Wigan Community Link Worker Service Evaluation

May 2016

Innovation Unit


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Executive Summary

Executive Summary

The Wigan Community Link Worker (CLW) service has been jointly commissioned by Wigan Borough Clinical Commissioning Group and Wigan Council with the aim of improving the health and wellbeing of local people through better connections to appropriate sources of support in the community. It was set up as a pilot in 2015, run by City Health Care Partnership (CHCP). It started off with 11 practices and grew to cover the whole Borough (63 practices) from November 2015. In March 2016, funding for the service was extended for a year to March 2017.

The service accepts referrals from primary care, the hospital and social care. Link workers spend time understanding their clients' individual situation, needs and aspirations and then help them to access community based support and activities and to utilise their skills and experience through volunteering. The expectation is that the service will help people be well and independent in the community, thereby, in time, reducing demand on GP and secondary care services and preventing the escalation of need.

In February 2016, Wigan Borough CCG and Wigan Council commissioned this formative evaluation. It aims to offer a better understanding of how the service is working, who is using it and what difference it is making to clients and referring services. The insights will support both commissioners and the provider in thinking about what the service will need to run effectively and maximise its impact at scale.

Findings

Throughout the research, we encountered consistently high levels of commitment and buy in to the service from stakeholders. The joint commissioning team are champions and active supporters of the service; they are committed to learning from the pilot to support scaling up. The wider CLW team have been invested in delivering help that is easily accessible, responsive, supportive and practical. They have also been working to increase referrals and the visibility of the service, to generate evidence and surface learning. The health and care professionals that are engaged with the service appreciate its value and have been promoting it to their colleagues and patients. The Wigan Deal promotes a shift in service culture that makes the ground fertile for approaches of this kind, focused around people, encouraging participation in the community and creating new relationships between citizens and service professionals.

The key lines of enquiry in this evaluation were: cohort - better understanding the profiles of users; process - how the service works in practice; and impact - what difference the service is making to people's lives and to referring services.

Between January 2015 and March 2016, the service supported 784 clients. An analysis of the cohort data reveals that just over half were over 55 and that social isolation and mental health issues such as anxiety, low mood and depression were the most recurrent presenting issues, along with financial difficulty.

It also appears that there are two main types of users. One, larger group of clients needs signposting and some light handholding to increase their knowledge and confidence and access the right support. Another, smaller group of clients, have more complex needs which often include some degree of mental ill health. These clients draw on the service more intensively than the first group and for a longer period of time.

Our enquiry into the emergent evidence of impact suggests that both client groups are benefitting significantly from the CLW service. The fact that the service has been operating at scale for under 6 months and the limitations of the data that is currently available have not made a full impact analysis possible. Moreover, the preventative nature of the service and the complexity of some of the cases it deals with, mean that quantification and attribution of impact will always be difficult.

However, it is clear that the service is making a difference in the lives of its clients and the difference is starting to be visible to referring professionals as well. People say that 'having someone that really listens', being helped to move things on 'there and then' and having someone they know they can come back to if they need, make this a service that is truly helpful and unique. Client stories suggest that CLWs help people 'get back on track', feel supported and become involved and able to contribute in their community. There is anecdotal evidence of reduced pressure on mainstream services.

Recommendations

One of the questions at the heart of this formative evaluation has been 'Who does the service help most?' Having cast the net wide in the first phase of the pilot, with loose referral criteria and a wide footprint covering the whole of the Borough, commissioners were committed to understanding whether and how they should hone the service in on a more specific target group.

Our recommendation is that the service retains wide referral criteria and a low threshold for access. This would mean making a conscious choice to use the service as an **initial filter or triage**, the first port of call for any people who present with social needs alongside or rather than medical needs and do not have the knowledge, ability or confidence to access available support to address these. Our research suggests that the 'initial filter' is one of the important functions the service has been fulfilling so far. When asked who should not be referred to the service, the CLWs we spoke to consistently replied that there shouldn't be significant barriers to access, as they can and do help all the people that are referred in some way. Our interviews with clients confirm this. Moreover, GPs told us that they do not have the time to identify the most suitable referrals for non medical needs and they greatly value the help of CLWs in doing that.

Indeed, if this service is to be one of the **engines of culture transformation**, in line with the values of the Wigan Deal, then the model of front-loading the investment in a relational exchange that aims to understand people's needs and aspirations and maximise the relevance and impact of referrals seems a very appropriate one.

The 'initial filter'/signposting function is not the only one that the service is fulfilling at the moment. It also provides **case management and navigation** for clients with more complex needs, some of whom are accessing other

specialist services. Our interviews suggest that the CLW service adds value and, in some cases, manages to replace some specialist services, for example when people decide they no longer need counseling as a result of seeing a CLW.

As referrals pick up and the service reaches capacity, there is a real risk of overstretching and losing the unique value of the service, for example if quick fixes are sought in the interest of meeting demand. We believe that the next phase of development for the service should be about **focus and consolidation**. While we advocate for maintaining loose and inclusive referral criteria, our recommendation is that, as long as team capacity remains at current levels, the number of GP practices that are involved in the scheme should be reduced. Criteria for selecting a smaller core of participating practices could include: evidence of demand to date; demographics and need; service development focus areas in the emergent GP clusters (i.e. mental, health, older people), and a commitment on the part of participating practices to contribute to the business case for the service, through maintaining a minimum level of referrals and, for example, carrying out audits to evidence impact. Such a reduction in the CLW practice portfolio will enable a greater degree of investment in relationship building, establishing feedback loops, generating evidence and increasing commitment and buy in from practices.

We also suggest that some level of **codification** of the service (for example, blueprinting the user journey for typical client profiles and developing a framework for a discharge process) will help streamline interactions, align expectations and make practice more consistent as the service scales up.

Moreover, investing in an **interoperable information system** that streamlines data collection and harvests data on a patient's use of services across pathways will be essential to developing a strong business case. This will also provide the infrastructure for **embedding feedback loops** across the service.

Our research suggests that what makes the service special is that it puts relationships back at the heart of care and creates a space for a very human, personal and rounded way of helping. To **develop and nurture the skills and qualities of CLWs as relational workers**, we recommend that the service creates more spaces for the team to regularly engage in peer support and reflective practice, also through supervision relationships within the team and/or within referring services. In our experience, to foster a culture that enables relational working, the service should be clear about its values and principles; strong on setting key boundaries and rules; and loose, iterative and reflective about everything else.

Finally, we suggest that enlisting CLWs, clients and health professionals in co-designing and **co-producing the service** going forward will be key to keeping it relevant and impactful. This will mean creating spaces for reflection, testing and learning within the service. It will also mean being creative about ways to actively engage clients, for example, acting as champions for the service and buddies to other people.

This is an exciting time to be developing and scaling the Community Link Worker service. As **place based models** of care emerge across Wigan and the practice of integrated working becomes embedded, CLWs could play a pivotal role in multidisciplinary teams. Their location within general practice, their experience and existing networks will be an invaluable asset to the local health economy.

1. Introduction

Introduction

The Wigan Community Link Worker (CLW) service was set up as a pilot in January 2015. It was commissioned jointly by Wigan Borough Clinical Commissioning Group and Wigan Council.

Community link workers were introduced to provide additional support in primary care and acute settings for individuals who present with 'non-clinical needs'. The link workers are also integrated within the adult social care pathway. The aim of the service is to help people to connect to appropriate support with an emphasis on voluntary sector services and community based activities. There is also a strong focus on fully understanding an individual's situation and environment, helping them to access these community based opportunities and to utilise their skills and experience through volunteering.

The service aims to:

- improve the health and well-being of local people by connecting them to community based activities which support their independence and reduce reliance on acute or specialist services,
- address non-clinical demands on primary and acute services by delivering a tested intervention which connects people to sources of support within their community,
- make effective use of voluntary and community sector assets by improving connections and relationships between local communities & voluntary sector organisations and traditional providers of health and social care,
- support transformational changes to the way we deliver health and social care through a new model that focuses on individual assets and community resources.[1]

The business case for investment in the service outlined a set of individual, organisational and system wide benefits.

Organisational & system wide benefits were identified in the business case as:

- providing early intervention and preventative approaches that reduce hospital utilisation and reliance on specialist & targeted services,
- more effective use of primary care resources thus enabling improved access for those patients who require clinical interventions – for example, for the management of long term conditions,
- strengthening and transforming the role of GP services as a community resource that connects people to appropriate support and activities,
- developing a skill mix in primary care which meets the needs of patients,
- building strong and effective relationships between traditional health providers and the local voluntary and community sector, and making better use of existing community resources and assets,
- tapping into community assets and increasing the number of volunteers and those who are active in their communities.

1 Source: Community Link Worker Service Specification, NHS Wigan Borough Clinical Commissioning Group

Individual benefits have been identified as:

- person centred support that enables individuals to access community activities and a broad range of support to keep them independent and connected to their communities,
- individuals able to take greater control of their own health and lives,
- improvements in physical and emotional wellbeing,
- access to peer support.[2]

The service, delivered by City Health Care Partnership (CHCP) CIC, worked initially across 11 GP practices in Wigan. From November 2015, it scaled up to cover 63 practices and in March 2016, it had its funding renewed for another year, to run to March 2017.

In January 2016, Wigan CCG and Wigan Council commissioned an evaluation to take stock of what the service was learning so far and how it was delivering on the outcomes set out in the business case.

The aim of the evaluation was to:

- understand the impact of the Community Link Worker intervention on service users and their families,
- understand the impact of the Community Link Worker service on general practice, acute settings, adult social care and voluntary and community organisations,
- assess the extent to which the Community Link Worker service is delivering the anticipated benefits identified through the original business case,
- describe and review referral pathways, criteria and service user characteristics in order to inform and shape the service model.[3]

2 Source: Community Link Worker Evaluation, Scope of requirements, NHS Wigan Borough Clinical Commissioning Group

3 ibidem

Innovation Unit carried out this evaluation between February and May 2016.

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2. Evaluation: Rationale and Methodology

Evaluation

Rationale

This evaluation was commissioned at a time when the service had just started to scale up from the initial cohort of 11 GP practices to the whole of the Borough; growing from a team of 2 to 11 FTE community link workers.

It was agreed with the commissioners that the evaluation should be formative in nature and that our analysis should offer a better understanding of how the service is working (process), who is using it (cohort) and what difference it is making to clients (impact). This will support both commissioners and the provider in thinking about what the service will need to run effectively and maximise its impact at scale.

Methodology

We used data analysis and a set of qualitative interviews to gather findings and inform the recommendations set out in this report.

We analysed the following sets of data and information, provided by CHCP:

- data set for all referrals from January 2015 to February 2016 (date of referral; date of first, second and third appointments; total number of interactions; source of referral; referrer; GP practice; presenting issues and onward referrals)
- provider reports issued between December 2015 and February 2016
- case studies and user journeys

We held a stakeholder workshop in March 2016, that was attended by 15 people[4] representing: commissioners, the provider, CLWs, GP practices and community and voluntary organisations involved in the service. The aim of this workshop was to take stock of the expectations, ambitions and experience of the service from the perspective of these different stakeholders.

We interviewed 26 people[5], including: commissioners and people running services in the three different pathways (primary care, adult social care and acute), patients, community link workers and representatives of voluntary and community organisations that receive referrals from CLWs.

Moreover, with help from the CCG, CHCP and 4 GP practices, we were able to create and analyse a set of 'mini audits'. These 'mini audits' brought together data on patients' use of primary and secondary care services before and after being referred to a CLW. This data was gathered for a small sample of 20 patients across 4 GP practices. There is currently no single place where this data is collected. Therefore, to produce these 'mini audits', information had to be extracted manually from three different databases: DCRS (the database used by CLWs to record their interactions with clients), the practice's clinical system and the risk stratification tool.

In 2 of these 4 GP practices we also carried out interviews with a GP, the community link worker and a small sample of patients (7 overall) to gain an in-depth understanding of people's experience of the service from different perspectives. The two GP practices were Brookmill and Bryn Cross. Brookmill has been involved from the beginning of the pilot and Bryn Cross is a more recent participant. They were selected because they are both high referrers and they have different demographic and geographical characteristics.

4 See appendix for full list of participants

5 See appendix for full list of interviewees

Caveats

We want to highlight a few caveats around the quality and robustness of the data available for the evaluation.

The data collection system used in the pilot (DCRS) has not been designed for this service, so there have been limits to its suitability to collect all of the relevant information for the CLW service. Due to a number of changes during the roll out of the service, there may also have been inconsistencies in the way in which data was manually inputted. The provider has been aware of this limitation and has experimented with additional data collection processes that have helped to compensate for it. However, this means that the availability, quality and consistency of the data, while being sufficient, is not always as good as it could be.

There are some discrepancies within the data, partly owing to the fact that current data collection arrangements require CLWs to input information across three distinct databases and because CLWs have had different degrees of access to clinical systems in different practices. For example, the number of overall clients recorded in DCRS does not match the number of people flagged as CLW clients in the risk stratification tool. We also noticed a small number of inconsistencies between figures in documents provided by CHCP which could be owing to the process of reconciling data from different sources.

The amount and nature of the data that is currently available, and the fact that the pilot has only been operating at scale across the 63 practices for under 6 months, does not make it possible to carry out a thorough and conclusive analysis of impact at this stage. Our findings draw on: qualitative interviews with a small sample of patients and professionals; the audit that Dr. Weems carried out for his patients at Brookmill Medical Centre, and the data contained in the 'mini audits' carried out in 4 additional GP practices. The sample of 'mini audits' is small and, whilst informative, does not aim to provide a representative picture of the service across its entire geographic footprint.

We saw a significant increase in referral numbers, particularly from January 2016 onwards. We could only analyse data for January and February 2016 and suggest that an analysis of the following months could reveal interesting insights on, for example, the number of DNAs in relation to the overall number of appointments or whether and how the characteristics of the overall cohort change as more referrals come through to the service.

3. Findings

As outlined, the framework we have used in our enquiry has three main foci: cohort, process and impact. In this chapter we set out our findings in each of these areas, service level insights and more granular reflections and data for each of the pathways.

Cohort

Who is using the service most

The commissioners' hypothesis in setting up this service was that most clients of the service would be people whose issues were driven by unmet social rather than medical needs[6]. The expected clients were people who are socially isolated, probably older, possibly going through some significant life change like bereavement, losing their job or relationship breakdown. They could have a low level of mental health need and lack the confidence or knowledge to access a range of existing support services.

The client personas that have emerged from this research have been largely consistent with the hypothesis just described. Typically clients will be middle-aged to older, struggling with low to moderate mental health issues and some physical health issues. These issues may be compounded by social difficulties such as isolation and financial troubles. Their social networks will be weak, absent or unable to support them through the low point in their life that they have reached.

They may be, themselves, the core of somebody else's network of support and feel overwhelmed by this pressure. They will have reached a crisis point, either because of a life event or as a result of ongoing mental and physical health issues. They may not know what to expect from the link worker but, on meeting them, they are willing to engage and receive help to try and get things back on track.

An analysis of the data[7] gathered by the service between January 2015 and February 2016 indicates that[8]:

- Of the 784 clients who engaged with the service between January 2015 and February 2016, **40% were over 65** and 52% over 55.
- **Social isolation** (184 records), and **mental health issues** such as anxiety, low mood and depression (234 records combined) are the most recurrent presenting issues, along with benefits and **financial advice** (106 records). The service also engages with a number of **carers** (53 records on the database and a recurrent theme in case studies and in referrals coming through the acute pathway).
- **56%** of clients required up to **2 interventions** and **20%** required **5 or more**.

6 In 2010 the Marmot review found that around 70% of health outcomes are determined by social factors, and just 30% by clinical interventions.

7 Source: Community Link Worker Reports: January 2015 - January 2016; February 2016; Community Link Worker Case Studies.

8 Please note that, as no information on ethnicity was provided in the data set, we have not been able to analyse this aspect of the cohort.

Who the service helps and how

An analysis of the data on the number of interactions suggests that there are **two typical user profiles**. One group of people have needs that require interventions of low time intensity, such as the provision of information and signposting. A second group of people have more complex needs and seek continued support over a longer period of time.

For clients in the **first group**, typical engagement with the service will involve a face to face introductory conversation lasting about one hour, where the CLW will talk through the client's issues, needs and aspirations, make suggestions, develop a plan and possibly make a referral to a community organisation. This will be followed by an email or phone call where the CLW will provide information or check in with the client, or possibly by an outing where they accompany the client to an activity or appointment.

People in the first group are likely to have a combination of both less complex needs and higher levels of activation than people in the second group. Insights from our conversations suggest that having a full hour with someone who listens to your needs, and then offers suggestions and takes actions that are tailored to these needs, is of great value to people whether or not they require further interactions with the CLW.

For clients in this group, interactions with the CLW might lead to: better information and increased confidence to take action for themselves; the resolution of a practical issue such as applying for a blue badge or setting up ring and ride; or an onward referral to a relevant service. Whilst feedback from clients is not currently collected systematically by the service, client interviews demonstrated that CLWs help people in the first group in a way that is different from, and significantly adds value to, what is available through other services in the system. Using CLWs more consistently as a triage and referral resource could help save resources elsewhere in the system and improve the relevance and effectiveness of referrals.

> "Someone said to me: 'You have done more for me in half an hour than I achieved in four years.'" **CLW**

> "There is no one I haven't been able to either refer onwards or give information to. (...) Small things can make a huge difference." **CLW**

> "I wanted to get out of the house more because I knew it would help me manage my anxiety. My GP suggested I see the link worker and the link worker helped me find a volunteering opportunity at the local food bank and night shelter. Now I'm running the food bank on a Thursday." **CLW client**

Clients in the **second group** have more complex and entrenched needs. They are likely to struggle with their mental health and they may be accessing other specialist services, which either have long waiting lists or fail to offer them support that meets all their needs. The typical scenario for this group of clients could be that, after the first face to face meeting, the CLW helps the client with applications and referrals to, for example, social services or carers allowance; accompanies and/or drives them to appointments or community activities, and generally continues offering practical and emotional support over a longer period of time.

CLWs have helped people in this group in a number of ways, notably averting an immediate crisis (such as eviction) or solving practical issues that the client did not have the information (or power!) to resolve on their own. There is anecdotal evidence that some clients find the support from the CLW to be more helpful than IAPT services (particularly counselling). Indeed, a CLW mentioned at least two examples of clients who had an appointment booked with the IAPT service and went on to cancel it after the CLW intervention.

Clients know that CLWs are there for them if they need. They may draw on CLWs for help, advice and sometimes even befriending, over a prolonged period of time and 'on demand'-features that few other services offer. It is easy to speak to a link worker and, whilst they are professionals, they may feel more like friends or allies. Whilst it is difficult to pinpoint exactly what would happen without these interventions (and therefore calculate the savings they generate), it is clear that for clients with more complex needs, they can help prevent crisis and deterioration and, importantly, make life feel better!

"If they ring services they don't get anywhere. If we do, things happen. It's the same when you accompany people to places - when you are there with your badge it makes a difference to how people are treated." **CLW**

"Most of them do have a key worker, but the link worker helps more - they link my patients' care together." **GP**

"Things are so much better now I have the link worker. They're more of a friend than anything else - really listening and helping you open up. I don't know what I'd do if I had to stop seeing them." **CLW client**

It is important to point out that the types of **referral vary quite significantly** according to the referring professional's understanding of what the CLW service is and isn't for. For example, some GPs will refer people who they feel are ready to take action to address some of the issues in their lives, given the right support. Others will refer people whom they feel the system is unable to help, hoping that the CLW approach will offer a solution to them.

In some cases, people will be referred to counselling services and to the CLW at the same time. Since waiting times for counselling are notoriously long, CLWs are used as a "bridge" service, offering support whilst people wait for their turn in the queue for more specialist support. In the social care pathway, a recurrent reason for referral is that clients would like to access activities but feel unable or unwilling to do so on their own and/or do not have access to transport. In some cases, the initial CLW assessment revealed that clients that were referred because they were unable to attend activities in fact had more complex needs. These needs had to be addressed before they could engage with the kind of support the CLW service is in the position to offer.

"The people I will refer are the ones that have been seen several times and keep coming back. [...] I realise that things have deteriorated for them [...] I will assess the needs of the patient at the time and its severity. If they have social and financial issues and I feel they are ready to engage with the service I will refer them." **GP**

"Often we get referrals from doctors who don't know what to do with people anymore." **CLW**

"Let's say the social worker is seeing an elderly lady who is interested in painting. I will send suggestions to the social worker (a list of up to 20 groups and activities), and together they decide on a local painting group. If the client has no one else to go with her and does not want to go on her own, the social worker will make a referral to the CLW." **Community Knowledge Officer**

A closer look by pathway[9]

Primary care

- 56% of clients referred by general practice were women.
- 36% were over 65 and 48% were over 55.
- Most (75%) people referred by general practice required up to 3 interactions therefore falling into the first group of clients who need more light touch support (including signposting and onward referral to other community or statutory services).
- The vast majority (79%) of referrals in this pathway come through GPs, but some are also made by practice nurses (13%) and healthcare assistants (4%).
- Mental health issues such as anxiety, low mood or depression were prominent among presenting issues for clients in general practice, as well as social isolation and need for financial advice.

Sheila has been living alone since her husband passed away last year. When meeting the CLW she is teary and emotional. She says she is a 'worrier' and has always been that way. She talks about her family and friends who, she says, are really good to her. She refuses to be referred for counselling over her recent bereavement, but admits that she does need a hobby. At first she is reluctant at the suggestion of joining a knitting group, but at the second meeting with the CLW she decides to try attending some community events, like Dominoes on a Wednesday afternoon and Spring View clubhouse every two weeks. She is now looking forward to socialising.

Dave is 32 and alcohol dependent. He separated from his partner, has little contact with his teenage children and has been suspended from his job. He was referred to the CLW after being diagnosed with a tear in the lining of his stomach. He joined the Leigh Recovery Partnership 18 months ago, but did not complete the programme. The CLW listens to Dave's story and arranges a meeting with the Recovery Partnership for the following day. He goes along with him to the meeting, where Dave makes a new 10 week plan of alcohol reduction. During the following 10 weeks the CLW supports Dave in keeping up his commitment. He meets and phones him regularly and helps him join the gym and attend confidence building classes. Dave reaches his goal to reduce his alcohol consumption and then embarks on a detox programme. Four weeks later he is abstinent. He regains contact with his children and is due to return to work.

9 Source: analysis of raw data set shared by CHCP ranging from January 2015 to February 2016.

Adult social care

- 62% of clients referred through the social care pathway were women.
- 51% were over 65 and 63% over 55. On average, social care clients are older than clients referred through general practice, but younger than clients referred through the acute pathway.
- Clients referred through the social care pathway were also the most likely to require 5 or more interventions (49%). This is consistent with insights emerging from conversations with CLWs that suggest that social care referrals have the most complex needs.
- Social isolation is the most common reason for referral through the social care pathway, followed by transport advice. Indeed, the professionals we interviewed in this pathway said that referrals are mostly made when people find it difficult to leave the house. Lack of transportation is often a key reason for their isolation.
- There have been some instances of inappropriate referrals through the social care pathway. For example, some people were referred who were immobilised and needed a level of support that was clearly outside the remit and expertise of the link worker role. These instances have been flagged by the provider and have reduced over time.

Marc is 30. He has a learning disability and lives with his mum. His dad passed away six months ago. His mum says that he has little motivation to get out of bed on the days when he is not attending day care services. The CLW has a chat with him and his mum. Over the following three and a half months, the link worker sees him six times and helps him register and have an induction at the gym; complete an application and DBS check to work with the elderly at a day centre; become confident taking public transport on his own; and apply for a ring and ride pass so he can go to evening discos with friends. Marc is now getting out more, he is more confident using public transport on his own, his health and fitness have improved by going to the gym and he is enjoying volunteering.

Acute care

- Of the 135 patients that were referred to the CLWs in the hospital in February and March 2016[10] through various channels (hospital staff, voluntary organisations in the hospital, patient family members...) 74 (54%) took up the support offered by the CLW and were referred onwards to CLWs based in the patient's GP practice.
- 65% of clients referred through the acute pathway were women.
- The majority of clients in the acute pathway were older patients, with 72% being over 65 and 84% over 55, making this group of clients the oldest across the three pathways. Younger clients referred through this route tend to be people with chaotic lifestyles who are frequent attenders at the hospital.
- Falls and breathing difficulties are among the most frequent reasons for hospital admittance for patients referred through this pathway. Recurrent issues recorded by the CLWs based in the hospital are: long term conditions (such as COPD), mobility problems and pain; anxiety and depression; and substance or alcohol abuse.
- Clients referred through the acute pathway are the most likely (83%) to require 3 or less interactions with CLWs based in primary care. This might be because interventions consist mostly of referrals to other services.
- Issues that people tend to need help with are: finances; benefits and entitlements; accessing social activities and support groups for specific conditions; and carer support.

Andrew lives alone. He has no living relatives and is quite lonely. He suffers from COPD and when he becomes short of breath (usually at night) he becomes anxious and may call an ambulance. Andrew is referred to the link worker who makes an appointment with the community physiotherapist and goes along with him to it. In the appointment he learns relaxation techniques, exercises that help slow his breathing down and exercises to help clear his chest. The link worker introduces Andrew to the Community Warehouse, an organisation that helps people who are socially isolated to get involved in activities and build new friendships. The link worker also refers him to AWARM for home energy efficiency, fire safety and benefits assessments. Andrew is now waiting to have a new heating system installed through a government grant.In 2015, Andrew had over 40 hospital admissions. Since referral to the CLW in December 2015, his admissions have reduced.

10 Source: data collected by CLW working in WWL Trust.

Onward referrals and gaps in the system

The data collected by the system on onward referrals shows some interesting initial patterns about need and community provision, however, alone, it does not provide a full picture. In part this is because rich and detailed insights will always need to be drawn from those making and receiving referrals to complement higher level statistics. Equally, there is an opportunity to collect more granular and accurate data at the point of referral which is part of the wider recommendations on the information system and feedback mechanisms that are outlined in this report.

In this report we suggest embedding feedback loops that connect CLWs to referrers in health and social care services and to service providers in the community. This will generate richer information on the degree of take up of the community based support and activities and on how people go on to utilise their skills and experience through, for example, volunteering. Connecting people both as clients and as contributors to services in the community is one of the key features of the CLW service. Deriving richer insights on how it delivers on this function and whether and how commissioners can support the voluntary sector to partner in this effort at its best, will be important in thinking about scale.

From the data available, there is an indication that about 56% of initial referrals from the CLW are to the community and voluntary sector, with 6% referred into primary care services and 4% into social care[11]. Our qualitative research builds on this picture and we have found that typical referrals have fallen into 5 categories:

Volunteering

- Direct volunteering opportunities such as the food bank or day care centre
- Support through Age UK to find volunteering opportunities

Community activities

- Cooking classes
- U3A
- Book groups

Peer support groups

- Mental health support group
- Alcohol support group

Specialised voluntary sector support

- Pensioners Link
- Age UK
- Citizens Advice
- Wigan and Leigh Carers

Health and care services

- Health trainer service
- Social services
- IAPT
- GP (for access to other health services)

11 Source: Community Link Worker Report: March 2016

As well as increasing engagement with community activities and appropriate uptake of statutory services, commissioners have intended to use the CLW service as a magnifying lens to surface any gaps in service provision.

Below are the main gaps highlighted by CHCP's reports and conversations with CLWs:

- The lack of affordable, accessible transport is a recurrent issue and a driver for social isolation.
- The lack of free befriending services - an existing befriending service is free for the initial period of six weeks and then charged at £14/hour, which makes it unaffordable for many people who need it.
- The unavailability of befriending support for people who have carers.
- Long waiting times for counselling services.
- Long waiting lists for CAB's debt advice service.
- There is no HIV support in the borough.
- LGBT support groups are only available for younger people.

Process

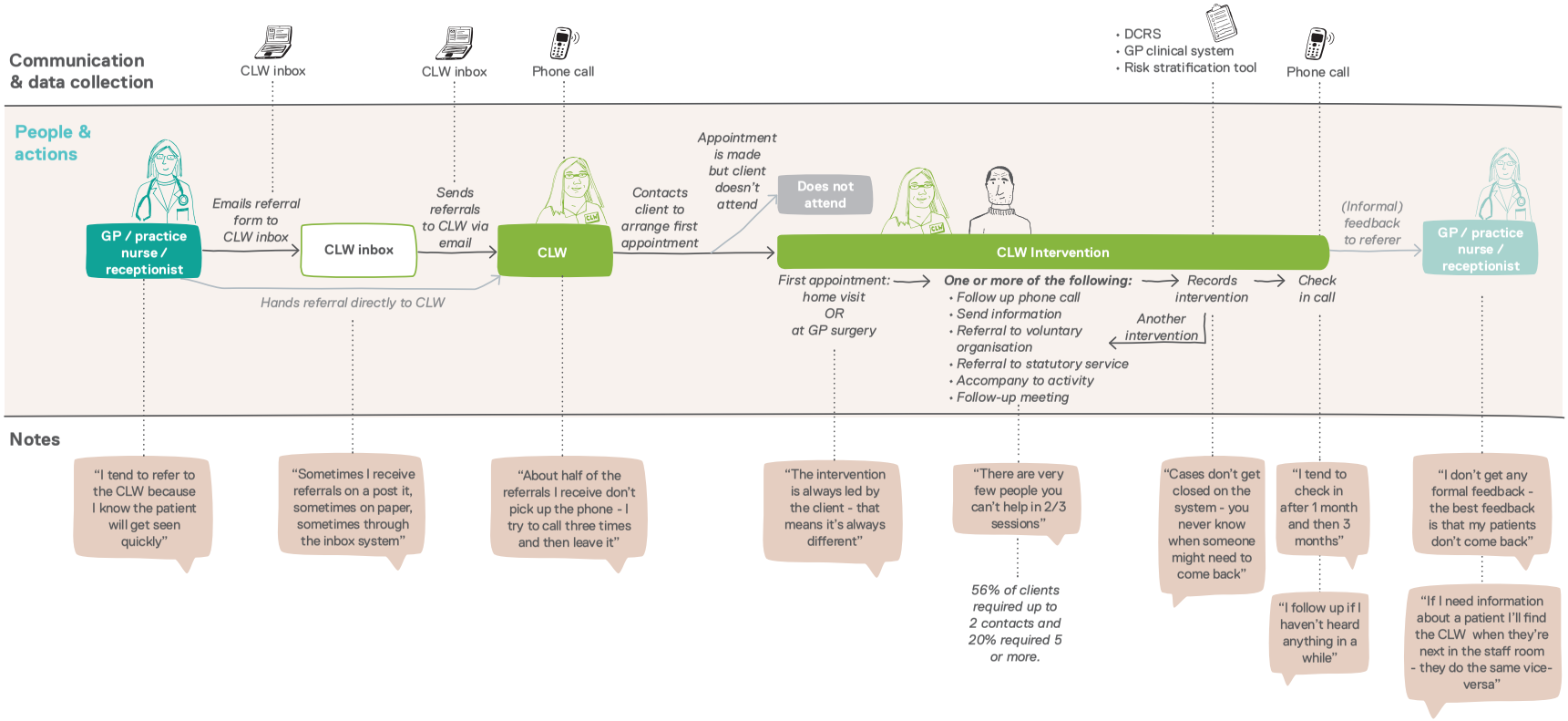
How the service works - a description of the pathways

Primary care pathway

Patients are referred to the CLW by any member of practice staff; this could be a GP, receptionist, community nurse etc. Typically, the referral will take place by sending a form through to the CLW inbox that is managed centrally by an administrator at CHCP. Sometimes, the referral will be made directly to the CLW in question.

Once a referral is received, the CLW will contact the client in order to arrange an initial appointment of about one hour at the GP practice. The CLW will facilitate a conversation with the client about their aspirations and needs, helping them to identify opportunities for improving or managing their conditions. As a result of this initial appointment, the client may be referred to additional services, receive information over email about community activities or have an appointment booked, for example, with a debt advice service. If the client is able to follow up on these actions independently, the CLW will make a follow up phone call to check on the client. If the client requires more support, the CLW may attend initial activities or meetings alongside the client and will continue seeing them as needed. The staff member who made the referral will be able to ask the CLW for feedback or check their patient's notes, however, there are no systematic feedback channels. Client cases are never officially closed.

Primary care pathway

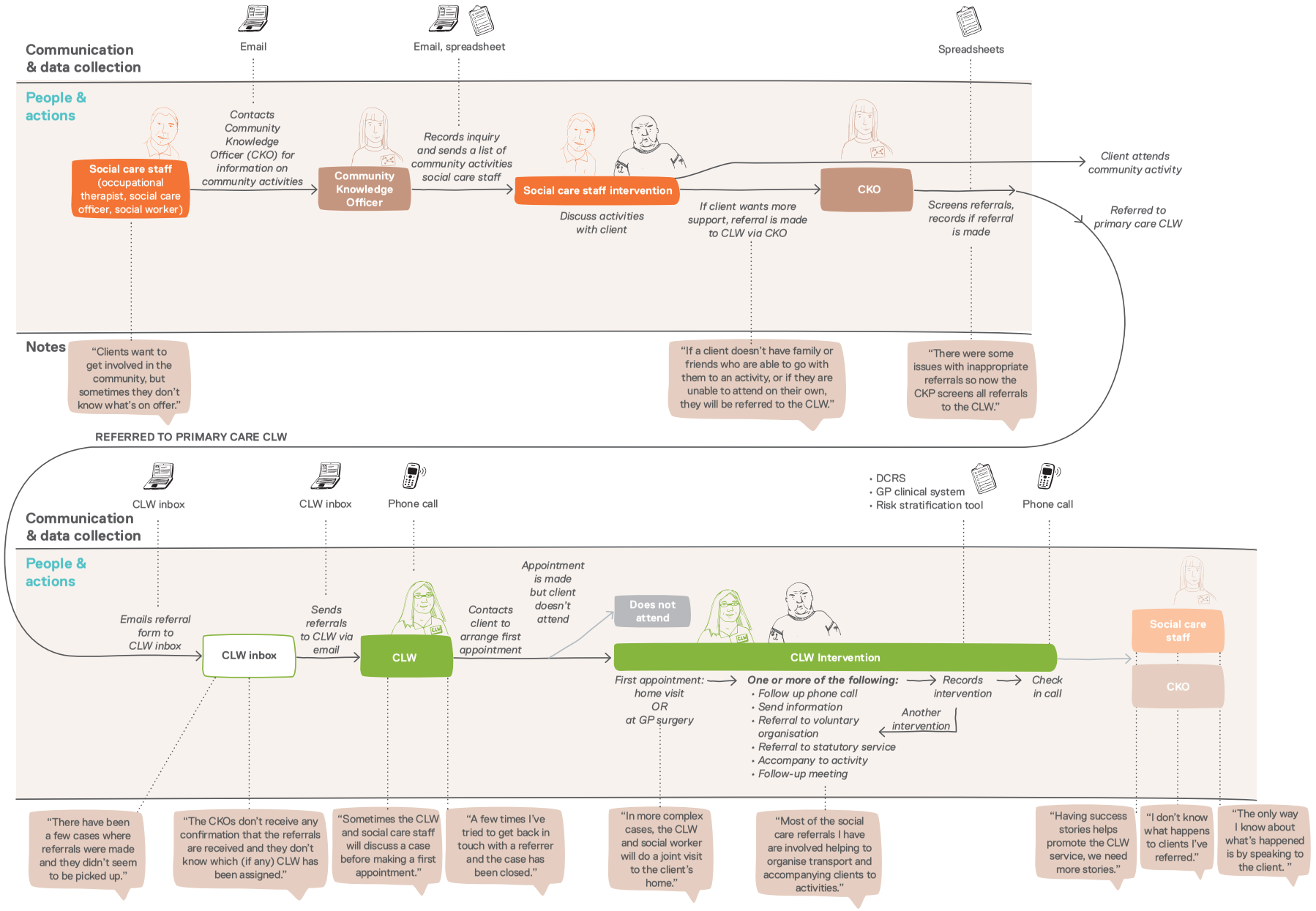


Adult social care pathway

When working with a member of frontline social care staff (Social Care Officer, Social Worker, Occupational Therapist etc), a client may identify an interest in becoming more involved in community activities. The social care staff will contact the Community Knowledge Officer (CKO) who will send them a list of activities available locally. The social care staff and client will discuss this list and the client may then decide to pursue an activity independently. If the client is not able to attend the activity on their own (either because of a lack of transportation, absence of support from friends and family or a lack of confidence) then they will be referred to the CLW via the CKO. The CKO will send the referral through to the CLW inbox and the CKO or social care staff will not typically receive a response from the CLW service after making this referral.

The CLW will make contact with the client to arrange a first meeting. Sometimes the CLW will get in touch with the member of frontline social care staff who made the referral to discuss the case and, particularly in complex cases, arrange a joint visit. The CLW intervention will be delivered either at the client's GP practice or at their home. The nature of the intervention will follow the same pattern as described in the primary care pathway, with certain types of intervention more characteristic of the adult social care pathway (such as helping to arrange transportation). There are no systematic feedback channels to either the CKO or social care staff so feedback relies on the CLW, social care staff and client. Client cases are never officially closed.

Adult social care pathway

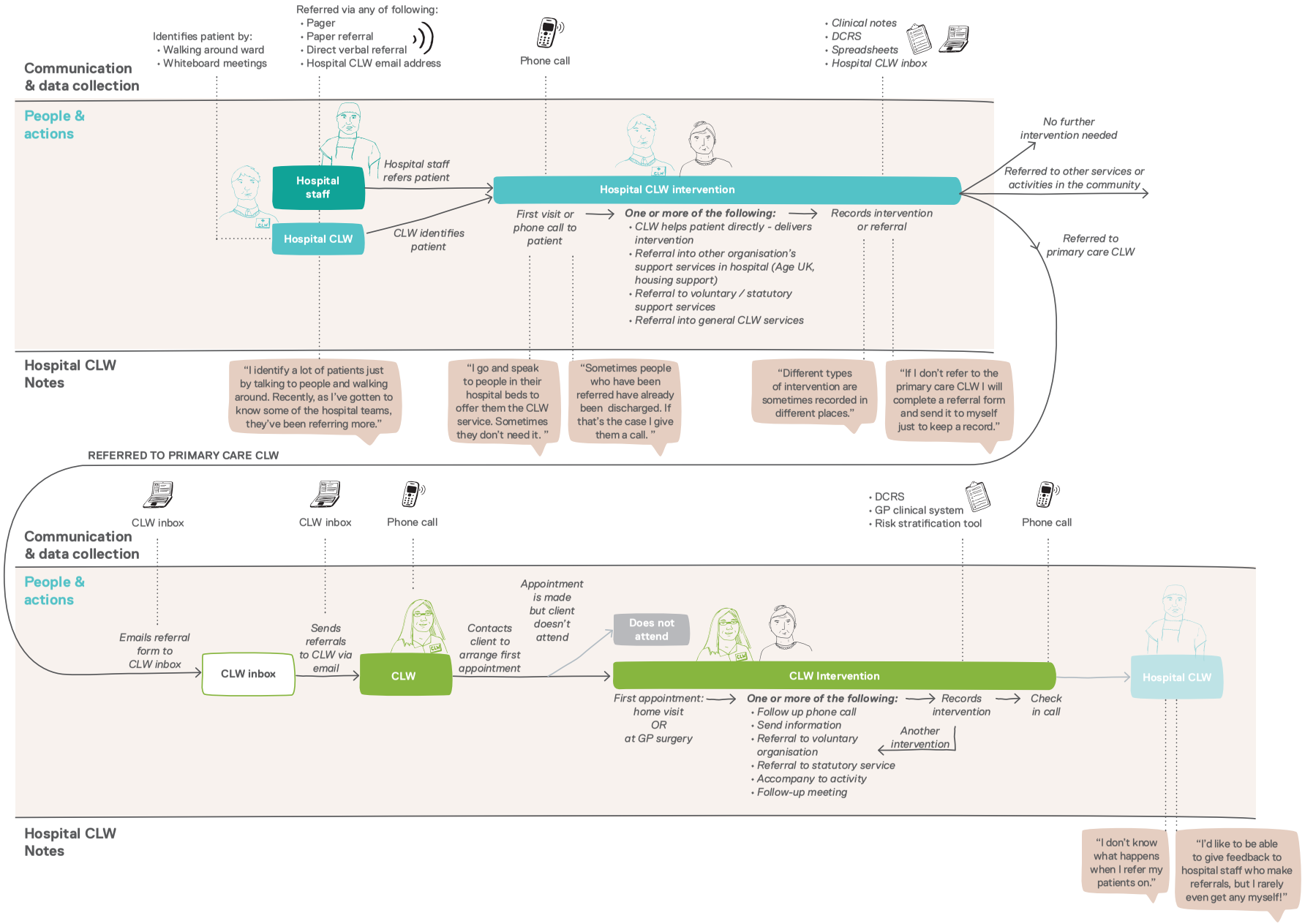


Acute care pathway

There are numerous channels for the CLW based in the hospital to identify patients that could be helped by the CLW service. In some cases, hospital staff will refer directly to the hospital CLW through a number of channels including by pager, referral forms or face to face. In other cases, the link worker will, themselves, identify patients who could benefit from the service by attending whiteboard meetings or simply walking around the wards. The link worker will visit a patient (or call them if they have already been discharged) and discuss their challenges and aspirations. They will offer onward referral to a primary care CLW and/ or to other support services (including some services that have staff working in the hospital such as a housing support team). Some patients will decline this support.

If the patient is referred to a primary care CLW, the nature of the intervention will follow the same pattern as described in the primary care and adult social care pathways, with certain types of intervention more characteristic of the acute care pathway (such as support with management of long term conditions). There are no systematic feedback channels to the hospital CLW who, therefore, cannot bring feedback to hospital staff. Client cases are never officially closed.

Acute care pathway



Understanding the service - highlights from the story so far

The CLW service was launched in January 2015 with 2 community link workers working across 11 GP practices in Wigan. From November 2015, the team grew to 11 FTE community link workers. Between December 2015 and March 2016, prolonged leave and the departure of some team members have stretched the capacity of the service and required some 'juggling' on the part of the operational lead and the CLW team to retain cover for the large geographical footprint of the service. The service is currently recruiting to bring the team back up to its intended size.

In the first months, up to the end of October 2015, the number of new referrals were between 20 and 40 each month[12]. Including initial and follow up contacts, the team of 2 CLWs delivered between 40 and 70 interactions each month. The rates of take up of the service from people who were referred to it were between 90% and 100% for most of that time. The total number of people supported by the service grew from 23 to 313 between January and the end of October 2015, with variations in the number of referrals in different months. During this period, referrals came mostly (74% on average) from general practice, with some months (June, September, October) showing higher rates of referrals from social care (between 30% and 60%).

Between November 2015 and February 2016[13], the number of new referrals ranged between 98 and 246 per month. The total number of people supported by the service grew to 784[14] by the end of February 2016; almost treble the number that had been seen before the expansion of the service. Whilst the majority of referrals continued to come from general practice (69% on average between November 2015 and February 2016), the number of referrals from the acute pathway grew significantly in February (29%), following the investment that the team made in building relationships and raising awareness of the service within the hospital. The proportion of social care referrals remained more or less constant throughout the whole life of the service and accounted for an average of 8% of total referrals between November 2015 and February 2016.

Between December 2015 and February 2016 there was a step change in the number of monthly referrals (from 94 to 246) and total number of contacts (from 207 to 486). This increase was driven by the growth of the team to 11 FTEs from November 2015. It is interesting to observe that the size of the increase in clients and contacts, though significant, is not commensurate to the increase in the size of the team. This can be explained by the fact that it takes time for referrals to pick up once the team is in place (the acute pathway is a good example of this). We also need to take into account fluctuations in team size and the fact that a team of 11 FTE CLWs (at periods reduced to a smaller team, due to sick leave and team fluctuations) is currently covering a population of 320,000 across 63 GP practices. CLWs cover between 6 and 11 practices each. They are spread thin, with important implications in terms of the time they have available to build and consolidate relationships and look after their caseload in each practice.

12 Source: Community Link Worker Report, January 2015 - January 2016.

13 Source: Community Link Worker Reports: January 2015 - January 2016; February 2016.

14 Source: raw dataset shared by CHCP. Note that one table in the Community Link Worker report, February 2016 mentions 848 as total number of users. We are using the total resulting from analysis of the raw dataset.

"Things have moved around whilst we are recruiting for new team members. I'm currently covering 10 GP practices across 16 sites. It's not possible to go to each of them every week." **CLW**

The data also shows a marked increase in the rate of DNAs (do not attend) in January 2016 (23% compared to much lower rates in previous months). As no later data on DNAs was available we are unable to determine whether this shift represents a trend or an exception. Over the coming months, monitoring data as well as reflections from the provider on capacity will offer important pointers on reach and effectiveness.

A closer look by pathway

Primary care

- **72% of all referrals**[15] throughout the life of the service **came from general practice** and all patients referred to the service are seen within general practice settings.
- An analysis of GP practice referral trends shows that **67% of referrals came from 15 practices**.
- **Brookmill Medical Centre** has been by far the most active referring practice, accounting on its own for 21% of all referrals (130 referrals between January 2015 and February 2016). **Dr Spielman & Partners, The Chandler Surgery and Foxleigh Family Surgery** follow with around 40 referrals each over the same period, accounting for 6% to 7% of the total each.
- There is no clear correlation[16] between practice size and the number of referrals made. Out of the 15 highest referring practices, 5 are also among the practices with the largest list sizes (13 of the 57 practices we were able to access list size data for have lists ranging from 7,500 to 16,900). Generally, practices referred between 0% and 2% of their patients to the CLW service.
- There is no clear correlation between deprivation indices and the number of referrals made. Of the 15 practices with the highest levels of deprivation, 6 are amongst the top 15 referrers to the CLW service. The practice with the highest deprivation index (Intrahealth Marsh Green, 56% deprivation index) referred 13 people to the CLW service and is number 12 in the list of top referrers.
- In practices with high numbers of referrals,

15 Source: Community Link Worker Report, February 2016.

16 Source: data on practice list size and deprivation indexes, courtesy of Wigan Borough CCG's and Wigan Council's business intelligence teams.

a key driver of success for the service is the **relationships** that CLWs build **with practice teams**. Attending practice meetings, developing relationships with members of staff in the practice and making the service and its impact visible to them plays a vital role in increasing the number of referrals. Working across several practices, CLWs can struggle to find the time to be present and connected in all practices. For example, going out on a home visit or accompanying clients to appointments may mean that they miss their slot in a practice and are therefore absent from it until the following week.

"Having only half a day per week in a surgery is not enough. Often you can't be there if you are accompanying someone to a meeting and it means missing weeks at a time. Ideally you would have 1 or 2 days in each surgery." **CLW**

"I've started prioritising the practices that refer most. I don't have time to build relationships with the other practices and frankly I don't know what I'd do if their referral numbers started picking up." **CLW**

- A measure of success for the CLW service in general practice is **freeing up GP time** by supporting people who use the service regularly. The data currently collected by the service does not include their use of primary care services before and after contact with the CLW, but an audit carried out by a GP who has been a champion of the service suggests that CLWs could be reducing the time that GPs spend with the most frequent attenders.

- Currently, CLWs should record information in at least two **databases** after each contact: DCRS and the clinical system. CLW access to clinical systems to input data has been mixed, but has recently been established across all participating GP practices. As the service grows to scale, it should develop a more efficient data collection system in order to cut duplication and enable access to information about clients' use of primary and secondary services. This will help determine the impact that the CLW service has on reducing demand for other services.

- There are no established channels or mechanisms for the service to provide **feedback** to referrers other than informal catch ups. Equally, CLWs report that they often don't know what happens after they refer their clients to other services. One of the CLWs interviewed contacts clients two or three months after their last meeting to see how they are doing. Establishing this as standard practice would be a good way to generate direct feedback from clients. Access to patient notes in the clinical system will also enable CLWs to see whether the frequency with which they access the practice services has reduced. Systematically inputting notes into the clinical system is the simplest way of providing feedback to referrers. Although GPs say that they see the difference the service makes when frequent attenders attend less often, testing ways of proactively providing feedback (in addition to recording contacts in the clinical system) could enhance the credibility of the service and in turn grow the number of referrals.

Adult social care

- On average**, 10%** of referrals throughout the life of the service have come through the adult social care pathway. Whilst the number of referrals in the primary care pathway and, over the last couple of months, in the acute pathway has been steadily increasing, the number of referrals coming through the adult social care pathway has remained largely constant.

- Interviews with council staff suggest that this is the pathway where **communication** flows present the most challenges. Community Knowledge Officers (CKO) find it frustrating that they rarely have contact with the CLWs- they often don't know which CLW is handling a referral and they don't receive information about the outcomes of interventions. CLWs have also mentioned that some social care referrals have been inappropriate and that getting in touch with social workers to discuss referrals is difficult and time consuming, for example, when a case has been closed with social services after a referral to the CLW has been made. Some CLWs have had regular meetings with social care staff to discuss cases, however, this practice seems to have been lost now that the service is handling a greater number of referrals.

"The main issue is that they aren't here. Staff haven't seen them. They don't know who they are." **Social care staff**

"I email a referral and I am never sure if it has been received." **CKO**

- There are three CKOs, each based in one of the three localities across the borough (Wigan, Leigh and Ashton). CKOs suggested that CLWs could be **co-located** within these locality teams in order to improve communication between the two services and so the CLW can benefit from the CKOs' knowledge and connections with services and activities in the community. Whether through co-location or regular check-ins, it will be important to invest in improving communications across the social care pathway. The service might also consider whether to allocate a CLW or small team of CLWs to manage social care referrals. This could enhance the social care pathway by enabling stronger relationships and communication between the services. Equally, this would help the CLWs to develop skills that are more relevant to this cohort of clients.

- CKOs also suggested that CLWs could input notes from their interactions with referred clients into Mosaic, the database used by social services, thereby providing **feedback** and visibility to referrers on interventions and, possibly, outcomes.

Acute care

- Referrals through the acute pathway started in December 2015 and have seen a **significant increase in February 2016** (increasing from 13 in January to 71 in February, which accounted for 29% of overall referrals in February). This increase reflects the team's investment in learning about which services and settings lend themselves most to finding prospective clients as well as developing relationships and raising awareness of the service within the hospital.

- Initially, the CLW was based within the integrated discharge team and they gradually developed links with the access team (A&E and front of house), COPD clinic, MacMillan Cancer Service, bereavement nurse and voluntary service providers based in the hospital, who all make referrals to the CLW service. As the CLW gets more and more established in the role, the service has grown its visibility and reach within the hospital.

- The main aim of the CLW service in the acute pathway is to **reduce readmissions** by referring to the primary care CLW. The expectation is that the service should, in particular, help older people and people with chronic conditions to live better in the community and stay out of hospital. It is early days to draw any conclusion on impact, however, the profile of clients referred through this pathway (see the cohort section for more detail) suggests that the service is reaching this target group. There is also anecdotal evidence that some patients supported by the service are not coming back into the hospital as often as they did in the past.

- Building a solid business case for the service in the hospital will require developing an understanding of readmission trends and translating the impact of the service into number of bed days saved. Currently, the CLW who works full time in the hospital gathers **data** about patients and referrals through spreadsheets and makes a record of clients who accept referrals onwards in the DCRS database, managed by CHCP. The information recorded is detailed and valuable, but the fact that records currently do not connect with hospital databases means that the opportunity to provide and acquire visibility on the full story of patients' interactions with services and their impact is missed. The service is exploring how best to connect with hospital databases and tracking systems.

"The discharge tracker generates alerts for people with a high risk of readmission, for example, if a patient turning up at A&E has a long term condition, has had referrals to social services in the past or has been readmitted within 30 days of discharge. It enables more proactive and collaborative working across the hospital teams." **Wigan CCG**

- There are currently no established channels to provide **feedback** to referring professionals or for the CLW within the hospital to find out about what happened post referral to CLWs in the community. Inputting into the hospital database and connecting to the discharge tracker could help improve this.

"I would like to be able to give feedback to referrers so they know what has happened to their patients and so that they will continue referring." **CLW, Hospital**

Emerging themes

Gathering data and managing referrals

From early on in the evaluation it became clear that **collecting the right data** to document activity and demonstrate impact is currently a challenge for the service. The database currently in use - DCRS - was designed for the health trainer service. It is difficult and costly to adapt it to the requirements of the CLW service. This has put an unnecessary administrative burden on the service.

The operational manager has had to design and test different ways of collecting information to fill the gaps between the DCRS framework and the commissioners' data collection requirements. This has meant that CLWs have needed to spend significant amounts of time inputting into several databases and forms about each client interaction. The result is an inefficient use of time and inconsistency of data.

Communication channels, particularly for referrals, also appear to be less than optimal. Currently, referrals are supposed to be emailed by referrers (including the CLW based in the hospital) to a central inbox, monitored by an administrator at CHCP. The administrator receives a referral and passes it on to the CLW who is based in the client's GP practice. In reality, referrals are sometimes made directly to the CLW in the GP practice. Some CLWs, particularly in the hospital, will email referrals to themselves after receiving them through a different channel to ensure that CHCP has a record of them. This takes time and does not happen consistently. Moreover, some referrers have mentioned that, when they use the CLW inbox, they are not sure whether the referral has been received or if any action has been taken as there is no response to these emails. Referrers outside of the primary care pathway will also not be aware which CLW has picked up the referral if they need to follow up or send additional information.

This system also means that information relating to numbers and types of referral is collected manually by CLWs (and reported directly to the service manager) rather than being systematically embedded within the data management system.

We understand that CHCP are already in the process of exploring what new system could best meet the data collection requirements of the service. In our opinion, such a **data collection and management system** should enable:

Core functions

- Inputting all the relevant information on clients and interactions (as per commissioning requirements) once. This will at least require interoperability with all clinical systems in general practice and, ideally, also with Mosaic (the social care information management system) and the hospital system.
- Extracting information about: client demographic characteristics, CLW contacts, use of other services over time - in general practice as well as, ideally, in hospital and social care - in a format that enables ease of analysis (i.e. excel spreadsheet or similar).

Desirable functions

- Interfacing with a simple referral form and logging referrals.
- Sending feedback messages and/or clarifying questions to referrers.
- Flagging CLW patients on the risk stratification database.
- Storing data from patient centred outcome measures.
- Syncing with CLW diaries in order to track appointment times and DNAs.

Communication

In launching any new service, communicating clearly its aim and benefits are both a key condition of success and a difficult thing to get right. Even more so when the service is as different from traditional services as the CLW offer. There are two foci to communication: the first is about referral criteria and purpose and the second is about feedback loops around impact. Both are extremely important.

The operational manager and the team have been aware of the challenges relating to communications and have been testing different ways of reaching out to referring professionals across the three pathways. The service has deliberately set very loose referral criteria to test and learn about the cohort and who can most benefit from the intervention. This has meant that the nature of referrals has depended on each referring professional's perspective and understanding of the aims and remit of the service. While the service has seen some inappropriate referrals, we think that the strategy of not setting strict boundaries around the target cohort has paid off, both in terms of reach and learning for the service. As the service evolves and learns about the value it brings to each pathway, its **promotion and narrative** should become more targeted and compelling for the referring professionals. As the community of users (both clients and referrers) grows, inviting them to be champions and allies in promoting the service will also be a powerful strategy.

Relationship building, alongside more general communication and promotion of the service, has been at the heart of the service's success in driving up referrals, for example, in the hospital and in the highest referring GP practices. This should remain a core element of the CLW role with a conscious focus on seeking and offering feedback on the difference that the service makes to people's lives. Whilst cultivating personal relationships remains the main way to exercise this practice, a smarter data collection system will help make this aspect of the service's communication approach richer and more effective.

Codifying practice

As set out in our analysis of the cohort, there are two main profiles of clients using the service: people who need signposting and a degree of handholding and people who need emotional and practical support over a longer period of time. Interestingly, when we asked CLWs to estimate how many people they saw in each of these groups, it was hard to get a clear answer. This may have been because clients in the second group, though fewer, take up a significant proportion of CLW time and attention. This suggests that the service has not yet developed a clear picture of who it is serving and of the trends in the length and nature of average interactions. This is not surprising, given that the majority of time and effort for both CLWs and the operational manager has been directed at increasing referrals and ensuring service delivery, with little time left for reflection, analysis and learning about the service.

Our conversations also suggest that in their interactions, CLWs are largely guided by their individual judgement and experience and that there is no explicitly shared practice and few opportunities to informally compare and reflect on practice between colleagues. We think that allowing professionals to use their judgement and experience in shaping their interactions, rather than over-regulating behaviours with rules and policies, is crucial to enabling the service to be responsive and flexible. However, we suggest that it would be helpful for the service to make its guiding principles explicit, to **blueprint** key steps in the user journey - clients' exit from the service in particular has emerged as an area where practice and expectations vary quite significantly - and to

be clear about boundaries and the possible scope of interactions for different groups of clients. This would offer guidance to CLWs as well as clarifying the service model to ensure consistency and fidelity at scale, particularly as the team changes and grows over time.

This **codification** of the service should be done **with and by the CLW team** before possibly being tested with patients and referring professionals. The focus should be explicitly on reflecting on and learning from practice (within each CLW's current practice there are already a number of good ideas that can be built on). As already mentioned, this should not be about creating a rulebook, but rather about defining the boundaries, shape and character of the service, - outlining the space which, in each interaction, will be filled by the experience, need, skills and sensitivities of each individual client and CLW.

Foci for such a codification exercise could be:

- Underpinning **principles** (as an example, some of the principles that we identified through conversations were: listening and whole person assessment; starting with people's assets; hands on, timely, practical help; open door policy).
- Developing a blueprint of **user journeys** for key client groups (i.e. short simple vs long complex interactions).
- Clarifying expectations and processes around **clients' exit** from the service
- Establishing **boundaries** in relationships with clients and in the scope of the service.

Improving **feedback** is an area where both CLWs and some referring professionals would like to see things done differently. We suggest a session to share current practices and generate ideas as a starting point for a strategy for the service going forward.

> "Some people don't want to let you go [...] Sometimes I don't feel there is an actual end to it." **CLW**

> "It is difficult for CLWs to tell someone they can't help anymore. There are no boundaries. A potential problem is seeing people for too long." **CLW**

CLW role and capacity

It was an ambitious choice for the pilot to cover the whole of the geography of the borough. For 11 FTE CLWs to cover a population of 320,000 across 63 practices, resources need to be stretched quite thin. Each CLW works across between 6 and 11 practices. This feels inefficient, considering the fixed costs in terms of travelling time between practices and attending essential meetings. We already discussed the limitations of being deployed over such a large portfolio of practices. Though list sizes and numbers of referrals may vary, we suggest that CLWs should have at least one full day in each of the practices they serve, or more for larger and more active practices. This would enable stronger relationships within the practice and ensure that they have enough time to see clients within a short waiting period, even when they need to go out on home visits or attend appointments with clients.

We recommend considering the option of allocating a team of CLWs to manage social care referrals and, ideally, be co-located with the CKOs in locality based teams. This would help improve communication between services and develop the skills and contextual understanding that is specific to the pathway. While it is clear that CLWs are a generic rather than specialist workforce, allocating **teams to specific**

pathways may offer an opportunity for improving networks, focus and learning in each area. There is learning to be drawn from the success of the CLW working full time in the hospital.

Reviewing the CLW **job description** and reflecting on actual vs ideal practice is an important thing to do, especially at a time when the service is feeling stretched.

We sketch out below our understanding of the main components of the CLW JD and an initial suggestion of how they could be spread across the CLWs' time:

- Client contacts (face to face, telephone, follow up actions such as information gathering and referrals) 70%
- Admin (data inputting and timesheets) 5%
- Developing and maintaining links with community groups 5%
- Developing and maintaining links with referring professionals and organisations 10%
- Personal and team development, learning, reflection and support 10%

> "There is the risk that, as we get busier, we focus on the quick fixes." **CLW**

> "I set up a catch up meeting with CLWs, but only one was allowed to come. They don't have time." **CKO**

CLW team skills and support

Throughout our research, it was clear that the service is highly appreciated and is making a difference to the lives of its clients. The quality and value of the service hinges on the qualities, commitment, skills and passion of the people who deliver it. Whilst the current team came across in our research as generally strong, capable and committed, we were not sure whether the degree of its success can be put down to design or luck, in terms of the skill mix that is at play.

A number of the CLWs have been seconded from health trainer roles, bringing skills, such as motivational interviewing and coaching, that are not a requirement of the CLW's person specification, but in many cases proved invaluable in enabling these professionals to help clients to the degree that they did. Several CLWs mentioned knowledge of mental health issues as being very important to their work. We suggest creating posts for **more experienced** CLWs within the team, who can play a supervision and management role, as well as having a caseload. This should enhance the quality of the service and help retain talented professionals within the team.

The service requires link workers to deploy their ability to connect, communicate, understand and use their judgement in order to determine the course of action to take in supporting a client. In our experience, to build and nurture these skills - and, crucially, to look after frontline professionals' own well-being - there need to be regular **spaces for learning, reflection and peer support, as well as clinical supervision** from more experienced team members and colleagues in the referring pathways. We suggest that learning, reflection and development activities should be designed in partnership with the CLW team and included explicitly in the CLW job description and monthly work plans.

"We sometimes call each other to check in and ask for advice. [...] There is no time for this in team meetings. [...] We don't know what other CLWs do." **CLW**

"I am lucky. I am well connected with people in the practice and there are people I can talk to." **CLW**

"We are not mental health practitioners. With the drip drip drip of working with people with mental health issues, all you need is something in your personal life to add itself on top ..." **CLW**

"We need mentoring and somewhere to off-load." **CLW**

Impact

The CLW service aims to have a positive impact on its clients, existing health and care services, the community and voluntary sectors and on the wider culture of delivering health and social care in Wigan.

As we already mentioned, the nature of this evaluation is formative and its focus has largely been on qualitative rather than quantitative analysis. The data available at the time of this evaluation does not support the development of a robust business case. It could be argued that, even as the data collected by the service grows in size, breadth and quality, the preventative and holistic nature of the service makes it difficult to produce a comprehensive cost-benefit analysis.

However, the qualitative research we carried out (including an analysis of user journeys and in-depth interviews with clients, CLWs, clinicians and professionals who have experienced and interacted with the service) coupled with an analysis of samples of existing data, have surfaced rich evidence of impact, in some areas more extensively than others.

On clients

The service aims to improve the health and well-being of local people by connecting them to community based activities, which support their independence and reduce reliance on acute or specialist services.[17]

Interviews with clients, clinicians and CLWs suggest that the service is having significant impact on the lives of its clients, for example, helping people in crisis to tackle and resolve issues quickly and supporting people with longer term challenges to build confidence, develop plans and make behaviour changes through becoming active in the community.

17 Community Link Worker Service Specification, NHS Wigan Borough Clinical Commissioning Group.

A distinguishing feature of the CLW service is the relationship between the link worker and client. Unlike other services, there are no limitations on the nature of each intervention, the length of each intervention or the number of interventions that each client is entitled to. This means that each of these elements are determined by both the clients' needs and the CLW's assessment of them. Without these limitations, clients have the opportunity to connect with the CLW in a way that they don't experience in other services. Many interviews revealed that the thing that had the most impact was that 'the CLW had the time to actually listen'.

Our analysis suggests that some of the service's success stories may be strongly linked to the qualities of link workers, whose level of skills and commitment are exceptionally high. It is important to ensure that the service is designed to consistently make these outcomes possible. While CLWs invest in building trusting relationships with people and making them feel like someone is there to help them, they also need to carefully manage the risk of creating a relationship of dependency with the people they support, particularly those with more complex needs.

Immediate, practical support

The open and relational quality of the CLW service is coupled with its practical nature. Link workers will focus on short and long term goals and help clients to identify and enact solutions to them. In 50% of cases this will take place over a short period of time (less than 2 interactions) and the link workers are able to take immediate action. The link worker listens to a client's wishes and helps them to identify a suitable opportunity in the community based on those wishes. A distinct feature of this role is that the link worker will then support the client to access this activity - it is rare that a client leaves a session without some action being taken.

"The CLW actually makes it happen there and then - you can't just go home and forget about it". **CLW Client**

For clients who come to a CLW at a time of crisis, it is often necessary to immediately put something in place, whether through attending an appointment together with Citizens Advice, taking them to the food bank or calling a housing officer to fix a broken boiler. For some clients who are not in crisis and already have an idea of what they need to get back on track, the link worker role is to simply make this happen. For example, making a referral to an alcohol detox programme, finding someone a volunteering opportunity or driving someone to a book group.

Access to appropriate support services

For clients with more complex needs, the CLW service has been their entrypoint to accessing statutory or community support services. These clients were described by one professional as 'the ones that have slipped through the net'. They may have never had the need to access services until a change in situation (whether medically, socially or financially triggered) left them struggling to look after themselves and unaware of what support was available. Or, in some cases, they may have been in the system for a long time, regularly accessing different statutory services and being referred onwards, without resolution. With knowledge of local services and the time to listen to people and understand their needs and aspirations, CLWs have been well placed to identify appropriate places for onward referral.

"I'm waiting to have an operation on my knee, but first need to lose a lot of weight. I'm not really mobile and was depending on a few friends and neighbours to do my shopping and take me places. Mealtimes were the hardest - going back and forth, again and again from the kitchen would knock me out. The link worker helped me get a social worker, who got me a trolley to bring my food from one room to the other - it's made a huge difference, you can't even begin to imagine - I never knew help like this existed." **CLW Client**

Improved relationships

Whilst the link worker service is targeted at individuals, it has had an indirect, and in some cases direct, impact on clients' families and friends. There can be a direct impact on family and friends when the support offered to a client is in the form of registering a family member as a carer, supporting a client to access benefits to help a family member in their care or when a family member or friend makes a request to see the CLW themselves. Indirectly, when clients are able to address their underlying problems and improve their wellbeing, they become more independent and tensions within relationships can be relieved. Two clients described how they had become dependent on their mothers to accompany them to places, even to meetings with the link worker and all of the interviewees were aware that the challenges they were facing had put strains on their relationships.

"Feeling more confident through working with the link worker has had a big impact on my relationship with my other half. He didn't know how unhappy I was. Now I feel I can tell him what I need and have a night off from looking after the kids now and then."**CLW client**

"Now that my husband has been registered as a carer and we've been able to get support from the foodbank, we are fighting a lot less. We have time to talk about other things than whether we will be having jam sandwiches again for dinner." **CLW client**

Increased involvement in the community

Vibrant social networks are a foundation of wellbeing[18]. In addition to developing and improving existing social networks, CLWs have supported clients to build new social networks. This is particularly impactful considering the large proportion of clients who are referred due to social isolation. In interviews, it became clear that some clients were referred to the link worker because of their explicit interest in meeting new people. Others identified that the challenges they were facing had driven away former friends ('they all just thought I was mad') and they were unable to access peers who had similar experiences to them.

Support building networks has principally occurred through:

- Volunteering
- Education (further education/ mother and baby classes)
- Employment
- Peer support/ befriending services

"The first baby classes my link worker sent me to were really hard. All of the children were so good and Lindsay was running around like crazy - they all thought I was a bad mother. My link worker eventually found a class that was a perfect fit - it's in a sort of jungle gym where Lindsay can run around and I can sit and natter with the other mums. It's great to get out of the house and I've even seen some old friends there from my pregnancy classes." **CLW client**

"My parents just kept telling me to stop drinking - they don't understand- they're old fashioned. In this group we are all in the same situation and we listen to each other. It's where I met my girlfriend and we try and keep each other on track." **CLW client**

Confidence

In many cases, CLW clients are aware of what they need to do, they are simply unable to take the first step to doing it; with a lack of confidence often playing a large part. This has been observed across a spectrum, from a client who is too nervous to attend a community group on their own to a client who is unable to leave their home without accompaniment.

18 http://www.nhs.uk/Conditions/stress-anxiety-depression/Pages/improve-mental-wellbeing.aspx

For those who have spent long periods of time in isolation, 'confidence is often one of the largest factors holding them back'. Offering clients time and space to explore what they are interested in and supporting them make the first step has had a significant impact on clients' sense of confidence.

"It's weird, just getting out and meeting new people I've progressed so much - I don't know what was holding me back. Now I'm attending classes, on a placement at a local school and earning my own money. I feel like an ordinary woman." **CLW client**

"I always like to go places with my mum. All the time I have seen the link worker she's been here. Getting used to meeting new people has meant I'm more comfortable being on my own. Like now- in this interview - I wouldn't have done this a few months back." **CLW client**

Motivation and activation

Findings from our interviews suggest that the service can have a positive impact on activation levels, understood as 'the knowledge, skills and confidence a person has in managing their own health and health care'[19]. For example, by supporting clients to tackle immediate challenges and equipping them to avoid or more effectively manage future challenges. The role of the CLW as a coach, who holds clients accountable for achieving the changes they want to see in their lives, can also crucially help sustain motivation.

"When I started seeing the CLW I felt I didn't really have a reason to get up in the morning. I've been able to start volunteering which has showed me that I can give something back - things aren't as bad as they seem. I've been doing more and more days of volunteering each week and I hope to start a befriending scheme soon." **CLW client**

"None of the detox programmes I did in the past worked. This time was different, I went from drinking 6 litres of cider a day to nothing in a few months. The biggest difference was having people there to help - my link worker who I now see as more of a friend, the peer support group he sent me to and a support worker." **CLW client**

'I know how I felt then and can recognise when I'm starting to feel it again. I don't think I'll end up back there, I've got tools now so I can manage it before it gets bad.' **CLW client**

On the flip side of the relational and motivational nature of interactions, there is the risk that the strong connection between the client and CLW may create a sense of dependency. Particularly in the absence of a clear process and expectations around clients' exit from the service, both clients and CLWs may find it difficult to decide when it is time to end an intervention.

19 Supporting people to manage their health, The Kings Fund, 2014.

'Things are so much better now I have the link worker. They're more of a friend than anything else - really listening and helping you open up. I don't know what I'd do if I had to stop seeing them.' **CLW client**

On services

The service aims to address non-clinical demands on primary and acute services by delivering a tested intervention which connects people to sources of support within their community[20].

Although it is too early - and the data is not yet readily available - to be able to demonstrate that the service drives a reduction in demand for health and care services, our research suggests that it is having a positive impact on services. This impact is articulated in the quality of the support available to patients, the positive experience of health professionals, and the drive for culture change within the wider system.

Primary care

The benefits set out in the business case for general practice were: freeing up GP time and allowing more effective use of primary care resources; developing a skill mix in primary care that meets the needs of patients and transforming the role of GP services as a community resource that connects people to appropriate support and activities.

Health professionals' experience of the service

The primary care professionals interviewed were very positive about the link worker service. They described how they found it frustrating that they were not able to provide sufficient support to some patients, especially when their challenges were not medically related or were linked to lifestyle and the management of specific conditions. One GP reported that they sometimes would spend time researching non-clinical interventions for patients who were in desperate need of support, for example, for a patient who had serious financial difficulties. However, it is typically not possible for GPs to offer this type of support within 8-10 minute appointments, nor is it a good use of their time or an effective application of their knowledge and expertise. One GP described the CLW as a valuable complement to the rest of the services within the practice.

"People come to the GP and expect to find all the help they need. It is great to be able to offer this kind of support (CLW) within the practice and people trust it because they associate it with their GP." **GP**

'It is disheartening when people keep coming back. I feel I don't help." **GP**

"Rather than spending time looking things up I will pass patients onto the link worker- they can take the time to understand exactly where the patient should be referred. We'd be lost without the link worker." **GP**

20 Source: Community Link Worker Service Specification, NHS Wigan Borough Clinical Commissioning Group.

"It's easy to feel like you should be everything to everyone- it's a lot of pressure. If there is a better service available to patients then they need to be able to access it. And the link worker will both help them find that service and motivate them to go. The link worker has time to do that." **GP**

Impact on service use

An audit carried out by a GP, who has been a champion for the service from its inception, suggests that in a sample of 43 patients referred to the CLW service between January and October 2015, 62% have seen a reduction in GP appointments by an average of a third. For these patients, appointments have gone down from 4.2 over 5 months prior to CLW involvement to 1.4 over the 5 months subsequent to coming into contact with CLW.

However, attendances increased over the same period for some clients. This could have been owing to the fact that clients were referred to the CLW at a moment of crisis and continued to need medical support.

The 'mini audits' carried out as part of this evaluation did not surface any definite trends in terms of reduction in service use. This analysis should be done more regularly over time in order to build robust evidence.

Anecdotal findings suggest that in some cases there has been a slight reduction of demand in general practice and in specialist services. However, this has not yet had a tangible impact on GP workload.

"There has definitely been an impact - some patients who were coming all the time now aren't attending as frequently." **GP**

"I'm not any less busy - I'm still working to ten minute appointments." **GP**

"Reducing demand on GP time has been a byproduct of the service." **GP**

Adult social care

In adult social care, the role of the CLW has typically been to support clients to attend activities in the community, reducing isolation and supporting independence.

Complementing the offer of social services

Our analysis suggests that communication in the adult social care pathway could be improved and that referrals, unlike in other pathways, have not seen a significant growth over the life of the pilot. However, we also found that social care professionals value the CLW service and recognise that it provides clients with a level of support that goes beyond the scope of what social care can offer. Moreover, CLWs have made referrals to social care for clients who had been in need of and not previously accessing statutory care, 'picking them up' before their needs became more severe.

"The adult social care staff work closely with the client and Community Knowledge Officer to find an opportunity in the community and develop a plan for the client to pursue it. The CLW is the final link in the puzzle - we make sure the client carries out this plan." **CLW**

"The link workers are a great asset - they enable clients to achieve outcomes that we wouldn't be able to achieve without them. For example, I know they've done brilliant work helping clients with learning disabilities to travel independently." **CKO**

"I've only referred a few clients to the CLW, but on each occasion they went above and beyond anything I could have expected. They helped one client to get a DBS check, start volunteering and to attend the gym. It's all been such a confidence boost and helped turn his life around." **Social care staff**

Acute care

In the acute care pathway, the aim for the service is to lead to reductions in readmissions, particularly for patients with long term conditions and frequent attenders. The service also aims to make the discharge process smoother by linking in with support services in the community.

It is too early to draw any robust conclusions about impact. However, our interviews suggest that staff in the hospital appreciate the ease of referral and single point of access for a wide range of support for patients in the community.

"Previously, it was hit and miss. There were multiple organisations working in the acute trust with very few referrals to them - nurses didn't have one single point of access. The link worker provides that single point of access to all of the support that is available out there in the community." **Hospital staff member**

Case studies and our interviews also evidence that CLW interventions have helped some patients avoid an admission and get back home faster, with the right support and equipment. However, given the number of agencies involved in complex cases, even when you can evidence a reduction in bed days, it is always going to prove difficult to attribute causality.

'One patient had been visiting the hospital 4-5 times a month. In December they met the CLW in hospital who referred them to a primary care CLW. Since seeing the CLW they haven't been back to the hospital for at least 5 weeks.' **CLW**

'I fell again in February- since my stroke 2 years ago my husband's been caring for me on his own and didn't know who to ask for help. That fall was the final straw - he called an ambulance and I ended up in hospital even though I wasn't really hurt. He didn't know what else to do. A link worker appeared by my hospital bed - they told me there were people out there who could help.' **CLW client**

On the community

The service aims to make effective use of voluntary and community sector assets by improving connections and relationships between local communities & voluntary sector organisations and traditional providers of health and social care[21].

The CLW service has the potential to benefit the community and voluntary sector (VCS) in a number of ways; building links between community and statutory services, facilitating the uptake of community and voluntary sector services and activities (particularly those that are already commissioned) and helping the Council and CCG to identify gaps in existing provision in order to support the development of new initiatives. When working effectively, these goals will be beneficial to the statutory, community and voluntary sectors as well as the wider Wigan community.

Each of these elements will feed into the wider health and social care strategies across Wigan and there is a great opportunity to share resources and knowledge in this area. For example, building on the council's model of the Community Knowledge Officer who offers an invaluable resource of up-to-date and thorough knowledge of community provision that can be accessed by all council workers.

Building links between community and statutory services

As a bridge between the statutory and voluntary sector, maintaining an active knowledge of services and relationships with those delivering them is a key element of the CLW role. This is challenging due to the volume and constantly changing nature of the sector - according to one VCS representative there are over 1400 community and voluntary sector groups in the borough.

Efforts have been made to build and maintain links between the CLWs and the VCS. For example, CLWs are encouraged to spend time visiting local organisations and, during the pilot phase, an event was held to introduce the CLW and VCS workers which was very successful. As the service has become busier there have been less opportunities to engage with the community more widely and some CLWs have found it difficult to maintain up to date knowledge of the provision available.

Enhancing the community and voluntary sector

By offering clients a catalogue of local services, the CLW helps to ensure that clients have access to all of the support available locally and it enables services and activities to be utilised to their maximum potential.

Interviews suggest that this increased access to local activities has had a significant impact on the lives of clients and some impact on the activity of services themselves. For example, Age UK were commissioned to deliver a peer support service that it was difficult to recruit for. The CLW service had a large number of clients over the age of 65 who were interested in volunteering and so the Age UK service shifted to provide tailored volunteering support to this age group. This service had excellent feedback from the CLWs who referred to it and it enabled Age UK to provide support to 65 people (January - August 2015), 45 of whom went on to access other Age UK services that they might not otherwise have come into contact with.

21 Community Link Worker Service Specification, NHS Wigan Borough Clinical Commissioning Group

"We are mostly run by volunteers and to try and get to every GP surgery ourselves is very difficult. In a way we see the CLWs as our organization's marketing team." **VCS delivery staff**

"The CLW has the potential to make a really big difference - organisations like ours have a lot to offer people but we find it hard to get a clear message out and know there are still a large number of people who we don't reach. All that's needed is a little bit of information and motivation." **VCS service manager**

Identifying gaps in provision

Commissioners require the CLW service to report regularly on any gaps in services they identify. CLW's thorough understanding of needs and direct contact with support provision in the community is an invaluable source of strategic insight for commissioning.

A similar and more developed model is already used by the Community Knowledge Officers who have the opportunity to feed their knowledge of gaps in provision into the Market Development team where they sit. This information can be used to target resources and stimulate growth in particular areas. For example, this feedback may result in convening relevant organisations to develop new ideas, commissioning new services from the council, enabling access to large grant making bodies (such as Big Lottery) or facilitating collaboration between providers.

Transforming the way care is delivered

The service aims to support transformational changes to the way we deliver health and social care through a new model that focuses on individual assets and community resources[22].

In addition to the immediate impacts of the CLW service on individuals, public services and the uptake of community and voluntary sector activities, the CLW service embodies a radical model of delivering health and social care. This is true at all levels, from the culture of seeing patients as people with aspirations and goals, to the operational elements of linking between services and communities and finally the strategic commissioning approach that recognises shared goals across different systems.

Starting from a place that recognises the assets that already exist within individuals, services and systems is an approach that builds on a much wider strategic trend within the Wigan Deal and Greater Manchester's integrated approach to health and social care[23]. Through the example outlined below, there is some evidence that over a short period of time, the CLW service has been a test of and a catalyst to new ways of working. This initial energy needs to be fostered in order to achieve the transformational impact it has the potential to.

22 Community Link Worker Service Specification, NHS Wigan Borough Clinical Commissioning Group.

23 Developing Asset Based Approaches to Primary Care: Best Practice Guide, Greater Manchester Public Health Network, 2016.

Culture change at Brookmill Medical Centre

"You can't underestimate how much of a change it's required to start seeing patients as people rather than a list of medical problems - just by remembering that we can make a real difference to their lives." **Practice manager, Brookmill Medical Centre**

"There's a real sense of possibility about what a GP practice could become, starting with what matters most for patients." **CLW, Brookmill Medical Centre**

By starting with the person rather than the condition, the CLW service models an exciting approach to health and care. Their presence within traditional healthcare organisations has the potential to not only transform the lives of the patients but equally to enable and expose practices to new ways of working. At Brookmill Medical Centre, one of the early adopter practices, this change in culture has been significant. The practice has embraced a more holistic approach to health and is now hosting community and voluntary sector drop-ins within one of the practice's spare rooms. This means that patients will be able to meet with Citizens Advice or Age UK within the familiar surroundings of their local surgery. Whilst this is merely a pilot phase, opening the surgery up to the community (and to even non-patients) is testament to the impact of integrating a CLW within existing primary care provision.

In the acute care pathway, there are early indications of a similar culture shift.

"The CLW service requires a big cultural change. It means recognising the impacts of a patient's wider environment- right now, when dealing with day to day illness, clinicians don't think about what's going on for the patient outside of the hospital such as social needs. We need to remember it's not the COPD that brings them into the hospital, it's the anxiety." **Hospital staff member**

Client journeys

As part of this evaluation, we undertook 7 in-depth client interviews, to gain an understanding of the user experience and impact of the service on the lives of the people it supports. In arranging these interviews we targeted clients whose profile included recurrent features of typical user personas complex needs, involvement of adult social care, requiring home visits, low level need , interest in volunteering, debt issues and long term conditions. The common user type that was not represented in these interviews was that of an elderly person experiencing social isolation the clients that we tried to approach in this group were anxious about or unable to participate in this process.

It is notable that the element that is shared between each of these stories is the positive experience of the client's interaction with the link worker. We offer here 7 client journeys, which exemplify the quality of experience and impact that we have described in this chapter. Client names have been changed to protect their anonymity.

Harry

PROFILE

Harry is 58. He admits he's 'not been a good boy in the past' and spent a number of years in prison. The thing that gets him up in the morning is his grandchildren who mean everything to him.

For the past ten years or so, Harry has suffered from depression and on two occasions has tried to kill himself. He goes to his GP surgery every week to collect a week's worth of medication.

IMPACT

Impact of the CLW service on Harry's life

The CLW has helped Harry to **gain regular access to his grandchildren** - something that he has been fighting for over a long period of time. He has started **volunteering at the local foodbank and night shelter**, both of which have given him a strong sense of purpose and perspective on his own challenges. He **plans to become a befriender** to support men of his age suffering from depression.

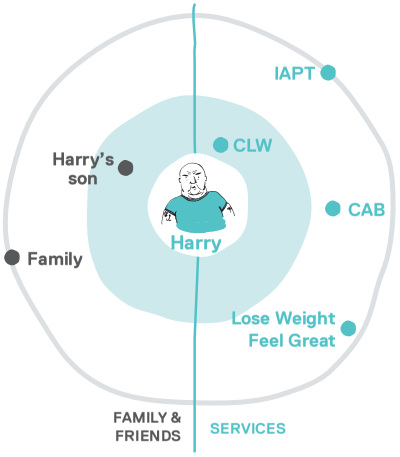
Whilst there are still some days when he struggles to get up in the morning, he feels much **more able to manage his condition**. In particular, he now **feels able to talk** about how he is feeling with his friends and family.

Harry's use of services

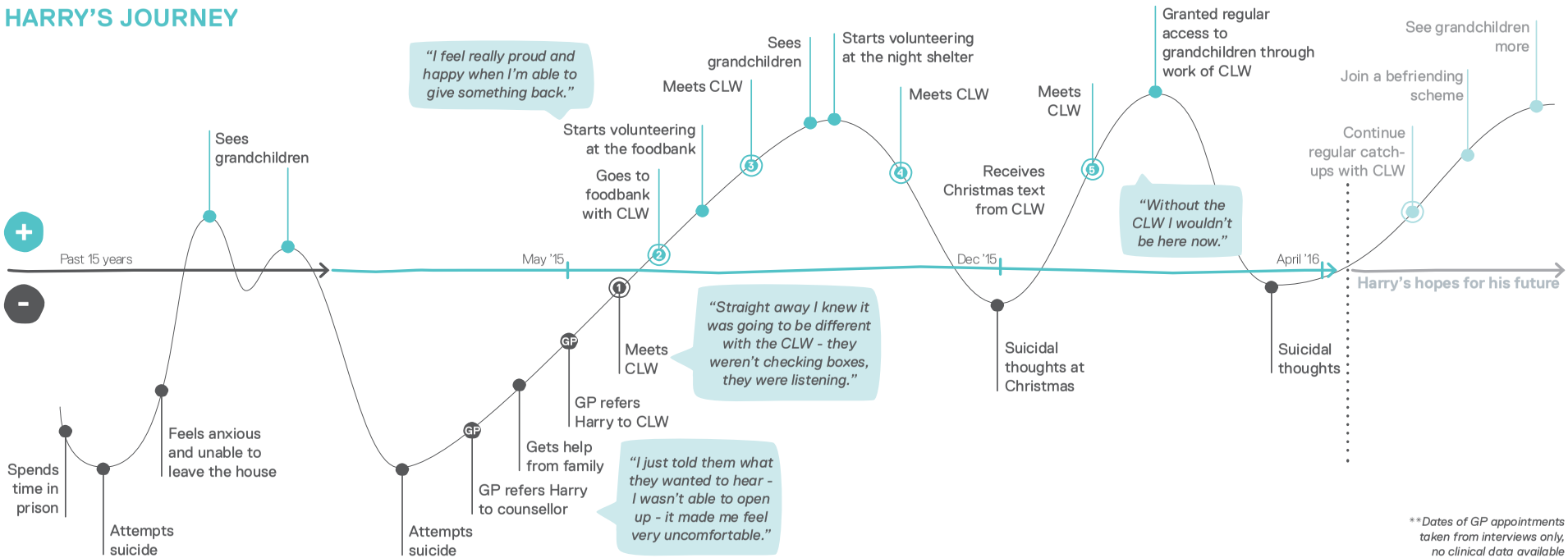
5 CLW visits

- 5 visits to CLW, ongoing catch up calls and informal meetings
- No longer accessing IAPT service

NETWORKS OF SUPPORT



HARRY'S JOURNEY



***Dates of GP appointments taken from interviews only, no clinical data available*

Sue

PROFILE

Sue is 62. She met her husband when they were both working night shifts at the Holiday Inn - she was on the desk and he was on the door.

She suffered a minor stroke 2 years ago whilst on holiday in Egypt for their wedding anniversary. She has since been suffering from the physical and psychological symptoms of the stroke.

Over this period she saw her GP and specialists regularly who all **made her feel like she was inventing her symptoms**. Her **husband left his job to become her carer** and they found their **savings were quickly disappearing**, exacerbating the tensions that had been emerging in their marriage...

IMPACT

Impact of the CLW service on Sue's life

Through the CLW, Sue and her husband received two **emergency food packages** from the foodbank. She has also received equipment that is helping her to **better manage her condition** at home and will be attending a tribunal for her benefits assessment alongside an advocate from Citizens Advice.

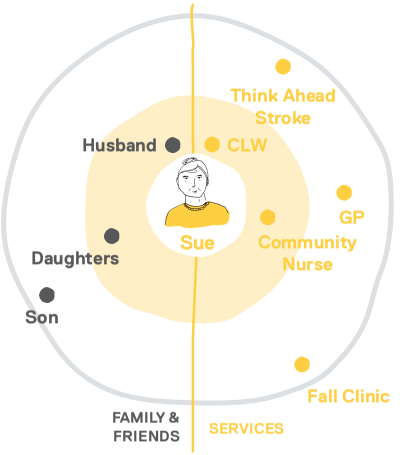
All of this has had an impact on Sue and her husband's **relationship**. They are **no longer consumed by the challenges** they face and are much more confident knowing where to go for help. Once she feels stronger, she **plans to start volunteering** at the foodbank as she feels it is her turn to give back.

Sue's use of services

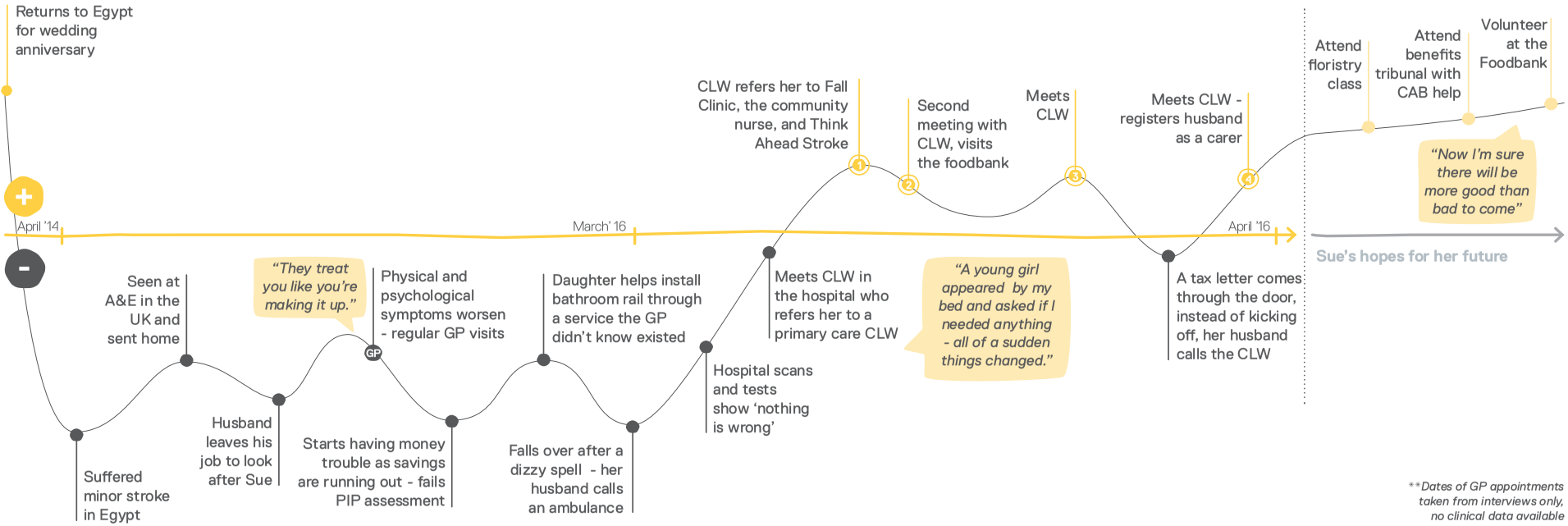
- 4 visits to CLW, ongoing catch up calls
- No longer visiting her GP regularly
- Has not been back to A&E since her fall
- Accessing regular support from a community nurse

4 CLW visits

NETWORKS OF SUPPORT



SUE'S JOURNEY



***Dates of GP appointments taken from interviews only, no clinical data available*

Dave

PROFILE

Dave is 32. He was drinking 6 litres of cider a day and was told he didn't have long to live.

He knew that **alcohol was linked to most of the problems he was facing** - but was convinced that no one would be able to help. He has accessed **many different services over time,** most recently failing to complete the Leigh Recovery Partnership programme.

What he really wants is to be able to see his children and for them to see him as a role model. He has suffered a series of medical issues linked to his alcohol and to being attacked one night when drunk in Leigh.

IMPACT

Impact of the CLW service on Dave's life

Through support from the link worker and other services, Dave has been able to **stop drinking completely** over a period of about 6 months (although he is still smoking cannabis regularly). Through the peer support group that the link worker referred him to he met his girlfriend who has also recently become sober.

Stopping drinking has been particularly **difficult for his social life**; he is no longer able to go out with some of his friends for fear of being tempted to drink. His new lifestyle has, however, given him the chance to **meet up with old friends from school and work** and to **improve his relationship with his parents and children.**

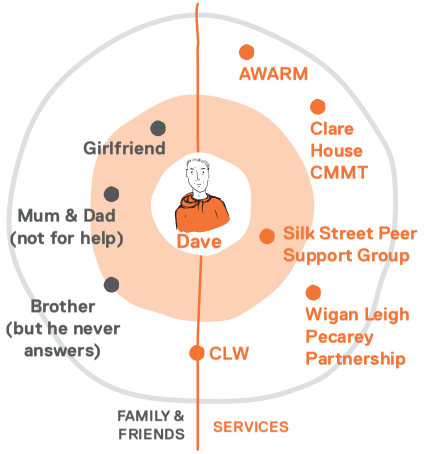
The link worker has been very important to him, listening and giving him time to talk about his challenges. He **sees the link worker as a friend** and hopes they will continue working together.

Dave's use of services

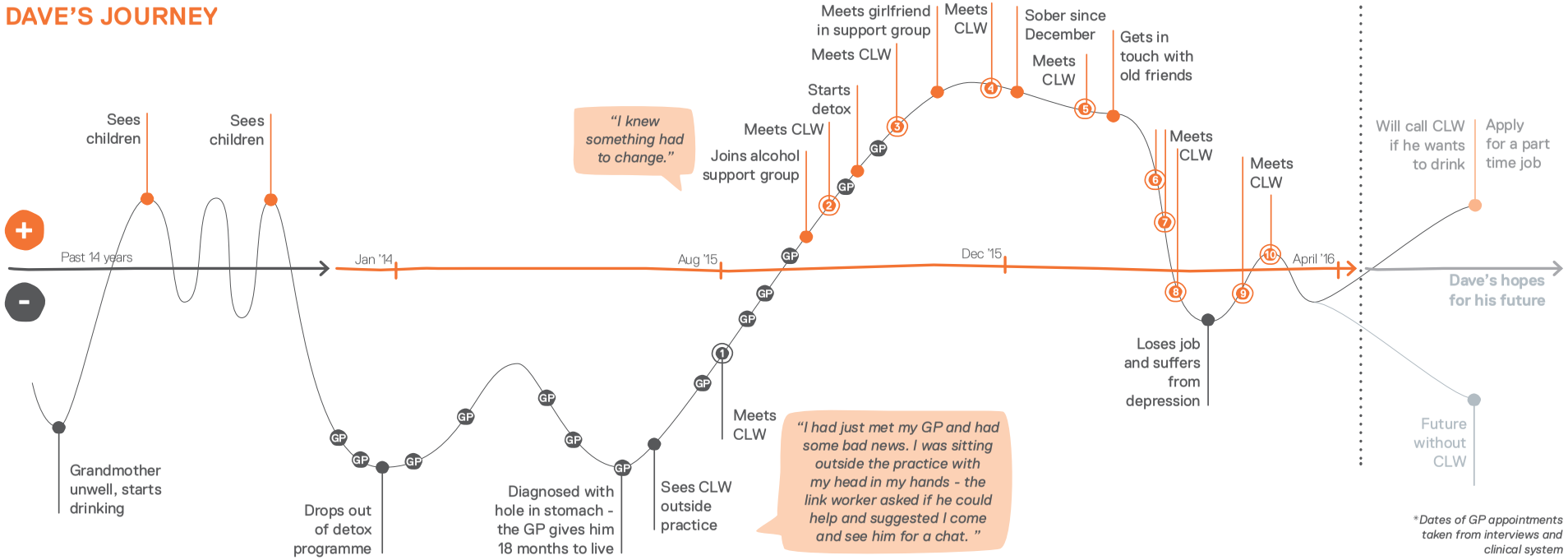
- Interview and dates of appointments with his GP suggest a reduction in Dave's use of primary care services
- 10 meetings in total, ongoing informal contact with CLW
- Continued involvement with the Leigh Recovery Partnership
- Continued hospital attendance due to ongoing health issues

10 CLW visits

NETWORKS OF SUPPORT



DAVE'S JOURNEY



*Dates of GP appointments taken from interviews and clinical system

Sophie

PROFILE

Sophie is 22. She was studying law at university and in her second year started **feeling anxious and depressed** - she realised that the course wasn't for her.

She saw her GP regularly because her mental health was seriously affecting her well-being. She was prescribed medication and it took a long time to find the correct doses. During this period she **didn't like to leave the house** alone, often relying on her mum to accompany her. She started seeing a psychotherapist and **realised that something needed to change**.

IMPACT

Impact of the CLW service on Sophie's life

Sophie had a **clear idea of what she needed** to get back on track - she needed to find an activity that would keep her busy and allow her to give back to others. She brought this intention to her first meeting with the CLW, and together they identified opportunities for volunteering locally. She **started volunteering** at the foodbank once a week and, as she built up confidence, was **given more and more responsibility**. Now she manages the food bank on a Thursday morning and volunteers at the local night shelter.

This experience of supporting others, coupled with her own experience of being supported through a period of mental ill health, has helped Sophie to **identify her long term ambition** of becoming a counsellor. She is currently applying for counselling courses.

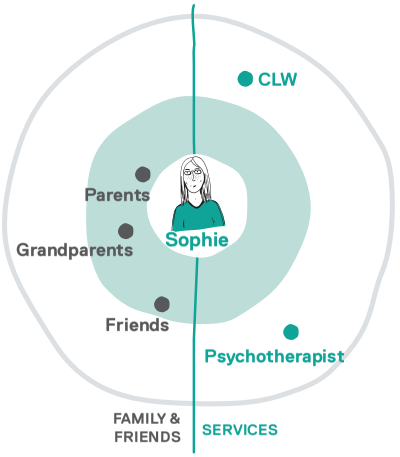
She recognises that the link worker helped her to make much faster progress than she could have made on her own.

Sophie's use of services

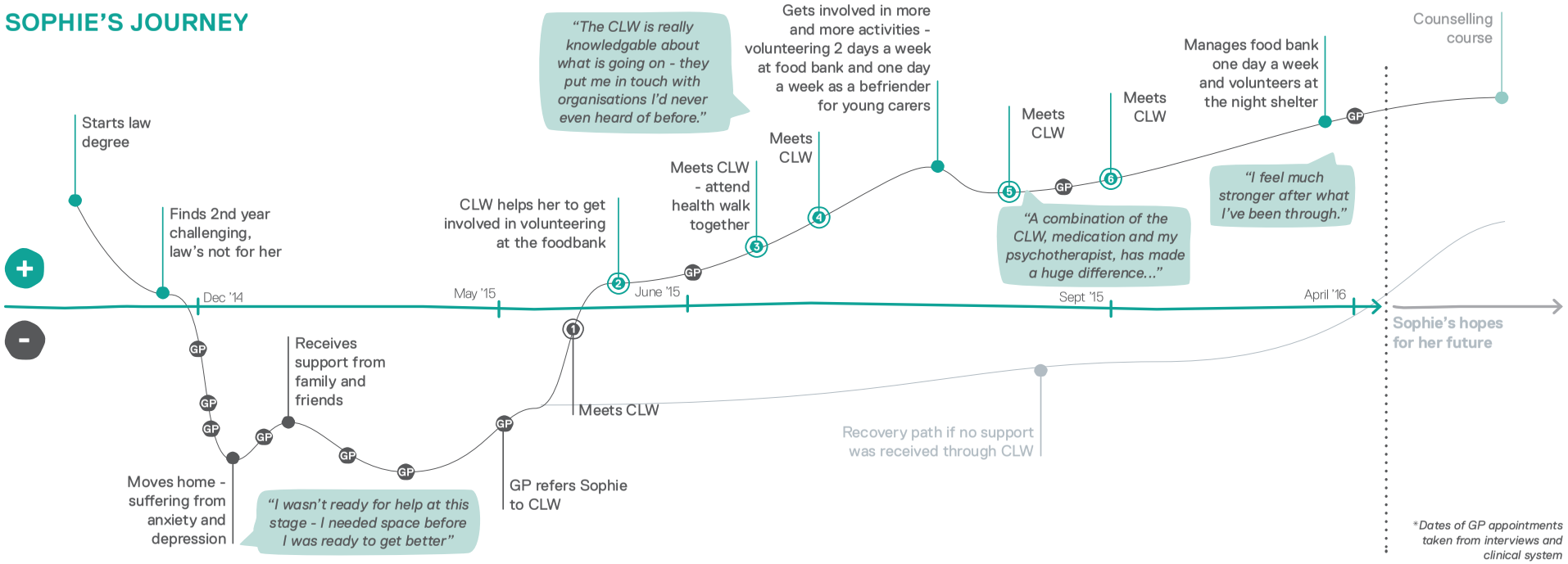
- 6 visits to the link worker, no longer needs to see them
- Reduced levels of attendance at GP - from 2 appointments/ month before meeting the link worker to 0.5 appointments/ month
- Continuing to see her psychotherapist privately

6 CLW visits

NETWORKS OF SUPPORT



SOPHIE'S JOURNEY



Rebecca

PROFILE

Rebecca, 24, has a degree in textiles and two children. During her last year of university things started going downhill and she was often **stressed and overwhelmed** - her father was ill, and she was pregnant with her second daughter. When she finished university she **spent her days at home** or at her mum's - always with her children. She was frightened of ending up like her mum who was agoraphobic. She went to see her doctor because she had been feeling down and experiencing stress related **physical symptoms** - fainting at night, heart pains, difficulty sleeping...

She sadly **lost her mum** in August last year, at which point things started becoming worse again. Her mum had been her **dad's carer** and she took up this role, visiting and supporting him everyday as well as continuing to look after her children.

IMPACT

Impact of the CLW service on Rebecca's life

Rebecca felt frustrated with her situation and **wanted to do something with her life**. The link worker helped her to find baby classes in the area which in turn helped her to **build confidence and start making new friends**. She has also been selling aloe vera products as part of a scheme called 'Forever Living' which has meant she has been **earning her own money**.

Rebecca has started reflecting with the link worker on what she wants to do with her life. She has **decided to become a teacher** and is about to start a placement at a local school whilst she takes some maths exams in order to qualify for a PGCE.

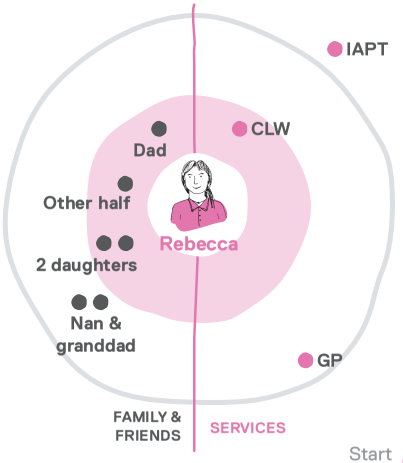
Through this process, Rebecca has **improved her relationship with her partner** and he is now helping look after the children more often. Her physical symptoms are gradually reducing and she hopes that the GP can **refer her father to the CLW service** for support managing his condition.

Rebecca's use of services

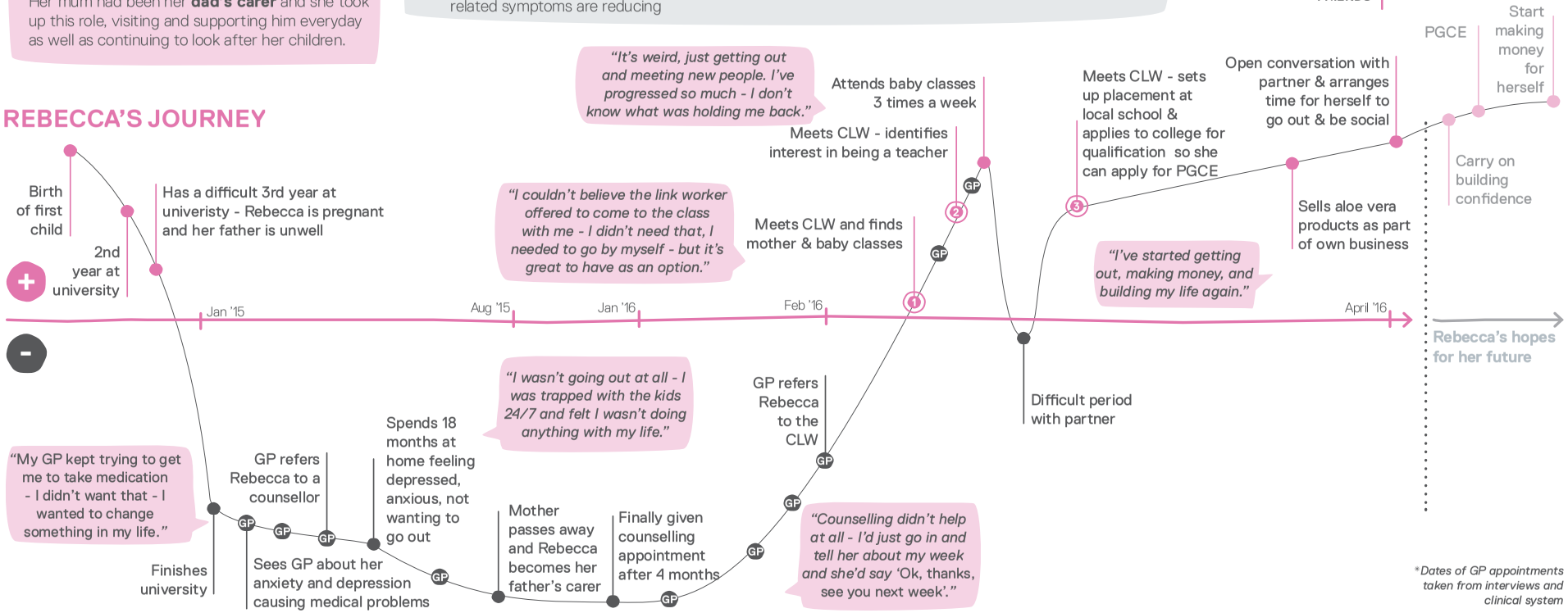
- 3 visits to the link worker, one more follow up meeting expected
- No longer using IAPT services - 'the link worker service is so much more helpful'
- Too early to see a reduction in use of GP services as CLW intervention is ongoing, however, stress related symptoms are reducing

3 CLW visits

NETWORKS OF SUPPORT



REBECCA'S JOURNEY



*Dates of GP appointments taken from interviews and clinical system

John

PROFILE

John is 63 and lives alone. 3 years ago he **hurt his knee** and had to stop playing bowls and snooker. Since then he has needed to have regular appointments at his GP surgery and Wigan Infirmary. He is **not able to leave his house** very often and depends on friends and neighbours to help - lending him a shower because he can't get into his bath, driving him to the pub, taking him to the GP etc. Before his knee operation can take place, he needs to lose weight and cut down on smoking. The trouble is that because he isn't able to get out and about due to his knee, both of these things are proving very difficult. He'd been referred to a health trainer in the past but wasn't sure if it was for him.

IMPACT

Impact of the CLW service on John's life

The link worker visits John at home which means he doesn't need to rely on someone taking him to the GP surgery. After seeing his condition, the link worker referred him to an OT **to better equip his home**. This helped him access a rolling trolley to bring his food in from the kitchen, a bar next to the toilet and a support block for getting into the bath. These have all made **a huge difference to his quality of life**.

Through Age UK he has been put on a **waiting list to access a bungalow** because it's so difficult for him to go up and downstairs in his current flat. In the meantime, the link worker has been speaking to his housing provider to see what temporary measures they can install.

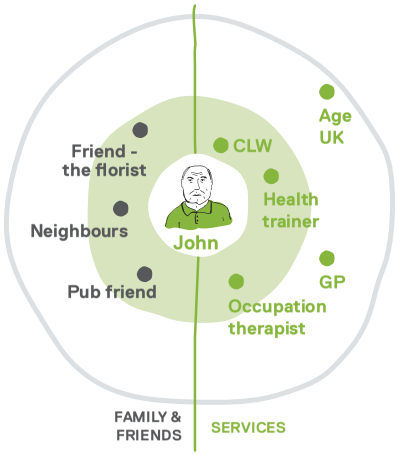
The link worker regularly gets in touch to make sure John is OK and **he will call the link worker if he is worried about anything**. Recently he called the link worker to help him with his benefits forms and he has said he will get back in touch if he needs further help with this.

John's use of services

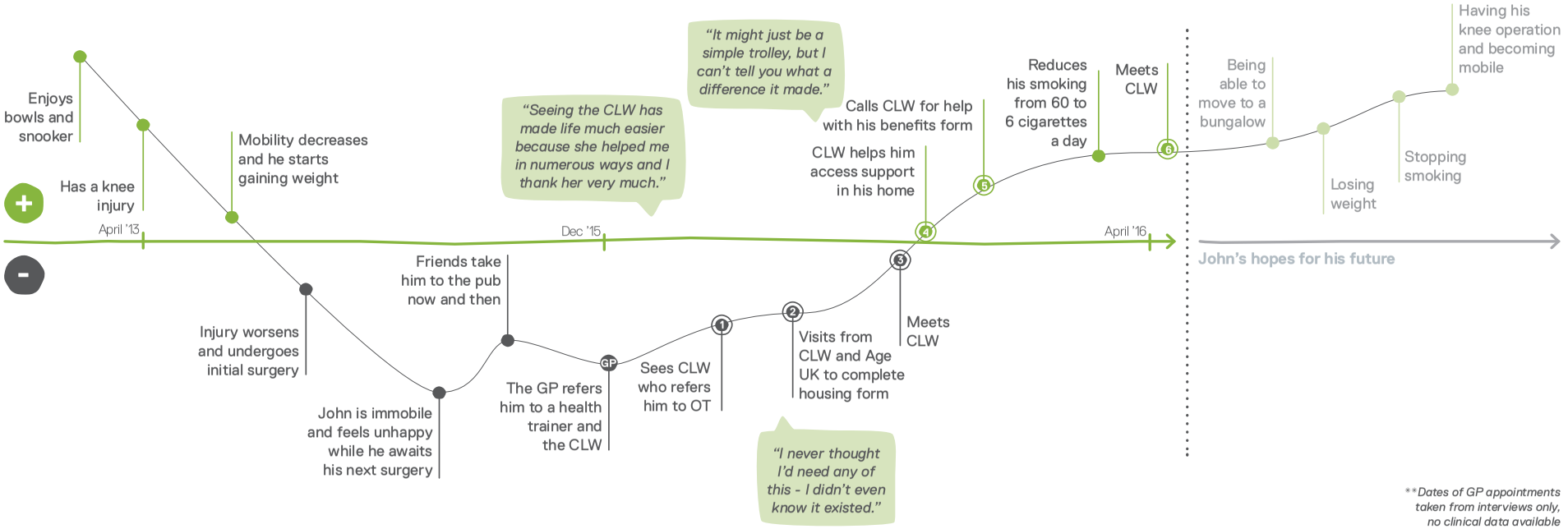
6 CLW visits

- In the past 12 months John has seen his GP 9 times and outpatient services 5 times
- John has seen the link worker 6 times, both at home and at his GP practice
- He is also seeing a health trainer regularly

NETWORKS OF SUPPORT



JOHN'S JOURNEY



***Dates of GP appointments taken from interviews only, no clinical data available*

Sam

PROFILE

Sam, 42, was diagnosed with **schizophrenia** 10 years ago when, one evening, he started hallucinating and ended up causing £20,000 worth of damage to his home. He was kept in hospital for 6 months and 'all **my friends stopped being friends with me** - they thought I was mad'. He spent the next 5 years in and out of hospital and in supported accommodation.

The past 5 years have been much better now that he is living in his own flat, taking medication and being supported by a range of services. Nevertheless, he was still **feeling down and insecure**, dependant on his mum to accompany him places and spending a lot of time in his flat alone.

He got in the habit of drinking 30 cups of coffee a day and has quite severe sleep problems. In his spare time he listens to U2 and Coldplay and enjoys writing poetry and lyrics to songs, with the ambition of publishing a book one day.

IMPACT

Impact of the CLW service on Sam's life

After 5 years of steady improvement, Sam was finally **ready to start building his new life**. The link worker helped him **start volunteering** for a sports group for children with behavioural difficulties. He is also volunteering at a local day centre and will be attending a cooking class and walking group with his link worker as well as a peer support group and a book group. He hopes he will be able to keep on top of all of these activities.

These activities have helped **build his confidence** and get him out and about. His mum is his main carer, and since seeing the link worker he has become much **more independent**. As such, his parents have decided to go on holiday and Sam will meet with his GP and the link worker over this period to make sure he is doing OK.

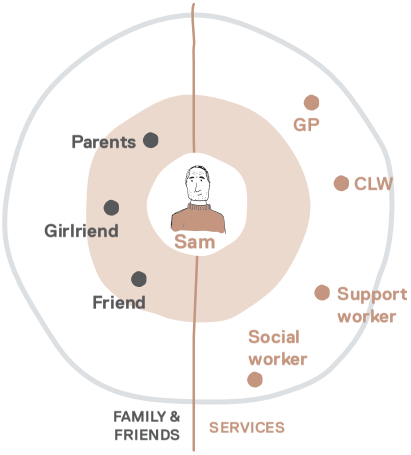
He is still suffering with sleep problems but feeling much happier and able to deal with it. He is **very optimistic** about the future.

Sam's use of services

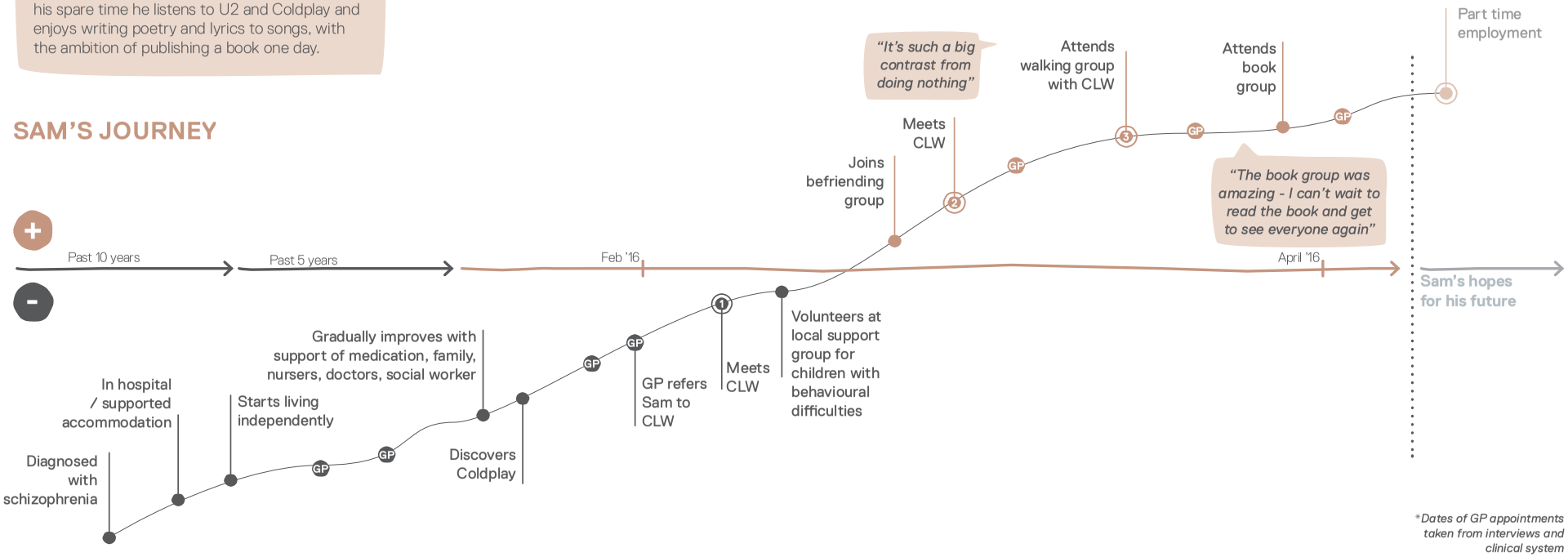
3 CLW visits

- 3 contacts with the link worker, and 4 check in calls
- No reduction in GP attendance identified

NETWORKS OF SUPPORT



SAM'S JOURNEY



*Dates of GP appointments taken from interviews and clinical system

4. Recommendations

Recommendations

Throughout this report we set out our findings on: who has been using the CLW service most; how the service is working in practice - what is working well and what could be done differently; and what difference it is making to clients, other services and the wider community.

In this section we offer some suggestions, based on our findings, about how to support the service to transition from pilot to scaling, so that it may realise its transformational potential in the system and achieve maximum impact.

CLWs and the wider system: an engine for radical cultural transformation

A key goal of this evaluation was to help commissioners better understand the service's cohort of users and identify who benefits most. In the cohort section, we talked about how there appear to be two groups of users: one, larger group needs signposting and some light handholding to increase their knowledge and confidence and access the right support. These are the people for whom this service was originally intended. The original hypothesis, substantiated by the findings of our qualitative research and anecdotal evidence, was that the service would help them maintain a level of wellbeing and independence and avoid crises.

Another, smaller group of clients have more complex needs, which often include some degree of mental ill health. These clients draw on the service more intensively than the first group and for a longer period of time. Both groups are benefitting significantly from the CLW service and say that 'having someone that really listens', being helped to move things on 'there and then' and having someone they know they can come back to if they need, make this a service that is both truly helpful and unique.

The questions commissioners and the provider could be asking at this point are: are both these types of clients the 'right' people to target, or would it be better to tighten referral criteria? Reflecting on what we heard from CLWs, referring professionals and clients themselves, and learning from the experience of social prescribing programmes elsewhere[24], we suggest the service should retain wide referral criteria and a low threshold for access.

This would mean making a conscious choice to use the service as an **initial filter or triage**, the first port of call for any people who present with social needs alongside, or rather than, medical needs and do not have the knowledge, ability or confidence to access available support to address these. Invested with such an explicit role, the service could test extending its referral criteria to include self-referral and 'refer-a-friend' access routes.

Our research suggests that the 'initial filter' is one of the important functions the service has been fulfilling so far. When asked who should not be referred to the service, the CLWs we spoke to consistently replied that there shouldn't be significant barriers to access, as they can and do help all the people that are referred to them in some way. As we already explained, our interviews with clients confirm this. Moreover, we know from conversations with GPs that they do not have the time to identify the most suitable referrals for non medical needs and that they greatly value the help of CLWs in doing that.

Indeed, if this service is to be one of the **engines of culture transformation** in line with the values of the Wigan Deal, then the model of front-loading the investment in a relational exchange that aims to understand people's needs and aspirations to maximise the relevance and impact of referrals seems a very appropriate one.

24 See Bromley by Bow's contribution to Social Prescribing Hangout, Innovation Unit, 16.05.2016 http://www.innovationunit.org/our-projects/projects/social-prescribing-making-it-happen

The 'initial filter'/signposting function is not the only one that the service is fulfilling at the moment. As we already mentioned, it is also providing **case management and navigation** for clients with more complex needs, some of whom are accessing other specialist services. Our interviews suggest that the CLW service adds value and, in some cases, manages to replace some specialist services, for example when people decide they no longer need counseling as a result of seeing a CLW.

The question has been raised of whether such a function in the CLW service creates duplication in the system. The answer should be considered in the medium rather than short term. Some extent of duplication cannot be eliminated, however, if the preventative hypothesis underpinning the service proves right, we should see a significant proportion of clients with more complex needs hitting crisis point less frequently. Moreover, as a place based model of care develops across Wigan, we expect that putting the CLW role at the heart of emerging multidisciplinary teams will reduce duplication and create powerful synergies across services.

While we advocate for maintaining loose and inclusive referral criteria, we do suggest that some level of **codification** of the service (for example, blueprinting the user journey for typical client profiles and developing a framework for a discharge process) will help streamline interactions, align expectations and make practice more consistent[25].

From casting the net wide to focus and consolidation

In the first phase, the pilot cast its net deliberately wide, in an attempt to understand as much as possible about the need for and impact of the service. Achieving cover across 63 GP practices and raising the visibility of the service across the three pathways has been a success, but now that referrals are picking up, this spread risks to stretch the service beyond its capacity.

Overstretch will mean risking to lose the unique value of the service, if quick fixes are sought in the interest of meeting demand. It will also make it hard to evidence impact, as CLWs are spread across many practices, with varying rates of referral.

We suggest that the next phase should be about focus and consolidation. Reducing the number of participating GP practices will enable CLWs to **focus on a manageable portfolio**. This will also allow them to invest in building relationships and testing new and better ways of doing things within the practices they cover. The exact size of a CLW portfolio in general practice should be defined with the service, based on list sizes, referral rates and characteristics of the practices. However, as a guiding principle, we think that CLWs should spend at least one full day in each of the practices they cover and that some of their time should be protected for reflection and supervision[26].

25 For more detailed suggestions, see the chapter on Process.

26 For more detail and suggestions about the CLW job description see the chapter on Process.

We recommend **reducing the number of GP practices** that are involved in the scheme, as long as team capacity remains at current levels. Criteria that can be used to determine which GP practices remain in the programme could be a mix of:

- evidence of demand – i.e. number of referrals to date,
- demographics and need – 6 of the top 15 referrers are also in the top 15 list of indices of deprivation,
- the types of services that the practice/ federation/clusters are planning to develop (i.e. a focus on older people, addressing mental health needs…),
- a commitment on the part of participating practices to generate learning for the service, through maintaining a minimum level of referrals and, for example, carrying out regular audits to evidence the impact of CLWs interventions with patients.

If the service coverage across general practice is reduced, referrals from social care and the hospital, where there is no CLW in the patient's own practice, may need either to be managed by a CLW team that services the pathway (we have recommended this as a structure for the social care pathway) or to be divided among the wider CLW team deployed in the community.

If the service is ultimately to develop sustainable business models relevant to each pathway, this level of **focus and buy in** from referrers will help determine the real value of the service for health services and the extent to which they themselves can contribute to the cost of the CLW service.

Smart ways to record and gather data that tells the whole story

Accessing data was a challenge throughout this evaluation, owing to a combination of: a lack of clarity about data protection restrictions, generating a reluctance to share data on the part of the provider; the mixed quality of data collection processes and the absence of a central repository of information about both CLW interactions and patients' use of primary and secondary services.

The 'mini audits' we commissioned from Wigan CCG and CHCP for this evaluation model a process of intelligence gathering that should become central to the way that the service reflects on its impact. The lack of interoperability between systems poses no small challenge to the achievement of this, but the service cannot begin to make a case for, i.e. reduction in GP consultations or in readmissions, without tackling the data collection challenge. In the process section we made some suggestions on the essential and desirable functions that a new **data system** should fulfill. Investing in 'getting this right' is key to developing a strong business case for the service.

In terms of what information should inform learning and evaluation of the service going forward in addition to what is already collected, here are some pointers:

- Use of services in the 6 or, if possible, 12 months prior and post interaction with CLW. In particular: GP consultations, A&E attendances, readmissions. If possible also including the client's use of the ambulance service and contacts with specialist services, such as mental health, drug and alcohol services. The risk stratification score and changes to it over time may offer some indication of impact, however, we believe that, on its own, it is not

a useful measure because it only captures variation of use in secondary services and is influenced by many external factors.

- Patient centred outcome measures, such as the Warwick-Edinburgh Mental Wellbeing Scale, Outcomes Star and measures of social isolation, patient activation, etc.... We note that the pilot had planned to incorporate the use of the Outcomes Star as an outcome measure, but that has not happened yet. Whatever the choice of measure, this is an approach that we recommend focusing on.
- Qualitative feedback from referring professionals in the three pathways.
- Information about patient engagement with voluntary sector service providers, both through referrals and volunteering.

Embedding feedback loops

As well as gathering wider data and analysing it more consistently, we recommend **providing greater visibility to the system** about the difference that the service is making. Feedback at the moment is happening in unstructured and opportunistic ways rather than systematically. This misses an opportunity to generate better intelligence and to promote the value of service.

We recommend investing in a smarter data collection system that can make it easy for both CLWs and health professionals to see what happened after a referral. Ideally, the system could also allow direct communication between CLWs and referrers about a case. Moreover, some feedback loops should be established within the system, for example, setting aside time for CLWs to access notes and take stock of clients' use of services post referral; to make follow up calls to clients a couple of months after discharge from the service; to connect with colleagues in the voluntary sector to find out about the take up and outcomes of their referrals and to offer feedback to referring colleagues in health services.

Creating the conditions for great relational working

What makes the service uniquely helpful is the fact that it puts the emphasis on **relational interactions** rather than professional specialism. In other words, the service puts relationships back at the heart of care and creates a space for a very human, personal and rounded approach to support. Getting this kind of intervention right requires professionalism, knowledge, strong relational skills and a very good ability to use **judgement** and think creatively in responding to an endless variation of circumstances.

To develop and nurture the skills and qualities of CLWs as relational workers, the service could:

- create spaces for the team to regularly engage in peer support and reflective practice,
- establish (formal or informal) supervision relationships within the service - possibly creating more senior posts within the team - and/or within referring services. These should support CLWs to develop their skills and knowledge, as well as ensuring they remain well and resilient in the face of the emotional pressure that they can be facing as part of their job,
- be explicit about giving people permission to use their judgement, sensitivity and creativity in doing their job and offering clear guidance about key policy guidelines, i.e. around safeguarding.

To create and foster a culture that enables relational working, the service should be:

- clear about its values and principles,
- strong on setting key boundaries and rules, for example, around safeguarding,
- loose, iterative and reflective about everything else.

We talked earlier in this report about how some level of useful codification should aim to define the boundaries, shape and character of the service and outline the space that in each interaction will be filled by the experience, need, skills and sensitivities of both clients and CLWs.

Engaging CLWs and clients in shaping and refining the service as it grows

We made a number of suggestions in this report about ways that the service can refine and rethink some of its elements. Enlisting CLWs, clients and health professionals in **co-designing and co-producing the service** going forward will be key to keeping it relevant and impactful. This will mean creating spaces for reflection, testing and learning within the service. For example, earmarking time to enable CLWs to inform the development of the service and its practice, based on their experience. It will also mean being creative about ways to actively engage clients, for example opportunities for them to act as champions to the service and buddies to other people with similar challenges.

Putting CLWs at the heart of place based models of care in Wigan

This is a great time to be developing a service model like Wigan's CLWs. A time ripe with change and ambition, as well as challenge, for the NHS as a whole and for individual local economies. With a joint CCG and Council investment in such a person centred, asset based service, Wigan is ahead of the curve of national developments in health and care. As **place based models of care** emerge across Wigan and the practice of integrated working becomes more embedded, CLWs could play a pivotal role in multidisciplinary teams. Their location within general practice, their extensive experience and their broad and vibrant existing networks will be an invaluable asset to the local health economy.

The announcement of investment in the service from the CCG and Council for another year shows their commitment to the service. Their ambition should remain to make a strong case for how the service adds value to Wigan's health economy – not simply in monetary and cost-benefit terms, but more widely, as a vector for culture transformation towards better, person centred, preventative, co-productive services that create more resilient communities.

5. Appendixes

Interviews

SERVICE OVERVIEW			
Yvonne Hughes	City Health Care Partnership	Operational Lead, Community Link Workers	10/2/2016 & 17/02/2016
Giles Bridgeman, CHP	City Health Care Partnership	Contract Holder	09/03/2016
CLW focus group	City Health Care Partnership	8 CLWs from the November intake	24/02/2016
Claire Roberts	Wigan Borough CCG	Assistant Director, Strategy & Collaboration	19/05/2016
Diane Nicholls	Wigan Borough CCG	Locality Executive Support Officer	10/02/2016
Lynne Calvert	Wigan council	Service Manager, Live Well	26/04/2016

PRIMARY CARE PATHWAY			
Dr. James Weems	Brookmill Medical Centre	GP	23/02/2016
Sahra Kay	Brookmill Medical Centre	Practice Manager	23/02/2016
4 CLW clients	Brookmill Medical Centre		04/04/2016
Geoff Goodman	City Health Care Partnership	CLW	04/04/2016
3 CLW clients	Bryn Cross Surgery		26/04/2016
Jane Wilkie	City Health Care Partnership	CLW	26/04/2016
Dr Fiona Jones	Bryn Cross Surgery	GP	26/04/2016

ACUTE PATHWAY			
Julie Aulton	Wrightington, Wigan and Leigh NHS Foundation	Strategic Integrated Discharge Coordinator	02/03/2016
Nikki Lawson	City Health Care Partnership	CLW	15/04/2016
Christopher Broadbent	Wigan Borough CCG	Urgent Care Lead	07/03/2016

ADULT SOCIAL CARE PATHWAY			
Paul Haunch	Wigan Council	Community Knowledge Officer Manager	11/04/2016
Julie McGregor	Wigan Council	Community Knowledge Officer	11/04/2016
Amanda Thomas	Wigan Council	Community Knowledge Officer	13/04/2016
Clair Broomhead	Wigan Council	Social Care Officer	27/04/2016

COMMUNITY AND VOLUNTARY SECTOR		
John McArdle	Age UK	31/03/2016
Carol Sankey	Think Ahead Stroke	14/03/2016

Stakeholder workshop

23/02/2016 Participants list

NAME	ORGANISATION	ROLE
Claire Roberts	Wigan Borough CCG	Assistant Director, Strategy & Collaboration
Diane Nicholls	Wigan Borough CCG	Locality Executive Support Officer
Lynne Calvert	Wigan Council	Service Manager, Live Well
Mohammed Khan	Wigan Borough CCG	Project Accountant
Yvonne Hughes	City Health Care Partnership	Operational Lead, Community Link Workers
Giles Bridgeman	City Health Care Partnership	Contract Holder
Miriam Bell	City Health Care Partnership	Public Health Operational Manager, North West
Esther Jackson	Pemberton Surgery	Practice Manager
Sahra Kay	Brookmill Medical Centre	Practice Manager
Janet Ingham	Dr Xaviers Practice	Practice Manager
Sarah Shannon	Age UK	Together for Health service
Kendal Grey	Citizens Advice Wigan	Citizens Advice Wigan
Geoff Goodman	City Health Care Partnership	Community Link Worker
Nicola Lawson	City Health Care Partnership	Community Link Worker
Martin Broom	Healthwatch Wigan	Director
Cath Dillon	Innovation Unit	Senior Team Leader
Francesca Cignola	Innovation Unit	Programme Lead
Chloe Grahame	Innovation Unit	Trainee Researcher and Project Coordinator

GP practice referrals, list size, and deprivation index[27]

PRACTICE NAME	NO OF REFERRAL / PRACTICE	% OF GP REFERRALS	GP LIST SIZE	DEPRIVATION INDEX
BROOKMILL MEDICAL CENTRE	130	21.00%	7960	27.65
THE CHANDLER SURGERY	44	7.11%	4093	23.89
FOXLEIGH FAMILY SURGERY	40	6.46%	2319	28.61
DR SPIELMANN & PARTNERS	37	5.98%	6924	33.06
ZAMAN	20	3.23%	4106	24.67
DRS D'ARIFAT, ELISLAM, WAN & SHAIKH	19	3.07%	6226	36.41
GUPTA K	17	2.75%	2049	32.67
BRYN CROSS SURGERY	16	2.58%	5853	n/a
DR ALISTAIR & PARTNERS	15	2.42%	6095	21.67
PITALIA SK	15	2.42%	7518	20.51
THE DICCONSON GROUP PRACTICE	14	2.26%	8375	29.93
INTRAHEALTH MARSH GREEN	13	2.10%	2716	56.15
DALTON TM	12	1.94%	2969	35.14
MARUS BRIDGE PRACTICE	12	1.94%	5202	22.33
ELLIOTT STREET SURGERY	11	1.78%	4462	n/a
STANDISH MEDICAL PRACTICE	11	1.78%	11921	12.08
BEECH HILL MEDICAL PRACTICE	9	1.45%	13030	24.66
GRASMERE SURGERY	9	1.45%	8190	n/a
LILFORD PARK SURGERY	9	1.45%	3646	30.83
PEMBERTON SURGERY	9	1.45%	9659	38.52
PENNYGATE MEDICAL CENTRE	9	1.45%	16684	25.85
PREMIER HEALTH TEAM	9	1.45%	2810	28.34
INTRAHEALTH FAMILY PRACT	8	1.29%	1756	21.66
ASPULL SURGERY	7	1.13%	5391	21.52
BRADSHAW MEDICAL CENTRE	7	1.13%	8893	27.42
DR ELLIS & KREPPEL	7	1.13%	4376	24.66
DR MUNRO & PARTNERS	7	1.13%	n/a	n/a
DR JD SEABROOK	6	0.97%	4252	25.62
DR TUN & PARTNERS	6	0.97%	8012	25.54
MEDICENTRE	6	0.97%	5438	35.87
OLLERTON A	6	0.97%	3329	21.34
XAVIER CA	6	0.97%	4736	27.14
DR AK & N ATREY	5	0.81%	4733	32.28
DR KK CHAN	5	0.81%	4422	29.52

27 Source: raw dataset provided by CHCP, data provided by CCG and Wigan Council's business intelligence teams.

DR MAUNG & PARTNERS	5	0.81%	1933	29.1
LEIGH FAMILY PRACTICE	5	0.81%	8119	36
LOWER INCE SURGERY	5	0.81%	3955	39.79
ASTLEY GENERAL PRACTICE	4	0.65%	2822	18.31
DR PT MAHADEVAPPA	4	0.65%	2323	17.97
INTRAHEALTH TYLDESLEY	4	0.65%	4708	33.09
PLATT BRIDGE HEALTH CENTRE	4	0.65%	3488	38.76
SHAHBAZI SS	4	0.65%	3139	23.24
DR TRIVEDI	3	0.48%	4112	32.26
SIVAKUMAR & PARTNER	3	0.48%	4258	16.84
SULLIVAN WAY SURGERY	3	0.48%	7534	n/a
DR CP KHATRI	2	0.32%	4619	26.76
DR R ANDERSON & DR M AHMED	2	0.32%	5811	14.37
DR S N SHARMA AND PARTNER	2	0.32%	n/a	19.56
HATIKAKOTY N	2	0.32%	n/a	n/a
BRAITHWAITE SURGERY	1	0.16%	5127	16.19
DAS DN	1	0.16%	1520	33.09
DR M PAL	1	0.16%	2703	23.5
DR S VASANTH	1	0.16%	2448	33.65
INCE SURGERY	1	0.16%	3256	40.99
INTRAHEALTH LSV	1	0.16%	1823	25.14
BILLINGE MEDICAL PRACTICE	0	0	n/a	n/a
DOUBLET-STEWART MPH	0	0	n/a	27.49
DR ANIS & ANIS	0	0	4837	24.38
DR PATEL, KAMATH & PARTNERS	0	0	7877	31.75
ESA BH	0	0	2766	31.83
MANOR PRIMARY CARE	0	0	n/a	n/a
SEVEN BROOKS PRACTICE	0	0	4105	n/a
ULLAH M	0	0	3350	32.54
No practice recorded	5	-	-	-