types and outcomes of appointments recorded on Elemental by Community Link Workers, where the date of the appointment was within the reported year, are shown by number and percentage.

Table 2: Number and percentage of appointments by type

Appointment type	Number of appointments	% of appointments
Telephone	3148	56.9
GP practice (ward visit)	1487	26.9
Community (1 to 1 (face to face))	379	6.8
Scheduled appointment	189	3.4
Text	112	2.0
Video call	86	1.6
Other	83	1.5
Not selected	28	0.5
Email	21	0.4

Of the 5533 appointments recorded, 59.9% were telephone appointments, 33.7% were face to face appointments and a further 4% were text, video call and email engagements.

Table 3: Number and percentage of appointments by outcome

Appointment outcome	Number of appointments	% of appointments
Attended	3468	62.7
DNA (Did Not Attend)	1149	20.8
Rescheduled	381	6.9
Cancelled	337	6.1
Not Selected	198	3.6

For the 1037 annual referrals that were finalised (complete, discharged or closed) at the date of data extract (29/05/2024), and where the patient engaged with the CLW service (fully or partially), a total of 3989 appointments were recorded as having been arranged by the service.

On average each patient engaging with the service had 3.8 sessions with the CLW recorded in their case activity. The average was higher for those fully engaged with the service (4.1 sessions) compared with those only partially engaged with the service (3.5 sessions per patient).

The number of appointments or sessions delivered to each patient ranged from 0 to 19 in the finalised case activities. Finalised case activities are the cases where patents fully or partially engaged with the CLW service and where the referrals were complete, discharged or closed following the completion of the support for the reasons(s) that the patient were referred for.

Social Prescriptions

In total 2097 social prescriptions were delivered during the year. This compares to a year 1 total of 1756 social prescriptions.

Table 4 presents the percentage of interventions prescribed for each quarter in the year 2 of the service by the primary category of the intervention.

Table 4: Percentage of interventions prescribed for each quarter by primary category of the intervention

Primary category	Qtr 1 (May 23 - Jul 23)	Qtr 2 (Aug 23 - Oct 23)	Qtr 3 (Nov 23 - Jan 24)	Qtr 4 (Feb 24 - Apr 24)
Mental health	51.6	54.2	53.8	47.8
Social support	47.1	45.8	49.9	45.9
Physical exercise	14.0	13.8	12.5	15.1
Clinical support	5.0	4.0	1.9	3.8
Diet & nutrition	3.4	2.0	2.7	2.5
Mental health service	0.3	1.4	0.7	1.6
Advice and support	1.1	1.0	0.8	0.9
Counselling and CBT	0.3	0.3	0.5	0.1
Other (< 0.5% each)	5.0	8.8	6.5	6.0
Unknown	10.3	11.1	13.8	18.4

Some examples of social prescribing destinations include:

Mental Health and Wellbeing

- Listening Ear.
- Mikeysline.
- Crossreach Counselling.
- Highland Hospice Bereavement Services.
- Breathing Space.
- Mind Hub.

Poverty and Income

- Citizens Advice Bureau.
- Highland Council Welfare Support Team.
- Triage – (employability skills).

Physical Activity

- Active Health.
- Highlife Highland Leisure Activities.
- Nature for Health (N4H).
- P4W Walk – Paths for all (Health Walks).
- The Puffin Hydrotherapy Pool.
- GP Movement and Activity Programme.
- Clarity Walk.

Family/Carers Support

- Highland One Stop Shop (HOSS).
- Change Mental Health Carer Services – Caring Connections.
- Thriving Families.
- Connecting Carers.

SWEMWBS Outcomes

The short version of the Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS1) is a validated tool which is used to assess positive aspects of mental wellbeing and is measure of outcomes achieved with patients. 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 and appropriate to do so.

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 5 summarises the number of times SWEMWBS was completed for patients pre and post case management with those referred to the service in year 2, 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. Some caution should be used in interpretating this as SWEMWBS has been shown to vary by age and gender and no statistical testing of this data was undertaken.

Table 5: SWEMWBS measurements at start (Pre) and end (Post) of case management for referrals made during the reported year (as at 25/05/2024)

Number completed (SWEMWBS Pre)	Mean score (SWEMWBS Pre)	Number completed (SWEMWBS Post)	Mean score (SWEMWBS Post)
802	18.2	227	21

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 (29/05/2024) so these numbers may be subject to change.

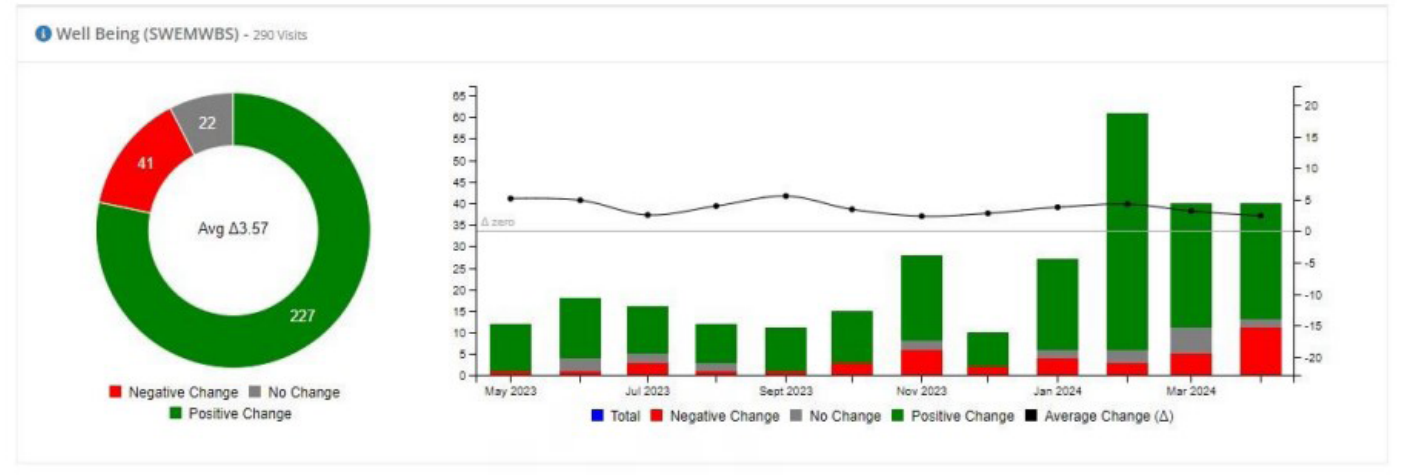
Not all patients had SWEMWBS measurements taken at both pre and post case management. There could be several reasons why a patient has no SWEMWBS measurements recorded either pre or post management. Some examples could include, the patient declining the offer to complete the SWEMWBS questionnaire, or the patient may have disengaged from the service and the therefore the post measurement was unable to be taken. Where these were available scores were paired and compared to look at any change over the period the patient was being supported by the CLW service.

1 Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS) © NHS Health Scotland, University of Warwick and University of Edinburgh, 2008, all rights reserved.

2 Warwick Medical School, University of Warwick. Warwick-Edinburgh Mental Wellbeing Scale, How to use WEMWBS, Collect, score, analyse and interpret WEMWBS. Available from: https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/using/howto/ [Accessed 05/07/2023]

Figure 8 below summarises the changes in paired scores for cases closed during year 2. There were a total of 290 patients with paired scores within this time period;

Figure 8: Change in SWEMWBS measurement paired scores by month in which case was closed.



Note: The figure presented above is taken directly from a report available in the Elemental system.

227 patients had an increased score, 41 a decreased and 22 had no change. The average score for these patients increased by 3.6 points between the initial and final measurement i.e. pre and post engagement with the CLW service. Academic evaluation of SWEMWBS suggests that, minimally, a 1-point change in SWEMWBS can be statistically meaningful at the individual level[2].

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

Following receiving funding from the Chief Scientist Office, University of the Highlands and Islands (UHI) has been evaluating the Community Link Worker (CLW) service within Highland in a way that captures the relevance of findings for other remote and rural areas of Scotland.

The aim is to capture impact on:

- Patients.
- The third sector.
- The wider health care system.

Data collection tools have been developed to capture impact in each of these areas. The aim of the research is as follows:

- To investigate the impact of the introduction of community link workers on rural, remote and regional centre dwelling individuals, their families and carers, the third sector, and primary care providers.
- To identify the barriers and facilitators to the implementation of a community link worker social prescribing programme outside the large metropolitan contact.
- To identify indicators of change for monitoring and measuring the impact of community link worker social prescribing outside urban areas.

Quantitative data collection

A questionnaire was developed by the research team to gather quantitative data a part of the study. Following challenges with the original study design, distribution and response rates, a revised questionnaire was developed and introduced in August 2023. The revised research tool adopted the ICECAP format; the ICECAP capability measures aim to capture outcomes beyond health. The revised questionnaires were sent directly to all patients who completed a period of engagement with the CLW service. Patients could also access an online version of the questionnaire using a QR code.

Caldicott approval for transfer of Elemental data from NHS Highland to UHI for analysis was obtained and sample Elemental data extracts were shared with UHI to allow development of data queries. This will allow for additional analysis of data to be undertaken to support the aims of the study.

Qualitative data collection

A total of 34 participants have taken part in 25 individual interviews and 2 focus groups. These have been conducted online and via telephone and have included patients, third sector organisations, GPs, a practice manager, and community link workers. The Qualitative data collection has now been completed and analysis and identification of emerging themes is being progressed. The final report for the evaluation is due in December 2024.

Case studies

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

Case Study - Sarah

Background

Sarah is a woman in her mid-fifties. She was referred to the Community Link Worker (CLW) service by her GP for help with mental health & wellbeing and exercise.

Issues

She had to leave a very busy job due to poor health.

She found herself becoming increasingly more isolated at home.

She felt she had a bit of 'empty nest syndrome' following her children moving away from the area.

She had no access to the internet.

Fibromyalgia, migraines and low mood.

Support

Following a person-centred assessment that included the CLW listening carefully to what mattered the most to Sarah. The CLW and Sarah discussed each of the areas that Sarah had identified as struggling with and explored potential options that were available to address these. The CLW worked with Sarah to identify which of the areas that she might like to try and address first. Sarah talked about looking for opportunities to get out and meet other people, try some gentle exercise and wanted to find more purpose to her week. Sarah loves reading and had often thought about writing a book one day. She was also interested in the idea of yoga and wild swimming. Sarah was not online and was unable to search for things herself.

The CLW worked with Sarah to identify the kinds of support activities that she had mentioned through their sessions. The CLW researched opportunities in Sarah's local community, matching Sarah's needs and priorities with available activities etc. The CLW went through a series of options and discussed with Sarah what would suit her best.

These included:

The CLW provided information about a local book club.

The CLW provided information on local yoga classes.

Contacts for a local wild swimming group provided.

CLW researched and provided Information provided on workshops that Sarah could access for wellbeing activities.

CLW made enquiries to local college and the local community to try and find a Creative Writing course for Sarah to attend.

Outcome/Impact

Sarah decided to start attending the local book club which she loves and now attends monthly

Sarah indented to try the yoga class and swimming group but unfortunately has had some health problems that has meant that this has had to put this on hold.

Through meeting others at the local book club, Sarah found there was interest from others in a creative writing group. They have now set up their own creative writing group, which is going well.

Sarah said she was feeling much better in herself, so much so that she has now organised a solo trip to relax, and she hopes to get some ideas for her writing.

Sarah's Short Warwick Edinburgh Mental Well Being Scale (SWEMWBS) scores improved.

Feedback

"At the start of the process, I was given three choices: to wait a long time for counselling, to go back on antidepressants or to see the link worker. I'm so glad I chose the last one, you have made such a difference, I can't thank you enough. Not only did you make suggestions and connections for me, but you have checked in with me along the way which really helped me along."

Case Study – Joanne

Background

Joanne was referred to the CLW by the GP for support with mental health, wellbeing and sleeping difficulties.

Issues

During the initial appointment with the CLW the cause of the sleeping difficulties were established as:

- Financial pressures including debt and arrears of rent.
- Feelings of isolation.
- Concern regarding location of privately rented accommodation- antisocial behaviour potentially affecting their children.
- Recurring health issues.

Support

Joanne and the CLW agreed that a blend of both face to face and telephone appointments would work best as Joanne works full time. Following the identification of Joanne's sleeping difficulties at the initial appointment and subsequent further person-centred conversations, Joanne and the CLW worked together to identify four goals to work towards.

These included:

- Stopping smoking.
- Start yoga classes as part of learning to relax.
- Apply for a local authority house.
- Discuss health worries with GP.

The goals would help Joanne save money, socialise and improve sleep.

Social Prescriptions:

1. Referral to free Smoking Cessation service.

2. Following a discussion on the options available, Joanne was guided to the free GP Movement and Activity Programme (GPMAAP) at the local leisure centre.

3. Joanne declined a referral to the welfare team. Joanne had shared that she had a plan to recover from debt by working more hours.

In addition to the Social Prescriptions the CLW and Joanne discussed and agreed the following actions:

CLW provided Joanne information on how to achieve healthy sleep.

Joanne discussed plans to take ownership of debt.

CLW provided assistance to arrange a face-to-face GP appointment to discuss ongoing medication and health concerns.

CLW provided Joanne a letter to support housing application.

Outcome/ Impact

Following a referral to smoking cessation services Joanne stopped smoking with the aid of nicotine replacement products.

Joanne attended yoga classes via the GP movement and activity programme. After becoming aware of what was available Joanne included their children in activities in the local leisure centre.

Joanne is now on the local authority housing list.

Joanne reported improvement in quality of sleep managing to have a full night's sleep.

Improvement of mood was demonstrated.

An increase in the SWEMWBS (Short Warwick Edinburgh Mental Health Wellbeing Scale) score.

Feedback

Most importantly for Joanne, she felt listened to.

At the end of the sessions Joanne felt in a good place and has a more positive outlook to their future.

Joanne reported the CLW motivated and supported her to follow plans and maintain healthy lifestyle changes.

Case Study – George

Background

George, a male patient in his late fifties was referred to the CLW by his GP for multiple reasons: social isolation and loneliness, weight management, housing and mental health and wellbeing. George has previously suffered a back injury in the workplace.

Issues

Poor housing conditions.

Weight management.

Not confident using technology.

Chronic obstructive pulmonary disease (COPD), anxiety, constant pain.

Support

Following several person-centred conversations with George, the CLW helped George to try and unpick what mattered most to him. The CLW listened to George, and discussed some of the issues that he might want to address. The CLW and George discussed each of the areas that George had identified as struggling with and explored potential options that were available to address these. The CLW worked with George to identify which of the areas that he might like to try and address first, understand the life challenges George was facing and to help him decide on some of the changes he would like to make and how to implement these.

A summary of social prescriptions, made with George's agreement are listed as per the following:

Social Prescription made to Citizen's Advice Bureau to check entitlements.

Social Prescription made to the Hydrotherapy Pool for physiotherapy.

Social Prescription for SMART recovery to help with giving up smoking.

Social Prescription made to Chest Heart & Stroke Scotland (CHSS) for COPD.

Social Prescription made for My Self-Management.

During George's 4th session with the CLW, it transpired that he only has an old mobile phone and is not confident in using the technologically to access the internet.

Social Prescription made to Red Chair for digital training.

Outcome/Impact

George stopped smoking following a bad COPD attack.

George has been applying for alternative accommodation.

George has begun to eat healthier and has lost some weight.

George is now attending a private pool to exercise.

George reports feeling empowered, inspired, and able to help and encourage friends.

George's focus has shifted from challenges and problems to a real interest in learning new things and is thinking about doing a qualification at UHI in technology.

Case Study – Alex

Background

Alex was referred to the CLW (Community Link Worker) by the GP as due to being socially isolated following their family's relocation to the Highlands. Despite the move being positive for the family overall, Alex was struggling to make new contacts and missed their friends and family.

Issues

Social isolation.

Loneliness.

Low mood.

Anxiety.

Prolonged grief.

Support

The CLW and Alex spoke in-depth about several issues that Alex was experiencing and together explored potential options that were available to address these. The CLW is able to discuss these issues at length and can provide a lot of knowledge about some of the resources, activities and services available in Alex's local area that could provide help and support for some of the issues that they identified.

In partnership, the CLW and Alex developed a plan, which included the following:

Referred to Decider Skills to help with confidence, mental wellbeing and social contact.

Information and support provided on how to self-refer to Cruse, if they felt that they wanted to talk further about their grief or attend 1:1 grief counselling – either now, or perhaps in the future, when they felt ready.

Supported to consider and engage in volunteering, to develop confidence and increase social interaction.

Referral to Befriender made to provide some longer-term support for mental health.

Outcome/Impact

Regular check-ins between Alex and the CLW to review progress, goals, outcomes and any challenges or barriers.

Alex said that they felt the benefit of talking out loud about their grief and loss. In doing so, they came to the realisation that they had not been able to move on and would therefore benefit from bereavement counselling.

Alex attended the full programme of Decider Skills and advised that they found the sessions beneficial; it was helping them recognise their emotions and reduce their anxiety. They felt more optimistic moving forwards.

Alex is currently on the waiting list for Befrienders Highland and is optimistic that this will be a supportive experience.

Alex stated that it is their intention to contact a local charity, as they now feel ready to begin volunteering.

Following the sessions, Alex felt they were able to be kinder towards themselves.

Alex found that they were beginning to look forward again with hope, rather than feeling sad.

Feedback

At the 8th and final session Alex was working through their grief following a recent and close bereavement. Despite this, they felt that they now had the tools available to help cope; and understood that grief was a normal reaction and knew to seek help if their feelings persisted.

Alex said that the CLW support had supported them to get to a point where they felt ready to contact Cruse for bereavement counselling to talk about their prolonged grief.

Alex‘s Short Warwick Edinburgh Mental Well Being Scale (SWEMWBS) score increased from 15.84 at the initial appointment to 20.73 at the final appointment with the CLW.

Alex advised that they had benefitted greatly from their sessions with the CLW.

Challenges

Elemental software package

Many of the initial challenges with the Elemental software package have been overcome. Relationships have strengthened with the Customer Success Manager which has led to more effective partnership working. The Elemental knowledge sharing sessions and knowledge-based webinars released on the customer success portal has made it easier for users of the system to access the support and guidance available. There are more robust processes in place to manage issues with the system as they arise and regular meetings with Elemental staff have improved the response time and allowed shared understanding of system issues and what needs to improve to overcome specific issues with the system. Recent pauses in development work by Elemental may impact on the pace of improvement work for the system.

Recruitment

As with many posts within the health and care sector, there has been a number of challenges in recruiting to vacant posts. Where vacancies have arisen, a corresponding reduction in referrals to the service has been seen. However, the introduction of peripatetic CLW's has been helpful in supporting the service to pick up referrals where there is a vacancy.

Accommodation within GP practices

Availability of a suitable space to see patients within GP practices remains an issue. Some GP practices have no accommodation available for CLW's and in some locations there is little or no affordable alternatives. The CLW service works more effectively when a CLW is embedded in the work of the practice. We have seen that when a CLW is accommodated within a practice that there are generally a higher number of referrals and improved working relationships between the CLW and members of the practice team.

Referral rates

GP Practices have been referring to the CLW service at different rates. Referral numbers in some practices have exceeded the capacity of the service while in others the number of patients referred has been below the available capacity for that practice. Work is ongoing to monitor and review referral rates at all practices. Overall, 11 practices made referrals that exceeded the available capacity and the referral rates for 16 practices was below the available capacity. Work has been undertaken to review capacity based on referral rates from the previous year, what practices have feedback about the capacity they are likely to use and whether they think the capacity they currently have is sufficient.

GP Practice Feedback Survey

In April 2024, a Microsoft Forms Survey was sent to the 29 GP Practices that currently benefit from a Community Link Worker Service. The aim of the survey was to better understand how the CLW service has been operating over the past two years, provide insight into what prompts GPs to make a referral to the service and understand the impact the service has had on the practice.

20 survey responses were returned. A summary of the findings can be found below:

Do you want to continue to access the CLW service?

Out of the **20** survey responses returned, all of them said **yes**

How has the CLW service been received in your practice?

"Well. It's a service that remains open to a variety of patients and problems and that is a welcome and refreshing change."

"Very well. We are grateful to the service and regularly refer our patients."

"Excellent service to our patients."

"CLW service has been received very positively within the Medical Practice."

"Very well - it's a well-used service which is very worthwhile for patients."

"Amazing. Has really helped many of my patients and generally get positive feedback. Patients are very open minded to this service which has surprised me."

"It has been well received. Now that we have had an ongoing service, we are able to better understand what support CLWs can offer and how patients can benefit."

"Generally well received although referral rates may vary across sites due to high levels of locum usage."

"The CLW team have become an integral part of our team. Our community has engaged exceptionally well with the service."

"A slow start but definitely an asset for the clinical team."

What has gone well with the CLW service?

"All in all, it runs very well here in the practice and the CLW is very approachable and involved."

"Approachable and helpful CLW. Easy to refer via Elemental. Timely response to patients. Good feedback from patient about how useful it has been."

"I have only had a positive experience with this service! So nice to have support with signposting which we don't have enough time for in our 10-minute consulting."

"Our CLWs are clearly committed and caring. It was great to have them at our practice team meetings this week sharing cases and progress to date."

"Provided support to patients for non-medical issues, which frees up GP time, but provides positive support to patients."

"The service is really helping patients access services within the community that the practice is or were unaware of."

"Our CLW onsite has been a valuable asset to refer patients to. This is a straightforward and popular referral process for our clinicians."

"Help taken away from GP's heavy workload."

"The community have engaged extremely well and the team are very collaborative."

"The amount of time and consistency given to the patients helps greatly."

Are there any areas in which the CLW service could be improved?

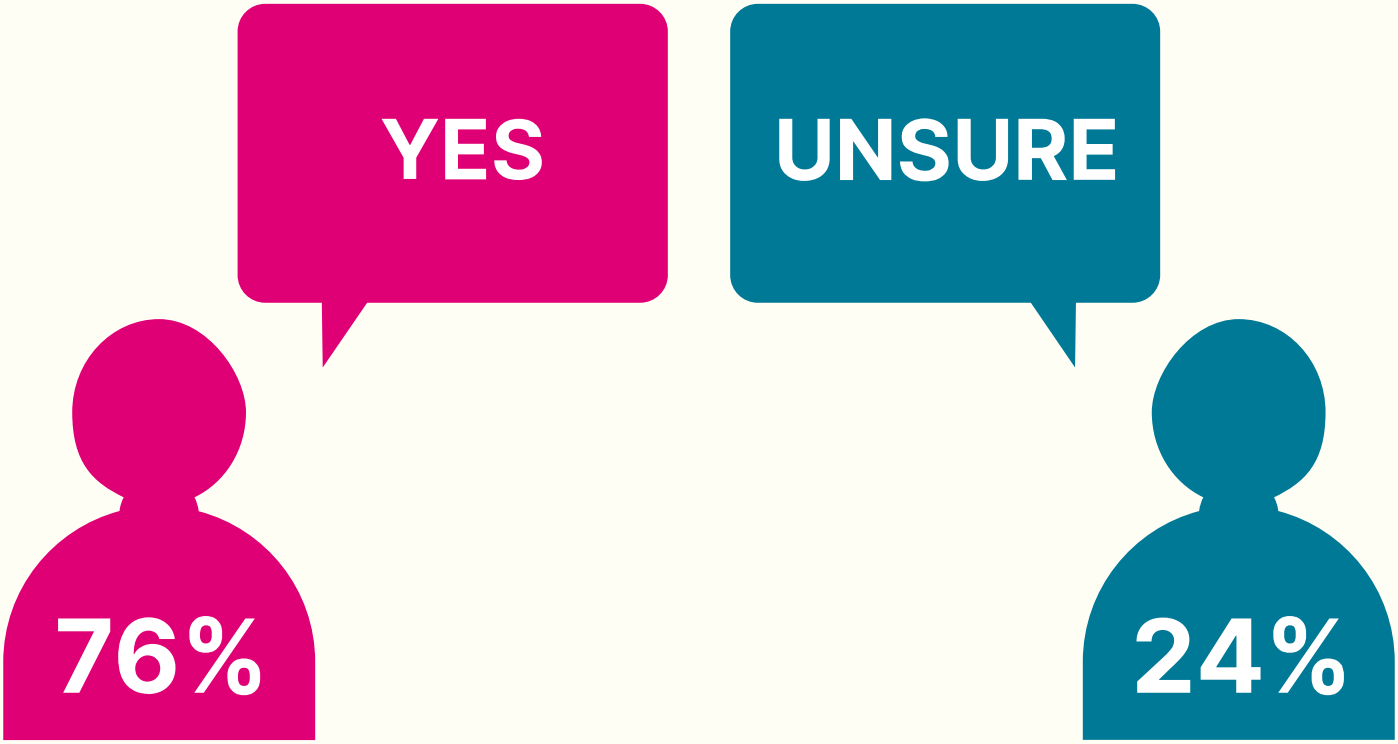
38% of practices responded 'yes' to the above question.

What do you think could be improved with the CLW service?

Of the 8 responses to the above question, a summary of responses/ identified the areas of improvement are noted below:

- To share the Directory of Services with GP practices.
- Reduce the number of tick boxes on referral form.
- Increase the CLW resource/ number of CLW hours available.
- To have more Foundation Year 2 (FY2) doctors and GP Specialty Training (GPST) access to the CLW service. However, it would be a big challenge in relation to space constraints at the practice.
- To have access to a CLW onsite when there is a CLW vacancy at the practice.
- Clearer processes/pathways around how services integrate/compliment (e.g. Primary Care Mental Health, Welfare and Health Partnership, Change Mental Health Outreach Worker, etc).

Do you think that having the CLW service has helped save practice staff time?



Of those that responded the majority (76%) said that the CLW service has helped save practice staff time.

Looking Forward

Service Expansion

Additional funding from the Primary Care Improvement Plan budget was allocated to the CLW service earlier in 2024 to expand the Service to all GP practices across Highland.

In efforts to tackle health inequalities, the original allocation of CLW resource was targeted at patients living in the most socio-economically deprived areas of Highland using the Scottish Index of Multiple Deprivation (SIMD). SIMD is less sensitive to rural deprivation which meant that resource was mainly focussed on more urban areas in Highland. To ensure a continued focus on health inequalities, distribution of the additional resource will be done using a GP Cluster-Based Model (organising link workers into clusters with each cluster serving as a focal point for coordinating services and support). The service expansion will be rolled out in Autumn 2024.

Directory of Services (DOS) Development

The development of the Directory of Service has been running for one year and the project has been extended until Summer 2025. The first phase - scoping and planning of the directory has gathered over 1500 entries from throughout Highland. Each entry includes details of the service, group, activity or resource and how to find out more information. This information is now in the process of being transferred onto the Elemental platform to form the directory website.

In addition to being available to Community Link Workers, the directory will also be available to all practice staff and members of the public through the Highland Third Sector Interface website. This will allow anyone looking for support in Highland to easily access information about services, local community groups and activities to support them to improve their health and wellbeing.

Social Prescribing Network and Co-ordinating Group

Following the two social prescribing events held in June and September 2023, the first Highland Social Prescribing Newsletter was issued in February 2024 as a means of keeping those who attended the events, and anyone in Highland interested in social prescribing, updated with examples of best practice, national and local developments.

An additional action from the social prescribing events was to establish a Social Prescribing Co-ordinating Group. A multi-agency group has now been established and includes representatives from Change Mental Health to share learning and good practice from the Community Link Worker Service. The group has been meeting and is starting to explore what a social prescribing framework for Highlands might look like.

A Social Prescribing section has also been created on NHS Highland's website and will be updated with the relevant information.

Notes

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