Item No: 14

Meeting Date: **Wednesday 23rd June 2021**

Glasgow City
Integration Joint Board

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Community Link Worker (CLW) Programme Update

Purpose of Report:	This paper provides an update on the Community Link Worker (CLW) Programme, part of the Primary Care Improvement Plan.

Background/Engagement:	The CLW Programme is part of the Primary Care Improvement Plan approved by the IJB. A steering group oversees the programme and reports into the Primary Care Implementation Leadership Group. The Steering Group has representation from a range of services/partners including: • Health Improvement • Primary Care Development Officers • Primary Care Support & Development • GPs –Clinical Directors, GP involved in Deep End Work • Glasgow Centre for Population Health • Scottish Government.

Recommendations:	The Integration Joint Board is asked to: a) note the contents of this report.

Relevance to Integration Joint Board Strategic Plan:

Page 42 of the strategic plan; section Shifting the Balance of Care – supporting general practices to have expanded teams providing care and support to patients

Implications for Health and Social Care Partnership:

Reference to National Health & Wellbeing Outcome:	1. People are able to look after their own health and wellbeing and live for longer 5. Health and social care services contribute to reducing health inequalities

	9. Resources are used effectively and efficiently in the provision of health and social care services.

Personnel:	Two staff (1 manager and one CLW) and three further staff are being recruited to support the 2021/22 expansion. All other staff are employed through commissioned organisations.

Carers:	CLWs offer support to carers/family members/guardians.

Provider Organisations:	The service is currently provided by 2 commissioned organisations: The Health & Social Care Alliance Scotland and We Are With You.

Equalities:	An Equalities Impact Assessment for the programme has been undertaken EQIA - GCHSCP Community Link Workers | Glasgow City Health and Social Care Partnership

Fairer Scotland Duty:	The CLW programme in Glasgow City is a deprivation-based programme and therefore positively contributes to alleviating the impact of socio-economic disadvantage experienced in the most deprived areas of the city.

Financial:	The current programme is commissioned until January 2023 with a combination of PCIP funding and additional funding from the Scottish Government.

Economic Impact:	None

Sustainability:	None

Sustainable Procurement and Article 19:	None

Risk Implications:	Any risks related to the Community Link Worker element of the PCIP will be recorded and monitored through the risk register in place.

Implications for Glasgow City Council:	None

Implications for NHS Greater Glasgow & Clyde:	Will provide support for and relieve pressure from General practice and potentially wider primary care services

Direction Required to Council, Health Board or Both	
Direction to:	
1. No Direction Required	☒
2. Glasgow City Council	☐
3. NHS Greater Glasgow & Clyde	☐
4. Glasgow City Council and NHS Greater Glasgow & Clyde	☐

1. Purpose

1.1 The purpose of this paper is to provide an update on the delivery and expansion of the Community Link Worker (CLW) Programme.

2. Background

2.1 The CLW programme originated in Glasgow where the concept and initial development took place, led by the Deep End Practice's and partners (2014). With the revised GP contract, the Community Link Worker programme became one of the 6 core components of Primary Care Improvement Plans across Scotland.

2.2 The current CLW programme provides CLW resource to 41 GP practices across 13 clusters along with 2 thematic CLW posts – one which supports a small number of practices around asylum seekers and the other which is embedded in the Youth Health Service.

2.3 The CLW programme was established as a programme focused on tackling inequalities and which took a deprivation focus. The allocation of CLWs to practices was based on a model which ranked practices on the combined score of number of patients and percentages of patients in the 15%-20% most deprived neighbourhoods.

2.4 Throughout the duration of the Primary Care Improvement Plan we have continued to have a dialogue with the Scottish Government about the level of need within Glasgow, seeking further resources to support an extension of the CLW programme. To provide the full service to every GP practice within the city would cost approximately £7million.

2.5 In December 2020, the Scottish Government allocated £600k non-recurring funding to Glasgow City HSCP to support the extension of the CLW programme.

2.6 There is early work underway via the Scottish Government's Short-life Inequalities Working Group on a range of programmes including the CLW programme which may influence future direction of the programme.

3. Procurement

3.1 Funding is allocated directly to Glasgow City Integration Joint Board (IJB) for management via the Primary Care Implementation Plan. Our NHS Standing financial Instructions require a commissioning process for the current service and any future monies.

3.2 To meet our requirements and ensure transparency the existing CLW programme has been commissioned via a two-part process. The initial process developed a Framework to which organisations could apply to be on. Following a scoring process against key criteria, six organisations were successful in being added to the framework.

3.3 The second stage of the process was a series of mini competitions (1 per cluster) to which these organisations were invited to tender for work at individual cluster level. All clusters were invited to participate in this stage of the procurement process, and all have contributed to this. The feedback has been that this was a welcome and useful exercise.

3.4 Currently there are 2 providers delivering on the CLW programme in Glasgow city. The Health & Social Care Alliance Scotland have 34 CLWs across 11 clusters; and We Are With You have 7 CLW across 2 clusters, along with supporting the CLW asylum seekers post which takes referrals from a number of identified practices. The final CLW post is managed directly within the Youth Health Service.

4. Service Expansion

4.1 The Primary Care Implementation Leadership Group approved the further expansion of the programme in February 2021.

4.2 Once complete, this will increase the number of GP practices with a CLW from 41 to 81 and the number of CLW from 41 whole-time equivalent to 66.4 whole-time equivalent. 19 of the 21 GP clusters will have CLW resource.

4.3 Recruitment of new staff is underway in the clusters which the existing suppliers are currently working in. A further 6 clusters are out for procurement and once suppliers are identified for these, recruitment of staff will take place. The full additional workforce should be in place by late Autumn 2021.

4.4 Programme Reach and Costs:

	Number of practices	**Number of CLW**	**Number of clusters**	**Total Cost**
2020-2021	41	43 WTE (2 thematic)	13	£1,957,923
2021-22	81	66.4WTE (phased)	19	£2,855,139
2022-23 (Jan23)	81	66.4WTE	19	£2,919,533

4.5 The current contract runs until January 2023 and a commissioning process will start in late 2021 to plan for the new contract. It should be noted that the contract will revert to the value of £1.957m (equivalent to 43 CLW in the current contract) unless additional funding is granted from the Scottish Government or other sources.

5. Service delivery from April 2020 - March 2021

5.1 As a result of COVID 19 a revised delivery model had to be implemented. CLWs moved to home working in March 2020. Over the last year as restrictions have eased/been re-implemented, CLWs have operated a blended approach. A significant amount of appointments have been undertaken using

telephone or online platforms, while walking meetings and face to face meetings have taken place with smaller numbers of patients.

5.2 Additionally, a number of CLWs supported their practices in targeted work with shielding patients early on in the pandemic. This resulted in a spike in referrals in quarter one.

Table 1. Referral numbers:

Quarter	Number of referrals
1st April – 30th June 2020	1,501
1st July – 30th Sept 2020	913
1st October – 31st December 2020	1,151
1st January – 31st March 2021	1,375
TOTAL	4,940

5.3 Referrals dropped in quarter two, following the initial influx of referrals for patients who were shielding in quarter one. Subsequently referrals have increased as the year progressed.

5.4 Engagement rates with CLWs were high across the programme and overall 6,012 unique individuals were supported in 2020/21 (This is higher than the number of overall referrals as some cases from 2019/20 carried into Q1, and also some cases were re-visited as a result of implications of the pandemic).

5.5 CLW's work with patients to address a wide range of social and emotional issues. They may support people who have health conditions, but their role is non-clinical. The CLWs use a person-centred approach to support people to address the issues they wish to focus on at that point in time. The CLWs often signpost and refer people on to other organisations or supports, such as local third sector organisations, financial/money advice services or local activity groups. They may provide an advocacy role. They may also support people to engage with other groups and organisations by initially accompanying people until they are confident to access the service themselves.

5.6 Some people only need one or two appointments with their CLW, while others require longer support depending on the range and complexity of their needs. Key presenting issues include poverty (income, welfare support, debt, food and fuel poverty), mental health and wellbeing (anxiety, depression, low mood, stress, suicidal ideation) and social isolation. Many people have a range of issues that they are keen to seek support with.

5.7 Group work is offered across the CLW programme and is led or supported by CLWs. Walking groups have been active across clusters when restrictions have allowed. Additionally a number of groups that were meeting prior to the pandemic moved online and continued to meet, including the Young Adults Project in Drumchapel.

5.8 We Are With You developed a number of online groups based on needs identified with patients. These have included a women's wellbeing group, a men's group, and an 'It's your sleep' group. These sessions all evaluated very positively. Participants of the 'It's your sleep' group showed an improvement for 50% of people between the start and end of the group (using sleep scores from the NHS Sleep Self- Assessment). Impressively, at the 6 week post

group check in the sleep scores had improved for 90% of participants by an average of 200%.

5.9 Throughout the pandemic CLWs have been sharing information about pathways and services changes with non-CLW practices in their cluster. Additionally an email address was set up for specific queries from clusters. Two clusters in the North East agreed to share CLW capacity for 1:1 support during the pandemic. Two separate approaches were adopted, the most successful was when CLWs embedded in the new practices one day per week rather than receiving referrals remotely.

5.10 During the last year, digital exclusion became a notable issue across communities. To date, CLWs have issued over 60 IT devices and data through the Connecting Scotland programme, and have also tapped into third sector provision for individuals. These devices have enabled individuals to stay or become socially connected and have been a key tool for CLWs supporting those experiencing social isolation and loneliness.

6. Outcomes

6.1 Case studies:

Case Study One
Jason was referred to the Community Link Worker in 2020. He had a long history of addiction and mental health issues, both of which had come to a head resulting in a prolonged period of antisocial behaviour. This had resulted in him being issued with notice of eviction by his housing provider. At the point of referral there were no other support agencies involved. The Community Link Worker met the individual for an assessment appointment and quickly established that the individual was a vulnerable adult who was experiencing suicidal thoughts and who was potentially experiencing financial abuse from neighbours. The Community Link Worker raised an adult protection referral to Social Work, and this triggered a vulnerable adult assessment. Given Jason's long history of difficulties and inconsistent engagement with services the Community Link Worker found they had to advocate for him. As a result the investigation did result in Jason being identified as a vulnerable individual he was subsequently: ● allocated a social worker ● referred to the Community Mental Health Team ● referred to the Addiction Recovery Service The Community Link Worker acted as a regular and trusted contact for Jason throughout this. Jason had real difficulty keeping appointments so the Community Link Worker made several home visits to ensure that contact was made. Jason had also destroyed some of his household furniture, so the Community Link Worker made a successful application to the Scottish Welfare Fund for a new bed, table and sofa. The multi-disciplinary team is now working together to identify a suitable supported accommodation placement, and the eviction notice has been put on

hold until this is in place. The Community Link Worker has been able to step back now that suitable supports are in place.

Case Study two
Joy was referred by GP with the reason that she was depressed. Joy is 26, seeking asylum and lives alone with her young daughter. She talked about feeling lonely, isolated and was very emotional during our initial conversations. Joy spoke of missing speaking with other adults. I offered Joy walk and talk appointments, due to her level of isolation, rather than phone/ online appointments. Joy is engaged with the Anchor Centre already for trauma counselling, but had no other support or contact out with of this. Joy and I talked about her strengths and interests. We explored local volunteering options including the Pantry, and a crafting skills project. She was really interested in the latter so I organised an interest visit, accompanied by myself, accommodating the Covid restrictions. Joy loved the project and chatted with the staff about new ideas and crafts for the project. She was keen to attend so I made a referral. I had to advocate for Joy, for the project to be more flexible for her childcare arrangements to be accommodated. I identified the Reach Health Project as another source of support, and they provided clothes vouchers and food parcels. For more long term support to combat loneliness and provide activities for her son also, I referred her onto Sahelyia, the wellbeing support organisation. With Christmas approaching Joy was very worried and felt guilty that she had little for her son, having spent the little money she had on buying him a Christmas gift. With Joy's permission I put a request out for donations of Christmas decorations, and I was able to present her with a tree and lovely decorations for their home. In addition I supplied a gift from our gift drive with Morrisons supermarket. Through Connecting Scotland programme, I was able to provide Joy with an IPad and data package. Joy was delighted as this will help with homeschooling her son. Joy has told me that she feels more positive and relaxed, and shows a significant improvement in her wellbeing scores. She now knows that she is not alone and has connections to sources of support for her and her son, for their future.

Case Study 3
Rebecca contacted the GP surgery to chase up a referral to CAMHs for her child who had been struggling with their mental health at a young age. During the consultation, Rebecca mentioned that the family's housing situation added to the stress at home and the GP referred the family to me for support. During our first phone appointment Rebecca highlighted that her daughter wasn't getting the same support at school as she had previously been, and her behaviour was becoming more challenging. We got her daughter matched with a befriender from a local charity who takes her out on a weekly basis and also linked her in with local arts and craft groups for kids as drawing and painting really helped her to relax. Rebecca mentioned that the house they were in had a limited number of bedrooms and with several young children there was not enough space. Her daughter's mental health made the lack of space very challenging for the family

as she had nowhere to go and unwind when he felt anxious or overwhelmed. Rebecca was also really keen to get a home with a garden so her children could play outside safely. She was also a carer for one of her parent's so a home closer to where they live was essential. I supported Rebecca in completing several application forms for other housing associations. I drafted a supporting letter which was signed by the GP in support of a housing transfer with their current housing association. Two months later the family were rehomed in a larger property with a garden. I applied to a charity grant for the family, which got the family a cooker, and signposted Rebecca to the Scottish Welfare Fund Community Care Grant which provided a washing machine and some other essentials. I have supported Rebecca emotionally with regular phone calls during the period of months I have worked with the family. Rebecca found the situation at home very stressful and challenging at times and would get in contact with myself to talk through what was going on for her when needed. The family are now settled into their new home in time for Christmas. Rebecca's feedback 'Thank you so much for all your help, I would never have got here without you'.

6.2 Feedback from GPs

These comments have been recorded either for direct correspondence between CLW and GP or as part of a check-in by service provider.

"Our links worker has remained an excellent team contributor throughout though has been working remotely. The nature of the referrals has not changed, and she has continued to receive referrals of our most vulnerable patients for mental health, addiction, isolation, financial and holistic support."
"I'm so glad I've got you to refer patients on to when I don't know the answers to what can help them. It makes me feel relieved knowing I'm not leaving them without the support they need and means I can focus on other (medical) issues that they might be having. Thank you!"
"Importantly, she is happy to take on difficult patients leading to fewer consultations with ourselves. She has been a real asset and she is good at feeding back information to us about patients we have referred."

6.3 Feedback from Patients

These feedback comments have been taken from messages sent directly to CLWs and those summited through patient satisfaction questionnaires.

"The support I have had from my GP Practice and in particular my CLP has been outstanding, I don't know where I would be now if it wasn't for you. The help you have given me has opened up a whole host of opportunities for me that I would never have been able to do by myself. I feel like I have met so many other people that understand what I am going through and it has totally put me at ease, and that's all thanks to you encouraging me and finding suitable help for my situation."

"[My CLW] was a great help to me during a very stressful time in my life, there were times I didn't think I could get through the day but [my CLW] was always at the other end of the phone to talk to me and help me realise I wasn't along. [My CLW] is the reason I am here today"
"I am still experiencing the same anxiety symptoms, but [my CLW] has been helping me with these issues going forward"
"[My CLW] helped push my comfort zone and come up with alternatives I hadn't thought of. I'm a work in progress but at least now a bit further down the line"
"You helped me more, by listening and helping me understand what was going on and what my options were, than the people that should have been helping me"

6.4 One of our providers utilise the Short Warwick Edinburgh Wellbeing Scale (WEBWEBS) at entry and exit to the CLW programme. Completion of this is voluntary and return rates are just over 50%. Within quarter 4, of those who completed the assessment, 73% of participants reported a detectable improvement in their wellbeing at the end of their involvement with the Community Link Worker. 23% experienced no detectable change and 4% experienced a detectable decline in wellbeing. Given that many people who use the CLW service have a range of health and social conditions, then this level of improvement is very positive.

7. Recovery planning

7.1 CLWs have received Covid-19 vaccinations and have access to lateral flow testing.

7.2 Across the City CLWs are increasing time spent in practice and the number of face-to-face appointments in practice. Some GP practices struggled for space to host their CLW prior to the pandemic. The additional restrictions in place mean that there are challenges for CLWs' return to practice in the short to medium term.

7.3 Together with our two providers we will consider what a blended model of delivery could look like for the CLW programme, ensuring CLWs remain an embedded member of the GP practice Multi-disciplinary Team, while also recognising the benefit of telephone/online appointments for some patients, and work-life balance for CLWs.

8. New developments

8.1 Separate funding has just been secured to fund a thematic CLW to work with the homeless population. This post is currently being procured. This CLW will be recruited as part of the emerging service model within the homelessness and complex needs service, with a focus on supporting vulnerable patients to access primary care, community and third sector resources, and to link this group with their local practice and it's attached CLW.

8.2 A pilot initiative is currently underway in the North West of the City to explore the role CLWs can play supporting patients with barriers to self-management of diabetes. The pilot will see CLWs working with individuals to understand the digital support needs for using the My Diabetes My Way app. CLWs will utilise motivational interviewing and peer support groups to explore self-management. It is anticipated there will be learning for the community health literacy component of Maximising Independence.

9. Emerging Issues

9.1 Moving forward, it is anticipated that there will be an increase in the numbers of people who may require support with their mental health and poverty related challenges. There is already feedback that a number of practices are seeing more people presenting with issues relating to unemployment. Wider poverty changes are likely to lead to an increase in people presenting within primary care who require support to deal with social circumstances and mental wellbeing in addition to and instead of clinical care.

9.2 The pandemic has had a significant impact on the local third sector, some of whom have furloughed staff, others have refocused their delivery, and many whose funding profile has changed significantly with the introduction of the Glasgow Community Fund. The face to face support which most third sector organisations use has been severely compromised by COVID 19 and it will be some time before organisations are able to return to previous ways of working or move to a more blended approach. CLWs rely heavily on being able to engage their patients with the wide range of services provided by the third sector. Where this support is limited or is not available, CLWs require to support patients for longer, and in less productive ways.

9.3 The CLW programme can only succeed in the context of the effective delivery of community and primary care services.

10. Recommendations

10.1 The Integration Joint Board is asked to:

a) note the contents of this report.